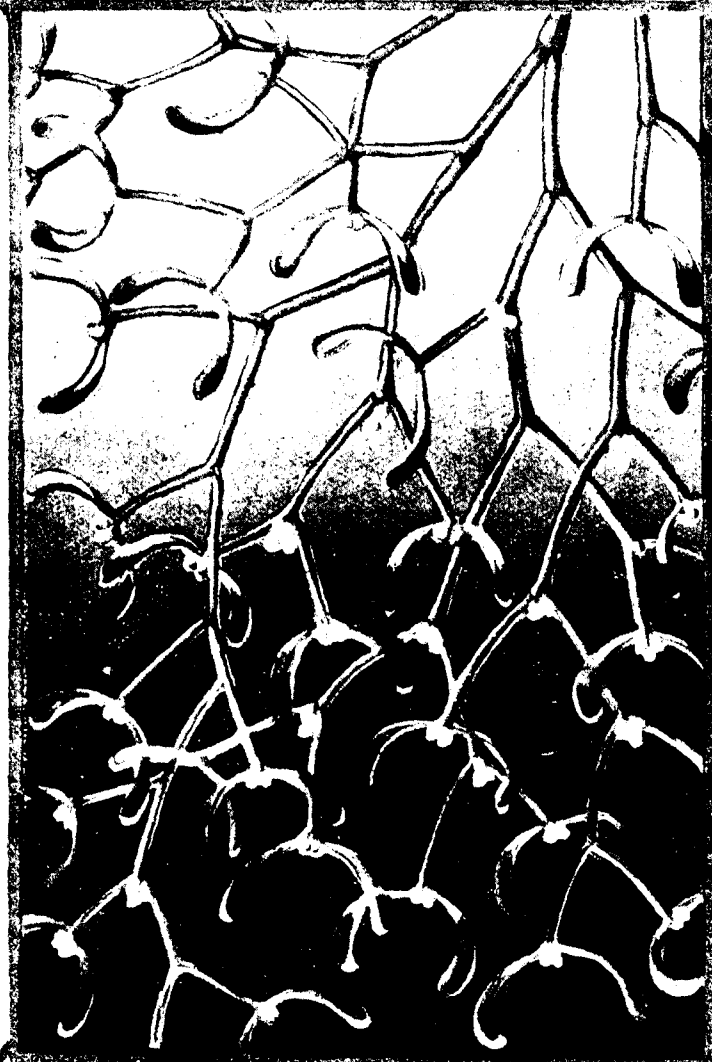


HYPOTENSYL

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AND
HEPATIC
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AND



FOR
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BLOOD
PRESSURE

mistletoe

HYPOTENSYL

for

HIGH BLOOD PRESSURE AND ITS ASSOCIATED SYMPTOMS

Composition.

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Action.

The administration of Hypotensyl serves two purposes. It reduces the high blood pressure, with relief from the headaches and lassitude generally associated with it. By affording relief from constant or frequently recurring high blood pressure, Hypotensyl assists in preventing the advent of pathological changes such as hypertrophy of the muscular tissue of the heart and arteries, also renal lesions, which are frequently the result of prolonged hypertension, and which influence the further development and maintenance of high blood pressure.

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THE Medical Practitioner

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VOL. VIII.]

APRIL, 1937.

NO. 7

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
COPY OF THE WRITTEN STATEMENT OF THE ACCUSED IN

C. C. 1038 OF 1936.

LT. COL. V. MAHADEVAN.

Complainant.

versus.

DR. V. RAMA KAMATH.

Accused.

Written statement of the accused herein.

1. The accused states that he has not defamed P.W.1

2. The Medical Practitioner has been doing its best to further the cause of medical education and serve the larger interests of the profession and of the public. For sometime past the subject of co-education and also the closure of the Lady Willingdon Medical School for Women has been the subject of discussion in Medical circles and elsewhere. The report of Lt. Col. Hingston on the L.M.P. Examinations published in the columns of The Medical Practitioner focussed attention on the subject and the Madras Medical Council appointed a sub-committee to consider this report and suggest reforms. The sub-committee by a majority was inclined to the view that Lt. Col. Hingston's views in some respects could not be sustained and that the poor results in recent years of the Lady Willingdon Medical School for women were not due to any inefficiency in teaching, but to other causes. The Madras Medical Council also passed a resolution which was seconded by P.W.1 himself suggesting that there should be a State Medical Faculty for conducting examinations for non-university Medical Education. The Secretary of the All India Medical Licentiate Association, Madras contributed an article under the caption "New L.M.P. Course" in The Medical Practitioner published in the 1935 April issue of The Medical Practitioner (Exhibit XV-B) referring to the alleged inefficiency of the teaching staff in the Lady Willingdon Medical School for women as judged from the poor results of that School and The Medical Practitioner the columns of which were always open to both schools of thought promised in Exhibit XV-C to give its views on the subject. Mr. Arasu's speech in the Legislative Council advocating the closure of the Lady Willingdon Medical School for women and Dr. Natesa Mudaliar's reply thereto referring to the rivalry of the two schools and espousing the cause of women's schools had also appeared in the news papers and in the proceedings of the Madras Legislative Council (Exhibit XVI).

3. There was also some dissatisfaction in the women's schools relating to appointment of examiners and the procedure followed in the conduct of the examinations and

certain irregularities were stated to have been noticed and want of uniformity of the standard in practical examinations by examiners forming different batches which led to communications to the Surgeon-General or President, Board of Examiners (Exhibits 17, 18, 20 and 21 are some of them) and which led to the interference of the Surgeon-General. A meeting was also held (Vide Exhibit XI) to consider the matter and the matter culminated in the interference by the Surgeon-General with regard to the examinations held in October, 1935 and a correct list of examiners was also published for the first time in G. O. for 1935 (Exhibit XXV page 7) the Civil Medical Lists in which they have hitherto appeared being incomplete and wrong in several particulars.

4. As the women's schools fared comparatively better than the Stanley Medical School, in the examination conducted till 1932, (Vide remark at the bottom of page 3 of Exhibit XXII G.O. No. 2484 of 1932) and in the Inter School Prizes Competitive examinations conducted by outside agencies and also in the examinations held in October 1935 under the personal supervision of the Surgeon-General it was thought in some quarters that reforms were necessary in the conduct of the L.M.P. Examinations, that preponderance should not be given to any one School in particular that the venue for the conduct of the Practical examinations should be changed and that it was desirable that the conduct of the examinations should be handed over to an outside agency unconnected with any of the Schools in particular.

5. In these circumstances, The Medical Practitioner published the article (Exhibit A-1) bona fide and without any malice on the information available, drawing the attention to certain facts which are true or substantially true and there is no reference in it to P.W.1 nor is it defamatory of him. While pointing out that the teaching in the Lady Willingdon Medical School for women was not bad as might be thought in some quarters to avoid all future controversy or criticism it advocated the establishment of a State Medical Faculty for the L.M.P. Course which was itself the subject of a resolution as stated above in the Medical Council. In doing so, The Medical Practitioner which is a responsible journal, was only doing a public duty in regard to a public matter and for the public good and if reference has been made in it to the President of the Board of Examiners it was only with reference to his official capacity and not to his private character.

6. No specific intention or motive on the part of the accused is attributed or proved in spite of a vague and unfounded statement in the complaint. It is alleged in paragraph 15 of the complaint that the accused has shown personal enmity. What is that enmity, is not stated at all in the complaint. It is submitted that section 499, Indian Penal Code cannot be invoked by vague general allegations of mala fides or enmity and when no concrete instances are alleged and proved. This is most essentially required to constitute an offence of defamation, else the complaint would fail. The vague reference to intention or enmity in the complaint is also an afterthought. In the absence of any motive or mala fide intent on the part of the accused the publication of the article in question must be presumed to be bona fide especially as the accused is himself a medical practitioner and in such capacity and also as a journalist he is interested in the subject of medical education.

7. The other statement in the complaint, paragraph 15 that the accused is set up by certain enemies of the complainant to write and publish an article of this kind now in question has also not been proved and the allegation is quite groundless, and vexatious.

8. The article makes no mention of any particular person. It is directed against the officials and official bodies and their official conduct in discharge of their official functions in general. It is the system of education that is imparted, the method of examinations that are conducted, the nature of the composition of the Board of Examiners, the principles under which the members are appointed and the Superintendent of the Stanley Medical School is appointed as the Ex-officio President and so on that are criticised and commented upon, and neither any particular official or person, nor his personal work is touched, and condemned. The allegation in paragraph 8 of the complaint that the accused has made direct imputations against the complainant is

groundless and untrue. It is equally groundless to allege, as in the same paragraph, that the accused meant the complainant himself (he may be the Superintendent of the School for the time being) as if he as Lt. Col. V. Mahadevan I.M.S. is personally responsible for the state of affairs complained of or as he "manipulated the results" or "adopted improper means in the conduct of examinations" and so forth. This language is not the language used in the article, but the language in the imagination of the complainant himself.

9. In these circumstances, were there anybody to feel aggrieved or to feel interested in mending and improving matters as suggested in the article it is the Government, and the Government have not thought fit to complain.

10. If the complainant imagines that the comments made in the article, are true and apply to himself personally as Lt. Col. V. Mahadevan, even then the publication of the article was made in the interests of public good in the interests of the student population and in the interests of the prestige of the Government as their guardian. This may be inferred from the very heading of the article, and from the request that is made to the Government at the end of the article to follow two other Provinces, (United Provinces and Bengal) and to establish a State Medical Faculty. The statements in the article that the control of Medical examination and Medical education for the Licentiate's is as such one Man's show do not refer to the Superintendent of the Stanley Medical School, but to the Surgeon-general and were based on bona fide informations and reports then available to the accused. But when it was alleged that the appointment of examiners was not in the hands of the Superintendent technically, accused at once i.e. in the issue of the very next month (November, 1935) expressed an unqualified regret and published it as prominently as the main article. An immediate expression of a regret of this kind proves the bona fides of the accused.

11. In the light of the evidence adduced and the facts elicited it has to be conceded that the statements of facts in the article in question are true and the reference to the selection of examiners by the President Board of Examiners, which was the only fact alleged to be untrue in the complaint, receives strong support from the Surgeon General's letter referred to in the G. O. for 1935, Exhibit XXV which speaks to what was understood to obtain in actual working. In any event when the attention of The Medical Practitioner was drawn to this as an inaccuracy, it published a correction under the same caption in the very next issue and as prominently as the main article and this also shows the bona fides of the accused. Unfortunately there is a printers error in page 15 column 2 in the passage referring to "way" and "how" in which "way" should read as "why".

12. It is only the system as to the conduct of the medical examinations has been the subject of criticism and there is nothing in Ex. A-1 which is prima facie or otherwise defamatory. The evidence of P. W. 1, and that of his witnesses who are either his close friends adherents or subordinates cannot, it is respectfully submitted be acted upon. P. W.s 2, 5 to 7, and 9, most of whom are badly disposed towards the accused for some reason or other have further conceived an impression that the article in question was a reflection on their work as examiners and in that frame of mind cannot be expected to speak with any sense of detachment.

13. The witnesses have been asked to give their personal impressions as to the article as a whole though none of them have been able to point any particular word or passages as defamatory. It is the opinion of the Court that must prevail and not that of the witnesses. None of the witnesses were cited in the first instance and they have been subsequently brought up to support the complainant.

14. The fact of the complainant not being satisfied with the apology that was published shows also the vindictiveness of the complainant.

15. The accused submits that the attempt on the part of the prosecution to prove the enmity between the P. W. 1, and the accused and the anxiety evinced by the prosecution to identify the reference to 'one man' in the article with P. W. 1, has failed. It

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has been shown that right up to the date of the publication of the article Ex. A-1 there had been no bad feelings between the parties Vide Exhibits I to IV, VII and VIII. And the complainant had admitted that the accused had published laudatory articles about him and his work.

16. Admittedly the Government had not thought fit to take any action. P.W. 1. has come to court after considerable delay and this prosecution has been launched not in furtherance of justice but to silence bona fide and independent criticism. The complainant has rushed to the criminal court after a convenient after thought with the purpose of gagging an enquiry conducted by a Government Committee regarding the poor results of the Lady Willingdon Medical School for Women in 1935.

17. The accused is himself a member of the Medical profession and a member of the Madras Medical Council and has served the public in various capacities without fear or favour. His honesty of purpose has never been doubted as will be evident from the letter to him from Major-General Sprawson Director-General Indian Medical Service (Exhibit XXXVIII) and the letter of Major-General Breadfield Director General designate herewith filed which the accused prays may be treated as part and parcel of this written statement.

18. The accused has been put to a lot of expense and worry as a result of this prosecution for doing what he conceived to be a public duty. P. W. 1. who is a big official of the Indian Medical service holding the dual position of Superintendent Stanley Medical School and President Board of Examiners, is naturally at a considerable advantage, while the accused has to suffer serious disadvantage too numerous to mention.

19. It is respectfully submitted that apart from there being nothing in Ex. A-1 which is defamatory there are abundant materials already on record to show that the statements therein are correct and that the accused has committed no offence whatever.

20. The accused humbly prays that in the circumstances this Hon'ble court may be pleased to discharge him.

Dated at Madras this 22nd day of September, 1936.

Sd. V. Ramakamath,
Accused.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 of 1936.

Dr. P. Krishna Wariar, age 57, 8-10-36. I am a retired Civil Surgeon and at the time I retired I was in the Selection Grade. I was also the Personal Assistant to the Surgeon-General from December, 1929 to April 1934. I was also conferred the title of Rao Bahadur by the Government. Ever since I have become the P. Assistant to the Surgeon-General the Superintendent of the Stanley Medical School used to be the President of the Board of examiners of the L. M. P. examinations. This continued till I retired. There were no official complaints so far as I remember against this practice. There used to be some complaint as regards the conduct of the examinations but not relating to one of the Superintendents being the President: Dr. Lazarus made some complaint privately about the conduct of some examinations the details of which I do not now remember. Dr. Lazarus was then the Superintendent of the Lady Willingdon Medical School. Probably there were a larger number of examiners from the Stanley Medical. There was no talk about this larger number between me and the Superintendents of the other schools. I do not remember of any desire to have a common centre for the holding of the practical examinations. If I remember the practical examinations were held

in the Stanley Medical School. I now heard that they are being held in the Medical College. I can't say why the centre was changed. It is not usual for the Surgeon-General to interfere with the list of examiners sent up to him by the President Board of examiners. There was one instance while I was the personal assistant to the Surgeon General when in an anonymous letter a few questions were sent up to me in advance. Probably in 1931 or 1932 I can't say. I asked the Surgeon-General what to do with it, but no action was taken by him. If I remember right the few questions were in medicine and surgery of the L. M. P. examination. These questions did appear subsequently in the examination papers. I knew most of the staff of the Lady Willingdon Medical School while I was the Personal Assistant to the Surgeon-General. I should say they were well qualified for the posts they occupied: I knew Dr. Varadachariar Civil Surgeon. He was acting as the Superintendent of the Tanjore Medical School for a short period. He was Civil surgeon in various places and as a civil surgeon he is expected to be qualified in surgery. I saw in the papers that he was appointed Stanley Medical School during the absence of P. W. 1. I do not know where he is now. I see Ex. 10. (Rules for the conduct of the L. M. P. Examinations). These were brought into effect while I was the Personal Assistant to the Surgeon-General. The rules must have been modified and sent to him (S. G.) for his approval by the President Board of examiners. That was the usual practice. I find these rule No. 7 which is crossed. Rule No. 7 was deleted (deleted) at the instance of the President Board of Examiners as is seen from Ex. 34 a communication from the Surgeon-General's office dated 13-3-33, relating to the matter. I see from the civil medical code that Kilpauk Division belongs to the 2nd Dist. and not to the 1st Dist. My impression is that Stanley Medical School has a much larger number on the staff than the other schools. I could not say if there is over representation on the Board of Examiners from the staff of the Stanley Medical School having regard to the number of qualified professors in that school. The Surgeon-General is the final authority for appointing examiners for the L.M.P. Examination. It can't be said that the President Board of Examiners is the sole authority for appointing Examiners. The recommendations or proposals for the appointment of examiners are submitted to the Surgeon-General. These proposals are submitted by a Committee. I do not now recollect who all form that Committee. The Superintendents of the 3 medical Schools and the Principal of the Medical College form the Committee. I retired in 1934. I do not remember having seen any interference by the Surgeon-General, to the recommendations made by the Committee to him. His refraining from interference with the list is due to the fact that he is satisfied with the list. I see from Q-2 that the Surgeon-General in the year 1933 has made alterations in the list of examiners sent by the Committee. I see that in 1932 there is also one alteration in the recommendation made by the Committee in Ex. Q-3. In 1934 also the Surgeon-General has made one alteration in Ex. Q-1. I see the list of corrections to Civil Medical Code and at page 5 rule 4 () I find that normal fees will be chargeable to the families of officers and free medical service only for themselves. I was reading Medical Practitioner while I was in office. That journal was taking some interest in medical education and articles on that topic were frequently appearing. To my knowledge if there be any errors or mistakes in the journal and if they be pointed they were corrected: I see a letter from Sir F. Connor. The letters bear his signature. I am familiar with his signature. This is a letter addressed to the accused, Ex. 35. It points out an inaccuracy in an article and I find it corrected in Vol. V p. 281 under the caption "a correction". Vol. V is Ex. 3 and the correction at page 281 is Ex. 3 (a). I see a letter from Col. Bradfield dated 2-7-35 addressed to the accused and signed by him, Ex. 36.

Cross examination. For the professional subjects there are five qualified professors in the Lady Willingdon Medical School and not for Vellore, I could not say. I know only one. There I know personally only the senior professors in the Lady Willingdon Medical School. There may be other qualified lecturers too. I can't say exactly the total number of qualified lecturers and professors in the Stanley Medical School. I can't fix the number even approximately. I have not made any calculation of the number of examiners appointed from each school as compared with the strength of the staff in each

school. In the light of the above my statement in chief examination that the Surgeon-General generally does not interfere with the recommendations of the Committee is not quite accurate. It is clear from these that the Surgeon-General goes into the list carefully and makes his own alteration. That this system of the submitting proposals or recommendations for the appointment of examiners to the Surgeon-General is well known. If any one were to say that the Superintendent of the Stanley Medical School as President of the Board of Examiners was appointing examiners and according to his own whim and fancy it is incorrect. I am not acquainted with the system of setting question papers, and valuing answers. I know that all the examiners sit together to finally decide the results. The examiners belong not only to the 3 medical schools but also to the Medical College. The examiners are all respectable gentleman and are not likely to act dishonestly or improperly. Having regard to the system of examination it would not be accurate to describe it as a one man's show. I see Ex. A-1. I have seen it before soon after its publication. My son-in-law brought it to my notice. I read once again the 3rd paragraph beginning with the words "Ever since" at p. 15 col 2. to the end of that column in that page. The writer of the article makes a complaint about the Superintendent of the Royapuram Medical School being also the President of the Examiners.

Question. Does not that passage contain an insinuation that the Superintendent of the Stanley School taking advantage of his position as President of the Board of Examiners is appointing only such examiners who will be partial to his institution.

Counsel for the accused objects on the ground that the witness is invited to give an opinion on an ordinary English passage which does not contain any technical or peculiar expression.

I uphold the objection and overrule the question.

Cross to continue.

(Sd.) Abbas Ali,

Chief Presidency Magistrate, 8-10-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI Esq., M. A., LL. B., BARRISTER-AT-LAW,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 1, recalled and sworn 12-10-36. Cross examination resumed. I do not recollect having made a record of the private complaints made by Dr. Lazarus. Nothing was done thereon. It was an oral complaint. The complaint was made to me merely privately and not with a view to take any official action. To my knowledge the Surgeon-General did not take any action on the anonymous letter containing the advance copy of questions. I see a letter written by General Sprawson dated May 5, 1931 from Ootacamund. General Sprawson was the S. G. then. The letter is Ex. R. This letter probably refers to that incident of leakage of questions referred to in my chief. The new rules which I referred to in my examination in chief were submitted by P.W. 1 to the Surgeon-General for his approval. I see Ex. 10 rule 7. This rule was deleted, I believe in the S. G.'s office.

Re-examination. I say from the fact that rule No. 7 is struck out in Ex. 10 that S-G.'s office deleted it. The scoring is not initialled. The President Board of Examiners submits the list of examiners to the S. G. every year. If any of the examiners are not available or if there are complaints the S.G. will make enquiries and make the necessary changes. I have no personal knowledge of what takes place in the Selection Committee of Examiners. It is well known to the medical world the procedure as to the selection of the examiners. By the expression "medical world" I mean those medical

men who are interested in the medical examinations. My answer in cross examination as to the procedure regarding the selection of examiners was based upon rules and not from my personal knowledge.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS

BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 2, Dr. R. J. Dyson, sworn age 41, 12-10-36, I am the Chief Medical officer M.S.M. Railway. I am an M.B. Ch. B. of Leeds, D.P.H. Cambridge, D.T.M. and H. Cambridge. I am a member of the Madras Medical Council. I am the Vice-President of the Madras Medical Council. I am also an examiner for B.S. Sc of the Madras University. I know the accused as the fellow member of the Madras Medical Council. I read the "Medical Practitioner" edited by him. As a member of the Medical Council I say he is an able member essentially a protagonist of various causes in matters relating to the status of the L.M.P., in examinations particularly of L.M.Ps. and other matters relating to the independent medical profession. I know the minutes the Madras Medical Council directing Lt. Col. Hingston to inspect the L.M.P. Examination and make a report. This was I believe, in 1934 while I was on leave. He eventually made a report. So far as I know the report was not accepted as final. Eventually, a subcommittee was appointed to consider the question of L.M.P. Examinations among others. I was appointed as chairman and convener of that Committee. Accused was one of the members of that Committee. It has submitted a report to be discussed at the next meeting of the Medical Council that is to be held this month. I was appointed as an Inspector to inspect the L. M. P. Examinations held in April, 1936. Accused was also one of the Inspectors. I was present at the meeting of the Board of Examiners to consider the passes for April, 1936 examinations. The things I noticed at that meeting were firstly 1. The names of the examinees concerning whom there was a doubt were read out by Chairman of the meeting P.W.1 and grace marks were given by the examiners at the meeting. The names of some other examinees who were presumed to have passed were not read out and so far as I could see the examiners had no check on the candidates whose names or numbers were not read out. The examiners had not the copies of the tabulated marks with which they could check the results. There was also a question concerning some orders issued by, I believe, the Chairman Board of Examiners controlling the method of examinations. These were read out by a member of the Board and they appeared to be to me definite orders regarding the method of examination. It was then stated from the chair that they were for guidance only and the actual method should be left to be the discretion of individual examiners. From my point of view it did not appear to me to be desirable to issue orders which were later said to be no orders. Major Mc. Robert raised the question. Accused made a complaint to me with regard to what happened to him viz. he was refused permission to inspect the L.M.P. Examination held in the Medical College by one of the examiners (a chemical examiner). I informed the S.G. within 24 hours of the complaint.

Question. You have been reading The Medical Practitioner. What is your impression of the accused as an editor and as a journalist?

The prosecution objects to the question, as the opinion of this witness is canvassed.

The objection is upheld. I see Ex. 37, minutes of the Madras Medical Council dated 28-10-35 in which I have been appointed President and Convener of the meeting. Resolution No. 8 at p. 3. The resolution is Ex. 37-A.

Cross examination. I am not an examiner for the L.M.P. I did not know that before the meeting the examiners were each given a copy of the tabulated marks giving

the result of the examination; I recollect P.W.1 did give me a copy of the results of the examination but he did not give the particular document from which he read out either the names or the numbers of the examinees. I do not recollect if the paper that was handed over to me was the very paper from which the President read out the numbers. I do not recollect being told that the other examiners had access to the tabulated results. I do not remember if any one at that meeting wanted me to see the original or the copy. I do not remember if any thing was asked by any examiner and refused. I went there immediately before the meeting started. The majority of the examiners were there before I went.

Question: From your knowledge can you say what these examiners were doing from the time they arrived to the time the meeting took place.

Answer. Certainly not till I went.

I do not recollect having written to S. G. with regard to these matters. A paper was handed over to me. I looked through the paper containing the instructions. I do not recollect if the paper containing the instructions started with the words which are found in the paper now handed over to me. I have not got that paper with me. I do not know if they were addressed as "Instructions for the guidance of the examiners". I do not now remember what they were called. I do not know if the report of Col. Hingston was approved, but I do know that the matter was not left at that stage as final.

By court. I see Court Ex. I. I see paragraph 2 of the file of Board meeting held in April, 1936. This minute refers to the episode of the question raised by Major McRobert which gave me the impression I have already stated in my chief examination this day.

Re-examination.—Nil.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 4, Dr. Tirumurti, sworn, age 50, 12-10-36. I am the Professor of Pathology, Medical College, Madras. I have acted as the Principal Vizagapatam Medical College. I acted as a Vice-chancellor of the Andhra University. I have been an examiner for the Andra, Madras, Bombay and Mysore Universities. I was also an examiner for the L. M. P. Examination. I receive communications from the President Board of Examiners for the L. M. P. examinations. I am not aware of the rules relating to the appointment of examiners. I am also a member of the Madras Medical Council for over 6 years. I know the Medical Council appointed a committee to consider the report of Lt. Col. Hingston: I was appointed a member of that committee. I did not attend the meetings of that Committee as no intimation regarding the dates were sent to me. I sent a letter to the convener setting out my views on Col. Hingston's report. The convener of the Committee was Col. Mahadevan. I see Ex. 5. This is the letter sent by me dated 7-7-35. It bears my signature. The letter contains my personal views regarding the disparity of results as between the Stanley Medical School and Lady Willingdon School. I have read Ex. A-1. I am a subscriber to the "Medical Journal". The subject of having a state medical faculty has been agitating the minds of the members of the medical profession for several years. Dr. U. Rama Rao, asked me for my views. I have given him my views. I think it was prior to Ex. A-1. The impression left on my mind was to change the existing system and to request the Surgeon-General through the Government to bring into being a State Medical Faculty.

Cross Examination.—I attended the meeting of the Medical Council at which Col. Hingston's report came up for consideration. Because a Sub-Committee was appointed I say Col. Hingston's report was not approved. I see Ex. S and I see at page 5, and the last line runs thus "and in the meanwhile the report submitted by Col. Hingston be

approved and forwarded to the S. G. for immediate action". I say in spite of that Col. Hingston's report was not approved because a committee was appointed to go into that very report also. I recorded U. Rama Rau's proposition for the purpose of a discussion. I suggest that the Committee that was appointed by that resolution was appointed for the purpose of going into Col. Hingston's report and reporting there on and it was because of that I wrote dissenting minute. I do not pretend to be a careful reader of The Medical Practitioner but I am a reader of it, and at the time I received the copy I glanced through it cursorily, but after receiving the summons from this court. I went through Ex. A-1 once again more carefully. I may say I went twice over. I knew the superintendent Stanley Medical School refers to my friend Col. Mahadevan. I see passage beginning from in Ex. A-1 "we refrain from commenting ending with earlier". I read it now with more care, I say there is no insinuation against Col. Mahadevan that he is using all improper methods for the purpose of securing better results for his school. There is nothing personal in it at all. A perusal of the passage shows that the writer reserves his reasons for the better results to himself. "Why and how" connote the causes for the production of these results. According to me expression "why and how" in this particular cannot be split up and they mean more or less the same thing. When a person says he refrains from comment it does not necessarily mean that if he publishes it would redound to the discredit of the person or persons referred to. It may be that the person refrains from commenting because for the time being he has not got fuller facts. The expressions for the "time being" are not there. To me it makes no difference "showed better percentage" or obtained better percentage". The words "President" does not mean personal. If the word had stopped with President I would have said it referred to P. W. 1. but in as much as it refers to President Board of Examiners, I say it refers to the whole system of the Board of Examiners of which the President also forms a part. He is asking the readers to form an opinion themselves. Where is the insinuation there? Writer is calling upon the readers to form their opinions. I see the passage in Ex. A-1 page 16, col. 1 beginning with "increased percentageending with October examinations". This is a bare statement of facts. Where is the insinuation there? The words "the fact" refers to percentage of result and not to more efficient training in the passages referred to.

(Sd.) ABBAS ALI,

Chief Presidency Magistrate,

12-10-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A., L.L.B., BARRISTER-AT-LAW.

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 4, recalled and sworn, 13-10-36, cross examination continued. I see Ex. T. This is a letter I sent to the President Board of Examiners Stanley Medical School dated 15-3-35. This was subsequent to Col. Hingston's report being communicated to the Council. This was in 1934. When I sent Ex. T, I did not consider Col. Hingston's report as I had not the report with me but my July letter did consider the report. I see Ex. T, again I would like to modify my previous answer and say I am not sure if I saw Col. Hingston's report before I sent Exhibit T: I see a copy of a letter dated 15-2-35 from which I refresh my memory and state that Ex. T was sent by me in pursuance of a requisition to state my opinion about Col. Hingston's report. I see my two reports, Ex. 5 and Ex. 1. I say my opinions have not undergone any substantial change. Depict means to draw a picture. It does not contain any insinuation "mysteries of very poor results" etc also do not cause any imputation. I am as much a friend of the accused as I am of the complainant. I am a friend of both. I remember the accused has written about 2 appreciative articles about my work.

Re-examination. At the time I wrote Ex. T, I did not have all the materials which I had when I wrote Ex. 5.

(Sd.) ABBAS ALI,
Chief Presidency Magistrate,
13-10-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A., LL.B., BARRISTER-AT-LAW.,
Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D.W. 5. Hajee Khan Bahadur B. M. Lodbikahn Sahab, age 63. I am a retired Presy. Magistrate for the City of Madras. I was a First class Magistrate for several years. I know the accused as a doctor for 7 or 8 years. Some years ago he was also a Municipal Councillor. I have seen Ex. A-1. The accused showed me this: I read through the article some time ago. Accused brought a copy of Ex. A-1 and asked me if the article was defamatory. I asked him to leave the book with me. I consulted the penal code and my impression (is that) the article is not defamatory as it is a criticism. He criticises certain official systems and methods under which the Board of Examiners are constituted. The way in which the examiners themselves are selected and so on. He criticises these systems and in the end he suggests certain improvements.

Cross-examination. Accused is one of the many doctors whom I consult. I am not a subscriber to The Medical Practitioner. That was the first time I saw the journal when accused brought it and showed to me. Accused brought Ex. A-1 and asked me to give my opinion. I said I could give my impressions but not my opinion. He told me that a prosecution was pending against him for defamation. I also read the proceedings in the papers. Before he showed the article to me he did not tell me that I should be one of his witnesses. When I told him my impression he said he would cite me as a witness. When he first came to me he said you are a Magistrate please see this article and give your opinion. I did not see any papers connected with this case. I did not read the complaint filed in this case. The complaint sets out the imputation charged. I did not ask for a copy of a complaint to find out the imputations. I went through the article carefully. Since I have no knowledge of the facts of this case I am not competent to give an opinion on isolated sentences or expressions. Reading as a whole my impression is that it was only a criticism of the system prevailing.

Re-examination:—Nil

(Sd.) ABBAS ALI,
Chief Presidency Magistrate,
13-10-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A., LL.B., BARRISTER-AT-LAW.,
Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 6. Dr. R. Ramanjulu Naidu, age 62, sworn. 29-10-36. I am a private practitioner now. I am a Government pensioner. I am the Vice-president of the All-India Medical Licentiate Association, Madras Branch for the past 20 years. I was also the Vice-president for some time of the South Indian Medical Union. I am also a member of the Standing Committee of All India Medical Licentiates Association, Bombay. I was also the first member of the Advisory Committee of the Indian Medical Journal. I am a subscriber and reader of the Medical journal published by the accused. I had occasion

to write to the "Hindu" about the L.M.P. Courses, and I wrote one as early as 1934. Ex. 38 is the article appearing on May, 4, 1934. I have made some suggestions for the reform of that course. My own opinion as regards the examinations conducted in the Royapuram Medical School for the L.M.P. is questionable and the opinion of the public is that there was something fishy about it. I read an article in the October issue of 1935, Ex. A-1. My impression on reading the article is that the writer has attacked the system on (the) whole, i.e. the present system of the L.M.P. education as well as examination; As far as I see, I did not gather the impression that it was a personal attack on any person. I know one Syed Abdul Karim son of Syed Khader Sahab Hony. Magistrate Madras. I am their family doctor. Syed Abdul Karim is employed in the Madras Corporation as a teacher. In 1932, I had occasion to examine this person before he was sent to P. W. 1, who was the Surgeon, First District. I examined him and found him fit. The boy went to me after he was examined by P. W. 1. He made a complaint to me. I advised him to appeal to the Medical Board. He appealed to the Medical Board who declared him fit.

Cross-examination:—I did not attend the Medical Board. I was told he was passed by the Medical Board. I was not present when P.W. 1. examined the young man, as to his medical fitness. I was never an examiner for the L.M.P. nor was I a member of any committee selecting examiners. I do not know personally how the examiners are selected and how the L.M.P. examinations are conducted. I was never a teacher or professor in any of the Medical Schools. I have read Ex. A-1 carefully for this case. Excepting the word, "one man show" which might be objectionable, I do not see anything in the nature of an attack on the President, Board of examiners. I read the article in question again. Col. 2 page 15 is an attack on the President Board of examiners. "If the powers of electing examiners are vested in the Superintendent of the School as President of the Board of Examiners, it comes as a slur on him". When I was reading the article, I was not thinking of the individual who was actually the Superintendent of the Stanley Medical School. The writer wishes his readers to form their own opinion. Specially an adverse opinion as to how and why the Stanley Medical School showed better results than the other schools from 1929. The word "refrain" does not necessarily mean that if disclosed it would not be complimentary. It may be complimentary too but the writer does not wish to compliment and so he refrains. The expression, "comment" has not been used to my knowledge with reference to praiseworthy or meritorious conduct on doings of men. "If the word "comment" is used along with the words "refrain" it generally conveys unpleasantness". I read a passage beginning with "increased percentage and ending with October examinations". There is no insinuation in that passage.

Re-examination:—The suggestion that this passage connotes that the better results of the Stanley Medical School in the previous years was not due to better teaching is far fetched.

Question.—Your attention was drawn to a passage in page 15, column, 2, beginning with the words, "the fact that" and ending with the words "made matters worse". You said it was an attack on the President Board of examiners. Is it an attack on the individual who happens to be the President or the System. The complainant's counsel objects on the ground it is leading.

Note.—This witness in his cross examination stated that it was an attack on the individual and used the words "him" and immediately after the answer was recorded added by saying that he meant the system allowing that.

I was the clinical teacher of the outpatients department Surgical side for the M.B.B.S. students.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A., L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 of 1936.

D.W. 7. Dr. S. Thambiah, sworn age 46, 29-10-36. I am a lecturer in the Madras Medical College and also the Registrar, General Hospital. I am an L.M.S. of Madras. I am an M.R.C.P. Edinburgh, D.T.M. and H, London. I served in the army during the war and obtained a temporary commission. I was awarded the military cross. I have been an examiner for the L.M.P. course for several years. In 1926-27, I was an examiner in Materia Medica and from 1931 onwards for medicine. I was a lecturer in Royapuram and in Tanjore Medical Schools. I have read Ex. A-1. I read it in a cursory way and threw it aside—I formed no opinions. I simply looked at the heading which says "Madras needs a State Medical Faculty" after I received the summons in this case, I read it over twice. I formed the impression that the article gives facts and figures in support of the need for a State Medical Faculty. In the article there is a reference to a one man's show, at p. 17. One man's show would refer to the Surgeon-General from which it precedes and for the conclusion. There is also a passage at p. 15 col. 1 about the middle beginning with the words Surgeon-General and ending with the words "Madras Government." The President Board of examiners sends me the order signed by him. Further than that I can't say who appoints me or other details. I was an examiner in 1926. This was the year I joined. There was a re examination for the L.M.Ps. in several subjects owing to the leakage of question papers. Col. Foster was the Superintendent at that time, the President Board of examiners for the L.M.P. was the Principal of the Medical College. I remember to have attended a meeting of the Board of Examiners for the L.M.P. examinations to consider the result of the October, 1934 examinations. I remember at that meeting to have drawn the attention of the President to a large number of failures in Physics in the two girls schools and I questioned the cause and if there was an agreed syllabus. It was told that though there was an agreed syllabus (but) it had not been circulated to the schools concerned. It was not private conversation. I brought it officially to the notice of the President. Subsequently I was an examiner in October, 1935. October 1935 examination was held in the Medical College. I was not an examiner for April, 36. In October, 1936, the examinations for the L.M.P. were held practically on the lines of the University examinations.

Cross examination :—I do not recollect having perused the article even when I glanced through the heading when I received the journal. I got a summons yesterday morning and once a couple of weeks ago. The accused sees me pretty often for one thing or other. The accused asked me if I had read the article, I said I had not. He asked me to read it. I said I won't, but I read it after I got the subpoena from the Surgeon-General. This case, I should think has become "causes celebre". I read the articles recently and formed an opinion. The editor says that the medical education is controlled by Surgeon-General whereas the conduct of examinations is in the hands of the President, Board of Examiners. By the first of the two sentences, beginning with the Surgeon-General with the Government of Madras and ending with under the authority of the Madras Government, the idea conveyed in the sentence is that the Medical Education of Licentiates is under the control of one man. In the second sentence, the idea is that the conduct of Medical examinations for licentiates is with one man. The word Surgeon-General is not used in the 2nd sentence. There is no reference anywhere about the Surgeon-General appointing President Board of Examiners. The third sentence states that the President is appointed by the Government of Madras. When I read the article twice my attention was not arrested by the words, "one man's show". I do not know who appoints the examiners. After the proceedings of meeting was over, I brought it to the notice of the President when all the examiners were still there about the low passes of the two Women Medical Schools in Physics.

Re-examination. Nil.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A.LLB., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C.C. 1038 OF 1936.

D.W.8. Mabel Isabella Solomon 25 years, on 29-10-36. Sworn: I am an L.M.P. Lady Willingdon Medical School. I completed my course in October, 1934. I attended Royapuram Government Hospital for my practical examination along with other candidates from my school. For short cases we attended and were examined by Dr. Findlay and Kanakasabesan, 4 of us were in one batch. The four candidates included me and one Mary Mathen. Mary Mathen came from Lady Willingdon Medical School. She studied in Vellore Missionary Medical School. She went before another batch of examiners, two Colonels. The rest 3 of us were examined by Dr. Findlay and Kanakasabesan. She went before Col. Mahadevan and Col. Cruikshank. Before we 3 entered the examination room, she went away to the other batch. We were waiting to be called. We went there as we were called. When we went there we did not know before whom we were to appear. After going there we were called to go inside the ward. One Asst. came and took Mary Mathen before the Colonels, either the same man or somebody else took us to the other batch. While we were waiting in the room Lt. Col. Mahadevan happened to pass that side and we all wished him. He recognised Mary Mathen and wanted her number. She was crying because she failed many a time. Col. Mahadevan asked her number. She said something very slowly. I can't say whether she gave the number or not. I could not hear. I also passed and all the 3 other girls. I was asked to give a statement to the Principal of Lady Willingdon Medical School. I see Ex. XXXIX. This is the statement I made and with two others. Mary Mathen did not sign it. It is dated 24-4-35. The facts stated in Ex. XXXIX are correct.

Cross examination : Mary Mathen was studying at Vellore under Dr. Findlay. What I said is correct, viz., that at the time I was speaking of she was a student of Willingdon school and before that she was studying at Vellore school under Dr. Findlay. Personally I have not known that she had ever been studying in Stanley Medical School. She told us that she had been doing clinical work for one month in Stanley Medical School and that she was never a pupil in Stanley Medical School. I did not refer to the second interview because I was not questioned about it. We did not make a written complaint soon after the examination. Our results were out in October itself. We had nothing to complain then. But the results of the April examination batch was bad. I wanted to do something for it. We all joined together and wrote it. We ourselves wrote it. This petition was typed in the Gosha Hospital. I do not know who typed. We gave a manuscript to Dr. Lazarus. Mrs. Parakutty wrote out the manuscript and gave it to Dr. Lazarus. All of us together sat and had a talk and Parakutty wrote it. April results were very bad. Dr. Lazarus was Superintendent of Lady Willingdon School. We mentioned the facts to fellow students immediately after the examination. We were not asked then to write this out. In October we did not report this to Dr. Lazarus. We three of us volunteered to write this letter and after writing it we gave it to Dr. Lazarus. We had no personal conversation with her before sending it to her. I have not said anything about April examination in Ex. XXXIX. Miss Parakutty is working in Cochin state. I do not know when we wrote Ex. 39. Dr. Lazarus and Col. Mahadevan were on good terms. There was a question about the abolition of Lady Willingdon Medical School at that time. I was under Dr. Lazarus as a house surgeon in the hospital at the time I wrote that petition. From Octr., 1934 to Octr. 1935, I was house surgeon in Caste and Gosha Hospital.

Re-examination.—Nil.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS,
BEFORE ABBAS ALI Esq., M. A. LL. B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 9. Dr Hilda Mary Lazarus, age 46, sworn, 12-11-36. I am a member of the Women medical service. I am a graduate of the Madras University in arts and medicine. Besides I am a F.R.C.S. Edinburgh and M.R.C.S England. I am also D.G.O. of Endland. I was a fellow of the Andhra University. I was an examiner in Gynaecology and midwifery in the Universities of Madras and Andhra province. I was an examiner for the L.M.P. examination in 1927 and 1928 and 1932 and '33. Besides as a member I was serving as a member of the women's medical service in the provinces. I am the Superintendent of the Lady Willingdon School from 1927 with an interval of 2 years. I am also the Superintendent of the Government Victoria Caste and Gosha Hospital. The Lady Willingdon Medical School was started in 1923 exclusively for women students. It is a Government Institution. It sends up candidates year after year for the L.M.P. examination. It is efficiently staffed and equipped for the course it teaches. As the Superintendent of the School I am also a member of the committee for selecting the examiners for the L.M.P. Examinations. The President Board of examiners makes out a consolidated list of probable examiners from the list sent to him from various institutions. Till September, 1935 copies of the consolidated list of examiners were not supplied to the members of the committee. To my knowledge no minutes of the meetings were prepared or supplied to the members until September, 1935 when he the Surgeon-General presided and circulated it to the members. Till about 1933 members of the committee of selection did not have adequate notice of the meetings of the Committee. President Board of examiners arranges these meetings. For want of adequate notice my institution used to be represented by my assistant. The Vellore School did not send a representative. The President complained that the Superintendents did not attend the meetings of the Committee of selection. I asked for timely notice and I have been getting it since then. I know of an instance when the meeting lasted for about 1/2 an hour. The President reads out the list of examiners from the consolidated list and he suggests the paper setters and the examiners. These are approved or disapproved by the Committee. Sometimes alternative names too were suggested in case some of the nominees were not available. Sometimes members of the Board suggested other names but the President vetoed it i. e. did not approve of them for reasons which he said sometimes he received from the Surgeon-General which he represented were verbal and sometimes he had other reasons which he did not care to place before the Board. No copies of the consolidated list of examiners were placed before us at the time of the meeting. There used to be only one copy and that before the President and the President used to read the names from it and tick off. Normally about 28 paper setters are selected. For practical there would be 2 to 4 examiners for each subject; in all about 40 or 50 examiners. President Board of examiners reads the names of a certain (persons) for each subject and if the committee approves of their names he will tick off. The President will ask, "I hope you have no objection". We say no, if we have a chance. I say if we have a chance as the President Board of examiners ticks off the names so rapidly that we have no time to say. We were not satisfied with the way these proceedings were conducted. I complained to the Surgeon-General about 1934. At various stages I represented matters to the Surgeon-General. Sometimes orally and sometimes in writing. I have no knowledge if the Surgeon General interfered with the list sent by the President. To my knowledge the list of examiners as finally chosen was not circulated to us. From September, 1935 the Surgeon-General presides over the meetings for the selection of Board of examiners. The meetings are held in the Surgeon-General's office. There are certain rules relating to the conduct of these examinations. These rules were amended in 1933. I was not consulted about the proposed amendments before the amendments were brought into force. President Board of examiners issues circulars or instructions to the examiners from time to time. The President did not consult me before he issued the circulars for the guidance

of the examiners regarding the conduct of the L.M.P. Examinations. Till April, 34 and 35, my school did very well as compared with the men's medical school. My school fared very badly in Surgery even though we carried off the interschool prizes for surgery.

In April, 1935, also my school fared badly in surgery. In 1934, October my school fared slightly better in surgery, than April of the same year. There was a drop in medicine in the percentage of passes in April '35. A number of factors contributed to the bad results. They are:—

1. Method of delivery of questions to students, that is to say: a circular was issued by the President, Board of examiners in 1926 by Col. Hingston and in 1927 by Col. Foster. This was done to secure that there was no leakage of papers. Different schools adopted different interpretations of the circular. Ex. 13 is the circular (copy) I refer to. Theory paper examination was held in each school. There was no common centre. In my school I had the questions dictated and also written on the black board. I came to know that students of other schools had "roneoed" question papers which were roneoed in a separate room and supplied to students.

2. The answer papers were sealed in a cover and on the top of the cover we write the name of the school from which the answer papers emanated, which gave a clue to examiners from which school the answer papers had come. The students do not write their names in the papers.

3. Clinical examinations were held in a place familiar to the students of one school and foreign to the students of my school. The clinical examinations were held in Royapuram Hospital and some of the Practical examinations were held in Stanley Medical School. The women students were labouring under a complex because they had to go to a new and a strange place, besides 50 % of the examiners in clinical medicine and surgery in April, 1935 were from the Stanley Medical School and not a single one from my school.

4. The grouping of students for sending them for the practical examination was done by the President Board of examiners. There were 3 batches of examiners in clinical surgery where standard of marking was not uniform. Some were strict, some lenient and some were moderate. My students had not the advantage of appearing before all the 3 batches of examiners. This was in April 34 and 35.

5. I had a communication from Dr. Findlay one of the examiners that the women students would not answer the questions put to them as they were labouring under a complex that however well they may have answered they would fail, as they had heard a rumour that only 2 women students would be passed.

I presume the batches of examiners for some of the practical examination were made by the President especially in the clinical surgery. But in the year I was an examiner in midwifery we formed the batches ourselves one intern and one extern. In April, 1934 and 1935 the rule that one of the examiners should be internal and one external was not observed. In April 34 and 35 my school students were sent to batch No. 2 for clinical surgery. The examiners in that batch were Dr. Findlay and Dr. Kanakasabesan. From the figures I had received from the President Board of examiners the percentage of passes for all the schools, appearing before that batch of examiners was the lowest.

In theory papers the marks obtained by the candidates were sent up to the President directly by each individual examiner and tabulation in clinical was not always done by the examiners. I have attended the meetings of examiners held to consider the passes. No intimation was given to the examiners to attend half an hour before the meeting time to see the marks obtained by the various candidates. There were 40 or 50 examiners and there was one list for each year subject and it was impossible for all the examiners to look into the details of the marks. For a time after the introduction of the 5 years course there was no agreed syllabus for the new subjects introduced. During the time the examinations were held in the Stanley Medical School, there was a preponderance of examiners from that school. In 1934 and 1935, I suggested some reforms, to the Surgeon-General in the conduct of examinations. I see Ex. 20 and 21. They are true

copies of letters sent by me. Ex. 21-A is the original of Ex. 21. An informal conference was held in December, '34, to consider suggested reforms in the office of the Surgeon-General presided over by the Surgeon-General. I was present along with other superintendents and certain conclusions were aimed at. Ex. XI is the agenda for that meeting. Since September, 1935 students were arranged in alphabetical order and not school war. There was a common centre for the written examination in the Medical College for all the schools. Practical and clinical examinations are being held in the Medical, college, General Hospital and in the women and childrens hospital Egmore. The examiners send the question papers direct to Surgeon-General who gets them printed for distribution to students and sends through his P. A. to the centre for distribution. The question papers are set months before the date of examination to avoid the examiners inadvertently, laying particular stress during teaching. The examiners were chiefly extern after September, 1935. My school has fared very well after the introduction of these changes. My school got 72% in surgery in October, 1935 and 68% in April, 1936 while the Stanley Medical got 22% in October, 1935 in surgery and far below my school in April, 1936. As our teaching is systematic throughout the years, we don't have tutorial classes in our school. From 1933 or '34, or even earlier I had occasion to complain to the Surgeon-General about the holding of special clinics in the Stanley Medical School. In these special clinics there were topics that came into the question paper later. The selection for admission to both the Government Medical schools was done by a special committee until last year and was presided over by the Superintendent Stanley Medical School and the rules passed by Government for selection were strictly adhered to and no one below the requisite qualification was admitted. Neither my staff nor my students had any difficulty in adjusting themselves to the new 5 years' course except in the new subject until a definite syllabus was laid down. Dr. Mathuram is quite well qualified to teach surgery for the new 5 years course. She is an F. R. C. S. in General Surgery and Gynaecology. Dr. Satur is also a F. R. C. S. in General Surgery, with midwifery as her special subject. Mrs. Parakutty ammal was teaching chemistry in my school and she was specially qualified to teach the subject. I have read Ex. A-1. "Madras Needs a State Medical Faculty

I see at page 16 of Ex. A-1. The passage beginning with at the 6th line "It may be seen.....there has been a gradual increase.....in the Stanley Medical School". The facts stated in that passage are correct. The facts stated in the next sentence, "yet the women medical schools did on the whole much better" is also correct. I see further down in the same column a passage beginning with "Interschool...and ending with papers for the competitive examinations were set by examiners who are not the lecturers of any of the schools" The facts stated therein are correct. I see the last line of col. 2 on page 16 beginning with "The surgeon-general appointed the lecturer and ending with and 66.7% of passes in midwifery in the middle of column 1 at page 17. The facts stated in that passage are correct. But I can't vouch for the correctness of the reason mentioned in line 5 of page 17 column 1 to the effect that examiners were appointed to guard the interest of each school. The system of having the superintendent of one of the schools as the President Board of selection and of the Board of Examiners did not commend itself to me. I think the Superintendent Vellore Medical School also did not approve of superintendent of one of the schools being the President. At the informal conference held in December, '34, it was suggested by the Surgeon-General that the Presidentship of the Board may be given in rotation to Superintendent of each of the medical schools. Neither I nor the Superintendent of Vellore Medical School agreed to this suggestion. Since so many improvements were made in the course I thought it better to have a neutral body of examiners with a neutral President. I know D. W. 8. She studied under me. She and 2 other qualified Lady doctors complained to the Surgeon-General through me. I see Ex. 39.

Cross examination:—The Lady Willingdon Medical School was established in 1923. In 1927, I became the Superintendent of the Lady Willingdon School with an interval of 2 years. I continue to be one. When I took charge there was a system of medical examinations prevailing for the examination of L.M.P. students. At that time I believe there were more than 4 or 5 medical schools for L.M.P. Course. Principal, Medical College

was President Board of examiners at that time. It was subsequently changed in 1927. I took charge in May, 1927. Probably this change began from the academic year of 1927. There was no conference formal or informal during the two months that I was here as Superintendent prior to the introduction of the change at which the subject of the change in the Presidentship was discussed on or resolved on. The Surgeon-General as the head of the department generally sends up proposals for any change to Government for approval. The Govt. it is that makes the final order. The order must have been communicated to me.

(Sd.) Abbas Ali,
Chief Presidency Magistrate.
12-11-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI Esq., M.A. LL. B., BARRISTER-AT-LAW.,

Chief Presy. Magistrate.

C. C. 1038 OF 1936.

D. W. 9. recalled and sworn, 19-11-36, Cross examination continued. Prior to the middle of 1927, the President Board of Examiners for the L.M.Ps. was the Principal of the Medical College. As the Principal Medical College was also the Superintendent of a large hospital with an extensive private practice a change was made. Col. Hingston was the last Principal of the Medical College who was also President Board of Examiners. In the year 1927 there were 5 or 6 medical schools for the L.M.Ps. Col. Foster was the Superintendent of the Royapuram School. There was dissatisfaction with regard to the conduct of the L.M.P. examination from about 1931 onwards and in 1932, I complained to the then P. A. to the Surgeon-General about the leakage of questions in some of the subjects. There was an agitation against the Superintendent of one of the schools also being a President of the Board of Examiners in the year 1933 and so when General-Sprawson was the Surgeon-General, Dr. Scudder of Vellore told me that she requested the Surgeon-General to make the change. She requested Surgeon-General when he visited Vellore some time in the year 1933. That is my recollection. I did not make a complaint to the Surgeon-General prior to April, 1934 that the Superintendent of one of the schools should not also be the President Board of Examiners. The President Board of Examiners has been appointing the examiners up to September, 1935. I am aware of this practice from January, 1929 to September, 1935. I am sure of this practice because those are the rules. In the year 1929 a new set of rules came into force. The above rules were amended in 1933. Therefore it would not be correct to say that the Surgeon-General makes the appointment but these appointments are made by the president Board of Examiners with his approval. I know a new set of rules were introduced in Jan. 1929, but there must have been some rules before that. I have been the Superintendent Lady Willingdon Medical School from May, 1927, to the end of Jan. 1929. The rules as regards the appointment of examiners that were in existence between 1927 and 1929, I have not read but I have read rules issued by Col. Hingston and Col. Foster for the conduct of L.M.P. Examinations. I do not remember if I sat in any committee between the years 1927 and 1929. I can't say if there was or was not a committee for the purpose of selecting examiners in 1927 and 1928. I can't say whether a committee for the selection of examiners came in existence only in the year 1929 or whether such a committee came into existence prior to 1929. I can't say when the Committee came into existence. I will not say I did not take any interest in the appointment of the examiners but it may be that the examiners were appointed for 3 years at a time and as I was at first for only a period of one year, I did not have to enter into the mode of selection of these examiners. I have read the rules for the selection of examiners framed in 1929.

I read the rules framed in 1929. I presume the Surgeon-General is the final authority because the appointments are made by the President with the approval of the Surgeon-General. Apart from my presumption, from a perusal of the rules, I do not know personally if the Surgeon-General is the final authority. I do not know the practice obtaining prior to September, 1935 about the final appointment of examiners. I did try to find it out but I did not succeed in finding out. I asked the Surgeon-General whether he received the minutes of the selection committee meeting. I also asked the Surgeon-General that the minutes of the selection committee meeting be kept. The minutes of such meetings were not sent to me prior to September, 1935. Probably I attended some 3 of these meetings during the years 1932-33 and 34. I did not attend the meeting held in 1931. I did send a representative of mine to that meeting—One Dr. Hardy the Assistant Superintendent. Under rule 9 of 1929 rules only the Principal of the Medical College is accorded the privilege of delegating a representative to attend the meetings of the selection committee. No similar power is given to the members of the other committee but as no objection was raised by the President Board of Examiners or the Surgeon-General in the year, 1930, I continued that practice in 1931 also for want of timely notice. To my recollection the notice was very short. Between the receipt of the notice and the meeting there were hardly 3 or 4 days. The Superintendent of the Tanjore Medical School attended the meeting. It is possibly being a moffussil person timely notice was given to him. I can't say whether the notices were received by me by post or through a messenger. I think I have written to the Surgeon-General or to the President that I have not sufficient notice of meeting, but I am not sure to whom I wrote. I am not sure if I did so in 1932. I have received a communication about my not attending the meetings. I do not know if it is from the Surgeon-General or the President Board of Examiners. It was in reply to this communication I had stated I had not timely notice to enable me to attend the meeting. I see Ex. 10-B a circular of the Surgeon-General wherein Surgeon-General requests the Superintendents themselves to attend the meetings. I do not think I addressed a letter to the President requesting him to give me more timely notice of the meetings. I find from the rules framed in the year 1933 that the Superintendent Vellore Medical School or her representative made a member of the Selection Committee. I say the rules with regard to the selection of examiners was not strictly followed. It was laid in the rules that that the would be examiners should have certain amount of teaching experience of some years. But I can't say offhand how many, and that they should not be examiners for more than 3 consecutive years :—that there should not be more than one examiner under any conditions from the same school in the same subject. The last one was amended in 1933. All the above rules were not adhered to and so I say the rules with regard to the selection of examiners was not strictly followed. Under some of the rules there were such clauses which permitted the laxity of the rules. The Superintendent of the Medical Schools were required to send the list of examiners recommended by them. So far as I know this was done with regard to my school. The Superintendents were not asked to observe the rules while sending in their recommendations but they were asked to send a tabulated list specifying the years in which the professors or lecturers were examiners during that quinquennium. I was asked to send up a list of examiners giving their names, their qualifications, the experience they had had as lecturers, the subject for which recommended and the years they had been examiners during the last quinquennium. I did not send up each and everybody's name. I recommended only persons who were capable of being appointed. Judging from the consolidated lists, I must say that some of the recommendations were not eligible for examinership according to the rules. By consolidated list I presume a list of all the examiners sent by the heads of various medical institutions. I did not hear any complaint that a name of an examiner sent by any one particular institution was not included in the consolidated list. I did not see any consolidated list because it was not circulated. But after September, 1935, I have seen consolidated lists. A little while ago, I said "judging from the consolidated list I must say that some of the recommendations were not eligible for examinership under the rules" I said this as the President read out the names of the examiners from the consolidated list he had in his hand. The Committee for selection is a committee consisting

of 4 persons if all should attend. Principal of the Medical College or his representative is a member of this committee. On occasions on which I attended, the Principal or his representative attended the meeting. I attended the meetings of the Committee in 1932, 1933 and 1934. I cannot say if in all these years Col. Newcomb as the Principal of the Medical College attended these meetings. I now recollect that he attended the meetings held in the year perhaps, 33 and 34. I remember to the best of my recollection in one year a representative of the Principal of the Medical College attended. As the consolidated list was being read out the names of the persons were ticked off by the President. The names in some cases were read so quickly that we had no time to approve or disapprove of the names. Such a thing actually happened in December, 1934. When he does read slowly we have opportunity to discuss. I did not hear any complaint from anybody that the President failed to include a name which was recommended or included a name that was objected to: I do not know if the S. G. adds to or subtracts from this list. The Surgeon-General is the final approving authority of the examiners. I see Ex. M. It states that the appointment of examiners for the L.M.P. Board examinations rests with the Surgeon-General. There have been deviations regarding the appointment of examiners from 32 to 34 from the rules. So far as the Committee was concerned they allowed them to continue as examiners who were more than 3 years. There was one member who was examiner in two subjects to which the Committee objected but was told by the President that the Surgeon-General had given him special permission. There was another instance where the committee recommended a person as an examiner in two subjects but the President objected to it.

When there was more than one examiner from the same school in the same subject it was contrary to rules framed in 1929 and yet this rule was infringed in 1934. There was more than one examiner in each subject from each school.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS. BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 9, recalled and sworn, cross examination continued on 20-11-36. The consolidated list must be correct. I do not suggest that he omitted any names. If I had asked for the consolidated list I do not think the President would have refused to hand it over. The meeting that was held in December, 1934 lasted about half an hour and in my opinion the time was not sufficient for the proper selection of paper setters and practical and clinical examiners especially as the members of the committee were not supplied with a tentative list which had to be sent up to the Surgeon-General for his approval. That day one of the members of the committee had to hurry off to attend a meeting at the S. G.'s office. I did not make a written complaint to the President that he hurried through the meeting, but I complained orally to the President at the shortness of the time. I did not specifically complain to the S. G. that the meeting held in December, 1934 was rushed through. The selection of examiners in December, 1934 was for the April, 1935 examinations. The results were published by the end of April or so. About July or August 1935, I complained to the S. G. that the poorness of the result was due to the fact that 50% of the examinees in Surgery and Medicine were from the Stanley Medical School. I was asked to explain the poorness of result in my school. The above reason was one of the reasons I gave. I see Ex. 31. I find from it that there are 50% of the examiners for Surgery in the year 1933. I see for the year 1934 there are 50% of examiners in medicine and 50% in surgery all of them of Stanley Medical School. The results of my school in spite of the introduction of a higher standard was 71% and 78% in surgery against 61% and 76% of the Stanley Medical School. These are the results of April and October examinations. As far as I am concerned when I sent the list of examiners I did not infringe the rules. I clearly indicated and gave full particulars in the

columns to enable the President in drawing the consolidated list to know if they were eligible or not. The rules framed in 1933 give wide discretion to the committee to depart from them if there are no suitable candidates for examinerships. I was aware of the rules framed in 1933 when I sent the names of examiners to the President. I see Ex. Q-4. This bears my signature. This is a list of examiners sent by me for the year 1935 to the President sent by me on 25-9-34. I see a letter No. B-57 dated 26-9-33 from the President Board of examiners. I must have received a similar letter. I see in Ex. Q a file of papers on p. 79 there is a letter B-57 dated 26-9-33, Ex. Q-5. I see Ex. Q-6 a reply sent by me enclosing a list of examiners for 1934 in which I make reference to Ex. Q-5. The same thing was repeated in the year 1935. Ex. Q-4 is the list of examiners recommended by me on the 25th of September, 1934, for the year 1935. Abhyammal is an assistant lecturer in the Lady Willingdon School. I may have orally mentioned her name to the President Board of Examiners. I see from the list now shown to me her name has been included in the list of examiners sent for approval to the S. G. From the S. G.'s letter I see her name has not been accepted. I believe in the year 1933 or 32 when Col. Newcomb and Dr. Scudder were present (and) when the name of Dr. Maduram was read out by the President (which name) I had recommended from my school, the President said that her name could not be included and that the reasons were confidential, and that the Surgeon-General did not want her name to be included in the list. He did not tell us that he was going to send up her name. Yesterday for the first time I noticed that Dr. Maduram's name was sent up to the S. G. but not approved presumably on account of the footnote added by the President. I see para 1 of my letter to the Surgeon-General, Ex. 21. The last sentence in that para is correct. By batch, 2, I mean Dr. Kanakasabesan and Dr. Findlay. I would not be surprised to know if all the Vellore Medical students appeared before this batch. Stanley Medical School has more students than the other two medical schools put together; as a matter of fact it is too overcrowded for efficient teaching. I know Miss Mary Mathen. She was a student under me in Lady Willingdon Medical School for a short time just one term. I got a statement from her under instructions from Surgeon-General. This I have certified as true copy. This is a copy of a statement of Mary Mathen sent to S. G. at his request. It is Ex. U. (received from S. G.'s office) The girl students were showing a higher percentage of passes till 1933 as the atmosphere was not so strained. Up to 1933 the examinations were held in Stanley Medical School. P. W. 1 became President of Examiners in 1930. In 1934 as the atmosphere was strained there were fewer passes. It did not affect the 2nd and 3rd year medical women students. The permanent lecturer in surgery of my school went away on leave after April, 1934 for one year. Dr. Maduram was permanent lecturer in my school. The lecturer in Surgery could not devote her full time to her subject because she had heavy gynaecological work, in addition to her work. The number of beds for surgery was very limited in my hospital as I had 300 patients to 160 beds. I have only 25 beds at my disposal for surgery. I made a request to Government to get an additional lecturer in surgery. In Stanley Medical School there are more lecturers in surgery (but) not adequate for the number of students there. In my school surgery is taught to 3rd and 4th years students according to the curriculum laid by the Government. About 90 are taught in surgery in the 4th year in Stanley Medical School. In the years 1931 to 1934, and in 1935, a good number of passed intermediate students are in the Stanley Medical School, whereas in my school to the best of my recollection there were 2 passed intermediates and 3 failed intermediates.

(Sd.) ABBAS ALI,
Chief Presidency Magistrate,
20-11-36.

(True copy)

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 9, recalled and sworn, 26-11-36. Cross examination continued. I see Ex. W. a letter dated 12-12-32 from P. W. 1. to Superintendent Lady Willingdon Medical School. I did not receive any letter from Dr. Findlay to the effect that the women students were under the impression that only 2 students would pass. P.W. 1. sent me tabulated statements of the results of percentage yearwar and subjectwar from 1929 to '34 excepting April 1930. Ex. Y series are the statements. I may have sent a telephone message to the President Board of Examiners to send me the missing statements. I can't say if I have received the tabulated statement of the result for April, 1930. The last sentence in item 5 of my chief examination is what I heard and not what Dr. Findlay wrote to me. She did not make any such statement to me nor did she write to me in that strain. I did not inform the S. G. about the rumour that only two students were going to be passed. I have read Col. Hingston's report on the I.M.P. Board of Examinations. I see Ex. Z this is the reply of Mrs. C. Parakutty Amma to the President Board of Examiners about the low percentage of passes in Chemistry. I see Ex. AA with 3 enclosures they bear the signature of Parameswaran, Professor in Physics.

(Sd.) ABBAS ALI,

Chief Presidency Magistrate,
26-11-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.
BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 9, Dr. Miss Lazarus, recalled and sworn, 14-12-36. Further cross examination continued:—I see Ex. DD—a letter dated 2nd August, 1935 addressed to the President Board of Examiners from the office of the Surgeon-General. This is with reference to his letter dated 26-10-34 from the President to the Surgeon-General. I see Ex. EE. I received a copy of it dated 19-1-35. I see Ex. FF. I can't say if I received a copy of it. It is a G. O. dated 19-6-35. It was reported to me by my lecturer about copying in examination in a particular institution. I do not know personally about it. I am not aware of any single instance of a student of my school having been rusticated. I do not know if Col. Mahadevan has dismissed, debarred, and rusticated students who were found copying. I see Ex. GG. This bears the signature of Mr. Warriar Personal Assistant to the Surgeon-General who has signed the order of dismissal of a student reported to be copying. I am not in a position to contradict you were you to say that punishments were awarded in cases of seven students found copying. I see Ex. HH, HH-1, and HH-2. I did make the suggestions to the Surgeon-General. Ex. HH is a suggestion with regard to the posting of students. Ex. HH-1 is a memorandum from the office of the Surgeon-General dated 9th October, 1936. Ex. HH-2 are the minutes of the meeting held on 7-10-36. I believe Dr. David who is a part time lecturer in the Lady Willingdon Medical School, was also an examiner in the Inter-school prize competition. 47% of the students of my school passed in midwifery in April, 1936. In October, 1935 the results in Surgery in my school were 72% passes. In April, 1936 in surgery 68% of my school passed and in October, 1936, 50% of my school passed.

Re-examination:—As we had no consolidated list before us, we were not in a position to know beforehand the particulars regarding them. In answer to a communication by me to the Surgeon-General I received a copy of the letter dated 30-5-35. This is

Ex. 44. The Surgery results in our school after the venue was changed to General Hospital were never as bad as the surgery results in our school in 1934 and 1935. The Superintendent of the 3 schools had to attend the informal meeting at the Surgeon-General's office after conclusion of the meeting of the selection Committee. Among the examiners there should not be more than one examiner in each subject from any one school. I know nothing about Exhibit AA. I saw it for the first time in Court.

(Sd.) ABBAS ALI,

Chief Presidency Magistrate.

14-12-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. Abdul Karim, sworn, 3-12-36. age 36, I am employed in the Education Department, Corporation of Madras since November, 1931. During this period I was directed to appear before the Surgeon 1st Dt. for medical examination as to fitness for service. I appeared before P. W. 1. who was the Surgeon 1st District. I received an order after that that my services were dispensed with as I was found unfit for entertainment in the public service. I wrote a letter to the Commr. (Madras Corporation) Mr. Warren. This is the letter I wrote Ex. 40. The facts stated therein are correct. It is dated 6th October, 1932. Subsequently I was asked to appear before the Medical Board. I was found fit and I was reinstated in my former appointment. My father is a retired Government pensioner. I get a salary of Rs. 34 per mensem.

Cross examination.—Accused asked me to give evidence. I got a summons in this case. I have known the accused for the last 2 months. He does not know any of my people. He came to me regarding this case two months ago and asked me if it was true if such and such a thing happened. Subsequently I appeared before the Board nearly 3 months later and declared fit. When I appeared before the Board I had no fever or tired feeling.

Re-examination. Nil.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI ESQ., M. A., LL. B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. 1038 OF 1936.

D. W. 11, Dr. Miss A. B. Hardy sworn, 40, 3-12-36. I am an M.B.B.S. of Madras, M.R.C.P. Edinburgh. M.R.C.S. London also D.T.M. and H London and L.M. of Ireland. I am the Assistant Superintendent Lady Willingdon Medical School and I am also the warden of the students Hostel, attached to it. I am also the physician in the Govt. Victoria Caste and Gosha Hospital. I am connected with the Lady Willingdon Medical School since 1923, and I have been lecturing in that school on various subjects from time to time. About the year 1928, the Superintendent Stanley Medical School was the President Board of examiners for the L.M.Ps. Before 1928 the Principal of the Medical College was the President Board of Examiners. We are not satisfied with the change. Even after the change the results of my school used to be good as compared with the results of the Stanley Medical School till about 1933. Then the results began to deteriorate and in April, 1935, the results in Surgery of our school were very bad. I was an examiner for the L.M.Ps. from 1931 to 1935. I cannot account for the deterioration of the results in my school. They are inexplicable. We had good batch

of students. We had the same efficient lecturers as before except in Surgery as in April, 1935 the lecturer in Surgery went away on leave. Lady Students did not like to go to Stanley Medical School for examination. It was stated that they felt the strange surroundings and certain incidents used to occur from time to time at the examination which made them unhappy. One student reported to me that an examiner asked her if her ignorance was due to lack of clinical materials in the hospital or if it was due to bad teaching. Another student told me that she was very much upset because one of the examiners sang a love song in Malayalam at the clinical examination and the thing that upset them most was the Mary Mathen incident. The incident is her transfer from one batch of examiners to another. I was an examiner and during my examinership I came across an instance when a student was transferred from one batch of examiners to another. It is a male student. I do not recollect the year. I cannot say what is the evil but the other students were affected at the differential treatment and it was known that the standards of different batches of examiners varied. In Surgery and Medicine there was absence of uniformity in the various batches of examiners. As regards the methods of examination in medicine, I am aware of the lack of uniformity in the standard. In clinical medicine there used to be 3 sets of examiners. One set of examiners would mark a case purely on the merits of the case sheet writing, but other examiners would take both the merits of the case sheets and the results of the oral examination and some examiners would not even read the case sheets but give marks on the oral answers. I do not know if there was any feeling about this in the Stanley Medical School but we felt that the method should be standardised. To my knowledge the President arranges the batches of examiners and the candidates who appear before them. There was a rule on paper that all the marks in each subject should be consolidated but actually it was not put into practice. I have attended meetings of the committee of selection of examiners on behalf of my school. The written rules were not actually conformed. Some objections were raised in one year by the Superintendent of the Tanjore Medical School to the choice of some examiners but they were not heeded. Col. Lorimer was the Superintendent of the Tanjore Medical School. Col. Newcomb presided over that meeting. I was asked to offer my remarks on Col. Hingston's report with regard to the conduct of the L.M.P. examinations held in April 1934 or 35. I see Ex. 41. This is the report I sent in 1935. I am not aware if any of the examiners of a particular batch were taken away but I have come across a few occasions when an examiner forming a member of a particular batch was taken away for a little while by the President but not out of the room. I cannot say why he was so called aside.

Cross Examination:—Col. Hingston was for some time the Surgeon-General with the Government of Madras. Col. Hingston made adverse remarks about my teaching as imparted to the Lady students of the Lady Willingdon Medical School. Ex. 41 contains my remarks on Col. Hingston's report. Col. Hingston put down the bad results to the inefficient teaching of the lady students. At that time there was a move to close down the Lady Willingdon Medical School. I am anxious naturally that that should not be done. I do not agree with the remarks made by Col. Hingston about bad teaching want of clinical experience etc. The examinations of 1931, 32, and 33 were held in the Stanley Medical School and yet the results of our school were good. In the year 1933, the standard of examinations for the L.M.Ps. was raised. The minimum percentage of marks required for a pass were raised at the same time the period of the course was raised from 4 years to 5. The results for the year 1934 also were good and also in many of the subjects in 1935. Only in surgery in 1935 there was a big drop. I was an examiner from 1931 to April 1935, both inclusive and that in medicine. The complaints I heard from students I did not reduce them to writing. I have not informed in writing to any of my superiors the three incidents narrated by me today which militated against the success of my students. I cannot name the student who complained to me that her examiner asked whether the ignorance was due to bad teaching or lack of clinical materials. It was in 1934 or 1935. I do not remember. I cannot give the names of the students who told me that the examiner sang a Malayalam love song. I do not know personally if Mary Mathen was actually transferred from one batch to another. I do not

attribute any improper motive to col. Mahadevan. With regard to marks we had to hand it over to senior examiner. Dr. Williams was my senior examiner. Senior examiner it is who sends the marks to the President Board of examiners. After handing over my marks I took no more interest in the matter. Always it was the senior examiner who used to hand over the list of numbers of the students whom I have to examine. Whoever was the examiner does it. It was not the President who hands over the paper—The rules I refer that were not conformed to are the rules of 1929 and 1933. Exhibit X and X-(a). After April 1935 I have been given an additional lecturer in the teaching of medicine to assist me. The lecturer has equal qualifications. Anything more than 50% of the results is in my opinion are good results. In 1934 October, 60% of my students passed in Physics which I consider very good results.

Re-examination. I thought it was no use to complain to my superiors the three incidents narrated in my chief examination.

(Sd.) ABBAS ALI,
Chief Presidency Magistrate,
3-12-36.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI Esq., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

C. C. No. 1038 OF 1936.

D. W. 12, Dr. Miss Findlay, sworn 10-12-36. I am a B.A. M.D. Manitoba University. I am the Vice-Principal Vellore Medical School. I am also in charge of the General-Surgery department of Vellore Missionary Medical School Hospital. I have acted as principal several times. I teach surgery. I came out to India in 1908 but began services in the Vellore Medical School since 1920 and till 1928 I was teaching several subjects such as Pathology, Hygiene, and Medical Jurisprudence etc. In the year 1934 during absence of Dr. Scudder I attended a meeting for the selection of examiners held in Madras under the Presidentship of the President Board of Examiners. I do not think I attended any other meeting and in 1935 I attended another meeting with Dr. Scudder, and this year I attended again in the place of Dr. Scudder. We were asked by the President Board of Examiners to send a list of professors eligible to hold the post of examiners for the L.M.P. Examinations. We sent the list. At the meeting the President has a consolidated list of all the examiners sent by the various medical schools and medical colleges before him. He takes up each subject of examination and reads up the name and the required number of examiners in each subject is chosen. In 1936 I was given a copy of the consolidated list not before that. I believe Dr. Scudder was given one in the year 1935. Yes, she was given one. I do remember now. We could modify the list but I did not do so as I did not know many of the examiners. Yes, objections are raised to examiners. I remember Dr. Lazarus objecting to Mr. Selvarayan being an examiner. She objected on the ground that he was not teaching that year, but he was appointed. I forget now I believe he was appointed because it was difficult to secure an examiner in Physics. This was in 1934. When I went with Dr. Scudder in 1935 there was some discussion about a doctor from Vizag being an examiner. He was not allowed to be an examiner on account of the expense. There was I believe a question as regards examinership in Medical Jurisprudence. P. W. 1's name was objected to because he was the examiner in another subject. P. W. 1 said that the S.G. requested him personally to be one and we all agreed. The meetings lasted for about 1/2 to one hour. The meeting in 1934 lasted for about 1/2 an hour. I was an examiner in Surgery.

We have 4 examiners in Surgery. Two of them paper setters and the other two were called additional examiners and they assisted the examiners in clinical and operative surgery. I noticed from the conduct of the students that some reforms were necessary. As an examiner I found it very difficult to get answers from them even for simple ques-

tions. I thought there was something the matter somewhere especially because some of our best students were most confused. Some of the examinees had preconceived notions about the cases they were examining not always helpful to them. I thought that too needed reformation. After we got 6 examiners in surgery the students did not appear before all the examiners. The trouble about this method was that there was no uniformity in giving marks. Some students appeared before examiners who gave marks more easily than others which was not fair to the students. I always objected to operative surgery being held over till the last which meant students remaining in Madras for about a month or so. Once in the year 1935 the students got into their head that only 10% were going to pass and that 90% were going to fail. I asked where they got hold of the idea but they could not give any answer as the papers too had not even been corrected by then. I refer to the women students of the Vellore Medical School. I do not know about the others. They had a feeling that they were going to have a stiffer examination in Surgery, and I was supposed to be the stiffest and my students were afraid of Kanakasabesan and vice versa. There was a bad result in the Lady Willingdon School. She (Dr. Lazarus) wrote and asked me for the cause of it and if it was due to the fact that the students were specially bad or to any other result. I told her that my students were just as bad as hers and that even men students were also just as bad and that the students seemed to be confused, as a matter of psychology. I told her that I did not approve of our methods of examining. I told the same thing to P.W. 1, who came in as we were examining. I told him that all are failing that something is wrong with our method of examining. One student told me that one of the examiners had asked her if she came from Vellore and when she said yes, she was asked all about Tippu Sultan and that she did not get any other oral question on Surgery. One of them was asked if she approved of kissing and she said that she did. She was further asked if she was in the habit of kissing dogs and that she was asked the disease that would be communicated by kissing dogs. The question of kissing was about Hydatid Cyst. Remarks were made about their clothing. I think these extraneous questions put to the women students had something to do with regard to their mental attitude. I do not think the system has been changed. But the place is changed and the personnel of the examining body was changed. The girl's mental attitude was much better, and the results were better than 1935. We have a 250 hospital attached to our school. We have an expert and efficient body of teachers in our staff.

Cross examination : I did not attend any meeting prior to 1934. Nobody called for the list and it was not refused. I do not suggest Col. Mahadevan did anything that was ungentlemanly, dishonest or improper at the meetings for the selection of examiners. I am blaming the system and not P.W. 1. I made a request to P.W. 1, to examine my students early and send them away. He agreed to make arrangements but did not do it as he had difficulty as there were other students too from outside and it would lead to confusion as there were other out of the way students who would want the same concession. I do not know anything about P. W. 1 having manipulated the results or marks or any such thing. Nor have I heard anything about it.

Re-examination :—Nil.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

BEFORE ABBAS ALI ESQ., M.A.L.L.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate,

C. C. 1038 OF 1936.

D. W. 13, Dr. Miss Innes, sworn, 10-12-36. I am the professor of medicine in the Vellore Medical School since 1933. I have been an examiner in midwifery and medicine for the L.M.P. examination. In 1934, or 35, I was an examiner in practical and clinical medicine along with Captain Krishnaswamy. On the last day another examiner was substituted for Captain Krishnaswamy. I had conducted the examinations with the captain for 3 or 4 days. Dr. Paul was the substitute. He belonged to the Royapuram.

Hospital. I did not like the change as I found a difference in the standard. I raised this question at the Board meeting held to consider the passes for that examination and with a view to adjust the inequalities I addressed a letter to P. W. 1. and suggested that the list of two sets of students be compared and where there was marked discrepancy the same to be considered and adjusted: I have a copy of my letter to him, Ex. 42 is the copy of the letter. Before 1931, we used to have meeting of clinical examiners amongst themselves to consolidate the marks. I was also an examiner with Col. Skinner on another occasion for the L.M.P. examinations. The great difficulty was to keep supervisors out of our hearing. When we, myself and my colleague wished to confer we found them listening and we had to ask them to go to the other end of the hall. I do not know who the supervisors were. Mary Mathen was a student of my school. She left my school for another school. Our school got a communication from the S. G. on the question of admission of girl students in Royapuram Medical School. I see Ex. 43 this is the letter. The pencil note is in the handwriting of D. W. 12. Dr. Findlay. I got a subpoena to produce this letter.

Cross examination:—I have seen the journal "Medical Practitioner". I do not take any intelligent interest in this journal. I see a copy of the Medical Practitioner for June 1934. Ex. BB and on P. 208 I see an article "why force purdah on woman". I see another copy of Medical Practitioner for the month of July, 1935, Ex. CC. I see bottom of page 224 and the top 5 lines of the 2nd column. Captain Krishnaswamy was the senior examiner. Krishnaswamy had to be changed as the I. M. D. examinations were going on at the same time and as Krishnaswamy had to sit with Major McRobert Krishnaswamy had to go away. I made some suggestions to Dr. Paul for a further conduct of that day's examination and he agreed. One student had already been examined prior to that.

Re-examination:—Nil.

(Sd.) ABBAS ALI,
Chief Presidency Magistrate.
10-12-36.

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IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

C. C. No. 1038 OF 1936.

BEFORE ABBAS ALI ESQ., M.A., LL.B., BARRISTER-AT-LAW.,

Chief Presidency Magistrate.

LT. COL. MAHADEVAN v. Dr. V. RAMA KAMATH ... Accused.

Charge:—Sec. 500 I. P. C.

Plea of the accused:—Not guilty.

Judgment dated 25-1-1937.

This is a case of defamation filed by Lt. Col. Mahadevan I. M. S., Surgeon, first District, Superintendent, Stanley Medical School against Dr. Kamath a private medical practitioner. The accused is the editor of a monthly medical journal called "The Medical Practitioner" and in an issue of October 1935 under the caption "Madras Needs a State Medical Faculty"—he published an article which the complainant says defames him. The article is marked Ex. A. 1 and in substance is as follows.

It deals with medical education in Madras and the method of conducting examinations for the 3 classes of practitioners. (1) Graduates of the Madras University, (2) Military Asst. Surgeons, (3) Licentiates. Regarding the last of these he points out that there are 3 medical schools in the Presidency. The Stanley Medical school for men and the Lady Willingdon medical school for women both under the control of the Local Government; the Vellore Medical school for women run by the American Mission. Years ago the Madras Board of examiners consisted of a President and two members chosen by the Government from the staff of the Medical college, the president being invariably the Principal of the Madras Medical College. Of recent years all this underwent a change. The Principal of the Stanley Medical school was made the President of the Board of examiners and "the selection of examiners was left to his choice". This arrangement gave rise to discontent in the other two schools but as the results at the examinations compared favourably with those of the Stanley Medical school the discontent did not take a serious turn till a couple of years ago. But discontent arose when the results of the Stanley Medical school began suddenly to improve and those of the other two schools comparatively deteriorated. The writer openly suggests that this was due to the Superintendent of that school being the President, Board of examiners. To help readers to arrive at correct conclusions a statistical table of percentage of passes from the 1st to the final year in all the 3 schools from 1929 to 1935 excepting 1930 is appended. The writer comments that the results show a gradual increase in the percentage of passes of the students from the Stanley Medical school whilst the students of the two women Medical schools did on the whole much better. He admits the possibility of this being due to more efficient teaching but finds it difficult to reconcile with the poor results obtained in the October examination.

All this I gather is an attack upon a system whereby the principal of one of the rival schools is made the President, Board of examiners. But the writer also gives another reason for publishing these tables and that involves a defence of the comparatively high level of teaching in the two women medical schools. In an issue of his paper in the month of April he had published a letter from the Honorary Secretary of the Local branch of the All India Medical Licentiate's Association complaining among other things that the teaching imparted to pupils at the Women Medical schools was not satisfactory. Lt. Col. Hingston who was deputed by the Madras Medical Council as a visitor at the final L.M.P. examination reported that the teaching of Medicine and Surgery was not satisfactory. The tables are intended to prove that both Col. Hingston and the Secretary are wrong and that the Medical Practitioner itself which had published adverse remarks against the teaching of medicine and Surgery in both the women medical schools had relied upon materials

which it now found unsatisfactory. The writer then goes to give an instance of how the high standard of teaching of the women schools was completely vindicated under a different system of examination. He says the "Inter-school competitive examinations are held every year for awarding prizes in Pharmacology, Medicine and Surgery. From the year 1927 to 1934, the Stanley Medical School did not get the prize in Surgery even once, whereas the Vellore Medical School got once, the Tanjore Medical School twice, and the Willingdon Medical School 4 times. In Medicine the Stanley Medical School secured the prize only once, the Tanjore Medical School once, the Vellore Medical School twice, and the Willingdon Medical School for three years. In Pharmacology, the Stanley Medical School secured 2 prizes, the Vellore Medical School one, the Tanjore Medical School one, and the Willingdon Medical School three prizes. The papers for these competitive examinations were set by examiners who are not the lecturers of any of the schools."

A more pertinent illustration which seems to me to be the genesis of the whole article then follows; "During the discussion of budget for the current official year on floor of the Madras Legislative Council an alarm was raised by one of the Honourable Members of the Council that all was not well at the Lady Willingdon Medical School for women as shown by the results of the examination in that school at the last April examination, and even a suggestion was made to close the school. The then Minister in charge of the Medical Portfolio promised that he would hold an enquiry about the poor results at the Lady Willingdon Medical School to find out the real causes at work, which produced such bad results. In the meanwhile the Head of the Medical Department, Major General Sir Frank Connor who we are told, has heard rumours that even the question papers were smuggled on some occasions, took a most sagacious step by changing the examination centre from Royapuram Hospital to General Hospital. All the examiners except three were appointed from outside the three schools. The Surgeon-General with the Government of Madras was not only judicious but also very fair in the choice of the examiners at the recent examinations. As it was reported that the teaching of medicine and surgery was bad at the Women Medical Schools and that female pupils fared comparatively well in midwifery, the Surgeon-General appointed the lecturer in Medicine of the Vellore Medical School, the lecturer in surgery of the Lady Willingdon school, and the lecturer in Midwifery of the Stanley Medical School as examiners to guard the interests of each school. We are told that the examiners who set the question papers sent them direct to the Surgeon-General and they were cyclostyled under the direct supervision of the Surgeon-General. The final results as published this month show that the Vellore Medical School stood first having secured 76.47 per cent of passes in Medicine, 86.66 per cent of passes in Surgery, and cent per cent in Midwifery. The Lady Willingdon Medical School stood second having secured 64.7 per cent in Medicine, 72 per cent of passes in Surgery, and 90 per cent of passes in Midwifery. The Stanley Medical School stood third having secured 31.25 per cent of passes in Medicine, 22.09 per cent of passes in Surgery, and 66.7 per cent of passes in Midwifery. These results prove to a great extent that the teaching of Medicine and Surgery at the Women Medical Schools is not bad as was indicated by the results at the last April examinations and that there were other causes at work which depicted the Women Medical Schools to be what they really were not."

Col. Mahadevan very naturally feels himself aggrieved by this article and charges the accused with having defamed him. He complains that the article imputes to him that he as President, Board of Examiners has abused his position, appointed flexible examiners, and with or without their connivance has seen that more of his pupils pass and lowered the marks of the students of the other schools. With the other imputations which he wants to read in the article I do not agree, but I agree that the article is plainly capable of the construction set out above. To that extent it is *prima facie* defamatory. I brush aside all the evidence that has been let in to prove that the article is defamatory. It has not helped me in the least to know that this person or that thinks the article defamatory, when it is written in plain English quite capable of being understood by the English reading public.

The question I have to decide is whether the accused is privileged in writing the article.

There are two factors to which I must advert and which stand out prominently. The first is the absence of any ill-will in the accused towards Col. Mahadevan and secondly that the article is primarily an attack upon a system and an institution and not on an individual. In the circumstances of this case the two have a bearing on each other. An attack upon a system may involve the person representing that system but if there be privilege in law for that attack the individual is merely a pawn in the game, a victim of circumstances, having no right of redress in a criminal court even though some passages here and there may not be strictly justified. But if there be ill-will or malice towards the individual there is always the possibility of the occasion being used to give vent to private feelings and every passage will have to be justified.

As to the first Col. Mahadevan does not suggest any enmity between him and the accused. He says "I have never been friendly towards the accused nor have I been unfriendly towards him. In 1933 I gave him medical advice. I went to his house as a consultant with the late Dr. T. K. Krishna Menon". Several exhibits have been filed by the defence to show that the mutual relations between the two were quite cordial. In Ex. I the accused's journal, the complainant is congratulated for the good results in the recent examination and again in Ex. II the complainant is congratulated for bringing about the 5 years course for the L.M.P.s; and in Ex. III for his sagacity in bringing His Excellency to inaugurate that course. Ex. IV has an appreciation of the complainant. It is not denied that the complainant proposed the accused as a member of the Sub Committee to draft the code of professional ethics. As late as October 1935 shortly before the article complained of was published the complainant seconded a resolution by the accused for the creation of a medical faculty in Madras. In the earlier years apparently these compliments were mutual. I find the accused in 1933 proposing the name of the complainant to a committee for the recognition of medical titles of foreign countries and the complainant proposing the name of the accused to a disciplinary committee. It is not suggested that the accused has a personal interest in any of the 3 institutions that came under discussion in the article complained of, or in any of the students that were ploughed in the examination. The only motive that can therefore be imputed to the accused is writing this article is that he desired to ventilate a public grievance in a public manner and to do the handsome by the staffs of the two women medical schools whose standard of teaching he had commented upon adversely in his paper upon conclusions drawn from results of examinations and which opinion he thought he had good reason later to revise.

The evidence of Dr. Lazarus leaves no doubt in my mind that of late years there has been dissatisfaction in some quarters with a system which places the principal of one of the schools of equal status in the unique position of being both the President of the Committee for the selection of examiners as well as President of that Board. The fact that principals of the other schools were on the committee or that the list had to be finally approved by the Surgeon-General appears to have made no difference in this attitude. It is not for me to say whether the discontent was founded on reasonable grounds or not. I am merely concerned with the facts so far as they presented themselves to the mind of the accused.

The discontent was apparently simmering when in 1934 the Medical Council appointed Col. Hingston to attend the L.M.P. examinations. His report was very unfavourable as to the teaching of surgery in the Lady Willingdon Medical school and medicine in the Vellore medical school. This was submitted to the opinion of a committee the members of which were not unanimous in accepting the opinion as wholly correct though the report was apparently passed at the meeting of the council. The crisis however arose when at the budget session of 1935 a member of the Legislative Council raised the question of closing down the school which was followed by an undertaking given by the Government to hold an enquiry into the poor results of the examinations of the Willingdon school. Then came the April examination, which again showed poor results.

The Surgeon-General called upon the principal of the Lady Willingdon school to explain. She amongst other reasons ascribed the poorness of the results to (1) method of selecting examiners (2) the place where the examination was held (3) to the preponderance of examiners from the Stanley Medical School. As a result of this complaint the Surgeon-General directed the examinations for October to be held under different conditions altogether. The examiners were different and the examination itself was held in the Medical College. The result was very different from that of the examination held in October 1934 and April 1935. The very subjects in which the women students were supposed to be inefficient, the lady students from the Willingdon and Vellore medical schools scored a higher percentage of marks both in surgery and medicine than the students of the Stanley Medical School. Col. Mahadevan says that this was due to his absence on leave for 100 days before the examinations were held. This may be so and possibly it was so but this is a matter of opinion and in all probability the accused genuinely differs from that opinion. The accused started an agitation for the institution of a State Medical faculty. He brought up his resolution to that effect before the Madras Medical Council and that resolution was seconded by the complainant himself. The object was to create a faculty for the purpose of controlling education and conducting examinations of medical students for non university medical qualifications. Considering the caption of the article complained of both the resolution and the fact that it was seconded by the complainant are very important.

The resolution was obviously intended to remedy what the author thought an unsatisfactory state of affairs with which the complainant must have concurred. On these facts it seems difficult to hold that the accused was not justified in dealing with a subject of so wide an interest to medical profession at large and especially so to a public institution like the Lady Willingdon medical school in a paper devoted entirely to medical topics and intended to be read primarily by the members of the Medical profession. It is a matter of some nicety to decide how far it would be possible to deal into the subject without directly involving in the criticism the head of the institution—the representative of the system that was being condemned. If after stating the facts as the author has done and he was entitled to do he were to add expressions such as “we do not intend to impute anything improper to the Superintendent Stanley Medical School” or words to that effect they might seem altogether ironical and it is doubtful whether they would save him from this prosecution. It must be remembered that the accusation if any is only by necessary implication, but that implication already existed in the resolution brought forward by the accused before the medical council for the establishment of a faculty for the conduct of examination which was seconded by the complainant, and which according to him involves the abolition of the present system of “Board and its President”. It was implied in a far more serious way in the action taken by the Surgeon-General in holding examinations in October under conditions wholly different from those which prevailed under the system of “Board and its President” with results so diametrically conflicting with those of the earlier examinations. But neither in my view is a reflection on Col. Mahadevan. Discerning people will easily see the various factors beyond the powers of Col. Mahadevan may have contributed to the results of the examinations being poor at one time and place, and good at a different time and place; Clinical examinations held in a place familiar to the students of one school and foreign to the students of another, all other factors being common, will obviously be to the advantage of the former. Women students it may generally be admitted labour under a complex when they go to a new and strange place, the student who has had the advantage and being examined by his own teacher will generally fare better than one appearing before a stranger. It is also well known that different examiners expect different standards of efficiency from examinees and indeed the factors which contribute to good or bad results are too numerous to be enumerated. It is in all probability the first 3 factors mentioned above that contributed to the better results of the Stanley Medical school with 50% of examiners from that school, and the venue—the school itself, the results could not be otherwise. Col. Mahadevan even deserves neither praise nor blame for this. Either falls to the system. “There would

not have been any room for conjectures”—says the accused. “Fair or unfair if the examinations in the 3 medical schools were conducted all these years outside Royapuram Hospital by an agency which had nothing to do with the training of the students in these schools”. This passage seems to me to be the clue to the whole article—a plea to equalise all things so that no one school should be placed in a position of advantage or disadvantage with reference to the others.

Two passages which have been selected for special animadversion are, where the accused states that the Superintendent of Stanley Medical school selects the examiners and that “whole subject of examination is a one man’s show”. To the first complaint I attach not much importance. It has been proved that the selection of examiners is by a committee and is subject to the final approval of the Surgeon-General. But the President must in the natural course of things exercise considerable influence and such a preponderance of examiners from that school raises a fair presumption that this is so. But I see nothing improper in this. It does not mean that that influence has been exercised either unfairly or for ulterior motives. The accused moreover corrected this error in the very next issue and expressed his regret.

There is more force in the complaint about the expression “One man’s show”. It would have been better had the accused not said so. I do not accept his explanation that it refers to the Surgeon-General. It seems clear to me that it refers to the Superintendent of the Stanley Medical school. But it would be unfair to condemn a writer for the use of some unfortunate expression here and there when writing an article of the nature under discussion. The object of Col. Mahadevan in coming to this court is obviously to vindicate his character under an impression that the article contains an attack upon him, but on my findings he stands completely exonerated of any blame for results over which he could possibly have no control. Indeed the high efficiency which the L.M.P. course had attained was due to his efforts as is recognised by the accused himself. I hold that the accused did not intend to defame Col. Mahadevan, that his criticism was primarily directed against the system and that on the materials before him the criticisms were justified and comes within the protection of exception 9 to section 499 I. P. C. Accused is acquitted.

(Sd.) ABBAS ALI,
Chief Presidency Magistrate,
25-1-37.

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THE Medical Practitioner

VOL. VIII.]

APRIL, 1937.

[NO. 7

SEARCH AFTER TRUTH.

At the time we wrote the Editorial "Madras Needs a State Medical Faculty" we could least conceive that we would be dragged to a criminal court for the purpose of getting vindicated anybody's honour, much less that of Lt. Col. Mahadevan. The judgment of the learned Chief Presidency Magistrate which is published elsewhere has clarified our position and that of complainant and both the complainant as well as the accused cannot ordinarily have any grievance each in his own light, that he did not have justice. In law, Criminal as well as Civil, a journalist who by his writing is alleged to have defamed any individual, cannot claim more justification than a private individual can, though journals and newspapers are expected to serve the public in all possible ways and cannot at times spare even an individual apart from the Department or the System of which he may be for the time being a unit in whatever position, in case the criticisms levelled against the individual are all in public interest and for public good. So, if an individual belonging to a system or to a department is found corrupt and if the corruption is proved to be dangerous to the public, journalist and even an individual is justified in publishing the various acts of this individual which connote corruption. But, we did not go so far, for, our purpose in writing the article was merely to justify the need of a State Medical Faculty for controlling non-University Medical Education and Medical Examinations. Incidentally, we had to refer to the existing system which we found was full of faults. It was not possible for us to give our own opinions or reasons how and why certain events occurred but the events given publicity by us in the

Editorial complained against by the Prosecution did take place, was proved by the prosecution itself and the learned judgment amplifies these events. The fact that Lt. Col. Mahadevan seconded the resolution proposed by Dr. Kamath on the floor of the Madras Medical Council recommending to the Government to bring into existence a State Medical Faculty for the control of non-University Medical Education and Examinations, is a proof positive that the seconder of the resolution endorsed the views of the author of the resolution that all was not well with the present system.

When two contending parties enter a court, each is trying to search the truth and nothing but truth for putting the case of each before the presiding officer. But the Accused in criminal courts in India is in a most disadvantageous position not being allowed to depose or else we would have sworn why we refrained from commenting why and how the results of the Stanley Medical School showed better percentage than was the case in 1929 or earlier. At the time we wrote that fateful Editorial and till we entered the police court, we could not ourselves find out the causes. That is why we published the results which we collected from various sources, not excluding the Stanley Medical School and allowed our readers to have their own judgment. The prosecution gave its own impressions about the word 'refrain' and said that we refrained as we had something bad in our mind, i. e. "dishonourable and dishonest motives". We had no opportunity to swear it was not so. We knew at the time we wrote the article that almost all the Examiners were Government Medical Officers and that all of them were honourable gentlemen or ladies. Some of them were requested by the defence to tell the court about the causes of the disparity

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of the results about which we could not know anything more than the mere fact that there was disparity. The Superintendent of a medical school, Assistant Superintendents of two medical schools and other teachers who had been the Examiners also deposed why and how the results in their schools deteriorated. Apart from the inherent defects, in the system of Examinations, such as want of uniformity of standard of examinations due to various causes, preponderance of examiners of a particular school, advantage of familiar surroundings for the same school, different methods adopted in the matter of delivery of question papers, want of uniformity in posting candidates so that they could have chances of meeting all the sets of examiners, and interference with the original posting of examinees and posting a few before another batch of examiners, a few witnesses must have also amused the court and later those who watched the proceedings of the court that there were other extraneous causes that baffled the examinees belonging to the fair sex. One of the examiners was said to have sung a love song while examining. Another examiner questioned about Tippu Sultan and nothing more was asked of her by the examiner in the Surgery oral, a third was said to have questioned a girl examinee if she approved of kissing and some were questioned about their clothing. It was also said that the examinees belonging to the fair sex came with an obsession that they were sure to fail and would not answer questions during the practical examinations. Apart from the inherent defects in the system and extraneous events which were the causes for the disparity of results, it was deposed by no less a person than an ex-Personal Assistant to the Surgeon-General that in 1931 he received question papers in Medicine and Surgery sent to him along with an anonymous letter days before the examinations were actually held, (Vide page 143) and it is really a matter for surprise why this event went unnoticed by the authorities, beyond a D. O. written by then Surgeon-General to Lt. Col. Mahadevan which runs thus :

Ootacamund, May, 5, 1931.

Dear Mahadevan,

I am satisfied there can have been no leakage in the examination paper. I don't know how many people see the questions previously

—The only people should be yourself and the examiners. We will talk it over later.
Yours Sincerely,
(Sd.) C. C. SPRAWSON.

We were forced by sheer dint of circumstances to search after truth to justify the simple word 'refrain.' If we were left alone, the public and the profession and with them the authorities concerned in conducting non-University medical examinations would not have known the actual reasons of bad results as deposed by some of the examiners. We wonder as will others, who go through the full proceedings of the case, if the Surgeon-General who effected the changes in the methods of Examination in October, 1935, knew what others could not know about the causes of bad results in women schools. That the Surgeon-General must have felt the necessity of reforms brought about by him is evident from the deposition of Dr. Lazarus (Vide page 153) and also from the Agenda of a conference that met at the Surgeon General's office on 11-12-34 consisting of Superintendents of the three existing Medical schools and presided over by the Surgeon-General himself. This Agenda is published as exhibit No. XI.

It is clear from the proceedings of the case that a woman student by name Mary Mathen from the Vellore School was attending the Royapuram Hospital and later was admitted into the Willingdon medical school and that she was taken away from one batch and posted to another during the course of examinations. During the period of our trial when we had to search after truth for our defence we learnt that Mary Mathen had another companion at the Royapuram Hospital by name Laxmikutti, also, from the Vellore School and both of them failed more than twice, the latter in medicine and the former in surgery and both passed creditably in 1934. We were also given to understand that these students while they were attending the Royapuram Hospital applied to the Surgeon-General for admission into the Stanley Medical School and that their applications were rejected, they being asked to seek admission into the Lady Willingdon Medical School. It was also said that these two girls did not wish to be at the Lady Willingdon and later applied for readmission into the Vellore School but not be taken into that school. During this period and even later some girls from the Willingdon School also indicated a desire to seek admission for

training at the Royapuram Hospital in spite of an order from the Surgeon-General that girl students should not be admitted into this institution and even after this order one or two girls were found attending the Royapuram Hospital as casual students till the Superintendent of the Hospital had actually to request those concerned not to go against S. G.'s orders. It is not known why these few girls preferred to be trained at Royapuram Hospital instead of at Victoria Gosha Hospital even against the advice of the Surgeon-General and if the Surgeon-General is not aware of this tendency it is desirable that he institutes an enquiry to find out the real cause. If some of the girls prefer co-education why not allow them to be in the boys' school especially so when they pay for their education, unless the Government have reasonable objections?

The main peg on which the body of the prosecution was hung, was our comments on the Selection of Examiners. Our attempts to search after truth regarding this item were not in vain. The learned Magistrate found materials in our comments to establish a *prima facie* case against us. But in one of the recent G.Os regarding the administration reports of medical schools, the Surgeon-General did actually say that the Examiners were appointed by the President, Board of Examiners, assisted by a selection committee and we did not feel sorry to keep company with the Surgeon-General though at the cost of the indignation of Lt. Col. Mahadevan. After all the learned Magistrate has the following most lucid interpretation of the effect of having the President, Board of Examiners as the Chairman, Selection Committee for examiners, in the person of one of the Superintendents from the three schools:

"It has been proved that the selection of examiners is by a committee and is subject to the final approval of the Surgeon-General. But the President must in the natural course of things exercise considerable influence and such a predominance of examiners from that school raises a fair presumption that it is so."

The Surgeon-General has not seen his way to effect a most important basic reform in spite of his knowing from the other two Superintendents that they preferred the old order of things of having the Principal, Medical College as the President, Board of Examiners. It is also said that when the Surgeon-General suggested that the President Board of Examiners might be the Superin-

tendent of each school by rotation, the Superintendents of women medical schools did not like the idea and persisted in their request to the Surgeon-General that the President should be a neutral agency. We have no idea how far the resolution of the Madras Medical Council regarding State Medical Faculty has taken a practical shape with the Government. But till the Government decided one way or the other regarding this resolution, we are at a loss to understand what prevents the Government to make S. G.'s reform complete by giving effect to the general consensus of opinion that the President, Board of Examiners should be one outside the medical schools. This is another deduction of search after truth.

The Medical Practitioner is a unique journal specially brought into existence to ventilate the grievances of the Medical Profession with regard to Medical Education, and Medical Relief so that these two items which are now under the control of 'one man' the Surgeon-General may come under the legitimate control of the Medical Profession as is the case in other civilized countries. The one man's control has been a great handicap for the homogeneous growth of the profession which is now divided in water tight and even air tight compartments both in service and in private practice. With the main purpose of effecting necessary reforms in the Medical Administration in all its branches in this Province if not in this country, we have been striving not to lose any opportunity of taking advantage of passing events. It is for this purpose we agitated for the need of a State Medical Faculty in this Province. But the unfortunate result of our agitation was a Libel case against us. Even this event has been to the medical profession a blessing in disguise in helping us to promote the aims and objects of The Medical Practitioner. Reform and progress are the inherent attributes of evolution. It can not be otherwise with the Medical Profession. Though the sequela of our agitation to reform Medical Education and the conduct of Medical Examinations was a criminal complaint against us, the proceedings of the case, have not only abundantly proved the necessity of reforms advocated by us but also made the Madras Medical Council consider the desirability of having only one standard of Medical Education. The Medical Council has since submitted their unanimous opinion while forwarding the

report of the Medical Curriculum and Examination committee that whether it is desirable to run two rival medical institutions, schools and colleges when the newly introduced five years' course in the schools is made identically equal to that of the University standard. If the Government agree with the Madras Medical Council well and good. If not, the proceedings of the Libel case against us including the judicial findings in the case will we hope open the eyes of all concerned including the Government that it is not prudent to entrust the machinery of Education and Examinations of the Medical Licentiates to a single individual and immediately institute a State Medical Faculty. We do not mind our sufferings either in the past, present or future so long these sufferings lead to help the profession, the public and the Government to evolve a Medical Profession worthy of its noble and as sacred ideals. We have therefore published the proceedings of the case against us in detail to help all to get at Truth with the Search Light of facts stated on Oath.

It will not be out of place if we take our readers to a side track in this case and request them to read the evidence of one Mr. Abdul Kareem, a teacher in the Madras Corporation and the Exhibits, XI & 'P' published elsewhere. We refer our readers to the

evidence regarding this subject deposited by Lt. Col. Mahadevan appearing on page 113 last issue. We tried to get at the records from the Surgeon-General's office concerning this complaint through the Court but were told that no records were available. It is clear from Exhibit 'P' that the Surgeon-General did not hold an enquiry regarding the allegations against the clerk. The complaint is a serious one and such complaints are usually heard in other offices of District Surgeons. This is one amongst the many other events which we came across while on our trial and about which we request the Government to enquire into, in the interests of Administration. Stories like this are common to be heard but as difficult to prove. There are two persons concerned in such stories and we should say the one that offers is a worse sinner than the one who receives. So usually nothing could be done to prevent the giving or the taking. But in this case, it is alleged that something was demanded and the man from whom the demand was made did complain mentioning his witnesses but it looks as if the complaint was not pursued. Public interest demands an enquiry, especially so as the person complained against, is still in the very office where the Corporation teacher was sent to be examined for his physical fitness in 1932.

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CONGESTION.

COPY OF EXHIBIT NO. XI
**Agenda for the informal Conference of the Superintendents of
 Medical Schools, Madras and Vellore to be held on the
 11th December 1934, at 12-30 P.M., in the Surgeon
 General's Office.**

1. To consider the scheme for the registration of Medical Students.
2. To consider the proposal to prescribe uniform standard for the admission of students to all the three Medical Schools.
3. To modify rule II of the rules prescribed for the admission of students to Medical Schools.
4. To add Physiology and Botany to the list of optionals *Viz.* Physics and Chemistry prescribed for candidates applying for admission.
5. To discuss the question of publishing a calendar for the Stanley Medical School.
6. To discuss the proposal to abolish surety bonds for stipendiary students.
7. To discuss the proposal to have a common centre at Madras, for holding the written examinations of the L. M. P., Board.
8. To discuss the syllabus in Physics.
9. To provide a rule for verification and checking the addition of marks obtained by candidates appearing for the L.M.P., examinations as in the case of University Examinations.
10. To review the results of the April (L.M.P. Board) examinations.
11. To discuss about the valuation of answer papers.
12. To formulate a rule that six questions may be given in each paper and the students be required to attempt 5 questions only.
13. To fix the date of 1st Professional examination.
14. To formulate a rule that Superintendent of other medical schools be consulted by the President, Board of Examiners before prescribing New Rules and Regulations.
15. To discuss the proposals for the retransfer of the appointment of the President, Board of Examiners from the Superintendent, Stanley Medical School to the Principal, Medical College, Madras, as it was till 1927.
16. To discuss that the President, Board of Examiners may be required to keep a Minutes Book to record the proceedings of the Committee for the appointment of L.M.P., Board of examiners and also of the Board of Examiners.

Office of the Surgeon-General with the
 Govt., of Madras, dated 10th December,
 1934.

Sd....10-12.
 (By order).
 Personal Assistant to the Surgeon-
 General with the Government of Madras.

MAH. 10-12.

To

The Superintendent, Stanley Medical School, Madras.
 " Lady Willingdon Medical School for Women Madras.
 " Principal, Missionary Medical School for Women, Vellore, Care of the Superintendent, Lady Willingdon Medical School for Women, Madras. Id....10-12.

Additional Agenda.

17. To discuss about the printing of question papers.
18. To discuss the question regarding the insufficiency of the period of six months to cover the prescribed course in Physics Chemistry and Biology.

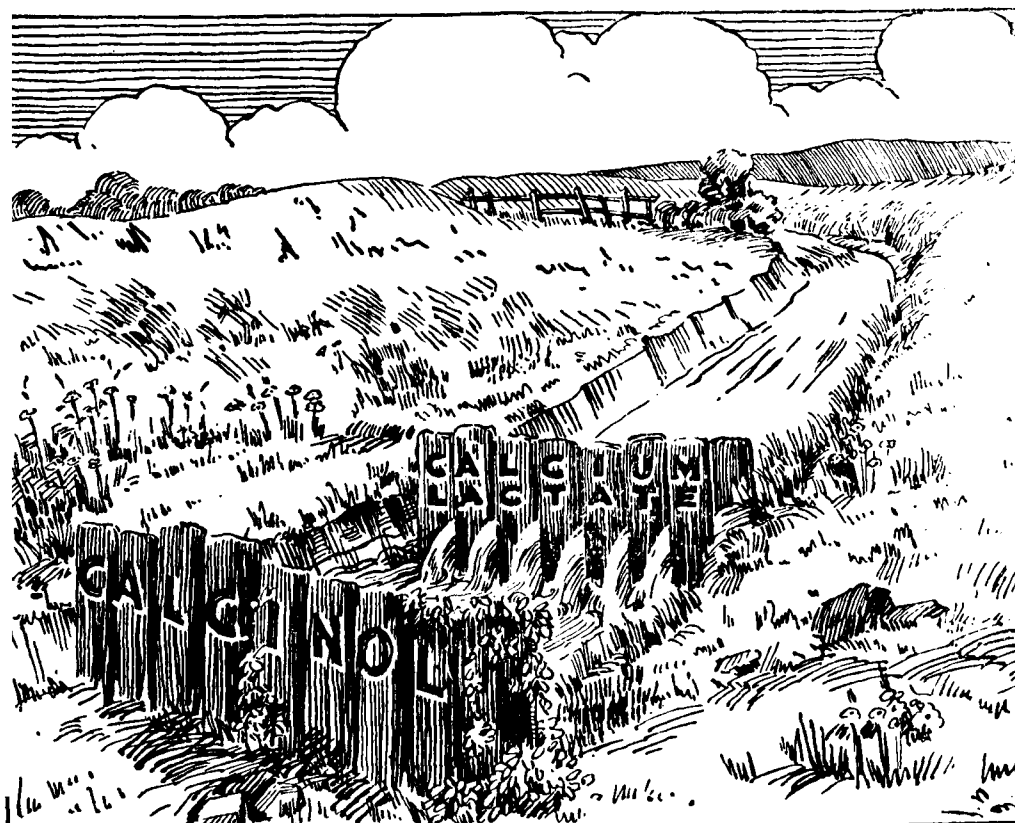
Note.

Any other subjects may be brought before the meeting.

(1) Inter. School Prizes.

(2) President—Selection Committee.

[The lines under some paras are marked by us-Ed.]



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Hence I request your honour, in the interest of justice, to send me to another District Surgeon for my Medical Examination and reinstate me as a teacher in the Corporation School.

When the clerk of the Surgeon's office asked me the fees, my brother was present.

For which act of kindness I shall ever feel thankful.

I beg to remain,
Sir.

Your most obedient servant,
(Sd.) C. SYED ABDUL KAREEM,
Late Assistant Corporation Muslim
Boy's School, Seven Wells
Street, G. T. Madras.

N. B.—I have explained the facts regarding my Medical Examination, through my father, to the Education Officer on 24th September, '32.

IN THE PRESIDENCY MAGISTRATE'S COURT, EGMORE, MADRAS.

COPY OF EXHIBIT 'P' in C. C. NO. 1038 OF 1936.

Medical Department.

Received	Registered.
From (Name) Major V. Mahadevan, F.R.C.S., M.R.C.P., I.M.S.,	
(Designation) Surgeon, 1st District,	
Post box (Station) Madras.	

Telegraphic address.

To The

Personal Assistant to the Surgeon-General
with the Government of Madras, Madras.

Mis No. 133-1, dated 22nd November 1932.

Sir,

Ref:—Your memo. No. 2695-1 E dated the 18th
November 1932 Medical examination of Mr.
A. C. Syed Abdul Kareem, Teacher, Corpora-
tion School.

I have the honour to state that this office was never kept opened after 1 P. M. To say that I examined the teacher at 3 P. M. is a mis-statement. In fact, I remember to have examined all the candidates before 12 Noon on this day. A copy of the certificate Mis. No. 133 dated the 19th September 1932 is herewith enclosed.

I have the honour to be,

Sir,

Your most obedient servant,

(Sd) V. Mahadevan,

Major, I.M.S.

Surgeon, 1st District.

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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THE Medical Practitioner

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VOL. VIII.]

MAY, 1937.

NO. 8

Original Articles

*MODERN VIEWS REGARDING
THE STRUCTURE AND FUNC-
TIONS OF THE KIDNEY AND
GLOMERULO-NEPHRITIS.

By RAO BAHADUR DR. T. S. TIRUMURTI, B.A.,
M.B. & C.M., D.T.M.H.

*Professor of Pathology, Medical College
Madras.*

In the early years of the last century, Dr. J. Blackall of Exeter made observations on the relation between albuminuria and dropsy and stated that in such cases the kidneys were probably diseased. But, we owe to the genius of Richard Bright, the brilliant discovery of the relation between albuminuria, dropsy, uraemia, apoplexy and kidney disease. Though Bright's clinical description of the disease has not been improved upon by subsequent workers, many advances have been made in our conception regarding the functions and pathology of kidney disease by researches along several different lines, especially of a bio-chemical nature.

The conception of the structure of the kidney was that it was composed of three parts, the Bowman's capsule, containing the glomerulus, secretory tubules richly supplied with blood and collecting or conducting tubules. The conception that the kidney was composed of a number of units, called nephrons, came in only recently. The kidney is built up of a large number of nephrons. It has been estimated that each kidney contains five millions nephrons. Each nephron is composed of a capsule, in which there is a

vascular tuft of capillaries, called the glomerulus, with its attached secretory tubule. The afferent artery which enters the capsule breaks up into a knot of capillaries, forming the glomerulus. These capillaries reunite into the efferent vessel, which leaves the Bowman's capsule and this afferent artery breaks up again into a new set of capillaries, which are distributed to the secreting tubule. The blood supplied to the secreting tubules is, therefore, exclusively via the glomerulus. Therefore, in each secretory unit there is a double capillary system. A knowledge of this fact is necessary to understand the physiological functions and the pathological changes in the kidney.

The chief function of the kidney is to keep the calls of the body so far as non-volatile substances of metabolism are concerned at normal composition. The functions are :—

- (1) removal of non-volatile waste products, urea, creatinin etc.,
- (2) removal of acid products of metabolism in the form of acid phosphates,
- (3) maintenance of optimum salt concentration,
- (4) excretion of water and
- (5) elimination of toxins due to perverted metabolism or derived from outside the body.

From the blood in the glomerulus by a process of osmosis water and sodium chloride are removed. This appears to be purely a physical passive process. But the salt content of the urine is not the same as that of the blood. There is often three times as

*Lecture delivered at the Ramnad District Medical Association at Karaikudi on 10-4-1937.

much salt in the urine as in the blood, though the salt content on both sides of the glomerulus is the same. Therefore, the filtrate formed in the glomerulus should undergo concentration somewhere. It has been shown that such concentration takes place in the convoluted tubules.

Not only is the salt but all the soluble and diffusible crystalloid substances of the blood pass out with the water through the thin capillary wall of the glomerulus. But the wall of the glomerulus holds back the large protein molecules and other colloids and the cells of the blood. In the tubules not only the water is reabsorbed but also the chlorides and sugar, so that normal blood values may be maintained. This reabsorption is due to the active secretory activity of the epithelial cells of the convoluted tubules. Thus, the conception of what is known as a renal threshold has been found necessary. Water, chlorides and sugar are substances which have a renal threshold value. In conditions of disease, where the secretory tubules are affected, the reabsorption of these substances may not take place. If substances, such as, sugar are present in a larger quantity than normal in the blood, they will be excreted in the urine, because sugar in the blood has been raised above the renal threshold value. Similarly, in conditions of disease of the kidney when the renal threshold is lowered, even though the blood sugar may be normal, it may leak out in the urine.

Recently, our attention has been drawn also to what is known as "the reserve power of the kidney." The demonstration of such reserve power has altered our views regarding the structural and the functional nature of the nephrons. It is held that there is a large excess of nephrons, over and above what is necessary to carry on the excretory work, which is demanded of the kidney during normal metabolism, even after a large meal. It has been shown that at any one time, only a certain proportion of the total nephrons are active and that each unit of nephron passes through alternative phases of rest and activity. These alternations are manifested in an irregular manner by an increased blood flow through the glomeruli, i.e., all the glomeruli in a particular field are not uniformly affected at the same time. Each unit of nephron functions for only a fraction of the time according to demand,

One unit out of every four is active at any one time.

Certain substances, which act as diuretics, increase the number of nephrons which become active and certain vaso-constrictor substances diminish their number. If some of these nephrons are thrown out of activity as a result of disease, the remaining nephrons will be forced to have shorter rest periods, if the kidney efficiency has to be maintained. Within certain limits each individual nephron can respond to a permanently increased demand. Here, the functional reserve of the kidney comes into play.

The function of the nephron is the elaboration from the blood of a fluid which differs from the blood by the exclusion of certain substances and by the concentration of others. If the nephrons fail to function, the urine will have the same composition as a protein filtrate of the blood plasma, because no concentration has been attempted. If the glomeruli are damaged, the capillary wall will let through not only crystalloid substances of the blood but also the larger protein molecules. Therefore the more severe the inflammation, the greater will be the damage to the capillary endothelium and the greater the approximation of the composition of the urine to that of the blood.

Hoidenhain's secretory theory of urine production has been abandoned. In the glomerulus there is a simple passive filtration of water with the simple diffusible crystalloids, such as, sugar, chlorides and urea. But when glomerulus is inflamed, the larger protein molecules, chiefly albumin, pass through the glomerular membrane into the urine. The globulin molecule is larger in size than that of the albumin. Therefore, albumin diffuses much more readily through membranes than globulin. In conditions of inflammations of the kidney the amount of albumin in the urine greatly exceeds globulin. Normally, the albumin globulin ratio in the blood is as 3:1. In certain forms of Bright's disease, owing to a passage of albumin in larger quantity than globulin in the urine, the albumin globulin ratio is reversed and the total quantity of protein in the blood is diminished, thereby diminishing the colloidal osmotic pressure of the blood.

We should remember that the proteins of the blood do not pass normally out of the capillaries to act as tissue nutrients. The

amino-acids of the blood can diffuse out of the capillaries to form protein for the tissue cells. But, the blood proteins themselves do not supply the requirements of the protoplasm of the tissue cells. The main function of the blood proteins, which are colloid in their nature, is to maintain the colloidal equilibrium of the blood. If the total proteins of the blood are diminished, either due to nutritional causes or to albuminuria or in any other manner, there is a lowering of the colloid pressure in the blood which, as I shall explain presently, will lead to the development of oedema.

THE FACTORS CONCERNED IN THE DEVELOPMENT OF OEDEMA

Three factors are concerned in the interchange of fluid between the blood and the fluid in the tissue spaces:

- (1) the permeability of the wall of the capillary,
- (2) the intra-capillary pressure, which continually tries to force the fluid of the blood through the capillary wall and
- (3) the colloid osmotic pressure of the plasma proteins, which tend to keep the fluid in the capillaries and to abstract more fluid from the tissue spaces back into the blood.

In acute glomerulo-nephritis the walls of the capillaries of the glomerular tufts are damaged by the inflammation, which renders them more permeable. The exudate from the glomerulus assumes the characters of an inflammatory exudate, which is evidenced in the albuminuria in the acute stage of the disease. But in the disease called nephrosis, which has recently been differentiated as a separate entity even though there may be a heavy albuminuria, there is an absence of evidence of inflammation of the glomerulus. In this condition the cause of the hyper-permeability of the capillary walls is not demonstrable by the microscopic examination of the affected tissue. Something has, however, happened in nephrosis to bring about the hyper-permeability of the capillary walls of the glomerular tuft. But the exact nature of the change, which has made the delicate walls of the capillary abnormally permeable, is, as yet, unknown. It has been suggested that in nephrosis the capillaries of all the glomeruli are in a state of permanent patency. It has been shown that the dilatation and consequent stretching of the capillary wall increases its permeability.

The second factor in the production of oedema, viz., increased intra-capillary pressure is evidenced in the oedema which results from failure of compensation of the heart in the later stages of chronic glomerulo-nephritis and the nephritis following benign or malignant hyper-tension.

The third factor, viz. the colloid osmotic pressure comes into play in the oedema of nephrosis and sub-acute glomerulo nephritis and in the types of the oedema, known as nutritional oedema, famine oedema, oedema of anaemic conditions, etc., In nephrosis and sub-acute glomerulo-nephritis owing to albuminuria there is a considerable depletion of the proteins in the blood and, therefore, a diminution of the colloid osmotic pressure. Owing to a fall of this pressure, the fluid from the tissues is not abstracted back into the venous end of the capillary.

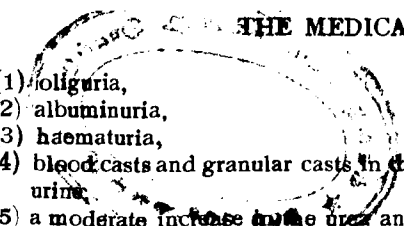
It should be remembered that, at the arterial end of the capillary, the intra-capillary pressure is more than the colloid osmotic pressure and, therefore the fluid of the blood is forced from the capillary into the tissue spaces. But, by the time the blood reaches the venous end of the capillary, the intracapillary pressure has fallen lower than the colloid osmotic pressure and, therefore, the tissue fluids are abstracted back at the venous end of the capillary. Thus, in health a normal balance is maintained between the fluid in the blood and that in the tissue spaces.

Excluding "surgical" kidneys, the "medical" kidneys may be divided into three main groups:—

- (1) the vascular or arteriosclerotic group,
- (2) the degenerative group, e.g. nephrosis,
- (3) the inflammatory group—acute, sub-acute and chronic glomerulo-nephritis. In this group may be included also the types of focal nephritis.

I shall deal with the last group of kidneys and specially, with the relation between some of the symptoms and signs and the pathology of the disease. Acute, sub-acute, and chronic glomerulo-nephritis are merely the different stages in one and the same disease and no sharp line of demarcation can be drawn between one stage of the disease and the other.

During the first stage of glomerulo-nephritis there is a generalised oedema. The following changes are also noticed:—

- 
- (1) oliguria,
 - (2) albuminuria,
 - (3) haematuria,
 - (4) blood casts and granular casts in the urine,
 - (5) a moderate increase in the urea and non-protein nitrogen of the blood,
 - and (6) a slight rise of blood pressure.

In the second stage of disease the generalised oedema persists; there is a diminution in the amount of urine excreted; the urine is loaded with albumin and contains fatty and granular casts. The cholesterol is increased in the blood. But there is no increase in the urea or non-protein nitrogen of the blood.

In the third stage of the disease there is no oedema; the specific gravity of the urine is lowered. There is polyuria. The normal daily variations in the specific gravity of the urine are not seen. The urine contains no albumin or only a trace of it. Hyaline casts are usually present. The blood cholesterol is not increased. There is a marked retention of urea and non-protein nitrogen in the blood. There is also a marked rise of blood pressure, which however does not rise above 200 m.m. of Hg. The patient may show in the later stages signs of heart failure or uraemia.

The oedema in the first stage of the disease is due to a universal generalised capillaritis due to the action of circulating toxin. There is an inflammatory exudate into the tissue spaces which may be termed as "albuminuria into the tissues." The protein content of the oedema fluid in the acute stage of the disease is high and resembles that of inflammatory exudates. Whereas, the oedema in the second stage of the disease is due to the altered albumin globulin ratio of the blood and diminished protein content and consequent lowered colloid osmotic pressure.

The earlier belief that oedema was due to retention of salt has been shown to be untenable for many reasons. A salt relating kidney is a myth. There is a pre-renal deviation of salt into the tissue spaces along with the fluid, which causes the oedema. Therefore, there is a less amount of salt which is excreted in the urine. The retention of salt does not cause the oedema, but the oedema causes the retention of salt. The salt which has been deviated into the tissues along with the fluid is capable of retaining the fluid in

the tissues. This explains the benefit of a salt-free diet. A salt-free diet is therefore useful not only in conditions of renal oedema, but also in cardiac and other forms of oedema.

The slight hypertension of the first stage is due to a certain amount of retention of urea and non-protein nitrogen in the blood and the hypertension of the third stage is due similarly to the retention in a larger amount of urea and non-protein nitrogen and also to a compensatory general rise of blood pressure, so that there may be a larger amount of blood flow through a considerably restricted number of functioning nephrons.

The disappearance of the oedema in the third stage of the disease is due to the disappearance of the albuminuria and the return of the albumin globulin ratio of the blood to the normal. The polyuria of this stage is due to the inability on the part of the epithelium of the degenerated tubules to concentrate the glomerular exudate. The oliguria of the first stage is due to the small number of the glomeruli which are functioning. The urea retention in the first and third stages is due to the same cause; the oliguria of the first and second stages lead to the increased specific gravity of the urine. The polyuria of the third stage leads to the diminished specific gravity of the urine and the inability on the part of the secretory epithelium to concentrate the urine results in a fixity of the low specific gravity.

The casts in the urine in the first stage are characteristic of acute inflammation and in the second stage shows the desquamative and degenerative changes in the tubular epithelial cells.

A knowledge of the pathology of the disease and the co-relations of the signs and symptoms to the lesions characteristic of the different stages lead us to rational methods of treatment. We see the benefit of restricting protein in the diet in the first and third stages of the disease and the liberal allowance of protein in the second stage of the disease; the advantage derived by a salt-free diet; the danger of using Salyrgan and other powerful diuretics in the first stage of the disease; the benefit derived from them in conditions of cardiac oedema following renal disease; the impossibility of flushing out the kidneys by a large intake of fluids in the first stage, where the glomerular capil-

laries have become obstructed and the desirability of giving rest to the glomeruli which are inflamed by cutting down the intake of nitrogenous foods and salt and also restricting the water intake; and the inadvisability of bringing down the blood pressure in the first and third stages by a resort to drugs.

As I have no time to deal with the other types of "medical" kidneys, I shall content myself if my address to you this evening has been in any way helpful in stimulating you to think about the signs and symptoms of the disease in relation to the lesions which are found in it. Such a knowledge will enable you to be more efficient in the rational treatment of the disease.

TRAUMATIC AFFECTATIONS OF JOINTS.

By

DR. R. KALAMEGHAM, B.A., M.B.B.S.

Though Traumatic affection of joints is a very wide subject, every item of this Special Branch of Surgery by itself teeming with literature that would make monographs by themselves. I have ventured to talk to you on this subject with an idea that the fundamental principles which I place before you may help you to some extent while treating your patients suffering from injuries of the joints.

I shall confine myself to a namphi arthrosis or slightly movable joint and a diarthrosis or a freely movable joint and not synarthrosis or immovable joints.

Such a joint as we are to concern with today is made up of two or more bony ends articulating with each other. The bony ends are covered with cartilage which is avascular. The bones are held together with ligaments and a joint capsule. The joint capsule is lined in the inside with a layer of secreting epithelium the synovial membrane which covers every area in the interior of the joint except the articular cartilage. It dips down into the recesses and runs over the fibrocartilagenous discs as in the knee and shoulder. The outside of the joint capsule is strengthened with thickenings of the same tissue becoming what are called ligaments. In addition, the muscles and tendons give strength to the capsule. With an idea of

allowing free play in the periarticular structures many bursae are interposed between the tendons or muscle bellies and the capsule. Some tendons in some of the joints have tendon sheaths with an investing layer of secreting epithelium. The deep fascia in a few places form condensation to form ligaments to hold down the tendons. Then we have the usual subcutaneous fat and skin.

Injury to a joint may be acute or chronic. Acute trauma may be due to:

1. Overuse of a joint,
2. a wrench or a twist,
3. forcible movements beyond the range.
4. blow or contusion,
5. fractures near a joint and into it.
6. burns.

Chronic trauma may be due to

1. continued overusage.
2. erroneous deflexion of body weight,
3. continuous misuses like callosities and bursae.

In both types of injury the brunt is borne in a majority of cases by the synovial stratum, either immediately or at a later stage in the story.

SYMPTOMATOLOGY.

In acute cases of joint injury there is:—

1. acute pain,
2. acute swelling which may be in the joint or in the periarticular tissues due to lymph stasis or extravasation of blood,
3. limitation of movement or even loss of function.
4. deformity in a few cases where we have a dislocation or a fracture as well.

In chronic cases we have the same symptomatology except that the pain is not so acute. While the pain is absent in a resting joint it may appear on the slightest movement.

There is also limitation of movement though to a less extent. The range may be limited by pain appearing after a certain range in the movement of the limb. Deformity is there again in the sense that the muscles around the joint are wasted owing to disuse atrophy and the joint itself may be swollen and bigger than its counterpart of the other limb.

The Traumatic Disabilities that we are to consider today are:—

1. Contractures of periarticular structures—burns.
 2. Injuries to muscles,
 3. Injuries to ligaments, Avulsion fractures.
 4. Injuries to bursae,
 5. Injuries to capsule.
- all these are periarticular structures.

Injuries to articular structures are

1. Injuries to Synovia,—synovitis, villous arthritis.
2. Injuries to articular cartilage
3. Injuries to joint fibrocartilage, Semi-lunars.
4. Injuries to bones fracture dislocations and patella.

General traumatic joint lesions are.—

1. Volkmann's ischaemic contracture
2. Osteochondritis juvenalis.

Treatment of injuries to joint structures resolve into the following lines.

1. Rest of an absolute type to the injured structures by means of a plaster of paris casing or better by an adhesive plaster strapping. Fixation is a better term because it does not mean a general immobilisation of a whole joint but only a fixation of the injured structure as for instance a sprain of the ligamentum cruciatum or the anterior annular ligament of the ankle joint.

2. Mechanical or manipulative. This applies mainly to chronic joint trouble where we have to break down a few adhesions in a stiff joint etc.

3. Operative as in bony blocks, or the removal of joint mice within a joint etc; and which does not come under auspices of this talk.

It is important to localise the site of injury before treating the same and as I go along I hope to give you an outline of the diagnosis and treatment of the Traumatic disabilities just before mentioned, in a general way.

BURNS.

A case of severe burns results in a good amount of loss of tissue, and healing takes place by granulation tissue. The result of a granulating wound is a contracting fibrous tissue which in course of time limits the range of movements in the direction in which we have the fibrous tissue bands. This fact is worth while remembering in recent

cases of burns and when treatment is instituted the limb must be so immobilised that the burnt tissues are put on the stretch as in the case of a burn of the finger; and care must also be taken to see that surfaces that are close together normally as the axilla are separated as far as possible just with an immediate object of preventing the adhering of the granulating surfaces and with a view to put the granulating surface on the stretch. In spite of our special care, cases happen, where failure has come to happen; and in these cases operative severance of the bands of scar tissue followed by pedicled skin grafting is the method of choice.

INJURIES TO MUSCLES.

This usually results in over-stretching the muscles either actively or passively, resulting in the rupture of a few fibres of the belly. The result is that there is a haematoma forming at the site of the injury together with a surrounding area of oedema due mainly to lymph stasis. We get in acute cases a swelling at the site of injury with tenderness at the place. Regarding movements that could be elicited only certain movements that put into action that particular muscle are painful and the patient resists such an interference from his doctor while other movements are painless. Pain may be localised to a particular muscle by passively stretching the muscle or actively contracting the muscle. In chronic cases there is not so much of pain, swelling or disability.

In treating acute muscle injuries, *Rest* to the muscle is achieved by strapping the swollen part to prevent any further exudation, by positioning the limb in such a way as to bring the ruptured fibres to as close a contact as possible and immobilising it with adhesive strapping. Massage is indicated to drive away the exudate and that in a very gentle way only with a slight petrissage kneading movement in massage and effleurage stroking towards the centre in massage. Active movements of all kinds available in the joint, except those that put the ruptured fibres on the stretch, must be encouraged with a view to prevent joint stiffness which, in case it happens to set in, must be treated later on by manipulation. This rest is enjoined for about a week after which the patient is allowed to resume his normal work which is usually not a vigorous one; but physio-

therapeutic measures must be continued for some more time.

INJURIES TO LIGAMENTS.

Ligaments by themselves are very strong structures designed to withstand a very great amount of tension. So much so, one has to be cautious in diagnosing a rupture of a ligament, for as is very usual there is a bony injury at the site of insertion of the ligament, what is called an avulsion fracture. The importance of X-ray evidence is of absolute necessity in such cases of ligamentous sprains. At this stage may I point out the subtle difference between a sprain and a strain? While a sprain is a complete rupture of one or more fibres of a muscle or ligament a strain is just a stretching of the fibres, without loss of continuity.

Treatment of this condition lies in manipulating to bring the ruptured ends together and keeping them in position by suitable methods for some days and continuing physio-therapeutic measures as in the case of muscle injuries. If avulsion fracture is present and if conservative methods fail, operative measures have to be undertaken for immobilisation purposes.

Injuries to bursae and articular capsule do not show by themselves alone. The synovial membrane shares in the bargain and exhibits an effusion into the joint or within the bursa. In acute cases of this type absolute rest to the joint structure together with suitable physio-therapeutics will invariably do good.

Treatment of chronic injuries will be treated under the heading adhesions.

Acute injury to the synovial membrane results in what is called a synovitis with an effusion of synovial fluid into the joint space thus distending the joint. The differential diagnosis between an acute bursal effusion and a synovial effusion is that in bursae only a few areas of a joint surface look swollen unless the bursa communicates with the joint as the sub-deltoid bursa, while in joint effusion the whole circumference of the joint looks swollen. There is pain in a synovitis and any movement is painful and difficult as well, due to the distension. Treatment is by absolute immobilisation in a plaster cast and when the effusion is absorbed physio-therapeutic measures are to be instituted. In a case of injury to the knee joint, if there is too much of fluid that one suspects is difficult of absorption then a

tapping of the joint can be attempted. Here one is never overcareful for a joint requires the strictest aseptic and antiseptic technique that modern surgery is capable of. Warning is not out place here that a joint will be crippled for life just for the non observance of even a trivial detail in the asepsis of the technique which one can well afford to ignore in the surgery of any other part of the human body. When the exudate is absorbed passive movements once a day through the entire range permissible in that joint is to be instituted to prevent adhesions or ankylosis, together with suitable physio-therapeutic measures.

In moving such a joint pump handle movements are to be avoided as they are liable to cause much more damage than what the original one had inflicted.

INJURIES TO ARTICULAR CARTILAGE.

It is usually due to an indirect violence and due to the avascularity of the cartilage very little pain is felt at first. The repair is never by a regeneration of the original hyaline cartilage which is not sensitive. The injured cartilage is slowly absorbed by the synovial fluid which is present in a synovitis. Then overgrowth takes place in the shape of inflammatory tissue either from the synovial membrane or from the underlying bone and the injured area is slowly filled up with a type of sensitive and fibrous type of cartilage with fibrous tissue bands connecting this area with either the opposite articular surface or the periphery of the synovial membrane. The result is that the patient complains of pain on moving the joint—a type of adhesion in the joint leading to a fibrous type of ankylosis. Treatment consists in prolonged rest with extension to keep the joint surfaces apart till active symptoms subside and after several months manipulation and suitable physio-therapeutic measures are to be instituted. Nevertheless the joint remains sensitive and very little can be done to alleviate this.

INJURIES TO FIBRO-CARTILAGES.

This type of injury is more common in the knee joint than in any other. One is always familiar with a footballer's knee which gets locked in the middle of the game with subsequent inability, when the usual type of shaking that is available on the field unlocks the joint and the patient walks home with a swollen knee which prevents him from football for some months to come. To go into

the internal derangements of the knee joint would require a whole evening by itself and so elaboration is out of place, to day. The history is a familiar one for diagnostic purposes and after preliminary conservative treatment by immobilisation after unlocking the joint and when symptoms have subsided operative removal of the semilunar cartilage must be advocated. I may assure you the patients are none the worse for the operation for at least in the ordinary rounds of life the operated joint will not let them down.

INJURIES TO BONE.

As was pointed out just before, any patient suspected of a sprain of a ligament near a joint must be x-rayed to reveal any possible bone injury. Treatment lies in accurate apposition of the fragments and immobilisation till the bone unites followed later on by physio-therapeutic measures. Prolonged immobilisation of a case of avulsion fracture gives rise to a stiffness of the joint and this gets on to be all right when active movements are instituted. In these cases adhesions may develop and it is not a very difficult task to set it right by manipulation.

I dare say every one of you have seen sometime or other fractures of the *patella* and *olecranon* and the signs and symptoms are familiar to every one of us. In cases where there is no gap between the bone fragments, conservative immobilisation is all that is wanted while if the fragments are separated operative intervention is necessary.

We now come to the consideration of Chronic joint trouble with trauma as its origin. Whatever the pathology may be the end result in these untreated cases is either an adhesion or an ankylosis. So treatment of a chronic joint trouble is the treatment of adhesions and ankylosis, in lay parlance the treatment of joint stiffness.

Stiffness may be due to :

1. prolonged immobilisation,
2. bony blocks,
3. scar tissue,
4. traumatic and suppurative processes about a joint.
5. adhesions,
6. ankylosis.

Stiffness due to bony blocks may be due to :

1. myositis ossificans,
2. excess of callus near a joint,

3. unreduced dislocation,
4. malunion.

Treatment of these is mainly operative.

Stiffness due to contracting scar tissue has been already dealt with.

Stiffness due to traumatic and suppurative processes periarticular in nature, is due to one of the following:

1. prolonged immobilisation after a compound fracture,
2. septic arthritis without cartilage involvement and
3. periarticular suppurations.

Treatment consists in gradual extension in a splint or graded extension in stages under an anaesthetic.

ADHESIONS.

Adhesions are apt to follow :

1. sprains involving the capsule, ligaments, and muscular insertions,
2. Fractures through or in the neighbourhood of joints,
3. dislocations,
4. contusions of joint cartilages,
5. prolonged immobilisations and
6. periarticular inflammations.

How to prevent adhesions?

1. Allay inflammatory reaction and remove strain on the injured part,
2. Obstruct local effusion of blood by pressure,
3. Massage injured structures early,
4. early active function to be promoted,
5. protection of torn structures from body weight.

Some axioms in the differential diagnosis of joint injury.

1. A painful joint which is rigid in all directions is probably a seat of arthritis or joint involvement; but if there is rigidity in only a few directions it is certainly not an arthritis but only an adhesion.

2. A joint whose range of motion increases with use is free from active arthritis and in simple adhesions the range of movement must not diminish with use except very temporarily as a result of pain.

3. Stiffness following arthritis is a slow continuous process, while in adhesion the stiffness is quick in appearance even as early as 48 hours.

4. Pain is present on sustaining body weight in arthritis while in adhesion pain is

easily localised on moving the joint in one direction only.

5. Temperature is present in an arthritis while in adhesion it may be absent.

Treatment of adhesions.

1. Active or passive movements.
2. Manipulation under an anaesthetic.

Active and passive movements: These must be painless, and fractures must be protected by suitable splintage before attempting movement. The joint must be moved once in every direction with the greatest gentleness. If the pain is worse and continues to grow, stop the line of action and rest the joint.

Manipulation of a joint.

Indication is when the adhesions do not yield to passive movements.

Rules for breaking down adhesions.

(a) a short anaesthetic like ethyl chloride is good since patient comes out quickly and sees the change that is effected in the joint and co-operates with us for further movements.

(b) One should compare the normal range of movements of the other limb lest we should overdo it in the injured one.

(c) Place the limb in the fully corrected position and give a short rest to allay reaction. Massage should be started early.

(d) Do not use a pump handle movement, but use a steady force in one direction at a time and that too only once.

(e) If you hear a snap that is the best, but if you hear a loose giving way of the structures rest the limb in the new position for 2 days and then start massage and movements.

All these apply only to joints where there is no destruction of joint tissue as in a septic arthritis.

Stiffness due to prolonged immobilisation.

HONE No : 3034

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The best form of movements is that that is being conducted by the joint in ordinary course of life.

Stiffness due to bony blocks.

1. Myositis ossificans,
2. Excess of callus near a joint and tumours near a joint.
3. Unreduced dislocation.
4. Malunion.

Stiffness due to contraction of scar tissue.

Prevention has been dealt with already and treatment otherwise is operative.

Traumatic and suppurative processes around a joint :—

1. due to prolonged immobilisation,
2. traumatic septic arthritis without cartilage involvement.

3. Suppurations about the joint.

Treatment is by gradual extension in a splint or extension under anaesthesia.

Ankylosis.

1. Bony,
 2. Fibrous
- (a) Sound-absence of active disease.
(b) unsound.

Preventive ankylosis in good position.

Treatment is operative.

Volkman's ischaemic contracture.

Osteochondritis.

Tennis elbow. or radio-humeral bursitis.

Examination reveals :

1. a feeling of increased elasticity,
2. passive movements are painless,
3. x-ray is negative,
4. but if a fist is made and wrist palmar flexed there is pain at the site of the lesion.

Osgood is of opinion that it is due to a bursitis beneath the tendon of the extensor digitorum communis over the radio-humeral joint. Removal of the bursa is the treatment.

Abstracts

THE DOCTOR OF TOMORROW.

[By Dwight Anderson, Director, Public Relations Bureau, Medical Society of the State of New York. Before the One Hundred and Sixteenth Annual Meeting of the Medical Society of the County of Monroe, Rochester, N. Y., December 15, 1936]

The Doctor of Today has been summoned before the court of public opinion. He is accused of failure to make his services available to all the people who need them. It is alleged that he is indifferent to the sufferings of those who are deprived of medical care because they are unable to pay for it. Government-controlled health insurance is to bring together the impoverished sick and the idle doctors.

It is an historic scene we are witnessing. On the issue of this trial of the Doctor of Tomorrow will depend the fate of the Doctor of Tomorrow. In this connection the words of Schiller come to mind: "For in today already walks tomorrow." In the past centuries of the doctor's tradition, as he struggled to make a scientific art out of a superstitious necromancy, no such charge was ever lodged against him. Not until we reach the present age, in the plenitude of a civilization surfeited with too much of everything, do we find him accused of not giving enough, of withholding his services. So now he comes to trial.

I am going to try to picture the scene on this occasion assuming that I have been selected to act as the doctor's advocate. The jury consists of six men and six women. Some of them have been patients of the doctor. Two were so poor they could pay for nothing, and the doctor took care of them free. Two of them could pay him, but have not. Two others do not believe in doctors and are a little bored to have to serve on the case. The remaining six have been patients at one time or another. All are typical American citizens: a chauffeur, a silk merchant, a lawyer, a college professor, a clerk, a retired business man, and among the women, a stenographer, a milliner, a telephone operator, a burlesque strip dancer, a clubwoman, and a house wife.

The jury has heard the testimony. There were four witnesses: a social worker, a sociologist, a professional uplifter, and a

politician. It could be seen that the evidence they presented, though it was mainly hearsay, produced a profound emotional effect upon the jury. The witnesses were apparently disinterested. They made strong claims in behalf of the underprivileged, alleging that women everywhere were dying for lack of medical care while the doctor sat idly twirling his thumbs in his office. They pictured children suffering from disease and defects while the doctor spent his idle time on a golf course, careless of their suffering.

The prosecution's case was well presented because it was heavily financed. Contributions had been made by a few large employers of labor who wished to give their employees cheap medical care instead of higher wages. Pressure had been brought to bear by politicians convinced that nothing in the country was conducted as well as they could run it if given a chance. Thousands of jobs and millions in perquisites were to be the prize if they could get the doctor under their control. His occupation, economically, rated as the third in magnitude in the land.

So the thing the jury was called upon to decide was whether the doctor was to be forced to work for the politician under a system of health insurance conducted by the state and paid for by contributions from the state augmented by a sickness tax levied on the employee and the employer.

In his defense the doctor summoned, for the most part, other doctors. They were men of the highest standing in their profession. But it was easy to see that the jury was unconvinced, that they regarded this testimony as self-serving. Only one non-medical witness, J. Weston Walch, a school teacher, went on the witness stand in a pamphlet which he wrote with that title. The jury paid close attention to what was said by this unbiased student.

In rebuttal, the prosecution called a physician who had spent most of his life in academic work, far from the actual practice of his profession. He presented the problem not in terms of actual human behavior as the plan would work out in practice but in the form of figures, charts, and designs on a sheet of paper. Nevertheless, his testimony weighed heavily with the jury who knew nothing of the elemental human values of confidence and trust which

contribute to the success or failure of the therapeutic relationship.

So it is at this juncture that the case is closed, and the time comes in the course of things for the doctor's advocate to rise in his place and address the jury.

And were I to be his advocate I should argue like this in the court of public opinion:

You see before you here today a man not to be judged as other men are judged. His habits of life have led him to tincture his idealism with realism. He is a man addicted to facts. He has mistakenly thought, until now, that his best arguments would be the universal knowledge of the millions whom he has served without charge, the discoveries he has perfected and given without pay to the world, the efforts he has made to discipline himself and his brothers to the highest perfection of which they are capable. He has not thought the issue would be decided by the contestant who could shout the loudest. So he appears here unprepared. In fact, it was not until the last moment before the case was called, that he bethought himself to find an advocate.

In his defense you have heard evidence that in countries where this scheme has been in operation vital statistics fail to show health conditions as good as in our own land, the healthiest in the world. But the answer comes that the plan might work better in this country than in England or Germany. We asked and failed to get an answer, whether government here had proved itself able to administer affairs even as well as in those European countries where health insurance has dismally failed to produce conditions as favourable as already exist in America.

The substance of the doctor's defense is that he cannot do his best work under health insurance, whose incentives and rewards will be alien to the attainment of excellence. The doctor submits that doing less than his best will effect a gradual deterioration of his character, lowering the quality of medical service. Obviously nobody wants this. Here, then, is a sharp conflict of opinion. The witnesses on the other side, who are not doctors, can see no reason why this should be so. We contend that if they were doctors they could see it. On this clear-cut issue you are forced to decide which view is most likely to be right.

Now I ask you to decide that the doctor is most likely to be right because of all that you know about him. Certainly he has the best reason to be right, spending his life in the care of the sick. You see him constantly trying to eliminate the causes of disease, knowing full well that the greater his success the less will be the demand and the pay for his services. Now if his opposition were affected by his financial interest would not this grasping attitude be reflected in other things that he does? Would he not patent his discoveries and sell them at a high price? Would he not demand pay in advance everywhere he goes? Having the power to heal, and having, at the moment of greatest suffering and anxiety, when he is first called, the opportunity to exploit the sick, why does he not do so, if he is the type of man to think first of his own selfish interest? If money alone were his aim, would he spend it for post-graduate education to better discipline himself to serve you? Would he advocate always those measures, in the profession and out of it, which make it more difficult to become and to remain a doctor, to the end that the bungler, the incompetent, and the mercenary may not impose on the credulity of the sick under the sanction of the superiority which the title of physician gives him? Yes, there is self-interest here, of the sort that is contained in the struggle for perfection, but it is the kind of self-interest which protects the public more than it protects the doctor.

When your life is in danger through sickness you place your entire being unreservedly in his hands with full confidence in his ability. Don't you think he is worthy of trust in deciding this matter? Don't you think he *must* know, better than any one else, when he says that this scheme will make it impossible for him to render you full service, impossible for him to continue to be as worthy of your confidence as he is now? Who knows any better than he does, what will happen to him, and by the same token, what will happen to you? Certainly none of the other witnesses you have heard are likely to know so well. They cannot see the situation as realistically as he does because they are not men actively engaged in giving medical care to people.

This is a bauble gift which is offered you. It will vanish at the touch. There is no substance in it. It is a part of the corrupting psychology of the day that we can get some-

thing for nothing; that life can be made easier than Nature intended it to be. Few have the courage to say with Cassius, "The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings." During the difficult recent years the ego of the crowd has been unable to bear the knowledge of its incapacity to walk on its own feet, and so there must be scapegoats. The demagogue began to feed the crowd the flattery which it has loved to hear throughout all ages of history. The people were given "*panem et circenses*." The mob was fired with zeal to find, and to punish, those who had brought about their confusion and despair. Now, today, in this forum of public opinion, the doctor is the last of these scapegoats to be put into the dock. If you decide against him, it will not be the first time that the world has turned against its real benefactors.

You have been told that many are without medical care, but you have not been told how many. The statistician who testified showed you figures that more than ninety percent of the people who were questioned in a survey covering a certain year were able to obtain medical care. Yet the statistician did nothing to find out why less than ten percent went without it. That question was not asked. There is no evidence before you whatever that any one seeking medical care was denied it.

Members of the jury, you cannot be healed unless you seek to be healed. A system of medical care cannot be forced upon you to good purpose. It cannot be, and it should not be, brought to you without effort or sacrifice on your part. Its acceptance by you will be measured by the value which you put upon it, and having given little, you will receive little. This is a law which cannot be escaped. It is with the illness of the flesh as with that of the spirit: "Seek and ye shall find."

Ladies and gentlemen of the jury, the fate of the doctor is in your hands. You can make him master of his house, or servant in the house of another. But whether he be master or servant he will still try to heal the sick, for such is his nature, different than that of other men. Healing has been his chief concern since the early dawn of recorded history. It is his chief concern today. It will be his chief concern to-morrow. Take his tools away and still he will seek to heal the sick. Relax his disciplines and still he

will seek to heal the sick. Put over him a clerk to dictate his prescriptions, a supervisor to interfere with his diagnosis, he will yet attempt to heal the sick. History recounts that the long list of physicians who ranked high in favour of the public for achievements in other walks of life were doctors first, and second they might be governors, as John Winthrop of Connecticut, or William Bull of South Carolina; or soldiers, as Leonard Wood, Walter Reed, and William C. Gorgas; members of the Continental Congress and a signer of the Declaration of Independence as Benjamin Rush; authors as Oliver Wendell Holmes and S. Weir Mitchell; an etcher as Sir Seymour Haden, or a social reformer as Rudolph Virchow; and still their first concern has been the healing of the sick.

In the second century many a great Roman relied upon the good offices of a medical slave, and though the Doctor of Tomorrow become your slave he will be healing you. In the darkness of the middle ages, with his skill taken from him in ways different from, but in effect similar to, what you are asked to do to him now, nevertheless, he tried to heal the sick. We find him as Guy de Chauliac, chaplain and physician to three popes in the fourteenth century; we find him as Francois Rebelais in the fifteenth century, author and physician; later in the seventeenth we find him as Thomas Sydenham, a puritan captain of horse in the Civil Wars, but his first concern was to heal the sick. In our own time, Sun Yet Sen and Georges Clemenceau offer plenty of proof that the physician, drawn aside to other paths in life, retains a native instinct to bind up the wounds which society inflicts upon itself, even when the wounds are sustained in contests against such wise leadership as the physician himself represents.

Perhaps the doctor is now to pay the penalty which often is exacted of the honest man. It is said that "Glad are the feet of him who brings good tidings." But the doctor recognizes the charlatan in many an optimist. The doctor knows that sickness, accident, and death must come to all of us. He knows that he who seeks to moderate the cruelty of these ills must work hard for this accomplishment. He knows that life is meant to be difficult, that rewards are meant to have their price, that things ought not to be made to seem easier than they really are. He has

had the courage to tell you this, in the very teeth of the quack who would make you think that you are under-privileged. He knows that nature has been working for millions of years to make man fit to pay a great price to insure his own existence, and that the best health insurance that can ever be obtained is that which comes individually by struggling to get it. The doctor knows, and he has said, that mankind cannot rely for self-improvement upon mere legislation put into operation by a beneficent government. The doctor knows that the man of yesterday, today, and tomorrow is lost who depends for his salvation on giving less to society in order to get more. His advice has been frequently unpleasant, his instructions often entailed personal effort and self-denial, his warnings on occasion have been ominous. His feet were not always glad.

He has had the courage to tell you these things in the face of the popular clamor that some mysterious force has stolen your birth-right, which the *magi* will now return to you.

He has had the courage to tell you these things because they are the truth. Even he has sought the truth about life and death. He is different than other men. He is not to be judged by the standards of other men. He will not bring you good tidings for the pleasure of seeing your faces beam with pleasure, unless they are true tidings. For he knows that this is only to ponder to a worse ailment than any we are trying to remedy, including false hopes which can be cured only by the ultimate tragedy of disillusionment. As is his way, he has told you the truth, that life is hard, the way to the hilltop long and steep and difficult. For his plain speaking it is possible that you may condemn him, for he has been condemned by others before because he did not applaud ignorant altruism, change which was not progress.

But no matter what you do to him, he heals the sick today and will still heal them tomorrow. "For in today already walks tomorrow." Under socialism, dictatorship, monarchy, despotism, or democracy, still he will heal the sick, as best he can. If you try to pluck him by the arm, he will pull himself away to keep on in the path he has chosen, though it now be a tortuous one, for he is not as other men are, easily persuaded. You may call after him: "But here is a

different way for you to be paid, so you can make more money and heal more people." His reply will be: "Do not hinder me. What do you mean, 'more people'?" My hands are full; day and night I care for those who come to me, who need me most and prove it by the act of seeking me. My time belongs to them, not to others who through indifference or ignorance may have no faith in me, though I run after them. I am too busy to experiment with plans and schemes. I must heal the sick."

Whatever you do to the doctor you can not divest him of this privilege, responsibility, and prerogative, which at long last, is what matters most to him and to you.

So now I leave with you, members of the jury, the fate of the accused. Do with him as you will. Do with him as you must, under the law and the evidence; remembering, as you consider your verdict, that it will be as momentous a decision for you as it will be for him; remembering that he brought you into the world and helped to keep you here.

Thus might the doctor's advocate present his defense at the bar of public opinion.

We all await the verdict.

The Journal of Medicine March, 1937.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

(The Eye, Ear, Nose and Throat Monthly)

Resume on Allergy.

(1) Allergy may briefly be defined as a natural sensitiveness of the organism to a chemical or physical substance which is harmless to most individuals.

(2) The symptoms of the allergic reaction may occur in any part of the body and depending upon the location of the reaction we may have asthma, hay fever, hyperesthetic rhinitis, eczema, urticaria, angioneurotic edema, gastro intestinal allergy, migraine, vernal conjunctivitis and other less important conditions.

(3) The allergic predisposition is inherited. In lower animals the anaphylactic tendency is not inherited but depends upon the action of a sensitizing dose of the ant

(4)—Etiology:

A. Inherited tendency toward but this does not mean the inherit

specific form of allergy or sensitiveness toward a specific antigen.

B. Exciting factors. The allergic individual becomes sensitized to some particular substance and upon second exposure the attack ensues. The attack occurs, therefore, when the individual is secondarily exposed to that amount of antigen beyond his or her tolerance. The substances capable of exciting allergic manifestations are endless.

- (1) Foods by ingestion or direct contact.
- (2) Epidermals: hair, dander, feathers, etc.
- (3) Pollens.
- (4) Miscellaneous: orris root, drugs, chemical, bacteria and bacterial products.

C. Contributing factors to the allergic manifestation include mechanical (dust, sand, chalk), chemical irritants (gasoline, turpentine acid fumes); thermal (heat, cold, humidity); infectious (bronchitis, sinusitis); and neurogenic (excitement, annoyance, anger, fear). Some factors ordinarily considered as secondary may at times be primary—especially heat, cold and light.

(5) Diagnosis:

A. Nature of the attack such as hay fever, wheezing, urticaria, dyspepsia, coughing, gastro enteritis, etc.

B. Heredity.

C. Eosinophilia.

D. Positive skin tests and history of exposure to positively tested antigen.

(6) Skin tests should include tests by all antigens with which the sufferer comes in contact.

(7) Treatment consists in either the elimination of the offending substance or of desensitizing the individual by the injection of extracts of the material to which the patient is sensitive, beginning with minute doses and gradually increasing it as tolerance increases. The object of the treatment is to reach a dose high enough to protect the individual from the natural exposure to that substance.

The spotting of the specific antigen in a given case is not altogether an easy task and requires time, patience and numerous tests. Moreover an individual may become sensitive to different antigens from time to time. The fact that an individual is sensitive to a certain antigen as evidenced by a positive test does not apply that the antigen is

the cause of symptoms. One or more other antigens may be operative. When the offending antigen or antigens have been discovered, avoidance of any contact therewith or desensitization thereto almost always affords marked, and more often than not complete relief. In the meantime attention to the secondary causes as enumerated above, attention to hygiene and general health and such symptomatic measures as epinephrine and ephedrine should not be overlooked.

Prevention of Chronic Sinusitis

REA E. ASHLEY

Southwestern Med. 20:349 (Sept.) 1936

Too little attention has been paid to the prevention of chronic sinusitis. We are beginning to realize that the majority of chronic sinus infections can be prevented by proper treatment of their etiologic factors. We now appreciate better than before the role of diet, the endocrines, allergy, and improper local treatment of the nose during the common cold, in the development of chronic sinusitis. Preventive treatment must begin during the early years of life. In the main the predisposing causes of chronic sinusitis can be placed in four general groups: physiological effects, malformation of the structural framework of the nose, allergic tendencies, and infections.

Ashley reviews the pathology of the nose in head colds, especially the work of Fink, Kerr, and Dechez, and then presents the following hypothesis:

First, the common cold, in its early stages at least, is primarily a transient allergic manifestation.

Second, this allergy develops because of a filterable virus made active by the failure of the body to adjust itself to unfavourable climate and environment.

Third, the purulent discharge follows the invasion of the tissues by a variety of bacteria superimposed on a vulnerable, allergically prepared mucous membrane. These bacteria may be present within the body itself—in the sinuses, tonsils, or adenoids—or they may be introduced from without.

Fourth, most of the serious complications are due to the secondary and not to the primary invaders.

The allergic theory is substantiated by the nasal congestion with watery discharge from the nose and eyes, the sneezing, lack of fever, the marked increase in eosinophiles in the stroma and secretion, absence of leucocytes, and absence of bacteria in the tissues. The rationale of the treatment as employed by the author is based on the assumption that this theory is correct. An outline of the general plan of treatment includes the following procedures:

When the patient is seen early the usual advice as to elimination, room temperature, diet, etc., is given, with instructions to take every 3 hours a capsule containing $\frac{1}{4}$ grain ephedrine, $\frac{3}{8}$ grain luminal, and $\frac{1}{600}$ grain atropine.

Ephedrine internally has a definite action in reducing swelling of the congested nasal mucosa. Luminal gives the patient a feeling of well-being and tends to check unpleasant nervous reactions from the ephedrine. Atropine lessens excessive nasal secretions and stimulates the sympathetic nervous system, thus aiding in diminishing the nasal congestion.

Active local treatment is begun at the first sign of nasal congestion, and aims at the establishment and maintenance of free aeration and free drainage. This is accomplished by depleting the congested nasal mucous membrane, by stimulating the vasoconstrictors with early return of the blood vessels to normal, and stimulating the cilia to removal of excess mucus.

Regardless of the severity of the attack, and the age of the individual, the local treatment is as follows:

Thin strips of cotton saturated with a solution of 5 per cent neosilvol and $\frac{1}{4}$ per cent neosynephrin (buffered to an Hp. of 7.3) are gently packed into the nose with a bayonet forceps; the excess solution of the strips will run into the nasopharynx. The strips should fit snugly, but not tightly. The first strip is placed between the septum and the middle turbinate, as high up and as far back as possible. The second strip is placed between the inferior turbinate and the septum, extending well back and up into the middle meatus. When space in the nasal cavity permits, a third strip is placed low down on the floor of the nose in contact with the inferior turbinate throughout its entire length.

The strips are allowed to remain in place for about 10 minutes. The patient is then instructed to blow the nose gently; usually a copious amount of mucus is expelled. If the mucus cannot be blown out, the nasal cavity is sprayed with warm Ringer's Solution, which not only dislodges the mucus but seems to have a tonic effect on the nasal mucosa. Examination of the nasal cavity then shows the mucous membrane greatly depleted, with space for drainage and breathing.

The ideal treatment is twice a day for the first few days, then once a day as the symptoms subside, and finally the interval between treatments is lengthened, depending on the clinical appearance of the membrane and cessation of symptoms. The treatment is of value even after the purulent stage is well advanced, because it facilitates drainage and relieves the nasal congestion. Home treatment consists of a spray containing $\frac{1}{4}$ per cent isotonic neosynephrin buffered to 7.3 Hp., used as frequently as necessary to maintain adequate nasal respiration.

Headaches of Nasal Origin

T. S. BURGESS

Fulton Co. M. S. Bul. 10:5 (Sept. 3) 1936.

Headaches of nasal origin may be classified as follows:

(1) Those associated with suppurative sinus infection. (2) Those associated with nonsuppurative or hyperplastic sinusitis. (3) Those without any involvement of the sinuses. The latter group may be further subdivided into vacuum headaches, and the neuralgias.

Suppurative sinus headaches are easily diagnosed and caused probably by the pressure of enclosed pus. Frontal, anterior ethmoid, and maxillary sinuses produce pain above the eye on the involved side. Posterior ethmoid, and sphenoid produce pain in the parietal and occipital regions. Acute sinusitis is accompanied by tenderness to pressure over the involved sinus. Usually there is no tenderness in chronic cases.

Hyperplastic ethmoiditis and sphenoiditis produce pain of the neuralgic type from involvement of the contiguous nerve trunks. It is usually located in the temporal and occipital region, occasionally frontal.

Vacuum headaches are due to some obstruction interfering with the free exchange of air between the nose and sinus. It is most common for the frontal sinus, but has been described for an anterior ethmoid. The sinus itself is normal. It may be due simply to subacute swelling of the mucous membrane about the ostium of a sinus, or it may be due to a deviated septum, enlarged middle turbinate, or hypertrophied uncinat process. Relieving the obstruction cures the headache.

Neuralgias are those of the supraorbital, anterior nasal, and infraorbital nerves, and the sphenopaleatine ganglion syndrome. Headaches have also been described from involvement of the vidian nerve. The first three types are marked by pain in the areas of distribution of the involved nerve, and tenderness to pressure over the nerve. The sphenopaleatine syndrome is most interesting. It is due to involvement of a sphenopaleatine ganglion, which is a very important nervous structure located just lateral to the mucous membrane behind posterior tip of each middle turbinate. The late Greenfield Sluder was the first to describe this as well as the vidian syndrome, and made a very extensive study of the problem. In both of these conditions headache is located on the side and back of the head and never crosses the midline. Therapeutic test is application of cocaine to the region of the nerve structure, which should result in prompt relief of the headache. Treatment consists in application of drugs to this region, or alcohol injection of the nervous structure. Two cases illustrating sphenopaleatine ganglion neuralgia were presented.

Diathermic Tonsillectomy by Electrocoagulation

R. C. McLAUGHLIN.

California & West. Med. 43:39 (July) 1935

Tonsillar remnants may be removed with little trauma or inconvenience as possible. Patients who require tonsillectomy, and who are partially or wholly disabled with such diseases as tuberculosis of the lungs or glands (scrofula), cardiac lesions, hemophilia, make suitable subjects. In certain individual cases where the tonsils, acting as foci of infection producing pathologic changes in other parts of the body, may be treated and sterilized

effectively by electrocoagulation without their complete removal. Hemorrhage is less frequent by this method, and carries some economic advantages.

There are also certain disadvantages in the method.

For their complete removal tonsils require frequent treatments at intervals of seven to ten days and lasting over a period of six to eight weeks. Some patients become impatient of this lengthy treatment, despite their initial enthusiasm, and require considerable persuasion to complete their treatments. Sore throat follows each diathermic application in varying degrees, as well as some toxic absorption. This produces more or less fatigue. In a few cases the soft palate and uvula become quite swollen, but is usually shorter than that following surgical tonsillectomy. Complete removal of the tonsils is not always accomplished because definite knowledge of removal of the capsule cannot be certain, as in the surgical tonsillectomy. Portions of tonsillar tissue may remain, and may become embedded and concealed by scar tissue. In the author's experience scar tissue formation is much more common following the diathermic method than the surgical method. It is difficult to determine, at or near the final treatment, whether one is coagulating lymphoid or muscular tissue.

Cancer of the Esophagus

WILLIAM L. WATSON

New York S.J.M. 36:1615 (Nov.) 1936.

Treatment of esophageal cancer by divided doses of X-ray is usually followed by symptomatic and radiographic evidence of improvement and occasionally apparent complete regression of tumor occurs. Of sixty-eight cases so treated, thirty-three are alive; eight for one year or more and two for two years. In the previous series of cases the average length of life for all cases was 4.8 months.

If a radium tandem is to be used, heavy filtration of the capsules is recommended.

Surgical exposure of esophageal cancer and implantation of gold-filtered radon seeds into the tumor and tumor bed is suggested as a method of treatment offering several logical advantages.

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MEDICAL ASSOCIATIONS.

The past and the present Secretaries of the Ramnad District Medical Association are mainly responsible for making us write a few lines about Medical Associations in this country, if not in this Province. We had not only an invitation to attend the Ramnad District Medical Association on 10-3-37 but had actual pressure to attend this function to which we could not but yield, the invitation from the secretaries being more than a formal one. The fact that a prominent member of the Madras Provincial Medical Service was to preside over the gathering was yet another factor which prompted us to go to Karaikudi where the members of the Medical Profession of Ramnad District were to meet. We cannot hide yet another circumstance which attracted us to Karaikudi. We have been hearing these few years that Independent Medical Practitioners in Ramnad and neighbouring Districts had the courage of starting and successfully conducting private hospitals to give medical relief to the public suffering from not only general medical and surgical diseases but also in the special diseases such as those of the Eye, Ear, Nose and Throat. This being the realisation of the vision which The Medical Practitioner had in the distant horizon of the Medical World in India, a country which is a world in itself, we yearned to have a personal vision in close quarters. Our impressions about these private institutions will appear elsewhere in these columns as the subject matter to be treated in these columns is about Medical Associations.

The need of the Medical Associations and their aims and objects are well known to

the members of the medical profession as the scientific truths are, which enable them to exercise their profession; but, unfortunately if one were to judge the utility of these Associations by the strength of the members belonging to them, the conclusions arrived at, are as astounding as they are true. The causes of this unbelievable truth are not far to seek. Medical Services and Medical Education are at the root of all these causes. In all other civilised countries, service in whatever department followed education. It might be so with all other services except the Medical Services in this country. It has not been possible to demonstrate in this unfortunate country that there is only one scientific system of Medicine. The Government have been mostly responsible for the existence of this confusion of faith in the scientific system of Medicine, by establishing rival medical schools to teach indigenous systems of medicine all of which could have been incorporated into one scientific system by introducing special courses of study in the existing Medical Colleges and Schools. Political ambition more than patriotism has been responsible for these state of affairs. It may be said that this was so at least in this Province. The late Raja of Panagal established a school of Indian Medicine in Madras but the painful fact that he preferred to die in the hands of doctors not trained in the school which he started, should convince all other apparently doubting politicians and real exponents of indigenous systems of medicine, that the origin of establishing a School of Indian Medicine in Madras at least was Politics and not Science. By this, we do not mean to say that Indigenous systems are unscientific. It is quite possible, as

mentioned by us above, to incorporate all systems of Medicine into one Scientific entity to cure human ills, if honest attempts are made in this direction.

With the advent of British rule, the British Government first had their doctors imported into this country from Great Britain and as the exigencies of Military rule had to precede the civil administration, the Government naturally preferred and found it more economical to have the Military Doctors to treat even the civil population as the safety of civilians depended in those days of warfare, on the Military. After some time, the Military Doctors found the need of Assistants to help them in the hospitals but not outside hospitals. It was found cheaper to train the *natives* for this purpose. So the imparting of the knowledge to the menial assistants to Military doctors necessitated training classes for these which gradually grew into Medical Schools and Colleges. Till about quarter of a century ago, those trained even in Medical Colleges could ordinarily be assistants, though of a higher order than those trained in the Medical Schools. As the civil administration expanded, the Government had to employ proportionately more Indians in subordinate service and the needs of medical relief also grew. So, primarily to look after these subordinates, Government had to establish Dispensaries and Hospitals. These were put in charge of those trained in schools and colleges respectively. With the growth of these institutions, the faith of the people in Allopathic system increased and the young *natives* of the land thought it useful to undergo training in these military schools and colleges as civil pupils. When the civil pupils outnumbered those required for military, the Government established civil dispensaries and hospitals and put the civil pupils in charge of them as Hospital Assistants and Apothecaries. From the Hospital Assistants evolved the Sub Assistant Surgeon called Licensed Medical Practitioner, if he chose independent practice and from the apothecaries evolved the Civil Assistant Surgeons who had the University qualifications. So the history is plain and uncontrovertible that Medical Education followed Medical Service in this country. So it is no wonder that Medical Services rule the medical profession and the Indian Military Service, conveniently known as Indian Medical Service, has the lion's share in the rule.

Naturally, the history of evolution of Medical Associations depended entirely on the history of medical services and not on the growth of scientific system of Medicine, as prevailing in other countries. Without going into the past history of all the Medical Associations, we will only refer to a few typical ones and among these there are two of the All India type, the older of the two being the All India Medical Licentiates' Association and the younger of recent origin is the Indian Medical Association. The former, as its name implies, admits only the Medical Licentiates and the latter admits practitioners of all denominations, belonging to the scientific system of Medicine. The Medical Licentiates' Association was started primarily for agitating against service grievances. The incentive to start the Indian Medical Association was also grievance but against medical services, especially the superior as against the subordinate service. Both these Associations justify their existence but both are not popular to the extent they deserve to be, as the grievances to guard against which they were started have been assuming different forms as time passed. The pay, prospects and other emoluments for Sub Assistant Surgeons had reached such a stage that the concern for these items of agitation cannot at present serve any purpose and the association should sooner or later change the mode of its existence if it were to continue its prosperity, much more its utility. The Indian Medical Association should concentrate its activities more to put down the castes and creeds in the profession than to secure the superior coveted positions now occupied by the I. M. S. Provincial Autonomy should be taken advantage of and may be done so with all its defects without necessarily lessening the universal zeal to attain swaraj. Serious attempts should be made to have one uniform standard of medical education in the near future and the inferiority and superiority complexes should be made to disappear at least in the working of Medical Association though it may be difficult to cure individual idiosyncrasies.

The Presidential Address delivered by Dr. Tirumurti, a prominent and popular member of the profession, and as popular a figure in the Madras Provincial Service, has been published elsewhere and we draw the attention of the readers to the same. He has demonstrated that it is possible to participate

and popularise the noble dictums of the profession, without abusing the official individuality. We cannot put a professor of pathology in the category of an orator and we presume Dr. Tirumurti will not find fault with us on this account but we can certainly say that none could invent and formulate a better motto for the Medical Associations to follow than the one he placed before the Ramnad District Medical Association in the following words:

"A Medical Association is not a trades union. It is a fraternity of enlightenment and culture. Service and Sacrifice are its watchwords. To import the paltry spirit of bargaining into it is to sound the death-knell of the calling."

Soon after Dr. Tirumurti placed his motto before the audience, he said that 'it is a good sign of the times that we have practically in every district in our Presidency, a District Medical Association.' The 'good sign' was a real vision to us when we saw a decent gathering of members of a district medical association coming from distant places eager to make the function a success in contrast to what we have been seeing in enlightened cities where such gatherings of members residing in a city with all possible facilities of conveyance, had to be adjourned for want of quorum. We were delighted the more, when we saw in the gathering medical men running private hospitals of their own, in addition to the missionary doctors from neighbouring stations, all of whom found time to attend the Annual Meeting of their Association. It was also a matter of great satisfaction that a medical officer in charge of a neighbouring district did not only respond to the invitation but materially helped the function by taking upon himself, without notice, the responsibility of delivering a lecture on Empyema, a duty assigned to somebody else who could not respond to the invitation.

It must be a great pleasure to Dr. Tirumurti and as great a pleasure to those who could imagine the high and noble implications conveyed in his motto to have a practical demonstration of at least some of the tenets in the motto.

The self training Dr. Tirumurti has been having as a Pathologist must have stood him in good stead in making researches in the pathology of the rickety growth of medical associations in which there are 'no artificial bars to membership.' He rightly

pointed out the diseased spots and these he said, were 'the suspicious, the hesitant, and the unwilling.' But we cannot agree with his modest calculations that they were 'very few.' Dr. Tirumurti had suggested rational treatment to cure suspiciousness, hesitancy and unwillingness. We do not find any necessity to reiterate the remedies but will refer our readers to Dr. Tirumurti's address published elsewhere, in full. The treatment suggested in the Presidential address was not only curative but preventive also. The advice to the public referred to, in the address, regarding the selection of a doctor will certainly serve as a good preventive remedy in popularising medical associations.

Medical Ethics and the responsibility of the medical profession to the society were also dealt in the Presidential address. Violation of the Code of Medical Ethics seems to be more common than it is usually considered to be so. The Medical Councils which have statutory disciplinary control over the registered medical practitioners receive a large number of complaints from some practitioners against others. But generally the complaint is the result of an existing jealousy and not a sincere and honest attempt to correct an erring brother. Even for crimes, reformation is considered a more suitable punishment. The chances of jealousy in these complaints will be far less if all the practising doctors are members of a common Association which is run on the lines of Dr. Tirumurti's motto.

The only profession which cannot afford to neglect the social well-being of the people is the medical profession, as this item is of vital importance in the treatment of diseases. The ills of society apart from actual diseases cannot be cured by prescriptions of doctors either written or oral, however eminent. Mass action is necessary to cure these ills and the only places to discuss these social problems are medical associations. The Medical Associations in this country should take a lesson from the British Medical Association where it is said the Parliament does not venture to pass any Bill concerning the welfare of the public, unless this association is consulted. Associations can claim authority if they are really representative and strong. The existence of sectarian associations having a variety of conflicting interests cannot even help its members to carry out their programme.

Unlike as in other countries in the west and in America, Great Britain has been running medical schools and colleges for the purpose of granting several diplomas and degrees. Yet it has been possible for the profession to be united under one association as the Parliament does not interfere to create invidious distinctions in those possessing variety of medical qualifications all of whom are treated alike for the exercise of the medical profession either in Government or private institutions giving medical relief. So, as mentioned by us above, the first attempt to attain solidarity in the medical profession should be reform in the Medical Education so as to have one uniform standard.

The District Medical Associations and others run on non-sectarian principles will gain more strength and ensure their popularity if they inculcate in their motto one more tenet 'all for one and one for all'. This is at present conspicuously absent even in the Sectarian Associations which at times appear as if existing for a few individuals. The Associations should be made to exist for guarding against legitimate grievances of its members either of an individual or of a group of individuals.

It may be possible for the votaries of all other professions not to think of God and take full credit for all their achievements. But in the medical profession, even the most eminent member is humiliated one day or other that his care and skill, however sincere and devoted, cannot at times count to save his patient's life. He will also be convinced that patients whom he never thought would survive a particular illness rallying round most wonderfully. So it is not possible for the members of the profession to forget the wonders of Nature, otherwise known as Divine Force. Above all other things, if a Spirit of Godliness prevails amongst the members of the profession, they can run not only Medical Associations worthy of the profession to which they belong but bring relief to the suffering humanity with little or no disappointments.

OURSELVES.

The Medical Practitioner was brought into existence to devote itself for the uplift of the Medical Profession in this country. With the above object in view, it has been agitating against the water-tight compartments in the profession brought about by the pernicious system of Medical Education. The journal has been doing propaganda and serving the profession to bring about harmony and with it prosperity. The incentive to start the journal was the unsatisfactory state of affairs which existed in the Madras Medical Council prior to 1929 when Dr. Kamath contested a seat in that Council and gave a pledge to the electorate that if he was returned he would start a journal not only to set right the affairs of the office of the Council but to do service to the profession in all possible and desirable ways. Thanks to the members of the profession with whose help and co-operation it was possible for The Medical Practitioner to agitate and make the Registrar, Madras Medical Council, work the office of the Medical Council with a level of efficiency contemplated in the existing Medical Act and the rules framed thereunder. It may be imagined to what extent the affairs of the Madras Medical Council drifted prior to 1929 and till about the year 1934 when its Registrar did not do the most important duty of publishing the Medical Registers in time. The most chronic and indolent sore of want of uniformity in the standard of medical education which has been eating the vitals of the medical profession and for which no sound and rational treatment could be thought of so far is bound to heal if the Governments in this country and of this province in particular carry out the reform suggested by the Madras Medical Council regarding the Medical Education of the Licentiates, which has been brought to a standard identical to that of the University graduates and the general educational qualification of the entrants to the Medical Schools is raised to the Intermediate standard. The Medical Practitioner, whose Editor is a member of the Madras Medical Council has been responsible for the initiation of this reform and the profession, especially the Licentiate section of it should be thankful to the members of the Special Committee deputed for this work by the Madras Medical Council, who with the

help of the Convenor and Chairman of the Committee worked out the details. We trust that those who are interested in the harmonious growth of the medical profession in this country will make this reform an item of practical politics which they could do with little or no difficulty and as expeditiously during these days of Provincial Autonomy.

The Medical Practitioner having played its modest part in realising and bringing over the first and the most formidable difficulty which has been obstructing the homogeneous growth of the medical profession or at least having shown the path towards it, now intends to devote its columns on a larger scale than it has been doing for the discussion of medical subjects and keep its readers in touch with the advances in the different branches of Medical Science for the benefit of its readers, a large section of which are mofussilites,—if we may use an Anglo-Indian colloquial expression—having little or no facilities for post-graduate training. The Medical Practitioner being an organ for propaganda and service and as this can be possible if only a large section of the profession read the journal, the management did fix the subscription at an humble figure of only Rs. 2 a year, an amount which hardly pays the cost of the journal though it may help to run its machinery. It is not possible for the management to make the journal a paying concern. For, disinterested public work is incompatible with the worship of Mammon. Public work is the creation of public spirit, a commodity being invisible, cannot be made available for sale. But the work of its creation is visible as is the world, the creation of the Almighty.

As our capital for conducting the journal is not money, we took some time to search after our collaborators amongst the members of the Independent Medical Profession, who are likely to co-operate with us in our service to the medical profession. We are glad to announce that we can in future depend upon the permanent help of an auspicious number of five, each representing a special branch in Medical Science. As our readers, especially those outside this province, are likely to be inquisitive who they are, we are introducing them through these columns.

Dr. K. Narayanamurthi, M.D., will be in charge of Medicine, including the Tropical Diseases in which all of us, living in Tropical India, are and should be specially interested. Dr. Murthi soon after he graduated at the Madras Medical College underwent the usual course of a House Surgeon, and conducted research in Pernicious Anaemia and Sprue under the Madras University from 1929 to 1931, being granted the Fellowship of that University. During this period, he was deputed to the Tropical School of Medicine, Calcutta to work under the late Col. Acton, Director of the School to make a special study in Haematology. From 1931 to 1934, Dr. Murthi got exceptional opportunities for conducting investigations in connection with Anaemias of Pregnancy under the Indian Research Fund Association. During this period, he collected statistical information regarding Maternal Mortality and Morbidity in the city of Madras. Soon after, he spent nearly a year in tracing Radiological findings in Sprue which he did in collaboration with the staff of the Government Radiological Institute, Madras.

Dr. B. M. Sundaravadanam, B.A., M.B., F.R.C.S., (Eng), Honorary Surgeon, Government General Hospital, Madras, will contribute articles in General Surgery, his speciality. Dr. Sundaravadanam, after graduating in Arts at the Madras Christian College, joined the Madras Medical College and after a successful career in that institution spent a year at the General Hospital undergoing training as a House Surgeon. In 1927, Dr. Sundaravadanam went to England for higher studies. After qualifying himself as M.R.C.S. & L. R. C. P. (Lond.) he became a Fellow of the Royal College of Surgeons (England) in 1931. From England, he went to Vienna and underwent special Post-Graduate courses in Surgery. Soon after he returned to India, he was first appointed as an Honorary Surgeon, Government Royapettah Hospital, Madras, where he worked for about two years and a half. After the Madras Government General Hospital was equipped with additional Surgical Blocks, Dr. Sundaravadanam was appointed as a Surgeon in this hospital where he has been working for the last two years. This is the first Honorary appointment in the Government General Hospital for a Surgeon from

amongst the members of the independent medical profession. It may also be said that Dr. Sundaravadanam is the first F.R.C.S. (Eng) amongst the members of the independent medical profession.

Dr. M. Subramania Aiyar, B. A., M. B. C. M.; the oldest graduate in Medicine amongst the members of the independent profession now in active practice in Madras, will fill the columns in the Journal pertaining to Midwifery and Gynaecology. Dr. Aiyar first qualified himself as a Graduate in Arts from the Presidency College and became a Graduate in Medicine in 1901 and entered the Madras Provincial Service in the same year and served as an Asst. Surgeon in the then Government Maternity Hospital, Madras, now called the Hospital for women & Children. On account of exigencies of service, he had to be transferred out of Madras, as Sanitary Assistant to a District Medical Officer, a job for which Dr. Aiyar had no liking. So he resigned Government service in 1907, and started the life of an independent medical practitioner in Madras where he has been since practising. After the re-organisation of the Honorary Medical Service in this Presidency, Dr. Subramania Aiyar was appointed in 1925 as an Honorary Physician in the same Hospital, where he served the first six years of his professional life as an Assistant Surgeon in Government service. At his 60th year, he had to give up honorary service due to age restriction. Though styled as Honorary Physician, he held equal professional rank and status with his stipendiary colleagues in the hospital who are now styled as Obstetric Surgeons, the first such Surgeon being the Superintendent of the Hospital. It will not be out of place if we were to mention that Dr. Subramania Aiyar was a personal friend of our lamented, senior Editor, the late Dr. M. S. Krishnamurti Aiyar, and it will please even the departed soul to see Dr. Subramanyam Aiyar associating himself with the activities of The Medical Practitioner, of which the late Dr. Krishnamurthi Aiyar was one of the two origin founders.

Dr. G. Joseph Gnanadickam, who till 1934, was in charge of the Ophthalmic section of the Tirupattur Swedish Mission Hospital will look after the special Ophthalmic columns of The Medical Practitioner. Dr. Joseph, as he is popularly known, joined the Swedish Mission Hospital in

1925 soon after he passed from the Madras Medical School. Dr. F. Kugelberg, M.D. who made a name as a famous Eye Surgeon in Southern India was the origin founder of this Missionary institution which came into existence in 1919. During the period when Dr. Joseph was in Missionary service, over 2000 Eye operations were performed yearly, of which not less than 700 were for Cataract and about 100 for Glaucoma (Trepining). Dr. Joseph was in sole charge of the Eye work in this institution from 1930 to 1934 when he left this hospital and started a private Eye Hospital in Trichinopoly. Dr. Joseph has carried with him not only the skill of an Ophthalmic Surgeon but also the true instincts of Missionary spirit of service, both of which are conspicuous in the Joseph Eye Hospital at Trichinopoly.

D. T. S. Shetty of Chettinad will give the readers the benefit of his knowledge in the diseases of Ear, Nose & Throat. After qualifying himself at the Madras Medical School in 1925, and working as a House Surgeon at the Government Royapuram Hospital, he served in a private charitable Hospital at Kanadukathan, known as S. A. Hospital, till 1930 when he went to Vienna for specialising in Eye, Ear, Nose and Throat Surgery. After spending one and a half years in Vienna, he returned to India and joined duty at the S. A. Hospital. As this hospital had not the necessary equipment for him to exercise his special knowledge in the Ear, Nose and Throat diseases, Dr. Shetty ran a private clinic in addition to the S. A. Hospital. But the pressure of special work was such that he left private service and opened a private hospital of his own in 1934, for the treatment of diseases of his speciality for the benefit of the poor as well as the rich, the former being treated free. The special hospital has an outpatient attendance of 50 on an average, and there is accommodation for 15 inpatients in detached wards.

In addition to the above five members of the Independent Medical Profession to whom we are grateful for having consented to serve the profession by giving its members the benefit of their special knowledge, there will be others in Government service working in City Hospitals whom we have requested to help our readers with their valuable experience, not merely of academic interest but such as may be useful to the

general practitioners many of whom either for want of time or facilities or both cannot afford to visit the well equipped City Hospitals. It has also to be said that even in case they can afford to come to Madras for special training there is no provision in any of the teaching institutions now existing to meet the demand of post graduate training. We have in contemplation an idea to make a humble beginning by instituting a Poly-clinic with the help of those who are capable of running the same not only to advise and treat patients but teach those who desire to learn, especially the junior members before they begin their career as general practitioners. It has been our sad experience that in spite of increased period of training both in Colleges and Schools and the House-Surgeon courses immediately following such training, those just entering the profession are lacking in necessary experience for private practice. It is our earnest desire to make The Medical Practitioner useful and attractive both to the junior as well as senior practitioners to the extent our financial position may permit.

News and Comments.

Unemployment: For a long time this question has been looming in the minds of politicians more than in the minds of anybody else including the Government. The recent turn of events in India with regard to political development has woken the Government as mass contact in political world has materialised into realities and those responsible to run the Government and who would not see in spite of their eyes, and would not hear in spite of their ears are now feeling too late, for their artificial blindness and deafness. The late Mrs. Besant's founding of the Young Men's Indian Association in Madras during her agitation for Home Rule for India, brought into existence in the City a University Club; Mahatma Gandhi's village reconstruction was followed in almost all provinces by parallel Government schemes aided by the Central Government, Pandit Jawaharlal's war cry of unemployment and economic depression is synchronous with the recent circular of the Government of India to Provincial Governments to cure unemployment especially in middle classes

and industrial employees and even Legislation is contemplated to tackle the question of unemployment. The activities of Government follow instead of preceding those of the political leaders, in other words, Politicians lead the Government in ameliorating peoples' sufferings.

It is most unfortunate that the Medical Profession has not realised the relationship of Politics to human welfare, much less the welfare of the profession itself. We refer our readers to the Editorial which appeared in the last September issue of The Medical Practitioner, under the caption 'Reform and Responsibility' where we pointed out the responsibility of the Medical Profession with regard to Politics and explained at length the definition of Politics. That there is unemployment in the Scientific Medical Profession very few could deny, though this statement cannot be reconciled with the painful fact that India does not have enough number of qualified doctors to look after its teeming population. So if the Medical Profession is not to be excluded from His Excellency's programme of relieving unemployment in this country, we would most respectfully point out to His Excellency and his advisers to begin work with the members of this profession and show a lead to the Politician. There is enough and more material to solve this question with little or no difficulty if this question is handled carefully and as sagaciously. Apart from solving unemployment it will directly save large amount of public money, now spent on Medical Services as the unemployed in the Medical Profession, at least the majority, do not wish to be absorbed in Government Service. The remedy is as simple as it is rational. Stop further recruitment in the medical services on the curative side excepting a small number for actual administrative purposes. Stop unwholesome and unequal competition between state paid practitioners and private practitioners by restricting the private practice of the state paid to consultation, only. Stop quackery by special legislation, if necessary, by restricting practitioners of indigenous systems of Medicine to be within the bounds of their systems and granting special license to all those who wish to practise Medicine as such and who could not be brought within the purview of existing Medical Acts so that there may be disciplinary control even over

quacks. These three 'stops' will not only solve unemployment in the medical profession but advance the growth of Scientific Medicine and remove the nickname for India, a hot bed for all known and unknown diseases. The solution of unemployment in the medical profession would directly help in removing unemployment in other professions including industries, as sickness disability is one of the important causes of unemployment, and the problems of medical relief to the masses have to be solved by the members of the Independent Medical Profession. No Government however rich can dream of touching even the fringe of this problem when it is known that the Governments in all provinces felt it hard to maintain their paid staff, counting approximately 10,000 during the recent retrenchment days. They can never dream of increasing the number to meet the demand of 350 millions of population.

A Bright Vision: Our recent visit to Ramnad District in connection with the Annual Meeting of the Ramnad District Medical Association at Karaikudi brought us in contact with some members of the independent medical profession who have been able to conduct private hospitals doing as much and even more work than the ordinary Government District Hospitals. All these institutions are within 5 to 7 miles radius from Karaikudi. The biggest one we saw was run by Dr. S. Subramaniam. This institution has to be judged by the work it has been doing and not by the building in which it is accommodated or the number of doctors attending to the patients. It has an outpatient department and the inpatient department consists of Medical, Surgical and Maternity wards. In addition to the dispensing department which is an essential item in all hospitals, this private hospital is equipped with X-ray and Bacteriological Departments. The whole institution is run and managed by one individual assisted by an Assistant, a nurse and two or three nursing orderlies who look after dispensing also. That this hospital has been doing good, responsible Medical, Surgical and Maternity work is testified by no less a person than the District Medical Officer of Ramnad and, if we remember right, a District Collector also did write his impressions on the Visitor's Book about the utility of this Private Hospital. Side by side with the remarks of

the District Officers of the Government, we were pleased to see the testimony given by Pandit Jawaharalal and Sjt. Rajendra Prasad the President and ex-President of the Indian National Congress. Only two miles away from Karaikudi, it was a pleasant sight for us to see another small yet magnificent and well equipped private hospital and that for the treatment of special diseases of the Eye, Ear, Nose and Throat. This institution outbids District Hospitals in its specialities and the equipment of the special departments especially of the Ear, Nose and Throat which compare very favourably with those of such clinics in the city of Madras run by Government and private practitioners. Dr. T.S. Shetty the owner of this institution has combined the grandeur of the city institutions with the simplicity of the villages surrounding which this useful special hospital stands. One cannot but admire the rare courage of this young medical man hailing from the most distant district of South Kanara who had to make a special study first of the people of the villages speaking a language foreign to his own mother tongue and as foreign environment and habits of the people. Dr. Shetty while starting his hospital could not perhaps forget the equipment of the operation theatres of Vienna where he had special training under the world renowned Surgeon-Professors. The inpatients who number about 15 on an average are accommodated in detached wards which are small village houses in themselves. The hospital had an average out-patient attendance of 50 a day.

We were told that there are three or four other private hospitals under the ownership of Nattukottai Chetties whose presence in the Ramnad District must have been an encouragement to these private practitioners to start private hospitals of their own.

We very much regret that we missed the opportunity for want of time, of visiting the Swedish Mission Hospital about 10 miles from Karaikudi, a splendid institution started by an eminent and very popular Missionary, Dr. F. Kugelberg, the famous Eye-Surgeon, who did very useful work for the suffering humanity in the Ramnad District and attracting patients from the neighbouring districts as well. We learnt that it is a self-contained well-equipped institution having all modern requirements for the diagnosis and treatment of diseases not excluding the special organs, the Eye, Ear, Nose and Throat. It has the

additional credit of being a training ground especially for Eye Surgery. Two of its medical officers who left this institution have been able to run Eye Hospitals, the first one, Dr. Gurupadam at Coimbatore, the second Dr. Joseph at Trichinopoly. Dr. Gurupadam is running the hospital under the control of a mission. Dr. Joseph has been able to run his private hospital in the way the well organised Christian missionaries run them. While at Trichi for a few hours, we paid a visit to two private practitioners of the place in addition to visiting Dr. Rajan's clinic. The latter requires no special mention from us, as Dr. Rajan is as well known as is his work. Dr. Kalamegham who is also an Honorary working at the Government Hospital, Trichi as an Assistant Surgeon has his clinic equipped with an X-Ray plant to help him in his Orthopaedic work. Dr. Raghavan, the other practitioner whom we visited, is practising in Electro-Therapeutics.

The object of our publishing our impressions is not to give publicity to the private practitioners but to the work which they have been doing quite satisfactorily earning at the same time public and professional approbation. Such impressions we thought would serve as an incentive to other private practitioners to do useful work to the public in the way at least a few have been doing in the mofussil with little or no outside help but depending on self-help. These institutions, will, we trust be an eye opener and make the Government realise that if private practice is encouraged it will meet the demand of medical relief by the masses more satisfactorily than what is now obtained from the hands of the Government.

Rural Medical Relief : The South Indian Medical Dinner, more suitably called the Pan-Schismatic Medical Dinner which was held in the Connemara Hotel, Madras, on the 24th March seems to have done a lot of good to the medical profession in this province, though we have reasons to believe that a few officers in high position might have resented references to their official positions and responsibilities. Such references cannot be compatible with such functions. All the same, it is possible with a certain amount of restraint to take advantage of the presence of persons holding high office and solve even some knotty problems concerning the profession, not forgetting that however high a person be in the

official ladder, he cannot be a free man though he may personally be inclined to be so. But on the whole, the profession had much to gain on account of this Dinner. Apart from after dinner speeches, the before dinner contacts and talks serve many times more than the public speeches. It was so with regard to talks about Rural Medical Relief. Rural uplift has nowadays assumed very great importance and is on the lips of everybody, from the Viceroy to the humble peasant. This programme can never be complete without Rural Sanitation and Rural Medical relief; but the persons who can be most useful to carry out the last two items of the programme are forgotten and they are made use of as tools and not as agents, a position which they have every right to occupy. Just at this juncture when the village is the focus of activities both to the Government and the politicians, the Madras Government have thought it fit to style the Subsidised Rural Medical Practitioners as something resembling a Bat, i.e. neither a bird nor beast. They are called independent medical practitioners and were treated as such till the entry of the Congress into Legislatures. The success of the Congress in politics and civics and local affairs have been such that the party which was adversely affected, perhaps, beyond redemption and which was in power on the eve of the last elections, in their desperate plight suspected every man they could see as having congress sympathies. The defeated party was perhaps inwardly conscious of the influence of the medical men and brought these independent practitioners in the category of dependant service people, a ban on their freedom in connection with elections. We refer to this incident to make our readers realise that the Government is conscious of the influence of the medical profession on account of its inherent virtues which can be made use of. We wish the unfortunate down trodden subsidised practitioners are conscious of their influence, or at least are made conscious of the same by those who can do so. The Pan-Schismatic Dinner did to a certain extent help the few Rural Medical Practitioners who attended the same to realise their worth and their usefulness. These two commodities command more influence than money. The Rural Practitioners who came in contact with a large number of elders in the profession in service and in private practice have been able to canvass a large

volume of sympathy for them. They have taken advantage of the expression of the sympathies and are now organising a Provincial Conference of the Subsidised Rural Medical Practitioners, to be held in Madras in the near future. In addition to the members of the profession they may reckon upon the encouragement from at least two influential City Dailies, the Mail and the Hindu, whose Editors were also the guests of the profession at the South Indian Medical Dinner, and are expected to know all about Rural Medical Service. The Medical Journals including The Medical Practitioner will also be at their service, as in the past. We trust the subsidised practitioners will try to make hay when the sun shines, in the interest not only of themselves but also of the rural population.

Reorganisation of I.M.S.: The lengthy Press Communique published by the Government of India in answer to the questions raised on this subject by the members of the Indian Legislative Assembly last March, is quite beside the interests of the growth of the medical profession in this country and savours much of political vested interests. In spite of the fact that "the Services Sub-Committee of the First Round Table Conference recommended the abolition of the civil branch of the I.M.S. subject to the maintenance of the rights of persons appointed before the new constitution came into force," the Government of India have been bold to flout the suggestions on grounds which would appear most flimsy to those interested in the harmonious growth of the medical profession in this country, be they of British or Indian nationality. We cannot blame the European members of the I.M.S. if they directly or indirectly bring pressure on their brethren in the India Government or elsewhere when we know that the Indian members in the Superior Medical Services in the provinces cannot think of anybody but themselves with regard to the most vital question of the homogeneous growth of the medical profession in the country of their birth. Medical Relief has been a transferred subject for over 16 years in the provinces under the change of popular Ministers and all these years, the same portfolio was under the control of Indian members of the Executive Council of the Viceroy. The result of this transfer power to Indians was that the P.M.S. has taken the place of the I.M.S.,

with little or no benefit to the medical profession at large or even to the medical services below the P.M.S. The profession as a whole has more grievances against the P.M.S. as against the I.M.S. and it is not always correct to say that the I.M.S. has been responsible even to create disruption in the medical profession in this country for their selfish ends. The rank and file in the medical profession have not been able to approach those having the strings of the Government, and it is too much to say at this juncture what is in store for the Scientific Medical Profession under the democratic rule of Provincial Autonomy, when the fate of important questions has to depend upon popular vote. The passing of the All India Medical Council Bill in the Indian Legislative Assembly throwing the largest section of the members of the medical profession outside the purview of this Bill at a time when this Assembly had an overwhelming majority of Indians and the Member of the Viceroy's Executive Council in charge of this Bill was an Indian, did shake the faith of the medical profession in the then Democracy. It was also proved then that Indian interests were secondary to the interests of those who held office in spite of the officer being an Indian. Democracy has now taken a different turn; yet it is always safe for the profession to depend upon itself. The Indian Medical Service was the first that came into existence into this country and not the scientific system of Medicine that followed it. This service will be the last to disappear. So an attempt should be, by all those interested in the welfare of India, to establish the scientific medical profession which should command an influence to control all the problems concerning the people's welfare and not merely to replace the I.M.S. by the P.M.S. The India Government fully knows that there is no medical profession worth its name and its influence, or else there would not have been quibbling of words and ideas in the Press Communique recently published on the reorganisation of the I.M.S. attempting to make things appear quite the reverse of actual realities, though there was nothing to prevent the India Government to carry out the suggestions of the Services Sub-Committee of the Round Table Conference. The Sub-Committee did make valuable suggestions to meet all objections real or imaginary and suggested "(1) that in order to provide a war reserve, provinces of the

future should impose the liability to military service on a sufficient number of their officers and (2) that provinces should take steps to recruit a fair and adequate number of British officers to meet the requirements of the Army and British officials in India and pay them such salaries as would bring about this result. They also contemplated that a number of officers in I.M.S. might agree to sever their connection with that service in order to join provincial medical services on the terms indicated above."

We cannot boast of having expert knowledge about the military requirements of Medical Services but regarding the Civil, we may inform the India Government that their argument that the I.M.S. Officers only should look after the British officials cannot hold water. It is really disquietening that the Government of India should incriminate racial feelings when they are fast disappearing. If this argument is pressed too far, they will be doing a disservice to the members of the I.M.S. themselves as the effect of this unhealthy reasoning is likely to lead to social and professional ostracism. The Government must know that the European population do get the services of qualified Indian doctors and there are at least a few Indian doctors having settled in Great Britain, commanding decent practice. If the Government curtail the privileges of private practice to the State-paid Medical officers, especially those at the top, many Britishers are likely to settle in India as private practitioners and the Government will not have the necessity of retaining State-paid private practitioners for an imaginary purpose. We should say that if the Government in this country treat the full time medical services in the way they are treated in Great Britain, India can afford to have a good contingent of British Medical Practitioners settling in India as many of them have done in other British Colonies. The Press Communique recently published by the India Government has created more dissatisfaction, especially in medical circles, and it is too much for the Government or the public to expect good work in medical institutions in an atmosphere of competition and job hunting. In spite of all that is happening, it is creditable that at least a few officers are keeping cool heads which quality is perhaps due to the inherent virtues of the noble profession

and one could guess at times their feelings on account of threatening ostracism. The agitation for the retaining of I.M.S. is really speaking, the work of a few interested who have to depend upon service prestige more than professional prestige to get along. We wish those interested in the medical relief of the public will concentrate their attention on the healthy growth of the medical profession and not on medical services and find out ways that those in service love their profession more than the office.

Who is Senior Again? With the return of Lt. Col. Cruickshank from leave and assuming charge of the Office of the Superintendent, Government General Hospital, Madras, an armistice was declared on the question of seniority. Lt. Col. Plumtre's going home on leave creates a temporary vacancy in the office of the Principal, Madras Medical College and there are signs of another war for seniority in that institution. It was reported in newspapers that the Madras Government was preparing a special list similar to the one existing in other Government Departments grading the medical officers according to seniority so that there may not be room for over-looking seniority. The question of reckoning seniority in the Medical Department between Provincial Service officers of the cadre of Civil Surgeons and the members of the I.M.S., will not be an easy one and cannot be made on par with other Departments. The Indian Medical Service has a history of its own quite different from the Indian Civil Service. An I.C.S. officer is first appointed as an Assistant Collector and after some time he is put in charge of a division and called Sub-Collector, both the Assistant and the Sub-Collector are to be under a District Collector, as the very names imply, whereas the I.M.S. officer gets the rank of Civil Surgeon on the day he enters the Indian Medical Service and is posted as a District Medical Officer. So it will be a Herculean task for anybody to make a list of the Civil Surgeons belonging to I.M.S. and P.M.S. service in the way such lists are done in other departments. Fortunately there are no other appointments in the Medical Department in the city of Madras at least, which are coveted the most at present, other than the posts of the Superintendent, Government General Hospital and the

Principal, Medical College and if the Civil Surgeons in these institutions had a shift every 5 years as all District officers and even the Governors or Viceroy's have, there would have been more peace at these two institutions and less disharmony with it in discipline, and all concerned would have minded their duties more than their positions.

The necessity for the agitation of preparing a seniority list seems to have risen on account of only three appointments which are occupied by members of the I. M. S. The newspapers whose columns have been opened for the discussion of this topic do not seem to have been supplied with the full history of appointments in the Madras Medical Department especially the Provincial side of it. News published in these columns and comments thereon under the caption 'Who is Senior?' and the items of news that followed under the heading 'Superintendent, Madras General Hospital and the Principal, Medical College', if were made available to these newspapers, the trend of arguments on these posts would have been quite different. The question of seniority coupled with merit for the purpose of making appointments of Civil Surgeons does not seem to exist in the Madras Provincial Medical Service. As has been mentioned in these columns repeatedly, individual merit as judged by those who recommend these individuals, without the slightest regard for seniority cum merit, is the only consideration for the selection of Assistant Surgeons to be promoted as Civil Surgeons. Consistent with the policy now prevailing, quite recently three Senior Assistant Surgeons have been superseded by three Assistant Surgeons who are many years junior to them. The necessity for this supersession is said to be War Service, though nothing was mentioned in the conditions of service that those who put in war service would have preference over seniors with regard to the appointment of Civil Surgeons. The aggrieved Senior Assistant Surgeons approached the Madras Provincial Medical Association, a service association specially brought into existence to guard the interests of the members of the Provincial Medical Service to make their supersession a service grievance and agitate. The fact that no action seems to have been taken by this association should be an eye-opener that supersessions are condoned or at least winked by this

Service Association. The Civil Surgeons belonging to this Association who are the aspirants for the three posts cannot have any grievance against a history that has been repeating itself. If such a history could go undisputed with regard to Indians, it is but natural that the European element belonging to the I.M.S. service of our rulers should continue to rule, which they do quite consistent with the present policy followed by the Government, i. e., choice and selection by the Head of the Department who is expected to know who is the best amongst the candidates and who, of course in his turn depends or has to depend on his adviser or advisers. So far, so good, regarding the Superintendent, General Hospital and Principal, Medical College, which appointments are not reserved to any special cadre but seems to be the gifts of selection. But it is regrettable that the Government went out of the way with regard to the filling of the temporary vacancy of the Principal, Medical College, Vizagapatam, by overlooking the claims of one who had acted as the Principal of that College several times and who, in addition, commanded the approbation of the Andhra University, having been its Vice-Chancellor more than once. This is indeed as glaring as it is humiliating and shows in addition inconsistency in established principles. All the same, we mean no disrespect to Major Collins, who, we are told, is a capable officer.

Before closing, we would once again appeal to the Government to take into their consideration the suggestions made in the columns of *The Medical Practitioner* in its January-February issue to combine the appointments of the Superintendent, General Hospital and the Principal, Medical College into one as was the case in the past. Let a splendid opportunity be not lost for bringing about this reform which will bring with it peace and harmony in these two teaching institutions, by making Lt. Col. Curickshank as the first Dean who, we are told commands the popularity both of the Indian as well as the European members of the Medical Services in these two institutions. It is said that the senior Medical Officer of the General Hospital who was also the Principal, Medical College in good old days was allowed consultation practice, but unfortunately, there seems to be a convention without reason that consultation practice

with regard to a surgeon includes operations. If this latter item is excluded from the existing convention, there cannot be any objection to allow the Dean consulting practice.

A severe yet sincere critic: A young Bachelor of Medicine and Surgery, from a mofussil station, sent us a communication on 19-3-1937, in response to a general appeal addressed to him in common with others to encourage *The Medical Practitioner* by enlisting himself as a subscriber. In the course of a lengthy communication, this young graduate criticises the Editorial Policy of *The Medical Practitioner* and concludes with a hope that the future policy of the journal should be consistent with his suggestions and makes his hope an indirect condition for his enlistment as a subscriber. All the same, he remits his subscription which reaches us with his letter. We are thankful for his co-operation as well as for his suggestions all of which are as a matter of fact not outside the sphere of the activities of *The Medical Practitioner*.

This new subscriber criticises the policy of *The Medical Practitioner* by pointing out at the very outset that our doing 'service to the profession in all possible ways,' though 'a praiseworthy aim' is partially centred round the extent of saying that our even goes to the extent of saying that our sincerity is not as much towards the other classes as towards the Medical Licentiate. We would have taken this charge as a real compliment, if our caste was different from that of the Medical Licentiate. He says that in our zeal to serve the Licentiate we are unfair to other classes. "For, instance, you complain against the decision of the Government to apply different names to honorary medical officers according to their qualifications. I cannot see what the basis of your quarrel is. I think it is only fair to apply different designations to people of different qualifications. I am not entering here into the question of superiority, real or otherwise, of one qualification over another. Your demand for identical designations for graduates and licentiate is unfair. In my opinion, if you gain this object among honoraries, your next step will be, as a natural and logical corollary, to agitate for a similar equality of status among the paid men too. According to your lights, this is

one of your ways of abolishing what you term (the caste system) in the profession." The example quoted to indicate our unfairness has, instead of serving the purpose of a complaint, given us yet another opportunity of attacking the uncharitable, inconsistent and uncalled for policy of the Government in making the Honorary Medical Officers amongst the Licentiate as 1st Grade, 2nd Grade and 3rd Grade Licentiate Honorary Medical Officers. The original G. O. on Honorary Medical Officers made no distinctions in the nomenclature of the Honoraries. There was no oral or written complaint by anybody to the Government to call the Honoraries by the qualifications they possess, nor this practice is in vogue in other civilised countries including Great Britain, which is famous for variety of medical qualifications. Designations are given in service to denote the nature of the work done by a particular medical man in a hospital. For example, a person assisting a surgeon is to be called as an Assistant Surgeon, and one assisting a Physician, as Assistant Physician. So the designation in service, Honorary or Stipendiary, should indicate the nature of the work done and not the qualification possessed by the officers. We did suggest to the Government more than once that even designations given to the Medical Officers in service is a misnomer. A person doing independent work in a mofussil hospital to be styled as an Assistant Surgeon or a Sub-Assistant Surgeon is meaningless. If, as our new subscriber suggests, castes should exist in the profession and should be labelled as such till they are made to disappear, all the honoraries in the Government institutions should have a prefix or suffix to indicate the qualifications they possess. It is preposterous and most uncharitable to label only a Medical Licentiate as such.

The other trenchant criticism against us runs thus, "Your argument often is, that the licentiate form the bulk of the medical profession and serve a larger number of people than the graduates, and therefore are as good as graduates, if not better, and are entitled to at least the same rights as the graduates. This is not good logic; for if strength of numbers is to be the criterion in India among those who profess to practise healing art, those whom we call quacks form the largest number and have the largest clientele and therefore should be given pri-

privileges and status above any class of medical men." That the Medical Licentiates outnumber the Graduates nobody can deny nor does this graduate do so, but we ask our readers including this graduate if they could point out anywhere in the 8 volumes of *The Medical Practitioner* where we said or even hinted that the Licentiates as a class are 'as good as graduates if not better'—we trust the writer refers to qualifications in the word 'good' and not 'qualities'. We did repeatedly refer to the bulk, and the usefulness of the Licentiates in connection with our criticisms against the Indian Medical Council Act and have been expressing as repeatedly that all registered practitioners should enjoy equal rights and privileges as is contemplated in the Medical Acts not only in India but throughout the world. The simile of quacks used in the communication is as unhappy as it is uncharitable.

The last criticism in the form of a suggestion is that *The Medical Practitioner* should devote itself to remove castes in the profession by agitating to bring into existence one uniform qualification such as the M.B.B.S. and not by establishing either a State Medical Faculty or a College of Physicians or Surgeons. There was an Editorial in *The Medical Practitioner* some time ago where it was mentioned in clear terms that the only rational way of removing castes and creeds in the medical profession was to have one uniform qualification. The young Graduate might not have read that Editorial. These criticisms have given us an opportunity of gauging the depth of feelings of one class of practitioners against the other even among youths and justify our endeavours to bring about unity in the profession in spite of the existing diversities to dispel which *The Medical Practitioner* is trying hard, not without hopes of success. The fact that this young graduate has, after all, in spite of his feelings, enrolled himself as a subscriber of *The Medical Practitioner* is itself a proof of our fond hopes. Our attempt always has been to lift up those that deserve a lift but never to let down those who are in the higher rungs of the profession.

Institute of Hygiene and Public Health.—It is said that the Government of India have accorded sanction to the opening at the All India Institute of Hygiene and Public Health of two new sections, one for

Sanitary Engineering and the other for Maternity and Child Welfare. The Institute must have been working with these two additions from the beginning of the year. The present courses of study for the Diploma of Public Health of the Calcutta University and the Diploma of Public Health and Hygiene of the Faculty of Tropical Medicine and Hygiene, Bengal both given at the Institute, include Sanitary Construction and Planning and so the new Sanitary Engineering Section will be of immense value to those qualifying for these two diplomas. Maternity and Child Welfare Section existed in the Institute even before, but was maintained as a temporary measure by the Countess of Dufferin Fund, but from the first of April, 1937, this organisation and also the Sanitary Engineering will be directly under the Government of India. The Maternity and Child Welfare section will, as usual, grant a special Diploma and it is said that only those holding the M.B.B.S. Degree will be eligible for this Diploma. This is certainly a retrograde step and should be protested against by those interested in the welfare of this country. The Maternity and Child Welfare work is assuming a very great importance being considered and rightly so as the very foundation of health of a growing nation. It should be the concern of the Government to encourage a study of this subject amongst all qualified practitioners. Apart from this consideration, the invidious distinction shown to only one class of practitioners will be resented by the medical profession and it is highly desirable both in the interest of the medical profession, as well as of the public that all qualified practitioners are allowed to qualify for the Maternity and Child Welfare Diploma. It might be remembered that soon after the inauguration of the Public Health course by the Calcutta University at the Institute of Public Health and Hygiene at Calcutta, we pointed out that the interests of the Medical Licentiates who had been given the benefit of the L. T. M. and D.T.M. Diploma of this Institute till then, should not be neglected, as it was not possible for them to seek admission for the Public Health Degree of the Calcutta University. Maternity and Child Welfare, training, being the most important accompaniment of Public Health knowledge, this should be made available to all qualified practitioners alike.

Mr. H. Theodore: Mr. H. Theodore, B.A., I.S.O., Manager, Office of the Surgeon-General with the Government of Madras, who is retiring on the 29th July, 1937, will go on leave prior to retirement from 29th instant. Mr. Theodore entered Government service in 1905 and after serving in the Government Secretariat for some years in various capacities, was selected to be in charge of the office of the Surgeon-General on 21st May, 1915. He held this office for exactly 22 years and 7 days. The senior surviving members of the Medical Department who are aware of the state of affairs of the office of the Surgeon-General in the latter part of the 19th century might remember the influence of the Manager of the Office of the Surgeon-General. It was said that even the Surgeon-General depended upon the goodwill of his Manager regarding his tenure of office and at times the Surgeon-General was nervous about his own transfer. The lot of the subordinate officers under the Surgeon-General could be very well imagined by those who had the benefit of the reign of the Manager of the old days. Suffice it to say that permanent tenure of office was enjoyed by some and as many suffered not being in a place for even a few months. It took several years of hard work for the immediate predecessor of Mr. Theodore to bring the system of transfer of medical officers to the level obtaining in other departments of the Government. During the tenure of office of Mr. Theodore, it will be bare truth when we say that nobody could feel whether Mr. Theodore had anything to do with the transfers in the Medical Department and if there were to be relics of permanent settlement very near to that which was in the old days, they could be seen only in the city of Madras, for which the responsibility is entirely on persons who held the office of the Manager. The general feeling in the medical circles seems to be that the Surgeon-General's office exists only for transfer of the medical officers in the Medical Department and the popularity of this office is usually based on such transfers. Very few know the volume of work turned out in this office which is responsible for an annual expenditure of nearly a crore of rupees. In addition to the legitimate duties for which the Surgeon-General is paid, there must be at least 20 other departments of which the Surgeon-

General is the *ex-officio* head and the body to do all these multifarious duties paid and unpaid is of the Manager of the Office of the Surgeon-General. The Editors of newspapers and journals are expected to know of public officers more than the officers themselves and *The Medical Practitioner* being entirely devoted to matters medical, can claim to know more of the Surgeon-General's Office than the lay newspapers. It has not been possible for us to find a single person whether a medical man, woman or lay member of the public having anything to do with the office of the Surgeon-General, who said anything unpleasant about Mr. Theodore. It looks as if Mr. Theodore identified himself with nothing animate or inanimate excepting his official duties and responsibilities. It was possible for Mr. Theodore to keep open the doors of his private residence as widely as the doors of the office of the Surgeon-General and nobody even the lowest in the service had any difficulty in getting near Mr. Theodore whether he was seen in the office or in his residence. He has been courteous and sympathetic even to the most wicked while in troubles, and to-day when he lays down the official mantle, all now serving in hospitals, in other medical institutions and others who have retired have a good word to say about Mr. Theodore. The Government did appreciate Mr. Theodore's services by making him an I.S.O. in 1930. The secret of Mr. Theodore's popularity is his spiritual temperament. As far as we know of Mr. Theodore, we could see him nowhere except in the office of the Surgeon-General and his house. We wonder whether others have seen him elsewhere. If he walked outside his house either early morning or late in the evening almost every day, it was to the church. It could be safely said of this person that he was a staunch disciple of Jesus Christ, who was able to preach the doctrine of the Holy Bible by his actions and not by sermons. It is therefore no wonder that he is appreciated by all without exception whether he be I.M.S., P.M.S., or S.A.S. and equally by those belonging to the women branches of medical services not to mention about the rest belonging to the medical department doing menial service. We wish Mr. Theodore a long life in the days of his well earned rest.

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Correspondence Reports Etc. RAMNAD DISTRICT MEDICAL ASSOCIATION.

Annual Meeting, 10th April, 1937

PRESIDENTIAL ADDRESS.

BY RAO BAHADUR DR. T. S. TIRUMURTI,
B.A., M.B. & C.M., D.T.M. & H.
Professor, Medical College, Madras.

Ladies and Gentlemen,

I thank you sincerely for your kind invitation to preside over your annual meeting today. The invitation came to me from your District Medical Officer and the President of your association, Dr. B. V. Varadachari. He is a particular friend of mine. Dr. B. V. Varadachari and myself were college-mates and lodge-mates. The members of the lodge held him in respect and esteem even during our college days. His exemplary character and dignified conduct commanded the loyalty and affection of his friends. I am sorry he is not present at to-day's meeting, as he had to go on leave owing to indifferent health. He asked me whether his absence from the station would make me change my mind to be with you all at this meeting. I did not wish to deny myself this privilege and pleasure of meeting so many of you. I trust I will be voicing the feelings of the Members of this Association when I request your Secretary to write to Dr. B. V. Varadachari that we pray for his speedy recovery to normal health and wish him a long life of happiness and usefulness to the profession.

THE MOTTO OF A MEDICAL ASSOCIATION.

I wish the following motto adapted by me from the motto of the Teachers' Association of the Hindu Theological High School, Madras, can well be adopted by every Medical Association:—

"A Medical Association is not a trades union. It is a fraternity of enlightenment and culture. Service and Sacrifice are its watchwords. To import the paltry spirit of bargaining into it is to sound the death-knell of the calling."

It is a good sign of the times that we have in practically every district in our Presidency a District Medical Association and in a few towns and taluq headquarters other Medical Associations, affiliated to, or inde-

pendent of the District Medical Association. The aims and objects of all these Associations are, in general, common and well-known to all of you. They are to meet and discuss the problems in the understanding of the nature, etiology, diagnosis, prognosis and treatment of diseases to obtain valuable advice and help, if possible, by bringing the patients to the Association meetings, and inviting discussions on specific points on which further elucidation is required or confirmation desired, and to create a spirit of esprit-de-corps. These are the main objects for which these Associations have been founded. At such annual meetings we take stock of our activities and achievements during the year. It is wise on these occasions to note down also our defects and deficiencies and with a view to progress, draw up a programme for the future. A certain amount of healthy self criticism is a sure way to greater achievements. Are we as an Association functioning as efficiently as it is possible and how do we compare with similar Associations in other countries, which are in the vanguard of progressive medical science? Are all the members of the profession in the town, taluq or district, as the case may be, members also of the respective Medical Association or Union or Club by whatever name the body may be called? These are very helpful and important questions which the Association should not burke to discuss. Clear thinking in self criticism will not land you in a slough of pessimism but will lead you to the ladder of optimism and guide you with unfaltering steps to ascend to the heights of achievement, which our profession in other countries has demonstrated by its attainments.

THE SUSPICIOUS, THE HESITANT AND THE UNWILLING.

Why do some members of our profession still keep themselves aloof from those Associations in which no artificial bars to membership or considerations of qualifications or service have been provided in the rules? Such persons are, I am glad to say, fortunately very few. To those who are incorrigibly anti-social in their nature, I have nothing to say, except that they are misfits in the profession. Those who are suspicious of the benefits derived from the Association have only to attend a few of the meetings to have their doubts dispelled. The hesitant will do well to invite the attention of

the leading active members of the Association to the offending rules or bylaws or activities, to which he may take objection. But he should not complain on personal dislikes and prejudices about certain office-bearers or members and keep aloof on that account. If he believes in democracy and fraternity as agents for the common good of the largest number, he should sink his individual opinion, so long as such opinions are not of a vital nature. As against those who are unwilling, a public opinion should be created by joint efforts of every one in the profession.

THE SELECTION OF A DOCTOR BY THE PUBLIC.

No person who loves his profession and is genuinely interested in the noble calling will fail to enrol himself as a member of an association constituted by his fraternity. It is essential to be in it, if he wishes to attain ability as a physician and feels that he should shoulder the collective responsibility to advance the capacities and enlarge the usefulness of his calling. These are the two main objects of Medical Societies. It is only the man who is striving for such a goal to whom can be trusted the sacred lives of men, women and children for the prevention of disease and cure of illness or alleviation of suffering. We should therefore tell the public that when they select a doctor they should select a man who willingly seeks the advice and help of his professional brotherhood and is not afraid to lay himself open to the criticism, if any, of his compeers.

By being a member of the local Medical Society, he is constantly reminded of his responsibilities and the high ethical ideals for which the profession stands. By registering ourselves and joining the Association we undertake to behave ourselves in a fraternal spirit, serve public interests, put the interest of the patients above our own and work for the integrity of ourselves and our group. We bind ourselves to observe all the provisions of the Oath of Hippocrates, in letter and in spirit. By a proper judicious propaganda, the public should be made to realise that a physician who is a member of his Medical Society is a better doctor than one who is not.

OUR DEBT TO SOCIETY.

It is a sad mistake to think that we have done our duty by merely alleviating pain and

suffering, if it is not possible to effect a cure. We have not repaid our debt to society, when we merely heal the sick. Our social obligation is as important as our medical obligation. The channels for social work are a great many in this land. The profession has only recently awakened to a sense of its social responsibilities. As intelligent citizens, belonging to one of the learned and noblest of professions, we cannot but exercise the obligations of a citizen, if we are in fact so, rather than in name, in exchange for the social advantages of citizenship. Even though our chief function shall be the preservation of the integrity of our noble calling and advancement of the science of medicine, we should not fail in our social obligations to make our country a fit place to live a healthy honourable life. All honour to those who have distinguished themselves in these fresh fields of noble selfless and self-sacrificing work.

THE HEART OF THE MEDICAL PROFESSION IS GOOD.

Our profession is greatly indebted to Dr. V. Rama Kamath, whom all of you know well as a senior member and as the Editor of 'THE MEDICAL PRACTITIONER' for having originated the idea of a 'Provincial Medical Dinner' and for having successfully organised and cleverly conducted it. Though there were other organisers for this dinner, Dr. Dyson, Chief Medical Officer, M.&S.M. Railway, Dr. M. Subramania Iyer, B.A., M.B.&C.M. and myself, I should say that the entire arrangements had to be made by Dr. Kamath and to him all the credit is due. I feel I shall be failing in my sense of responsibility, if I did not mention this fact at this meeting. My statement will be corroborated by the few members of your Association, who kindly responded to our request to join us in the function and honoured us by their presence. The Editors of the Madras Mail and the Hindu papers who were the chief guests of the Profession at the Dinner were pleased to publish a detailed report of it. I am sure, almost all of you must have read the reports. The object of the dinner was nothing else but to bring all the Members of our fraternity together, so that the existing artificial inequalities may be forgotten, at least for the time being, and the occasion of the dinner may be utilised to gauge the soundness of the heart of the profession and to give an

opportunity to all those who have a vision to devise ways and means to lay the foundations on surer and sounder principles for the reconstruction of a great and mighty medical profession, which can function as one body, actuated by common ideals, namely, to strive to discharge the medical obligations to their fraternity and science and to undertake the social obligations to their community, their country and their civilisation.

Whatever may be the defects and deficiencies in the arrangements of this experimental dinner, which has been happily termed 'get-together-dinner', the organisers have been motivated with the best of intentions to serve the interests of our fraternity. It is hoped that the cordial relationship, which showed itself during the time of the dinner, will grow more and more in strength and better mutual understandings will like hoops of steel bind the various classes of members in the profession. I pray that this hope will soon be realised. I have much pleasure in giving it as my opinion that the 'Dinner' has revealed the fact that the heart of the medical profession is still sound and there is no need to get into a paralysing pessimism.

TRUE RELIGION MUST GUIDE THE PROFESSION.

The whole country only recently celebrated the centenary of Sri Ramakrishna, the Saint of Dakshineswar. His teachings were directed towards the perception and realisation of the essential unity and harmony of the spirit behind all the apparently diverse forms of the various religions in the world. Communalism and sectarianism, creeds and dogmas, distinctions fan the denominations, the fire of conflict between classes of our people and are the enemies of peace and progress, harmony and happiness. The physical sciences have annihilated distance and intensified the spirit of rivalry and animosity, greed and rap. True religion ought to bind us in bonds of love and sympathy. We who pride ourselves in the knowledge of the sciences should not be guided by the tenets of a new materialistic grabbing religion. May the religious spirit of Sir Ramakrishna be infused into the scientific spirit of the Medical Profession!

Let me thank you once again for the kind invitation to preside at your annual meeting

to-day. It is no small pleasure to me to meet you and renew your friendship.

The Ramnad District Medical Association

The seventh annual gathering of the Ramnad District Medical Association (formerly Chettinad Medical Association), affiliated to the Indian Medical Association, took place on Saturday the 10th April, 1937 at the S.M.S. High School buildings, Karaikudi.

The proceedings began at 10-30 A. M. with the general body meeting presided over by Dr. F. Ysander, Vice-President of the Association in the absence of the President Dr. B. V. Varadachariar, District Medical Officer, Ramnad. The following office bearers were elected for the new year:—

President . Captain B. Dayananda Rao
Vice-President: Dr. F. Ysander
Secretary . K. S. Srinivas
Joint Secretary: K. R. Ratnaswami
Treasurer : S. Subramanian
Members of the Executive Committee :
Miss. E. Ivatts
T. S. Shetty
S. Rajaram Bharathi
B. Krishnaswami
Auditors : M. S. Venkateshan
R. Bheem Singh

After the welcome address by Dr. F. Ysander, Rao Bahadur Dr. T. S. Tirumurti, B.A., M.B. & C.M., D.T.M. & H. was proposed to the chair. The outgoing secretary T. S. Shetty presented the report for the year 1936-1937 and it was adopted.

Dr. Tirumurti moved the following resolution from the chair—"The members of the Ramnad District Medical Association place on record their sense of great loss sustained by the medical profession by the demise of Dewan Bahadur Dr. C. Natesa Mudaliar, M.L.C. and authorise the secretary to convey to the members of the bereaved family their sympathy in their grief."—Dr. Tirumurti said,

The late Dewan Bahadur Dr. C. Natesa Mudaliar—was a prominent and senior leading member of our profession. We had known each other since our student days in the Medical College. He was one of my good friends and well wishers. He was connected with various institutions, education.

nal, social, political and cultural. Though he was a busy popular practitioner, he found time to interest himself in various public and associational activities. It is not necessary to catalogue the large number of his valuable services to all the institutions, organisations, associations and movements with which he was connected.

He took an active interest in the health and welfare work of the Madras Corporation. He was a champion of all good causes. The depressed classes found in him a strong supporter of their aspirations. The poor patients received in abundance his sympathy and free professional advice and help. He never failed to espouse the cause of the wronged individual. Unsparring in condemning injustice, social, departmental or otherwise, he was a strong advocate of the fallen and the oppressed. Genial in temperament, popular with the poor and the rich, friendly with all classes and communities, cosmopolitan in his outlook, he had no enemies in his profession or among the practitioners of other systems of medicine than his own. He was an ornament to our profession. By his varied activities for the welfare of the people who sought his help and participation in all these organisations for the progress of human welfare, he rose to a high place in the esteem of the people. There was always a smile beneath his big bushy frightening moustache. The fearfulness of the moustache was removed by the kindness of his countenance. Whatever differences we may have in the matter of his political opinions, we have admired his activities outside our professional sphere. He has been a great example to the members of the medical fraternity. His name will long be remembered not only by the medical profession but by the public of our presidency.

The resolution was passed unanimously the whole gathering standing.

In his presidential address Dr. Tirumurthi felt sorry that Dr. B. V. Varadhachariar, the President of the Association, was not present at the conference as he had to go on leave due to indifferent health. On behalf of those assembled and of himself, the secretary was authorised to communicate to Dr. Varada Chariar their hope that he is improving in health and prayed for his perfect recovery, happiness and long years of usefulness to the profession.

Dr. V. Rama Kamath spoke of the good work done by the Ramnad District Medical Association which was replied to by S. Subramanian and T. S. Shetty.

After reading messages from sister associations and well wishers by T. S. Shetty, the gathering adjourned for lunch.

The afternoon session started with a paper on "Traumatic affection of joints" by Dr. R. Kalamegham of Trichinopoly. Dr. S. T. Achar, M. D. of Tanjore could not attend the meeting and in his place Dr. S. Padmanabha Sarma, M. B. & C. M. District Medical Officer, Madura spoke on "Empyema." The chairman delivered an interesting and impressive lecture on "Modern conception of the Pathology of Bright's Disease." After discussion on these subjects the President in his concluding remarks congratulated the Association on its usefulness to the profession and was greatly pleased to find that members from distant parts attended the meeting. With the vote of thanks, the functions closed with a tea party and a group photo.

Affairs of the South Indian Medical Union.

To

The Editor, The Medical Practitioner,
Dear Sir,

At a general meeting of the South Indian Medical Union held on 15-3-1937, at 6 p. m. at No. 32, Broadway, Madras, two resolutions, one for the abolition and the other for the affiliation of the Union with the Madras Branch of the All India Medical Association were discussed at length.

A careful observer of the proceedings of the day would not fail to note with grave concern, some of the causes which led the members to indulge in matters affecting the very existence of the Union. A broad review of the progress of the Union for the past 5 years would throw some light on the real state of affairs. The annual reports clearly show an all-round depression, whether it be finance, membership, meetings, or medical politics. There seems to be a tendency of late, to discard and ignore the noble policy of the Union, viz to promote, help and look after the honour and dignity and well being

of the profession and introduce a feeling of mutual help among its members.

The annual meetings are getting very irregular and the elections show party prejudice. Discretion in choosing office bearers and members of the Council seems to be overruled by party spirit. Honorary medical men muster strong both in the office and the council. This has naturally strengthened the doubt in the minds of some of the members that there are splits in the independent medical profession—the Honoraries and the Independent Medical Practitioners.

The journal, the official organ of the association deals more with external than internal affairs concerning the welfare, honour and dignity of the members. The G. O. No. 877, ms. p. h. 3-7-1936, has affected dignity and honour of the independent medical profession as a whole. I am not concerned with the particular individuals. The Union does not seem to have realised this. Matters are being allowed to settle by themselves. Talks about independence seem to confine within the four walls of the Union hall without taking a practical shape outside. "L.M.P. examinations and the necessity for raising the ordinary educational qualifications" was an article sent for publication in the journal of the Union. Members concerned, I do not know for what reasons, sent this to the waste paper basket. The Anti-septic, The Medical Practitioner and other popular journals published the same. The Secretary, Local Self Government has acknowledged the article. The Surgeon-General with the Government of Madras recommended the suggestions contained therein to the Government.

The foregoing are some of the points which have contributed largely to an all round depression in the affairs of the South Indian Medical Union. I hope better conditions would prevail hereafter. The new office bearers and the members of the Council would leave no stone unturned to keep the policy of the Union in force and thus help to maintain the solidarity in the Independent Medical Profession.

U. D. GOPALA RAO.

Reply

From General Secretary & Publicity Officer,
THE SOUTH INDIAN MEDICAL UNION

It is true that a very few members present at the last Annual Meeting criticised the affairs of the Union and its Journal strongly. But the general opinion of the members present was not in favour of this attitude. This will be seen from the fact that the two resolutions moved by two members hardly found any support. In fact, one resolution was unanimously voted down. The other was withdrawn. There have been some difficulties in the Union but the Office-bearers are confident that the matters will be set right easily in the near future.

As to how far the Journal of the Union serves the need of the profession in the Presidency, it is chiefly for the profession to say. As far as the members of the Union are concerned, with the possible exception of a very few, there has been no complaint about the policy pursued by the Journal upto now.

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List of Postings of Sub-Asst. Surgeons for the month of April, 1937.

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. C. Narayana Menon	Penitentiary, Madras	Reserve duty, Govt. Hd. Qrs. Hl. Madura.
2	„ K. S. Sanjiva Rao	Leave	L. F. Dy. Mudukalathur.
3	„ J. R. Moses	L. F. Dy. Mudukalathur	Govt. Hd. Qrs. Hl. Ramnad.
4	„ F. Padamadan	Orissa Province	Police Hl. Malappuram.
5	„ S. Somasundaram Pillai	L. F. Dy. Vidyapuram, Tanjore	L. F. Dy. Peralam.
6	„ V. Ramalinga Iyer	L. F. Dy. Peralam	Govt. Hl. Kumbakonam.
7	„ M. Lakshminarayana	Govt. Hl. Chicacole, Vizag Dt.	Reserve duty. K. G. Hl. Vizagapatam.
8	„ A. Achuthan	L. F. Hl., Bhavani	Jail duty, Madras.
9	„ P. P. Narayana Nair	Govt. Dy. Kavarthi	Govt. Mental Hl. Calicut.
10	„ K. P. Sankaran	Govt. Mental Hl. Calicut	Govt. Dy. Kavarthi.
11	„ K. Krishna Rao	Leave	Govt. Dy. Palmaner.
12	„ P. S. Vaidyanathan	Govt. Hd. Qrs. Hl. Ramnad	Govt. Dy. Tiruvallur.
13	„ S. Sankara Rao	Govt. Dy. Tiruvallur	Leprosy work, Tirumani.
14	„ P. K. Kumaran	Stanley Ml. School, Madras	Reserve duty, Govt. General Hl. Madras.
15	„ R. V. Narasimham	L. F. Dy. Vayalpad	L. F. Dy. Puttur.
16	„ P. Jayaram	L. F. Dy. Puttur	Tuberculosis Sanatorium, Tambaram.
17	„ K. P. Nayagam	L. F. Dy. Ettapur,	Govt. Hd. Qrs. Hl. Salem.
18	„ A. Gopalan Nambiar	Police Hl. Coimbatore	L. F. Hl. Bhavani.
19	„ C. S. Venkatasubramaniam	Govt. Royapuram Hl. Madras	Stanley Ml. School, Madras.
20	„ C. S. Mohanaragam	Orissa Province	Govt. Dy. Saidapet.
21	„ E. I. Devapriam	Govt. Saidapet	Reserve duty, Kodaikanal.
22	„ S. Raju Iyer	Orissa Province	L. F. Dy. Perambalur.
23	„ A. N. Subbiah	L. F. Dy. Perambalur	L. F. Dy. Sendurai.
24	„ V. Balakrishna Iyer	Orissa Province	L. F. Dy. Vayalpad.
25	„ N. H. Moses	Leave	Govt. Hl. Narasaraopet.
26	„ V. Muthuswami Iyer	Orissa Province	Police Hl. Coimbatore.
27	„ C. Narayana Menon	Penitentiary, Madras	Govt. Hd. Qrs. Hl. Madura.
28	„ B. Surya Rao	Municipal Dy. Nandyal,	Govt. Hd. Qrs. Hl. Masulipatam.
29	„ P. S. Vaidyanathan	Govt. Hd. Qrs. Hl. Ramnad	Reserve duty, Chingleput.
30	„ M. Somalingam	Leave	Reserve duty, Bellary.
31	„ N. Sundara Rao	Leave	Govt. Hl. Adoni.
32	„ T. R. Venkataraman	Orissa Province	Reserve duty, Vellore.
33	„ N. Saktharama Rao	Leave	Govt. Hd. Qrs. Hl. Coimbatore
34	„ P. M. Sridharan	Govt. Hd. Qrs. Hl. Coimbatore	Jail duty, Madras.
35	„ V. Muthuswami Iyer	Orissa Province	L. F. Dy., Thondamuthur.
36	„ C. Ramachandra Iyengar	L. F. Dy. Thondamuthur	Police Hl. Coimbatore.
37	„ P. Bhima Rao	Orissa Province	Govt. Hl. Palmaner.
38	„ P. K. Kumaran	Govt. General Hl. Madras	Festive duty, Little Mount.
39	„ P. S. Vaidyanathan	Leave	Govt. Royapuram Hl. Madras.
40	„ M. Gopala Menon	Govt. Hl. Cochin	Reserve duty, Govt. Hl. Cochin
41	„ L. A. Ramaswami Iyer	Orissa Province	L. F. Dy. Sankaridrug.
42	„ L. Viraswami	X-Ray Training, Barnard Institute of Radiology Madras	Barnard Institute of Radiology Madras.
43	„ O. Krishnan Nambiar	Govt. Hd. Qrs. Hl. Madura	Reserve duty, Kodaikanal.
44	„ M. Nagaswami Iyer	L. F. Dy. Tirupattur	L. F. Dy. Manamadurai.
45	„ N. Saktharam Rao	Leave	Govt. Hd. Qrs. Hl. Calicut.
46	„ D. Rajah	Govt. Hd. Qrs. Hl. Calicut	Govt. Hd. Qrs. Hl. Coimbatore.
47	„ Mrs. Daniel Kirubakaram	Leave	Govt. Hd. Qrs. Hl. Masulipatam.
48	„ Miss. V. Kalyani Ammal	Leave	L. F. Dy., Repalli.
49	„ Miss. P. Mahalakshmi	L. F. Dy. Repalli,	Govt. Hl. Rajahmundry,

List of Postings of Sub-Asst. Surgeons for the month of April, 1937 (continued)

No.	Names of Sub-Asst. Surgeons.	From	To
50	Dr. C. R. Narayana Iyer	L. F. Dy. Valangiman	Leprosy Officer, Group V Districts, Madura.
51	„ S. Vaidyanathan	Leprosy Officer, Group V. Districts, Madura	Leprosy work, Tirumani.
52	„ Miss. K. Bernadette	Leave	Govt. Hl. Proddatur.
53	„ K. Vanamraju	Reserve duty, Cocanada	Govt. Hl. Amalapuram.
54	„ P. K. Kumaran	Festive duty, Little Mount	Govt. Hl. Villupuram.
55	„ M. Somalingam	Reserve duty, Bellary	Govt. Dy. Harpanahalli.
56	„ V. Krishna Rao	Govt. Dy. Harpanahalli	Govt. Hd. Qrs. Hl. Bellary.
57	„ S. Thiruvengadam	L. F. Dy. Pallipet	L. F. Dy., Puttur.
58	„ L. A. Ramaswami Iyer	Orissa Province	Govt. Hd. Qrs. Hl. Salem.
59	„ R. Shanmugham Pillai	Govt. Hd. Qrs. Hl. Salem	L. F. Dy., Sankaridrug, Salem.
60	„ P. Somasundaram Pillai	Orissa Province	L. F. Dy., Mimisal.
61	„ Muhammad Ayub Khan Sahib	Govt. Hl. Chicacole	Govt. Hl. Rajahmundry
62	„ B. Yerram Raju	Govt. Hl., Rajahmundry	Govt. Hl. Tuni.
63	„ P. Bhaskara Rao	Govt. Hl. Tuni	L. F. Hospital, Pithapuram.
64	„ T. Joga Rao	Govt. Hd. Qrs. Hl. Cuddapah	Govt. Hd. Qrs. Hl. Kurnool,
65	„ A. R. Venkata Rao	Govt. Hd. Qrs. Hl. Kurnool	Municipal Branch Dy. Nandyal.
66	„ M. Narayan	Rajah Mirasdar Dt. Hd. Qrs. Hl. Tanjore	L. F. Dy., Valangiman,
67	„ M. Lakshminarayana	Reserve Duty, K. G. Hl. Vizagapatam	Govt. Hl. Tanuku,
68	„ S. V. Raghavalu Naidu	L. F. Dy. Sendurai	Govt. Hl. Karur.

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A Monthly Medical Journal

EDITED BY

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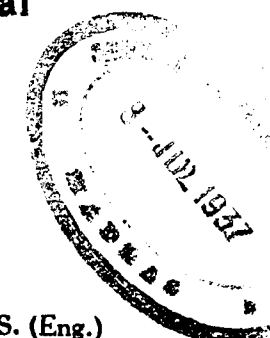
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JUNE, 1937.

[NO. 9

Original Articles

MADRAS MEDICAL COUNCIL

REVIEW OF THE PROCEEDINGS,

APRIL, 1937 SESSION.

BY

DR. V. RAMA KAMATH.

Member, Madras Medical Council.

The Madras Medical Council met on the 5th April and due to the unavoidable absence of the President and the Vice-President, Dr. (Mrs.) Monahan, M.D., was proposed to the chair. As the Vice-President for the year had to be chosen on this day, that item in the agenda was first considered by the Council and Dr. T. S. Tirumurti, B.A., M.B., C.M., D.T.M. & H. (Lond) was unanimously elected as the Vice-President for the year. The meeting continued for two days, 5th and 6th, but the agenda not being completed, the Council had to meet on the 7th, but the meeting was dissolved for want of quorum. It is highly regrettable that in spite of the statutory obligation brought into force and referred to by me in the last review of the Council proceedings, the April session had to be dissolved without finishing the agenda notified for the session. As was mentioned by me in the last review, the Council felt the necessity of a specific rule, as it was found that the members absented themselves in the past, even though the meeting of the Council was summoned the day following when the Council first met for a particular session and a large portion of the Agenda remained unfinished.

The Council meets only twice a year and the work of the Council has been increasing, it was therefore found desirable to make the attendance compulsory by the introduction of the following rule:

"The Council shall hold two ordinary meetings every year for the transaction of business on such days and at such time as may be fixed by the President. Each meeting shall ordinarily commence on a Monday and shall be continued from day to day until all the subjects included in the agenda have been disposed of, provided that no meeting shall be held on a public holiday."

A remedy more drastic has now to be found to prevent the members of the Council absenting from the meeting of the Council. In all democratic institutions the law provides a remedy of automatic removal of members from those bodies in case they do not attend a specific number of meetings, held consecutively. The re-instatement of such members has also been provided for by a vote of such bodies. It is not practicable to apply this safeguard in the case of the Madras Medical Council which meets only twice unless the statute makes the attendance compulsory on the pain of the absentee member losing his seat even in case that person does not attend one single meeting. The other less drastic and more alluring remedy is to pay the members a sitting fee in addition to the 1¹/₃ 1 class railway fare which the mofussil members now enjoy. Almost all the provincial medical Councils pay their members a sitting fee, the minimum for a day being Rs. 15 for ordinary meetings and a larger amount for the meet-

ings of the Special Committees. To my mind even the sitting fee does not appear to be a safe preventive remedy, for it has been my personal and painful experience to hear in the Madras Medical Council some members making remarks at times during heated debates to the effect, 'I cannot waste my time,' and there were as many occasions as I heard such remarks, for me to protest and to draw the attention of the President as I personally could not brook them, though they came from the lips of high officials. The sitting fee of a humble sum of Rs. 15 is not likely to make this remedy a fruitful one in the case of members of the medical profession who earn multiples of this amount within a period of 5 hours when the Council usually continue its sittings. The most rational remedy will be to make all the seats of the Council elective and permit registered medical practitioners to attend the meetings. The profession will then know what is going on in the Council and who deserve to be their representatives. All this may take time perhaps even more than the life-time of an Indian; till then the Government should find a remedy so that the Madras Medical Council does not flout a statutory rule which has both the force of a mandate and a moral.

I have reviewed the proceedings of the Council under the heads under which they were reviewed in the past.

REGISTRATION.

Groups.	Total at the beginning of 1936.	Total at the end of 1936.	Number added in 1936
Part I Those registered in the British Register.	244	254	10
Part II Graduates of Madras Province.	1,133	1,407	80
Part III Medical Licentiates and the rest long in the Part I or Part II.	4,062	4,199	144

There are at present 5,500 practitioners in the Provincial Medical Register all told and

in the course of last year 234 practitioners got into the Medical Register out of which four were already in the Register but they got themselves transferred from one part to the other by paying additional fee. Two medical graduates after qualifying themselves for British qualification did not wish to be grouped with Part II and two Medical Licentiates did likewise, one becoming a Graduate and the other getting a British registrable qualification. The artificial superiority complex, more than anything else, must have been responsible for these transfers. The grouping of the practitioners in three parts is an anomaly when it is known that the Medical Registration Act does not make any distinction in practitioners for conferring on them the special privileges of registration, the fee charged being the same for all. The causes that led the framers of the Madras Medical Registration Act to group the practitioners under three parts cannot be imagined unless it be to make the Medical Act a matter for laughter by the generation that followed the framers of the Act. The only conceivable reason that might have prompted the then wonderful legislators might be to sanctify the British Medical Register. It is now possible for a Singapore or Ceylon L.M. & S. to be in Part I of the Madras Medical Register if they first get into the British Register, the L.M. & S. of these countries being British Registrable qualifications, whereas a Graduate of any other Indian University should be in Part III, the omnibus Part in the Register which admits anybody that cannot grace the columns of Part I or Part II of the Register. There is an urgent need to amend the existing Provincial Medical Act to suit the present conditions and the sooner it is done the better.

The Council recommended to the Government the Registration of Dr. (Miss) B. Siebers, M.D. and Dr. (Miss) E. Tysse, M.D. both from America now working at the Vellore Missionary Medical School treating their application as special cases requiring the consideration of the Council in view of the good work turned out by that Missionary Medical Institution and to be consistent with the past policy of the Council which registered practitioners from foreign countries though these countries did not reciprocate with regard to Indian Medical Qualifications. For this purpose Dr. (Mrs) O. M. Monahan moved the following resolution:

"That the Madras Medical Council reconsiders its recent decision not to register any medical practitioner, who possesses only qualifications issued by non-reciprocating countries, and to follow its former custom of making an exception in favour of medical missionaries from such countries, by placing their names on the register, as this custom can be shown to be in the best interests of the Presidency."

As this resolution gave no discretion to the Council and was of a general nature, I moved the following resolution by way of amendment:

"That the Madras Medical Council reconsiders its recent decision not to register any medical practitioner who possesses only qualifications issued by non-reciprocating countries and will take into consideration individual applications for registration from practitioners from foreign countries, who belong to recognised medical missions in this province."

The amended Resolution was passed by the Council, Dr. T. Satakopan and I. T. C. Mahadevan dissenting.

It might be remembered that while reviewing the last October session proceedings of the Council, mention was made of a reference to the Madras Medical Council by the Indian Medical Council whether the Portuguese Medical qualifications could be recognised by the latter Council on reciprocity basis. The Madras Medical Council replied in the affirmative, on condition the Portuguese Government recognised Indian medical qualifications and permitted those possessing Indian qualifications to practise in Portuguese Colonies. The Portuguese Government Nova Goa have since informed the Medical Council of India that they would permit Indian Medical Graduates, practitioners licensed by the College of Physicians and Surgeons, Bombay and those passed out of the Burma Medical Schools. Evidently it looks as if the Nova Goa Portuguese Government must have permitted all those mentioned by them in the letter addressed to the Secretary, Medical Council of India as none passed from other Provincial Medical Schools would have approached the Nova Goa Government for permission to practise in Portuguese India. The reply of the Portuguese Government referred to above was sent to the Medical Council for further consideration and the Madras Medical Council adopted the following resolution:

"The Council is of opinion that reciprocity to practise should be extended by the Portuguese Government not only to University Graduates but also to all practitioners in India registered under the Provincial Medical Acts."

During the Bengal Partition days, there came into existence in Calcutta one or two Swadeshi Medical Schools under the management of eminent members of the medical profession in Bengal, many of whom possessing British qualifications as well. A few from Madras who qualified themselves from these schools were registered in the Madras Register by the orders of the Madras Government. Nearer in this province, the Missionaries were running a medical school at Neyyur, Travancore State. Some who passed out from this school were also registered in the Madras Register under the orders of the local Government. In Great Britain, when the Medical Registration Act came into existence in 1858, the Parliament thought it necessary to bring all those who had been practising Allopathy, though not possessing qualifications granted by any existing medical schools and colleges, into the British Register. So, a time was fixed soon after the Medical Act was passed within which such practitioners should apply for Registration. In India, those who were responsible to frame the Provincial Medical Acts and who copied the sections from the British Act did not copy the section conferring this concession and a few more sections and rules the omission of which has made the Provincial Acts more vested in interests and as much less democratic. A few years ago, one or two practitioners who passed out from Calcutta Medical Schools mentioned above, applied for registration and last year a few who passed out of the Neyyur Medical School and who were at present working in some of the Missionary Hospitals did also apply for Registration. On the latter occasion some members of the Council desired to recommend to the Government for Registration only those passed out of the Neyyur Medical School and at present working in missionary hospitals and there was a general feeling that these practitioners should be in the Medical Register. But I brought to the notice of the Council last year as well as years ago, when the question of those passed from Swadeshi Calcutta Schools came before the Council, that the Council should not make invidious distinctions but should register all those who possessed the same qualifications not mentioned in the schedule and who were recommended in the past by the Government for Registration and that a notification should be published to the effect that the

Madras Medical Council would consider the applications of all Allopathic practitioners whose qualifications were recognised by the Government in the past if they applied within one year from the date of notification. This did not appeal to the majority of Indian members of the Council though I could get support from one or two European members. At the last session of the Council one practitioner who passed out from the Calcutta Swadeshi Medical School applied for registration and it was a pleasant surprise to me that a few Indian members who voted with me on the last two occasions were against me and many who were against me last year and even on a previous occasion were with me when the following resolution was passed by the Council :

"The Council resolves to recommend to the Government the registration of Mr. P. S. Ramaswamy Ayyar under section 13 of the Act and directs the Registrar to publish a notification that all those who possess this qualification or any other qualification registered in the past may apply for registration within one year from the date of the notification."

I usually demand poll on resolutions of public or professional interest, for obvious reasons. I thought there was no purpose in demanding a poll regarding the above resolution as both the purposes were served. But I should say I was relieved when Lt.-Col. Mahadevan, a nominated member of the Council, took my place on the last occasion and demanded a poll and the result of the poll was :

For—Drs. N. Venkataswami Chetti, J. Findlay, O. M. Monahan, V. Rama Kamath. Against—Dr. T. Satakopan and Lt.-Col. V. Mahadevan.

It was mentioned in the last review that the Council referred the matter of Registration of additional qualifications to the Registration Advisory Committee, consisting of three members of the Council. All of them opined that only the additional qualifications granted by Universities only might be registered. As this opinion was likely to exclude additional qualifications granted at the Calcutta School of Tropical Medicine and Institute of Hygiene even to non-graduates, I moved the following resolution which was adopted unanimously by the Council:

"While approving the recommendation of the Committee, the Council resolves to

add to the list, the Medical and Public Health qualifications granted by properly constituted bodies recognised by the Central or the Provincial Governments."

DISCIPLINARY CASES.

The case against Dr. V. Kannappa Pillay reported in the last review came up before the Council. The charge against him was :

"That in giving evidence as a witness in the Court of the Sub-Divisional Magistrate, Tuticorin, in a case brought by a certain person against his daughter, you deposed openly to facts against the wishes of the female patient who was under your treatment for complaints of an extremely private nature, without her consent and without the express direction of the presiding Magistrate. And that you have thereby contravened the provisions of section 24 of the Code of Medical Ethics."

The Council passed the following verdict :

"From the evidence before the Council, the Council considers that you are not guilty."

The next case decided by the Council was against Dr. J. Paul. The charge against him was :—

"That you have been using your letter-heads as a medium of advertising yourself and your services, that you have thus contravened the provisions of para 6 of the Warning Notice and Section 1(a) of the Code of Medical Ethics, and that you have thereby been guilty of infamous conduct in a professional respect."

The verdict was :

"The Council considers that you are guilty of the charge and warns you not to repeat such offences in future and directs you to destroy all the objectionable letters-heads immediately."

At the instance of Dr. U. Krishna Rao, the Council adopted the following resolutions for the guidance of practitioners and the Registrar was requested to publish the same in the Medical Press :

"The Madras Medical Council resolves to inform all Registered Medical Practitioners to conform to paragraph 24 of the Code of Medical Ethics, as published by the Council. Whenever they are asked in a Court of Law to divulge professional secrets, they should first of all claim privilege, not to divulge the same and, if this is overruled by the Court, get this claim recorded and then answer the questions under the express direction of the presiding Judge or Magistrate."

It might be remembered that Drs. F.A. Scott, B. A. Nilson, K.C. Toyle, C. Narayana Rao and M. Shiva Rao were asked to explain why they violated the provisions of para 22 of the Code of Medical Ethics. All of them having submitted to the Coun-

cil apologies, further considerations about this subject were dropped.

Sub-Collector of Gudur reported to the Council alleging that Dr. K. Rajagopalan of Satyvedu Village issued a false certificate regarding age of a particular individual. As per the usual procedure the Registrar demanded an explanation from the practitioner before his case was reported to the Council. The practitioner denied the allegation and said that on a certain day a boy aged 17 and appearing as such came before him and on examination the practitioner certified his age to be 17. The practitioner also mentioned a possibility that the certificate issued by him might have been meanly taken advantage of by another person 10 years older. The marks of identification were not noted on the certificate. At this stage of preliminary enquiry, the Vice-President who was then in charge of Council Office remarked that there was no *prima-facie* case against the practitioner. The three members of the Disciplinary Committee gave three different views and the Council decided to drop the matter.

A report was received by the Registrar from one Dr. Satyanarayana Rau that one Dr. Kondal Rau was distributing leaflets in Telugu drawing attention to his professional skill and abilities. Explanation being demanded from the practitioner by the Registrar, he submitted that the leaflets were distributed by a grateful patient without his knowledge and he had since warned his patient not to do so. The disciplinary Committees to whom this report was sent for opinion, by majority, were for accepting the explanation of Dr. Kondal Rau, but the Council decided to summon Dr. Kondal Rau before the Council at its next meeting.

Information was received by the Registrar that Dr. Gopala Sarma of Giddalur, Kurnool District, was resorting to advertisement in Cinema notices soliciting private practice. The practitioner explained that he was not responsible for the advertising as it was done by the proprietor of the Cinema who happened to be his patient and that soon after the practitioner came to know about it he requested his patient not to do so. The Council accepted the recommendation of the Disciplinary Committee and dropped further proceedings.

MISCELLANEOUS ITEMS.

Ways of the Government are, at times, very strange indeed. The Madras Medical Council passed a resolution requesting the Government to make nominations of the officials to the Council in the name of the office and not in the name of the person occupying the office. They would not do so and when the period of nomination of Lt. Col. Pandalai expired, Lt.-Col. Newcomb was nominated and before he could take seat in the Council, he took leave and went home preparatory to retirement. We trust the Government would now at least consider the suggestion of the Council and while filling the vacancy created by Lt.-Col. Newcomb's retirement make the nomination in the name of office occupied by Lt. Col. Newcomb i.e. Principal, Medical College. If the Government do not wish to be wise even after an event and nominate Lt. Col. Plumptre to represent Madras Medical College to take the place of Lt. Col. Newcomb, the Madras Medical Council will not have the benefit of the presence of a Head of a teaching institution for one full year until Lt. Col. Plumptre returns from leave which he is availing on or about 1st July 1937.

The Madras Government have been adamant with regard to another resolution submitted to them about the designation of honoraries belonging to the Licentiate's class when they refused to reconsider the orders already passed by them. While recording the concerned G. O. I moved the following resolution :

"While recording G.O. Ms. No. 30 dated 5th January 1937, the Council reiterates its opinion already forwarded to the Government that it is against the spirit of the Madras Medical Registration Act to make any invidious distinctions in the denominations of Medical Officers in honorary service at least, and requests the Government once again, to treat all registered practitioners alike in the matter of their denominations in honorary service."

This was lost, Drs. V. Rama Kamath, Y. Suryanarayana Rao and Mrs. O.M. Monahan being for, and Lt. Col. V. Mahadevan, Drs. Miss F. Findlay, N. Venkataswami Chetti and T. Satakopan, being against.

Having come to know about the above Government order before it was included in the Agenda I armed myself to meet the situation and gave notice to the following resolution on the same subject :

"The Council reiterates its opinion that the denominations in honorary service, 1st grade, 2nd grade and 3rd grade Licentiate Medical Officers are not consistent with the spirit of the Madras Medical Registration Act and requests the Government to reconsider its order."

After prolonged discussion, the resolution was put to vote and was passed. The readers might remember that this subject was discussed in the columns of *The Medical Practitioner* more than once and it was also mentioned that the exciting cause for the change in the designation arose when two medical licentiates applied to be promoted as Hon. Asst. Surgeons from the grade of Clinical Assistant. One from Government Royapuram Hospital working in the Surgical Unit was said to have been recommended to the Surgeon General by the Surgeon in Charge of the Surgical Unit to be promoted as Hon. Asst. Surgeon and the other was reported to have been similarly recommended by the D.M.O. Guntur. The action of the Government has to be condemned both morally as well as legally, especially if this order is made applicable to the honoraries who were clinical assistants before the order in question was passed. The Licentiate Honoraries who joined Honorary Service before this order should not be made to suffer on account of this order and as the order is against the spirit of the Medical Act, I have been persistently agitating against this G. O. in the Medical Council and I am very much disappointed that Dr. Venkataswami Chetti, a person of cosmopolitic views, and Lt. Col. Mahadevan who has been doing so much for the Medical Licentiates, and who is reported to have recommended a Medical Licentiate to the post of Hon. Asst. Surgeon, did not support the cause of Medical Licentiates on the floor of the Medical Council. The facts that a Medical Licentiate working in the Government Royapettah Hospital had the benefit of the previous order and is now an Hon. Asst. Surgeon in charge of Eye Department and that the two honoraries now refused by the Government to be made Hon. Asst. Surgeons were recommended by two I.M.S. Officers, have been keeping the other Honorary Licentiates most sad.

The readers will be glad to know that the Government of India have been pleased to treat all Registered Medical Practitioners alike in the matter of issuing vaccination certificates to those sailing abroad except-

ing those bound for East and South Africa and Iraq, giving effect to the resolution passed by the Madras Medical Council and submitted to the Government of India. While recording the G. O. on this subject, I proposed the following resolution :

"While thanking the Government of India for partly conceding to the request of the Madras Medical Council against the counter signature demanded by them on vaccination certificates, the Madras Medical Council respectfully requests the Central Government to communicate to this Council why it is considered necessary to obtain the counter signature of vaccination certificates only in the case of passengers proceeding to East and South African Ports and Iraq."

But after some discussion, I withdrew the motion as the Vice President was requested by the Council to obtain necessary information.

On the resolution passed by the Council at the last session protesting against the policy of the Government in permitting the lay Health staff of D. P. H. Department to do inoculations, the Government passed the following order :

"The Government consider that the substitution of qualified medical practitioners for health inspectors and other health staff for wholesale anti epidemic inoculations is impracticable at present, both for financial and other reasons. They are therefore unable to accept the proposal of the Madras Medical Council contained in its resolution passed at its meeting held on 27th October 1936."

But the Council have once again requested the Government to reconsider their order. This question has been discussed in the columns of *The Medical Practitioner* threadbare more than once and needs no further comments from me. The profession should now make the Government feel its resentment.

As the Registrar has some legal difficulties to keep the Medical Register quite correct, the Council have recommended to the Government to amend the rules framed under section 11 of the Medical Act so as to enable the Registrar to keep the Register to the level of its requirements.

There were a few more miscellaneous items of routine nature concerning office establishment etc. of little or no importance to the profession and hence not considered in the Review.

The Excise Department wished to know the opinion of the Council if Indian Hemp and its preparations may be brought within the scope of the restrictions under the

'Dangerous Drugs Act'. Lt.-Col. Mahadevan proposed the following resolution seconded by Dr. M. R. Guruswamy Mudaliyar.

"The Council agrees to the inclusion of all the preparations from the medicinal hemp to be brought within the scope of the restrictions under the Dangerous Drugs Act."

Dr. N. Venkataswami Chetti proposed an amendment as follows, which was seconded by Dr. V. Rama Kamath :

"The Council, while agreeing to the inclusion of all preparations from the medicinal hemp in the Dangerous Drugs Act, recommends to the Government that facilities be afforded to registered medical practitioners to possess without licence, sufficient quantity of all the preparations of medicinal hemp for the exercise of their profession."

After discussion, the amendment was put to vote first ; it was lost, four voting for and five against it.

The original resolution was then put to vote and carried, eight voting for and one against it.

It is very unfortunate that the official members of the Council do not realise the difficulties of the private medical practitioners. Nothing would have been lost if the Council passed my amendment, as in the case of more Dangerous Drugs such as Cocaine and Opium, the Registered Medical Practitioners are permitted to possess a specified quantity of these two drugs and their preparations, without having a license. I intend to bring to the notice of the Government the unreasonable attitude of the Council in not approving my amendment and request the Government on behalf of the independent medical profession to permit them to possess a specified quantity of Indian Hemp and its preparations and I trust the Government will be more conciliatory and sympathetic towards the independent medical practitioners than the official medical men who happen to be members of the Council.

RESOLUTIONS BY MEMBERS

Dr. T. S. Tirumurti moved :

"In rule 4 (i) of the rules framed under section 24 (i) (iii) of the Madras Medical Registration Act, 1914, for the words 'the Committee shall report to the Council,' the following words be substituted : 'The Committee shall then advise the President in cases wherein they consider that further proceedings should be stopped ; the President may then direct that proceedings be stopped without further reference to the Council and the Registrar shall inform the complainant of the resolution of the Com-

mittee ; in other cases the Committee shall report to the Council."

An amendment was proposed by Dr. V. Rama Kamath to substitute the words "wherein they unanimously advise" for the words "wherein they consider." This was accepted by the mover and became part of the original resolution.

The resolution as amended was passed.

Dr. V. Rama Kamath gave notice of nine resolutions.

Only the first two resolutions were taken up for discussion and the rest seven have to lie over till the next meeting of the Council as the meeting had to be adjourned for want of quorum.

The Council feels that it is desirable in the interest of the medical profession and the public that post-graduate training is necessary for all who pass out of medical schools and colleges before they are registered and to consider if such training is possible under the existing conditions, appoints a committee consisting of the President, Dr. R. J. Dyson, Dr. (Mrs.) Monahan, Dr. U. Krishna Rao and the mover of the resolution.

As the consensus of opinion was against making post graduate training as a condition for registration, I omitted the words 'before they are registered' from the resolution and it was passed by a large majority.

The second resolution regarding the designation of Licentiate Honoraries has been referred to earlier in this Review.

SPRUE.

By

DR. K. NARAYANA MURTHI, M. D.

DEFINITION :—Sprue is a peculiar tropical disease, which manifests itself by morbid changes of a chronic inflammatory and degenerative type in the alimentary canal, due to an unknown cause, with symptoms of raw and sore tongue and mouth, the passage of large pale frothy motions, and its progress being marked by remissions and exacerbations occurring at different intervals with periods of comparative freedom from all symptoms.

This definition is by no means complete; as of late it is discovered that the stomach also participating in the degenerative changes resulting in the diminution of the 'internal secretion' which is found necessary for the

maturation of the red blood cells. (Castle, Townsend and Heath). This fact led some eminent doctors to think if the disease could be ranked with the other deficiency diseases. But there seems to be large amount of evidence to show that Sprue is a symptom complex arising as a post-sequelae of either Amoebic Dysentery or Bacillary Dysentery. (Murthi and Malcomson).

HISTORY: The disease was first described 150 years ago by Hillary. Later on it has been variously described by different writers as psoriasis, tropical aphthae, white chronic tropical diarrhoea, Ceylon sore mouth etc. etc. With more consistency, the Dutch physicians have adhered to the local term current in Java. "Indische Spruw" and this word anglicised into sprue, has gradually been adopted throughout the East to designate what is now a recognised and familiar disease.

CLIMATE: Sprue is of peculiar interest in that it has characteristic type of regional distribution as opposed to climatic disease. That is to say, it is almost invariably seen in persons who have lived within a certain well defined area beyond which it is practically unknown. Although it is a disease of warm climates, it was noticed to develop for the first time in temperate climates, only however in individuals who give history that they resided in the tropics. Another evidence to show that the disease has a regional distribution is that though Central Africa is a tropical country, sprue was unknown in that part of the country. It is endemic and widely prevalent in the countries where it is present. In regions of similar latitude and atmospheric conditions it does not occur. The endemic home of sprue appears to be Malaya, Sumatra, Java, extending into India and Ceylon, South China, Central America, Porto Rico, Australia, Fiji Islands and Japan. In tropical states of America, in England and Africa it is very seldom seen. Authentic records of Sprue in North and Central Africa, Palestine, Egypt and Arabia are rare.

ETIOLOGY: The author has made a close and careful study of over 200 cases of sprue admitted and treated at the School of Tropical Medicine, Calcutta and at the Govt. General Hospital, Madras. It is found that it is more common among Europeans and Anglo-Indians. Of late

several cases of sprue were seen among the Tamils and Telugues, at any rate among the well-to-do South Indians in our presidency. It starts very insidiously in the Europeans who live in the tropics, especially among those of the well-to-do classes. It seems to be a disease of adults, who are above 25 years and it is very rare under 10 and above 60 years. It occurs in families wherein a number of persons are found to be affected by it. Close contact seems to have a large bearing in the etiology of the disease. Therefore in the investigation of any case it is very essential to take the family history and the previous history into consideration. There have been cases in which father suffered and died from the disease, and some of his children subsequently were attacked by the disease. So, the fact of heredity seems to play some part in the etiology of the disease. Prolonged contact through food and utensils used by the patients suffering from Sprue may lead to the occurrence of the disease in those who use them. The author had come across a few cases where there was no history of the incidence of the disease in the family. In a single instance, the husband suffered from Sprue and he died of it. Later, the wife got it. She was found to be neurasthenic and she had the typical symptoms of sprue. She was afraid her husband's fate would overtake her.

The incidence of more than one case in the same family had been reported from Madras, Bombay and Ceylon. This observation favours the infective theory. It is very important to keep the patient uninformed of the nature of the disease. Sprue produces a marked depressant effect on the patient. It is of interest to note that although a patient suffering from tuberculosis of the lungs and a patient suffering from Sprue are equally emaciated and appear alike, the former feels always hopeful even on the day of his death, while the latter feels most despondent of life.

While speaking on heredity it is important to bear in mind the endocrine factor in the etiology of the disease. The right function of the endocrines happens to be an acquisition from the parents. If all the endocrines become exhausted, the body emaciates and gets the appearance of an old man. In sprue it is likely that premature senility is brought about by the premature exhaustion of the endocrine system. When the function of the

endocrines is defective, the defensive mechanism fails or gets exhausted. So, a toxic or infective condition may be superimposed in cases of sprue. (1) the loose skin often forming wrinkles as in senility (2) no subcutaneous fat and (3) all the internal organs of the body as heart, liver, including the musculature of the stomach and intestines are found to be atrophied. These three conditions point out definitely that the endocrine insufficiency may be one of the etiological factors in sprue. Such a uniform atrophy of all organs of the body can be noticed only in sprue. It cannot be said, with the present knowledge of things, that a particular gland is at fault.

There are other theories regarding the causation of sprue. The theories that were in vogue for some time and now obsolete have also to be mentioned as the text books still copy them. Such obsolete theories which were once as much believed as they are now discarded, will perhaps serve the only purpose of making the readers comprehend, the unsettled and as much mysterious nature of the causation of this wonderful disease.

1. HELMINTHIC THEORY: Several helminths were thought to be the causative factors in sprue. At one time *Stercoralis strongyloides* was considered to be the cause, but this theory has been given up, since the worm is found in normal individuals without causing any pathogenic symptoms. This helminth is now proved to be a non-pathogenic one.

2. PROTOZOAN THEORY: Various organisms, as amoebae, spirochaetae, flagellates etc. have been found in the stools in cases suffering from sprue. Spirochaetae euryratae is one of the commonest spirochaetae found in abundance in stools. It is a Gram-negative organism. But none of the protozoa has been demonstrated to be the cause.

3. FOOD WITH DEFICIENCY OF VITAMINS: The theory of vitamin deficiency was ably put forward by Nichols and Cantli and subsequently by Elders. Elders thinks that deficiency of fat soluble Vitamins A and D and unbalanced tropical diet brings about the disease. But his theory did not receive much support. A vitamin deficiency has been suggested by Col. Mac Carrison to be the cause upon apparently inadequate grounds. The author's patients are well-fed people, with whom no question of a second thought

of deficiency in their diet should arise. In those cases where a probability of a deficiency of vitamins was thought of, injections of vitamins B and C were given without any good results. Col. Mac Carrison's argument that vitamins are not absorbed by the degenerated villi, when given by mouth, in sprue, does not hold good, as there is now the possibility of administering vitamins through other routes.

4. THE YEAST OR MONILIA THEORY: The yeast was originally found by Kohlbrugge in 1901 and later named *Monilia psilosis* by Ashford. *Monilia* has been isolated in the stools of several cases of sprue. It seems to be only a coincident infection. But in severe cases, it may be found as a terminal infection.

5. CALCIUM DEFICIENCY THEORY OF SCOTT: In 1923, Scott, impressed by the similarity of the symptoms of sprue with those in other diseases arising out of calcium deficiency, suggested that calcium in blood, especially the organic form, was deficient in sprue. The existence of symptoms like tetany, cramps, loss of weight and oedema which are present in sprue, lends a certain amount of support to his theory of calcium deficiency.

W. C. Vines believed that sprue is due to acid dyspepsia induced by excessive proteins, fat and citrates in fruits, resulting in depletion of free calcium in blood. This free calcium is found to be reduced by about half that of the normal. The author has failed to confirm his results in his cases.

6. SYNDROME THEORY: In chronic dysentery, especially the bacillary type and also in pernicious anaemia, sprue-like symptoms are found to develop. But sprue is a definite clinical entity and it has typical symptoms and a typical course. Therefore the etiological factor may be different. It is possible to get sprue associated with a fungus or of a bacterial infection or a sprue invaded by a protozoan. But, personally, the author thinks that some of the cases of bacillary dysentery that are to become chronic, before they settle finally as sprue, have to pass through three phases of the disease.

(To be continued)

*OPHTHALMOLOGY AND OBSTETRICS

Their Relationship

By

DR. G. JOSEPH GNANADICKAM

Eye Hospital

While ophthalmology and obstetrics are supposed to be the most paying branches of the medical profession, the relationship between these two has not been appreciated in this country to the extent that is essential in the interests of the profession.

Before I get into this relationship proper, a bit of history may not be out of place as to which of these two is older. Surely, one may expect the science of obstetrics to be considerably more ancient as it must date from the birth of the very first child in the world, but historically speaking, ophthalmology has older records. The earliest record of an obstetrical case is found in the Bible, in the book of Genesis, where we read of a spontaneous version in an arm presentation. This is dated somewhere about 1725 B. C. But the first record of ophthalmology is dated about 500 years earlier. It is found in the code of Hammurabi wherein it is said that if a physician opened an abscess in a man's eye with successful results, he was to be well paid, but if his surgery failed and the eye was destroyed, he was to have his fingers cut off!

Though these two branches have an ancient beginning, the relationship between each other became evident and progressive only after the advent of the ophthalmoscope in 1851.

It is unfortunate many of us have not understood this close relationship. A better knowledge of the eye conditions in pregnancy will considerably help an obstetrician to decide as to what should be done in certain difficulties and the purpose of this paper is to draw your attention to the importance and significance of such a knowledge.

It is said that 90% of pregnant women present some eye symptom or other. One may not entirely agree with this, but a study of the eye conditions in pregnancy has brought forth a certain ophthalmological

test for the diagnosis of pregnancy. The test is like this.—If a drop of the patient's serum is instilled into her own conjunctival sac, there is a primary spasm of accommodation with no later reactions in normal women, but in pregnant women, there is a subsequent dilatation of the pupil. This test, however, is not entirely trustworthy.

There are a number of minor eye troubles such as blepharitis, stye, etc., occurring during pregnancy, most of them due to general nutritional impairment resulting from the added burden on the woman's metabolism. These are easily treated and are not of much consequence. But, in certain women with low vitality, especially in the villages and slums, there occurs a serious condition called Keratomalacia. We usually see it from about the seventh to the ninth month of pregnancy. It starts with a cloudiness of the conjunctiva which gradually gets into a dry condition. The cornea becomes involved next. It gets bazy and dry and then on the slightest provocation gets ulcerated. The devitalised condition of the eye is not able to withstand the deteriorative process and the whole eye simply breaks down. If this patient comes before the destruction of the eye, mere dietetic treatment with plenty of Vitamin A brings immediate relief also cod liver oil in any assimilable form. Such cases are a problem not so much for the medical man as his treatment is not merely medicinal, but it is more a problem for rural economists and relief workers as it is mainly a question of affording proper food.

In early stages of a first pregnancy, you may find, especially in delicate ladies of the higher class, complaints of eye pain, giddiness, multiple vision, dull sight and all that. They have nothing to do with pregnancy generally. Most of these patients are emotional and possibly hysterical.

The most important ocular complications arising in pregnancy are due to albuminuria. It is here that a knowledge of such conditions will give one a proper guidance in the diagnosis and management of certain toxæmic conditions in pregnancy.

In cases of persistent vomiting, the obstetrician is considerably in doubt as to whether the pregnancy could be allowed to continue. In those cases, if an examination of the

fundus of the eye reveals a hæmorrhagic retinitis, or at least a halo of cloudiness about the optic disc, it always denotes a general toxicosis and an early interruption of pregnancy is indicated. For one who has seen a normal fundus, hæmorrhagic retinitis is very clear. Dark red patches of blood in the retina are quite typical and are easily detected.

Albuminuric retinitis is not unusual. It is recognised as characteristic white spots about the central area of the retina. The vision is reduced, but it usually comes back after labour. The pregnancy may be permitted to go to term in these cases, though the diminished vision and the retinitis may cause alarm; but the patient has to be kept under prophylactic treatment, for the albuminuria.

But, when this albuminuric retinitis occurs with sudden blindness and eclampsia, the prognosis then is very serious, both for the mother and the foetus. The mortality is very high in such cases. This condition generally occurs in multipara about the latter three months of pregnancy. The fundus may also show flame-shaped hæmorrhages, oedema of the retina, etc. If you want to give a chance for the mother, the uterus should be evacuated within 36 hours of the onset of blindness.

Optic neuritis, when present without any demonstrable cause, might be from the general physiological reactions of pregnancy. You will find the margins of the disc diffused, considerably congested and the nerve head swollen. The prognosis is good, even though the patient is blind for the time being. Severe cases, however, are prognosticators of probable eclamptic fits to follow and have to be watched very carefully.

Retrolbulbar neuritis may be present with or without toxæmia. It is marked by sudden loss of vision or central scotoma for colour, but if you examine the fundus, you will find it quite normal. Generally, these symptoms clear away in a few days, but if they don't, it is advisable to induce labour just to save the sight of the patient. The rapid restoration of normal vision immediately following this procedure is startling. Of course, every other possible cause for retrolbulbar neuritis, as paranasal sinusitis,

oral sepsis, etc., must be eliminated before labour is induced.

It is possible sudden blindness occurs from severe renal disease. Here also fundus changes may be nil. Blindness in these cases is followed by uræmic symptoms. Immediate termination of pregnancy is the only rational treatment. Such a procedure will prevent convulsions and coma of eclampsia and quickly restore the patient's sight.

Physiologic changes in the pituitary gland during pregnancy give rise to varied disturbances of vision owing to pressure of the enlarged gland on the optic chiasma. I do not go into it in detail as it will be too technical and will not be of much practical interest to the general practitioner. For the same reason, I have not dealt with the pathology of the various conditions I have mentioned.

The occurrence of serious eye changes in one pregnancy does not predispose the patient to similar complications in subsequent pregnancies, except where there are permanent lesions in the liver or kidney.

You would have noticed by now that to utilise these conditions as prognostic signs, a certain amount of knowledge of ophthalmoscopy is necessary. I may tell you fundus examination of the eye is not after all such a difficult affair as some people imagine, especially in these days of electric ophthalmoscopes. Moreover, the retinal conditions enumerated above are so clear and typical that they can never be missed by any one who knows well a normal fundus. I wish, in the interests of your patients, if not of your practice, you realise the need for a routine examination of the fundus in cases of pregnancy, especially where you expect trouble. The ophthalmoscope must find as prominent a place as the stethoscope in an obstetrician's kit.

Coming now to the parturition stage, there is not very much to say. Toxæmic complications may be continued during labour also and their significance is the same. Where labour is difficult and where there is a vascular disease, one may see a transient paralysis of the extrinsic eye muscles due to small cerebral hæmorrhages about the area of their nerve roots. They are not very serious and do not generally cause permanent harm.

*Paper read before the Chettinad Medical Association.

Puerperium is usually free from eye complications. But, in multipara with frequent deliveries and where there had been excessive loss of blood, retinal haemorrhages may occur.

Lactation period may show signs of debility in the eye by way of head-ache, inability to read, etc. Rest and refractive corrections are then indicated. As a result of the physiological changes peculiar to this period, one may come across optic neuritis, but the prognosis is good even though the sight is apparently lost.

Instrumental deliveries are responsible for certain injuries to the eye in the newborn babe. Improper application of forceps or difficult extractions can cause small haemorrhages around the nerve nuclei of the ocular muscles and the result may be a permanent ptosis of the lid or squint, etc.

It may not be out of place to mention a word about Gonorrhoeal Ophthalmia in the newborn babe. Fortunately, it is not so severe in form and comparatively frequent as in the West, but still, it is serious enough to deserve faithful observance of prophylactic treatment. As you know, the eyes of the infant get infected with Gonococci during the passage. The only sure way to prevent the infection taking root is to instil a 2% Silver Nitrate solution in the eye immediately after birth. This should be done as a definite routine. I know some doctors and midwives hesitate to do it fearing the irritation this Silver Nitrate solution may leave. But, that easily passes off in a few days and it is too small a thing for the risk involved if this precautionary measure is not taken.

I think I have said enough to point out the importance of a knowledge of ocular complications in pregnancy. Upon proper diagnosis and interpretation of the various eye symptoms depend the safety of not only the sight but also of the life of the patient and the purpose of this paper is only a plea for the routine examination of the eye in all complicated obstetrical cases, at least when ocular symptoms are present.

RURAL RECONSTRUCTION- MODEL VILLAGES.

BY

G. T. GOPALAKRISHNA NAIDU.

Asst. Dist. Health Officer, Chittoor.

INTRODUCTION:—It is really a sign of the times that Rural Uplift, Village Reconstruction and Village Polity are now subjects of healthy discussion both by the Government as well as the Public. Little or no attention was paid hitherto on the villager who was considered as an adjunct to an urban town rather than to the rural area to which he belonged.

SELECTION OF MODEL VILLAGES: There are about seven lakhs of villages in this mighty land of ours. If all the villages are to be improved, then probably about a lakh of Sanitary or Health Inspectors have to be employed with consequent addition of several supervising medical officers of Health. This is certainly impossible either now or even in the remote future, considering the heavy expenditure involved. What should be possible is that improved ideas on sanitation only may be imparted to these villages so that they can be adopted by them. The only nearest approach for instilling Sanitary conscience in a conservative villager is to show by example rather than precept in the actual field. This can only be done by intensive public health and other improvement in certain specified villages in each district so that these villages may serve as "model" and other villages for adoption.

CONDITIONS OF SUCH SELECTION: How then can we fix upon such a model village? The answer is not far to seek. A model village should as far as possible be very near the Head Quarters of a District or Taluk station so that people from the interior of the district or taluk may have occasion to see the village in its improvement, whenever they go to town. Further the village so selected should be within 3 to 5 miles from the Head Quarters, and never more than seven or eight miles. It should be easily accessible by rail or road; if it is the latter, it should be seen that regular buses or other services are available for easy approaches. Also, the selected village should be a festival, or epidemic centre, so that by the intensive improvement effected there may

not be occasion to call it any more an epidemic centre. Permanent improvement in a festival centre will gladden the hearts of the thousands of devotees, and it is quite the reason why a festival centre should be selected. Scope for expansion as village extension etc., should also be taken into consideration while selecting a model village. To add to this, it will also serve our purpose if there is a weekly shandy etc., in this village. And above all, the willingness of the unexciting domiciled villager (whose unshaking belief in Fate grows the more marked as his age advances), to contribute voluntary labour and help, should be enlisted. The whole question therefore centres round this viz., the sympathetic consideration with which we treat the villager who in his turn learns to believe in us and our work, and throws himself heart and soul along with us for the improvement of his village.

SURVEY: Having selected model villages, we should set about enquiring into their survey as public health, social and economic. Every house, every hut and every Ram and Gopal, should be met and information elicited. This is the first step in the right direction; for, in so doing we meet with every body in the village, discuss things and thus indirectly enlist his or her sympathy.

PUBLIC HEALTH SURVEY: Nature and source of water supplies, their number and situation, their adequacy or otherwise, should be elicited. If there is provision of latrines, burial grounds, recreation fields, etc., they should be noted. Disposal of manure and possible improvements for farm yard manure should also be furnished. The endemicity or otherwise to epidemics as Plague, Cholera, Small-pox, Malaria, Relapsing fever, Leprosy, Guinea-worm, etc., should be ascertained from village records and personal enquiry. The number of houses, names of inmates in each house, occupation, state of health and vaccinal condition of each one should be recorded. The average diet of each one should also be noted. The conditions of houses are equally important. Their ventilation, presence of kitchen and smoke outlets, proximity and condition of cattle yards to sleeping apartments, presence of rubbish heaps in and around houses, disposal of sillage and

night soil etc., should all be seen and recorded. Satisfactory findings can be effected by one who has the experience of having moved with villagers as otherwise results may be vitiated from inexperienced hands.

SOCIAL ENQUIRY: An insight into the several castes, and their social order, with particular reference to depressed classes should be had. Reasons for Emigration, Immigration have to be enquired into. Existence of Associations, Panchayat Boards, Vigilance Committees, Red Cross Associations, and Boy Scout movements may be elicited. The educational condition of the village is also not without its importance.

ECONOMIC ENQUIRY. All the above information without that of economic status of the villages cannot be useful. Hence an idea of the agricultural holdings, their value, the number of cattle possessed by the ryots and whether they are bulls, cows, buffaloes, sheep or goats, and their value should be ascertained. Estimates of other assets as furniture, jewellery, loans given etc., have to be enquired into. A certain amount of tact on the part of the enquirer is necessary. Else, the villager's distrust of foreign elements being proverbial, you cannot arrive at satisfactory findings. The nature of debts, whether mortgage, pledge, or otherwise and the villager's total liabilities have to be arrived at. The out-turn of crops, their value, the expenses towards cattle, labour, seed, manure, rent paid for land assessment etc., have also to be gathered for approximating the profit or loss account of each land holder. The domestic expenses as cost of food, grain, milk and its products, food pulses etc., expenses towards ceremonies, clothing, and education of children, have likewise to be enquired into. All the above enquiries are necessary; for upon their findings rests the future improvement of the village.

IMPROVEMENTS: We shall now come to the actual improvements which have to be effected. They can be brought about by co-ordinating the work of the various special departments such as Public Health, Agricultural, Veterinary, Educational, Industries, Co-operative, Forest etc.,

PUBLIC HEALTH DEPARTMENT: Public Health Officials can pave the way for adequate water supply. If protected water supply is not possible, then, digging of additional

wells, or conversion of step wells into draw wells, provision of tube or bore wells on the banks of tanks or rivers will be adopted. General sanitation as thorough cleaning of the village, removal of rubbish to distant manure grounds, satisfactory disposal of sullage by soak pits or filter trenches, provision of latrines and consequent reduction of soil sanitation are a few items of public health programme. Marshy areas will be reclaimed, anti-malarial operations will be undertaken, and incidence of Malaria minimised with the reduction of mosquito nuisance. People will be made to sleep in peace without the menace of the stinging mosquito. Visitations of cholera and Typhoid will be averted by periodical inoculations. Incidence of Small-pox will be prevented by timely vaccination. Medical and Maternity Relief, provision of model dairies and village extensions are a few of the major improvements which can be effected by public health department and these are given in detail in the subsequent paragraphs.

AGRICULTURAL DEPARTMENT: Officials of this department can help in conservation of animal dung and urine by erecting suitable sheds for cattle. For this purpose a spacious ground is necessary far from the dwelling houses. Cattle from the village should be tied nowhere else than the ground allotted for the purpose.

Agricultural implements in their improved form will be distributed to ryots on loan basis. Improved strains of seed grains will be given to agriculturists. Demonstrations in improved methods of cultivation are effective when they are repeatedly resorted to.

VETERINARY DEPARTMENT: This can actually effect improvements in the condition of cattle in general and milch cows in particular. Introduction of stud bulls is not new to our villages; and this is necessary. Epidemics of Rinderpest, Black Quarter etc., will be prevented by timely inoculation of cattle. Castration of animals can be done without any cost to the ryot. Poultry diseases will be prevented by an enthusiastic Veterinary Officer. Importation of good breeds of fowls, and supply of them to ryots with proper instructions to increase their race may be done as an experiment. Bee keeping and honey extraction is really very good

and villagers may be taught about this useful cottage industry.

EDUCATIONAL: This does not need over emphasis. If every man, woman and child can read and write his or her vernacular, and understand things, and act up to the acquired knowledge, I think we have reached a stage when we can bear any responsibility. Such a consummation will be reached in at least a model village if we have enthusiastic able teachers who should be well paid for their arduous task. Mass education should be advanced on the right lines. Adopt what ever method you can for improving youngsters, your aim is to make them more literate. Montessori Method or Daniel Method for the very young, Dalton's or Savur's Methods for the high school goers or the good old system of Guru Kula or any other revolting new systems—which also are as many as the different systems in Medicine—may be ushered in. The end justifies the means and we want a literate race. Libraries, Radio installations, and Cinema demonstrations increase the earnestness of the villager to learn more and yet more.

OTHER DEPARTMENTS: The other departments will do their individual work. The Engineer can improve village communications and bridge irrigation canals and channels where there are no roads. The Co-operative Department can make free grant towards part of the cost of godowns, and for village hall cum reading rooms and recreation grounds etc. Thus the "Nation Building" activities may be brought about by the co-ordination of various departments with the villager who is the back bone of the country and upon whose prosperity and contentment any stable administration will rest.

The improvements referred to in the foregoing pages are not complete unless a satisfactory Maternity service, supply of good and wholesome milk for improvement in the nutritive content of food, and above all, scope for extension of villages are effected. These are dealt with in detail here:

MATERNITY SERVICE AND MEDICAL RELIEF: Every child born has got the right to live a healthy life in this world. The parents, and the State are equally responsible for this. Antenatal care, proper attention during labour and subsequent careful watch and feeding of the innocent baby are the main

aims of a free Maternity Service. The suffering of people should be relieved by proper and timely medication. For this purpose a Doctor, a Health Visitor and a Midwife are absolutely necessary. They will be the guardian angels for the villagers during thick and thin.

DAIRIES: Location of cattle yards far away from human habitation has been dealt with already. Clean and Sanitary Cowsbeds, and neatly cleansed cows looked after carefully and fed well, yield very good milk. A fully and fed well, yield very good milk. A voluntary association can buy the milk and supply at reasonably cheap rates to the ryots in and around the model villages. Whole some butter will be obtained in the dairies as against the suspicious ones available now in the market. A well managed Dairy can look after extensive grazing grounds for cattle. Fodder of all sorts can be grown here, sufficiently and well.

VILLAGE EXTENSIONS: It should be the aim of the Sanitarian to advise the people to

construct well ventilated houses with approved plans. New grounds should be available, for village extensions and these should be utilised for constructing houses in parallel and perpendicular streets for proper insuflation of air. Small gardens or Parks in Centres of these extensions may be necessary.

NATIONAL UPLIFT: I have endeavoured to furnish a scheme which attempts to make the life of the villager content and prosperous. If we can make him still more happy by raising his money value, and the value of his yield, at the same time reducing the cost of several of his commitments and reducing rural indebtedness, we believe we have reached the goal. If a villager in a model village attains such a consummation, what then is the difficulty for the nation of agriculturists who need only to copy and carry into practice what they have learnt from these model villages?

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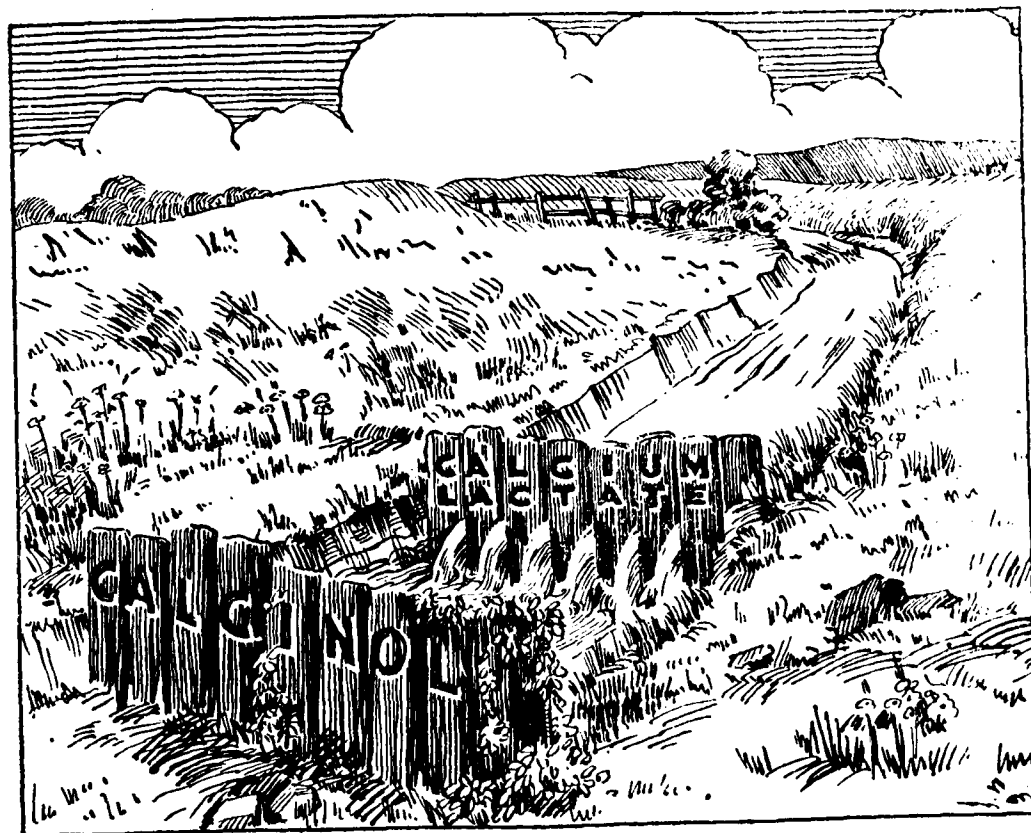
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Abstracts

ULCER OF THE STOMACH.

Appetite for food exceeds all other influences in governing the mind of man, the incentive to obtain food has with irresistible force at times impelled civilized man to regress to methods of procurement practiced by the most backward peoples on earth including cannibalism.

With food in hand and a disordered digestion man is the sum total of wretchedness, casting the black shadows of anathema over his entire mind and body.

Many literati of the world have given concrete examples in their writing of the ulterior influence exerted by a "bad" stomach.

Thomas Carlyle (1795-1881), the satiric Scot, is a point in instance, he suffered of a gastric ulcer, and the vitriolic sentences which dropped from his sharp pen and his mordant Philipics were dependent in their origin upon a "bad" stomach, otherwise this brilliant man whose works scintillate with the characteristics of genius, might have given posterity majestic periods and a philosophy of life comparable with the buoyant optimism of an Addison.

The first gastrojejunostomy for the relief of ulcer was performed in the year 1881 (Wolfer), two years later P. S. Conner removed the entire stomach of a patient suffering of cancer of this viscus. Shortly thereafter a captious doctor of medicine, who was undergoing the early stages of the male climacteric evolution, reminded the surgical profession 640 acres had been added to Spring Grove Cemetery, inferentially in anticipation and to accommodate the victims of the high mortality which would necessarily follow in this new field of surgery.

The sentiment herein contained, if tenable in specific application, would have gone a long way in controverting Thomas Malthus' (1766-1834) theory of over-population and underproduction of food to sustain the ever-increasing hords of earth's animate creatures.

Mortality was high in the beginning, but many of the graves remained tenantless. In the last decade of the century just past and the first and second decades of the present century, literature on ulcer and stomach

surgery was a formidable rival for the enviable place filled to repletion, in medical books and journals, by appendicitis. These topics vied one with the other for precedence as subjects of oratory at medical gatherings almost to the exclusion of all other business. Articles and essays on appendicitis and ulcer appear less frequently in current medical literature, but are more interpretive, less fulsome, reflecting more accurately the true status of post-operative relief, cure, morbidity and mortality.

In the formative period of stomach surgery, the experimental stage, if you will so designate, the immediate mortality following operation was inordinately high and end-results in patients which survived were exceedingly disappointing, ranging in the former between 10 and 25 per cent, while in the latter these figures rose respectively to 50 or even 100 per cent in some instances.

The causes of failure are not far to seek, inadequate preparation technically, and lack of experience on the part of those who endeavored to deal with gastric ulcer surgically, these are the principle factors which defeated the efforts of surgeons to accomplish relief for the ulcer patient. In correlation were erroneous diagnoses, improper selection of patients for operation and absence of post-operative management of the ulcer patient which had been submitted to operation. The period reeked of unqualified specialism at its worst. Stomach surgery passed through a long tedious travail before arriving at the commendable position of the art as now practiced, laboratory methods of confirming the diagnosis were undeveloped, the X-ray was unknown and gastric analysis, still in swaddling clothes, gave little or no aid to the clinician in his attempts to interpret presenting symptoms, and still the accomplishments of these pioneers in surgery of the stomach were great even over this long retrospect.

By and far, at the time, clinicians failed to comprehend numerous other pathological conditions which induce digestive disorders quite similar to those of ulcer of the stomach, moreover, they had not learned the stomach is capable of and frequently does fly the signals of distress in the absence of disease of this organ.

These phases of digestive disorder were but so many algebraic formulae in the calculus of attempting to determine the origin

of indigestion, pathological conditions of the stomach were uppermost in the mind of the surgeons in all instances wherein this viscus refused to follow the normal course in taking, retaining, digesting and assimilating food.

Correlation of extraneous pathological and neurogenic influences, which find their remote expression in the stomach, has become a definite means of interpreting clinical manifestations of disordered digestion, this is the most important contribution made by modern clinical medicine in the differential diagnosis of ulcer of the stomach.

Herein we learn the verisimilitude of symptoms is so striking as frequently to require, in addition to acute clinical discernment, the aid of an expert laboratory technician to properly interpret and classify the symptoms.

In devising surgical technic for dealing with ulcer pioneer surgeons were wont to say production of an artificial stoma is the essential, the location, anterior, posterior, pyloric or wall of the fundus, is of no material consequence, the purposeful objective being to relieve the organ of excessive activity by producing an outlet for stomach contents to take the place of the usual route which had "Been weighed in the balance and found wanting." This hypothesis was based upon hydromechanic rather than upon physiologic principles, excluding, as the speculation did, a consideration of the attributes of a living organ.

Diet, in conjunction with rest and medicaments, had long been known by the profession as being of prime importance in the treatment of gastric ulcer, this practice was promptly discarded by the pioneers after operating for ulcer and became one of the forceful links in the chain of failure which beset their labors.

The post-operative management of the patient, so highly essential to success in the surgical treatment of ulcer patients, was not in the dreams of the pioneers of stomach surgery, the hospital door closed behind the patient much after the fashion of that of the automobile repair shop of today.

Many theories have been propounded to explain the pathology of stomach ulcer, infection, trauma, lowered vitality, ulcer diathesis, familial inheritance, have all in

turn been suggested as causative factors and some have been successfully checked in the hutch.

Perhaps one should hesitate before adding to this imposing array of causes of ulcer, but as some success has followed the application of the principle herewith submitted we offer the following: There is something inherent in the patient which predispose him to ulcer of the stomach, this may, a times, be found in his chemical background Ca., Mg., Fe., K., deficiency, which render him susceptible to ulcer.

In any event the removal of foci of infection, diet and attempting to correct chemical imbalances has, at our hands, been followed in a number of instances by satisfactory results without surgically attacking the stomach.

Regardless of the cause or causes the final stage in the production of ulcer of the stomach is quite similar to that of ulcerative processes in other parts of the body, being based upon circulatory disturbances, blood-stream infection, thrombosis, local death with regional difference induced by stomach secretions on the necrotic margins of the ulcer.

An eminent internist, after a long, perhaps disappointing experience, said: "Once an ulcer patient always an ulcer patient." Well the subject of relief, "cure," of ulcer symptoms is not quite so dismal as this assertion would lead one to conclude, but there is a modicum of truth in the statement as some surgeons with a generous experience in dealing with gastric ulcer will testify.

The technic of stomach surgery for ulcer was put to many a hard test for existence in the period we sketch. Technic for the relief of ulcer symptoms has latterly developed into the adoption of rather simple procedures, (a) relieving the stomach of the extra effort to overcome emptying obstruction, (b) excision of the ulcer, (c) the more formidable operation of partial or total gastrectomy.

Advocates of these various surgical procedures are reporting increasing percentages of relief, however, when submitted to the solid ground of known facts, ten or twenty years after medical or surgical relief, many groups of statistics require drastic revision to conform with the patient's present condition.

Aside from digestive disorders ulcer may be followed by massive hemorrhage, perforation or cancer. Hemorrhage, even massive in character, is rarely fatal and is usually amenable to medical means for correction.

Operation for massive hemorrhage is rarely indicated and usually disappointing if performed, hemorrhage sufficient to endanger life and the additional demand of operation on the patient's reserve will probably close the scene.

The hypodermic use of parathyroid hormone or intravenous injection of 10 to 100 c. c. of citrated blood is very effective in controlling ulcer hemorrhage.

The calamity of ulcer perforation is exigent and success will, in a great measure depend upon the time elapsing between perforation (hours) and closure, and the extent of operative procedure employed in conjunction with securing a water-tight closure of the perforation.

Experience has conclusively shown the smallest amount of surgery consistent with securing this end is followed by the smallest operative death rate, gastrojejunostomy, draining the gallbladder or removal of the appendix, in addition to closing the perforation, is too much surgery for the patient to withstand. Further operation at the time is not practical, at least not expedient, other pathological conditions present may well be left for some future when the patient has survived the present ordeal and regained sufficient strength to undergo the necessary operative procedure.

The incidence of cancer, developing in the margin of ulcer is variously stated by different observers, 5 to 90 per cent of the one-third of all cancer, occurring in the entire body are said to have their origin in the margin of ulcer of the stomach. The post-operative history of this condition is one of the blackest chapters in surgery.

Post-operative complications of ulcer include new ulcer, adhesions binding the stomach to some adjacent organ, cicatricial contraction crippling motility and diminishing emptying time of the stomach.

For many years there has been a long, at times acrimonious discussion, at medical meetings, relative to the respective merits of medical and surgical treatment of gastric ulcer, some of the discussion has been of

little benefit to the profession and less to the patient. We believe the following to be a fair summary for guidance in the management of the ulcer patient: If after a fair trial of rest, diet and medication, at the hands of a competent doctor of medicine, who has had the full cooperation of the patient, ulcer symptoms persist, the patient should be referred to the surgical side. One of the greatest difficulties to overcome in any form of ulcer treatment lies in securing the cooperation of the patient, an individual who is in the habit of eating what, when and all he wants usually rebels at being compelled to follow a restricted dietary list.

In a remote past doctors of medicine were at times forced to perform operations for which they were not adequately prepared in consequence of methods of teaching then in vogue and owing to the isolated location of patient and doctor.

Fortunately these deplorable conditions do not exist today, the fundamentals of medicine, chemistry, biology, anatomy, physiology and pathology are intensively taught in American colleges of medicine, these instructions together with the requisite hospital training will properly prepare the diligent student to engage in general practice.

Conversely this training will not give the student a comprehensive view of the philosophy of life, as applied to the practice of medicine, which is essential in specialization, before attempting any of the various specialities in medicine one should spend five or eight years in general practice, attending medical societies, reading and otherwise improving his judgment i.e., becoming a specialist in general medicine before taking on one of the lesser specialities.

Some atrabilious wag has defined a specialist as one who knows more and more about less and less and a graduate specialist as one who knows less and less about more and more.

(Editorial Comments, *The Journal of Medicine*, Feb. 1937.)

NOTICE

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

Conservative Treatment of Surgical Lesions of the Upper Urinary Tract.

WILLIAM E. LOWER, M. D.,
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As is well known, the health of an individual depends upon the correct function of his various organs and not upon his anatomical structure. A man need not be an Adonis to enjoy health or achieve a lasting place in science and literature, as attested by the accomplishments of many anatomically deformed individuals, but to maintain his health, the preservation of the function of the organs must be borne in mind and must be considered in every surgical procedure.

It is often much easier to remove an organ than it is to save it, and when a good functioning second organ can take on the necessary work, such sacrifice may be the best procedure and the most conservative thing to do. No one would hesitate to remove a finger or a toe if by so doing he could relieve the patient of pain and suffering, for his other fingers or toes would preserve his economic status. However, in considering the surgery of the upper urinary tract, although we have paired organs—two kidneys and two and often more ureters—we cannot with complacency sacrifice one without throwing additional work upon the other. As a rule, the margin of safety is great and one kidney readily takes on the extra work. That is especially true if the additional work is given to it gradually, but often we see both kidneys involved—one more severely than the other—and the sacrifice of one might leave the other insufficient to carry on and maintain life. For example let us consider some of the conditions of the upper urinary tract to which our statement applies.

In the group of congenital anomalies of the kidneys, one may consider first, the *polycystic kidneys*, a familial condition which can often be traced through three or four generations. It is not noticeable or recognized as a rule in early childhood, but usually manifests its presence after the age of twenty-five or thirty years. Recently, however, I have seen it clearly demonstrated in a very young child. Not infrequently, attention is first

called to it by some slight accident, after which an examination reveals a tumor mass in the upper quadrant, and this usually is more marked on one side. Unless one is on his guard he may mistake this for a unilateral condition attributed to the accident and advise removal. Certainly the occasion for doing a nephrectomy under such conditions would not be a conservative procedure. Cysts may need to be punctured and occasionally hematomas may need to be evacuated in polycystic kidneys, especially when pressure causes much pain and discomfort, but removal no. They can generally be diagnosed by roentgen examination and by clinical examination.

In the *solitary cyst of a kidney*, which may attain considerable size and produce symptoms from pressure, the cyst should be removed but not the kidney with it as is so often done. The cyst, as a rule, can easily be resected and the kidney preserved.

Another congenital condition which is often unilateral but not infrequently bilateral is *hydronephrosis*. I appreciate I am treading on rather unstable ground in discussing this condition, as the profession does not hold a united opinion among genito-urinary surgeons, but here again the condition is often bilateral, both kidneys being involved but only one, perhaps, producing marked symptoms. Renal colic on one side and a marked hydronephrosis as shown by X-ray and pyelography may too often be the reason for removing a kidney, especially if there be marked compression of its cortical layer. Following such a procedure, the patient will be relieved of his immediate discomfort on that side but later renal colic occurs on the other side and examination will disclose a similar condition. It would have been much better to have recognized this primarily and have done a conservative operation on the first kidney. I want to emphasize here what I feel should be a rule—always do a bilateral examination. For years we have done simultaneous bilateral pyelograms at the same sitting with no complications following, although there was a time when this was considered a dangerous procedure. Perhaps it was when the medium was sodium iodide. By this method of examination you have the opportunity of making a comparison of the two sides—so very essential in this group of cases.

The exact method of treating a congenital stenosis which produces a hydronephrosis is also a much mooted question. From our own experience, we find we have obtained as good results from the more simple methods as by the more complicated plastic procedures. Dividing the aberrant blood vessels, relieving the ureter of adhesions will in most cases be sufficient. We have performed twenty-one ligations in our series of cases. Of one thing I feel sure: A nephrectomy should not be done primarily unless it can be proved that the condition is definitely unilateral.

The question in this connection which naturally suggests itself is—What about the cases of infected hydronephrosis? My answer is,—first try conservative surgery and if necessary, nephrectomy can be done later if the infection does not clear following drainage after removal of the obstruction. We have all seen many cases of infected hydronephrosis clear under proper drainage.

Renal Calculi—Renal calculi which do not pass always present an interesting surgical problem. If the stones can be removed by pyelotomy, the function of the kidney is seldom disturbed and when possible it should be the method of choice. We no longer bisect the kidney, for such a procedure is sure to damage the function of the kidney to some degree. The exception is in those cases where the stone may be imbedded in an outlying calix and the cortical layer over the stones is very thin. In such cases an incision directly over the stone may be the easiest way of removing it and this has the advantage of causing little additional damage to the kidney.

When stones fill one pole of a kidney or are in a double kidney and infection is present, resection of the kidney should be done, leaving the good functioning half instead of removing the entire kidney as is so often done.

In cases of bilateral stones of large size, the so-called stag-horn, they had better be left alone if the kidney function is not much impaired and dietary measures instituted to prevent their possible increase. We have seen patients live for years with bilateral large kidney stones without any untoward symptoms.

If stones occur in one half of a fused kidney, they may be removed, the kidney

divided, and fixed to supply better drainage and help to prevent recurrence.

Infected Kidney—In this group, which is a rather large one, of the infected kidney not secondary to ureteral obstruction, conservatism must be the watch-word for in most of these cases the infection is hematogenous and while one kidney may be involved more than the other, both are quite sure to be included. In the single carbuncle or Brewer's kidney, early removal seems to be the proper procedure, but these are not of frequent occurrence while the multiple septic infarcts are quite common and often produce symptoms more marked on one side, yet both are invariably infected by the blood stream.

There is, however, a group of cases of double kidney—two pelves and two ureters—in which one of the halves is infected and by far the most common is the lower half. After repeated lavages, many of these cases still remain infected and in such instances a resection of the infected part may safely be performed and the infection eliminated. This condition may occur on both sides and occasionally one of the double ureters will empty outside the bladder into the urethra or vagina and the upper part of the kidney drained by this anomalous ureter practically always becomes infected. Such cases can be cured by removing the infected half of the kidney and the other part saved instead of doing a nephrectomy as is so often done.

In tuberculous infections of the kidney, also a blood stream infection, early nephrectomy has been almost universally the method of treatment. It is quite common in this infection to have both kidneys involved—one perhaps more pronounced than the other, and in such cases it may be best to remove the one to relieve the bladder symptoms or drain the abscess, but I am not convinced that early operation, nephrectomy, is always the best procedure in early tuberculosis of a kidney. It may be better to wait until some immunity has developed against the tuberculous invasion. We all know that most patients do better after a badly infected kidney is removed when the other kidney has had some time to develop a compensatory function, rather than suddenly to throw all the work on a solitary kidney, and there is also less dan-

ger of a spreading infection which so often occurs before the protective process has become well developed.

The old caseous tuberculous kidneys are often seen. They seldom cause much local or constitutional trouble and their removal is scarcely ever followed by systemic reactions as may occur following the manipulation necessary to remove an acutely infected kidney. The same principle that we employ in local infections, it seems to me, should apply in lesions of the upper urinary tract.

Malignancies, of course, come under another category and the sooner they are completely removed the better, but in a rather rare type—the adenomatous growth—a simple removal of the growth sparing the kidney should be the procedure.

Conservatism may be applied equally well in lesions of the ureter. Dilatation and drainage in those congenital strictures is often followed by most striking improvement and even an anastomosis of one ureter to the other may be practical and a kidney conserved as demonstrated in a case of Dr. Higgins' in which we did an end to lateral anastomosis with complete relief of symptoms and conservation of the kidney.

The foregoing discussion represents the most common types of upper urinary tract lesions which should be treated conservatively, but the same principles are applicable to all surgical procedures.

(*The Journal of Medicine*, May 1937.)

The Common Cold.

Although scientific research has yielded no positive means of prophylaxis of the common cold, the approach to the same undoubtedly lies in the field of immunology. Vaccines and sera have been tried in large series of cases, without however producing sufficiently effective results to warrant more routine use. The recent prediction of Russell L. Cecil, of New York, is indeed encouraging. This author believes there will soon be available for prophylactic purposes a combination vaccine, containing both virus and pathogenic bacteria, which gives promise of affording "an active immunity against upper respiratory infections."

While the hope for positive immunization may eventually be attained, the present trend

is to concentrate on improved methods of sanitation and hygiene. The crowded public meeting place is a constant menace of spreading respiratory infections. Even with the progress which has been made in ventilation engineering this disease hazard has not been overcome.

The common cold in itself is not so serious a problem as its complications. Influenza especially in epidemic form, annually presents a situation of wide economic significance. The scourge of nasal sinus disease, otitis media and mastoiditis, to say nothing of the systemic complications, afford a serious picture well known to every physician. No wonder the search for a dependable preventive procedure, for what practitioner would not rather direct his efforts to the prevention of a cold than to its cure? His mission would be exceedingly more valuable and his attainment more thoroughly appreciated.

From the standpoint of the otolaryngologist there is little that can be added to what the general practitioner already knows and can do. When a patient with a cold presents himself, both find the task difficult. The tendency to demand treatment while ambulatory makes for a hit or miss program of management. The rhinologist directs his efforts to the nose and the internist to the body generally. Either method is inadequate without the other, and both to be ideal should be augmented by bed rest. It is unfortunate that this is so little appreciated, for it probably would do more than any therapeutic regime while the patient is ambulatory, to avoid complicating disorders.

Recent contributions along the lines of vitamin therapy have added much to our knowledge but the practical value of vitamins prophylactically remains to be more positively demonstrated. The same can be said of light therapy, although some enthusiastic reports based on small series of cases have appeared. The old preachment of maintaining a high bodily resistance still holds good and those measures which will ensure such a state must continue to be employed.

In the final analysis, there is little that has been added to either the prophylactic or curative treatment of the common cold in late years. Progress has been made in the field of sanitation from an engineering standpoint, but this alone has failed to

lessen the solution of our problem. If Cecil's prediction finally comes true, medical science will have attained an important goal, but until such a time we must content ourselves with the inadequate, empiric methods which have been handed down to us.

(*The Eye, Ear, Nose and Throat Monthly*, January 1937.)

The Pterygium

Relapses

DRS. MERIGOT DE TREIGNY AND COIRRE.

Paris, France

Translated by

THEODORE J. DIMITRY, M.D.

New Orleans, La.

The recurrences of the pterygium is a frequent happening; this fact is undeniable, but the percentages of such given us are so varied that an average would be without value. We can not harmonize authors who speak of 80 per cent recurrences with those who affirm that recurrences are unknown with their procedures: "Only a careless operator gets recurrences," some say.

It is prudent not to give figures before thorough and compared statistics are established. We consider in this want of uniformity the causes productive to certain unsuccessful operations.

The recurrences of the pterygium is almost always immediate, it is one of the characteristics that make it different from other tumors. A cancer takes weeks and oftener months, sometimes years to recur, the pterygium reappears soon; we know several cases where the pterygium reappeared even before the patient had left the hospital being still under the care of the doctor. These recurrences are sometimes very numerous; we speak here of the case of *Marin-Amat*, who noticed seven on the same patient; and the curious observation of *Marquez* who took care of a gendarme who had a binocular pterygium. One of the eyes healed perfectly after the operation; but the other one, operated on in the same manner, had nine consecutive recurrences.

Relapses produce a pterygium which has the same appearance as the first, this true both histologically and microscopically.

Therefore, it is not a question of degeneration. The only thing that is modified is the increased tendency for recurrences. The causes favoring these are numerous; here are some: *Cabannes* accuses the conjunctival contractions following such operations where too great excisions are made into the conjunctiva. *Martin* thinks it is the lack of cover for the edge of the corneal limbus and *Terson* attaches a great importance for proper adaptation at its limbus part, and to the scleral fixation which is as necessary as for an operation of strabismus.

Other authors, *Rubio* and *Dejean*, think, on the contrary, that by leaving a flat place of sclera uncovered, they realize a barrier for recurrences. *Urribel-Trencoso*, who practices in Mexico where the pterygium is frequent, thinks it essential to avoid tension of tissues. *Beer* spoke of this fact and was not an advocate of cuttings too extensive and difficult to manage. Some have accused the scar left in the palpebral slit; it is why many procedures displace it down or up in a protected region, sheltered by the lid and not exposed to movements at the lids contact which irritate it. Other surgeons think that recurrences are due to the remains of pterygium left on the cornea for which reason are not surprised by the care taken by *Deschamps* in his scrapings and of the width of excision recommended by *Gomez-Marquez* and of the insistence of many who perform cauterizations of different kinds.

All these operators tacitly assign the pterygium to a malignant tumor, thinking it necessary to remove completely and destroy it even in its smallest remains. We have seen others, on the contrary, use incomplete resections, even leaving particles of it and obtain sometimes good results. *Bocchi* thinks that cauterization operations irritate and are a source for exciting recurrences. All these facts have been noticed: but it is premature to conclude.

WHAT PRECAUTIONS MUST BE TAKEN TO AVOID RECURRENCES.

Whether it be deviated or removed the pterygium must be dissected with care. Remove the diseased conjunctiva, but be conservative of tissues, and do not pull but bring together over the exposed area without distortion of segment. If possible

deviate from the palpebral aperture and fix to the sclerotic. Clear completely the corneal insertion, if possible by scraping (method which we used several times with great success and seems very much forgotten) and avoid as much as possible the difficult autoplastics, for the moving of segments produces folds, scars and often rapid recurrence. You must remember that the immediate results must not be judged by the ingeniousness of its technic but by the quality of its results.

It seems to us that, if numerous operators are anxious to better the process of intervention, they must not neglect the post-operative care. The occlusion of the eyes and especially the binocular bandage kept on at least four days are indispensable for success. The keeping of a single bandage is also advisable for ten days. We were struck by a remark of Sedan, who tells of a man who had a pterygium and met with a serious injury to the other eye. His father had a pterygium and there were two brothers afflicted with the same disease. He had the habit of covering the injured eye because of irritation of contact with air by a little leather plate which he wore for 30 years. The eye, notwithstanding heredity and unfavourable conditions of life, never developed a pterygium. We are of the same opinion with Sedan, when he thinks that the ocular protection of his patient is the reason for which his injured eye was free from pterygium. The same argument may be applied to the post-operative period.

The care that the surgeon owes to his patient does not stop with the operation. If we admit what was said about the production of a pterygium, it is absolutely necessary to remove the patient from the uncriminating causes and insist on obedi-

ence to the opinion of oculists from the five parts of the world from whom we inquired on that subject. A few lines of Junes sum them up: 'pterygium recurs almost always when the subject is replaced in the same conditions as before the operation. On the contrary, I have seen often the cure maintained when the patient decided to change his profession and never go from the house in broad daylight and to have his eyes protected by smoked glasses after having applied under his eyelids of this salve of greenish gray color, viz., vaseline, 10 gr. iodoform 0. gr. 15, methyl blue 0 gr. 03.'

CONCLUSIONS.

1. Pterygium is rare in France, but frequent in countries where there is a strong light, dry heat, hot winds and abundant dust.

2. The habitual seat is the palpebral aperture; progression is slow, and in general, pterygium does not interfere with the sight.

3. Pterygium may, at any period of its evolution become abruptly invading; it may also go further than the center of the cornea. A stop of growth is often observed.

4. Pinguecula do not seem to be the real cause of that disease.

5. Pterygia do not present themselves as a tumor.

6. The tropical theory explains only a few peculiarities of the pterygium. Actually it does not give any proof.

7. There is question of tissue of inflammatory nature, of a form more or less chronic, in relation with the external irritants favored by the lids movement and movements of the globe.

(The Eye, Ear, Nose and Throat Monthly, January 1937)

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THE Medical Practitioner

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[NO. 9

MEDICAL ADMINISTRATION.

After struggling for over 50 years, India has been able to have a glimpse of political autonomy only in provinces. Thanks to Mahatma Gandhi and his faithful lieutenant Mr. C. Rajagopalachari for enabling India to have a clarity of the vision of the autonomy. Whatever might be the justification of the demand of assurances from the six provincial governments by the congress, legal and constitutional issues bearing on this demand and consequent fair and unfair criticisms launched against it, the results have been most remarkable. The Secretary of State for India did assure that the Governors in the provinces would not interfere with the Ministry in its day to day administrative duties and that interference with the government under the popular Ministers would be considered only under exceptional circumstances, if any administrative policy of the ministers endangered the interests of the services the minorities and peace and tranquillity. The Viceroy has since confirmed the views expressed by the Secretary of State more elaborately and less ambiguously. The province of activities of The Medical Practitioner being medical, we are concerned only with the Medical Administration in India and can say without fear of contradiction that the authority of the Ministers over the medical departments in the provinces cannot be questioned by the Governors. The answers given by the Premier on the floor of the Parliament a few days ago have made it plain that even the Parliament have no right in questioning the policy or actions of the Ministers in India. The Ministers under Democratic system of Government are the creatures of Public opinion and

good Government has therefore to depend entirely on the growth of healthy opinion of the public. And unless the members of the Public are themselves healthy, they cannot put forth uncontaminated, healthy ideas. The responsible and as onerous task of maintenance of Public Health devolves entirely on the members of the Medical Profession who form one of the most important and integral part of the Body Public. So, the members of the Medical Profession have a double function in shaping good government. Members of the Medical Profession, at least such of those who have been evincing keen interest in the growth of an independent profession in India are aware of the tremendous influence wielded by the medical profession in the country of our Rulers through their accredited representative, the British Medical Association. The unwary and even the callous amongst the members of the Indian Medical Profession must have gauged the purpose of this mighty British Association when it sent its Medical Secretary to visit India to have first hand information of the conditions under which the medical profession is existing in India. The Medical Secretary made an extensive tour visiting all the important cities and he is likely to publish his impressions in the official organ of the British Medical Association, if he has not already done so. We did have an opportunity of interviewing this person and published our own impressions about his visit. We have reasons to believe that some interested members of the profession did not relish our views but it would be more correct to say could not relish. But we cannot get out of our conviction that India can hope to get real self Government, even call it Independence, more speedily and with less risks, if

the British and the Indian people work for it in co-operation and in terms of equal partnership. With this faith. The Medical Practitioner is encouraged to approach the members of the Medical Profession practising in this country including the officials of all nationalities to help us with materials, suggestions and ideas as to the best ways which the Ministers should adopt to enable the Medical Profession to help the public in the administration of good government especially the Medical part of it. In the meanwhile we intend writing a series of Editorials about Medical Administration as seen in different provinces with the hope of enabling the profession in this country to play its part.

Management of public institutions which are mainly intended for those who cannot afford to take care of the sick, suffering from diseases requiring careful attention and observation on scientific lines, is the true mirror of Public Health Administration. If judged from the images seen in such mirrors, the vision is as appalling as it is deplorable. Very few patients, especially the humbler amongst them cannot be made to say that the hospitals, dispensaries and other allied co-ordinating public institutions serve the purpose for which they are meant. The sorrowful tales were being heard more and more when the control over medical relief and public health were transferred to the popular Ministers during the days of Diarchy and continue to be heard in some places more intensely during these days of Deadlock. The Heads of the Medical Departments are all most senior officials amongst the surgeons and physicians of repute. But even the most clever amongst such persons have not been able to perceive the pictures in the way those getting medical relief in the Government medical institutions are able to view them. The reasons for the pictures to be seen in two different forms are not far to seek. These Heads have to see into the mirror from a distance; consequently many rays are usually cut off from the vision and the few that are able to reach the offices are distorted having to pass through other intermediary bodies. At times, these bodies are so thick that the rays do not pass through them at all. The causes at work for such phenomena are so common and as glaring and require no specific mention. Suffice it to say that the medical budgets having been

rapidly growing in bulk in direct proportion to the prosperity of the intermediaries who carry medical relief into the mouths of the sick. There are three types of doctors who can be divided as such depending upon the nature of services rendered by them to the patients under their care. Some examine their patients and are content with their prescriptions and instructions in writing, the second type of doctors not only write prescriptions but explain how to administer them whilst the third type of doctors will not only prescribe and explain but actually see that their instructions are carried out and the patients get the benefit of their advice. Doctors in charge of Government charitable institutions should follow the third ideal. Then alone the poor patients committed to the mercy of the hospital authorities will get the full value of the money spent for them from public funds. Though the system of the Government in this vast country is uniformly the same in all provinces, the methods employed in the Medical Administration seem to be as varied as they are inconsistent with the purpose for which charitable medical institutions are intended for. The convenience and comforts of those who are in charge of the patients and not of the patients themselves are seen in evidence whether it be in Madras, Bombay, Calcutta or any other minor province. While in Madras it took the Government a little over a decade to decide that the running of private clinics or nursing homes was a trade and not permissible to the full time medical officers, the Government of Bihar allows its medical officers to run nursing homes in the Government Hospitals, the Physicians, Surgeons and Obstetricians being permitted to charge patients fees, 90% of which goes to the Doctors' pockets and 10% credited to the Government treasury. We are astounded to see that this trade is run in the Patna Medical College Hospital, a University teaching institution. It is no wonder that the policy of vested interests has been the direct cause of huge defalcations amounting to several lacs both in the city of Patna and also in Calcutta. The affairs in other provinces cannot be satisfactory though mismanagement did not reach the stage of detection. The remedy for the prevention of further defalcation was found in the appointments of two fat jobs in Calcutta, two non-medical persons being appointed to help one officer who is

occupying two offices as the Dean of the Medical College Hospital and the Principal, Calcutta Medical College. In Patna a retired civil surgeon is recently appointed as the Superintendent of the Patna Medical College Hospital who unlike in Calcutta has been given the control over the entire administration of the Hospital attached to the Medical College. This Officer though not doing any professional work in the hospital, is looking after the welfare of the in-and the out patients and is virtually their guardian in this respect. He is directly under the Inspector General of Civil Hospitals. From our personal knowledge of the administration of this hospital under the present Superintendent we can say that the Patna Medical College Hospital administration is an ideal one both in point of efficiency and economy. We may also have to say that the credit must go to the person who has a system of his own in looking after the institution with the zeal and enthusiasm of a householder who strives to get anything he wants for the welfare of those committed to his care. The inmates of the hospital get all they want and that more liberally than in olden days and any pie sanctioned for their wellbeing is actually spent for them in the form of food, or other materials or appliances. The administration is thorough in details from the kitchen to the outpatient dispensary, every item is being checked so carefully with a breach proof machinery so that it is not possible for anybody to eat the food of the patients or steal a drug of even the smallest value. We cannot conceive that a lay secretary could be as useful and vigilant in hospitals without the knowledge of the exercise of the medical profession which has as many loopholes of deceit which only an experienced medical man can detect; nor will the lay secretary know the wants of the sick to the extent a medical man can. It has also to be said that a medical man doing professional work in a hospital and who enjoys in addition unlimited privileges of private practice cannot be expected to do the work which a retired civil surgeon has been able to do at the Patna Hospital.

Our recent visit to King Edward Memorial Hospital, Bombay, an institution attached to the Seth G. S. Medical College where both the institutions are under the administrative control of one officer styled the Dean and who does no professional work either in the hospital or in the private houses of patients,

has been keeping us musing why the Government institutions in Bombay and elsewhere do not follow the administrative policy of the Bombay City Municipality, for the initiation and success of which the person in charge of those two institutions is mainly responsible. Nearer in Madras, years ago, during the unadulterated Military regime the Madras Medical College and the Government General Hospital were under the control of one Officer. It was possible for him to run the show of these two teaching institutions without any flaw and that because the combined head of both the institutions did not exercise his profession within the hospital or outside. The same work is now done by two officers both doing professional work in their respective hospitals and both treating patients outside the Government institutions. An experiment which the Government of Bombay did during the days of retrenchment by appointing a lay secretary for the Bombay Grant Medical College Group Hospitals was tried in Madras some time ago during the normal days when there was no financial stringency and the same officer who was relieved in Bombay after the experiment, was appointed temporarily to conduct the experiment in Madras and it cannot be a surprise that this lay secretary worked out economy. The same officer has been requisitioned to continue the work of the lay secretary. So far, it has not been possible for us to be convinced of the utility of this new office as we see that the Superintendent of the General Hospital is not relieved of his lay administrative responsibilities. The happy news of the possible closure of Deadlock in the Government of six out of eleven provinces in India and the dawn of Provincial Autonomy tempted us to invite the attention of the profession to the state of affairs of the Medical Administration in a few institutions with the hope that with the help of the profession, the Ministers in India will bring about a healthy uniformity of administration all through the country. The welfare of the profession depends entirely upon the Medical Administration and we trust that the members of the profession will in their own interests if not in the interests of the hospital-going population evolve a scheme of Hospital Administration best suited for the welfare of of the public.

MEDICO-LEGAL WORK.

Little or no interest is evinced by the Madras Government to keep abreast with the times with regard to Medico-Legal work. The Medical Department either here or in other provinces has been very active in modernising the system of medical relief in relation with only one part of it, the curative side which should be the concern of the Medical Profession and not of the Government Departments as in other civilized countries. The fact that the Madras Government is spending the highest amount very much near a crore of rupees for medical relief only, a sum much higher than that spent in sister major provinces and out of proportion on the population basis in other provinces, should convince all concerned that the present tendency of spending more money for the curative side of Medicine at the risk of developing other correlative departments such as those concerning Public Health, Medico-Legal Work etc., is not conducive to the economical expenditure of the public funds. At the time the Local Government was considering about the appointment of a Police-Surgeon in this province, The Medical Practitioner pointed out that this office should be independent of the control of the Police Department as at the time we rightly thought that the Madras Government was following the Government of other two major provinces of Bengal and Bombay where the Police Surgeon is not part of the Police Force for administrative purposes. But the Government adjusted perhaps to the needs of the Head of the Police who was at the time re-organising the Police Force in the city of Madras and the Police-Surgeon of Madras was made part and parcel of the ambitious scheme of the Police Chief. The Police-Surgeon of Madras has since been doing the work dictated to him by the Police Department and did no work of responsibility pertaining to this office as at Bombay or Calcutta. The designation of this office in Madras added to the pomp and got the person who occupied it emoluments fabulously disproportionate to the nature of duties performed by him. The person then selected was not one who would have ordinarily been promoted as a Civil Surgeon but he was given a start much higher than the one in his position in Government Service deserved and has been drawing a salary of one in the

cadre of Civil Surgeon though we are told that this appointment comes under special Miscellaneous nomenclature and does not actually belong to the Civil Surgeon cadre. We are also told that the person occupying this office cannot have any grievance if reverted to his permanent appointment as an Asst.-Surgeon nor can he aspire to get into the regular cadre of Civil Surgeons. The want of special Gazettes or any authoritative published document to give the public the information regarding the Government Departments, forces us to depend upon any available information which one is able to gather. It is not known if the Police Surgeon is allowed privileges of private practice. We will not be surprised if he is. But we know that he has the sole monopoly of issuing physical fitness certificates to the professional motor drivers and is permitted to charge Rs. 2 for each certificate granted by him. We mention this fact though a digression just to apprise the Government the members of the Medical Profession that every new appointment in the Medical Department especially those getting high salaries mean a material loss to the members of the independent medical profession. For, as in this case we are at a loss to understand why physical fitness certificates should not be granted by other registered practitioners even including those in Government Service.

The word Surgeon has assumed an importance for denoting a high position in the Medical Department in this country though in majority of cases the officer possessing this suffix or prefix to his designation does not function as a Surgeon. This name seems to be the legacy of the Military rule with which and for which a Medical Department was primarily started and the designations of Military rule continue as the country has not been able to evolve a medical profession worthy to function the needs of the public as other professions do under the Civil rule in this country. As the purpose of these comments is not to criticise denominations apart from the functions of the office, we would question the Government if the duties now performed by the Madras Police Surgeon could not be performed by the existing Government Medical Institutions as the Police Surgeon does at present only outpatient work of looking after the health of the Police Force. We fail to see the justification of an expenditure of

Rs. 700 a month, the pay of the present Madras Police Surgeon. The Police Surgeon of Bombay and Calcutta from where the name only of this office was borrowed does the responsible work of a Medical Jurist and assists the Legal Jurists in the exercise of law and order. He should be a medical man of high order and not only a mere surgeon as his name implies. He should have expert knowledge of all branches of Medicine not excluding Physics and Chemistry. Of course, law pertaining to Medical Jurisprudence should also be part of his special knowledge. He should be above want to be able to be above influence of any imaginable nature. The verdict of Judicial Officers presiding over the lowest or the highest tribunal either assisted by a jury or otherwise, depends at times entirely on the opinion of the Medical Jurist. It is common and most painful knowledge that innocent people are punished and the guilty escape punishment on account of faltering medical evidence. In spite of such revelations, the Government in this country and especially in Madras do not bestow any care and attention to have the assistance of a Medical Jurist for Medico-Legal work, worthy of the responsible functions, nor have they so far conceived the idea to make this person directly responsible to the Government and nobody else to enable the person holding this office to be as independent as his responsible and onerous duties demand. On the other hand, knowledge of one particular subject Chemistry which is an important part of the general knowledge to be possessed by the Medical Jurist, is given a place of importance which is against the interests of Medico-Legal work and even the canons of Ethics. The post of Chemical Examiner to the Government of Madras is for all practical purposes independent of the Surgeon-General and the professor of Jurisprudence who does all Medico-Legal work is made subordinate to the Chemical Examiner with regard to certain technical matters. The appointment of Chemical Examiner from amongst a member of I. M. S. is yet another legacy of Military rule which did not undergo change even after a century of British rule much against the advances in the system of Government and the growth of scientific outlook. A chemist possessing the qualification of a Chemical Examiner need not be a medical man but one dealing with Medical Jurisprudence should not only know

Medicine but all the allied branches of Medicine including Chemistry. Even on financial grounds the appointment of a special Police-Surgeon having no work which his compeers in sister provinces have, is not a sound proposition. The routine work which the Madras Police Surgeon is now expected to do may be done by a medical subordinate who is now assisting the Police Surgeon. The Professor of Medical Jurisprudence who is styled as Police-Surgeon in other provinces does not only the work of the Madras Police-Surgeon but also the Medico-Legal work which the Professor of Jurisprudence does in Madras. In Calcutta though the Police-Surgeon was a member of the I. M. S. till recently, it is now found that a member of the Provincial Medical Service in Bengal of the grade of Senior Asst. Surgeon as competent to discharge the duties of this office. In Bombay the Police Surgeon does not belong either to the I. M. S. or B. M. S. Service. The Professor of Medical Jurisprudence in Madras is now getting a consolidated pay of Rs. 800. If the professor of Medical Jurisprudence is given the assistance which is given to the present Madras Police-Surgeon, the pay of both amounting to nearly a thousand rupees, the Professor of Medical Jurisprudence could be able to discharge the duties of the Medical Jurist. This arrangement will save a thousand rupees a month to the Government. The Government should not lose sight of all round advances in the present civilization and should evolve a department for Medico-Legal work where the Medical Jurist occupies the position he should in the interest of Criminal Justice and other functions pertaining to this office having a chemist to assist him. In the meanwhile the Government should seriously consider the advisability of paying the Chemical Examiner who is recruited from the junior grade of Asst. Surgeons a pay ranging from Rs. 600 to 1,200 though this Asst. Surgeon got his special qualifications at the cost of public funds. The Government should remember that Asst. Surgeons with similar foreign qualifications are doing the work previously done by Civil Surgeons in the Vizag Medical College and also in Madras. If this is possible in the Medical Department in the interest of finance, why not the same rule be applied to the office of the Chemical Examiner?

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News and Comments.

Ourselves: We are glad to announce that Dr. S. S. Rao M.D., one of the leading practitioners in Parel, Bombay has kindly consented to associate himself with the activities of The Medical Practitioner in Bombay. He will not only contribute his quota to the scientific Columns of the Journal but will keep us also informed about topics concerning the life and prosperity of the medical profession in Bombay Presidency. Dr. Rao is a graduate of the Madras University and is a native of South Kanara District. Soon after he qualified for the M.B.B.S. degree in 1922 he worked as a House Surgeon in the General Hospital, Madras and as at that time his parents were in Bombay, he settled in that city as a general practitioner. Though a stranger to the customs, habits and even the language of the place, it was possible for Dr. Rao to command popularity, especially amongst the labour class of the population in Bombay and its suburbs. Unlike the present younger generation who aspire to qualify themselves for higher degrees to occupy the position of a consultant, soon after they leave the Medical College, Dr. Rao made up his mind to be a Consulting Physician after he gained mature experience of a general practitioner. It was therefore possible for him to become a Doctor of Medicine of the Madras University, within a short period of hardly 6 months when he gave up his general practice, putting his younger brother a graduate of the Bombay University, in charge of the same so as not to disappoint his old clientele to have the benefit of the advice of a general practitioner. While at Madras, for a short time, he attended the wards presided over by Lt.-Col. G.R. Mc Robert, M.D., F.R.C.P., and Dr. M. R. Guruswamy Mudaliar, M.D. and passed the M.D. Degree at the very first attempt—a rare phenomenon in these days not inconsistent with the ambition of the young graduates who aspire to be Doctors of Medicine or Masters of Surgery, depending upon knowledge of books and the youthful memory rather than the exercise of the art of Medicine or Surgery which alone and not the former commodity that should help them to be consultants. We hope, that Dr. Rao's ripe and wide experience of a general practitioner in the populous city of Bombay will be made available to the readers of The

Medical Practitioner, when he is leading the life of a consultant.

Our Lay Secretary: They say the Lay Secretary attached to General Hospital Madras is an able person who has had extensive experience in the lay administration of hospitals and similar institutions both in India and England. It is rumoured that so far after his re-entertainment and after the experiment of the usefulness of this office the Lay Secretary does not find much work to justify either relief to the Superintendent General Hospital and his two lieutenants, the Resident Medical Officer and the Senior Assistant Surgeon, all the three who are now doing as much work as they have been doing before the Lay Secretary joined duty. We have no idea of the experimental stage of the work of the Lay Secretary; the economy shown might be due to double check of the existing order of things or single check of the Lay Secretary. We are also not in the know if the economy sought is at the expense of the comforts of the patients. The rich and those who can take care of themselves are not likely to suffer on account of experiments. There is a class of hospital going population on whom if experiments are made, either by lay or professional agencies, the results cannot be got out. It is such people that require protection. We cannot for a moment conceive that responsible officers will at any time be devoid of humane feelings to the suffering poor but there is always a danger of misdirected zeal even in well meaning officers. They aim only at one thing which justifies the expenditure involved in experiments. All city Hospitals have advisory committees who could serve as a healthy buffer between the zeal of enthusiastic experiments and the realities. The consideration of the welfare of patients apart, the advantage of this appointment should be secured in such a way that the Superintendent of the hospital would have time and energy to devote himself for the welfare of the education of the medical students. It will be a sound policy if the Superintendent, General Hospital and the Principal, Medical College are converted as one appointment, the Dean, to suit the academic nomenclature of the office now held by both. Such a change will be not only economical but will also be conducive to efficiency. The fact that the work of the Superintendent and the Principal was done by one

officer in the past could be a sufficient guarantee that this reform is within the bounds of practical politics.

Heartless Attitude: Democrats are considered to have softer hearts than the Bureaucrats and are therefore expected to sympathise with the humbler folk more than they would do with those in affluence. It is said that the Governors in provinces even under the rule of interim Ministers do not interfere with the day to day administration of the Ministers. The interim Ministers have been proclaiming that they are second to none in their democratic spirit. We are surprised to learn that the popular Minister in charge of Medical Portfolio in Orissa wants to send away all Sub-Asst. Surgeons who are not the natives of that province. They are 38 in number. The Madras Government have no places for these and consequently 38 Sub-Asst. Surgeons from the bottom in the Service list have been given notice of discharge. All the same, the Surgeon-General with the Government has with some difficulty absorbed the first ten amongst these unfortunate subordinates and did recommend to the Madras Government that it was not fair to discharge the rest and that the Orissa Government might with advantage keep them instead of recruiting inexperienced subordinates fresh from the Medical Schools. It is said that the Orissa Government would not yield and that these Sub-Asst. Surgeons have memorialised to the Madras Government to consider their case mercifully. It is hoped that the Orissa Government would re-consider their decision and be true to the principles of democracy which cannot be devoid of mercy. They may be, with regard to new admissions to the Government Service justified to consider the claims of only the natives of the Province till then it will be cruel policy to drive out of service the non-Oriyas already in the service of the Government. In the meanwhile we appeal to the Government of Madras not to be hasty in recruiting 12 Asst. Surgeons to the Madras Medical Service till the fate of the 28 Sub-Asst. Surgeons is settled favourably. How this will help the situation, we shall explain in the next para.

Unjustifiable Recruitment: Year after year the administration Report submitted to the Government by the Surgeon-General with the Government of Madras says

that the system of Honorary Medical Officers is working satisfactorily. It was said in one of the recent reports that but for the Honoraries, the Government would have had to spend more money towards the pay and emoluments of the Medical Officers. We cannot reconcile these statements to the fact that the Government have advertised through the Public Service Commission calling in applications for as many as twelve vacancies in the cadre of Asst Surgeons. We are aware that in the near future nearly half a dozen Medical Officers in the Civil Surgeon cadre are to retire and that arrangements should be made to fill as many Asst. Surgeons as an equal number who will have to be promoted as Civil Surgeons, and that the number of leave reserve of as many as 20 should be maintained. Leave reserve is a special anomaly in the Medical Department so also what is called Reserve Duty. The latter duty is a nuisance both to the person who is posted for such duty and also to the institution where the Reserve Duty Officer is made to serve. This nuisance costs the Government the full salary of the officer for no work done.

We have no patience to know the history of Leave Reserve in other Departments of Government Service nor do we find a necessity for it for our present purpose to condemn this wasteful policy. We know for certain that in the Judicial Department, District Munsiffs are recruited mainly from the young members of the bar. As soon as there are vacancies from any cause, as many as are wanted to fill the vacancies are taken in temporarily and immediately discharged when the incumbents return to duty. The discharged recruits are re-entertained as and when required till they are finally made permanent. Why this policy cannot be adopted in the Medical Department is beyond our comprehension. Apart from the question of Leave Reserve, why should not the Government fill the vacancies by the honoraries in institutions where there are more than one Medical Officer, the Government Medical Officer being made responsible for administration and medico-legal work etc. There are at present available many honoraries who have put in service under the Professors in the teaching institutions. Why should not these be given an honorarium and put in charge of teaching work keeping a bare necessary number of Senior Assistant

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Surgeons from Service? The Government is now under the direct control of the Ministry and there cannot be any more fear or excuse of interference except for three safe guards and the policy of substituting Honorary Service in the place of paid one far from interfering with safeguards would make the Ministry so popular that the British Parliament will soon find that there is no need for safeguards nor any party in power will demand assurances. We had occasions to discuss about the advertised recruitment in Madras Medical Service with persons in office and the first pertinent question they asked us, "What shall we do with Medical Graduates without employment?" Our reply was, "Are there only 12 at present, in this province?" There was no reply. Apart from the above considerations, if Government will be well advised if instead of recruiting raw graduates, they promote the graduates and others with foreign qualifications from amongst Sub-Asst. Surgeons now in service. Majority of them seem to have put in 15 years service on an average. The interests of Administration will be better served if men with experience are recruited instead of raw graduates. It is said that these Sub-Asst. Surgeons have memorialised to the Government through the Surgeon-General. There is nothing to lose but much to gain, at least by way of gratitude from the well tried faithful servants of the Government if the Sub-Asst. Surgeons with the necessary qualifications are promoted as Asst. Surgeons. This will enable the Government to absorb as many Sub-Asst. Surgeons likely to be discharged for no fault of theirs but only to satisfy the cruel sentiment in the form of nativity complex now prevailing in Orissa. Such a complex has not been visible with regard to higher services including the Head of the Medical Department in Orissa who hails from a native State.

Charity and Devotion: Though India is noted for the benevolent disposition of its people of whatever religion, there has been always a tendency after the advent of British Rule that those who spent large sums of money for charity in the shape of public buildings did so either to commemorate their names or with the idea of being decorated with titles by the Government. We hear very often in the neighbouring

Indian State of Mysore, philanthropists building additional wards in an existing hospital or building hospitals and handing them over to the Government with no endowment or funds for the lodging and treatment of patients, so much so that the Mysore Government finding it rather hard to run such hospitals have been encouraging ways and means to realise funds from outside the Government exchequer. We are glad to learn that Messrs. M. Sanjivappa & Sons, the well known merchants of Adoni, Bellary District, recently opened a Maternity Home for giving not only free maternity service to the public but to do welfare work for children. The institution is called Sri Venkateswar Maternity Home as a mark of devotion to the popular Deity which the name indicates. The opening ceremony was performed on the 4th instant in a quiet way, those present being the members of the family of late Mr. Sanjivappa, a priest, and the Lady Doctor in charge of the Home. Devotional prayers took the place of the usual eulogistic speeches. Pressure was brought to bear on the founders of this institution that the opening ceremony should be performed by any high official of the District. But the purpose of Messrs. Sanjivappa & Sons being pure and simple Charity and Devotion and not any return even by way of appreciation, the suggestion of publicity fell on deaf ears. Even the ever alert and vigilant news paper reporters have not been able to know that there is now at Adoni a well equipped, six bed Maternity Home with provision for further extension. We wonder whether the private medical practitioners at Adoni have come to know of the philanthropy of Messrs. Sanjivappa & Sons. The practitioners have a splendid opportunity of serving the rich or the poor maternity cases with the help of a sister of their profession and the benevolence of the founders. The aim of the latter being service, this rare opportunity should not be lost by the members of the profession to make their art popular at the expense of real philanthropy and devotion. The Practitioners in Government service at Adoni belonging to both sex will, we hope, not see this institution with an eye of rivalry but as a co-ordinating sister institution. A private firm of merchants is doing work similar to that expected to be turned out at the Government institutions which are managed with the help of public funds. We congratulate