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Corrigendum

- PAGE 282. In the Editorial on Rheumatism add the word "not" after "can" in the first line of this Editorial.
- PAGE 283. In the 7th line in para 2, read the word "Aetelogy" as "Asteology".
- PAGE 284. Second Column, 1st para in line 23 insert the word "it" after "what".
- N.B.—As we have to rush to the press whenever we find time we regret many printer's devils escape our notice and the above list of corrections cannot therefore be complete.—Ed.

NOTICE

Readers of The Medical Practitioner are requested to quote the Registered numbers appearing on post-wrappers against their names while corresponding with the Managing Editor as he finds it very difficult to identify the authors of the letters from a huge list of names, especially when names are identical.

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THE

Medical Practitioner

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VOL. VII.]

SEPTEMBER 1936.

[NO. 12

Original Articles

ON ACUTE RHEUMATISM

ABSTRACT OF THE MADRAS UNIVERSITY
ELIZABETH MATTHAI LECTURES 1935.

By

LIEUT-COL. G. R. McROBERT, M.D., F.R.C.P.,
I.M.S.

(Continued from the July issue.)

Lecture Two

Having considered the pathology and aetiology of rheumatism, I pass this evening to its manifestations in children.

You may remember that in my first lecture I referred to the unfortunate association of the term *articular* rheumatism with this disease and how I pointed out that such a term was inapplicable as the joint manifestations are not of primary importance.

The other two terms employed—rheumatic fever and acute rheumatism—are almost equally unfortunate when we are dealing with *children* as the disease is often neither acute nor febrile. It is rather a pity that most text book descriptions of the disease give an account of the manifestations typically seen in adults whereas its occurrence in children is much more common and incomparably more far reaching in its serious results.

It is essentially a disease of child life and it is during the early years that the foundations are laid for the crippling and killing fibrotic sclerosis in the heart which produces its final effects in adult life.

The high remittent fever, the great swelling of joints, the hyperpyrexia and the profuse sweats of adult acute rheumatism

are almost unknown in those under ten years of age.

On the other hand subcutaneous nodules and Sydenhams chorea are almost entirely confined to children in the first decade of life.

Although the great swelling of the joints characteristic of the disease in adults is not evident in children, it is quite common to have a slight degree of joint involvement and it is particularly to be noted that although the amount of swelling is relatively less the acuteness of the pain on movement is even greater than in older people.

A certain amount of confusion sometimes arises between osteomyelitis and rheumatism but in the former disease the constitutional disturbance is as a rule much greater and the tenderness is in the diaphysis and not in the actual joint itself.

There is as a rule no great difficulty in coming to a diagnosis in such cases as show fever, joint pains, tachycardia, subcutaneous nodules but that is not the type which we most commonly find.

The disease in children is typically sub-acute in its onset, chronic and relapsing in its course and the less febrile and more sub-acute the condition the more does the heart tend to be involved.

Many writers have described what they call the prerheumatic stage, but that is a bad term for what is really rheumatic cachexia. The causative agent has already invaded the body and makes its presence evident by changes in the blood which quickly loses a large proportion of its red cells.

The child concerned is usually pale and anæmic, listless and tired—unwilling to join in games with his or her companions restless at night, and with a poor appetite.

Right-sided epigastric discomfort not connected with food has been commonly observed and "growing pains" in the muscles and fasciæ are of every day occurrence.

On examination of the throat a condition of reddening or of chronic sepsis is almost the rule and streptococci can be isolated on culture.

In the first lecture I drew your attention to the close relationship between attacks of acute tonsillitis and the on set of attacks or relapses of rheumatism at an interval of 10—14 days after the attack. On going into case histories in Madras we find such a relationship to hold good here.

Even in comparatively mild cases a careful search for subcutaneous nodules may be rewarded by finding them over some bony prominence, the search being made easier if the skin is put gently on the stretch.

Various skin eruptions or exanthemata may make their appearance—one of the most typical of these being the nodular pretibial rash known as erythema nodosum an allergic skin phenomenon—probably not entirely specific.

The on set of chorea is perhaps the most frequent single sign of rheumatic infection.

Indeed we may find repeated attacks of chorea in a child who shows practically no other signs of rheumatic disease except perhaps a little tachycardia; but it has been quite definitely noted that many such patients in after years develop an insidious mitral affection which proceeds slowly but surely to severe stenosis.

We can be quite certain that with or without adequate treatment the arthritis and chorea will clear up. What we have to concentrate on is the cardiac condition and the treatment and general care must be influenced by the degree of cardiac involvement.

In all suspected and diagnosed cases of rheumatism the medical attendant must make himself familiar with the cardiac condition of each individual patient.

Careful note of the position of the apex beat and of the extent of cardiac dullness on gentle percussion must be made. If possible a two metre radiogram should be taken.

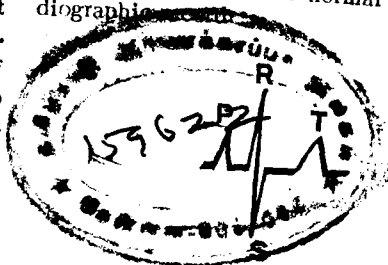
The clinical signs of cardiac involvement include movement downward and outward of the apex beat, an increase in the transverse diameter of the heart and weakening and muffling of the first sound at the apex with an increase in the intensity or reduplication of the second sound at the base.

Particular attention should be paid to the pulse. It is essential to have the pulse taken by a nurse who enjoys the confidence of the child and who, by taking the pulse frequently during the acute stages of the disease, will become so familiar to the child that nervous tachycardia will not spoil results of observations during the convalescent stages.

Nurses must be taught to take pulse readings in sleeping rheumatic children as the sleeping pulse rate is all important as a guide to prognosis and to treat during convalescence.

Although you will have to depend on ordinary clinical examination to guide you in practice we have in graphic records of the electrical changes which accompany each beat of the heart a valuable method of recording damage to the heart of a degree which cannot be detected clinically.

I presume that you are familiar with the general appearance of a normal electrocardiogram.



in which the P wave represents auricular activity, the RST complex that of the ventricles, whilst the interval between the commencement of the P and the R waves represents the time taken for the contraction stimulus to travel from the auricles to the ventricles along that narrow bridge of specialized conducting tissue the auriculo-ventricular bundle of His the only muscular link between the auricles and ventricles. The P. R. interval in healthy persons does not exceed one fifth of a second.

The use of the electrocardiogram confirms early and transient myocardial change when the physical signs have not yet developed. It should be noted however that as the

electrocardiogram chiefly records changes in the conducting system a small inflammatory bone situated at some distance from the conducting system may leave no record on the plate.

Normally the P of auricular wave is small, blunt and rounded. In 50% of cases of acute rheumatism it becomes bifurcated.

The most important point to note however, is the P-R interval. This is prolonged in influenza, bronchopneumonia, typhoid and diphtheria but especially in rheumatism, *a long conduction time occurring in a young subject in whom syphilis and digitalis therapy can be excluded is presumptive evidence of cardiac rheumatism.*

A point of some importance is that it has been noted that salicylates may definitely speed up a delayed conduction time presumably by lessening the inflammatory oedema of the A. V. bundle.

Although the commonest electrocardiographic change in acute rheumatism is delayed conduction and, that merely of a transient nature, all grades of heart block may develop from prolongation of the P-R interval to dropped beats.

Indeed in rare cases complete heart block may be the earliest manifestation of an acute rheumatic process.

Transient intraventricular block may occur with broadening of the ventricular complex and occasionally the isoelectric phase between R-T disappears.

The simple tachycardia of acute rheumatism is generally normal in its site of origin but in quite a number of cases extra-systoles arise from a temporary heightening of sensitivity in some spot in the auricles or ventricles.

A number of workers have reported the occurrence of acute auricular fibrillation, but this is distinctly rare except when induced by unwise digitalis medication.

Pericarditis is much rarer now than it was in the presalicylate days, but careful watch must be kept for the transient superficial friction rub which precedes the effusion of fluid and for Bamberger's sign—dullness tubular breathing at the lower border of the left scapula and over the left lower lobe of lung posteriorly—due to pressure of the distended pericardium and a combination of an inflammatory and collapsed condition in the left lung.

The treatment of an attack is summed up in one word—Rest, and by rest I do not merely mean confinement to bed but complete and absolute rest with the little patient doing absolutely nothing for himself or herself.

Upto 1912 or thereabouts six weeks treatment was deemed sufficient for most rheumatic conditions. Then it was that Poynton commenced his campaign for prolonged convalescence with supervision.

The advent of the Great War hindered progress in Great Britain. It was in America that the first rheumatic homes were set up. There are however numerous special convalescent rheumatic homes and special schools in all the big towns of England.

It is better to inform parents at the very beginning of an attack that the treatment will take at least six months and that the child's general health will have to be looked after throughout years to come.

A fatal result in the first attack is rare though we had an instance in the Hobart ward not long ago. A general severe carditis is usually the result of recurrent attacks of the disease.

In the worst cases the temperature is no guide to the prognosis. In a child with a temperature barely 99° F we may note ashen pallor rapid breathing, and tumultuous precordium and rapidly enlarging liver preceding a fatal result and sudden death when it does occur—generally takes place after a meal.

It is always a serious sign when a rheumatic child at rest or when asleep turns on the face or leans forward on a bed rest.

In such cases opium may calm the distressing restlessness and if possible nursing should be carried out in separate cubicles.

Some of you may remember a little girl of 7 in Hobart ward who used to ask the students not to examine her as it made her breathless. She had a well marked stenosis with a thrill and it required very little excitement to cause tachycardia and venous congestion.

For the relief of acute arthritis the salicylates are still unsurpassed.

The traditional employment of bicarbonate to counteract the toxic effect of the salicylates is not supported by any scientific evidence. It is advisable to push the drug and ten grains may be given every hour to a child of ten.

It has been observed that certain drugs which have a beneficial effect on rheumatic arthritis have also an influence on joint manifestations in serum disease.

Aspirin in adequate dosage for 10—14 days immediately following an injection of horse serum may prevent joint swelling, (but not the urticaria). Acting on this analogy it is now customary to give aspirin in large doses after tonsillitis attacks on the hope of diminishing recurrent attacks of rheumatism and a certain amount of success has attended this method.

Before leaving the salicylates may I remind you of the aphorism.

"A patient suffering from arthritis with fever who is not considerably better after 48 hours treatment by full doses of salicylates almost certainly is not suffering from rheumatic fever."

For the treatment of chronic manifestations it is better to do too little than too much.

A bed with high sides is essential as many choreics are so violent in their movements that they fall out of an ordinary bed. Furthermore the bed-sides should be padded so as to avoid damage from hard knocks.

Aspirin may be given on relatively large doses. I find that that is the favourite drug in most choreics in England supplanting chlorotone which used to be employed by many to quieten the nervous system.

Of recent years Nirvanol—phenyl-ethyl hydrantoin has been introduced chiefly for the choreic manifestations, but has not gained general acceptance as a reliable therapeutic agent. In using it a febrile reaction accompanied by a profuse morbilliform rash is produced and as there is an element of risk in the treatment it is hardly justifiable to take such measures to combat a self limited disease.

Complete rest in bed is undoubtedly the correct treatment for acute stages of rheumatic carditis.

A child's heart gains little by prolonged aimless rest in bed and general tone and mental outlook of the child suffer.

Once the infective process has subsided and the cardiac lesions are stationary there is little fear that a reasonable amount of graduated exercise and running about will produce cardiac failure.

Graduated exercise acts as a tonic to the heart. Tonsillectomy by dissection may be performed when the acute stage is over followed by the administration of large doses of aspirin for ten days.

Signs of rheumatic activity: Much information may be obtained from a study of the general condition—particularly the weight. A steady gain in weight is nearly always a propitious sign, and usually ceases whenever there is an active infection present. Close attention must be paid to the pulse rate which gives the best indication of the actual state of the heart.

Regular pulse charting by the same nurse throughout the child's stay in hospital is the only valuable method.

A persistent tachycardia over 100 beats per minute both when the child is awake and asleep is usually a sign of active disease and a recrudescence of the infection is often foreshadowed by a gradual quickening of the pulse.

Observation of the pulse during sleep is the deciding factor and if the heart is found to be beating at a lower and normal rate the excitable action by day is of no consequence.

Pallor and fatigue and oral temperature over 99 are indications for bed.

The measurement of the sedimentation rate of the red blood corpuscles in a standardized column of citrated blood—a method originally introduced by Fahraeus is valuable as an indication of the activity of the disease.

As in tuberculosis its value is solely that of an indication of activity—It is not a diagnostic measure, as the sedimentation rate deviates from the normal figure in pregnancy and in many diseases of very diverse natures.

If accurately performed however by an expert from time to time in the same case its value as an indicator of progress is undoubted.

When the physical signs in the heart have remained unaltered for some months, the child is getting stronger, gaining weight steadily, and desiring more freedom the time has come to consider whether complete rest in bed need be continued.

The patient may be allowed to get up gradually and to move about in stages.

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If he ceases to gain weight, loses appetite and becomes overtired during the day or sleepless at night, the limit has been overstepped.

Step by step we ought to train the heart to a life of gradually increasing activity.

Stress must be laid on the necessity for good food and fresh air during convalescence and also for the removal of any factors such as pathogenic protozoa, helminths which in this country retard recovery from so many different conditions.

I do not pretend that rheumatism in children is a major medical problem here as it is in England, but we have all, I feel sure, seen quite a number of tragic examples of the results of neglected subacute rheumatism. Such a one will be found now in the corner of Havelock ward, a child of less than 12 years of age with a failing heart and a history of repeated attacks of tonsillitis subacute rheumatism.

(To be continued).

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2	" G. Ramamurthi	Govt. Hl., Udayagiri	King Institute of Preventive Medicine, Guindy.
3	" L. V. Jagannadha Rao	Tk. Hd. Qrs., L. F. Dy., Addadigala	Tk. Hd. Qrs. L. F. Dy., Srungavarapukota, Vizag Dt.
4	" M. Anandan	Govt. Hd. Qrs. Hl., Calicut	Govt. Hd. Qrs. Hl., Cuddalore.
5	" R. Krishnamurthi	Govt. Hl., Cuddalore	Police Hl., Vellore.
6	" P. V. Krishna Iyer	L. F. Dy., Thondamuthur	L. F. Dy., Palladam.
7	" T. N. Nilakanta Ayyar	Govt. Hd. Qrs. Hl., Palamcotta	Leave Cancelled, Palamcotta.
8	" V. Venkataramanjulu Naidu	Govt. Hl., Palmaner	Govt. Mental Hl., Madras.
9	" V. N. Narayana Iyer	Govt. Hd. Qrs. Hl., Mangalore	Barnard Instt. of Radiology, Madras.
10	" Miss. K. Visalakshi	Rajah Mirasdar Dt. Hd. Qrs. Hl., Tanjore	Govt. Hl., Rameswaram.
11	" Mrs. S. Cyriacose	Govt. Hl., Rameswaram	Raja Mirasdar Dt. Hd. Qrs. Hl., Tanjore.
12	" Venkataramaswami Pantulu	Govt. Hl., Tadpatri	Govt. Hl., Palmaner.
13	" O. Krishnan Nambiar	Govt. Hd. Qrs. Hl., Madura	Leprosy Officer Group V Districts at Madura.
14	" B. S. Sahasranamam	Leprosy Officer Group V Districts at Madura	Govt. Hd. Qrs. Hl., Madura.
15	" M. Venkataratnam	Govt. Hl., Done.	L. F. Dy., Thondamuthur.
16	" K. Kunhiraman Nambiar	Penitentiary, Madras	L. F. Dy., Tiruvotthiyur.
17	" S. Somasundaram Pillai	Tk. Hd. Qr., L. F. Dy., Jayankondasholapuram	Govt. Hl., Nagapatam.
18	" I. P. Sankara Menon	Govt. Hd. Qrs. Hl., Ootacamund	Govt. Hl., Coonoor.
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20	" K. P. Chidambaram	L. F. Dy., Aravakurichi	Police Hl., Malappuram.
21	" P. K. Kumaran	Police Hl., Malppuram	L. F. Dy., Aravakurichi.
22	" P. Kunhambu	Police Hl., Malappuram	L. F. Dy., Mimisal.
23	" Mrs. S. Thomas	—	Lady Goschen Hl., Mangalore.
24	" Mrs. K. Kunjumalu Kave	Lady Goschen Hl., Mangalore	Govt. Hl., Puttur.
25	" Miss. A. Mathew	Govt. Hl., Narasapur	Govt. Hd. Qrs. Hl., Ellore.
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27	" A. Achyuthan	Tk. Hd. Qrs., L. F. Hl., Bhavani	Police Hl., Coimbatore.
28	" V. Gnanayya	L. F. Dy., Murungapuri	L. F. Dy., Aravakurichi.
29	" P. K. Kumaran	Police Hl., Malappuram	L. F. Dy., Murungapuri.
30	" S. Vaidyanathan	L. F. Dy., Punganur	L. F. Dy., Tirunpanandal.
31	" Mrs. Pushpam Aaron	Govt. Hl., Cochin	Re-posted. (to same place).
32	" Mrs. Kaveri Krishnamurthi	Govt. Hl., Cochin	Govt. Hl., Manjeri (re-posted)
33	" Mrs. E. Jayamma	King George Hl., Vizagapatam	Tk. Hd. Qrs. L. F. Hl., Pithapuram.
34	" Mrs. Nandamma Moses	Govt. Hl., Nandigama	Govt. Hd. Qrs. Hl., Masulipatam
35	" P. S. Sankaranarayana Iyer	L. F. Hl., Porayar	Tk. Hd. Qrs. L. F. Dy., Mannilam
36	" R. Ramachandran	L. F. Dy., Kanekal	Tk. Hd. Qr., L. F. Dy., Sulurpet.
37	" K. V. Suryaprakasa Rao	L. F. Dy., Porumamilla	Leprosy Officer, Group II Districts at Bezwada.
38	" H. Munjanath	Leprosy Officer Group II Districts of Bezwada	Govt. Hd. Qrs. Hl., Mangalore.
39	" S. V. Ponniah Avl.	L. F. Dy., Batlagundu	Tk. Hd. Qrs. L. F. Dy., Nannilam
40	" K. V. Rajagopal	L. F. Dy., Bungalowpudur	At the disposal of the Principal, Forest College, Coimbatore.
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43	" M. Venkobachar	L. F. Dy., Kurugodu	Tk. Hd. Qrs. L. F. Dy., Kudligi
44	" D. V. Moser Avl.	Govt. Hl., Nuzvid	Govt. Hd. Qrs. Hl., Nellore.
45	" Miss. T. M. Sundari Bai	Govt. Hl., Palakonda	& then to Govt. Hl., Kandukur Govt. Hl., Parvathipuram

List of Postings of Sub-Asst. Surgeons for the months of August-Sept.—Contd.

No.	Names of Sub-Asst. Surgeons.	From.	To
46	„ Miss. H. Rukmani	—	Lady Willingdon Medical School for Woman, Madras
47	„ Miss. K. M. Lakshmi Amma	—	Govt. Hl., Kollegal.
48	„ Miss. Vedavalli Thayar	—	King George Hl., Vizagapatam.
49	„ I. V. Narasimham	L. F. Dy., Sodam	Posted to same place on expiry of leave.
50	„ M. V. Ramaniah Chetty	L. F. Dy., Sodam	L. F. Dy., Kanekal.
51	„ Mrs. T. Vaiyanathan	Govt. Hl., Gudiyatham	Govt. Hd. Qrs. Hl., Cuddalore.
52	„ Mrs. D. Maturanayagam	Govt. Hd. Qrs. Hl., Cuddalore	Govt. Hl., Gudiyatham.
53	„ Mrs. Chellamma Nilakantan	Govt. Hl., Negapatam	Queen Alexandra Hl., Salem.
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55	„ R. Krishnamurthi	Govt. Hd. Qrs. Hl., Cuddalore	Police Hospital, Vellore.
56	„ Mrs. D. Mathuranayagam	Govt. Hd. Qrs. Hl., Cuddalore	Govt. Hl., Tindivanam.
57	„ Mrs. O'Gray	Govt. Hl., Tindivanam	Govt. Hl., Gudiyatham.
58	„ K. N. Subramaniam	L. F. Dy., Kaveripatnam	Govt. Hl., Dharmapuri.
59	„ N. G. Subramania Iyer	Govt. Dy., Paderoo	L. F. Dy., Orattanad.
60	„ K. R. Parthasarathy	Govt. Hd. Qrs. Hl., Chittoor	Stanley Medical Schl. Madras.
61	„ D. V. Moses	Govt. Hl., Nuzvid	Tk. Hd. Qr. L. F. Dy., Kovur.
62	„ Y. V. Basaviah Naidu	Tk. Hd. Qrs., L. F. Dy., Kovur	Govt. Hl., Kaudukur.
63	„ S. V. Ramaniah	Tk. Hd. Qrs. L. F. Dy., Tirutani	Govt. Hd. Qr. Hl., Chittoor.
64	„ K. Rajamannar	Group Leprosy Officer Chittoor	Govt. General Hl., Madras.
65	„ A. Venkataramana	L. F. Dy., Yerrakondapalam	Govt. Hl., Conjeevaram.
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73	„ P. Raman Nair	Govt. Hl., Erode	Govt. Hd. Qr. Hl., Mangalore.
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78	„ L. Veeraswami	Govt. Hd. Qrs. Hl., Cuddapah	Bernard Institute of Radiology, Madras for X ray training.
79	„ N. Sreeramulu	L. F. Hl., Kurupam	Tk. Hd. Qr. L. F. Hl., Salur.
80	„ B. Krishnayya Naidu	Tk. Hd. Qr. L. F. Hl., Salur	Govt. Hl., Penukonda.
81	„ V. Sivasambu	Govt. Hl., R. Udayagiri Gunjam Agency	Raja Miras Dt. Hd. Qr. Hl., Tanjore.
82	„ R. V. Narasimham	Govt. Hd. Qrs. Hl., Chittoor	Tq. Hd. Qr. L. F. Dy., Vayalpad
83	„ S. Hanumantha Rao	Tk. Hd. Qr. L. F. Dy., Vayalpad	Govt. Hd. Qr. Hl., Chittoor.
84	„ V. Kameswara Rao	Tk. Hd. Qr. L. F. Dy., Cumbum	Tq. Hd. Qr. L. F. Dy., Sidhout,

To be continued.

ACUTE PERFORATION OF THE STOMACH AND SMALL INTESTINE

BY

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Cases of acute perforations of the stomach and small intestine are generally diagnosed very late and the surgeon sees these cases only after marked general peritonitis has set in. Early and correct diagnosis is very important in these cases and morphia should not be given in these cases before a proper diagnosis is arrived at. Prognosis is good in early cases—hence the need for an early correct diagnosis. Immediate operation is the only course to be adopted and no conservative or palliative methods should be encouraged.

In this lecture, I am considering only the commoner types of perforations met with and mostly the pathological varieties, only touching upon the traumatic conditions here and there.

The commonest cause of pathological perforation of the stomach, and with this is included the first part of the duodenum for all practical purposes, is a chronic ulcer. Perforation is the most serious complication of gastric ulcer. It is very difficult to estimate the incidence of perforation in these cases, but some give it as even 5%. It is most commonly due to a chronic ulcer, but rarely, may be due to an acute ulcer. Males are more often affected and perforation occurs at an earlier age in women, when compared to men.

Perforation occurs more often in ulcers situated on the anterior wall of the stomach, nearer the lesser than the greater curvature and nearer the pylorus than the cardia. An ulcer on the posterior surface of the stomach perforates into the lesser sac. Very rarely, two or more perforations are found and this must be borne in mind.

IMMEDIATE CAUSE of perforation is the separation of a slopgh or the spread of the ulceration. The ulcer which till now was chronic and indolent rapidly spreads for some unknown reason. There is a history of a sudden strain or some mechanical violence as the cause in some cases.

Perforation is *acute* when the giving way of the ulcer leads to the contents of the stomach being poured forth into the general peritoneal cavity.

In *subacute* perforation either the stomach is empty or the extravasation is limited by adhesions to the abdominal wall, under surface of the liver or the omentum. In this type of case recovery without operation may occur if the patient is kept starved and at rest. Chronic perforations lead to perigastric and sub-phrenic abscesses.

The size of the actual perforation varies from a pin-point to an opening of the size of a four anna piece—it is usually about the size of a pea. The tissues for half an inch all around are usually oedematous, swollen and covered with flakes of lymph, while the amount of surrounding induration and hardness will depend upon the condition of the ulcer previously. In acute ulcers very little induration is present.

Immediately after perforation, gastric juice and food matter escape into the peritoneal cavity and run down into the pelvis, usually in front of the great omentum and give rise to intense irritation. As a result of this irritation, fluid is poured out into the peritoneum, at first clear in character, but soon containing flakes of lymph, which make it yellowish, while recognisable food materials may be seen in it. Rarely the peritoneal cavity is found to contain castor oil which had been administered to the patient, the perforation having been mistaken for intestinal colic.

For some hours, the peritoneum is in an acute stage of irritation—it being a chemical peritonitis to start with, but after 8 or 10 hours, infection sets in and peritonitis gradually supervenes with its classical pathological appearances.

CLINICAL SIGNS AND SYMPTOMS OF ACUTE PERFORATION.—In most cases, there is previous history, at any rate for some months, usually for much longer, characteristic of a gastric ulcer though only in a few instances has perforation occurred without any previous warning. Sometimes there is exacerbation of the previous symptoms for a few days before the perforation.

There is a sudden onset of intense, stabbing pain, “an indescribable agony”, as Moynihan puts it, situated first of all over the site of the ulcer, but soon radiating all over the abdomen and down whichever side

of the abdomen the ulcer lies. The patient may fall down or cry out with it and nearly always lies still, flat on his back and is not restless. He does not writhe about as in a case of colic. He may vomit once or twice but often experiences only nausea. The pain may have come on immediately after a meal or might have followed some exertion. The most important thing to note is that the pulse is normal. The rate is 80 and the blood pressure is within normal limits. This is a very important practical point to bear in mind in diagnosing a case of perforation. There are no signs of shock. The temperature may be subnormal at first. On examination, the abdomen is acutely tender, especially in the epigastrium, it does not move freely with respiration, the abdominal muscles are rigid and hard, like a board, their tight contraction often causing the abdomen to retract and present a scaphoid appearance. The liver dullness is lost only in a small percentage of cases and is an inconstant sign.

The initial severe pain passes off usually in less than one hour. The patient feels better, he thinks he has got over the attack, is able to walk about often and goes about his usual work or at least tries to. This is termed "the stage of Delusion". However, if the abdomen is examined at this stage, the local rigidity and tenderness persist and this should prevent any errors in diagnosis.

THE THIRD STAGE IS THAT OF PERITONITIS.—From about a few hours after the perforation, the pulse gradually rises, becoming weak and thready, the temperature is elevated one or two degrees above normal, and the blood pressure falls. Rigidity and tenderness become widespread and vomiting becomes more insistent. Distension occurs from ileus, the respiration becomes thoracic, and the patient's face becomes haggard with sunken eyes and an anxious appearance. If untreated, death occurs within three days.

DIAGNOSIS.—There is not much difficulty in the diagnosis of the majority of cases of acute peritonitis. Sometimes no definite diagnosis can be made in a catastrophe of the upper abdomen but these are cases in which the correct treatment is operative, e.g., perforation of the gall bladder or acute pancreatitis. These may be indistinguishable from a perforation of the stomach.

There is one definite syndrome in which the perforation of a duodenal ulcer resembles an acute appendicitis. In these cases the extravasated fluid runs down on the outer side of the ascending colon to the right iliac fossa and then to the pelvis. The rigidity and tenderness are most marked in the right iliac fossa, but nevertheless the rest of the abdomen is also rigid and tender, though to a less extent. On opening the abdomen in these cases, suspecting them to be cases of acute appendicitis, the appendix is found to be red and inflamed on the outside, probably with few flakes of lymph round about but there are no dense adhesions about the appendix which one expects to find if the appendix is primarily the seat of inflammation. On exploring a little further, yellowish fluid is seen welling from the right iliac fossa and pelvis. There are many more adhesions above, the omentum trying to wall off the infection in the upper abdomen. On extending the incision above, the perforation becomes evident. Biliary colic and acute intestinal obstruction have sometimes to be differentiated.

PROGNOSIS entirely depends on the time that elapses between the perforation and the time of operation. Within six hours the prognosis is fairly good, but every hour afterwards adds to the mortality. I have operated on 8 cases of perforation of the stomach and duodenum and of these only 2 recovered,—(a mortality of 75%) one of 6 hours' duration and another of 10 hours'. All the others were of more than 12 hours' duration, some even of 48 hours' duration. Once marked general peritonitis sets in, the mortality is practically 100%.

Hence the value of early and correct diagnosis and speedy treatment.

Treatment.—Abdominal section should be done immediately; no time should be lost in waiting for the shock to pass off, as the condition becomes worse as the peritonitis is spreading. The abdomen is opened by a right para median incision. On opening the abdomen, a little hissing sound due to gas escaping, may be heard; an yellowish fluid slightly bile-stained, oily, in appearance as if there are a number of fat globules floating in it, is typical of gastric perforation. In duodenal perforation, it is more greenish, due to a greater amount of bile. The peritoneum is acutely inflamed and

flakes of lymph may be found floating in the fluid. There are adhesions in the region of the ulcer, the great omentum trying to wall off the site of the perforation from the general peritoneal cavity. The stomach in these cases is generally markedly distended, with more of gas than of liquid. On palpating the stomach, the indurated region of the ulcer can be made out and on gently drawing the stomach down, the site of perforation is easily found, fluid and gas welling out of the stomach through the perforation, sometimes in such enormous quantities that it is a job to keep the site of perforation clear of this fluid.

If the ulcer is not seen on the anterior surface, an opening should be made in the gastro-colic omentum, and the posterior surface of the stomach examined. If there is a perforation here, the lesser sac will be filled with gastric fluid. Rarely there is a perforation in the 2nd part of the duodenum.

METHOD OF CLOSURE OF THE PERFORATION.—The perforation is brought into the best possible view by means of traction upon the stomach aided by retractors at the edges of the wound.

The closure can be effected by a continuous or interrupted suture. The first suture is placed at a little distance from the perforation on either side and this is tied and acts as a very efficient retractor. The next suture is passed and tied in the same way. If the perforation is of a very small size, a purse string suture can be applied. The area around the perforation is oedematous and there is a great liability for the sutures to cut out. A second inverting layer of stitches is usually employed. After the perforation is closed, a tag of neighbouring omentum can be brought to reinforce it. This is easily done in the case of a duodenal perforation. Very rarely when the perforation is large and closure is unsatisfactory, a free omental graft can be patched over the perforation. After the perforation is closed it is worth spending a few seconds looking for a second perforation.

POSTERIOR GASTRO-JEJUNOSTOMY.—Some advocate it as a routine. It is best not to do it. The patient is already in a state of shock and a gastro-jejunostomy certainly adds to the shock and length of the operation. Closure of the perforation is quite enough and in the case of an acute

abdomen, nothing more than what is necessary to save the life of the patient should be done.

DRAINAGE.—Within six hours it is not necessary. After that it depends on the individual case. The abdomen is drained suprapubically. For late cases of perforated duodenal ulcer, a second tube in the right flank to drain Rutherford Morrison's pouch is necessary.

In the *Stockholm surgical clinic*, gastrostomy as a routine is done in all these cases. The advantage is that it does away with the discomfort of thirst; the patient drinks any amount of fluid and this is let out of the stomach by unfastening the clip on the gastrostomy tube. Vomiting also can be prevented by evacuating the contents of the stomach through the gastrostomy tube.

AFTER HISTORY—The patients are free from symptoms for 6 months to 2 years but then they get the pain. Often a gastro-jejunostomy can be done afterwards.

ACUTE PERFORATION OF THE SMALL INTESTINE

The two common causes of perforation of small intestine as we see it here are (1) traumatic and (2) perforation of a typhoid ulcer.

I shall consider the first one briefly and only those cases without any external wound on the abdomen.

Traumatic perforations may be one or more in number. It is very difficult in these cases to diagnose a traumatic perforation in the very early stage; one should not wait for definite signs of peritonitis to set in before performing laparotomy in these cases. It is far safer to look and see than wait and see in these cases. All cases of injury to the abdomen should be closely watched and repeated examinations at short intervals, say every 5 or 6 hours should be made. There should be an hourly pulse chart in these cases. Cases of injuries to the abdomen should not be treated as out patients. Even if there is the slightest suspicion of injury to the abdominal organs, the patients should be admitted and kept under close observation. Even in a case of contusion only to the abdominal wall, there is rigidity and tenderness all over the abdomen and it is difficult to be sure that there is no injury to any of the internal organs. The single sign of a need for a laparotomy in these cases is

a rising pulse rate. That is why an hourly pulse chart is very helpful. If the pulse rate has risen by about 20 in about 3 or 4 hours, then a laparotomy is immediately indicated. Auscultation of the abdomen reveals no peristaltic waves and the heart sounds are heard all over the abdomen. The demonstration of free gas by the loss of liver dullness is possible only in certain cases.

Often on opening the abdomen in these cases, the perforation presents itself in the wound; otherwise the portion of the intestine lying underneath the part of the abdomen injured should be examined. As there is a great likelihood of multiple perforation, the gut above and below the site of perforation should be examined for some length. Systematic examination of the whole gut, a few inches at a time should be done in cases where the perforation is not evident.

The appearance of a traumatic perforation is very characteristic. The perforation has a pouting appearance with the mucous membrane everted and protruding well beyond the perforation in the serous coat.

Traumatic perforation occurred only once out of 8 cases that I have operated on for acute perforation of the small intestine during last 2 years. This case was that of a small boy who came to the O. P. department with a history of having fallen on some object, but was sent home. Next day he came in with symptoms of general peritonitis. There were two perforations in this case.

In all the cases, the abdomen should be explored to see if the other viscera have also been injured.

Treatment.—If a single tear is found, it is closed by a double row of sutures—an inner through and through and an outer seromuscular—the suture line running at right angles to the long axis of the bowel so as to avoid narrowing of the lumen of gut. More extensive lesions may necessitate the resection of the bowel with lateral anastomosis.

2. **TYPHOID PERFORATION.**—This is said to occur in 3% of cases of typhoid fever. Perforation generally occurs in the third week of the fever. Two of the cases that I operated on were those of patients who were admitted into the Hospital on the 16th

and 17th days of the fever, and curiously both developed perforation, on the night of the admission—the patients belonging to the very poorest class. My own impression is that perforation occurs more often in those cases of typhoid fever which have not had proper treatment and good nursing in the early stages, and also possibly in other cases where indiscretion in diet may lead to distension of the gut bringing about perforation of the already softened and inflamed Peyer's patches. Still in a good number of cases no definite cause can be adduced. Occasionally perforation is the first indication of the disease—ambulatory typhoid.

The perforation is usually quite small—it may be multiple, but situated close together. It is found in the lowest 3 feet of the ileum. There is no zone of induration around the perforation while the Peyer's patches are found to be very much inflamed and thickened. Perforation generally occurs on the anti-mesenteric border where the blood supply is poorest. The size of the perforation varies—it may be just a pin-point; in one case it was nearly $\frac{1}{4}$ inch long—just like a tear.

SYMPTOMS.—The patient is in a typhoid state at the end of the 3rd week, desperately ill. Early cases of perforation can be diagnosed only by keeping a close watch on the abdomen in all cases of typhoid, especially in the 3rd week. Any distension of the abdomen or pain in the right lower quadrant should at once be attended to.

There is a fall of temperature and rise in pulse rate and collapse. There may be abdominal pain and tenderness but the patient may be too toxic to call attention to it in the early stages. Local pain and dullness on the right side of the abdomen, with tenderness and rigidity most marked in the right lower quadrant of the abdomen are always suggestive of perforation. A rising W. B. C. count strongly suggests perforation.

Treatment.—The only treatment is immediate operation which is best done under local anaesthesia. The caecum and the lower ileum are examined. The perforation may be difficult to find but adherent flakes of lymph will point it out. The coil of gut containing the perforation is held between clamps while the perforation is

closed by a Lembert suture and an omental graft is stitched over it. If the perforation is a very small one, a purse string suture is the best. Often one meets with suspicious areas which appear to be threatening to perforate and these should also be treated similarly. The peritoneal cavity is drained if necessary. The mortality with operation is 75% and without operation 95 %.

Abstracts

TREATMENT OF DELIRIUM TREMENS

Preliminary Report of One Hundred and Fifty Consecutive Cases

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That a considerable mortality rate is associated with delirium tremens is a fact which is frequently overlooked by the practising physician. In a survey of the available literature as far back as 1910, one finds that the statistics concerned with delirium tremens show a wide range of mortality figures, the peak being reached in a reputable Boston Clinic which reported 37 per cent. Recently the death rate has diminished considerably, undoubtedly due to more intelligent treatment of these cases; so that the mean mortality in the past ten years has been approximately 10 to 12 per cent. It is because rational management of this disease has apparently produced favourable results generally, and in the hope of stimulating an effort to bring about a further reduction in the death rate, that this report is being made.

Because of the traditional negligence with which medical statistics are usually compiled, it is not possible to evaluate accurately a comparison between the results reported by other clinicians and those accomplished by us in the Psychiatric division of the Cincinnati General Hospital during the past three and a half years. Nevertheless, that our cases offered no better prognosis on admission than did those concerning whom reports have been made from other clinics is suggested by the probability of a nutritional caliber which is lower in patients admitted to the General Hospital than in

the general population, the probability of a greater incidence of other coincidental pathologic processes in our patients, and the fact that (because of the crowded conditions at the hospital) only those individuals are admitted by the Receiving Ward physicians who are considered definitely too ill to be cared for elsewhere. With these factors in mind, we feel that our crude death rate of 5.3 per cent is significant, and that our method of accomplishing this reduction merits consideration by those physicians who are called upon to manage patients with delirium tremens.

This report has to do with one hundred and fifty consecutive cases which were admitted to the Cincinnati General Hospital from July 1, 1934, to July 1, 1935. We have, over a two year period, conducted a survey which includes approximately three hundred patients. We are limiting this report to one hundred and fifty cases because we have not yet completed our statistical investigation into the entire group. It may be mentioned, however, that the mortality figures for the entire group are practically identical with those given for the one hundred and fifty cases under discussion this evening.

The cases included in this series were limited to those concerning whom there could be no question as to diagnosis. Patients with impending delirium tremens were excluded, though they received the same treatment as did the active cases. The presence of a complicating disorder—pneumonia, fracture, gastric hemorrhage, etc.—was not considered a significant factor in the selection of patients; so that the sole prerequisite to inclusion in this series was the definite diagnosis of active delirium tremens, regardless of what other pathologic process might be co-existent.

The treatment that we employ involves no principal or medication that is essentially an innovation. We have culled over the therapeutic suggestions that have been made by various physicians, and have attempted to organize therefrom a regime which would include the more rational and effective measures of each, which were possible of accomplishment in the circumstances under which we find ourselves at the Cincinnati General Hospital. We realize that our management of these cases permits of improvement in a more ideal environ-

ment; and we feel certain that with more adequate physical equipment, more nursing help, and increased latitude as to available medicaments, both our mortality rate and the average stay of such cases in the hospital could be further diminished.

We shall not go into the pathology, actual or conjectural, of delirium tremens. In considering this disease therapeutically, however, we need to remember that in delirium tremens we are dealing with a condition characterized by physical intoxication and by mental and physical excitement. Our therapy should have as its aims the speedy elimination of whatever toxins are present and the protection of those organs and physical functions which might be damaged by the intoxication, together with an amelioration of the excitement and the protection of the patient against the possible untoward results of abnormally great activity. The treatment, then, may be discussed under five main heads:

1. The safeguarding of the patient against injury to himself or to others.
2. The prevention of exhaustion.
3. The promotion of elimination, both gastro-enteric and urinary.
4. The decrease of intracranial edema and pressure.
5. The promotion of adequate nutrition.

SAFEGUARDING THE PATIENT—Anyone who has had the opportunity to spend some time with an active delirium tremens patient can readily understand how the patient's apprehension, hallucinations, and delusions might cause him to injure himself, perhaps fatally, in an attempt to escape the creations of a delirious brain; or how he might injure others in trying to defend himself against his imagined torturers. It is practically impossible, in most instances, to provide constant observation and protection for such a patient outside of an adequately equipped and staffed hospital. The physician in charge of such a case would be wise, both for the sake of the patient and in order to protect his own interests, to insist on hospitalization. Not long ago, on one of the surgical wards of the General Hospital, a fortunately robust nurse managed to grasp and hold on to the ankles of a patient who had developed delirium tremens after admission and who had started a dive

through an open third-story window. Incidents of this sort are sufficiently common to justify exercising the utmost in anticipatory caution in the handling of these cases.

PREVENTION OF EXHAUSTION—This phase of the treatment may be subdivided into two lanes of approach, both of them of considerable importance. Of the eight deaths occurring in this series of cases, four presented serious complications—the first, suppurative parotitis and bronchopneumonia; the second, severe gastric hemorrhage and lobar pneumonia; the third and fourth, heat stroke—complications which might of themselves, without the alcoholic factor, have caused the deaths of the patients. The other four cases were characterized clinically chiefly by signs of cerebral inflammation and by heart failure. We regret that of these eight fatalities, only two autopsies were obtained. In each of the two cases on which post-mortem examination was possible, however, one of the most prominent findings was that of a pronounced toxic myocarditis. It is our feeling that one of the main causes of death in uncomplicated delirium tremens is heart failure, both of itself and indirectly because of the increase in toxicity and impairment of organ function generally that is incident to an inadequate circulation. It is not difficult to understand how this failure may occur when we consider the actual intoxication of cardiac musculature that is present, and the additional strain that is placed upon an already intoxicated heart by the patient's excessive activity. In an attempt to anticipate the occurrence of such failure, we have inculcated into our routine treatment complete digitalization of the patient. It is our custom to begin digitalization of these cases immediately the diagnosis is made, to digitalize them completely in from thirty six to forty-eight hours, and then to administer a maintenance dose daily until recovery from the delirium tremens has been accomplished. In addition, the hypodermic caffeine and intravenous glucose that we give have as one of their purposes the re-enforcement of circulatory efficiency. Among the other drugs suggested by some clinicians for circulatory support are strychnine, camphor, strophanthus, and ergot. We have had no experience with these medications in deli-

rium tremens, so that we are not prepared to comment on their value. We feel quite strongly, however, concerning the advisability of cardiac medication; and it is our belief that this part of our treatment has played a large part in the diminution of our death rate. To give digitalis to these patients only after signs of heart failure have become manifest has proven, in our experience, of little avail. When the heart begins to fail in delirium tremens, the downhill course is usually rapid and the patient is overwhelmed to the stage of being unable to react favourably to medication of any sort.

The second item under the prevention of exhaustion is sedation. It is well known that if the delirium tremens patient can relax into sleep for six or seven hours, the disease is well on its way to being overcome. The obtainance of this sleep, however, is no simple matter. A search through the literature for recommended sedative measures in delirium tremens elicits a list that rivals the pharmacopeia as to all-inclusiveness, from morphine to hydrotherapy, and from the injection of magnesium sulphate intra-spinally to soothing reassurances. One writer recommends the use of a cluster of blue lights in an otherwise dark room. Another would have us take a bucket of tepid water, heavily impregnated with salt, and dash it over the patient. These latter two procedures go back many years. The more recent suggestions as to sedative methods are more specific medicinally; but they are so varied that one cannot but conclude that the problem of sedation in delirium tremens is still for the most part unsolved. In general, when choosing a sedative for these cases, it is well to remember that we are dealing with individuals who are already intoxicated, whose circulatory efficiency needs to be stimulated rather than depressed, and whose kidney function is fairly frequently impaired to some degree so that elimination of the sedative via the urine is not to be relied upon to too great an extent. We have found paraldehyde, administered orally or rectally, the most innocuous, the most rapidly eliminated, and the most uniformly effective of the sedatives available at the hospital. Despite its unpleasant odor and taste, we have encountered little objection to its ingestion on the part of our patients. The barbiturate group—orally, hypodermically, or intramuscularly—in ordinary

doses have seemed to have practically no sedative value; and we have hesitated to give representatives of this group in repeated large doses because of the depressing effect on the circulation.

When all of our routine measures have failed to secure rest in a patient, we have occasionally administered one dose of sodium amytal intravenously, to the extent of from ten to fifteen grains, with fairly good results. Because our use of this drug is limited by the small supply available at the hospital—it is relatively expensive—we have employed it only as a last resort. Using it thus in those cases who were most refractive to ordinary sedative measures does not justify a comparative evaluation as to its efficiency. It is quite possible that were one dose of sodium amytal given routinely and early, it might induce therapeutic sleep considerably sooner than do the usual sedatives.

Another procedure which has a certain amount of indirect sedative effect is spinal fluid drainage. Lumbar punctures are done routinely in our cases at the beginning of their stays in the hospital. When a delirium tremens patient shows no sign of improvement within forty-eight hours after treatment is instituted, a second lumbar puncture with drainage of the spinal fluid will not infrequently diminish his restlessness sufficiently to permit him to sleep. In the same category—namely of procedures tending to promote rest by reducing intracranial pressure—are the administration of intravenous glucose, the intramuscular and oral magnesium sulphate, and the hypodermic caffeine, concerning all of which we will say a few more words later.

It has been our custom to be quite cautious in the selection of sedative medication. We are aware that bromides, chloral, avertin, and other compounds have been warmly recommended, and are indeed in more or less common usage by physicians who report good results. Our policy, however, has been to avoid in so far as is reasonable the possibility of adding insult to already injured tissues. So that we abstain from chloral because of the likelihood of an already intoxicated heart; from avertin, because of the comparatively great incidence of liver disease in chronic alcoholics; from bromides because the large doses necessary to be effective occasionally may

produce intoxications in their own right, etc. It may be that we are overly careful; but on the other hand, it is possible that our elimination of most of the commonly used sedatives has had something to do with the lowering of our death rate.

We would like, at this point, to stress the contraindication to morphine that exists in the management of these cases. It has been definitely established—by Foster Kennedy, among others—that morphine increases intracranial pressure. A case in point is included in this series. The patient was admitted to the Medical service suffering from profuse gastric hemorrhage, probably ulcerous etiologically. He has given morphine, quite properly, every four hours for twelve doses, after which he developed delirium tremens and was transferred to the Psychiatric service. On lumbar puncture, 150 cc. of spinal fluid under exceedingly great pressure were obtained; and the interne withdrew the needle, not because of a diminution in the flow, but because he was, as he said, “afraid to remove more fluid.” The next day 65 cc. were obtained, and on the third day 75 cc. The probability of a casual relationship between the morphine this patient had received and the amount of spinal fluid obtained from him—the largest amount we have been able to remove from any alcoholic admitted to our wards,—is to be considered quite pertinent. That morphine increases the chances of death in a case of delirium tremens is not to be doubted. On the Psychiatric service of the General Hospital, the cardinal sin that can be committed by an interne is the ordering of morphine for a case of delirium tremens.

There is one other procedure calculated to promote rest which is to be highly recommended in cases of this type, though we have been unable to include it in our regime because of lack of facilities and a paucity of personnel. We refer to the use of hydrotherapy, which has been reported quite helpful, and which offers a method of sedation which adds not at all to the patient's toxicity.

Also worthy of mention at this point is the contraindication to mechanical restraint, except as it may be necessary as part of a hydrotherapeutic maneuver. A sufficiently numerous staff of nurses and orderlies, together with the use of hydrotherapy, would practically eliminate the

need for shackles, restraining jackets, etc. On our wards, because of our limited facilities, it is almost routine to shackle cases of delirium tremens. With us it is the lesser of two evils. We feel that could we make this unnecessary, we would remove what is definitely a physical and emotional irritant, and consequently increase the patient's chances for recovery and shorten his stay in the hospital.

PROMOTION OF ELIMINATION—We need not dwell long on the obvious importance of elimination. To rid the bowel of any accumulated sources of toxicity and for general purgative measures, a single dose of cascara followed by daily doses of magnesium sulphate are recommended. In addition, it is necessary to maintain an active kidney function in order to eliminate as rapidly as possible the accumulating products of a disordered metabolism. Here the caffeine, the intravenous glucose, and in some measure the digitalis provide the necessary diuretic stimuli.

DECREASE OF INTRACRANIAL EDEMA AND PRESSURE—That there is an irritation and edema of the brain and meninges, and an increase in intracranial pressure in delirium tremens has been demonstrated clinically and in the autopsy room sufficiently often to need no further discussion at this time. It is exceedingly important that we combat these pathologic conditions as intensively as possible: first, because of their existence per se; and secondly, because sedatives are much more likely to be effective where the brain is less toxic and irritable. The most simple direct method of decreasing intracranial pressure is by spinal fluid drainage. We recommend that this be done as soon as possible, and that the fluid be allowed to escape slowly until the drops are quite far apart. Although the edema of the brain is not always reflected by an increase in spinal fluid pressure in delirium tremens, we feel that the drainage of as much fluid as is readily removable, be it 5 or 50 cc., is likely to be of some aid. Concerning the factor of safety in the complete reduction of pressure by the removal of as much fluid as possible, we can report that in the approximately fifteen hundred cases of acute alcoholism and delirium tremens that we have treated in the past three and a half years, the procedure did not cause a serious

reaction in a single instance. We would remind you, however, that the fluid should never be allowed to escape too rapidly.

In addition to spinal fluid drainage, decrease in intracranial congestion is also promoted by the use of hypertonic glucose given intravenously, by intramuscular hypertonic magnesium sulphate, and by hypodermically administered caffeine, the last named having been demonstrated to have a definite diminishing effect on intracranial pressure.

Promotion of Nutrition—It has been suggested in recent years that some of the so-called alcoholic psychoses are not actually due to the alcohol itself, but rather to a coincidental malnutrition secondary to the alcoholism. More specifically, a lack of vitamins,—principally of the B group—has been blamed, and perhaps with considerable justification. Whether or not this also applies to the acute, brief episode that is delirium tremens is more problematical. Nevertheless, it is true that most individuals suffering from delirium tremens have either neglected their food needs because of lack of appetite for from several days to several weeks, or have derived little actual nutritional value from their food because of disordered gastroenteric systems. Our patients, consequently, have their ability to fight their disease limited by malnutrition. It is necessary, therefore, that we take steps to help the patient's nutrition in every way that we can. Because of the gastritis that is so often present, it is well to order a soft diet—in some instances, a liquid diet. The nourishment should have a high caloric value and, when possible, a high vitamin content. In those cases having an especially severe gastritis, lavage is indicated. In this connection, it has been our experience that it is usually unnecessary to pass a tube, as the patient will willingly drink one to two quarts of sodium bicarbonate solution and vomit it in order to relieve himself of his gastric distress. It is important to alleviate this distress, not only to promote nutrition, but to ameliorate the apprehensiveness and restlessness that is usually a concomitant of a sick stomach.

RESUME

These, then, are the five main fronts on which delirium tremens should be attacked: protection of the patient, prevention of exhaustion, promotion of elimination, de-

crease of intracranial edema and pressure, and the promotion of nutrition. To recapitulate, with less discursiveness and in a more orderly fashion, and with the addition of a few more details which complete our regime, our treatment of delirium tremens is as follows:

1. No alcohol is given to the patient from the time that he comes under our direction.
2. Absolute bed rest is ordered in an attempt to avoid, in so far as is possible, physical strain on the heart, and to give the patient the maximum opportunity for sleep.
3. Close observation on the part of the ward personnel is insisted upon, so that the patient has a minimum chance to injure himself or others.
4. Extract of cascara, gr. X, is given on admission, followed by one ounce of magnesium sulphate by mouth two hours later.
5. Magnesium sulphate, one ounce, is given every morning for three days, unless there have been more than four bowel movements the previous day.
6. Alkalies in the form of imperial drink are given three times daily.
7. Spinal fluid drainage is done as soon after admission as possible, and may be repeated as often as is indicated.
8. Fifty cc. of 50 per cent glucose are given intravenously two to four times per day.
9. Ten cc. of 50 per cent magnesium sulphate are given intramuscularly one to two times per day for two days.
10. Caffeine sodium benzoate, gr. VISS, is given hypodermically every four hours for six doses. If indicated, this procedure may be repeated.
11. The patient is digitalized in from 36 to 48 hours, and is then placed on a maintenance dose.
12. Paraldehyde (100 per cent), three or four drams, is given from one to three times per day for sedation. Intravenous sodium amytal may be used, though we would hesitate to recommend that more than ten to fifteen grains be given to any one patient. Hydrotherapy is indicated wherever possible.
13. A high caloric soft or liquid diet, supplemented by vitamin containing sub-

stances—especially of the B group—is ordered. If the patient has difficulty in retaining nourishment, gastric lavage with a sodium bicarbonate solution should be done.

14. Fluids are given according to the patient's desires. We have found that our results have been similar in the cases in whom fluids were stringently limited and in those in whom fluids were forced. The factor of the patient's comfort should be the determining one in governing the amount of fluids given.

15. Should the patient be asleep, he is not awakened for any reason, be it medicinal or otherwise.

We consider that the delirium tremens patient has recovered sufficiently to be discharged from the hospital when his delirium has ceased, his tremor is absent or markedly diminished, his apprehensiveness has disappeared, his appetite is definitely improving, his general physical condition is such as to permit him to be up and about, and—most significant of all the prognostically favorable signs—he is able to obtain a good night's sleep without, or with a minimum of, sedative aid. With these criteria for discharge, and with the regime that we have described, the average duration of our cases stay in the hospital has been 4-8 days.

This method of treating delirium tremens has been considered worthy of description because of the reduction in the mortality and in the duration of the disease that it has brought about in our wards at the General Hospital. There are a number of items in this treatment—some of them based on an etiological approach, other symptomatic in their efficacy. All of them, we feel, have rational elements. We realize that in private practice it is not always possible to hospitalize patients, and that it is frequently impossible to obtain the patient's co-operation in a regime as

intensive as the one we have proposed. Nevertheless, we present it as the most effective treatment for delirium tremens that we have been able to find. In those cases wherein the entire regime can not be utilized, it should be as closely approximated as possible.

Concerning those cases which might be classified as impending delirium tremens, it is probable that one might compromise and use only parts of the treatment with a measure of safety. It has been our habit, however, to treat these individuals precisely as though they were active cases; and it is our belief that by so doing we have aborted a large number of attacks, some of which might have had unfavourable outcomes had we temporized.

In conclusion, let us re-emphasize the fact that there is a considerable mortality associated with delirium tremens, and that there is considerable danger attached to the negligent management of such cases.

We hope to publish a more complete clinical analysis of these cases in the near future.

SUMMARY

1. A rational method of treating delirium tremens is presented.
2. One hundred and fifty consecutive cases were treated by this method in the Psychiatric Division of the Cincinnati General Hospital with a resultant crude mortality of 5.3 per cent, and an average stay in the hospital of 4.8 days.

ACKNOWLEDGMENT

I would like to acknowledge the assistance in this work of Dr. Maurice Levine, who introduced most of the items of this treatment at the General Hospital three and a half years ago, and of Dr. J. V. Cohn, who aided in the direction of the care of these patients and in the compilation of the statistics concerning them.

The Journal of Medicine Sep, 1936.

PHONE No : 3034

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

Performance Characteristics of Electrical Hearing Aids for the Deaf.

HENRY E. HARTIG, Ph. D. AND HORACE
NEWHART

Arch. Otolaryng. 23:617 (June) 1936.

There has long existed a need for a disinterested comparison of the performance characteristics of portable commercial carbon microphone hearing aids. In 1934 Dr. Horace Newhart proposed that an investigation be undertaken to determine whether significant differences exist between the hearing aids of various manufacturers. With the help of funds supplied by the Graduate School of Research Committee of the University of Minnesota the proposed investigation was commenced in July, 1934, as a joint project of the Division of Otolaryngology and of the Electrical Engineering Department.

The investigation led to the following conclusions given by the authors:

1. Among the various hearing aids of different manufacture on the market having as components a carbon microphone, a carbon amplifier and an ear-fitting receiver, there are important differences in the amount of amplification produced and tremendous differences in the intelligibility ratings.

2. The difference in performance does not depend measurably on the observed non-uniformity of response. In consequence, furnishing frequency response curves to the otologist with an hearing aid would be of no value.

3. Of greater importance is a wide range of response (as a minimum, from 200 to 300 cycles per second), freedom from singular peaks of amplification and sufficient amplification.

4. Of paramount importance is the actual aid that the user obtains in interpreting speech sounds and sentences correctly.

5. Hearing aids having a low intelligibility rating were also found to produce the greatest volume of noise by-products due to nonlinear distortion. It is concluded that these noise components are the principal cause of the poor intelligibility.

6. Portable hearing aids consisting of a carbon microphone and receiver only are

largely ineffective because of insufficient amplification.

7. At present probably the best means of determining the personal usefulness of a carbon microphone hearing aid of known merit for a given person is the discrete sentence intelligibility test.

8. An easily performed test for eliminating the most inefficient commercial hearing aids from consideration is suggested.

9. Tests made with bone conduction oscillators indicated that the relative merit is not appreciably effected by the substitution of bone conduction for air conduction when carried out on persons with normal bone conduction.

(Eye, Ear, Nose and Throat Monthly, August, 1936.)

The Fundamentals of Allergic Rhinitis with Particular Reference to Ionization Iontophoresis.

L. W. DEAN

Ann. Otol. Rhinol. & Laryng 45: 326
(June) 1936.

Allergic rhinitis is a most important etiologic factor in nasal sinusitis, and if it is not controlled the infection of the sinuses will persist. The most important thing in the treatment of allergic rhinitis is a proper diagnosis. With all the information secured it is not possible to outline a course of treatment and make a reliable prognosis. Many poor results are due to the fact that a thorough study is not made or because the physician uses only one type of therapy. The patients with allergic rhinitis observed by the author and his associates are mostly of the perennial type. While these patients have had good subjective results their noses have not returned to normal. An outline of the author's method of studying suspected cases of allergic rhinitis is given. The history is a most important consideration and yet in evaluating the history one must use common sense. In all cases of acute allergy the dates on which the patient had the acute upsets is most important. A study of the contacts on these dates may solve the problem. The nose and throat must be studied, because the treatment of almost every case of allergic rhinitis consists of the pathology in the nose plus a proper immunologic therapy. A person who suffers from rag-

weed hay fever may have, during the winter, symptoms of allergic rhinitis. Patients with atrophic rhinitis do not suffer from hay fever, but the nasal mucosa undergoes only the most moderate swelling and there is no nasal blockage. The fundamental allergic status of the individual persists regardless of the procedure used to get the desired result. In every suspected case of allergic rhinitis smears prepared from the nasal discharge should be studied. The relationship between eosinophils in the nasal discharge and allergic rhinitis has been studied and the results tabulated. A blood count should be made with particular reference to the number of eosinophils present. Dietary deficiencies must be considered. Malnutrition by decreasing the resistance of the cells of the mucous membrane to the entrance of allergens into the tissues and trauma of the epithelial cells are important factors in the sensitization of the organism. Endocrine disturbances should be sought for and corrected. Skin tests are made in every case. Patients may remain skin sensitive for many years. Intramucosal tests are now being made and compared with skin tests. More dependence is placed on the intramucosal test than anything else in determining the allergic status of the nasal mucosa. The best way to get a definite knowledge of the systemic allergic status of an individual is to make a passive transfer test. Tests should be made of bacterial allergic. Multiple sensitivity is the rule in allergic rhinitis. The leucopenic index of Gay and Ritter has proved to be of great value as an exact procedure in the study of food allergy. There is a non allergic type of vasomotor rhinitis. When ionization is performed, zinc enters the tissues as was demonstrated by Wenner. Ionization acts by thinning and splinting the mucous membrane. A biopsy from a human nose ionized three months before has shown areas of perfectly well developed ciliated cells. A common result of ionization, which lasts at least two years, is a thickened and more dense basement membrane. The mucous glands of the membrane undergo hyperplastic changes. There occurs a more or less complete paralysis of the parasympathetic nervous mechanism of the nose. Wenner had demonstrated in the web of a frog and in the ear of a rabbit the slowing of the blood stream in ionization.

The final results of ionization of the human nose as observed by the author are given. With the change in the epithelial lining and the interference with the secretion of nasal discharge, together with the formation of a thickened and more dense basement membrane, the absorption of pollen is interfered with. With changes in the membrane, one would hesitate to do repeated ionizations.

Ionization does improve most cases of allergic rhinitis. The less the sensitivity to allergens, the greater the relief. Ionization does produce deleterious results in the mucous membrane of the nose which last at least two years. Many changes are permanent. According to the author there is no excuse for using ionization if procedures that do not produce deleterious results will give a satisfactory response. Ionization should not be used unless the benefits derived are greater than the deleterious results produced.

The Eye, Ear, Nose & Throat Monthly, Augst, '36.

Does mastoiditis ever occur with an intact drum membrane?

A. Although not common, mastoiditis may be observed in the presence of an intact tympanic membrane. Clinicians have reported such cases which are probably different only in minor details. Of the various articles on the subject that of Love (Arch. Otolaryng. 17:297 (March) 1933) is of interest because it reveals several special phases of diagnostic significance. Love states that infection may extend from the middle ear to the mastoid and intracranially without gross pathologic changes in the middle ear. *Streptococcus hemolyticus* is probably the most frequent and most dangerous bacterial agent in the most severe cases. Love states further: "Minute examination of the ear canal and drum is imperative and any deviation from normal should be viewed with suspicion. It is important to exhaust every available diagnostic measure in order to come to an accurate conclusion. The condition is more common in children than it is in adults. The causes of failure in diagnosis are: (1) an insufficient history, (2) a failure to associate a distant manifestation with a possible otitis, (3) a lack of proper evaluation of minor anatomic changes in the external canal and the ear

drum, and (4) an insufficient follow-up of potentially dangerous cases. Swimming is a frequent cause of this type of disease. The expression *sagging of the canal wall* should be deleted from otologic usage and the term *edema* substituted, which describes accurately its location and extent."

Of what value is the X-ray examination in acute mastoiditis? Is it a definite diagnostic aid?

A. The X-ray examination of acute mastoiditis is in itself not a diagnostic criterion but becomes valuable only when the findings are evaluated in connection with the clinical and laboratory data. Beilin (Illinois M. J. 62:513 (Dec.) 1932) states that the X-ray examination of the mastoid reveals its type, the extent of its development, the cells involved and their location, the position of the sinus, as well as the character of the anterior sinus wall, and the tegmen tympani. Repeated X-ray examinations are of value, in determining whether the infectious process in the mastoid is clearing up, remaining stationary or advancing. In conjunction with the clinical observations the X-ray examination may indicate or contra-indicate surgical intervention. The presence of preinsidious abscess or epidural abscess may often be revealed by this examination. The X-ray examination of the mastoid is of cardinal importance, as well as indispensable as a diagnostic aid in all cases of mastoiditis.

(Eye, Ear, Nose and Throat Monthly, June 1936.)

Treatment of Acute Pleurisy in General Practice.

According to Sokoloff an attack of acute pleurisy should always be given careful consideration for, even in its mildest form it may be an indication of serious disease in the underlying lung or elsewhere in the body. Apparent primary cases in reality secondary to tuberculous tracheo-bronchial lymph gland, or sub-pleural tubercular focus in the underlying lung, too small to be diagnosed either clinically or by X-rays. This inflammation of the pleura may precede frank pleurisy symptoms by months.

In the treatment of dry pleurisy, he insists that the patient should be confined to bed, however mild the attack, till after pain and fever have subsided. Attention is paid to

the regulation of the bowels and to good and nourishing diet. Relief of pain is the most important consideration. Tinct of iodine or a mustard plaster are employed as counter-irritants, mustard plaster being ideal. In severe pain immobilisation of the affected side by adhesive plaster affords immediate relief. With the chest in full expiration strips of plaster about two and a half inches wide are applied starting across the vertebral column and tightly drawn round the affected side and finally attaching just beyond the middle line in front. They are placed at right angles to the vertebral column and do not follow the lines of the ribs. Each strip should overlap the preceding one by one third of its width. If the pain is in the upper part of the chest several strips may be attached to the anterior wall at the level of the fourth rib and pulled firmly over the shoulder below the spine and scapula. The plaster is removed in four or five days or sooner if the patient complains of itching. Should the plaster fail to relieve pain, codeine one-fourth grain by mouth is, exhibited every three to four hours. Codeine also controls the annoying cough. It may be usefully combined with aspirin five grains in a capsule. In those rare cases of extreme pain recourse may be had to morphia, one-fourth grain hypodermically.

When there is effusion with pleurisy complete rest in bed is imperative till the fluid entirely disappears. Spontaneous absorption will take place in nearly all small effusions and occasionally in large ones if the patient has complete rest in bed. If the general condition is good and dyspnoea and fever are not causing concerns it is advisable to continue rest in bed for several weeks in the hope that spontaneous absorption will occur. Depleting line of treatment to increase absorption is of doubtful value and only adds to the discomfort of the patient. In frankly rheumatic cases, sodium salycilate 20 grains, with double the quantity of sodium bicarbonate, is given three or four hourly. Calcium is able to favour absorption of the fluid from the pleural cavity. Calcium chloride 20 grains or calcium gluconate 60 grains is given orally every three to four hours or 10 cc. of a 10% calcium gluconate solution is given intravenously once or twice daily for four days, precaution being taken to inject the calcium slowly to avoid unpleasant subjective sensations. For effusions occurring as com-

plications of pneumothorax therapy in tuberculosis, he recommends the procedure of Kreich, to remove 5 to 10 cc. of pleural fluid and replace it by a similar amount of 10% calcium gluconate once daily for three or four days. Aspiration is recommended for diagnostic purposes (15 to 20 cc being sufficient), if effusion is causing cyanosis or dyspnoea, if there is continued fever, if effusion is increasing, in amount, if absorption fails to occur in spite of reasonable conservative treatment, if tubercles are present in the sputum and the opposite lung appears normal, effusion should be converted into therapeutic pneumothorax by gradual replacement of air. Not more than 1,500 cc. should be withdrawn at one time lest there be sudden shifting of the mediastinal contents.

Complications of aspirations are severe cough, pain, fainting or dizziness, hæmoptysis, pleural oedema and pleural shock resulting in sudden death. Any of these symptoms calls for immediate stoppage of the procedure and no attempt should be made to remove the fluid until at least 24 hours have elapsed.

(*The Medical Clinics of North America*, July 1936, p. 323).

Ozena.

A review of the recent literature upon atrophic rhinitis with crust formation reveals that the most effective management still

consists of faithful daily use by the patient of warm normal saline nasal irrigations. Added to this from time to time, office treatment consisting of gentle removal of any remaining crusts and the application of such stimulating preparations as Mandel's solution, ichthyol and scarlet red emulsion.

Mild atrophic rhinitis without crust formation, which is usually found in older patients, is best treated in the above outlined manner, perhaps less frequently applied.

Chronic suppurative sinusitis may require operative interference. Conservative measures would include shrinking solutions such as 0.5% ephedrine in saline as employed by the Proetz technique, mild silver protein packs, vaccine in some cases, and heat, best administered by diathermy.

Chronic catarrhal (infectious) rhinitis usually responds to mild silver protein packs.

Diathermy applied twice weekly for one month on one side in maxillary sinusitis and frontal sinusitis almost always produces rapid clinical improvement.

Chronic suppurative sinusitis in the ethmoids and sphenoids usually accompanies other sinus infection and seldom exists alone. Conservative treatment most often fails here, and operation is usually required. Operation is imperative in ocular complications.

(*Ear, Nose, and Throat*, Monthly June, 1936.)

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THE Medical Practitioner

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REFORMS AND RESPONSIBILITY.

The Editor of every journal or a paper is a human being and cannot but identify himself with a body and a soul. The existence of the former cannot be denied but the religion or temperament of many or of a few at least may make them revolt against the expression 'soul'. Our temperament cannot be a secret to those who know us ever since The Medical Practitioner was ushered into the world. We believe not only in the existence of a soul but its transmigration also. Whether others view us in the way we have been appearing ourselves in the columns of The Medical Practitioner must be known to those who read the journal for themselves or for those under whom they serve as friends or subordinates or both. What we have been writing in the columns of The Medical Practitioner is intended both for body and soul as we could not identify these two as separate entities. It is our conviction and we cannot swerve away from the conviction which has become part of our nature that what we write will not offend a body with a soul though at times due to physical derangement, the body forgets to reconcile with the soul on account of the intervention of the ego. The Medical Practitioner has been doing public duty specially regarding matters concerning the medical profession which it does in public interest and for the benefit of the members of the medical profession as a whole. So before we come to the subject matter of the subject under discussion we thought we should make ourselves understood as psychologically as the science of psychology itself with its bearings on the medical profession. Any physical assertion or expression is transmitted by the physical body which acts and reacts on

known scientific physiological laws. If the laws of normal health are transgressed, there will be abnormal happenings which sooner or later will bring about abnormal conditions in the body resulting in dysfunction or damage in the structure of the body. The damaged functions in a diseased body act and react in the domestic and social surroundings of an abnormal person. If they could be discerned as they usually are, by normal persons, the household or a society is not affected by such abnormal persons but if otherwise a particular household or society seriously suffers with the result that the normal power of judgment takes an abnormal turn giving rise to quarrels and squabbles resulting in civil and criminal crimes.

A scientific medical man can, if he chooses to display his scientifically trained mind, can detect abnormalities in a society and with an unbiased mind set right and reform the society and play a very important role in building up the society on healthy foundations and allay the turmoil of human weaknesses and in case the medical man is himself a perverted being, he is at times capable of making a heaven a hell. The medical profession can be made so flexible by immoral persons that a devil can get along undetected. Such persons if perchance if they be in authority will bring into existence complexes and obsessions which will make things appear quite the reverse of what they really are. So the influence of the medical profession in private or public life is more powerful than a dynamo both in velocity and intensity, in quality as well as in quantity. In spite of the tremendous powers of the medical profession even to do wicked things the inherent and the normally expected qualities and virtues of the votaries of the medical profession are re-

cognised universally as the noblest. It is on account of these virtues which cannot ordinarily be disassociated from the medical profession, we have been appealing and do so now when the services of the members of the profession should be requisitioned by themselves with little or no delay to keep this country as spiritual as it is. Everything else except spirituality has been conquered in this country and if India remains spiritual as she ever has been, bombs, machine guns and poisonous gas or any other new devices of the cruelly applied advancing science cannot affect her people either in actual war or the warfare of daily life. Let the members of the profession remember what the guileless patients tell them at times, 'Next to God you are our Saviour'. If this trust and faith is not abused, the medical men can achieve more than what other professions including the clergy could collectively do.

An opportunity of revolutionising India without a revolution and its consequent horrors of bloodshed, is fast approaching in the form of Elections to legislative bodies.

Politics is a science of good Government to make people live well. The wielding of this science on a large scale by selfish people towards their individual interests has unfortunately given a colour to politics and the term has assumed a bad and hence an evil reputation. The evil is in the persons and not in the word politics. The object and purpose of politics being the welfare of a nation, Medicine and Education play a most important role in Politics. But unfortunately the politicians who have taken to it as a profession, have been so clever to make it appear that they can handle any subject as cleverly as they have been doing Politics with the result that members of the public who are directly and legitimately connected with the medical profession and education are nowhere in Politics. Consequently politics does not yield the good fruits expected of it.

The so called politicians have been able to command most unwholesome influence over the masses that the masses are made to feel and believe that without such politicians the world would come to an end. Some of them to serve their own interests have been adopting methods to disrupt society and

which methods the politicians themselves attribute to Government and condemn the Government on the floor of Legislative Councils on public platforms and in the press. There is a tendency in this unfortunate country to bring about cleavage even in the professions and the profession which is most amenable to the influence of the professional politicians is the medical. The already existing vicious grades and compartments in the medical profession for which the British Government is primarily responsible, are made much of and interests are identified as service and non service. Within the service itself the existing disharmony is exaggerated. Same thing is being done amongst the members belonging to independent medical profession. To quote but one glaring example we might refer the readers to the part played by non-official members of the Legislative Assembly, who though they were in majority would not oppose the Government when the Indian Medical Council bill was enacted. Any amount of agitation was of no avail. Though the nature, quality and intensity of a grievance may vary in individual cases, the members of the medical profession whether they be in the Indian Medical Service, the Provincial Service, Subordinate Medical Service, England returned graduates, ordinary graduates, Licentiates, in urban or rural areas, all of them described above at times feel that they are not treated fairly by the Government.

In 1918 when the Indian National Congress met in Calcutta under the Presidentship of the late lamented Mrs. Annie Besant, an All India Medical Conference was held for the first time in the same city. Mrs. Besant had just then returned from Ootacamund where she along with two of her comrades were interned by the Government on account of her intensive propaganda for Home Rule. Dr. Rama Kamath who was then a member of the Home Rule League attended the Congress and also the medical conference, as a delegate. One of the resolutions in the agenda of the medical conference was with regard to a request to the Government to create a separate electorate for the medical profession. But the electorate was to consist of only medical graduates. Speeches after speeches were made by prominent members of the profession from all provinces including the late Dr. Ansari. The idea was most revolting to Dr. Kamath.

Being conscious that there would be a very small minority of licentiates present at the Conference Dr. Kamath was feeling nervous to rise and express his indignation for having excluded the licentiates from the proposed electorate. The sense of injustice done to the largest section of the members belonging to the medical profession overpowered Dr. Kamath and he stood up and was able to convince the fallacy underlying the selfish resolution, selfish because the resolution excluded the licentiates who were then and are now as good qualified medical men, as the graduates for the purpose of being in the electorate of the medical profession. The President of the medical conference was Dr. Rau of Bombay, a countryman of Dr. Kamath. Dr. Rau called Dr. Kamath aside while addressing the conference and was told in the ear that the licentiates formed the largest section in the medical profession and if these were given the franchise there would be a danger of I. M. S. men being returned to the Councils. This suggestion being as revolting as the idea of excluding the medical licentiates, Dr. Kamath had no other go than to expose the probable cause of Dr. Rau's apprehension. The apprehension Dr. Kamath said might be due to the fact that the graduates, at least some of them, did not recognise the licentiates as medical men whereas the members of the Indian Medical Service not only recognised the licentiates but also eulogised their services to the public and the Government wherever they had opportunities to do so. The President apprehending a division after Dr. Kamath's appeal abruptly dropped the resolution without pressing the same to vote.

We crave the indulgence of our readers for the above digression. We thought we should refer to this incident which might have some bearing on the topic under discussion.

Times have changed and have been changing rapidly since 1918 but the plight of the medical profession and the impediments towards the growth of a contented medical profession and with it the development of scientific medicine are still there. If the members of the medical profession felt a need to have a separate electorate for themselves in 1918 the need for the adequate representation of the

medical profession ought to be hundred fold more in 1936. Evidently an idea of safety is in the bosom of a few prominent members of the profession here and there on account of their association with the congress movement.

The members of the profession should remember that nobody except themselves can tackle the problems facing the profession as efficiently as their present lot demands; for nobody can describe the pain of the pinch of a shoe excepting the person who wears it. And nowhere can these problems be discussed and impediments be removed excepting on the floors of legislative bodies, no time is so opportune for the medical profession to think about the present or the future regarding themselves as it is now and nobody else can help the members of the profession excepting themselves.

Politics need not be a game with them. They are scientifically trained and as scientifics they are executing their profession. Unbiased they can make out who is what and what is what? They could scientifically make out the causes of perverse complexes and obsessions brought about in the minds of the public by interested professional politicians who are capable of making things appear as what they are really not. The love and concern of the politicians for themselves are made to appear as an anxious concern for their countryman and their country. The unfortunate circumstance of the National Congress permitting Congressmen entering into Councils as such is taken advantage of by many especially in the Madras Presidency.

Ambitious professional politicians who for the time being appear as Congressmen have made common cause with as ambitious persons who gave up the party and the principles with which they have been till recently attacking the National Congress more vigorously and vehemently than the Congressmen attack the Government. While such black legs can be charged for political dishonesty and treachery, the office loving Congressmen are trying to infuse faith in these recent converts in spite of the glaring fact and irony that many who signed the congress pledge and entered local councils in Trichinopoly, Tinnevely, Vellore, Mangalore, played the same game

as the new comrades, the recent converts to congress faith did with regard to another political party. All this indicates that the love for individual self is more in evidence even amongst those who wear khadar, a cloak to cover the true skin. Go a bit away from this cloak scratch the skin and the true man concentrated in himself is seen. There may be a very few instances here and there where medical men are approached to be enrolled as congress candidates but this is done in the interest of congress politics and not of the medical profession. Recent history has proved that it is not conducive to public safety for the members of medical profession to join with people of political ambition. The members of the medical profession who are trained on scientific and rational lines have to be as scientific and rational not only in the exercise of their profession but also in other matters they are to handle. If they prove and find out foul abscesses they cut them and let out the foul matter which if allowed to accumulate in the human system would lead to serious complications resulting at times in death. One such medical man a devoted congressman pointed out a foul abscess in the congress organization and when no remedy came, he cut the abscess himself in good faith. What he did in good faith has been considered as bad faith. This is a glaring lesson which the members of the medical profession should not lose sight of. India is not like other countries. The medical profession is still in a primitive state. If the medical men are earnest to improve themselves and their profession and work out ways and means to achieve the same by entering the legislative bodies they would be indirectly helping the political emancipation of this country as politics exists for the well being of a nation.

We have at present a medical organisation of all India name though not of the same fame as the All India National Congress. It is just possible that a few members of this association may contest elections on a political party ticket. One or two of them here and there will be a drop in an ocean. The profession should at least have 10 persons to represent them in the major provinces and 5 to 7 in the minor provinces. There is a pretty good number of congress men in the Indian

Medical Association. The General Secretary Dr. K. S. Ray who hails from Calcutta and the President Dr. U. Ram Rau are congressmen. We would suggest to the General Secretary to issue a whip to all branches in the provinces to pick out suitable medical men for each province and as Madras Presidency does not represent the Indian Medical Association to the extent the other provinces do, Dr. Rama Rau may arrange to call a conference immediately in the city of Madras or in 3 or 4 places and select 10 medical men for this province. After having done so the existing political parties should be approached and asked if they can accommodate the members of the profession in their list of candidates and the members of the profession should join a party which gives the profession enough facilities to lead a campaign in the interests of the medical profession consistent with public good. There is yet time and there are medical men prepared to serve the profession and the country.

As explained in the preamble of this subject medical men can not only purify election atmosphere but the councils also. Time and circumstances are opportune to demonstrate the importance of a noble profession in Politics. India as mentioned above is a spiritual country whose resources for a battle for whatever purpose ought to be only spirituality. We therefore studiously and with all earnestness at our command are appealing to the members of the medical profession as spiritually as the occasion demands and request them to treat the subject in the same spirit.

RHEUMATISM

The Medical Practitioner can take the role of the Medical Journals which devote themselves entirely for the discussion of scientific subjects. All the same a modest expression—that The Medical Practitioner is an unique journal devoted entirely for the uplift of the Medical profession in this country—will, we trust not wound the feelings of our readers in any step of the ladder of the profession. We have been attempting to the best of our capacity to make the journal as useful as it can be to the members of the profession especially to junior section of it publishing in its columns discussions on scientific subjects also. And with this purpose we have been

approaching and thankfully receiving help and co-operation from eminent members of the profession both in service and in private practice who have been giving the benefit of their experience by contributing articles to the journal.

In the July issue of The Medical Practitioner we published an abstract from a lecture on Rheumatism delivered by Major now Lt. Col. G. R. McRobert, Professor of Medicine, Madras Medical College. The author in his first lecture dealt on the Pathology and Aetiology of Rheumatism. In the abstract of the second lecture published above, the author considers the manifestations of the disease in children. In the Abstract of the third lecture which will be published in the next issue, the author makes a survey in a general way of the treatment of Rheumatism, its diagnosis, prognosis and other aspects of the disease as seen by him in the wards and outside the wards of the hospital.

Lt. Col. McRobert, has certainly done some good service to the profession by permitting us to publish an important subject of vital importance to the profession. He rightly said in his first lecture, "One of the most cherished doctrines regarding the distribution of disease is that acute Rheumatism is not found in the tropics." Later he has as modestly expressed his justification for choosing the subject on Rheumatism for the Elizabeth Mathai Lecture in the following words: "So far as I can find however the occurrence of the disease in S. India though well recognised here has not been recorded. The tendency to allow interesting and important case in S. India to go unrecorded is very marked—I can only suppose it to be due to a combination of modesty, over-work and climatic inertia." At the very outset of his lecture he emphatically says "that the old name acute articular Rheumatism must be abandoned as it tends to draw undue attention to joint involvement which is probably the least important feature of the disease." After we have gone through the lectures of Col. McRobert we are rather inclined to say that even the name Rheumatism for a disease described by Col. McRobert with its manifestations is a misnomer. This is a subject to be carefully considered by the members of the profession as it affects seriously the child welfare, adult welfare and the

welfare of the aged. A large number of accidental deaths commonly assigned as sudden heart failure may rightly be attributed to this dangerous disease. We therefore invite the attention of our readers for a careful study of the disease with a new outlook displayed by the author of these three articles.

News and Comments

An Apology: A pretty large number of our subscribers have been complaining to us and quite rightly so about a variety of irregularities in our office with regard to payment of subscription etc., to which we plead guilty. Though our activities to serve the profession and the public with a view to purify an atmosphere of corruption, hatred, jealousy, and a series of other such and similar weaknesses in society have materially increased the popularity and usefulness of The Medical Practitioner, these activities have brought us a few inveterate enemies here and there who are now up to wreck progress and reform. The Medical Practitioner is not the only means through which Dr. Kamath is serving the profession and the public. He has a few other hobbies such as the cooperative movement, civics, etc., in which he has been taking keen interest. Not being able to spoil the good name of Dr. Kamath in his public life these enemies are now seriously conspiring and attempting to interfere with his private life and have been able to tamper with the records and books in his office, some of which are found missing, with the help of his servants whom they have managed to get into their fold through the influence of the Mammon who has been able and is always able to help conspiracies even to attempt at the lives of human beings. Dr. Kamath though an invalid at present, has fortunately nerves in him to withstand conspiracies and plots of any description. His only guiding spirit the Almighty has been his search light so far to enable him to see through the plots of the conspirators and break them before they assume any form. Three servants and another who entered the service of Dr. Kamath in the garb of a copyist, though he was a qualified compounder and a typist, suddenly disappeared from his office on

some pretext or other when they smelt that Dr. Kamath was about to hand them over to the proper authorities for the crimes committed by them in his office. He did not take any serious notice of their disappearance as he rightly or wrongly believes that defending himself is more conducive to his present state of health and finance than taking up the role of a complainant unless he is actually forced to do so either in public interest and not in his own, or due to circumstances beyond his control. We therefore trust that our subscribers will sympathise with us in our present troubles and put up with all sorts of irregularities which might annoy them for the time being.

Dr. Kamath's present troubles have brought him many more friends and sympathisers. He has just got the services of a few who have undertaken the responsibility of helping him in his office not as mere servants but as the participators of the responsibilities of Dr. Kamath in his various capacities.

We therefore appeal to our readers to keep us informed about our shortcomings and we shall endeavour to the best of our knowledge to rectify the errors of omission and commission in our office which are the outcome of agencies of mischief and corruption against which Dr. Kamath has taken up a sword fearless of consequences to make the surroundings he lives in, sweeter and healthier than they are at present.

Women Medical Education: There is a strong rumour which cannot be without foundation that the Officiating Surgeon-General, Lieut-Col. Newcomb had written to the Government about the necessity of closing the Lady Willingdon Medical School for women on financial grounds. We have no knowledge if the Medical Budget for the coming year is in preparation and whether Lieut-Col. Newcomb has in view any schemes of public utility which in his opinion demand the immediate attention of the Government and which if not attended to would jeopardise public health and safety. Soon after the news of the abolition of the Lady Willingdon Medical School was communicated to us by one of the students of the Stanley Medical School, we were rather amused and not surprised as the same student brought us as astounding news that from next April

the centre for conducting Board examinations for the L. M. P. students would be the Stanley Medical School. There were a few more items of news which we refrain from publishing, as we are at present in the court of the Chief Presidency Magistrate and we do not wish to vitiate the atmosphere when the Magistrate is having the scales of Justice in his hands. All the same as the person who brought us the news is a failed student and as he felt very nervous to put in writing what he had to say, we thought we could get authoritative news from the Secretariat and went as far as the door of the room of the Secretary concerned on 6-11-36 late in the day when the clock struck 5. Though the Secretary was in the room till about 5-15 being specially very busy that day we thought we should not disturb him. We are two months behind the scheduled time when this issue ought to have been published. So we have published the news for what is worth without waiting for confirmation. As there cannot be smoke without fire and as the fire is a destructive element we thought we should write regarding the news though it may only be smoke which we saw and not the fire.

In the month of March 1936 we read in the columns of the 'Hindu' under the caption "The Medical Education Society" about a proposal to start a women medical college at Calcutta. We have published the cutting from the Hindu in the correspondence columns of the current issue. We endorse every line in the item of news in spite of the fact that we did recommend to the Local Government the closure of not only the Lady Willingdon Medical School but also the Vizagapatam Medical College as a measure for retrenching expenditure at a time when a few years ago there was a fright of want of finance in the Government Treasury not only in this province but throughout India. We thought at the time that closure of an additional school and a college would be less harmful to the public than the closing of the hospitals or reduction of beds and comforts of the sick admitted into the hospitals. We do not wish to make further comments on news not confirmed and if our information proves to be correct, we could only say that Lieut-Col. Newcomb who will be soon under orders of reverting to his permanent appointment, as the Principal Medical College and Chemi-

cal Examiner to the Government, might have waited for the arrival of the permanent Surgeon General before he did what he thought he should. His recommendation would have been doubly blessed and could have had better effect in case Major-General Sir Frank Connor agreed with Lieut-Col. Newcomb and sent the recommendation to the Government.

Rural Medical Relief: Soon after the discussion of the Budget when the Government shifted itself last May to the cool atmosphere of the Blue Mountains of Ooty, there appeared in the columns of the Madras dailies, articles which were designated as 'Press Notes' and in which the history of the development of the public utility schemes of the Government were embodied. The Rural Medical Relief Scheme was one of them. Though the object and usefulness of the scheme on the face of it could not be denied, the way the scheme was actually run by all concerned including the Government had created an impression amongst the subsidised practitioners, the medical profession and the public that the otherwise laudable scheme is utilised by ambitious politicians running the show of a democracy in the local bodies as well as in the Legislative Council for their personal aggrandisement. We consider the scheme as one of very great importance and it is dear to our heart and should be so to those, who are interested in the Rural Uplift without which India cannot lift herself to the level of other advanced countries. It is a strange irony that Mr. Jawaharlal Nehru the President of the Indian National Congress should have demonstrated in Calcutta his strong hatred towards the village life, when he replied to the civic address presented to him by the Calcutta Municipal Corporation at a time when political parties including the Congress are exhibiting their usefulness to the country to canvass the support of the public for entering the councils and make prominent mention of their concern for villages as the new Viceroy has been doing ever since he reached India. So did the Provincial Governments, this item of activity having attracted attention after the scheme of village uplift was inaugurated by Mahatma Gandhi in the Congress propaganda. No bad motive can be attributed to Mr. Jawaharlal Nehru for such an expression of opinion as his *bona fides* for

his love for India cannot be questioned even by his worst enemies. But we should say it only indicates the ideals of at least a few of Indian patriots who should not be reckoned on their face value as the type of patriots whom India needs to-day, a country which if bereaved of its villages cannot exist as such. And the great beloved Jawaharlal will have to create yet another India in his imagination for the services of the kind which are dear to his heart. Such ideals of patriotism displayed by even the President of the Indian National Congress justifies our fears that neither the congress nor any existing political party can represent the medical profession in the councils with a view to redress their legitimate grievances which are hampering the growth and prosperity of the profession to build itself as a homogenous contented fraternity for the service of this country whether it be in the villages or the cities.

Coming to the subject matter under reference we have here below quoted what appeared in the columns of the dailies in the Government Press Note on Rural Medical Relief early in the month of July 1936:

"The object of the scheme was to induce qualified medical men to settle permanently for practice in specified remote villages where qualified medical relief is badly needed, by the offer of a suitable subsidy which will help to maintain the practitioners during the first few years until they earn the confidence of the rural people and are able to build up a practice for themselves. Besides economy, the scheme had also other advantages viz., the relief of unemployment among medical men and development of the private medical profession. The scheme also provides for the employment of midwives for affording maternity relief to the rural female population."

The principles, the purpose and the utility enunciated in the above lines are very grand indeed, but may we ask the Government, or the person, or the persons who drafted this "press note" to lay their hands on their hearts and say if what was enunciated by them above was or has been put into practice either by the Government who inaugurated the scheme or those who were in charge of the scheme? Beyond this we do not wish to say anything further by way of comments on this press note which was published perhaps to white wash the walls and the surroundings of the Government Secretariat on the eve of the coming elections. Such a note regarding the Subsidised Rural Medical Relief Scheme far

from enlisting the support of those who are in daily touch with the scheme will estrange the feelings of not only those for whose benefit this scheme is said to have been started by the Government. Why and wherefore we do not wish to reiterate as the Government who are directly responsible for the press note, the public and the profession including the most unfortunate subsidised practitioners who are the very dupes of this scheme cannot forget what has been appearing in the columns of The Medical Practitioner these eight years of its life.

Does Constitutional Agitation Pay? Our readers might remember that soon after three Junior Assistant Surgeons were posted by the Government as Acting Civil Surgeons about five months ago, superseding many seniors above them, we brought this injustice to the notice of the authorities who were responsible in overlooking the claims of the seniors for no fault of theirs. Nothing was mentioned in the order posting these juniors as Civil Surgeons to indicate that as many as roughly 30 to 35 seniors did not possess the required service merit. Nor could that be probable. The war service rendered by these three was considered to be the cause for such a glaring supersession after a lapse of nearly 20 years. The injustice was naturally felt more keenly by a large number of senior Assistant Surgeons on account of an existing G.O. which the Government passed, when a Junior Assistant Surgeon some years ago memorialised to the Government to reckon his war service for promoting him over his seniors. It was laid down in that G. O. in unambiguous terms that war service alone could not be recognised for the purpose of the promotion of Civil Assistant Surgeons in service. It is said that there were nearly 35 seniors above the fortunate juniors who superseded their brethren as Civil Surgeons. It was reported in the columns of The Medical Practitioner a month after the event of supersession that the aggrieved Assistant Surgeons memorialised to the Government through the proper channels and later sent a request praying that a few representatives of theirs wished to wait on the Hon'ble Minister-in-charge of the Medical Portfolio in company with the head of the department. We now learn that the Government have sent rather an ambiguous reply to the memorial and have also informed the memorialists that

there was no need for the deputation. It is indeed sad that the Government have not found their way even to be courteous to their own officers all of whom are Gazetted Medical Officers. This attitude is likely to be misunderstood, especially so when deputations are of common occurrence during these days of democratic system of Government. It looks as if the Government do not mind the good will of their trusted officers who are not expected to talk as loudly as those who are not under the employ of the Government. Knowing as we do the atmosphere created by the political parties in the political field we wish to apprise the Government more in their interests than in the interests of those who have legitimate grievances against the Government that though the latter may be few in number in the eyes of the Government the ferment of political agitation now surging all round will certainly be able to turn milk sour. It is hardly necessary for us to point out to the Government that a contented service should be relied upon more than the Ministries however stable.

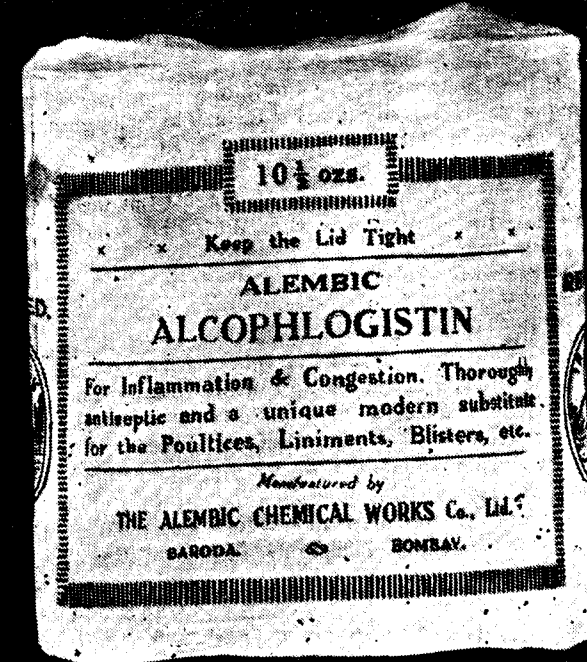
Post-Graduate Courses by the Andhra University. Dr. Kanakaraju, member of the Senate of the Andhra University should be congratulated on his success in convincing the Senate of the Andhra University about the necessity of instituting Post-Graduate training under the auspices of the Andhra University for all the Registered Medical Practitioners irrespective of their being graduates of the Andhra University or otherwise. We have been advocating the necessity of Post-Graduate courses for the general practitioners and soon after we learnt that Dr. Kanakaraju had given notice of a resolution to that effect to be moved at one of the meetings of the Senate of the Andhra University, we commended this resolution to the members of the Senate. We are glad to learn that the resolution was passed without a division.

When the Centenary of the Madras Medical College was celebrated we suggested that the inauguration of post-graduate courses would be a fitting memorial to commemorate the event. We thought at the time, and even now are of opinion that the task would not have been a hard one if the prominent members of the profession in

(Continued on page 228)

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Government service who were mainly responsible for the success of the Centenary made up their minds for the institution of the post-graduate training under the auspices of the Madras University. Our suggestion fell flat on the imagination of the organisers of the Centenary. We are glad that a young sister University not far from Madras has shown a lead to the other Indian Universities which we hope will soon follow the example of a rising University in the Andhra province. We trust that the professors attached to the Vizagapatam Medical College who possess high qualifications both Indian and foreign, would co-operate with the University authorities and make the post-graduate courses as useful as they should be during these days of ever advancing medical science. It may be desirable that the Andhra University publish the scheme of post graduate courses in all the popular leading medical journals and invite the opinion of the medical profession before they actually inaugurate the scheme.

Correspondence Reports Etc. Medical Education Society

INSTRUCTION FOR WOMEN

It was announced recently that Calcutta women are to have a medical college of their own. A society called the Ramakrishna Medical Education Society for Women has been formed and registered in Calcutta with Maharani Saheba of Santosh as its President; Maharani Bahadur of Nadia and Mrs. Umagauri Vasa as Vice Presidents and Sister Saraswati (Mrs. Ramabai Palekar) as the Secretary.

The imperative need for medical instruction for women is put forth in a statement by the Society which points out that during the period when the joint family system was prevalent in India, the grand-mother in every family was a physician. It was her responsibility to look after the health of the children and women-folk. Even con-

finement cases were conducted under her supervision and only in rare circumstances, when the case had gone out of her hands, would a male doctor be called in. Mother or mother-in-law would give her medical experience in due course to her daughter or daughter-in-law and thus the medical knowledge used to be handed down from generation to generation like many other family traditions.

But the joint family system is now fast disappearing and the modern girl does not get an opportunity to gain medical experience at her father's or father-in-law's house. This has meant a loss of a house physician to every home. Even for an insignificant case of indisposition in a family, medical aid from outside has become indispensable and consequently in an average family budget now-a-days a fairly large sum is set aside for medical expenses only. Thus from the standpoint of national economy it is essential that all facilities and encouragement should be given to girl students for taking up medical courses. On the contrary, the statement points out, it is found that in a city like Calcutta which is the centre of culture and education, only a poor attempt is made to popularise medical education for women. There are many difficulties in their way of having medical education, firstly because a very limited number of seats are available for them in the local medical schools and colleges. In 1934 the Calcutta Medical College had on its roll 713 students, of whom only 19 were lady students, secondly the majority of parents dislike their girls reading in medical schools and colleges where co-education is compulsory.

From the generous response which the organisers have already received from the public-spirited citizens of Calcutta they expect that support and sympathy for this cause will not be lacking. A group of experienced medical men very willingly have agreed to work as honorary teachers in their institution for women.



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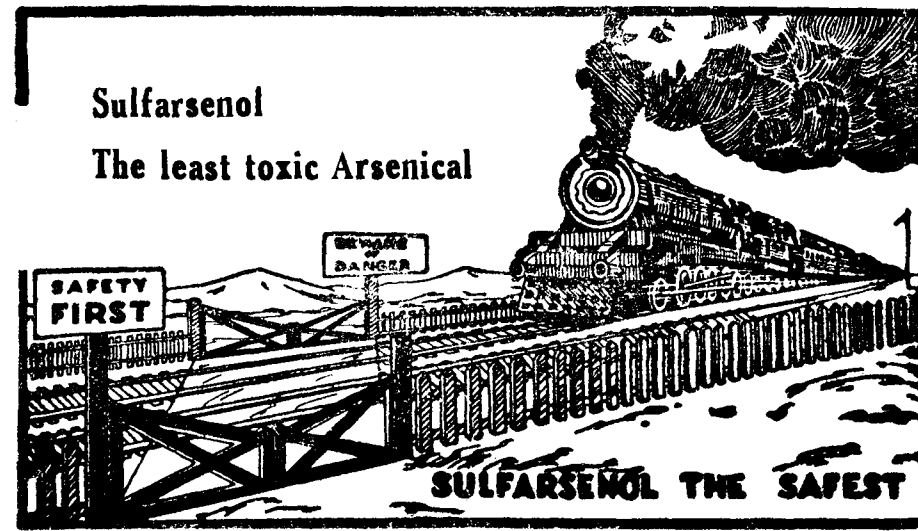
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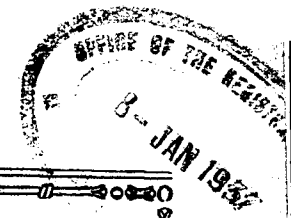
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A Monthly Medical Journal

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



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VOL. VIII.]

OCTOBER 1936.

[NO. 1

Original Articles

ON ACUTE RHEUMATISM

ABSTRACT OF THE MADRAS UNIVERSITY
ELIZABETH MATTHAI LECTURES 1935.

By

LIEUT-COL. G. R. McROBERT, M.D., F.R.C.P.,
I.M.S.

(Continued from the August issue.)

Lecture Three

In the first decade of adult life the joint involvement dominates the picture and chorea and subcutaneous nodules are much rare in their incidence.

It is just as essential as in the case of young children however to put the patient to bed promptly and to keep him there at rest until it is certain that the heart is unaffected or until the inflammatory process has ceased to be active.

The basis of the diet should be milk diluted with water so long as the patient remains febrile. Fluids should be allowed in abundance as the profuse sweating would otherwise lead to tissue dehydration.

As the fever declines vegetable soups, conies and chocolate may be allowed, but tea, coffee and meat and curries should be withheld.

The same rules hold good with regard to the administration of salicylates as in the case of children with which I dealt on the last occasion—remembering that the 48 hours response is a diagnostic as well as a therapeutic measure.

The wrapping up of the joints, the sponging in high fever and other nursing measures are dealt with fully in the standard text books and need not detain us further.

Even in adults, convalescence is prolonged and no undue haste in getting up and back to work should be countenanced.

Massage and passive movements of the affected joints may be begun as soon as the inflammation has completely subsided.

The hypochromic anæmia should be treated with iron-and-marmite when the acute symptoms have subsided.

The fact however remains that painful and troublesome as the joint condition is in rheumatism, it eventually clears up completely and any lecture on rheumatism in adults must be directed chiefly to the damage to the cardiac organ arising out of inflammation occurring during earlier years.

It is important to note that a history of past rheumatism cannot always be obtained. In the U. K. a history of rheumatic infection is obtained in about half of the cases only but this is no doubt due to too much attention being paid to a history of arthritic symptoms.

Careful interrogation of parents of practically all the mitral cases in young people admitted to my wards during the past year has enabled us to pronounce nearly all as sequelae of rheumatic infection.

Again and again attempts are made to show that in countries outside Europe and America mitral stenosis occurs in situations where rheumatism is unknown,

For example Mileney and Kellars reported in 1924 that mitral stenosis is the common heart lesion in north China although rheumatic fever is almost unknown there but subsequent investigations show that acute rheumatism is not so uncommon as was formerly supposed and according to Robertson and Chu quoted in the new 3rd Edition of Cowak and Ritchie "rheumatic fever is not so rare as we thought. Until now we have had no satisfactory children's department in the hospital and as most other cases occur in childhood we simply did not see them".

The same situation has existed in India and until quite recent years the predominating importance of medical diseases as crippling and killing factors has not been officially recognised in the government hospitals the efficiency of which has been gauged by the number of surgical operations performed annually.

Neither must any reliance be placed on p. m. statistics. In Hongkong it is reported that no case of mitral valve has ever been demonstrated at autopsy. You are all aware of the difficulty in obtaining p. m. examinations except in paupers dying of chronic dysentery and tuberculosis and until p. m. examination is compulsory for hospital cases as in Europe we shall be unable to estimate the distribution of disease from autopsy records.

We are justified I think in attributing our Wassermann negative cases of mitral involvement and adhesive mediastino-pericarditis in Madras to the same infection as that which causes an identical condition in Europe where if, we exclude congenital malformations, rheumatism is the only important cause of heart disease up to the fourth decade of life. After 40, syphilis becomes the important factor and after 50 arteriosclerosis.

The mortality during the active stage of the cardiac inflammation is heavy, 5% in the first year, 20% in the first ten years. Of these developing rheumatism in childhood 60-80% ultimately manifest clear signs of heart disease.

The distant future of the individual case depends upon *when* the injury to the heart by active rheumatism *will* end and the *extent* of the mischief which will then prevail.

Cases of rheumatic heart disease almost always display clear clinical evidence of valvular involvement, mitral stenosis being more than twice as common as aortic regurgitation and twenty times more common than aortic stenosis.

The diagnosis of chronic valvular disease of the heart is arrived at by the discovery of certain murmurs accompanying or replacing the normal heart sounds.

There is however no evidence to show that a systolic murmur taken together with a history of rheumatism is appreciably more significant than has a history of rheumatism alone.

For practical purposes it can be said that with few exceptions systolic murmurs are of little significance compared with those appearing in diastole.

The diagnosis of mitral regurgitation following the discovery of a systolic apical murmur is still too frequent.

As an organic affection of the mitral valve, mitral regurgitation is exceedingly rare without the more easily diagnosed stenosis.

We can to some extent gauge the degree of a valve lesion. If the presystolic murmur of mitral stenosis is heard only at times or has to be forced out by exercise or by raising the heart rate then the stenosis is early.

Although presence of a developed mitral stenosis imposed an extra burden on the heart, we know that cardiac muscle possesses an enormous reserve power.

The clinical significance of valvular disease lies much more in the fact that when the valve becomes diseased the myocardium suffers material damage.

The chief clinical sign of this damage is enlargement of the heart.

Grant has shown that the best guides we possess for prognosis in chronic valvular disease are not the characters of the murmur or the type of valvular defect but the degree of cardiac enlargement and the degree of heart failure as estimated by the patient's response to effort and by the presence of venous congestion.

Prognosis is good in cases with little or no enlargement and when exercise tolerance is good.

Only about 20% die within ten years. Half of them survive 10 years uneventfully with physical signs unchanged.

The prognosis is poor in patients with moderate enlargement and poor exercise tolerance, for 50% die within 10 years.

The average duration of life in the presence of venous congestion is only 2% years.

Prognosis is modified by the development of subacute bacterial endocarditis which reduces the average duration to six months, or the onset of auricular fibrillation which influences unfavourably the general prognosis.

In his recent investigation Grant's most important conclusion is that the general outlook for cases of valvular defect is not so bad as is generally thought even for syphilitic regurgitation.

Even in the majority of those patients who die there is no steady progression downwards - the original condition of valve lesion, heart size and exercise tolerance remains unchanged until death supervenes suddenly or within a year or two of the onset of congestive heart failure.

In cases of chronic rheumatic disease of the heart we should therefore take a long view and gauge the severity of the case by assessing the amount of cardiac enlargement and the degree of encroachment on the heart's reserves by the amount of exercise tolerance and the presence of venous congestion.

Treatment consists in the institution of a suitable mode of life—calculated to ward off as long as possible dangers which beset the patient.

The temperament and spirit of the patient must be considered and over fussiness must be avoided as tending to bring on a state of invalidism.

We cannot repair an already damaged myocardium but we can try to prevent further damage.

(a) In cases with no cardiac enlargement and good exercise tolerance it will only be necessary to forbid the more strenuous forms of work and exercise.

(b) With moderate enlargement and poor exercise tolerance, varying degrees of restriction will be necessary.

(c) With great enlargement and signs of venous congestion the patient will require treatment as for congestive failure.

The patient should be encouraged to take exercise within his limits of tolerance—Dyspnoea and undue fatigue must be avoided.

Suitability of work must be decided upon on the same principle, but unnecessary change of occupation must be avoided as unemployment adds worry. The patient should be particularly warned against sudden strains such as running.

Undernourishment rather than overfeeding is desirable as a load of fat means extra work for the heart.

Above all however, it is necessary to warm the patient against unduly exposing himself to infections.

Friends with sore throats and colds must be avoided as must also unnecessary exposure and damp.

Prophylactic use of anti-catarthral vaccines is advisable and chronically infected tonsils should be removed. Tobacco and alcohol should be limited and periodic medical examination may, by limiting exercise to within the limits of tolerance save months of tedious and grave illness.

It is only when serious complications such as auricular fibrillation or congestive failure appear that dry treatment becomes important though tonics, sedatives and expectorants have their occasional uses.

The complication of rheumatic heart disease with pregnancy is of frequent occurrence and merits our attention.

In patients with normal sized hearts, regular rhythm and no venous congestion pregnancy may be allowed to pursue its normal course under strict regular medical supervision.

During the later months the patient should be examined at least once a week and special attention should be paid to the presence of undue dyspnoea or tachycardia, enlargement of the veins in the neck, enlargement of the liver, persistent moist sounds at the basis of the lungs and oedema. In such cases the patient has been exceeding tolerance and should be admitted to hospital for rest and observation.

A number of patients came to the doctor with actual or impending failure with venous congestion and having survived the earlier months of pregnancy without difficulty. The choice of Caesarean section or premature labour is for the obstetrician to make but when it is decided to terminate pregnancy artificially no operative procedure

should be undertaken until the heart failure has received adequate treatment. Even in the most serious cases of cardiac breakdown the risk of delay entailed by devoting a few days to the relief of heart failure by medical means is infinitely less than the risk imposed by operative intervention when the cardiac condition is critical.

In patients with auricular fibrillation or with a previous history of congestive heart failure pregnancy should be prohibited or if present terminated in the first three months.

In my opinion sterilization should be carried out at the operation and in married women who have auricular fibrillation sterilization by abdominal section may be advisable if it is imperative to avoid pregnancy.

I do not intend to deal with the actual treatment of failure with congestion as that subject is familiar to all of you although the recent introduction of preparations of digitalis lanata—digoxin in particular—promise greatly to simplify and to accelerate the treatment of that condition.

In bringing this series of lectures to a close, I thank you for your attention and I hope that I have succeeded in stimulating you to further interest in this disease—little known but surely prevalent in Madras.

Acknowledgements are due to:—

1. Cowan and Ritchie—Diseases of the Heart—Edmond Arnold & Co.
2. Francis Bach—Rheumatic Diseases—Cassell & Co.
3. Schlesinger—Rheumatism—Churchill.

VITAMIN DEFICIENCY DISEASES

By

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

DEFICIENCY OF VITAMIN A

The effects of Vitamin A deficiency are most marked in infancy and childhood. These are a state of malnutrition with characteristic lesions in the eyes, hemeralopia, Xerophthalmia and in advanced cases, Keratomalacia.

ETIOLOGY: These conditions are caused by deficiency of Vitamin A in the diet associated (not necessarily) with severe digestive disorders and malnutrition; (2) Occurs dur-

ing acute infection as Cholera, Dysentery, Measles and Tuberculosis; (3) Affects children under one year, the most severe cases being met with in infants. With advancing age Keratomalacia occurs; less frequently only Xerophthalmia and hemeralopia become manifest. This difference in the influence of the age factor is probably due to the greater need for Vitamin A in infancy than in later life; (4) Cases are met with throughout the world; epidemics may occur though the condition usually occurs sporadically. (5) This condition is unknown in breast fed babies.

Vitamin A occurs in nature, in abundance, in the liver oils of certain fish as the cod and halibut, egg yolk, milk, and green vegetables as green beans, carrot, lettuce, spinach. According to Moore, the green leaves of plants contain a yellow pigment, carotin, which is formed by the action of sunlight. Carotene is the precursor of Vitamin A. Vitamin A is not present in plants as such. It is only formed in the body from the carotin. Vitamin A is stored almost entirely in the liver. It is colorless, and is thermostable in the absence of oxygen. However, in the presence of oxygen it is easily oxidised. The isolation of this Vitamin in the pure state is found to be impossible at present.

PATHOLOGY: Metaplasia of the cells of the body and substitution of stratified keratinising epithelium for the normal epithelium in the eyes are of common occurrence and also involvement of paraocular glands, respiratory, alimentary and the genito-urinary tracts. Eye changes are characteristic. The cells of the lacrimal glands are atrophied and keratinised, the secretion of tears is lessened, the conjunctivæ become dull. The conjunctival epithelium shows thickening of all the layers of cells: the superficial layer is keratinised, the epithelial and sub-mucous tissues are infiltrated with leucocytes, the cornea becomes cloudy and ulcerated and these ulcers may perforate the cornea. Deep ulcerations of the cornea lead to interference with vision or blindness. Other organs are similarly affected. The salivary glands atrophy and the mouth becomes dry.

SYMPTOMATOLOGY: This condition occurs in infants who are fed for a few months together on insufficient or poor quality milk. It occurs in older children fed on a

diet containing insufficient milk, egg, butter and vegetables.

ORDER OF OCCURRENCES OF SYMPTOMS:

1. Failure to gain in weight followed by actual loss in weight. 2. The child becomes less active than usual. 3. The skin becomes dry and scaly. 4. In older children night blindness is the first symptom. It occurs most commonly in bright sunny weather. It is not recognisable in infants. 5. The younger the child, the more rapid the disease progresses. 6. The eye changes appear in infants only when the condition is advanced. Conjunctivæ become dry, secretion of tears is diminished, cornea becomes ulcerated; the ulcers may be single or multiple and if they are not properly treated perforation of the cornea results. As a result of secondary infection photophobia, injection of the conjunctiva and suppurative conjunctivitis may result. Hypopyon may complicate a corneal ulcer. 7. In older children, the disease does not progress beyond Xerophthalmia, and the corneal changes are less frequent. The more rapid the growth, greater is the need for Vitamin A. Hence it is that the need for Vitamin A is greater in the case of infants than in the case of older children. The rapidity of the progress of the disease in the infant is due to the lessened resistance to infection. 8. Intercurrent infections of the skin, lungs, urinary, digestive and respiratory tract. 9. Death may result from bronchopneumonia or diarrhoeal disorder.

DIAGNOSIS: In early stages, the disease cannot be recognised. Diagnosis is aided by the cloudy appearance of the cornea and the presence of corneal ulcers. Where these eye changes are present, a knowledge of the previous diet of the patient is an aid to diagnosis.

PROGNOSIS: In milder cases where only the conjunctivæ and not the cornea is involved, perfect recovery of the eyesight is the rule. The prognosis in infancy is much more unfavourable than in later childhood. Usual cause of death is bronchopneumonia or acute gastro-intestinal disorder.

PROPHYLAXIS: To prevent Vitamin A deficiency in the diet, the supply of a sufficient quantity of Vitamin A in the diet of the child and the proper absorption of the same is essential. In most cases there is a complicating gastro-intestinal disorder. This is

significant in that even if the diet contains a sufficiency of Vitamins, the infant is not able to absorb this. Small, gradually increasing doses of Cod or Halibut Liver Oil is of great value.

TREATMENT: For mild cases occurring in older children, include in their diet a moderate amount of raw cow's milk, egg, butter, liver, and green vegetables besides the cod or halibut liver oils.

For advanced cases occurring in young infants, breast feeding is valuable. As gastro-intestinal disorders may be present feed carefully. In cases where the fish liver oils are not tolerated due to gastro-intestinal upset, cod liver oil concentrates may be of great value.

The eye condition must be attended to by a specialist.

The night blindness disappears within a few days of the administration of Cod Liver Oil. Kerophthalmia clears up in a few weeks.

VITAMIN B DEFICIENCY

The deficiency of Vitamin B in the infants' diet gives rise to infantile beriberi. It is a very common condition met with in China, Japan and the Phillipines. In India, it is quite common. In the U. S. A., it is not definitely established as a separate disease. It occurs in artificially fed babies. It does not occur in breastfed babies. Beriberi affects infants whose mothers have suffered or are suffering from Beriberi, even though these babies are breastfed. Babies of mothers whose breast milk is deficient in Vitamin B complex and babies who are fed on cow's milk or artificial food which is deficient in Vitamin B do suffer from this disease. This disease manifests itself during the first three months of life.

SYMPTOMS: In general, the onset is insidious. Order of occurrence of the symptoms: (1) Baby becomes irritable and restless; (2) sleep is interrupted; (3) gradual loss of appetite followed by (4) loss in weight and (5) signs of secondary anemia; (6) the change in the quality of the voice is said to be characteristic, aphonia may occur (7) there is general hypotonicity, muscles become tender, the baby becomes less active or inactive; (8) knee jerks absent; (9) meningeal symptoms and abdominal pain may result; (10) evidence of cardiac failure, associated with tachycardia, cyanosis, enlargement of the heart and edema.

Generally the disease is afebrile. Death is due to cardiac failure associated with convulsions.

Treatment consists in feeding the baby with foods containing Vitamin B complex such as handpounded rice, plenty of cow's milk, and Cow and Gate Standard Milk Food, or Glaxo.

VITAMIN C DEFICIENCY

INFANTILE SCURVY: Scurvy is a nutritional disturbance caused by a lack or insufficiency of Vitamin C in the diet. It is characterised by haemorrhages in various parts of the body and by painful swellings of the joints.

Infantile scurvy occurs among babies who are fed on artificial foods lacking in Vitamin C for several months together. It frequently occurs among breast-fed babies when the mother's diet contains insufficient Vitamin C.

As the symptoms take some time to develop (from six to nine months), the disease is commonly seen in the first half of the second year. During the first six months of the lactation period, the mother's milk contains Vitamin C in just sufficient amounts.

Probably, there is a familial or individual predisposition to this disease. Ability for the body to store up a supply of Vitamin C for future needs is always less than that for other Vitamins; it varies in different individuals.

OCCURRENCE VITAMIN C IN NATURE: Vitamin C is present in large quantities in green vegetables and fruits especially tomatoes, fresh cabbage and oranges etc. Vitamin C is the most unstable of all the vitamins, being easily destroyed by heating and by alkalization. As the heating incidental to the canning of tomatoes or tomato-juice is carried out in an acid medium, its vitamin content remains unaltered.

Infections may be a factor in hastening the development of the disease in children who are taking just sufficient Vitamin C. This condition is not related to other vitamin deficiency diseases as Rickets. It is often complicated by them.

PATHOLOGY: Bone, cartilage, liver, spleen, lymphoid tissue, adrenals, kidneys, lungs, and blood vessels especially the endothelial lining of capillaries and muscle cells,

including the heart muscle show atrophic and degenerative changes. The most marked effects of scurvy are found in actively growing and functioning cells as the endothelial lining of capillaries, epiphyseal junctions of long bones and the bone marrow. As such parts are mostly affected, the worst effects of the disease are manifest in them. The coagulation time of the blood, the blood calcium and the blood platelets are normal. The almost complete cessation of osteoblastic activity results in marked weakness of the bones and frequent fractures. Though the epiphysis is often displaced, permanent deformity is rare.

SYMPTOMS: The onset is insidious. The baby becomes pale, fails to gain in weight, loses weight gradually, appetite poor, baby is easily irritable and fretful. Mere touching his person gives the baby intense pain. Slight, tender swellings over the extremities is noticeable, the baby keeping the limbs in positions of rest and does not move the limbs for fear of pain. In teething babies, haemorrhagic manifestations are primarily responsible for the clinical picture; the gums especially those around the upper incisors are swollen, red and bleeding. Ulcerative stomatitis is common. Petechial haemorrhages, on the skin, bleeding from the nose, renal haemorrhage, post-orbital haemorrhage with edema and echymosis of the eyes, subperiosteal haemorrhages producing excruciating pain in the extremities especially at the lower end of the femur or humerus are common. Pain is due to stretching of the periosteum. The edema is due partly to the subperiosteal haemorrhage and swelling of the soft tissues over the affected area. Hyperkeratosis of the skin, a condition resembling eczema, changes in the nails and hair are frequent manifestations of general interference with cellular activity.

The heart is enlarged, pulse rate is increased. However, there are no permanent cardiac lesions. Respiration is increased as a result of anaemia, fear, and pain.

In advanced cases, the sternum is depressed and the osteochondral junctions become prominent.

DIAGNOSIS: In the early stages, pallor and failure of development may be a cause of more than one disease and a diagnosis of

scurvy is often overlooked. But, if orange juice is given as a therapeutic test the effects thereof will often result in a greater certainty about this condition.

In the advanced stages, a history of the child having been fed on a limited diet, makes the clinical picture easily recognisable. The presence of one or more of the haemorrhagic spots, pain in the extremities, a history of the child having been fed on a limited diet confirms the diagnosis.

DIFFERENTIAL DIAGNOSIS: Scurvy is frequently mistaken for acute rheumatic fever. Points against this are (1) absence of fever, (2) absence of heat, redness, or swelling of the joint (3) the pain and swelling of the extremities being located on the shaft of long bones.

Periostitis and osteomyelitis are characterised by (1) these diseases being localised to one area, (2) these are associated with fever and intoxication; (3) these have no haemorrhagic manifestations. Tuberculosis of the hip or spine, fractures due to conditions other than scurvy and paralysis from various causes may all be mistaken for scurvy. Exophthalmos and hematuria accompanying scurvy may be confused, respectively with tumours of the orbit and acute renal disease. Scorbutic changes are common in lower limbs whereas ricketty changes are common in the upper limbs.

The most effective help in the diagnosis of scurvy is in the X-ray picture of long bones. The essential points in the X-ray of a well-developed case of scurvy are:—

(1) a finely irregular, broadened well-calcified epiphysal line; (2) a small spur at the lateral edge of the epiphysal line; (3) an area of decreased density immediately to the back of the epiphysal line (4) a very thin cortex and glasslike transparency of the shaft; (5) A broad, finely irregular edge of the epiphysal centre of ossification of the long bones.

The early doubtful case of scurvy shows:

- (1) The broadened epiphysal line.
- (2) The dense shadow around the centre of ossification of the epiphysis.
- (3) The absence of trabeculations on the shaft.

The combination or co-existence of all these three signs is pathognomic of scurvy. Such cases should be repeatedly examined

with X-ray. The Vitamin deficiency in the diet should be rectified.

PROGNOSIS: As cure of scurvy depends upon the administration of a sufficient amount of Vitamin C, the addition of orange juice to the diet of the patient, in a short period of a few days produces the most dramatic and gratifying results of medical therapy. The appetite and color returns, the swellings and pain subside, child feels comfortable, the tissue turgor, anaemia and general nutrition improve in three weeks. Displacement of the epiphysis, fractures, deformity due to subperiosteal haemorrhages recover in course of time with proper treatment. In such cases, prognosis is good. It is bad when the disease progresses rapidly, when the patient is moribund due to loss of blood and when the condition is complicated by bronchopneumonia.

TREATMENT: As a prophylactic, daily administration of one teaspoonful of orange juice may be given or tomatoe juice which furnishes sufficient Vitamin C enough to prevent scurvy. Addition of orange juice to diet may be made from the first month onwards and it may be continued until a generous supply of Vitamins are added to the diet. Orange juice must form a daily and routine addition to the child's diet. This is especially so in the case of artificially fed infants.

For the cure of acute scurvy give half an ounce of orange juice twice or thrice a day. Boiled potato or potato water is rich in Vitamin C and it is very useful. In moribund cases rectal or intravenous injections of sterilised, alkalinised orange juice may be necessary.

Medicinal treatment is of no value. Fractures and dislocations may be treated by splinting and reduction respectively.

Intercurrent infections must be treated as they arise.

The most astonishing repair such as reformation of a long bone out of calcified subperiosteal haemorrhages, absorption of the old, displaced shaft occurs in the few months following antiscorbutic treatment. The subperiosteal haemorrhages invariably calcify and are ordinarily absorbed in a few months and no attempts should be made to remove the blood from a post-orbital haemorrhage.

(To be Continued)

Abstracts

THE FUNCTIONS OF THE MEDICAL PROFESSION *

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I thought I had read my last paper before this Academy several years ago when Drs. Mitchell, Bonifield, Knight and I spoke of some items pertaining to the medical history of Cincinnati; but when the Chairman of the Programme Committee asked me to read another paper I felt that I had a message which might be of service to the Academy, especially to the younger members. I shall not indulge in statistics nor shall I comment upon any strictly clinical subject.

My object is to present some observations upon certain broad principles which have and which must ever underlie the moral, social and economic structure of the Art and Science of Medicine. I have therefore, chosen as the subject of this paper, "The Functions of the Medical Profession."

The fact that the healing art has existed in some form since the early existence of mankind, and that it has adapted itself to the changing conditions of the development of the peoples of the world proves that it must have a definite relation to the needs and necessities of man. History has proved that the medical profession has, at least, kept space with the development of a more and more complex civilization, and that it has exerted a lasting influence upon many matters incident to the proper regulation of some of the features which have gone to make our present civilization possible.

My mind goes back automatically to the time of my entrance into the medical profession and a comparison with the present will serve to illustrate the evolution that has taken place in the past fifty years. Basing our opinion upon what has gone before we may be able to predict some of the changes which may happen in the next fifty years. The past fifty years have demonstrated the fact that many new functions have been added to the requirements of an up-to-date medical profession.

From a very insignificant position fifty years ago, public health activities have been advanced to the most important of all of

the duties of the medical profession. One must bear in mind that the germ theory of disease was in its infancy fifty years ago and that public health measures prior to that time were necessarily crude and ineffective. The discovery of the causes of many diseases led to what is now known as preventive medicine—probably the most brilliant and helpful of all the triumphs of modern medicine. Scientific investigation of the causes of disease has passed from a minor to a major function.

When we recall that the first definite proof of the role of bacteria in the causation of disease was furnished by Robert Koch in 1876 when he demonstrated the bacillus of anthrax and showed beyond the question of doubt that it was the cause of anthrax, one cannot fail to be amazed by the rapid application of this knowledge to the prevention of the inception and spread of diseases. This discovery laid the foundation for public health measures based upon accurate knowledge.

The conservation of the health of the public is necessarily just as much a government function as is any other affair that concerns the people at large, but both the government and the people at large have been very slow to recognize its significance. The medical profession felt the importance of this branch of government long before the public or the ruling powers awoke to the urgent necessity which compels obedience to the laws of hygiene, sanitation, and prevention.

Our public health service at the present time is both too cumbersome and too expensive. It is unnecessarily complicated and wasteful because of the multiplicity of agencies for accomplishing its objects. There is at present a National Department of Public Health, each state has its board, and each country and each city have independent organizations for the care of the health of the citizens. In addition to the above agencies many volunteer groups are aiding in the work.

The first question to be answered is why should unofficial bodies be concerned in the matter of public health? The answer is very simple—because our other (political) organizations do not function properly. Be the cause what it may, the time has come to weed out so many boards and to centralize

the control of these various agencies under the Federal Government—all subdivisions to be directed and controlled by one national board. My suggestion is that a Cabinet position of Secretary of Public Health be established, and that public health affairs all over the United States be put under the control of this department. In this manner we can secure co-ordination and co-operation—a possibility plainly lacking at the present time. Such a department is as badly needed as any of those at present embraced in the Cabinet. The creation of such a department would without question, reduce expenses and add vastly to the efficiency with which public health matters would be handled.

Another great advantage of the plan proposed above would be that opportunities for becoming acquainted with the health problems of the entire country by a large class of our younger physicians and thereby fit them for an intelligent appreciation of all of the problems associated with public health work. A thoroughly trained corps of medical workers would be produced and the public at large would be much benefited by their labors.

Within the past fifty years an entirely new medical field has developed—research into the cause and prevention of diseases. Theoretically this might be regarded as a function of the government, and our Public Health Service, along with the medical departments of the Army and Navy, have made most valuable contributions to this important branch of medicine; but many equal, if not greater contributions have come from individual workers. Often results have been achieved by the discovery of one man being applied *practically* by another—as witness the team work of Reed and Gorgas in the control of yellow fever.

Research in its broad sense includes the work of such men as Koch, Pasteur and Lister, but we must not lose sight of the fact that those who introduced anesthetics, radium, a new and improved splint, or one who discovered that pneumonia was a self-limited disease, or one who discovered that cholera and typhoid fever are water-borne diseases, were just as much research workers as were the former brilliant investigators. The microscope is not a necessary adjunct to every variety of research.

The question for future determination is as to the best method or methods to carry on these investigations. Thus far the private worker has given the best results, but there is every evidence that government agencies are rapidly increasing the value of their output. The answer to this problem may well be that the combination of the two methods may bring better results than either could produce separately. A continuance of present methods seems advisable.

Vast progress has been made so far as purely physical diseases are concerned, but there still remains the vast field of causation prevention, and cure of disturbed mental, moral and psychic conditions. Much progress in the elucidation of these states has been made by the medical profession, but there still remains a great field of border line cases which needs not only medical recognition but education of the public as to the true significance of the knowledge in the possession of physicians.

Take the subject of crime, for instance, as an example of a subject that has been left to lawyers, theologians and social workers for solution while we, who alone possess the keys to the elucidation of this problem sit idly by without raising our voices in protest against the ignorant, and often vicious manner in which the so-called criminals are handled. A definition of crime is impossible in a general sense but the causes, prevention and cure of criminal tendencies is a purely medical question and can only be answered by those who are sufficiently versed in problems of biology, physiology and chemistry to understand the basic problems relating to each individual. Crime is a disease incident to each individual and to classes, and treatment must be adapted to each person. Barnes, in his History of Western Civilization, says, "We attempt to regulate a twentieth century civilization by applying to it legal concepts and methods that have changed but little since 1700. The rules of legal evidence are hopelessly out of date and confused. In many ways they are exactly the opposite of the principles and processes applied in the field of scientific evidence which is designed to ascertain the factual truth in regard to some specific problem. The attitude taken by the courts toward crime and criminal responsibility is a composite or archaic

* Read at a meeting of The Academy of Medicine of Cincinnati, April 28, 1936.

legalism, religious superstition and metaphysical illusions."

We have permitted newspapers and moral reformers to brand those unfortunate individuals who are addicted to the inordinate use of narcotics as "dope fiends," and yet I am sure no one in my presence has ever seen an addict to morphia who was in any way "fiendish" or who developed any criminal tendencies as a result of the use of this drug.

A really great forward step has been taken by the Government at the suggestion of Dr. Treadway in the establishment of a *hospital* (not a penitentiary) for opium addicts. A step of equal, if not greater importance would be the establishment of a government hospital for alcohol addicts. By so doing, these classes will be mercifully and correctly removed from being classed as criminals and be rightfully regarded as being mentally sick. Governmental control of these patients will be needed in order to enforce the proper carrying out of treatment. Medical treatment instead of punishment must supercede present methods in many of the so-called criminal cases. Before leaving this phase of our discussion I wish to commend most highly the methods in use in our Juvenile Court under the direction of Judge Charles Hoffman. A visit to his court will give you an idea of the proper application of medical knowledge to intelligent court procedure.

War is an example of mass insanity. It converts sober minded citizens into howling maniacs and wholesale murderers. Medical investigation of the causes and treatment of war madness should be instituted.

The third function of the Medical profession to which I wish to refer is that duty of ours to pass on to succeeding generations to stores of medical knowledge we possess and the ethical principles which should go with medical knowledge.

Taken as a whole our medical colleges are successfully instructing their students in the essentials of medical knowledge and graduating students possessing a vast deal of medical lore. Medical education is far in advance of general education.

The consolidation and amalgamation of medical schools under universities has led to a very decided diminution in the number of medical schools and a very great addi-

tion to the requirements to become a physician. Here again, the State has entered the medical field through state and city universities, but a large part of the funds for carrying on this work has been contributed by organizations or by private individuals. At present private medical schools have largely disappeared (a few only remain), but so far as one can see they compete very successfully with State institutions, and turn out physicians who rank at least equally with those of State-controlled colleges. Each class should remain until such time as one or the other demonstrates a marked superiority.

It has been suggested, and I think very properly, that the teaching of ethics in our medical colleges is not receiving the attention it deserves. Enlargement of the curriculum has somehow shunted the consideration of the ethical features of medicine upon a side-track, and there seems to be danger that it will not again be hitched on to the train of medical knowledge. Every thing indicates that now is the time to inculcate into the minds of our students the high moral nature of their calling. Debasement of our ethical standards will surely lead to a moral degradation that should have no place in our profession. Competition, even though it be keen, is not incompatible with gentlemanliness or high moral tone. The suggestion is made, therefore, that our medical colleges establish chairs for the teaching of proper manners to the students entrusted to their charge and to demonstrate to them the necessity of being gentlemen as well as scholars. "The aim of ethics must be the provision of standards and knowledge leading to a complete and happy life here on earth."

One of the most serious and perplexing problems confronting the medical profession at the present time is the relation that should exist between physicians and hospitals. This question must be considered from the point of view of our relation with government controlled hospitals and those controlled by private individuals or non-government organizations.

By government controlled hospitals is meant those institutions which are conducted by any government agency, national, state or local political division. The term private is limited to those hospitals which are designed for both pay and charity pati-

ents. The former class is of but little significance from our point of view, but the latter class is of the utmost importance to the medical profession, in that a large percentage of our patients must, for most serious illnesses, seek these institutions for proper care and nursing. They also serve as educational centers for physicians and nurses. They become by necessity medical centers.

Fifty years ago private hospitals were primarily religious and secondarily medical institutions. If my information is correct there were at that time but four private hospitals in Cincinnati, all under church control.

The necessary use of hospitals for medical teaching was recognized many, many years ago, but instruction was confined almost exclusively to public hospitals, and the medical staffs were composed, to a very large extent of the teachers in the medical schools.

Fifty years ago the nursing in all of our hospitals was done either by members of religious orders or by men and women who had had no training for nursing, but who picked up what knowledge they had after they took charge. The introduction of real training for nurses was less than fifty years ago. This preamble is for the purpose of indicating the close association of our hospitals with the functions of the medical profession.

You all know that our present private hospitals have become possible only through the generous contributions of philanthropic citizens, and that their continuance would have been impossible without such aid.

Now, what needs to be pointed out is that the period of depression through which we have passed has left these hospitals in a very precarious condition. A large proportion of these hospitals all over the country are on the verge of bankruptcy, and their future seems very dark because of the certainty that large donations are not likely to be given. In other words, the private hospitals are seemingly forced into a position where they will be compelled to become self-sustaining. In order to accomplish this result there seems to be but two methods, either the number of charity cases must be reduced, or new sources of revenue must be found.

It seems probable that both methods will have to be employed to prevent the collapse

of the hospitals in existence. Reduction of the number of charity cases can be brought about by having the city or county care for their indigent patients either by treating them in county hospitals or by having the county pay for their care in private hospitals; that is, to pay at least the cost of their care.

The increase in revenue and a reduction of the number of indigent patients can be brought about by some plan by which people can insure hospital care by making small payments which will guarantee hospital care in case of illness. The plan of hospital care that enables a citizen to pay his way and thus retain his self-respect seems better than sickness insurance paid by the state. The plan under consideration in Cincinnati seems a reasonable and fair one. I suggest a very careful consideration of this plan by the Academy of Medicine.

The subject of the cost of medical care is one which has received an avalanche of opinions from all sorts of people, particularly from those who know little or nothing about it.

A slight amount of consideration reveals the truth of the statement that the largest item of cost of medical care is not the physician's fee. His charges are almost negligible compared with the cost of hospitalization. In the older days most patients received medical attention in their homes, but with the advent of private hospitals patients and their physicians realized that the care given by hospitals was so much better than they could receive at home that hospital care became almost a necessity.

Hospital charges were very moderate at first, because the organization of a hospital was very simple and much of its nursing was done by religious orders, the members of which received little or no pay. As the hospitals increased in complexity and efficiency new and expensive features were added, so that the cost per patient mounted higher and higher, until at the present time the daily per capita cost is about six dollars.

We now come to a consideration of what may be said to be the medical function in the ordinary sense of the term -- the practice of medicine. It has been pointed out previously that this is not the most important obligation assumed by the medical profession, but it is of the greatest importance to each

individual as distinguished from the efforts to prevent disease of the masses.

It is remarkable how certain words, phrases, or sentences obtain currency and wide acceptance without the average person taking time to consider just what the meaning of the word is, and it is also amazing how frequently people will quote words without attaching any meaning to their quotations.

One of the statements which has received wide currency and apparently almost universal belief is that "only the rich and the very poor receive proper medical care." When you stop to consider the meaning of those words their absurdity becomes at once apparent, because that leaves the vast majority of mankind in the class receiving improper or no medical care. Every physician knows the fallacy conveyed by this sentence, and every intelligent individual knows that physicians would starve to death were it true that they were not giving their best efforts to the care of the very class excluded by the sentence given above. It is from this class that physicians obtain the vast majority of their patients, and hence their livelihood. Stripped of false ideas, the sentence should read that there is a class of people of very moderate means who find it difficult to make ends meet when sickness invades the family. Be it said, to the glory of the medical profession, that not one of this class of persons need hesitate to call upon any member of our profession, and that he will receive as good attention as could the very rich or the very poor, and that charges for such services would be commensurate with his ability to pay. No honorable physician would make money the sole measure of his duty in the care of the sick. "The best protection for the individual physician and the present system of competitive medical practice lies in sincere efforts on the part of each physician to provide *all* his patients with competent pains-taking service and be guided by the principles of medical ethics in his dealings with the public and his colleagues."

The fact that many attempts are being made to regulate and standardize medical practice might be construed as a broad hint that present methods are all wrong and that there must be something radically wrong with the medical profession.

It is only fair for us to look for our shortcomings and acknowledge our faults, but at the same time our virtues should not be

covered up. It is possible, in fact probable, that the medical profession is somewhat overcrowded, and that this is particularly true of the urban centers. It is also true that preventive medicine has reduced the amount of illness very appreciably, thus increasing competition for practice; and the introduction of automobiles has made it possible for the rural physician to cover a much greater area and thus increase the number of patients he can attend satisfactorily, thus doing away with the necessity for so many practicing physicians. In view of the facts we may truthfully say that the supply of physicians exceeds the demand.

An attempt to remedy this overcrowding has been made by increasing the number of specialists and by more and more physicians entering government and industrial positions, but now we find that these outlets are not sufficient to take up the excess of graduates, so either some new vent must be found or the overcrowding will be worse in the future. Perhaps the wise way will be to limit the number of medical students.

Previous to the recent depression it might have been true that some physicians, particularly some so called specialists, became imbued with the lust for wealth, and that there was a tendency to "get rich quick," but when the crash came what class of people demonstrated their altruism and interest in the unfortunate to an extent comparable to the medical profession?

The medical profession, taken as a class, will measure up to a very high standard, much above the average level of mankind, and their ethical relations are far superior to those of business. It seems, therefore, that no attempt should be made to lower the ideals of medical practice by trying to make it a spoke in the wheel of industry. Efforts should be made to raise the standards of business to the level upon which the medical profession stands. When people talk of hiring out physicians to the government or to industry they are suggesting that the medical profession step down from a higher to a lower plane and exchange high principles for lower and more ignoble ones. Commercialization of medicine is unthinkable and most undesirable.

The suggestions for revamping the medical profession are due to an insufficient understanding of the problems to be solved. There can be no doubt that, in times past,

the medical profession has generously and willingly treated large numbers of our population who were not able to pay for medical attention, and I believe the profession is still willing to continue this method. A survey of the whole problem immediately brings into the limelight the question as to why there should be such a large proportion of the population who are unable to pay for their medical attention. So soon as this problem enters one's mind he realizes immediately that the difficulty does not lie with the organization of the medical profession, but with the civilization which permits so large a number of its citizens to be so poorly paid as to be unable to pay a reasonable amount for medical attention.

The fundamental question is, how are we going to raise the standard of living of the poorer classes so as to make them self-sustaining citizens? This is the problem facing the world—not the degrading of the medical profession, but the best method of alleviating the poverty and wretchedness of the masses.

I feel that I would be remiss in my duty were I not to refer to some living physicians who exemplify the ideals for which all physicians should strive. The physicians referred to have spent at least fifty years in the practice of medicine; they have stood for high ideals, their lives are open books in which can be read the lessons of honesty of purpose, faithfulness of service, fullness of knowledge and lives without spot or blemish. Because of their modesty their virtues have not been blazoned forth to the public, nor have they sought the fame to which they are justly entitled. As examples of real physicians I point with the greatest pride, the deepest admiration, and the most profound reverence to those physicians who represent the ideals of the general practitioner.

As examples of the type of physicians described above I wish to mention Dr. E. W. Mitchell, Dr. Allyn C. Poole, Dr. Oliver Holt and Dr. Elizabeth Campbell.

The following statement is reproduced as evidence that the legal profession is awakening to the necessity of higher standards: "Eighteen youthful attorneys admitted to the Utah bar took an oath never before administered to applicants to the bar in any state. The new oath, drawn up by the

American Bar Association, calls for adherence to the highest principles of professional ethics, as well as the usual promise to support, obey and defend the Constitution of the United States." The young lawyers swore that they would not act as counsel in any suit which appears to be unjust, nor in defense of any except such as those that are honestly debatable under the laws of the land. Furthermore, the oath required attorneys to swear that they will employ only such means as are consistent with truth and honour, and never to mislead the judge and jury by artifices and false statements. The confidence of clients must be preserved inviolate. No compensation can be accepted in connection with a client's business except from him or with his knowledge and approval. Attorneys under the new oath pledge themselves to abstain from all offensive personality and to advance no fact prejudicial to the honor or reputation of the party or witness unless so required by the justice of the cause. They pledged themselves also never to reject the cause of the defenseless or depressed or delay any man's cause for lucre or malice. The oath was administered preceding the opening of the January session of the Utah State Supreme Court, with Chief Justice Elias Hansen presiding.

In conclusion I wish to prophesy that the future of civilization will lie in the hands of the medical profession. The warrior has had his day; the priest has had his day; and the day of the lawyer is about over.

Press on! Prepare yourselves thoroughly for the task that is before you!

DISCUSSION

DR. SAMUEL IGLAUER: Dr. Oliver has given us a very interesting and instructive review of the progress of medicine during the past fifty years. From his ripe experience as a surgeon, teacher and citizen, he has drawn certain conclusions to which we should give heed. In addition, without attempting to act as a prophet, he has given us a glimpse of the future of medicine.

As pointed out by the essayist, the progress of medicine has kept pace with our economic and scientific progress in other fields. During the past fifty years we have witnessed the development of the machine age and of mass production. This has led to an enormous increase in our urban popu-

lation and a corresponding decrease in our rural population. This, in turn, has led to the overcrowded tenement house—to the city slums. The very comprehensive studies by Dr. Allen, of this city, have demonstrated the close relation of overcrowding to the incidence of communicable disease, notably tuberculosis, diphtheria and the acute exanthemata in under-privileged groups of our population. As a result of over-expansion, followed by depression, millions of people have been thrown out of work through no fault of their own, and have become a burden on the government, the community, and upon the medical profession. Besides those entirely without work, there has been a substantial reduction in the incomes of the great middle class, from which, as Dr. Oliver has stated, physicians derive their chief income.

Only a small group, probably about ten per cent of our population, has a family income of \$5,000 or more. A larger group, about forty per cent of the people, have a family income ranging from \$1,400 to \$2,500 per year. These persons can pay for ordinary minor service, but a severe illness may hang a mortgage around their necks for many years of their lives. Furthermore it is estimated that the annual cost for severe illness falls upon only a fraction of the entire population.

With the tremendous advance in medical science there has been a parallel increase in the cost of medical care. It may be stated that every new discovery in medicine has a tendency to increase the cost of medical care, although in a few instances when specifics such as sera and the like are employed, the period of illness is greatly shortened.

The medical profession may be grouped in the middle income group. In prosperous times the median net income of physicians amounted to about \$3,800. In other words, half the physicians received less than this amount. About twentyfour per cent had an income of less than \$2,000.

In my opinion many physicians as a class do not fully realize the burden of severe illness because, through mutual help, they are relieved from medical service costs, and also are extended courtesies by the hospitals with which they are connected. The general population and students of economics, on

the other hand, are giving this problem more and more attention, and various methods have been advocated to meet it.

Dr. Oliver has favorably mentioned one method of lightening the load, namely, group hospital insurance. This type of insurance is now in force in many large cities, for instance, in New York, Washington, Cleveland, St. Paul and Minneapolis. New York has 151 hospitals enrolled. At the present time the recently formed Hospital Council in our own city favours the Cleveland plan. In Cleveland they now have some 20,000 subscribers enrolled, and hope to have 30,000 by the end of the year. The cost per person amounts to \$9.00 a year and entitles the holder to twenty-one days of hospitalization per year. A similar plan in our own city would go far toward relieving the hospitals of part of their financial deficits. Under such a plan the physicians also would benefit, since the patient would have a residue in his savings to compensate the doctor. In common with Dr. Oliver, I think this matter worthy of the earnest consideration of the Academy.

The medical profession in Detroit and Washington have endeavored to meet the costs of medical care by a social service investigation and deferred payment plans.

Under these plans, patients are classified and treated according to their ability to pay, and are relieved of immediate lump payment for services delivered. These movements are a step in the right direction, especially since they show an awareness on the part of the profession of the problem at hand. In my opinion they should eventually be extended to provide for some sort of prepayment plan for medical services, but here I realize that I am on controversial ground which is beyond the scope of this evening's discussion. However in this connection I should like to mention Industrial Insurance as a prepayment plan, and I should like to have Dr. Oliver discuss it in closing. Without speaking from experience, I believe that Industrial Insurance, with all its faults, is far superior to the old system in vogue prior to its adoption. Industrial Insurance has at least one feature which Dr. Oliver will appreciate, namely, it does not give the lawyers a "look-in."

Referring again to the care of the indigent, while it is true that most physicians,

following the time-honored tradition of their profession, render free service to those unable to pay, and while the poor and lowly are always with us, under our present economic conditions the load is heavier than the profession can bear. There is no particular reason why physicians should be called upon to render so much free service, and in common with many writers on this subject I believe that the state should in a measure compensate physicians for this type of service rendered outside of hospitals. When physicians use patients for teaching purposes, they (the physicians) are compensated, for the best way to learn is to teach. That such a payment plan is feasible is well demonstrated in Detroit where practicing physicians are compensated by the Board of Health for certain types of medical service (immunization).

In his concluding remarks Dr. Oliver raised a fundamental question: "How are we going to raise the standards of living of the poorer classes so as to make them self-sustaining citizens?" If this question can ever be answered, many other problems will be solved along with it. A solution of this problem will require the best thought and effort of the statesman, the economist the labor leader, the philanthropist, and the physician.

(*The Journal of Medicine*, October 1936).

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Healing of the Newer Bumper Fractures of the Tibia

Walter G. Stern and Louis E. Papurt, Cleveland (*Journal A. M. A.*, December 28, 1935), describe the newer type of bumper fracture as characterized by a severe comminution and splintering of the midthird of both bones of the leg with many larger and smaller fragments, with long, linear fracture lines running up and down the tibia and, in the center of the comminution, a diamond or pyramid shaped fragment out of the cortex, usually on the anterior surface and often lying free from the rest of the fragments. The injury to the soft parts is usually severe and the fracture is often compound. Other types of injuries will occasionally produce the same characteristic features, such as injuries in mines from coal cars, falling rock and the like. The

mechanism of this fracture-producing violence is rather similar to the direct violence of the bumper of an automobile. In their treatment primary reduction and fixation is carried out by the elected method for about eight weeks. After eight weeks the cast, if applied, is removed and a plaster mold of the leg is made and measure taken for a walking brace reaching to the thigh, with lock joints at the knee. The plaster cast with walking iron or walking heel is re-applied. By this time usually sufficient fibrosis has taken place within the fracture area so that the leg is no longer flail and there is no danger of slipping of fragments. If this is not the case, the cast is reapplied and the patient is compelled to use his crutches for from four to six weeks longer. From the mould a model of the leg is made and a leather steel envelop brace with ring locks at the knee is constructed. This is form fitting and allows full weight bearing without any motion between fragments or any danger of angulation. The ordinary caliper brace is inefficient and does not completely immobilize the fragments. By this weight bearing and active function the circulation of the extremity is improved, muscle tone is re-established and bone production is stimulated. There is a gradual deposit of lime in the callus with increasing fixation of the fragments until solid union finally takes place. These fractures are extremely slow in healing. The average healing time in a series of more than 100 cases was 6.2 months.

The Journal of Medicine April, 1936.

Tannic Acid and Silver Nitrate; A Superior Treatment of Burns.

A considerable amount of work of the plastic surgeon consists in the removal of scars and deformities, the result of burns.

By giving a narcotic, removing the burned tissue as well as possible, applying five per cent tannic acid solution followed by ten per cent silver nitrate, keeping the surface dry and forcing fluids, we have a regime of treatment which not only saves lives and shortens convalescence but also minimizes scars and deformities. Unhealed areas which remain after removal of coagulum are treated by the application of oxyquinoline sulphate scarlet R gauze. Shock, toxemia and blood concentration are minimized and urine with albumin does not occur where

grease has not been applied. Infection is also held at a minimum.

The points of superiority over other treatments are:

1. The saving of lives that would be lost through the slower method of tanning.
2. The immediate stopping of the loss of body fluids, thereby preventing the consequent concentration of the blood.
3. The immediate prevention or very definite minimizing of shock.
4. The immediate prevention of the absorption of toxic products.
5. The prevention of infection by the short period of application of moisture and the early drying of the tanned tissues.
6. The saving of the kidneys and other organs from the effects of fluid concentration, and the absorption of toxins and infection.
7. The greater comfort of the patient.
8. The patient is safely carried past the first twenty-four hours, which is the most critical period following a serious burn.
9. The patient avoids the second critical period, that of infection and late absorption of toxic products.
10. The simplification of the nursing problem, especially in the first twenty-four hours.
11. The prevention of further breaking down of tissues which results from long application of wet dressings.
12. The prevention of chilling, which also results from the long application of cold, wet dressings.
13. The formation of a thin, flexible coagulum.
14. The speedy healing of the burned areas with a shortened period of hospitalization.
15. The prevention or minimizing of heavy contracting scars by early, rapid healing in the absence of infection.
16. The lessening of the amount to skin grafting and secondary corrective surgery.

(*Eye, Ear, Nose and Throat Monthly, Jan. 1936.*)

Tannic Acid Treatment of Burns

Grover C. Penberthy, M. D., Detroit, Mich.

Burns have carried a high mortality and are best treated in the hospital. The standardization in the treatment of diffuse burns by the use of tannic acid has materially reduced the mortality and this contribution by Doctor Davidson to the

subject has resulted in the saving of many lives.

Washing the chemical burns with water is essential before applying the neutralizing agent.

Proper first aid followed by early hospitalization and aseptically cleansing the burned area is important.

The tannic acid method of treatment, spraying with a freshly prepared 5% solution every 15 minutes for 4 to 6 hours, combined with the light tent, is effective and helps to simplify the treatment of a condition that can tax the patience, time and resources of the attending physician to the utmost.

The forcing of fluids and giving saline, either sub-cutaneously or intravenously, and blood transfusion are necessary to carry the patient through the acute period of toxemia.

Early skin grafting of the third degree lesions will minimize the amount of scarring and deformity. It will also lessen the period of morbidity and disability.

The severe burn case often requires subsequent plastic surgery to improve the function of an extremity or better the cosmetic result.

The Eye, Ear, Nose & Throat Monthly, Jan. '36

The Common Cold

T. J. LEBLANC and M. B. WELBORN (*Amer. Jour. Hyg., July, 1936, p. 19*) endeavoured to find evidence in support of the common belief that rest in bed is a valuable aid in treatment of the common cold. Their studies, made on hospital nurses from October to April, with a great preponderance of cases in December and January, lead to the conclusion that rest in bed diminishes the incidence of complications. It was not possible to contract a group having no rest in bed: the two groups studied were those who went to bed promptly after being ill and feverish and those who did not go to bed until 120 hours latter than the first batch. The second group had complications (acute sinusitis, acute otitis, quinsy, acute bronchitis or pneumonia) five times more often than the first; they returned to duty on the average 2.7 days latter and had two days more in hospital. The authors acknowledge, however, that there is some doubt whether the difference in duration of illness would have been shown if both groups had been free from complications. (*The B. M. J. 17th Oct. '36.*)

THE Medical Practitioner

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[NO. 1

OURSELVES

With the October issue the eighth year of the life of The Medical Practitioner will commence. Whether the journal has fulfilled the pledges given by Dr. Rama Kamath to his electorate when he first stood for election in 1929 to represent the registered practitioner in the third group of the Madras Medical Register must be within the knowledge of his electorate and other readers of The Medical Practitioner. The fact that in 1934 he was returned with almost an unanimous verdict of those whose cause the journal has been espousing without fear or favour in spite of an opposition openly shown by some officials in high position in the city of Madras who not knowing what they did went even against law and used their influence making those who listened to them dupes to their machinations. But the electorate was too clever to be a prey to the evil influence for obstructing progress and reform. It was most creditable that almost all who were for the time being under the yoke of officialdom demonstrated their courage openly as against the cowardice of those under whom they had to serve. They demonstrated that beyond the official duties, they as members of a noble profession owning rational reasoning, were as independent as any body could be. In spite of such snubs a few malcontents have been following the activities of The Medical Practitioner with a view to impede them. But The Medical Practitioner even with an invalid Editor has been able to resist the obstructions of these few who have been hampering a healthy, homogenous and prosperous growth of the medical profession. The path of progress and reform has never been smooth. It is thorny and at times stormy. It is during

storms that the courage of the captain of a ship and his crew is put to test. The sagacious captain cannot and will not take the credit of mooring the ship in the storm to safety for without the help of One who gives rise to storms for purposes of His own, the captain or his crew however valiant they might be, could not always save the ship nor themselves. It is during these storms that the human element is on its trial and our experience has been—and it cannot be otherwise with our readers—that The Medical Practitioner and its sympathizers have stood the test well. All glory to Him who has been guiding us all during storms.

If the Medical Practitioner exists today though in the same meagre form as it was at the time of its birth and though it may look precocious by comparison due to its age and bulk, it has been second to none in its zeal to serve the profession and it has been fighting in all conceivable fields where the interests of the profession were at stake. The Medical Practitioner acknowledges with gratitude the help it has been receiving from its readers who ungrudgingly have been supplying the sinews of war. These sinews are getting stronger by use though not to the extent we wish them to be—in direct ratio to the troubles we have been having ever since the demise of our beloved senior the late Dr. M. S. Krishnamurthi Ayyar. This noble soul was attracted to Dr. Kamath true to the saying that birds of the same feather flock together. He was an ardent lover of the profession. The fact of his being in service all through his life till he retired as the Sanitary Commissioner of Travancore did not deter him from giving expression to his ideals even at the risk of incurring the displeasure of his

official masters one of whom was the enlightened ruler of Travancore. It will not be out of place if we were to digress for a moment for the purpose of informing our readers the traits of character of independence that were at the bosom of the late Dr. Krishnamurthi Ayyar. There was a great famine in Travancore and a special European officer belonging to British Service was lent to Travancore Durbar to be in charge of Famine Relief. This European officer gave some instructions to the Sanitary Commissioner which being not consistent with the principles cherished by Dr. Krishnamurthi Ayyar he refused to carry out. This officer complained to His Highness about the Sanitary Commissioner. But the Maharaja curtly replied saying that the Sanitary Commissioner could not be asked to do anything against his principles. The Medical Practitioner has been maintaining the spirit of independence so dear to the heart of our departed colleague, consistent with the dignity and avowed principles of the medical profession without compromising even after threats and actual attempts to undo what has been done by it for the good of the public and the profession. Money has no consideration for The Medical Practitioner for it loves honour more than money. What the subscribers have been paying is spent in increasing its popularity through propaganda and service which we have been doing by increasing its circulation and sending the journal free of charge.

We have more faith in prevention than in cure and will endeavour wherever it may be, to prevent the obsession of a virtue appearing like a crime due to physical, mental or moral disabilities. Coming in contact with eminent and scientific members of the medical profession through books and journals dealing crime as any other ailment, we have been able to realise that crime is at times misconceived by those who are sitting in judgment on alleged criminals or those prosecuting them. We wish the members of The Medical profession especially those in official authority read and imbibe the advanced scientific views on crimes as propounded by eminent Physicians in advanced countries like America and others in the West. In India the Government medical officers in high position are usually consulted by the judiciary for

opinions on medical matters and are therefore in a more advantageous position than their brethren in private practice. Consequently the opinions of the Government medical officers, will have the desired effect in the matter of advanced Psychiatries about crimes and criminals. A thought provoking address by Dr. J. C. Oliver an eminent surgeon in America is published in the Abstract Columns of the current issue of The Medical Practitioner. The address deals most admirably about the functions of the medical profession in all details including the responsibility of the profession towards crime and criminals. We wish the readers of The Medical Practitioner go through Dr. Oliver's address and realise the importance of the members of the medical profession to build a nation and keep it physically and morally healthy.

Every province in India is in need of a nonofficial organization where members of the medical profession are trained not only to exercise the profession as such but to utilise their learning for the good of the public. It should serve as a clinical society as well as a society to discuss problems concerning the human society. The organization and existence of such a society is quite consistent with the functions of the medical profession. America is actually running such organizations and calls them Medical Academies. England is far behind America in advancement on such lines. The Federal system of Government in America is perhaps responsible to adjust the profession for the needs of the medical profession to serve the public and itself consistent with the system of Government. India will soon have a Federal System though perhaps not of the advanced type as existing in America. Medical institutions in the shape of hospitals to serve the sick originally came into existence in every country as a part of the functions of religious organizations. In India almost all the indigenous systems of medicine claim their origin from Rishis or persons of a religious order. At present the art of healing is under the control of non religious agencies. It is the medical profession who controls this art in all other civilised countries except in India where scientific system of medicine is entirely under the control of Government.

So the task of the medical profession to make itself usefully felt is much more diffi-

cult and complicated than in other countries. It is no wonder the scientific system of medicine has not advanced to the extent it is outside India. Politicians, social industrial and such and similar organizations have been usurping the functions of the medical profession even in advanced countries in the West and the East and the medical profession is feeling it to its cost. There are well organized associations in all civilised countries to guard and protect the interests of the medical profession. We have none in India so far excepting one in Calcutta, the Indian Medical Association which is still in an embryonic stage of its development for want of encouragement from the members of the profession itself. This is due to the fact of diversity of interests of its members who are made to live by the Government of the land in air and water tight compartments. In India, the scientific system of medicine being entirely under the control of Government the medical profession has very steep up hill work even to build itself as a homogenous entity. Our experience has been that the profession can not afford to advance and even exist without associating itself with Government officials in the Medical Department in case they wish to prevent the immediate danger of unemployment keenly felt by its members in private practice. The mentality of the public even in far advanced countries is to get free service from the members of the profession. It is thousand times more in India. In India the scientific system of Allopathy was introduced primarily to serve those who came to India to govern India. Medical Schools were introduced to train assistants to serve under the military medical officers. Universities started from Schools. The functions of medical graduates were for a long time restricted to be assistants though more dignified than the Hospital Assistants now styled as Sub-Assistant, Surgeons. Those trained from Schools are appreciably more predominant in the profession than those from University Colleges both in service and in private practice. The system of private practice in Scientific system of medicine began with those in service. To begin with there were no private practitioners in the system. The medical profession in India owes the development of private practice to its members in Government service. Private hospitals and nursing homes owe their origin to the

enterprise of the members of the profession in Government Service, the so called independent medical practitioners are now entirely depending upon their brethren in Government Service for the development of private practice on healthy lines.

The Medical Practitioner has been agitating to build up the medical profession in this country on the lines obtaining in other civilized countries and it never spared its criticisms against the Medical Officers in Government Service who have been misusing their privileges of private practice as such and seriously hampering the growth of independent medical profession. Signs are not wanting though much belated that the Government have realised the spirit of our agitation in this direction. We wish the members of the independent medical profession realise that the change in the angle of vision of the Government to recognise abuses of privileges of private practice by their officers, was due entirely to the officers of the Government including both medical and non-medical bureaucrats. It is within the knowledge of every Indian that there was a Hume, a Wedderburn amongst the bureaucrats and a Besant and at least a few like her amongst the non bureaucratic Europeans but for whose encouragement no body would have had the courage of even expressing the word Home-Rule and the later Indian expression Swaraj. If there were in the past lovers of India's freedom amongst the members of the steel frame, it will not be difficult to imagine there may be at least a very few amongst them even now nor is it inconceivable that there are as few though a microscopic number amongst the Europeans in the medical profession in service and outside Government Service who are anxious to show a helping hand to build up a healthy medical profession in this country. Amongst the Indian medical officers we have now certainly a large number to co-operate and help their brethren in private practice. We have to acknowledge most gratefully that members of the medical profession in Government Service have been showing their sympathies for their brethren in private practice through the agency of The Medical Practitioner, with admirable courage when their help was demanded for upholding righteous causes and when the members of independent medical profession at times found faltering to do

the same. This has been our experience in the past and even now.

We are convinced not without sound reasoning that the medical profession in India will win Swaraj more speedily and with less labour with the help of Government medical officers who can be trusted more than the non Government element in the present political field including the politicians. We pray God to give us strength and opportunities for service in the coming year to make our readers realise our ambition. The New Year is fast approaching. Though we are just publishing the October 1936 issue we hasten to send our greetings to our readers, wellwishers and sympathisers and pray Almighty for their health and prosperity. Without their help and cooperation we would not have been able to do even the little which we claim we have done. We shall continue to serve the profession in the coming year as we did in the past with heart within and God over head.

News and Comments

Civilization and Medical Profession: Soon after we wrote the Editorial "Reforms and Responsibility" in the last issue of The Medical Practitioner, we read with greatest admiration the most profound and thrilling address delivered by Dr. John Chadwick Oliver M.D., to the Cincinnati Medical Academy. We wish the readers of The Medical Practitioner not only read this address published in the Abstracts Columns of the current issue but imbibe the principles enunciated by Dr. Oliver so as to enable them to play their part more usefully in the future civilization of India. Civilization is a compact term and conveys all that pertaining to a nation in the matter of advancement. No advancement is possible unless there is an advancement in the system of Government. This is why we thought it was desirable that the medical profession should realize its responsibilities towards the coming reforms. The Medical Profession can if it chooses play a part in politics which no other profession can and that most rationally and scientifically and build a healthy nation to evolve an ideal civilization. This is the gist of the thought provoking address of an eminent Surgeon in America. We have eminent physicians and

surgeons (in their own ways) in India but we should say we did not come across one of the type of Dr. Oliver the living surgeon of Cincinnati and Dr. Mitchell the most famous dead physician of Philadelphia whose name must be familiar to all the living members of the medical profession throughout the world as an authority in Neurology and the time honoured useful therapeutic known as Rest Treatment. The latter was not only an author of medical literature but was an eminent author of prose and poetry on subjects 'of occasion', practical and useful to the public. The late Dr. Mitchell took an abiding interest in civic affairs and commanded such an influence to the great advantage of medical science in his native city. Dr. Oliver has vividly shown in his address the possibilities and opportunities which the medical profession has in evolving an ideal future civilization. Public Health, the role of physicians in the intelligent appreciation of all the problems associated with the public health work, Public Health Service apart from Independent Voluntary Health Organizations, their relationship to each other, the responsibility of the profession in educating the public on crime and criminals (which the lawyers, theologians and social workers cannot solve) and last but not of least importance, the building of morals providing standards of knowledge 'leading to a complete and happy life on earth'. All the above functions treated in the address of Dr. Oliver the Surgeon of Cincinnati could be put to practice by all the members of the medical profession in this country whether they be in Government Service or Independent Service. And is it too much for us to appeal to Major-General Sir Frank Connor, one of the leading surgeons in India till a few years ago, now the Surgeon General with the Government of Madras, and President, Madras Medical Council to take the place of Dr. Oliver in this province. He is occupying a most unique position as the recognised head of two sections of the medical profession which though appearing at present divergently opposite in their individual interests they can be merged into a healthy homogenous entity for the service of humanity. He is the Government in himself and a person who can command tremendous influence for good as he is the head of the entire medical profession in his capacity as the President of a Council representing the whole of the medical profes-

sion. Sir Frank Connor did express on the very day he took charge of the responsibilities of the President, Madras Medical Council, that he would have very much desired that the President was a creature of the Council and not of the Government. He has shown that it is possible to correct wrongs in a system without fuss as he did with regard to the conduct of examinations of the L. M. Ps. in this Province. If his predecessors in office here and contemporaries in office in other provinces could not make themselves felt to do good to the profession and the public, it is because they have been lacking in their imagination as they did not mind taking the independent medical profession in their confidence. Sir Frank Connor will be in our midst till next September. We say it is possible for him to be an Oliver for Madras even without an Academy. It is also possible for him to build an Academy in Madras before he lays down office. He can leave behind him foot prints which others may follow either here or in other provinces.

Trained Nurses in Conference: Seventh October 1936, the day when the representatives of the Nurses from India met in conference at the General Hospital, Madras, marks an epoch in the history of Nursing Profession in India. The conference was opened by the Officiating Head of the Madras Medical Department, Lt. Col. Newcomb. The conference was presided over by Miss A. E. Abram of the Presidency General Hospital, Calcutta who is the President of the 'Trained Nurses' Association. Lt. Col. Newcomb said amongst other things:

"The number of trained nurses in Madras seems to me quite inadequate for the requirements of the Province, as estimated by English standards. Much of the work which in England is done by nurses is done here by nursing orderlies."

From the doctors' point of view, nothing is more important than good nursing as a therapeutic measure in the majority of the diseases.

I would suggest that one of the most important objects that your Association should work for is to persuade girls of the right type to take up nursing."

The President reviewed the work of the Association and stressed on the necessity of building up finances of the association by increasing the membership which is now 605 on the roll as against 443 last year.

While giving an account of her work during the period under report Miss D. Hartly, Secretary of the Association brought to the notice of the conference the depressing conditions of the nursing staff in some hospitals in India. She said:

"The conditions under which most nurses work is appalling. Hospitals are invariably overcrowded and hopelessly understaffed, there is insufficient supervision and, except in the Mission Hospitals and a few of the Government Hospitals such as the Thomson and Lady Lyall Hospitals Agra, and a few others; their quarters are often almost unfit to live in."

Everywhere I saw people were anxious to persuade more suitable well-educated Indian and Anglo-Indian girls to join the nursing profession. We therefore visited schools where we received every welcome from teachers and scholars, who are now beginning to realise that nursing as profession requires people of the best brains and ability and that it is not the last refuge of the dunce."

The paper read by Miss Norah Hill, Organizing Secretary of the Indian Red Cross Society, Delhi, was most inspiring and as well as thought provoking. She dealt with the three most important aspects of the nursing profession. She divided the path of progress into three words which were self explanatory.

"One which I call 'domestic' which conceal your Association itself, a second which I shall call 'propaganda', and third which I shall call technical progress."

From the report of the proceedings which we read in the columns of the 'Madras Mail' we could gather that the Nursing Profession in India is in as helpless a condition as the Medical Profession. It is no wonder that the art of nursing a most coordinating factor, in relieving human ailments, is not appreciated either by those who are suffering or by those who are ministering treatment to the suffering. We may go a step further and say that even those who are in the nursing profession at least a large section of them do not seem to know the value and usefulness of their own profession apart from its being a means to earn their livelihood. Such a state of affairs is certainly most appalling and is the root cause of the dismal conditions so vividly described by the Secretary of the Association in her report. We had no opportunity of having first hand knowledge of the conference nor could we intrude though we wished it-as all our attention was required at the time in the Police

Court to defend ourselves against a Libel case filed by Lt. Col. Mahadevan the subject matter of the complaint against us being an Editorial which appeared in the October 1935 issue of the journal under the caption, 'Madras needs a state medical faculty'. We had therefore to depend entirely upon the report of the "Madras Mail" which did good service to the nursing profession in India by publishing a detailed report of the proceedings of the conference. The first thing that attracted us in the columns of 'The Mail' on 7th October, was a very fine picture of a group photo of the most prominent personages who must have attended the conference. We could only identify in this picture the officiating Surgeon-General, the Superintendents of two Government Hospitals, the General and the Special Hospital for women and children in the city of Madras whom we personally know. Amongst the ladies we could discern only the wife of a High Court Judge in Madras by the beautiful bouquet in her hand as it was said in the proceedings that Mrs. H. D. Cornish opened an Exhibition. We associated this bouquet with the delightful garland on the neck of Lt. Col. Newcomb and as garlands and bouquets are special features in such gatherings even when they are organized by Europeans in the oriental atmosphere of this country, we took the lady with the bouquet as Mrs. Cornish. Forms are the fashions of the day and substance follows forms as it must be the opinion of those who are building the civilised structures of society that forms should exist with substance. So our comments on the substance of what we read could not but concern the forms also.

These forms indicate the present tendency --to us it looks as an irony--that help is sought perhaps due to courteous ignorance or innocence, by those who are in need of it from the very persons in authority who are directly or indirectly responsible for the apathy now existing in the society, either it be concerning the noble medical profession or as important and as useful a profession of the nurses.

Miss Norah Hill the Organizing Secretary of Red Cross did not make a secret of communal bias and warned those who organized the conference that even well intended teachings from the Bible should be avoided in their activities. We feel that it could

not be difficult either for her or other interested in the nursing profession that real and as dangerous biases of more than one kind exist in the nursing profession. The European Nurses claim a pedigree of their own as distinct from their Anglo-Indian sisters and when the Indian nurses are concerned both the European and Anglo-Indian nurses form a separate group for themselves forgetting for the time being their inherent differences. We wish the organizers of the Nurses' Association realise this real danger which, if not got over, will not enable them to have either the sinews or the persons to run the Association successfully for the good of all and not of individuals. Self help is the best help. Even God helps those who help themselves. This is the teaching of the Holy Bible and it could also be found in all the other existing holy books.

Help from persons of the position of Surgeons-General, Inspectors-General and the Superintendents of big hospitals is certainly useful in its own way. Even here it is the person and not the official position he may occupy that has to be depended upon. Decorations are certainly symbols of appreciation and let these identify qualities of persons. Offices have machineries which the persons holding offices cannot themselves run. A humblest clerk in an office is at times capable of putting a tiny nail some where in the machinery, which itself cannot be seen but all the same works as a most powerful obstruction. It is not the medical officers nurses or lay public in high position that can realise the grievances of those in the rank and file of all the three groups. It is the latter that feel the want more acutely than those at the top. The several papers read by eminent persons at the conference reveal our feeling more than what we have expressed.

The grievances of the Nurses are identical with those of the Medical profession. There are worse biases of castes more complicated than communal biases. The Medical Practitioner has been doing its best to rid the medical profession of this canker. The Medical profession has to depend upon its sister nurses. The columns of this journal are at their disposal for any service. The combined cooperation and co-ordinating influence of the lay

news papers with the professional journals are sure to help both the nurses and the doctors. On the healthy growth of these two professions the world's health and happiness depend. We wish the European realises as much as the Indian that if both these nationals belonging to the two professions unite and combine giving up vested interests there will be a glorious future for India and not otherwise with all the labour and influence of these two nationals if they work discordantly. The woman folk in both the professions can serve as mothers and sisters remaining as maidens of service and wield a tremendous influence for good. The marvellous influence of women is being felt every day everywhere in the world even the most illustrious King Emperor renounced his Crown and Throne for the love of a woman. There are no better channels for the influence to spread than the activities of service to suffering humanity. We have before us men and women in India and more outside India whom the medical and the nursing profession can emulate and make India a power for the good of the whole world. The secret of greatness of India is in her spirituality. If men and women in the medical and nursing professions make use of this weapon India will have a glorious future.

Wanted a Matron: Just four days before we read the proceedings of the All-India Nurses' Conference, our attention was drawn to an advertisement appearing in the same paper where we read about the conference. This was published under the signature of the Personal Assistant to the Surgeon-General. Hospitals in the City and elsewhere being institutions in which The Medical Practitioner takes keen interest, we made enquires and learnt that the permanent matron, an Anglo-Indian lady had retired or likely to retire on account of illness and the permanent Assistant-Matron has been acting for nearly two years and nursing in the General Hospital is going on as smoothly as during the regime of old Matrons excepting perhaps for the inroads from outside the nursing profession which occasionally interfered with the discipline and not at all with the actual art of nursing. Such inroads existed and will exist in all hospitals so long as nursing profession shall

continue to serve in hospitals in the way it does at present under the existing administration. Even such inroads have been guarded against by the past and the present nursing staff to the credit of those immediately over their heads. The fact that the retiring matron is an Anglo-Indian and that the officiating incumbent also an Anglo-Indian, possessing the C. M. B. certificate and having a good record of work, made us inquisitive especially after we read both the proceedings of the Nurses' conference and also the advertisement in the "Madras Mail." A special reference was made by the President of Nurses' Conference which reference appeared in the 'Mail' with a prominent Head Line 'Salary offered for Madras Hospital Matron Inadequate'. So we sent for the Fort. St. George Gazette for the details referred to by the Personal Assistant to the Surgeon-General in the advertisement appearing in the 'Madras Mail'. Extract of the notification appearing in the Gazette is published in the Correspondence Columns of the current issue. A note in the Gazette to the effect "*Members of the nursing staff in the service of Madras Government need not apply*" made us blush and later muse after reading the proceedings of the nurses' conference. Lt. Col. Newcomb the officiating Surgeon-General during whose regime the General Hospital Matron's post was advertised, Miss Hartly, the Secretary of the Nurses' Association, Miss Norah Hill, Organizing Secretary of the Indian Red Cross Society, Miss Abram, the President of the Nurses' Association laid special stress in their speeches at the conference about the status of the profession and the Secretary said 'Everywhere I saw people were anxious to persuade more suitable, well educated Indian and Anglo Indian girls to join the nursing profession'. The special note referred to above prohibiting those in the Nursing Staff under Madras Government from applying to the Matron's post, is as vague as it is inconsistent with the views pressed by Lt. Col. Newcomb and others that followed him at the conference. It may mean either that those under Madras Government are not wanted or that even without their applications the claim of a suitable person in the Nursing Staff will be considered. The latter interpretation may look far fetched none the less charitable. We hope it is so or else the views about the status of nurses as expressed at the confer-

ence should be interpreted otherwise. Whatever be the intention of the author of the notification the charitable interpretation suggested by us gives an opportunity to an impartial fair minded administrator to tide over the other meaning which is certainly most uncharitable and against the prevailing ideas expressed at the conference that those in India whether they be Indians or Anglo-Indian should be encouraged to take to the Nursing Profession. Appointing the Acting Anglo-Indian Matron who satisfies all the conditions of the notification will be certainly the best encouragement.

The officiating Surgeon-General might perhaps not had opportunities of knowing about the administration of General Hospital (himself being in the chemical section of the Madras Medical Department) to the extent the permanent Surgeon-General does. Major-General Sir Frank Connor has a splendid opportunity of satisfying the sentiments expressed by Lt.-Col. Newcomb and others at the Nurses' Conference. We trust he will tide over the technical obstructions in the notification. There is another incongruity in the notification. The starting pay fixed for the new matron is Rs. 250 whereas the Asst.-Matron is now getting Rs. 288 and will soon reach Rs. 300 grade. Evidently this objection did not strike the author of the notification nor the officiating Surgeon-General. Sir Frank Connor can set right this sore also by confirming the officiating Matron now getting Rs. 288.

A Humble yet Notable Example : About three months ago we received a report of a 'Hospital Poor Fund' from the Hony. Secretary, a Medical Officer in-charge of a Local Fund Dispensary, (now a hospital) at Moolky, a place not big enough to be called a town though not a village. It is named in South Kanara as Moolky Petah. This seems to be an unfortunate petah which did not evolve into something bigger than a petah with the advent of time as is the case with majority of small stations rising into localities of importance. On the other hand the petah has been gradually dwindling from the position of a small yet important sea port having direct communication with Bombay and neighbouring small sea ports and with Cochin and other ports on the way to Cochin. It was said that it had direct

communication through the sea even with Arabia. Now this petah does little or no sea trade and even the internal trade is not of any importance. Consequently the people of this petah are not in a prosperous condition as they were once. Moolky being a native place of the Editor the organizers of the 'Hospital Poor Fund' naturally felt it a pleasure to let the Editor know that in spite of the poverty of the place it was possible for the organizers of this fund to do tangible good work in their own way and with poor finance at their command, so that the Editor may feel proud that the petah where he was born 52 years ago shows signs of development though not in money earning concerns but in its sense of duty of giving relief to the suffering poor. It is really a matter in which we have to feel proud as the origin founder of the poor fund is our esteemed friend and well wisher, and one of the oldest subscribers of The Medical Practitioner who though much older than the Editor shows his youthful zeal to serve the profession (to which he has the honour to belong) as well as to the public. The fund was started by this origin founder Dr. Karanje Rama Rao in 1913 at the suggestion of his life partner who is no more. From the report it is seen that the fund did not reach a tangible form till 1932 when Dr. Umesh Rao, the Medical Officer-in-charge of the Local Fund Dispensary at Moolky took charge of the fund. The Fund has now a Managing Committee with the Vicar of the local parish as its President and the members of the Committee represent a variety of local interests such as agriculture, trade, Government service etc., with two honorary secretaries, one of whom being the Medical Officer of the locality. The fund has now on its roll, donors, patrons life members, and subscribers, who finance the fund with amounts ranging from Rs. 100 to a humble amount of annas 8. By this means the fund has now a closing balance of a little over Rs. 2000 after spending Rs. 1500 towards the cost of constructing a maternity ward with an accommodation for 4 beds. The origin founder Dr. K. Rama Rao gave a donation of Rs. 300 towards this maternity ward which is named after his late life partner Srimathi Rama Bai.

We trust that this notable example of humble medical officers in Local Fund

Service will serve as an example to their more fortunate brethren in service or in private practice and is to be highly commended when it is known that in big cities Medical Officers in the highest ladder of service and commanding very lucrative private practice instead of serving the institutions for which they are paid as whole time officers are found running, private paying hospitals to cater the needs of the rich. We congratulate our esteemed friend Dr. K. Rama Rao and do so equally his successor in office and also their collaborators for running a scheme to help the poor, which was most dear to Dr. Rama Rao and his dearest life partner the late Srimathi Rama Bai.

Before closing we will be failing in our responsibility if we do not point out the want of imagination in the organisers of the Silver Jubilee Fund who, it is mentioned in the report of the Hospital Poor Fund, did not find their way to appreciate and encourage the activities of disinterested, quiet, public workers in a small petah.

A Request : An esteemed subscriber of The Medical Practitioner has made us a suggestion that the posting list of the Sub-Assistant Surgeons of the Punjab may be published in the columns of the journal. A similar suggestion came to us from U. P. a couple of years ago. We have insatiable zeal and enthusiasm to serve the profession especially those who are the Harijans of the medical profession. The Harijans of the human society otherwise known in the past, the panchamas, are attracting the attention of the higher castes for all sort of purposes especially the political, and a Gandhi is yet to be born in India to uplift the Harijans in the Medical Society. In spite of our financial limitations we have been making serious attempts to get collaborators to help us with news and materials to comment on the news concerning the profession in other provinces but we could not so far secure a Krishnamurthi even in this province who after his 60th year allowed himself to be yoked with the responsibilities of a medical journal of an unique type and whose activities are at present the subject matter of a libel case

against its Editor. The expression of sympathies from the public and the profession, the proceedings in the Court, and the publication of the proceedings in the news papers have kept us musing at times in the Court and outside the Court. And during the course of such musings, flashes of suggestions come across of our mind regarding the necessity of our increasing the quality and the quantity of our services through the columns of The Medical Practitioner and in other variety of ways to the extent the physical condition of an invalid can permit. The fact that the Editor is maintaining better health than he did before he was summoned to the Court is encouraging him to take other coordinating methods of serving the medical profession through the agency of service to the public at large. Though the Editor has to spend almost the whole day to get materials and persons to defend him, he is utilising his leisure hours to increase the scope of The Medical Practitioner. With this purpose in view, on the very day when the complainant, Lt.-Col. Mahadevan applied for an adjournment of the case which was allowed by the Court till the 12th November 1936, Dr. Kamath ran up to Bombay in connection with Journal work and on his way to and from Bombay in the train, and the retiring rooms of the Victoria Terminus Ry. Station he got ready the September issue of The Medical Practitioner. The October issue was got ready after the last witness Dr. Miss. H. M. Lazarus got down from the box in the Chief Presidency Magistrate Court and the court posted the case for further proceeding on 21st December. It is hoped that soon after the Editor comes out of Court God willing, the scope and the utility of the journal will be increased so as to make the journal an All India concern more than it is now.

Regarding the publication of the posting list of Sub-Assistant Surgeons in the Punjab and other places outside this presidency we will never stint our services either regarding this item or anything else soon after our hope as expressed above is realised.

Correspondence Reports Etc.

Extract from Fort St. George Gazette

29th September 1936 Page 1285

APPOINTMENT OF MATRON GOVERNMENT GENERAL HOSPITAL MADRAS

The appointment is permanently vacant.

2. The applicant must satisfy the following conditions:—

(a) She should be a natural British subject.

(b) She should be of a satisfactory character.

(c) She should be of sound health, good physique and active habits and free from any defect unfitting her for Government service.

(d) She should be not less than 30 years of age.

(e) She should have undergone at least 3 years training in the wards of a recognised training school for nurses in the British Isles, in a hospital of not less than 100 beds for Medical and Surgical treatment of men, women and children or the training in a recognised Medical Institution in India with additional training of not less than one year in the British Isles.

(f) She should have subsequently held satisfactorily some responsible post in a Hospital and produce sufficient evidence of capacity for hospital management.

(g) She should also possess the C. M. B. certificate.

3. Application should be accompanied with fee of Rs. 10.

4. (Not important).

5. Every application should be accompanied by the following documents.

(a) Evidence of date of birth.

(b) At least 3 certificates of character and conduct in original.

(c) Certificates of training referred to in paragraph (2) above and other testimonials in original.

(d) Treasury receipt for Rs. 10 paid in.

6. (Not important).

7. Applications should reach Surgeon-General not later than 1-11-36. Applications received after that date and which are

not in the prescribed form will be summarily rejected.

8. Applicants should be prepared to appear before the Surgeon General if so required at their own expenses on a date which will be communicated to them.

9. The selected candidate will be required to produce a certificate of physical fitness and she will be appointed on probation for a period of 2 years.

Members of the nursing staff in the service of the Madras Government need not apply.

All India Medical Conference

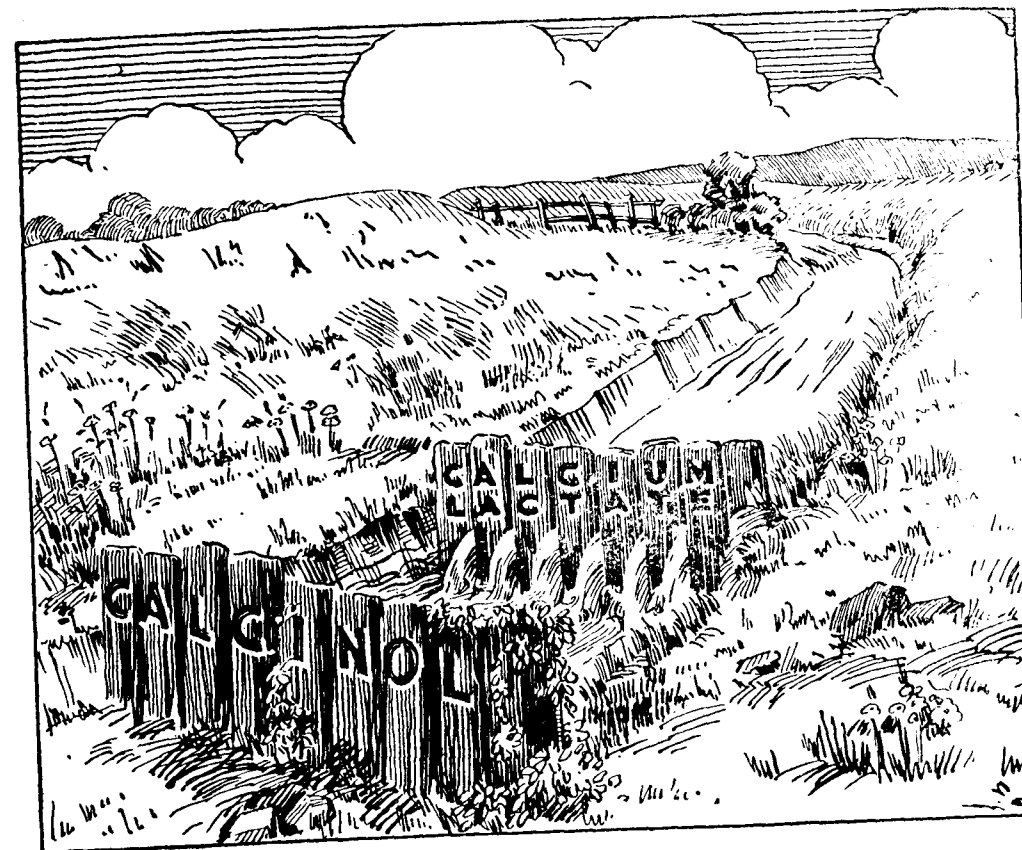
Under the auspices of the Indian Medical Association the annual conference of the members of the medical profession in India will be held at Karachi during the Christmas holidays for three days on 26th, 27th and 28th December. Members of the profession are earnestly requested to be present.

In addition to an Exhibition of scientific products and appliances by their manufacturers there will be a Scientific Section of the conference for the discussion of purely scientific subjects apart from the subjects of general importance to the profession.

Any member of the profession will be enrolled as a delegate of the conference on payment of Rs. 8 as fee which will entitle him to attend and take part in all the sections of the conference. Members of the Indian Medical Association will be charged only Rs. 5 as delegation fee. Non-members may take part in the scientific section only by paying Rs. 5 towards delegation fee.

Papers on scientific subjects or of subjects of general importance to the profession and any communications regarding the conference should be addressed to Major C. P. Bhatt, M. B., B. S., Hon. Organising Secretary, 13th All India Medical Conference, Karachi as early as possible.

Lodging for the delegates will be free. They may have to pay only for boarding.



To swallow Calcium is not sufficient.

To retain it is more important.

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Bombay Calcutta

Report on the working of the South Kanara District Medical Association for the Year ending 30-6-1936

The Association has finished the sixth year of its existence. The work of the previous year was kept up.

MEMBERSHIP:—The year opened with a membership of 50 on the rolls, of which 25 were resident and 25 non-resident. During the year 2 resident members joined and 3 resigned making a total of 24 at the end of the year on rolls. Among non-resident 1 joined and 1 resigned thus totalling 25 at the end of the year. The year closed with a membership of 49 including the Udupi branch membership.

FINANCE:—The usual membership fee of Re. 1 per month for resident members and Rs. 2 per half year for non resident members were collected. Out of a total demand of Rs. 663 for the year Rs. 274 were collected leaving a balance of Rs. 389 as arrears. The auditor of the year has cast the accounts in a regular method, thus giving us an accurate idea of the state of affairs of the Association. The Balance sheet as well as the income and expenditure account show a surplus. It is hoped that the arrears as per balance sheet will be collected soon and the financial position of the Association will be strengthened well. The Association places on record its grateful thanks to Mr. A. Umanatha Rao B.A., G.D.A., K.A. auditor for his honorary work.

MEETINGS:—There were nine meetings during the year. All of them were held in Mangalore. The occasion of the Annual meeting was availed of to bid goodbye to Dr. K. G. T. Menon I.M.S. the retiring District Medical Officer and an active member of the Association. A dinner was arranged at night on that date, at which farewell speeches were made and replied. The Association places on record its appreciation of the help rendered to it by him and wishes him a long and useful retired life. There were three visitors during the year. Lt. Col. V. R. Mirajkar F.R.C.S., I.M.S. paid a second visit. He gave a vivid description of the havoc caused by the Earthquake at Quetta. He had to bear the brunt of the professional work.

The late Col. Bhola Nath I.M.S. (Retd.) the President Indian Medical Association was entertained by the Association. He gave an idea of the working of that body and exhorted the Association to get affiliated to the Indian Medical Association. Dr. P. Venkatgiri M.B. & C.M. Lecturer in Obstetrics, Stanley Medical School, was the third visitor. He gave a very instructive talk on modern methods in obstetrics. We thank all these and other lecturers of the year.

MANAGEMENT:—The Executive Committee was strengthened by the addition of four more members, of whom three were from Moffussil, thus making a total of eleven. Dr. M. Shiva Rao retired from his Presidentship and Dr. L. P. Fernandes was elected in his place.

HABITATION:—The association offers its thanks to the Government of Madras for kindly allowing them the use of the Wenlock and the Lady Goschen Hospitals for their activities. It is with great pleasure the Association records its thanks to the District Medical Officer and his staff for their uniform kindness, courtesy and help to the Association during the year despite all their personal inconveniences.

UDIPI BRANCH:—The branch report having not been received it is not possible to give an account of its activities.

MEMBERS' ACTIVITIES:—In the District Board elections held during the year the following members of the Association were elected to the Board,

1. Dr. K. Vittal Shetty.
2. Dr. P. G. Achar.
3. Dr. P. Vittal Bhandary.

CONCLUSION:—The work during the year has been quiet and steady. It is hoped that more members of the profession will join and take an active interest in its working, so that it may serve the profession and public.

Mangalore.
11-10-1936.

Sd. K. R. KINI,
M. B. & B. S.
Honorary Secretary.

List of Postings of Sub-Asst. Surgeons for the month of October, 1936.

No.	Names of Sub-Asst. Surgeons.	From.	To
18	„ D. Suryanarayana	King George HI, Vizagapatam	Leprosy Officer, Group 1 Dts Vizianagaram.
19	„ R. Subramania Iyer	L. F. Dy., Manapparai, Trichinopoly Dt	Leprosy Officer, Group VI Dts Coimbatore.
20	„ M. A. Krishna Iyer	Group Leprosy Officer Group VI Dts Coimbatore	L. F. Dy., Manapparai Trichinopoly Dt.
21	„ Mrs. C. M. Alexander	Govt. Hl., Kollegal Coimbatore	Tq. Hd. Qr. L. F. Hl., Ambasamudram, Tinnevely Dt.
22	„ Ch. Swami Naidu	Govt. Dy., Harpanballi Bellary Dt	Tq. Hd. Qr. L. F. Dy., Sidhout Cuddappa Dt.
23	„ P. Vardarajulu Naidu	Govt. Hl., Hindupur Anantapur Dt	Govt. Hl., Penukonda Anantapur Dt.
24	„ T. Atchutha Rao	Govt Dy., Rajavommangi	At the Disposal of Dt. Supdt. of Police, East Godavari Dt.
25	„ Miss. E. A. Shantammal	Gosha Hl., Jeypore Koraput Agency	Govt. Hl., Tanuku. West Godavari Dt.
26	„ Mrs. R. K. Behara	Govt. Hl., Parlakemedi Gunjam Dt	Tq. Hd. Qr. L. F. Hl., Pithapuram. E. Godavari Dt.
27	„ T. K. Narayanaswami	Govt. Hl., Russelkonda	Presy. Jail for Women Vellore.
28	„ M. Venkataratnam	L. F. Dy., Thondamuthur	At the disposal of the Principal, Madras Forest College, Coimbatore
29	„ K. Achuthan Nair	L. F. Dy., Thirthala Malabar Dt	„ „
30	„ Miss. N. S. Peters	Govt. Women & Ch. Hl., Tuni, East Godavari	Govt. Victoria Hl. for Caste & Gosha Women Madras.
31	„ T. Gnanayya	L. F. Dy., Tirupanandal Tanjore Dt	At the disposal of D.M.O. East Godavari.
32	„ M. Kulu		At the disposal of the Executive Engineer-in-charge, Mukurthi Dam Construction, Gion Morgan.

N.B.—17 names from Serial No. 69 Dr. K. Satyanarayana were published in the September issue on page 264 by mistake. These 17 names and the above belong to the October list.

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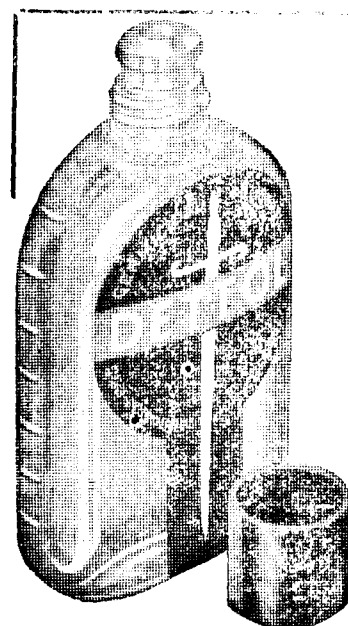
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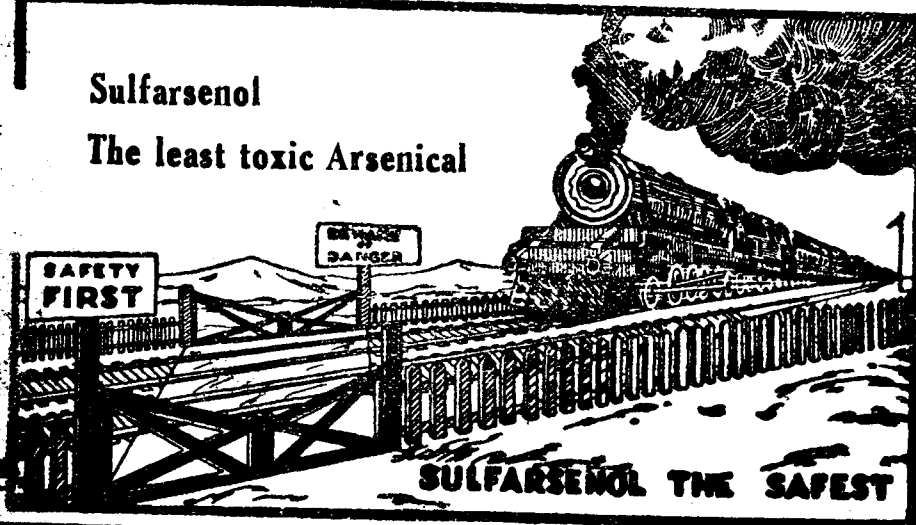
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A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,
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Corrigendum : On page 62 second column last line, 'extend' should be read as 'intend'.

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VOL. VIII.]

NOVEMBER & DECEMBER 1936.

[NOS. 2 & 3

Original Articles

MADRAS MEDICAL COUNCIL.

REVIEW OF THE PROCEEDINGS OF THE
COUNCIL,

OCTOBER, 1936 SESSION,

BY

DR. V. RAMA KAMATH,
Member, Madras, Medical Council.

As has been repeatedly expressed in the columns of The Medical Practitioner, this Journal was specially brought into existence to enable the Medical Profession in this province, to take more interest in their affairs and as the Medical Council exists mainly for the profession, the review of the proceedings of the Council has been one of the important features with regard to the subjects dealt with in the columns of The Medical Practitioner. For reasons already explained in the columns of The Medical Practitioner, I could not review the proceedings of the Council soon after a particular session as the irregularities of omission and commission were such till about a couple of years ago that I could not get the necessary materials from the Council Office in time. I have to acknowledge with gratitude the help and cooperation I have been getting from the readers of The Medical Practitioner, who have materially guided me to function as usefully as was possible for me with the limited powers of the Council and as limited responsibilities of the members constituting the Council and I am now in a position to let the profession know what is transpiring at the Council

soon after the minutes of the proceedings are confirmed. It has to be said that the affairs of the Madras Medical Council have taken a turn in the right direction and Major-General Sir F. P. Connor, its President since 1934 has been evincing keen interest in its affairs and the Council is made to realise that it is possible for the Surgeon-General with the Government of Madras to be democratic, though in an official bureaucratic garb.

There has been a change in the convention followed by the Madras Medical Council. Ever since 1915, the year the council came into existence, the Vice-President of the Council has always been an Indian Graduate or an L. M. P. Even this policy favoured repetition and did not mind a free choice. Last March, there was a change and I made a suggestion that even time-honoured conventions should be worked on some principle and it would be in keeping with the present tendency of respecting the feelings of communities or classes if the Vice-President who was to be elected by the Council was chosen unanimously, one from each group of practitioners now in the Medical Register for each year by rotation, so that all the three groups might be honoured. It was then said by a member that I ought to have proposed the convention at a previous meeting and not just then. But knowing as I did, the good sense prevailing in the whole Council, I proposed the name of a practitioner in the first group of the Register, which group had never had the honour to have a Vice-President from amongst them. Though the members who opposed my suggestion proposed one from the second

group, the latter magnanimously withdrew his name and the one proposed by me was unanimously elected. I referred to this change in my previous article and mention it now just to bring to the notice of the readers that the choice of the Vice-President in the person of Dr. R. J. Dyson was an unqualified success. Usually, the Vice-President has no opportunity of acting for the President, but it so happened that from March to last October, the Surgeon-General with the Government of Madras was on leave, and the Vice-President was actually in the office of the President and those who were in touch with the office of the Madras Medical Council could testify that Dr. R. J. Dyson did not make anybody feel he is an European who is rightly or wrongly more the latter considered in these days to be apathetic towards Indian interests. The term of office of the Vice-President is only one year. Dr. R. J. Dyson was virtually the President for this period, having had not only to run the office but to preside over the two meetings at the March and October session. I trust the Council will put a healthy convention into practice and choose unanimously next time one from the second group having respect to seniority, which should always go with such conventions.

REGISTRATION.

I have mentioned in my last article about the strength of the Medical Register and shall do so again in my next article soon after the Council closes its next session. Till 1933, it was not found possible either for a part time or even a full time Registrar of the Medical Council to publish the Medical Register in time which he ought to have done before the end of January every year. The present part time Registrar has been able to fulfil this statutory obligation and now the Medical Register is made available on 31st January, earlier never later. This timely publication has been appreciated not only by the profession but also by the public, as could be seen from the Budget estimate which the Registrar kept before the Council at its last session. In 1934, the first year when the Medical Register was published in time Rs. 208 could be realised by the sale of Medical Registers as against Rs. 26 the previous year.

Apart from the publication of the Register, the actual process of Registration is being done as precisely and as accurately

as is demanded by the Statute. The readers of the Medical Practitioner are aware that during the 'Black days' of the Madras Medical Council prior to 1933, it was possible for compounders and even for those without the compounder's certificate, to get themselves registered in the Madras Medical Register and such persons were functioning as any other Registered Practitioner did. The Register has been weeded out at present; and there cannot be any more fraudulent registrations in future. Even the qualified practitioners from countries outside India where the Indian Medical qualifications are not recognised are now refused registration, in the Madras Medical Register. Though there was a specific section which made it obligatory on the part of the Council not to register such of those from British Colony or any foreign country, where the Medical Degrees, Diplomas or Certificates of a British Indian Government or University is not recognised, the Council and even the Government have been blind to this section in spite of my having brought this to the notice of the Council more than once after I entered the Council. From last year better sense has been prevailing and the Council is now keen to perceive the implication of Section 20, which they had been flouting in the past. Such an action on the part of the Council, in a few cases last year, must have induced a German medical man to apply to the Surgeon-General seeking permission to appear for the final L.M.P. Examination so as to enable him to get into the Madras Medical Register after passing this examination—an easy unobjectionable way indeed. The Surgeon-General placed this application before the Council at its last session, and, after a good deal of discussion it was decided that the applicant should undergo the full 5 years' course and pass all the necessary examinations before he appeared for the final L.M.P. Examination.

Another important question regarding Registration had to be considered by the Madras Medical Council at its last session. Two registered practitioners applied to the Registrar to register the additional qualification, L. M. (Dublin) obtained by them after the primary registration. There has been at least one president, when L. M. (Dublin), was registered in the Madras Medical Register as an additional qualification. Following this precedent, the

Registrar would have been justified to register this qualification against the names of these two practitioners. Evidently, the Registrar seemed to have had doubts from what he could judge from the past records maintained in the office, if previous sanction of the Council was obtained by the then Registrar before he registered L. M. (Dublin) qualification. It appears that the present Registrar wrote to the Registrar-General Medical Council, Great Britain, if L.M. (Dublin) was recognised as a qualification for Registration and the reply was in the negative. The Registrar was well advised to refer this matter to the Council and suggest to the Council the desirability of having a schedule of additional qualifications as is being done by the British Medical Council, and, in India, by the Bombay Medical Council. So this question will be decided by the Council at its next session, and in the meanwhile, it has been referred to the Registration Committee of the Council.

MISCELLANEOUS ITEMS.

At the instance of the Vice-President of the Council, an important matter of procedure was decided by the Council. This was with regard to the uncertainty of carrying out the judgment of the Council in connection with the disciplinary cases, before the proceedings of a meeting were confirmed at a next meeting. The proceedings of a meeting of the Council require confirmation at a following meeting before they are given effect to. Till the recent decision of the Council, it was thought desirable to confirm the proceedings even of a judicial nature as those with regard to disciplinary cases. Legal advice was obtained and it was decided by the Council that its judgments in disciplinary cases be entered in a separate book and not in the minutes of the Council and be given effect to soon after such judgments were passed. The view taken by the Council is as legal as it is reasonable, but I should say that there was no necessity of maintaining a separate book for this purpose.

The Medical Council of India asked the Madras Medical Council its opinion with regard to the Registration of foreign medical qualifications and what action should be taken if the French and Portuguese Governments did not recognise the registrable Indian

qualifications. In this connection, it may be noted that in Pondichery, no doctor possessing Indian qualification can practise, whereas anybody possessing French qualification, as a matter of fact—even those without any qualification can practise in India. The Indian Medical Licentiate is not allowed to practise not only in French territories in India but also in Portuguese territories. Same is the case in Ceylon and the Malay States. But in all these places, quackery in other systems of medicine is permitted. Taking all the above circumstances into consideration, I proposed to the Council a resolution requesting the Medical Council of India "to recommend to the Government of India to correspond with the Portuguese Government in order that registered medical Practitioners in the provincial registers in this country may be allowed to practise in Portuguese India, and in case the Portuguese Government refuses to comply with this suggestion, that the Government of India may be requested by the Medical Council of India to enact suitable legislation to prevent practitioners from Portuguese India from practising in British India unless they are in the provincial registers." The Council reiterated its previous decision at an earlier stage that medical qualifications granted in countries, which did not recognise Indian registrable qualifications should not be recognised by the Medical Council of India.

The readers might remember that at my instance the Council passed four resolutions at the October 1935 session with regard to (1) nomination of Members to the Council, (2) minimum educational qualification for admission to Medical Schools, (3) formation of State Medical Faculty and (4) granting of medical certificates in the case of employees of local bodies. The following is the copy of the G. O. on the above resolutions:—

"The Government have carefully considered the recommendations made by the Madras Medical Council at its meeting held on the 28th October 1935 and proceed to issue the following orders:—

(1) Nominations to the Council under section 5 (1) (f) of the Madras Medical Registration Act: The President of the Medical Council is informed that in suggesting names to Government for nomination under section 5 (1) (f) of the Madras Medical Registration Act, he may recommend the

names of the heads of teaching institutions who are not otherwise represented on the Council. The Government do not consider that it is necessary to make these nominations in the name of the offices held by such representatives.

(2) Raising the preliminary general educational qualification for admission to medical schools: The Government have decided that it is not possible at present to raise the standard of the minimum educational qualification prescribed for admission to the medical schools.

(3) Formation of a State Medical Faculty for the purpose of controlling non-university examination: The matter is under the consideration of the Government.

(4) Questions of providing for second medical opinion on the certificates issued by Registered Medical Practitioners in the case of servants of local bodies: Orders have since been issued to all local authorities in G. O. No. 965, P. H., dated 27th March 1936, in the matter. A copy of the order is herewith enclosed."

COPY OF THE ENCLOSURE

"The procedure to be followed in regard to the grant of leave on medical certificate to non-gazetted government servants is laid down in rule 17 in Part I of Annexure II to Fundamental Rules. All District Boards and Municipal Councils are requested to frame regulations adopting the procedure laid down in rule 17 referred to above if the Fundamental Rules, have not already been adopted by them."

Unavoidably I was not present at the Council just when this G. O. was recorded by the Council. Or else with regard to first resolution I would have added a rider bringing to the notice of the Government the necessity of making nominations to the Council in the name of the office and not in the name of persons holding the office. At the time I proposed this

resolution, I gave reasons why the nomination should be made in the name of the office and not of persons. It may happen at times that a particular person nominated to represent a particular teaching institution retires and another may take this place in office, and in case the nomination is in the name of the retired official, this particular medical school or college might go unrepresented in case the retiring member does not resign before his term expires. All the same medical profession will have the satisfaction in future that the Madras and Vizag Medical Colleges as well as the three provincial Medical Schools will be represented in the Madras Medical Council as is the case with teaching institutions in General Medical Council. This is as it should be, as the co-operation of representatives in teaching institutions will be of immense help to a Council which exists to control medical education. At present, though Lieut. Col. Mahadevan is a nominated member of the Council, the nomination was not made to represent the Stanley Medical School but this person was nominated during the regime of Major-General C. A. Sprawson (now Sir) to fill the vacancy of a representative of those representing the Military Assistant Surgeons' class which class goes now not being represented in the Council. Dr. (Miss) Findlay is now a nominated member but when her nomination was made, the medical missionaries' interest as such weighed more than the Missionary Medical School representation. The persons occupying the office of the Superintendent of the Lady Willingdon Medical School had no chances of representation at all so far. We trust the present and the future President of the Medical Council will respect the G. O. the good purpose of which was beyond their imagination in the past.

(to be continued)

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VITAMIN DEFICIENCY DISEASES

By

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

(Continued from last issue)

DEFICIENCY OF VITAMIN D.

Rickets is a disease resulting from failure of the organism to metabolise properly certain substances notably calcium and phosphorus in a manner adequate to insure the normal supply of these ions to the growing skeleton and the proper deposition of the tertiary phosphate of lime in it, due to deficiency of Vitamin D.

Such a metabolic failure may arise in several ways viz:—

1. Insufficient intake of calcium and phosphorus with the diet.
2. Failure on the part of the gut to absorb the calcium and phosphorus contained in the diet.
3. Inability of the body to retain the calcium and phosphorus ions due to decrease in the power of the fluids and cells of the body to retain them.
4. Abnormal permeability to one or other organs through which calcium and phosphorus are excreted or abnormal tendency of these organs to excrete calcium and phosphorus from the body.
5. The normal calcification of bone may fail because local conditions inhibit the actual precipitation of the lime salts in the bone due to hydrogen ion concentration of the tissues, the total ionic strength of the fluid in which they are bathed, the presence of substances having a specific action antagonistic to calcification.

THE CALCIUM AND PHOSPHORUS METABOLISM:—The blood of a normal healthy infant contains 4 to 6 milligrams of phosphorus and 9.5 to 10.5 milligrams of calcium per 100 c. c. As far as calcium is concerned, this remains constant throughout life. As age advances and when the necessity for rapid calcification is lessened, the need for phosphorus wanes, until the adult blood contains only 2.3 to 3 milligrams of phosphorus per 100 c. c. In the rickety child, the calcium is present in about normal amounts but the phosphorus content falls to 1 to 1.5 milligrams per 100 c. c.

According to Howland and Krammer, if the numerical product, obtained by multiplying the number of milligrams of phosphorus per 100 c. c. of blood by the number of milligrams of calcium per 100 c. c. of blood exceeds 40 (forty) active rickets does not occur. If such a numerical product be less than 30 rickets is in an active state; while if the product be between 30 and 40, rickets may or may not be active. Clinically this is the best criterion for judging the state of rickets. Its significance from a chemical standpoint is doubtful. This theory does not hold good in renal rickets.

EXPLANATION FOR THE ABOVE THEORY:— Suppose, the phosphorus content is X milligrams and the calcium content is Y milligrams per 100 c. c. of blood, then if the numerical product obtained by multiplying X by Y exceeds 40, rickets does not occur. If such a numerical product is less than 30, rickets is in an active state. If it is between 30 and 40, rickets may or may not be active. How for this is reliable remains yet to be proved.

The administration of Vitamin D apparently permits better absorption of calcium and phosphorus from the intestines and it increases the ability of the body to retain these two ions. Once the administration of Vitamin D in sufficient quantities becomes effective, the calcium—phosphorus ratio becomes stable i.e., it cannot be altered in any way. Vitamin D has the power to raise both calcium and phosphorus when the level of either of these is lower than normal. Hence, a sufficiency of Vitamin D in the diet prevents the onset of rickets, whereas a deficiency of Vitamin D by leading to unstable calcium-phosphorus metabolism aids the onset of rickets.

Vitamin D occurs in nature, in large quantities, in the liver oils of the cod and halibut, in commercial coconut oil and in small quantities in human and cow's milk. It resists a temperature of 100° for 24 hours. But it is slowly destroyed by oxidation during long periods of time. Synthetically, it has been prepared by ultraviolet radiation of ergosterol—a sterol with three double bonds. Ultraviolet radiation of ergosterol increases its Vitamin D potency to 25,000 times that of cod liver oil during the first few moments of irradiation; but, further exposure to ultraviolet rays destroys the vitamin content. The condition known

as 'hypercalcinosis' is brought about by an excess of Vitamin D in the diet.

LIGHT AND ITS RELATION TO RICKETS:—

Light prevents and cures rickets, because it causes the synthesis of the antiricketic vitamin in the body of the irradiated individual. Under normal conditions, the sunlight is the natural bulwark of the child against disease.

Ergosterol, from which synthetic Vitamin D is made, occurs in nature wherever cholesterol is found throughout the animal and vegetable kingdoms and is abundant in the cells of the human body. It is without effect until it is irradiated with ultraviolet rays. When the child is exposed to sunlight the ultra violet rays contained in the sunlight acts upon the ergosterol contained in the cells of the body and thus produces Vitamin D in the body. However, the action of sunlight depends upon whether it is "Direct shine" or whether it is "sky shine". "Direct shine" indicates light coming directly from the sun. This should be distinguished from "Sky shine" i.e., the light available in the shade. With all this the action of sunlight is influenced by the time of exposure, the season and the latitude of the place. Ultraviolet rays obtainable from a mercury vapour lamp is also useful. Radiation obtainable from a carbon arc lamp varies in its antiricketic value.

The protective value of sunlight against rickets is reduced by high altitude, dust and smoke, pigmentation of the skin and by the seasonal variations. The disease is common in winter and early spring when the sun's rays strike the earth in an oblique manner, thus affording minimum protection.

Prematurely born infants, twins and triplets and children born to mothers suffering from osteomalacia, are all liable to suffer from rickets. These cases must be treated early and vigorously.

According to Elliot and Souther, mild cases reach their maximum incidence by the fifth month. Moderate and severe cases occur between the 12th and the 18th month.

There is no hereditary liability in men. Darkskinned races are most susceptible. According to Parker, rickets cannot develop in the absence of growth. In the

absence of growth, the conditions which produce rickets will produce osteoporosis. This condition is common in the temperate climates especially during winter and spring. Even in the tropics, when the children are not sun-bathed they suffer from rickets. Sex has no influence. A deficiency of Vitamin D in the diet greatly influences the onset and course of the disease.

PATHOLOGY:—The essential pathological changes caused by rickets are those of the skeleton i.e., failure of calcification. On account of this the bones are soft.

SYMPTOMS:—These are the results of softening of the bones due to defective calcification and their extent varies with the severity of the process and rapidity of the patient's growth. In cases of rapid growth, the bones are most severely affected. In chronic and advanced cases every bone may be involved. In cases of retarded growth, symptoms are not marked.

HEAD: The growth of intracranial sutures is extremely rapid during the first few months of life and the earliest sign of rickets which begins in the first quarter of life are in the head. There may be large areas, especially in the parieto-occipital region in which the ossification is retarded, producing the so-called cranio-tabes, the bones yielding easily to pressure with the finger. There may be depressed spots of bones which, on pressure, give the so-called "parchment crackling." In the frontal and parietal bones, thickening becomes so prominent, so as to produce characteristic broad forehead sometimes mistaken for hydrocephalus.

THORAX: Bending of the ribs, i.e. Ricketty rosary the formation of Harrison's groove and flaring of the costal margin results. The clavicle may be thickened and bowed forward in advanced rickets. Green stick fractures of the ribs are common from slightest trauma.

SPINE: If the disease sets in during the sitting period of the child's life, kyphosis of varying degrees results. When it occurs when the child is able to stand up lordosis takes the place of kyphosis.

In chronic, advancing cases, changes in the bones of the pelvis do occur.

THE EXTREMITIES: Various forms of bending of the shaft of long bones and

enlargement of the ends of the long bones are common. In longstanding cases, the finger joints become fusiform and the ends of the fingers become blunted.

Head rolling, and head shaking without nystagmus may occur. Sweating about the head is often a constant and striking symptom of rickets. Saturation of the pillows, clothing etc., which results from this, is one of the factors productive of the frequent infections of the upper respiratory tract from which rickety children suffer.

Atony of the muscles as a result of which the child becomes pot-bellied is a constant symptom of advanced rickets.

Pain in the joints results especially when this condition is complicated by scurvy.

Von Jaksch's Syndrome—the so-called anaemia pseudoleukaemia infantum—may result. Rickets, splenomegalia, and secondary hemolytic anaemia with leukocytosis characterise this condition.

Whereas some children are very well nourished and overfat, in longstanding cases the child may become marasmic.

Many rickety children are placid. Others are irritable, restless, fretful and whiny.

Special forms of Rickets are Late Rickets, Celiac Rickets, Renal Rickets, Congenital Rickets, Refractory Rickets.

The X-ray picture of the rickety bone reflects the pathology of this condition. The earliest changes are usually to be found at the junction of the cartilage with the shaft, but in certain cases, changes in the shaft are fairly well developed before the epiphyseal-diaphyseal alterations are definite. In the advanced cases, the curvatures, fractures and dislocations of the epiphysis are visible.

RELATION BETWEEN TETANY AND RICKETS: The relation between the calcium and phosphorus ions which results in tetany is the diametric opposite of that which produces rickets. As the relation between the two ions is unstable, the transition from uncomplicated rickets to that of tetany is easy and rapid. Calcium in the blood of an infant with tetany is low while the amount of phosphorus is normal or high. The tetanic state occurs during infection. In the treatment of rickets resulting in a rapid rise in the amount of phosphorus in the blood as often happens when large doses of phosphates are given to a child with active

rickets resulting in a rise in the phosphorus level and a lowering of the calcium level tetanic symptoms appear.

RELATION BETWEEN RICKETS AND SYPHILIS: An infant with slight derangement of the calcium-phosphorus metabolism, who would under normal conditions escape manifest rickets, when also forced to carry the added burden of an infection with the treponema pallidum may become ricketic.

PREGNOSIS: In uncomplicated cases, death is unusual. Patients recover on proper treatment. Hence, prognosis is good. Prognosis is bad in cases of young infants with severe involvement of the thorax. The longer the rickets persist, the greater the deformity.

TREATMENT: Prophylactic. From the second month onwards, whether the child is breast fed or artificially fed, it must be given halibut liver oil and this should be continued until third year of life, afterwards as the child is taking a mixed diet consisting of cereals, vegetables and milk, and as it is running about out of doors it may be discontinued.

Once the condition is diagnosed, the child should be given cod liver oil, or haliverol and he should be sunbathed for a few hours in the mornings.

Ricketic deformities should be corrected by surgical measures, massage or postural treatment.

In no case need the antiricketic treatment be continued beyond the third year of life.

DEFICIENCY OF VITAMIN B₂ OR G.

Pellagra is due to a deficiency of the growth promoting Vitamin B₂ or G in the diet. This condition is more common in the temperate zone all over the world, and in both sexes. Rare during the first two years of life and during adolescence, common between 3rd and 12th years of age. This disease is not inherited and is associated with a deficient intake of all the food materials. When free choice of food is interfered with Pellagra results. A child in an institution because of his great liking for sweets takes a diet mainly containing cheap carbohydrates, and he may fall a victim to Pellagra.

Predisposing factors are poverty, ignorance, filth, living on a diet deficient in animal proteins, milk, eggs, fresh lean meat,

taking in excess of carbo-hydrates, living in unhygienic surroundings, and frequent gastro-intestinal disturbances leading to vomiting and diarrhoea.

SYMPTOMS: In the child, the symptoms are likely to appear merely as a skin disease. Usually it sets in with skin lesions on the face. In cases following vomiting and diarrhoea, the skin lesions are quite insignificant in size and severity. In this class of patients, the skin lesions occur in the intergluteal fold of the buttocks, over the pubes, and the points of the elbows. These are dull red, nonpainful, non-itching areas with sharply defined outlines. Ulcerations may occur. In a young child suffering from diarrhoea and sore mouth, search the skin for patches of dermatitis. With repeated attacks, there is arrest of mental development though in such cases, body growth may be surprisingly good.

Complications as scurvy, starvation, edema and peripheral neuritis are common if other vitamins are also deficient in the diet.

Diagnosis is easy, though cases are often not diagnosed at first sight.

Acrodynia may cause confusion. This condition is characterised by loss of hair and teeth, itching of the palms and fingers, dermatitis of the fingers including the tips of the fingers. In pellagra, the finger tips are practically always free from the dermatitis and all the other symptoms mentioned are absent.

Prognosis is better in children than in adults.

Repeated attacks result in permanent injury to the brain.

Only cases of long standing complicated by severe malnutrition and dehydration die.

Chronic indigestion which is a prominent aftermath in the adult is less common among children.

TREATMENT: In mild cases, a well balanced diet works wonders.

For those with severe stomatitis and diarrhoea give plenty of milk with liver extract 1 to 3 oz daily or dried yeast in the same doses.

For dehydration, fruits and salts may be supplied. If necessary, give glucose solution by the skin route.

Coexisting infections as dysentery, hook-worm infections etc. must be treated promptly as soon as acute symptoms have subsided.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

THE CHOICE OF ANALGESICS

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It has been said that, "next to the saving of life, the relief of pain is a physician's most important function". Most patients can be made relatively comfortable in order to prevent the use of energy in the form of actual physical and nervous response to painful stimuli. Protection from these stimuli will allow the use of this energy for a better purpose. On the other hand, the indiscriminate and illogical use of analgesics is frequently unsatisfactory and may actually cause more damage than the pain itself. The type of analgesic should be chosen with care from an analysis of the patient's condition. Pain is an important factor from the diagnostic point of view, but once the type of pain, its situation, frequency and duration are noted it becomes unnecessary and the patient has every right to expect relief. Pain having served its purpose as a warning should be eradicated as soon as possible. The means by which pain is to be relieved depends largely on the type of pain and the causative factors. For rational therapy, therefore the physician must analyse the situation and proceed accordingly.

Obviously, the causative factor must be removed if and when possible. For example, an inflamed appendix should be removed; tabetic patients with root pain should receive the proper sort of antisyphilitic therapy. Headaches associated with some organic manifestation should be treated accordingly. In the meantime, however, it is the duty of the physician to control the symptoms which the patient manifests until such time as the removal of the cause is possible. Analgesics that are satisfactory for the control of one type of pain may be almost valueless in another case. In order to decide the type of analgesic to be used it will be of value to develop some sort of classification of the different types of pain.

PSYCHALGIA

In such a classification psychalgia, or pain without organic cause, should be considered first. It would seem that all pain, whether secondary to some physical pathologic process or associated with no chemical or physical cause, must have a psychologic component, the degree of psychologic component present varying with the patient as well as with the disease. There is apt to be a greater degree of fear and consequently a greater degree of psychologic pain in certain types of conditions than in others, and the diminution of fear or anxiety whether by psychotherapy or by physical means will very distinctly assist in the control of physical pain. Certain types of pain, particularly if there happens to be a large element of psychalgia, will respond poorly even to large doses of morphine. On the other hand, a small dose of some one of the barbiturates, together with a relatively small dose of morphine, may result in complete relief of the patient's symptoms. It is possible to relieve even the most severe types of pain in given individuals by strong suggestive therapy without the use of any of the chemical analgesics. The proper amount of psychotherapy correctly used, irrespective of the type of chemical analgesia necessary, is always of value and should never be neglected. Care should be used in the diagnosis and treatment of psychalgia, since if it is handled badly the patient's attention may be fixed on some symptom and increase rather than diminish the manifestations. If one is sure that there is no organic component in such a situation, one should be exceedingly careful in the use of any physical or chemical therapy.

Prescription 1. Sodium Bromide and Ammonium Valerate.

R Sodium Bromide ... 10.0 Gm
Elixir of Ammonium Valerate. 60.0 C. C.
M Label: One teaspoonful, diluted with water, three times daily after meals.

Prescription 2. Carbromal.

R Carbromal ... 5.0 Gm.
Divide into 15 capsules (or tablets)
Label: One capsule after meals and two before retiring.

Prescription 3. Phenobarbital.

R Elixir of Phenobarbital ... 60.0 cc.
Label: From one teaspoonful to one tablespoonful before bedtime.
(Each teaspoonful contains 0.016 Gm)

THE NEURALGIAS

The neuralgias present a serious problem from the point of view of treatment. Under the general term must be included, of course, certain treatment resistant conditions such as to douloureux, a typical neuralgia of the face, intercostal neuralgia, post-herpetic neuralgia and sciatic neuralgia. In the treatment of these, perhaps mechanical therapy or surgical intervention is in the end the most satisfactory. However, in the meantime the patient should be kept comfortable and in cases that are not too severe perhaps proper mechanical therapy combined with judicious analgesic medication may eliminate the necessity of surgical intervention. In such circumstances it must be remembered that because of the chronicity of these conditions morphine and its derivatives are contraindicated. Aminopyrine and salicylic acid derivatives are in general most satisfactory for the treatment of these cases.

Of the special neuralgias, trichloroethylene has been suggested in the treatment of the tic douloureux but at best should be used only as a temporary type of treatment. It is usually somewhat unsatisfactory. Even morphine may fail in handling this

Prescription 4. Aminopyrine.

R Aminopyrine 5.0 Gm.
Divide into 15 capsules (or tablets).
Label: One capsule every three hours as required to relieve pain.

Prescription 5. Acetylsalicylic Acid.

R Acetylsalicylic acid 5.0 Gm.
Divide into 15 capsules.
Label: from two to three tablets every three hours as required.

Prescription 6. Aminopyrine.

R Elixir of Aminopyrine, N. F. 60.0 cc.
Label: From one to two teaspoonfuls (each teaspoonful contains 0.16 Gm. of Aminopyrine).

Prescription 7. Trichloroethylene.

R Trichloroethylene ... 10.0 cc.
Divide into 10 ampules
Label: Inhale vapors.

particular type of condition and should not be used unless the patient is under the continuous observation of the physician.

NEURITIS

In contrast to the neuralgias, patients with neuritis show definite neurologic changes, such as sensory changes, changes in the reflexes and muscle weakness, etc. Since a great many of these cases

are associated with toxic conditions of some sort, care must be exercised not to prescribe any medication that will increase the toxic manifestation. In cases of neuritis, as in cases of neuralgia, mechanical therapy is of great value. As a necessary adjunct, however, one should include the use of proper analgesics. The pain in most of these cases will yield fairly promptly to the use of aminopyrine or the salicylates, but early in the treatment of the condition the pain may be so severe as to necessitate the use of morphine or one of its derivatives.

ROOT PAINS

Three important conditions come under the heading of root pains: tabes dorsalis, spinal cord tumour and radiculitis. In the first two, obviously, the important consideration is to treat the underlying condition. In spinal cord tumour, for example, the removal of tumour, if operable, will usually result in prompt relief of the pain. In the other two, however, the patient must be made comfortable by the use of analgesia, particularly during the period of treatment. During this time various types of analgesia may be used.

Prescription 8. Analgesic for Radiculitis.

R. Acetylsalicylic acid ... 3.5 Gm.
Acetophenetidin ... 2.5 Gm.
Caffeine ... 0.5 Gm.
Codeine Sulphate ... 0.25 Gm.
M. Divide into 15 capsules.
Label: One or two capsules at onset of pain.
May repeat in an hour.

A patient with tabes dorsalis whose pain is very severe, whether associated with the characteristic root pains involving the extremities or associated with a gastric crisis should be made quiet and should be relieved of fear of repeated attacks of pain. The use of one of the longer acting barbiturates is often of great value in such cases. Ordinary analgesics such as aminopyrine, acetylsalicylic acid and acetophenetidin will rarely have much effect but may be tried on such cases. Obviously, because of the frequent recurrence of attacks of such pain, morphine and its derivatives are contraindicated. A successful method of handling these cases is to administer intravenously one of the intravenous barbiturates, giving the patient enough medication to make him semiconscious and keeping him in such a condition for a period of from twelve to twenty-four hours; when the patient is

allowed to regain consciousness the attack may be gone. This procedure should be used with great caution, and not as a general practice. This type of treatment is to be used only in conjunction with the antisiphilitic therapy, which should be instituted as soon as the condition is recognized. In the treatment of radiculitis, on the other hand, the milder types of analgesia oftentimes serve quite satisfactorily. One may try aminopyrine, acetophenetidin or a salicylate.

Prescription 9. For pain in Spinal Cord Tumour.

R. Morphine sulphate ... 0.15 Gm.
physiologic solution of sodium chloride ... 10.00 cc.
M. Make a sterile solution.
Label: Give 1 cc. hypodermically as ordered (1 cc. equals one-fourth grain).

In the spinal cord tumor cases, the pain may be controlled with morphine or some of its derivatives until such time as the patient comes to operation.

HEADACHE, OR CEPHALALGIA

One of the most common conditions to which man is heir is headache. Since it may be due to a multitude of causes, it is obvious that different types of analgesia should be used according to the type of condition present. It is likewise obvious that, if the causative factor can be found, this should be removed. For example, in allergic conditions the patient should eliminate the reacting substance; or in brain tumor, the tumor if operable, should be removed. In meningitis the inflammatory lesion deserves immediate consideration from the standpoint of treatment. Local disorder, in the nose or throat; visual disturbances, such as refractive error, should all be treated as such. Frequently evening or nocturnal headaches are associated with syphilis and in such cases active antisiphilitic therapy should be administered.

Prescription 10. Acetylsalicylic Acid Combined with Acetophenetidin and Caffeine.

R. Acetylsalicylic Acid ... 3.5 Gm.
Acetophenetidin ... 2.5 Gm.
Caffeine ... 0.5 Gm.
M. Divide into 15 capsules.
Label: One or two capsules at onset of pain.
May repeat in an hour.

Prescription 11. Ergotamine Tartrate.

R. Ergotamine Tartrate ... 0.015 Gm.
Divide into 15 tablets.
Label: One or two tablets at the onset of an attack.

Prescription 12. Acetylsalicylic Acid with Acetanilid and Hyoscyamus.

R. Acetylsalicylic Acid ... 0.5 Gm.
Acetanilid ... 1.5 Gm.
Extract of Hyoscyamus ... 0.15 Gm.
Divide into 15 capsules.
Label: One capsule every two or four hours as needed for pain.

As a type of palliative medication the analgesic must be chosen according to the cause of the headache, if it is to be most effective. So-called reflex headache and headache associated with anxiety, excitement or depression may be controlled with relatively small doses of acetylsalicylic acid; the acetylsalicylic acid may be combined with other analgesics and caffeine. These drugs, on the other hand, have little influence on the patient with migraine or allergic headache. In ordinary migraine, most attacks can be controlled relatively easily by one or two hypodermic injections of ergotamine tartrate, or the ergotamine tartrate may be taken by mouth.

The use of ergotamine tartrate is not without some danger of ergotism. In some of these cases moderate doses of analgesic medication together with large enough doses of a barbiturate to induce sleep may result in complete relief of the symptoms.

Headaches that are associated with gastrointestinal upsets and toxic factors of various sorts, as after acute alcoholism, respond very well to acetanilid prescriptions. In the use of this drug, however, one must guard against habit formation and poisoning.

MISCELLANEOUS CONDITIONS

In patients who have increased muscular tone associated with cramping of the muscles and constant severe pain, one chooses the analgesic according to the condition present. For example, in patients with paralysis agitans, scopolamine hydrobromide administered three times daily over a relatively long period occasionally gives relief. During the attacks of pain the scopolamine effect can be boosted by the use of aminopyrine or if necessary an occasional hypodermic of morphine or one of its derivatives. On the other hand, muscle cramps as seen in athletes, which cause very severe pain, may be promptly relieved by the use of aminopyrine or acetphenetidin.

In thalamic disease the patient occasionally complains of very severe and almost intractable spontaneous pain. Obviously, no

operative procedure is possible under such circumstances. These cases, although rare are perhaps the most difficult to treat, frequently requiring large doses of morphine. Occasionally one gets better results by the use of morphine sulphate combined with one of the lesser analgesics such as aminopyrine or acetphenetidin.

The pain associated with dysmenorrhea presents a very important problem and one frequently encountered. In those cases in which there is some cause which can be corrected, this should be done rather than continuing the use of analgesics from month to month. However, in such cases it may be necessary to use some type of analgesia and in such cases the physician should attempt to estimate the degree of pain and use a drug that produces the desired degree of analgesia. Frequently these situations are a mixture of emotional disturbance and actual pain, and as a result a drug combination of an analgesic together with a sedative is of more value than a single analgesic drug. The use of acetylsalicylic acid or acetophenetidin combined with some mild sedative such as phenobarbital or amyral is usually quite satisfactory. Possibly the combination of aminopyrine and the barbiturates should be frowned on. The amount of the analgesic drug can be increased according to the severity of the pain. The sedative medication, however, should be about the same in most cases. In some instances the pain may be severe enough to require one of the opium derivatives.

Prescription 13. Acetylsalicylic Acid Combined with Amytal.

R. Acetylsalicylic acid ... 5.0 Gm.
Amytal ... 0.75 Gm.
M. Divide into 15 capsules.
Label: One capsule every three hours.

In the control of pain associated with trauma, one should not hesitate to use the opium derivatives in most cases unless one expects the cause of the pain to last for a relatively long period. Some qualification of this may be considered in the treatment, for example, of fractures, in which the introduction of a local anesthetic such as procaine into the fracture site may very markedly reduce the pain associated with reduction of the fracture and obviate the necessity for general anesthesia. The end results are said to be better than in

those cases in which general anesthesia is used.

Prescription 14. Neocinchophen.

R. Neocinchophen m 7.5 Gm.
Divide into 15 capsules
Label: One capsule every three hours.

Prescription 15. For Chronic Infectious Arthritis.

R. Acetylsalicylic Acid ... 3.3 Gm.
Magnesium Oxide ... 3.3 Gm.
M. Divide into 15 capsules
Label: One capsule every three hours.

One of the most satisfactory drugs in the treatment of the pain associated with the degenerative types of arthritis, such as hypertrophic arthritis, is cinchophen or neocinchophen. Since neocinchophen gives such excellent results and is less toxic, it should be used rather than cinchophen.

In chronic infectious arthritis the pain is relieved more satisfactorily by the use of salicylates.

SUMMARY

Much has been written during the past few years concerning the harmful effects of certain drugs. Perhaps aminopyrine has been most severely indicated for its supposed cause of agranulocytosis. There are still many who are afraid to prescribe this splendid analgesic because of the possibility of harm resulting from its use. The property of producing agranulocytosis may be due to the benzene ring; but many cases of industrial benzene poisoning have been noted without agranulocytosis. It is logical to believe that there may be an idiosyncrasy to the drug, just as there is to many other valuable drugs. It should not be discarded because of the unfortunate reaction in a few cases.

Similar criticism of the use of cinchophen and neocinchophen has been raised because this drug is presumed to cause liver damage. Studies on experimental animals have not proved that these drugs have a constant

specific liver toxic effect even when given in doses far in excess of the therapeutic dose. An analysis of the literature would indicate that these drugs may be prescribed safely when a proper indication for their use exists.

Many of the barbituric acid derivatives have been used for the relief of pain. The high comparative dosage of these drugs necessary for analgesic action makes their routine use for such purposes inadvisable.

Sensitization to acetylsalicylic acid is said to be frequent among allergic persons. Placing a small bit of the drug on the tongue and allowing it to dissolve will produce itching, cough or asthma in a short time in sensitized person.

The physician should recognize first of all the temperament and personality of his patient and secondly the situation, type and severity of the pain, and he should prescribe his analgesic medication accordingly. If the patient is a high strung, so-called nervous individual and there appear to be many emotional components in the situation, obviously much greater benefit will be derived from the use of some sedative medication in conjunction with the analgesic to be prescribed. On the other hand, a plethoric, nonemotional individual who has severe pain may be given an analgesic without the sedative component. It should be remembered in the use of this type of medication that habit formation is easily established and in those cases in which the pain is apt to be present over a long period drugs should be used which are least likely to induce habit formation. The narcotics, therefore, should be used rarely and only in emergency situations, not in those cases in which analgesic medication may be necessary over a long period.

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Abstracts

XIIITH ALL INDIA MEDICAL CONFERENCE, 1936, Karachi.

WELCOME ADDRESS

By

DR. A. SAID, I.M.D., (RETD)

Chairman, Reception Committee

EXTRACTS.

Dr. Said, while welcoming the delegates, said that though Karachi is the western most corner of a desert in India, to reach which they had to pass desolate scenes with 'pyramids of sand dunes' in the midst of 'thorny dust-brigined, bushes'. They must have noticed an agreeable change as they stepped into the city. Karachi, he said was a 'modern city, the Liverpool of the East which rose to its present position from a fishman's village eighty years ago,' and he hoped it would be 'the Aerial Clapham of India'. He eulogised the efficient municipal administration of Karachi and said that, with the advent of Sind being made a separate province it will grow to such an importance as to be called the Egypt of Asia. He expressed a note of warning, the with the material development of ing that Government should take care that the water logged province had a real danger premalaria to grapple which all possible preventive measures should be inaugurated. He expressed his satisfaction with the concern the Government was evincing regarding the danger of Yellow Fever. He concluded his remarks about Sind and Karachi by saying that Sind had a legendary history that India derived its name from the river Indus-the Sindhu flowing in the province and that Karachi is the real gateway of India.

While referring to the need of a Medical College in Karachi along with the existing Law and Engineering colleges, he gave his views about the teaching in medical colleges and dwelt upon the necessity of an uniform system of medical education. He said, "A successful physician and surgeon is not necessarily a very good teacher. There should therefore be a teaching corps created for our medical institutions. Vested interests should not monopolise the key-posts and service interests should not dominate the teaching profession. It is an unfortunate experience that several of these professors

have no heart for the teaching line and have not even the time to teach, as they have an eye on their private practice." He urged the need of research scholarships. Regarding the course of studies, he was for a five years' course and wished to curtail pre-medical course by one year. He would have only one degree, i.e., M.D. for all. He warned against the present danger of too much scientific theoretical knowledge in the place of practical bedside teaching.

He felt conscious to the fact that the medical market is glutted with unemployment, which he averred, was due to the mustering of medical men only in cities and big towns. He was of opinion that for 350 million population in India, there was no adequate number of scientific medical men. He wished that the Government should, instead of having travelling dispensaries, encourage private practitioners to settle in villages by offering them suitable subsidies. The rural private practitioners should also in his opinion be entrusted with rural sanitation. With the Government scheme of road development, he hoped, rural reconstruction with the help of medical practitioners, was a practical proposition.

With regard to Medical Relief in Karachi, he pressed for two well equipped General Hospitals, one to be run by the Municipality, the other by the Government, both co-ordinating with each other. He criticised the present policy of the Government in having only one District Hospital 'without some of the most essential requirements and conveniences.' This was a 'reproach' he said, 'which ought to be immediately removed.' He pointed out that 'lot of expenditure could be saved if Medical Practitioners and Surgeons of the city were engaged as honoraries in the General Hospital and Medical College as is the case in Bombay.'

He deprecated the policy of the Karachi Municipality spending 6½ lakhs of rupees out of the yearly income of 38½ lakhs, on public health, conservancy and medical relief and urged that this large sum especially the amount spent on medical relief could be better utilised by starting an up-to-date General Hospital. The Panel System, he said, was carefully gone through by those who drafted the scheme. In spite of opposition from some quarters, the Panel System would eventually be considered as



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the best method to give medical relief to the masses and this system coupled with the Honorary System of medical relief in the proposed Municipal General Hospital was the ideal method of medical relief according to his conviction. He appealed to the medical profession in Karachi to give a lead not only to the other towns and cities of Sind, but to the rest of India with regard to the introduction of the Panel System. He warned the future legislators and ministers that their work would be judged to a large extent by the ways and methods with which they approached the vast problem of medical relief.

Sick nursing by qualified nurses was, according to the views of Dr. Said, a costly item of expenditure, which the poor and the middle classes could not afford. He suggested to bring into existence a cheap class of nursing orderlies by introducing a special course of studies for them. Dr. Said wound up his address by expressing a note of warning against quacks who in the garb of Vaid and Hakims, used allopathic drugs and appliances and unscrupulously deceived the public by assuming bogus qualifications. He said, "They are a menace to the health and well-being of the community and the sooner they are prohibited from practising the allopathic system of treatment the better it will be for all concerned. Let us hope that one of the first fruits of provincial autonomy in Sind will be the passing of a bill prohibiting quackery, which I have no doubt will meet with universal support."

PRESIDENTIAL ADDRESS

By

DR. RAI BAHADUR B. N. VYAS, M. B.,

EXTRACTS.

The President thanked the Indian Medical Association for honouring him as the President of the Association for the year. He then referred to the sorrowful events of the death of Dr. M. A. Ansari and Col. Bhola Nath, the ex-Presidents of the Association and of the two leading Gynaecologists of Calcutta, Doctors, Sir Kedarnath Das and Narendranath Basu. He then spoke about the progressing achievements of the Indian Medical Association and its official organ and gave a specific instance how under the leadership of Dr. Bhopal Singh, the obnoxious amendments to Dangerous

Drugs Act, passed by the U. P. Government were repealed after a strenuous agitation by the local branch of the Indian Medical Association in U. P.

Dr. Vyas then addressed the Conference on important topics affecting the medical profession and began with the services open to the profession and said:

"The services open to the Profession are the Indian Medical Service, Provincial Medical Service, the Public Health Service, the Subordinate Medical Service, and now to some extent the Railway Service. It is right and proper that we should consider the position of Indian Medical profession with regard to these various services.

INDIAN MEDICAL SERVICES

With regard to the Indian Medical Service, I need add very little to what our late President, Col. Bhola Nath, said in his Presidential Address in 1934. I have no hesitation in acknowledging that this Service did a lot in initiating in India the scientific system of medicine. It has produced a number of distinguished and eminent medical men. I have no quarrel with the members of this Service, among whom I count a large number of personal friends. But on the other hand, I have equally no hesitation in saying that it has long outlived its use and the sooner it is scrapped the better at any rate so far as the Civil side of it is concerned. The excuse for keeping the Civil side of it was for the so-called war reserve. Later it was the necessity of maintaining European doctors for looking after the health of the European members of the various services, and now throwing aside all pretence they have established a Civil part of the Service to be imposed perpetually on the Provinces, filling up all the important administrative, educational and Civil appointments. It is difficult to speak with restraint on this uncalled for infliction of a Military Service on a civil population. With a large number of Indian Medical men with the highest qualifications available for any appointment, the best appointments in the Provinces are reserved for officers of this Service with, in good number of cases, very ordinary qualifications. The racial distinction has been carried so far that the Indian members of their own service have been relegated to smaller and unimportant stations in the Province. With the medical administration perpetually in

their own hands, no wonder, their, own interests every time come first. I could quote numerous instances of disregard of legitimate claims outside their service and also of the non-European elements of their own service. Recently in a province they needed a professor of gynaecology and obstetrics and a European officer of their service was selected when a large number of highly qualified and experienced Indians were available. Could there be any justification for such an appointment? While we are told the European members of the service insist on their being attended to by men of their own race, they deliberately appoint an European member of the service when a large number of patient are Indians in such a branch of medicine as gynaecology and obstetrics. We are told that medicine is a transferred subject under an Indian minister in all the Provinces. They evidently are powerless against the Governor in Council on the one hand and the Inspector-General of Civil Hospitals on the other. When the matters are represented to the Hon'ble Ministers they tell us that they can do nothing owing to what are known as devolution rules, which means that the powers with regard to the interests of the service are vested in the Secretary of State for India. The position of Indian entrants to the service has been brought down to a level that it is only due to the increase in unemployment, that they are able to find candidates for the service. The better qualified Indian neither desires nor is encouraged to enter the I. M. S. The Indian entrants will in future have the Viceroy's Commission. Their pay has been proposed to be reduced, and they are distinctly told that they will have no prospects on the civil side. I do not think that I have drawn an overcoloured picture. The New Reforms may or may not bring autonomy to India, but it has certainly rendered the future prospect of the Indian Medical profession gloomy. It has tightened the grip of the Indian Medical Service on the Medical administration of the Provinces, particularly of the European element thereof for a long time to come. We should bring to bear all the resources at our command, in the presently to be established Autonomous Government. We should try to convince the public the Legislatures and the Government, that though we have no ill-will against our European colleagues, yet we as a people do not desire anybody but Doctors of our

own race, to treat us just as European themselves like to be treated by no body except by doctors of their own race. Protesting and passing of resolutions have only resulted in tightening of their grip.

PROVINCIAL SERVICES

Provincial services have been the backbone of urban medical relief, just as much as the Subordinate Provincial Services have been the back-bone of the medical relief of rural areas. In spite of all the disadvantages in which these services have been placed, they have rendered splendid service in all the provinces; yet we must recognise that times are rapidly changing and we should have, as a profession, a larger outlook and consider the welfare of not this or that service, but the future of the profession as a whole. We must admit even these services have outlived their use in their present forms. Yet Government must have a service to look after their medical obligations. If therefore a Civil Medical Service on provincial basis is constituted, to replace the present Provincial Service, and recruited by open competition from the profession in general, it should supply the need of the Government. It would have a limited cadre, each district having one District Officer who would be the medical superintendent of the principal district hospital, an inspecting officer for the rural dispensaries and the principal medico-legal officer of the district. In large hospitals he would have a resident medical officer from amongst the freshly qualified young medical men from colleges and schools, as the case may be, on a temporary basis for a year or two. The main indoor and outdoor work should be distributed among the private medical practitioners with requisite qualifications on an honorary basis. Some similar arrangements would obtain in outlying rural dispensaries. Future administrative officers could be selected from amongst the most competent members of the new Provincial Medical Service. Of course, I am envisaging that the Indian Medical Service will gradually be eliminated. The proposed scheme will result in greater efficiency as each branch of medicine namely, medicine, surgery, ophthalmology, and, if necessary, gynaecology will be in charge of specially qualified men. There is no dearth of such specially qualified men amongst private practitioners. A scheme of the nature suggested would cost much less than the

present medical administration, and spare sufficient money for equipment of hospital and dispensaries.

THE PUBLIC HEALTH SERVICES

I hope that our new Legislatures would devote more time to medical relief and public health. The Public Health Services are starved for want of funds and their personnel is very inadequate. The public has paid very little attention to public health and its problems. They are so busy in the political turmoil that they have allowed this vital factor in the life of a nation to escape their attention. They are oblivious of the appalling infant mortality, lack of maternity care, continued prevalence of large number of endemic and epidemic diseases and the prevailing atmosphere of dirt, disease and death. No nation weak in bodily health can ever attain political power. It is futile to boast of our ancient civilisation and glorious past, while we continue to live surrounded by appalling unhygienic conditions. If we are to live amongst comity of nations on equal terms we must raise our public health standard upto that of modern civilised countries. This would need a considerable expansion of Public Health Services and sufficient funds to carry through schemes of improvement of public health. We as members of the medical profession should do all we can to focus public opinion on these matters and endeavour to bring public health questions to be given that importance which they deserve.

Closely connected with the matter of medical services is the question of unemployment among the ranks of the medical profession. If we succeed in persuading the Government through pressure of public opinion, to adopt some of the measures suggested for the improvement of medical relief and public health, the question of unemployment to a certain extent will be automatically solved. If the work of the Government, municipal and district board hospitals and dispensaries is carried out through the honorary agency in place of highly salaried and therefore limited staff of district and other hospitals, it will absorb a large number of young medical men, living so far on a slender private practice. Having the advantage of a hospital to work in, they would get additional experience and better status, they would be in a position to develop the private practice better than they have been able to do so far. The same

observations would apply more or less to the outlying dispensaries. The expansion of public health services and development of public health schemes would need a large number of products of our school and colleges. But all these suggestions, if you agree with me that they are improvements on the existing state of things, depend on the understanding and good will of others outside the profession. The question therefore that we have seriously to consider is whether we ourselves can do something in this direction. One thing is very clear. If all the medical men, qualifying, roughly about a thousand a year from colleges and perhaps double that number from schools, concentrate on practising in the large towns as more or less they are doing at present, the overcrowding and congestion in the profession which is already existing will intensify, leading to deterioration, further unemployment and misery. The present number of qualified medical men in scientific system of medicine is estimated to be 25,000 throughout India. When we compare this number to the total population even after taking into consideration the number of practitioners of various other so-called systems, it is a mere drop in the ocean. What then is the reason for unemployment? The reason to my mind is apparent. The majority attempt to establish themselves in large cities producing congestion and consequent unemployment. The Services can only absorb a fraction of the men qualified each year. It follows that the majority of the qualified men will have to depend upon private practice for their means of subsistence. The newly qualified young medical practitioner is disinclined to move away from the city and desires to follow in the footsteps of the doctors of the past generation. It is this tendency which has led to congestion and unemployment. They have to realise, whether they like it or not, that the future of the majority of coming generation of medical men lies not in the urban but in the rural areas. The vast number of Indian population with hardly any or no medical aid is waiting for them. We as a profession have so far always thought in the urban sense, the future members of the profession will have to develop a rural sense from sheer necessity if not from a patriotic point of view. The plan suggested to help our young medical practitioners to settle down in the rural areas is somewhat as follows:—

That a general survey of the district be made, and those areas which have no outlying dispensaries be divided into units of a certain number of villages with a small town in the centre where the practitioner is persuaded to settle and subsidised by the authorities concerned to the extent of a house, minimum equipment and a small allowance and left to develop his practice in the surrounding areas. It would necessarily mean a simpler life and perhaps an entirely new outlook in life. But he will, I am sure, in course of time be able to make a decent living, if he continues to observe the honourable traditions of the profession. He would more or less occupy the same position as a country doctor does in the United Kingdom. I am fully aware that the young practitioner, accustomed to the traditions of the town practitioners of the present day, jibs at the idea of rural life. Whether he likes it or not, the future of the majority of the practitioners lies in the rural rather than in urban areas, if ever-increasing products of our colleges and schools have to be provided for.

Another direction in which there is a considerable scope of employment for young members of the profession is, the development of industries for the manufacture of simple chemicals needed for medical purposes. These industries are developing at a more rapid rate than is generally realised. Simple chemicals like Hydrogen Peroxide, Potassium Permanganate are now imported in enormous quantity from foreign countries, which could with a little enterprise be manufactured in this country, and our young medical men with business tendencies can find considerable scope with great benefit to themselves and the country. There is yet another field for the younger generation of medical men—to help to utilise the products of research in indigenous drugs. Researches in this direction have found, and will continue to find a number of preparations derived from indigenous drugs which have been in use in the country for centuries. This will not only give employment to a large number of young medical men with a tendency in that direction, but will cheapen the cost of treatment which is at present prohibitive for the poorer classes. These when ready in suitable number will form the basis of Indian Pharmacopoeia. Col. Chopra's pioneer work in this direction has given great impetus for

the future development of this important work. When we talk of unemployment in the profession we mean that a number of our younger generation of medical practitioners are sitting with folded hands in large towns, waiting for practice to come to them. This I am afraid is due to the utter lack of enterprise. Unless enterprise and determination are forthcoming, they will have to continue to wait without success for practice which is unlikely to come to them.

While there is so much talk about unemployment, ever increasing numbers are seeking admission to the medical colleges and schools, so much so that all the colleges and schools have put a limit to the number of admissions and competition for seeking admission is increasing. I wish the system of admission to the Medical Colleges by open premedical competition, which obtains in the Lucknow University will find favour with other medical educational institutions in India. Through such a competitive examination, you not only get the best material available but save a lot of favouritism and heart burning.

The advent of the Medical Council of India and the inspection of the colleges, have revealed the fact that the different universities had more or less different standards which have now through strict inspections been brought more or less to uniformity. Some of them are lacking in equipment and personnel which when brought to the notice of the government and authorities were quickly attended to. So far as I know the medical schools have not only varying standards, but lack in sufficient equipment and efficient teaching personnel. They need considerable improvement both as regards equipment and teaching staff. Each Provincial Government treats these medical institutions according to their sweet will. The desire of the All India Licentiate Association to bring all the medical schools within the purview of the Medical Council of India is legitimate and justifiable. There is no other way of bringing uniformity of standard. But as these schools are under governing bodies called the State Medical Faculties in each province, outside interference is likely to be resented. I could suggest a number of ways to improve these institutions. But I do not want them mended but I want to see them ended. I want to bring all the schools and where there are

too many to be combined in one and raise them to the standard laid down by the All India Medical Council as the minimum standard for recognition. I hope you will agree with me that there should be one standard for all the medical education in India. The system of turning out medical men with a lower standard of medical education is pernicious and obsolete. Why the diseases and ailments of poor classes need a doctor with lesser qualifications passes understanding. It is a remnant of the times when "the Sahib needed a Doctor Babu to look after the natives". Reforms have come and gone but this obsolete system has been left untouched. It is difficult to understand the persistence with which the proposals to raise the standard of the school to that of the college has been turned down by some of the provincial governments. The usual plea is that there is still a demand for cheaper medical aid. In a poor country like India if the masses are to be afforded medical relief, the cost of treatment has to be necessarily cheap, but that does not imply a less qualified doctor. I wonder what would happen if a worker or a peasant in England was told, that he cannot be treated by a fully qualified doctor on account of the cost it would involve. Another reason given for not raising the standard of the medical schools is lack of funds. When the proposals are distasteful to powers that be, they turn them down for this unanswerable reason. The truth is that the agitation against this unjustifiable state of things has not been strong enough. We ourselves have not made efforts in this direction. I suggest that we tell the Government that the profession in India no longer wants a different standard of medical education in this country, and that the various schools be either brought up to the standard recognisable by the Indian Medical Council or abolished. I believe that strong and influential body of the All India Licentiate's Association agrees with us in this view. The education imparted in our medical colleges is second to none in any country. Among other things, it is shown by the fact, that our students are able to acquire the highest postgraduate qualification of the United Kingdom and other countries without the least difficulty. They can hold their own in any open competition. This is perhaps one of the reasons that the open competitive

examination for the Indian Medical Services has been abolished.

If sufficient number of medical graduates do not engage in research, it is not want of capacity but lack of facilities.

The Indian Research Fund Association in spite of inclusion of three representatives from the Indian Universities is still predominantly controlled by the hierarchy of the Indian Medical Services. Indian Medical men with a flare for research do not get the encouragement which they deserve. Our graduates flock to Europe in large numbers to get post-graduate qualification at great expense and trouble. I believe time has arrived for the expansion of advanced post-graduate training in various branches of medicine in our own universities. We might formulate a scheme for such a training, and submit it for consideration by the various universities. I have one strong grievance against the recruitment of teaching staff for our medical colleges. Some important clinical teaching appointments in majority of the universities, are still reserved for the members of the Indian Medical Services. With a large number of highly qualified Indian Medical men to draw upon, such a reservation has no longer any justification. Our protest against this unjust and uncalled for reservation should be strong and emphatic.

For maintaining the uniformity of standards in medical education in our universities, a central agency with sufficient authority to enforce it is essential. This now exists in the shape of Medical Council of India. The tremendous agitation which preceded its establishment is now more or less at rest. The Indian Medical Act is by no means perfect and needs to be considerably amended before it will satisfy the Indian medical profession. Unless it satisfies the aspirations of our licentiate colleagues it will continue to give cause for dissatisfaction. How this can be brought about, I have already suggested. The unity of action and solidarity of view and patience, shown by the medical profession against the high-handedness of the General Medical Council six years ago have triumphed at last. They have given recognition to our universities with retrospective effect. Most of us feel satisfied with the restoration of friendly relations on an equal basis with that body. Control of ethical standards and disciplinary

powers are vested in our provincial medical councils. These are functioning more or less satisfactorily. The provincial medical council acts need considerable modification, before they can be called satisfactory. The U. P. medical council have lately submitted a proposal to government for modification of the act. I suggest that the different provincial medical councils may take similar action, if not already taken.

I have referred above to the necessity of research in indigenous drugs with a view to find out as many drugs as possible of equal potency as that of British pharmacopoeia with a view to establish an Indian pharmacopoeia, suggested by Chopra Committee. While we are attempting to bring this about, the country is flooded with drugs and preparations of doubtful and even harmful properties. A large number of agencies of foreign countries like England, America, Germany, France and Italy have been established throughout India. They flood the practitioner with volumes of high sounding but worthless literature. Their agents tour the country distributing free samples and beguiling the practitioners in persuasive language to use their very doubtful wares. The practitioner is led to confuse genuine products with spurious preparations and drugs, and thus acquires a tendency of empirical ways of treatment. No law exists to prevent the flooding of the country with spurious and dangerous preparations. Such a thing would not be tolerated in any other country. We must influence the public opinion against allowing this country to be made a dumping ground for useless and harmful products from all over the world. Immediate legislation prohibiting the importation of doubtful and harmful products is called for. A clearly worded resolution expressing our views on the subject should be framed and sent to the government of India and various provincial governments.

You are doubtless aware that a large number of Insurance Companies are daily springing up all over India. I am not competent to give an opinion on the economic soundness of this development but, safeguarded with proper and well considered legislation, I believe, it is a development in the right direction. I am only concerned with the position of the medical profession *visa vis* the development of Insurance business. Ex-

amination for Insurance is a great responsibility on the medical man. He has to be adequately remunerated for undertaking this responsibility. The young practitioner with scanty practice is persuaded to do this work without adequate remuneration. This must be prevented. If the profession is united, the companies must conform to a uniform standard in this matter. I suggest that we should appoint a sub-committee of men of experience in this line to formulate proposals and advise the members of the profession to confine to them.

Our young practitioners have a legitimate grievance against tardy action for the suppression of bogus medical degrees. Laws do exist at any rate in some provinces to make it penal to adopt bogus medical degrees. But these are apparently so feeble in operation that the pernicious system continues to flourish. The quack escapes punishment by adding a word to a bogus degree which makes it pass for a degree of some other system of medicine. The laws against adoption and displaying bogus degree on signboards need to be considerably stiffened to put an end to this unlawful practice. We must draw the attention of the provincial governments to the necessity of early enactment against adoption of bogus degrees.

This brings me to mention of the ancient and indigenous system of medicine which have been flourishing in the country for centuries. A man belonging to our profession has to treat the subject with caution in dealing with it as we are accused of prejudice when expressing any view in this respect. However, I have not the slightest hesitation in saying that I have the highest respect for the systems and their genuine followers. My reverence for the systems is more or less of the same nature as that for Indian archaeology. Both Ayurvedic and Unani systems and their ethical code are suited to the temperament the spiritual leaning and simple life of the people of the country. But so are many other customs and traditions. Due to our contact with the material civilisation of the west, our customs and traditions are changing rapidly. How can then the ancient systems which have no doubt done splendid services to humanity in the past can continue to exist as they are? Acute observation, and correct deduction, urbanity of manner, sympathy, touch of spirituality and freedom from

greed for which Vaidas and Hakims were famous are now things of the past. Still it can only do so if an attempt is made to bring it into modern shape. I suggest the continuance of the ancient system on a modern basis in the following form. The preliminary educational qualification i.e. Intermediate in Science with organic chemistry and biology, should be made the minimum requisite for any and all systems which the candidate desires to adopt finally. He should also be made to undergo a training in what are known as basic subjects, anatomy, physiology, hygiene, pharmacology and pathology. The final two years should be reserved for clinical training in whatever system he wishes to qualify. The whole period of training should be five years as with us. This rule should not apply to Ayurvedic and Unani systems only but also to those who wish to qualify in Homeopathy. Some such similar regulations obtain in the United States of America. Training on these lines to a certain extent already exists in the Ayurvedic Faculty of Benares—Hindu University and Delhi and Lucknow Tibbia Colleges. But the training in the preliminary science and basic subjects—is inadequate and perfunctory. Until some such plan is adopted there is little likelihood of all recognised systems of medicine flourishing side by side with the scientific medicine and poor and rich alike are not likely to receive the best medical relief. We as a profession have neglected to study the subject of Ayurvedic therapeutics. It may not be rational but is full of valuable suggestions. There is much in it which we can learn with profit. Therapeutic value of gold and copper used by them for centuries has now been scientifically recognised by us. I have already referred to the necessity of research in indigenous drugs which have been used for hundreds of years. Such research will not be only profitable to the profession and the country but is likely to enrich the medical science.

Gentlemen, I thank you for the patience with which you have heard me. I have endeavoured to deal with some of the subjects which affect the profession as a whole, avoiding the temptation to enter into details. Longer speeches are neither in my line nor do I wish to tire your patience. You may or may not agree with all I have said but I wish you to believe that future welfare of

the profession has been my sole aim. 'Ours is an unfortunate country for colour, creed, castes, schisms, let the medical profession set the example of unity of aim and action. Given this, all the difficulties and disadvantages you are labouring under will be things of the past, and the glorious heritage of a noble profession will be yours.

On my own behalf and on behalf of the delegates from distant provinces of India who have assembled here at your kind invitation, I thank you heartily for the most cordial reception and the very kind words of your worthy spokesman, Dr. Said, the Chairman of the Reception Committee. The very fact that your association have had the enterprise to invite this conference to meet in your great and charming city, speaks volumes for the zeal of the medical profession of your newly constituted province. I feel sure that the public spirit shown by you will lead ultimately to the improvement of the lot of the medical profession, not only of your province but of the rest of India.

Speech.

BY DR. J. M. TALATI, M.B.B.S., (BOM.)
(D. O., OXON.) D. P. H. (LOND.),
Chairman, Exhibition Committee,
All India Medical Conference.

EXTRACTS.

Dr. Talati first thanked the Mayor of Karachi, who opened the exhibition, whom Dr. Talati described as the guardian of health and comfort and one responsible for the economic prosperity of the citizens of Karachi.

While speaking about the importance of the exhibition, Dr. Talati said that the medical profession should keep abreast of times and with the ever advancing medical science, there came into existence new drugs chemicals, instrument and appliances about which the profession should not only know but have a demonstration as to their importance with regard to examination, diagnosis and treatment of patients. Apart from the scientific value of the exhibition, he talked about its economic value to India, which had all necessary resources for the development of Pharmaceutical trade and industry, which, Dr. Talati said, could be stimulated and encouraged by exhibitions of the kind organised by the Karachi medical profession.

He then referred to Chopra Committee Report and pressed for a Food and Drug Act and Pharmacy and Poisons Act which, while serving the scientific purpose of standardising drugs would prevent the manufacture of spurious drugs and adulteration of drugs such as quinine. Regarding the latter drug, he said that the medical profession was very much deceived by unscrupulous medicine vendors who usually mixed chalk and such materials with quinine. The adulteration of such an important drug, which was the main weapon in combating Malaria was he averred a standing menace to public safety.

He advocated the immediate establishment of Laboratories, Central as well as Provincial for standardising drugs and

chemicals and to detect fraud in their manufacture and sale. He blamed the Government for their lethargy in this direction and referred to the existing Chimico-Bact. Laboratory in Karachi, which Dr. Talati wished to be enlarged to suit the purpose of a pucca Provincial Laboratory so as to be able to prevent adulteration of foods and drugs in the new province of Sind. Before closing his speech, he condemned the growth of a class of chemists and druggists who faked drugs and chemicals on a large scale or called themselves manufacturers of indigenous drugs, which they actually did by the most simple act of getting concentrated drugs from foreign countries and diluted them to required standards by merely adding the required vehicle.

NOTICE

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ALL INDIA MEDICAL CONFERENCE.

As organised by the members of the Medical Profession of Karachi, the annual All India Medical Conference was held in Karachi, last December on 25, 26 and 27 under the auspices of the Indian Medical Association. As per the convention the elected President of the year, of the Indian Medical Association, Rai Bahadur Dr. N. Vyas, presided over the Conference. The Chairman of the Reception Committee was Dr. A. Said of Karachi. Extracts from the addresses of these two have been published in the 'Abstracts Columns' together with the speech of the Chairman, Exhibition Committee. The latter is a new feature of the Annual Conference. The opening of the Exhibition in the past was only a formal affair and the exhibitors had been usually grumbling that in spite of a large expenditure, which they had to incur, they had not proportionate recompense by way of even an appreciation. We congratulate the organisers of the Conference on this desirable innovation which will not only add to the usefulness of such Exhibitions but help all concerned, the exhibitors, the public and the profession materially.

The Chairman, Reception Committee concentrated his address on the medical needs of his city not forgetting the wider spheres of topics concerning the medical profession. The Presidential Address was a routine enumeration of the grievances of the medical profession in India which one found in such addresses in the past without plans either to guide the members of the profession or the All India Association of which he is the head. We have been repeatedly expressing in these columns year after year soon after the annual

conferences met that what the medical profession needs are examples and not precepts which, due to monotony of repetition, lull all concerned to sleep and consequent inaction, without any stimulus for action. We are quite alive to the formidable obstacles to reform and progress, especially with regard to a profession from which all without exception expect free service. The section of the profession which could afford to render free service are the few fortunate members belonging to service. It is a strange irony, yet true, that those who are paid by the state from public funds are the persons who are benefited materially by free service while their brethren who style themselves as independent practitioners, depend mostly on public bounty and with all their ability and zeal for service, the public grudge to pay them as freely and as largely as they pay those in service, in spite of their knowing that the medical officers in service are paid handsomely while the so-called independent practitioners have to toil and moil to make an honest living. This is the psychology of a situation which has assumed the gravity of a fell disease and which, if not cured immediately, any amount of repetition of the grievances, whether it be concerning service or non-service, will have little or no effect on the sufferings of the rank and file of the profession without whom the profession cannot function as such.

The other canker which prevents the profession to organise itself into an utility service worth its name and importance, is the existence of castes in the profession both in service and outside. If the Indian Medical Association concentrated all its attention on these two problems and solved them, the rest of the grievances of the profession will be solved without any difficulty.

Even in advanced countries like America where the profession is a more homogeneous entity than in Great Britain and where the activities of the profession are more advanced, the profession is feeling that all is not well with them on account of its members having not realised their legitimate functions which have been usurped by others outside the profession in the name of industrialism, socialism and all such isms which, while depriving the medical profession of its legitimate dues, have been materially helping those who profess these isms, which are more often pseudo than real. There is nothing in the affairs of human organisation which is outside the province of the medical profession. To understand and practise medicine, a medical man should know all arts and all trades. While in America, eminent members of the profession are made to feel the inroads into the domain of the healing art by interested people, whose interference has seriously interfered with the prosperity of the profession, what would be the future of the members belonging to the scientific system of medicine in India where the treatment of social diseases such as Leprosy, Tuberculosis are controlled by those outside the profession and whose services are recognised more by the Government than of the members of the medical profession who are actually used as instruments to combat these diseases? The effect of this subordinate position which the members of the profession are forced to occupy has been far more detrimental to the interests of the profession in this country than it would have been in countries where the medical profession is well organised. We do not mind to reiterate what we said about the address of Dr. Oliver to the Cincinnati Medical Academy on the 'Functions of the Medical Profession' published in the last issue of *The Medical Practitioner*, pointing out to the medical profession in this country the urgent necessity of entering the councils of the local bodies the provincial and the central legislative bodies, where alone lies the salvation not only of the medical profession but of all professions contributing to the health and happiness of the inhabitants of this country.

The idea of the necessity of having an All India Association was first conceived in Calcutta in 1918 when the Home Rule activities of Mrs. Annie Besant were at their

zenith and when this country honoured her by electing her as the President of the Indian National Congress. The first All India Medical Conference was organised by the members of the profession in Calcutta under the leadership of Dr. Sir Nilratan Sircar. The Conference was held during the Congress session in 1918. But it took nearly ten years more to bring into existence the Indian Medical Association though eminent persons like Sir Nilratan Sircar were in touch with Congress activities, himself being then a prominent Congressman; perhaps even the idea of holding an All India Medical Conference must be due to his association with the Indian National Congress. It is true that persons like Sir Nilratan Sircar had eventually given up the Congress and formed another political group under the name of the Liberal Federation but the Indian Medical Association, which was cradled in the city of Calcutta perhaps in 1928, did contain staunch congressmen in the persons of Dr. Deshmukh of Bombay, its first President and Dr. Ray, its first General Secretary, and who has been continuing as such till this day in addition to many more occupying such and similar positions, including Dr. U. Rama Rau of Madras, the President of the Association for 1936. It cannot be said that these prominent congressmen could not feel the necessity of having at least a minimum percentage of medical men to represent the profession in the legislative bodies, when it is known that Dr. Deshmukh is representing the Congress in the Central Council and Dr. Rama Rau is the Congress nominee for the new Upper House in Madras. We did make an humble attempt and brought to the notice of the President of the National Congress the necessity of having representation for the members of the medical profession in the interests of the country itself. We could do so only through *The Medical Practitioner* and not by personal representation. We did not omit Mahatma Gandhi who has been controlling the activities of the Congress more effectively from outside than what he did from inside. We did not exclude the most trusted and honoured leader of this province, Sjt. C. Rajagopalachari, who we are glad, has been persuaded to represent the Madras University in the new Legislative Assembly of Madras. Having our own misgivings

whether the national leaders will have time to open the wrapper of a medical journal, we took advantage of the All India Medical Conference in which we have personal interest. We made honest attempts to be present at Karachi, but we had to be in the Presidency Magistrate's Court till the 23rd December and had to give up the idea. But we sent a draft resolution to the General Secretary of the Conference in time and the resolution ran thus:

"The All India Medical Conference feels the desirability of adequate representation of the Medical Profession in the legislative bodies and requests all existing political parties in India to make it possible that at least 10 members of the medical profession are elected for the Legislative Assembly in the major provinces and 6 in the minor provinces. For this purpose the conference suggests to the Indian Medical Association to make an urgent request on behalf of the medical profession to all political parties especially to The Indian National Congress, to choose members of the medical profession as candidates to the legislative bodies in the proportion mentioned in the body of the resolution."

It is not known whether this draft resolution was kept before the Subjects Committee of the Conference. We could not even know so far whether there were any technical or other impediments for the Secretary to comply with our request. Suffice it to say that nothing was done or perhaps could be done by the Secretary towards this end. We wish to be understood that we express our opinions frankly not with a spirit of picking up holes for the purpose of demonstrating such holes but to stimulate our readers who are scattered all over India that even the humblest amongst them should not lose any opportunity of serving the profession and through it the country, by trying to get themselves into the legislative bodies or helping their brethren to do so. We are encouraged to make this suggestion as we have communications at least from two rural subsidised practitioners of this province asking our advice whether subsidised practitioners could seek election in local or legislative bodies and we replied to them that they could do so. The hard lot of these unfortunate practitioners in villages has assumed such a gravity that these much talked of but least considered practitioners have lost faith in the leaders who have been advising them to settle in villages, themselves residing in

towns, and who must have realised that selfhelp is the best help.

Let us now consider that apart from the subsidised rural practitioners, how for the urban, including those in capital cities, could rely on the sympathies expressed by the two eminent leaders, the Chairman, Reception Committee and the President of the Indian Medical Association which were followed by the resolutions passed by an all-India body of the representatives of the profession, not the rank and file, but the pith amongst them, and if so, to what extent.

The subjects of the grievances dealt with in the two addresses and the speech made by the Chairman Exhibition Committee are all of them of vital importance to the profession. Neither these addresses nor the resolutions passed by the Conference give any hopes of their finding a solution unless those concerned have faith in prayers and such prayers not to God but to His creatures, be they the Government the persons constituting the Government, or any other authority.

Service grievances, displacement of service by honoraries, amendment of Medical Acts, Indian Medical Degrees Act for preventing quackery and the Lunacy Act, establishment of chemical laboratories at the central and local seats of Government for standardising drugs and chemicals and introduction of legislative measures for controlling pure drugs and food and such and similar things cannot be brought about by resolutions and speeches. The passing of Medical Council Act for India by the Legislative Assembly in spite of protests from the profession and the public throughout the country has, it is most unfortunate, not taught a lesson to those who still cast faith in others on questions which can be handled efficiently only by those who are affected or who have sufficient knowledge on the subjects to be dealt with by the legislatures. The utmost that could be done by associations or conferences and the leaders who hold the strings of such organisations, is to formulate schemes either requiring special legislation or the approval of the public and profession regarding any subject touching the health and welfare of the people and show ways and means to carry them out. As far as we remember, the All India Medical Conference passed a resolution some years ago to for-

mulate a scheme of rural medical relief and a committee was appointed to draft the same. We have personal knowledge that at least one member of this committee made elaborate preparations and we supplied this member all the available records with us about this scheme. Though we are not in a position to know the internal working of the Indian Medical Association, we get all the available proceedings of the annual all India gatherings and in the proceedings made available to us, so far we could not get anything to indicate that the Indian Medical Association had been able to give effect to the above resolution. When resolutions passed lie pending for years, what could the profession expect from the fresh resolutions passed by the Conference to be given effect to by the Government?

There are many things which a society without the intervention of Government or any such authority could set right and there are effective ways by which a society can force down good things in public or professional interest. One such thing that comes to our mind is the non-recognition of Licentiatees as qualified medical men by the Bombay Medical Union, a registered association of some status and standing. There is a branch of the Indian Medical Association in Bombay and the office of the All India Medical Licentiatees is now located in Bombay with its secretariat. Yet nothing has been ventured and nothing done to make this union recognise the Licentiatees as medical men in spite of the fact that there are at least a few members in the Bombay Medical Union, two amongst them being the ex-Presidents of the Indian Medical Association. Many members of the Bombay Union are congress men noted for their abundant sympathies for Harijans till late styled as depressed classes. But these patriots have not been able to take after the Harijans in the medical profession. It will be carrying coal to Newcastle if we were to suggest to the Bombay leaders what can be done to make the Bombay Medical Union bend to lift up the Harijans when in that city there are vivid examples of congress men trying to bend the Government by non-violent methods of Boycott or non-cooperation.

Medical Associations should take prominent part in combating social diseases like

Tuberculosis. The local bodies and the Government are run by human machinery subject to diseases as others outside these bodies. It is the duty of the medical profession to give a lead and start relief centres which can educate the public in preventive as well as curative measures. When public opinion gains strength, the local bodies and even the Government are bound to come to the help of the profession. Such and similar propaganda and service, if conducted by Associations or by prominent individuals in the profession who could afford to spare some time and a little money too, to begin with, would be not only a remunerative investment but will raise the profession in public estimation and of the Government and much more of the local bodies. Once such schemes of public utility get popular, they will run automatically, and indirectly be a means of finding employment at least for the rank and file in the profession. Foreign medical missionaries have been able to conduct and run medical institutions, a few of which at least in no way inferior to the best managed Government institutions and have been able to make them even seats of learning, one such at Vellore, S. India will soon impart university medical education. Why should not Indians imbibe the spirit of the missionaries and run at least their medical organisations in the same spirit? Why beg Government for honorary posts and try to get into the shoes of service men? India has enough and more material for medical service. Honest good service has always its value. It is bound to give an honest living. Amassing of wealth is a matter of luck which only few can possess. Such few may not be even persons possessing the required knowledge. It is our conviction and it should be the experience of many that those who love their profession and not money do not starve and eventually succeed in life. If medical associations hold conferences, demonstrate to the rank and file of the profession the high ideals of the noble and most useful medical profession, make them rely on self-help, draw up schemes to enable the members to utilise their learning, the leaders in the profession making some sacrifice by initiating channels to let in scientific service of public utility to be paid for and run by the public and not by Government, they would be doing real service to India.

Before closing, we wish to draw the at-

tention of the readers to a reference made in the Presidential Address regarding the necessity of imparting knowledge on modern lines in Anatomy, Physiology and other preliminary subjects so as to equip the practitioners of indigenous systems of medicine and also Homeopathy with up-to-date scientific knowledge so as to enable the practitioners of these systems to treat patients as scientifically as the practitioners of the scientific system do. A really sound and good idea which we expressed years ago, we went a step further and said that it is not fair for the Government to manage and run any school or hospital of any particular system when those who pay the taxes to the Government depend upon several systems. We pointed out that during these days of democratic system of Government, the Government could not refuse to supply a need demanded for a particular system of medicine and in a country like India where a large number of indigenous systems of medicine thrived and were being recognised by a large section of the public, it was only a question of time that all the provincial governments would be forced to run parallel charitable and teaching institutions in those systems, in which people had faith. The Ayurvedic and Unani Systems have been recognised by the provincial governments of Madras and U. P. There is now a strong agitation throughout the country that the Homeopathic system of medicine should also be recognised by the Government. These are fair and just claims and the Government cannot but comply with the needs of those who pay them the taxes. But a policy of patronising all the existing systems of medicine will necessarily tell upon the public finance, which had to be recuperated by the public themselves. Under the circumstances, the best course that we would suggest to the Government is to ask the votaries of every system of medicine to run their own hospitals and teaching institutions themselves, the Government being only responsible to see that only qualified practitioners of any system are allowed to practise.

On the whole we should say from what we could read from the proceedings of the All India Medical Conference made available to us that the function was as successful as it could be and we congratulate the organisers of the Conference about their

sagacity in inviting the conference to Karachi soon after Sind was made a separate province.

Lt. Col. MAHADEVAN, I.M.S. etc.

versus

Dr. V. RAMA KAMATH, L.M.P.

Our Acquittal.

As the clock struck 2 His worship, the Chief Presidency Magistrate Madras delivered judgment in the afternoon of 25th January acquitting us and holding that we did not intend to defame Lt. Col. Mahadevan and that our criticism was justified. We first thank God and offer our heartfelt gratitude to our wellwishers and sympathisers whose good wishes and prayers pulled us up unscathed. If the person who dragged us to a criminal court on the plea that we defamed him saw things as they were which one in his position is expected to do, he the complainant and we the accused would have continued as good friends as we ever have been before this tedious trial which lasted from June 1936 till about the end of January 1937, nearly seven months. Our sufferings cannot affect our friendship towards Lt. Col. Mahadevan whom we know from 1912, our first acquaintance being at the Madras General Hospital where he was at the time the Assistant to the late Lt. Col. Niblock the first surgeon of the hospital at the time when we underwent special training in surgery with the idea of settling in Madras. Our acquaintance ripened into friendship and we have been ever since watching the good luck of our friend who later entered the Indian Medical Service and came to this province to do civil duties. Our concern towards an old friend was all the more when he was appointed as the Superintendent of a medical school, our old Alma Mater which we still hold dear to our heart as all old boys of a school should. We were rather perplexed why our friend should see us quite different from what we really were and we are very much relieved that the learned Magistrate has made a special reference in the judgement that we bore no malice towards the complainant as he could see from the several exhibits which showed "that the mutual relations between the two were quite cordial" and we assure Lt. Col. Mahadevan and his other friends

and subordinates, who, along with their Chief, saw us in a different light, that we maintain the same 'cordial relations' adverted to in the learned judgment. Being in a criminal court for the first time in our life as accused, till we got ourselves accustomed to the ordeal, we did not also see things as they were; but the nature of our obsession was of a different type to the allegations displayed in the complaint. The fact that we have to defend ourselves against a formidable opponent in the person of an Indian member of the I. M. S. holding a responsible position as an administrator, educationist, and a surgeon of the first district in the city of Madras, who judges about the welfare of a large number of Government officials, did not perturb us as we did not feel we were the accused. Even if the complainant wished to vindicate his character under an impression that our leader, "Madras Needs a State Medical Faculty", contained an attack upon him, we could not know the reasons which prompted him to have recourse to a remedy which eventually proved to be worse than the alleged disease. We do not wish to say anything more at present, and will reserve further comments on the subject to a future issue after we get a certified copy of the judgment of the learned Magistrate, which we will publish in the Journal along with the complaint and the full proceedings of the case, so as to enable our readers to have a full knowledge of what transpired in the Court as the reports in the newspapers were very meagre and at times a bit distorted too. We do not blame the reporters much less those who conduct the leading dailies in the city, who have to interest themselves with all sort of topics. We are concerned only with the medical profession and its responsibilities to the public and will be failing in our duty, if we do not give a full account of this libel case which has assumed an importance quite beyond our expectation. Lot of facts have been disclosed during the trial and the statements made on oath by people in high and responsible position in life, including amongst them eminent members of the medical profession belonging to both the sexes in Government service and outside, should be perused by all interested in the medical profession and the authorities concerned, so that whoever might have been responsible for the untoward and unpleasant happenings disclosed in the case, the Govern-

ment may take suitable action and thus vindicate the honour and prestige of not only the medical profession but also the systems which were brought into existence by the Government to run a machinery for bringing into being medical men worth the name of a noble and sacred profession.

We are getting telephone messages, telegrams and letters in addition to personal calls from the members of the public, and the profession congratulating us on our having stood the test of a severe trial, the prosecuting counsel being an ex-judge of the Madras High Court who on the day of arguments brought a cart load of law books and attempted to establish crime when it did not exist as the learned judgment finally revealed. The accused is a dummy in a criminal court in this country and the credit of the trial should go to our honourable witnesses who spoke the truth and nothing but truth and enhanced the dignity of the trial assisting the learned Magistrate in arriving at conclusions not dissimilar to those contained in the article complained against excepting the term 'one man's show' which we would have sworn not to apply to the complainant if the accused had a right to get into the witness-box, a privilege denied to the accused in criminal courts. We bowed down with all respect to the judgment soon after it was delivered with a deep sigh of relief and gratitude to all who saved us from the clutches of an alleged crime. We take this opportunity and thank our numerous readers who have been flooding our table with congratulatory messages and beg to be excused for not being able to express our gratitude individually. We crave their indulgence for referring to this and other events in this issue which is converted into a combined one for November and December and hope to be able to keep pace with time in the near future.

News and Comments

Transfer or Abdication?:—The belated sense of responsibility in the Madras Government to consider that private hospitals run by its full time medical officers is a trade and as such, should be prohibited, has naturally led to consequences which, far from adding to the dignity and the prestige of the Government, show signs of unpleasant sequelae which are likely to tell upon the good name of the Government more

than the delay in not taking prompt disciplinary action to prevent disobedience on the part of those in service, who have been sticking to the opinion that running of private hospitals is a legitimate privilege of private practice. The statement made by the Minister in charge of medical portfolio, at the last session of the Madras Legislative Council in reply to an interpellation by one of the members of the Council that Lt. Col. Pandalai has been given time till December 1936 regarding the closing of his private 'surgical clinic' and a notification in the newspapers that Lt. Col. Pandalai is under transfer orders, connected with the fact that the 'surgical clinic' is said to be running still, leads us to an inference of causes and their effects. If this officer carries out the orders of the Government, well and good; if not, there cannot be any purpose is the transfer and it will have the effect of abdication honourable to those concerned.

All is well that ends well. It will be so, if the rumour of Lt. Col. Pandalai's retirement from service turns to be true. He will be a free bird and can carry out his ambition to be useful to the public unfettered. Unlike what has been happening in other civilised countries, the scientific system of medicine was inaugurated in India by service men and with it private practice. Privilege of private practice to whole time medical officers of the Government was allowed not to benefit the paid officers, but the public, who, during the early days of British Rule, had not private practitioners to serve them in their houses. The Government failed either to check or even curtail this privilege to the extent the demand for private service has been gradually supplied by private practitioners. This was entirely due to vested interests having taken good hold of those who run the Government. The fact that state-paid medical officers are not allowed private practice in any part of the world including the British Colonies, except in India, has been a great handicap for the homogeneous growth and prosperity of the independent medical profession. To that extent, the public also suffer, as it is not possible for any Government to supply all the needs of medical relief by paid agency. Consequently, the independent medical profession is to be led by their brethren in service even in the methods of private practice. It is so in

Madras and will continue to be so till a few more leaders in service retire and join the members of the independent medical profession.

The independent medical practitioners will gladly absorb Lt. Col. Pandalai as one of their own and we hope Lt. Col. Pandalai will reciprocate as cordially.

Health and Nutrition: In spite of our very grave disappointment that neither the profession nor its accredited representative Association did not take in our suggestion to attempt sending representatives of the medical profession into the legislative bodies, we will be failing in our duty if we do not place before the profession that portion of the address of the new Viceroy which concerns the medical profession in particular with the hope that it may serve as an eye-opener in the future. H. E. Lord Linlithgow addressed both the upper and lower Houses of the Indian Legislature at the joint session of both the Houses on 21-9-'36. Health and Nutrition of a nation require a life-long study by those who are interested in this problem and none are more qualified to tackle this problem than the members of the profession. It is not enough that the members of the profession discuss about any new research and arrive at conclusions themselves. Research conducted in laboratories have to be put to proof before such research might be taken advantage of for ameliorating the condition of the people and the few Government experts in whatever high position they may be, cannot put their research into practice unless with the co-operation of those who are in actual touch with the people and it is the general practitioner that should come forward for help to make research a tangible success. The Viceroy who talked of the problems of Health and Nutrition did so as a side issue while addressing both the Houses of the Indian Legislature. Unless there be a unit representing the medical profession in legislative bodies, the health and welfare problems will continue to be side shows of politics after the inauguration of provincial autonomy and much more so after India gets autonomy even at the the Central Government. The medical profession in India is a body without limbs and unless the limbs are brought into existence, this body can never function; so it is the duty of the future autonomous legislature to

press on the Government to bring into existence a medical profession worth the autonomy. The Viceroy's concern about the welfare of the people of this country could be discerned from his address wherein amongst other things His Excellency said.

"As you are, I think, aware that the two problems to which I attach the utmost importance are that of public health and the problem of nutrition as affecting human beings and animals alike. The problem of nutrition is at all times one of the vital concern to any country and on its solution hinges essentially the future of India as a whole. No effect that can be made to ameliorate the conditions and to assist in the solution of this problem can be too great and you may rest assured of my own continued and abiding personal interest in it. Hardly less material in its relation to the development and progress of India is the problem of public health. In this field in particular, co-operation and the maximum degree of continued and co-ordinated effort between the Central and the Provincial Government is essential. I am most anxious that all possible assistance should be available to those concerned with the investigations of the many difficult issues that arise and with the practical application of such remedial measures as may be required. I am accordingly taking active steps for the establishment of a Central Public Health Advisory Board, which, in collaboration with the Provincial Governments and with a constitution somewhat analogous to that of the Central Advisory Board of Education, shall apply itself to the realisation of this ideal."

The ambitious schemes which His Excellency intends to introduce in India in connection with Health and Nutrition can only be worked satisfactorily by the members of the profession and as the members of the profession in Government service are too small a corps to serve a country inhabited by 350 millions of people, it should be His Excellency's first concern to enable the medical profession to function to be able to carry out their legitimate responsibilities to the public when it is known that the profession itself is too weak to assert itself. The Viceroy's address to the Joint Houses is a historical document which should be read by all who are interested in the future welfare of the Indian nation and the members of the medical profession cannot fail to find in it clues which if taken advantage of in time, are likely to help them to find solutions for some of their vital grievances, the chief amongst them being the existence of the Medical Council for India.

A Central Board for Medical Councils: The Medical Council of India was brought into existence for serving no

other purpose excepting one, to look after uniformity of education of Indian Medical Graduates so as to get them recognised by the General Medical Council of Great Britain. Such a medical council with only one function and that for the benefit of one particular section of the medical profession which is far smaller than the other huge section of Medical Licentiates, does not exist and cannot exist in any other country. Apart from this aspect such a central council will be certainly incompatible with the new system of provincial autonomy. So consistent with the principles of provincial Autonomy the Indian Medical Act has to be scraped out. This has to be done and may be done with advantage if His Excellency the Viceroy can apply the same principle which he intends applying to bring about a "Central Public Health Advisory Board—analogue to that of the Advisory Board of Education" and constitutes another Central Board of the representatives of the Provincial Medical Councils with clearly defined functions. As it is, the Medical Council of India does not maintain a Register of qualified practitioners nor has it disciplinary control over those whose qualification it recognises. It is a body without life. The Provincial Councils have all of them copied the British code of Medical ethics with little or no regard to the conditions in India and even this code is not uniformly followed by the Provincial Councils with the result that the decisions of these councils vary materially with regard to the punishments to those who violate the code of Medical Ethics. It has not been also possible for these councils to be uniform in the standard of education of the Medical Licentiates. There are many other diversities in the ways the Provincial Councils have been functioning and it is desirable that these councils function uniformly. So, if as suggested by us a Central Advisory Board of representatives of all Medical Councils in India is brought into existence it will be possible to maintain a uniformly high standard of medical education not only for the graduates but all medical men. The All-India Medical Conference which met in Karachi last December, passed a resolution appointing a committee to suggest amendments to the Indian Medical Council Act. We trust this committee of medical men will not

fail to realise the significance of the term 'incompatible' referred to by us about the existence of an All India Medical Council after the inauguration of Provincial Autonomy and report to the Central Council of the Indian Medical Association the desirability of ending the Indian Medical Council Act than mending the same. They will do well in summoning an informal conference of the representatives of all the Medical Councils, who are interested in having a homogeneous medical fraternity. The Conference may conveniently held at the seat of the Central Government and His Excellency the Viceroy may be requested to open this conference. His Excellency will be too glad to have an opportunity of meeting a non-official conference which, if well organised, will, we hope, be a happy prologue to bring into existence an official Central Board of representative of medical councils. The officials of the Government can also be in this preliminary conference if they so desire. Such a conference will be able to solve yet another important question of the desirability of closing the Medical Schools in India which train the Medical Licentiates. Closing of the medical schools in India was the subject of a resolution passed by the All India Medical Conference and may be effectively solved by the representatives of provincial councils who are the best judges in the matter.

A Lost Opportunity : Late in December, an announcement was made by newspapers that Dr. G. C. Anderson, Medical Secretary of the British Medical Association had come down to India to get first hand information about medical practice in this country and to point out to the profession the necessity of having an organisation to look after the interests of the profession the implied organisation being the British Medical Association. We depend upon our memory to remember this news and may not be quite correct to the letter. Whatever might be the estimate of others about Dr. Anderson's Mission and whatever be the real intention of the British Medical Association in sending Dr. Anderson to India at this juncture, when the reforms have to be soon inaugurated in all the provinces, we were impressed that Dr. Anderson was a sincere person and gave expression to his views as frankly as we did about a few

topics that came uppermost to our mind during the brief period of our interview with him at Madras. It was a pleasant surprise to us that Dr. Anderson realised that the first step to attempt in building up a homogeneous medical profession was to do away with the existing castes in the profession. He sympathised with the lot of the Medical Licentiates for their not being brought within the purview of the Indian Medical Council Act, and when we said that this Act was passed by the Indian Legislature to satisfy the General Medical Council, Great Britain, he interrupted us abruptly by saying that the British Medical Association had nothing to do with the General Medical Council. Evidently, he wished it to be known that with regard to the pressure on the India Government for bringing into existence the Medical Council of India the British Medical Association had no hand in the matter. He was frank in admitting that the British Medical Association always favoured the I. M. S. as the Association was influenced at home by the retired members of the I. M. S. and the Association could not but take up their cause, the retired member of the I. M. S. being a section of the British Medical Association. He added that his Association had to depend upon these I. M. S. officers for all information regarding the medical profession, service or non-service. Having realised that the Association had only one side of the version, his purpose to visit India was to have a direct first hand information about matters connected with the medical profession in India. We could gather that Dr. Anderson was rather disappointed about the arrangement of his programme in the City of Madras. We felt as much delicate to ask him the causes of his disappointment as Dr. Anderson felt delicate to express them and there was a silence for a couple of minutes which marked the disappointment more than it was expressed. To us the causes cannot be far to seek. The organisation of the British Medical Association in Madras cannot be said to be as perfect as the British Medical Association would wish it. The real life of Associations of any kind anywhere, depends upon its secretary and the office-bearers. It is so specially regarding the Medical Associations in this country, many of which have mushroom growths and those that survive this growth

have a body without a life and in a very few that have a life, it is very precarious. But for these state of affairs, there would not have been a necessity for the B. M. A. to send their medical secretary to India on a mission.

We were glad to know from Dr. Anderson that he had a pleasant time in making his mission known to the members of the profession in the Punjab and a few other places which we now forget. The political turmoil, the indifference of the Government and in some instances, even obstruction, as indicated by the present policy of medical administration and medical relief in this country and the unjustifiable assertion on the part of the General Medical Council, Great Britain, must be some of the many factors which have been contributing towards a suspicious atmosphere regarding the mission of Dr. Anderson, though we could see for ourselves in spite of all justifiable suspicion, that Dr. Anderson's mission was one of goodwill. Those who are anxious to guide the destinies of the medical profession in this country would have done more justice to themselves and the interests they have at heart about the medical profession, if they made a gesture to Dr. Anderson by showing their goodwill to this visitor in spite of the past experience of this country with things and matters foreign. Non-co-operation and civil disobedience cannot be adopted as avowed policies for bringing about reforms, though it has to be acknowledged that these methods do contribute to some extent to hasten them. The atmosphere of suspicion and danger brought about by non-co-operation in the minds of those who are the actual agents to run the Government, have made the reforms worse than the existing conditions by the introduction of the Safeguards. The lovers of peace are at times capable of doing more than those who love war and the good the former may turn out will be substantially more both in quality as well as in quantity, as goodwill be devoid of the mist of suspicion. Even supposing for granted as a matter of argument, that the British Medical Association is bent upon doing more harm than good to the profession in this country, the tendency for harm would have been much less if the leaders of the medical profession make themselves felt that they were too good for any intended harm either direct or indirect. Faith begets

faith and even the wildest and most cruel animals can be tamed or at least made less harmful by love and not by hatred. Nobody else excepting the medical profession can study human psychology; they alone know the psychic treatment for any kind of mental phenomena and they are capable of treating obsessions or complexes often times with success or at least divert these phenomena in a way to be least objectionable to human society. Dr. Anderson's visit might have been utilised advantageously by the whole profession in India and there would not have been a necessity for him even to visit any city or cities except for the purpose of sight-seeing, in case the organisers of the All India Medical Conference invited Dr. Anderson to Karachi to attend the conference and gave him opportunities of knowing the Indian Medical Association and its activities to enable him to carry impressions of the medical profession in this country, which might help the British Medical Association to understand things as they really are, different from what they gauge from the retired members of the Indian Medical Service. We should say that the profession lost a good opportunity of creating mutual goodwill between the British and the Indian members of the medical profession in spite of real or artificial differences between them. All the same, we trust that we will not be disappointed in our impressions that Dr. G. C. Anderson came to India with an intention to do something really good to the profession in this country and though he had not opportunities to show his goodwill, he would be able to create a goodwill through the powerful organisation, the British Medical Association and make those who entertained suspicions, feel sorry in losing an opportunity of talking to or hearing a representative of the British Medical Association holding a high position.

A large number of subscribers are in arrears. The subscribers should be proud that the journal depends entirely on them for its existence and not on the advertisers. Our principle has always been to adjust our budget, which we are afraid we will not be able to do this year on account of heavy court expenses we have incurred and may have to incur if we are forced to go to the High Court. May we therefore earnestly request the subscribers to help us by paying the arrears when the statement of their account is sent to them individually which we extend doing by separate post.

Correspondence Reports Etc.

The XIII All-India Medical Conference.

RESOLUTIONS PASSED BY THE CONFERENCE.

1. This Conference places on record its deep sense of loss at the untimely demise of:

Dr. M. A. Ansari, Col. Bholanath, Sir Kedar Nath Das, Dr. K. N. Basu and Dr. K. M. Nandkarni, and conveys its heartfelt sympathy and condolence to the members of the bereaved families.

2. While reiterating the previous resolutions of the Conference held in 1934, regarding the amendment of the Indian Medical Council Act, this Conference resolves that a Sub-Committee be formed to consider the Indian Medical Council Act in all its aspects and draw up a draft bill to be submitted to the Central Council of Indian Medical Association.

The following shall form members of the Sub-Committee:

1. Drs. Narayan Rao U. B. 2. Rochiram A. Amesur 3. A. D. Mukerjee, 4. Jivraj N. Mehta 5. K. S. Ray (Convener) 6. B. Vyas 7. Tarachand J. Lalvani 8. B. C. Ray.

3. This Conference regrets the action of the Punjab Government in not withdrawing the ban on the Government Service men to join the Indian Medical Association, and requests the Punjab Branch to arrange a deputation to bring the facts to the notice of the Punjab Government.

4. This Conference resolves that the Provincial Governments be requested to so amend the Local Medical Acts as to give adequate representation to the Licentiates in the Provincial Medical Councils.

5. This Conference is of opinion that there is an urgent and vital need of passing legislation in the shape of a *Pure Drug Act & Pharmacy Act* for British India, on the lines of that of United States of America for the purpose of controlling the sale of drugs, as well as laying down the qualifications of the dispensers of drugs.

6. (a) This Conference calls the attention of the Medical Profession, the Government and Municipalities to the urgent need of Research in causes of malnutrition of the poor people of India and into the dietaries in various parts of India, and for the standardisation of "Balanced Diets" in different provinces, in accordance with the local dietetic customs of the people and the foods available during different seasons of the year.

(b) This Conference desires to draw the attention of the Government and the leaders of India to the fact that deficiency anaemias and diseases, tuberculosis, rickets, dental caries, infectious diseases, etc. spring from malnutrition. That the problem of prevention of diseases is partly a problem of the provision of sufficient and nutritious food for the people.

7. Whereas Tuberculosis or White Plague is insidiously making rapid inroads into populous cities in India and is responsible for high morta-

lity incidence as shown by the vital statistics of the prominent municipal bodies in the country, and whereas the disease is more or less endemic among the poorer section of the community and particularly among the children of school-going age whose parents and guardians can ill-afford to supply them with adequate amount of nourishing food like milk, fruits and eggs, and whereas these children grow up poor in vitality with low resisting power which makes them more susceptible to tuberculous infection at this tender age, this Conference strongly urges upon various local bodies, District Local Boards, Educational Institutions, Government and Private to carefully collect the statistics of the disease in their respective jurisdiction especially amongst children of school-going age and inaugurate schemes of free milk supply to deserving children of poor parentage in humbler quarters of the cities to provide them with adequate nutrition to fortify their constitution against the fell disease. The Conference confidently hopes that such schemes if earnestly pushed forward and assiduously carried out will succeed in their object of building up healthy generation of manhood and womanhood.

8. Resolved that this Conference reiterates its former resolution of 1935 that in Cl. 1 of Section 56 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."

9. This conference resolves that in view of the exhibition of obscene and indecent advertisement by means of newspapers, bills, and posters regarding medicines which are a nuisance and detrimental to the health of the public particularly the young experienced girls and boys, the Central and Local Government and the Local Bodies be requested to take strong action to stop it.

10. Resolved that the Government be requested to make the scheme for periodic health examination of school children compulsory and steps be taken for the preparation of suitable scheme for the training of medical men for the purpose.

11. This Conference registers its emphatic protest against the policy of the Secretary of State for India regarding nomination of candidates for the Indian Medical Service and demand that recruitment to that service should take place through open competitive examination to be held in India.

12. This Conference requests the Government of India (a) to amend the Indian Medical Degrees Act of 1916 in such a way to make it unlawful for the unqualified persons to write any letters or words, with their name which may denote in a direct or indirect way the resemblance of these letters or words to be genuine or bonafide medical degrees, and (b) to declare it an unlawful practice for such unqualified persons to place or write the designation of 'doctor' before their names.

13. This Conference views with great concern the recent influx of a large number of doctors from foreign countries with which

there does not exist any reciprocity and requests the Government to take necessary measures to prevent such influx.

14. Resolved that in the opinion of this Conference, Registered Medical Practitioners should not have any connection with unaffiliated institutions for the teaching of the Western Scientific system of medicine.

Resolved that this Conference requests the Government to initiate legislation to prevent any individual or corporate body to start or run any institution for the teaching of the Western Scientific System of Medicine, until such an individual or body satisfy some preliminary minimum requirements to be prescribed by the Provincial Medical Councils.

15. Resolved that this Conference views with alarm the rapid increase of "Open Chemists' Shops" owned and managed or attended by the Registered Medical Practitioners where consultation may be obtained free by all classes of people irrespective of their income or position in society.

Resolved further that this Conference is of opinion that it should be declared unethical for Registered Medical Practitioners to have any connection with an open shop where prescriptions other than his own are served.

Amendment "or of other Registered Medical Practitioners" in the last line, between the words "own", and "are served", was moved by Dr. J. N. Mehta, seconded by Dr. H. J. Wania. Resolution as amended was carried.

16. Resolved that this Conference views with concern the growing tendency of the well-to-do and middle class public of utilising free hospital facilities and thereby shutting out from the hospitals some of the poorer section of the public for whom such facilities are primarily intended and depriving the general practitioners of their legitimate income.

Resolved that the Indian Medical Association be requested to take active and early steps to remedy the above state of affairs.

17. Resolved that this Conference notes with regret the policy of some of the teaching institutions (official and non-official) in permitting their staff in charge of beds to hold positions in more than one teaching institution, leading to a state of affairs which is detrimental to the efficiency of the institutions.

18. (a) This Conference views with great concern and strongly disapproves of the retrograde policy of the Government of India and His Majesty's Government in perpetuating the I. M. S. and making it more dominant in the future Medical Administration of the autonomous provinces. Under such anomalous state of things the Minister-in-Charge will have no effective control in formulating medical and public health policy for the good of the people. (b) This Conference emphatically protests against the recent notification of the Secretary of State (Lancet Feb. 29th, 1936) reserving some high administrative appointments and research posts or the I.M.S. in spite of continued protest from the profession and the public.

19. While welcoming H. E. The Viceroy's proposal as envisaged in his address in Septem-

ber last to the two Houses of the Indian Legislature to start a regular Central Health Board this Conference is firmly of opinion that such a Board can serve useful purpose and achieve its object only if persons with first hand knowledge and experience in problems of health and nutrition are put at the helm of the affairs and sufficient funds placed at their disposal to administer their beneficent policy and programme.

20. (a) Rural medical relief and sanitation being intimately connected with any scheme of village reconstruction as fundamentally affecting the economic prosperity of a predominantly agricultural country like India, this Conference is strongly of opinion that the Government of India and Provincial Governments in the coming autonomous provinces should revise their public health policy in its essential aspects and give proper attention to it in their annual budgets. (b) In provinces like Sind and the Punjab and others, where irrigation projects of immense importance and great magnitude have been launched and vast areas of land are under water for greater part of the year, this Conference notes with regret that no adequate sanitary or drainage arrangements have been provided parri-passu with the irrigation schemes. This deplorable state of affairs have resulted in unprecedented water-logging of such areas with consequent high malarial mortality which has undermined the health of the countryside with considerable loss of man-power and economic ruination. (c) While recording its sense of appreciation of the recognition, none too early, by the Government of the paramount importance of rural reconstruction and the provision of the funds however inadequate in the central budget for the purpose, this Conference is emphatically of opinion that such half-hearted measures will not touch even the fringe of the problem. It urges the Government, Central as well as Provincial to make Public Health in the village reorganisation as the first charge on the state revenue; set up sufficient rural dispensaries under qualified hands; organise health and sanitation committees; Child & Maternity Welfare Centres; providing training facilities for days; undertaking drainage and sanitary schemes in water-logged areas, pushing antimalarial measures with all the vigour and liberalising quinine policy.

21. This Conference strongly disapproves the custom of demanding counter-signature of the Civil Surgeon on certificates granted by the Registered Medical Practitioners, as it is a great slur on members of the profession.

22. This Conference is of opinion that the Medical Schools of the present day have outlived their usefulness and should either be brought in conformity with the minimum requirements laid down by the Indian Medical Council or be closed down without any further delay.

Seven more resolutions concerned about thanks giving to Reception Committee and others who helped to make the Conference a success.

Review

Review of the Administration report of the King Edward VII Memorial Hospital and the Seth Gordhandas Sunderdas Medical College, Bombay for the year 1935-36.

It gives us great pleasure to review the report submitted by Dr. Jivraj N. Mehta, M. D., (Lond.), Dean, King Edward VII Memorial Hospital and the Seth Gordhandas Sunderdas Medical College, Bombay, for the year 1935-36, to the Municipal Commissioner for the City of Bombay, both these institutions being run by the Bombay Municipal Corporation. Majority of similar teaching institutions which are under the control of the Government have not as yet found their way to realise the utility of sending the reports of the administration of such institutions for review in the popular medical journals. The Indian Medical Gazette which is considered to be an official journal of the Indian Medical Service is having the sole monopoly of getting the administration reports of medical institutions in this country. Constructive criticism from non-official journals will certainly have a good effect in encouraging those who run institutions of public utility for public good and will also infuse a healthy spirit of rivalry which is needed for progress.

Comparison and contrast help a good deal those who review reports especially of institutions which not only treat patients but impart medical education. So we had the administration report of the Madras Government General Hospital before us while reviewing this report. We found that the report under review was more educative and methodical than that of the General Hospital, Madras. Comparisons are at times odious but cannot be avoided in public interest. But our purpose in comparison is to impress on the Government that an Indian in Bombay had been administering a College and a Hospital both of which train the students for the University Medical Course, with credit not only to himself but also to the medical profession. The Dean of these two institutions, Dr. Jivraj N. Mehta, has been able to control both the institutions as efficiently, or perhaps more than the similar institutions run by the Government Medical Officers in Bombay and other provinces. The credit is all the more when it is known that all the physicians and surgeons who are also the professors of the Medical College, are honoraries of no mean order.

The statistical tables containing classifications of diseases and operations including the special departments in surgery are indeed more elucidative and educative than those in the report we have for comparison. The report devotes itself in giving detailed information about the Hospital and its equipment, mention being made about the staff including the nursing department. The Dean does not lose any opportunity in bringing to the notice of the Bombay Corporation about the wants to make the teaching institutions useful not only to those who are trained to serve the public as doctors and nur-

ses but also to the public who resort to this institution in large numbers. The Dean complains that the Hospital worked "during the course of the year, very much in excess of its full complement of 354 beds in spite of a constant and persistent check exercised on the admission of patients". He makes constructive proposals and appeals to the Corporation to consider the necessity of raising another storey on the existing Hospital building, which would provide 160 more beds. He also taps the resources from where necessary help could be expected, if the corporation approves of his idea. The Dean points out the necessity of expanding the out-door department in an institution where attendance per day exceeds 1000 patients.

Dr. Mehta's concern for public welfare is not restricted to the development of the Hospital of which he is in charge. He maintains a broad outlook of the problem of medical relief and stresses the necessity on the part of the Bombay Corporation to study the vital problem of medical relief to a rapidly developing portion of the city towards the north, consistent with the present growing tendency of hospitalisation. Dr. Mehta draws the attention of the Bombay Corporation to the necessity of equipping the King Edward VII Memorial Hospital with paying wards at the Hospital under his charge so that middle class poor people, who are too poor to get into the costly nursing homes, but willing to spend an amount proportionate to their means for institutional treatment, might have recourse to cheaper institutional treatment, while suffering from serious diseases requiring scientific care.

If our information is correct, the King Edward Memorial Hospital and the Seth Gordhandas Sunderdas Medical College are amongst the very few co-ordinating teaching institutions where the hospital as well as the college training of the students are entrusted to one individual, a most desirable necessity in the interest of medical education, which was also in vogue in Madras nearly 30 years ago, and later given up not in the interest of the development of the teaching institutions but to satisfy the growing tendency of a love for private practice in those who were put in charge of these institutions. The advantage of such a combination could be elicited from the Report under review in which a statement about the working of the Medical College also is appended in as much detail as the Hospital regarding its equipment and its needs.

We wish the Madras Government and other governments peruse this report and run the teaching institutions under their control as methodically and systematically as is done in Bombay, where one Dean has been able to administer two institutions which train medical students for University Degrees. We also hope that the Bombay Municipal corporation realises its responsible duty to keep these two institutions up to date as a model for others to follow. There can be only one good ideal for Scientific Medical Relief and the corporation should resist the tendency occasionally noticed by us with regret of a few Municipal Councillors grinding their axes making public questions a target of personal aims.

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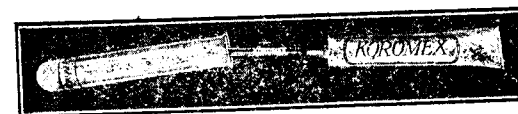
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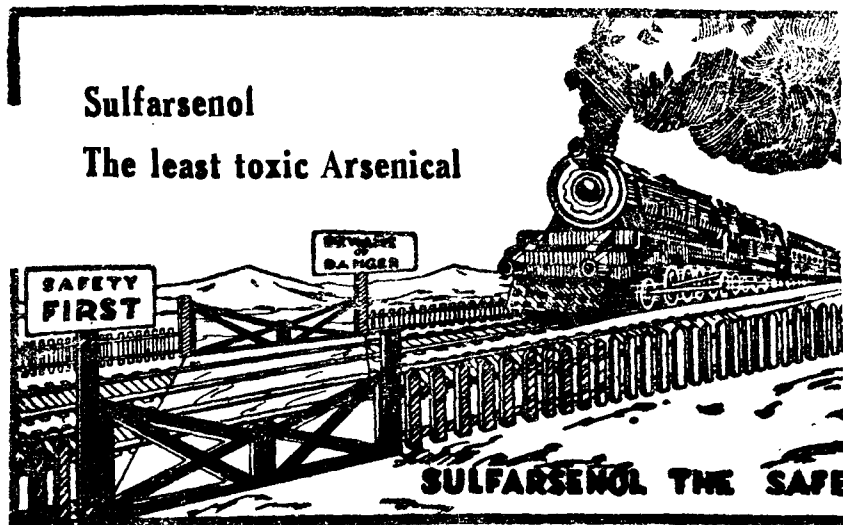
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