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The Medical Practitioner

A Monthly Medical Journal

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

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SEPTEMBER, 1937.

[NO. 12

Original Articles

SPRUE.

By

DR. K. NARAYANA MURTHI, M. D.

(Continued from last issue)

ITS INVESTIGATION

The diagnosis of Sprue is important, chiefly on account of the other diarrhoeas which simulate it. The insidious and protracted character of the disease, with symptoms so variable in severity and type, makes us in a large number of instances to miss it, and allow the disease to pass on through the three different stages mentioned in my last paper. Until the last stage is reached it is so difficult to diagnose sprue. A typical case of sprue can be diagnosed without any difficulty, especially if the case happens to occur in an endemic area. But so far as India is concerned, the endemic zones have not been marked out. Of late, our presidency has reported cases of sprue occurring in Ramnad, hill stations like Ooty and Kodaikanal, Madras, including its extension Mambalam, Godavary district and Vizagapatam. The cases reported from the afore-said areas were few, except from Madras. Anyway the western authors have recognised the important fact that sprue does occur in India and also that Indians do suffer from sprue, at any rate, the Madras. I made an attempt to study the epidemiology and endemiology of sprue so far as our city (Madras) is concerned. During this investigation I was able to spot

out endemic areas and endemic houses in our city wherefrom large number of cases were creeping into the city hospitals. Therefore without much difficulty, the cases could be identified. But when the symptoms and signs change, sprue escapes identification by clinical methods.

In arriving at a diagnosis, the history of the case is obviously of prime importance. Diagnosis of a case of sprue in an European with a history of residence in the Eastern Tropics (in the western tropics, the disease is unknown) where he has suffered from dyspepsia, occasional diarrhoea, lassitude and intermittent sore mouth is simple enough. But in an Indian, it is not often the case. In most of the cases there is some vague history of diarrhoea, preceding the onset of the disease. The first phase, which is only a mild Flexner infection escapes detection, because the early symptoms do not so much worry the patient. Most of the cases I have seen are diagnosed in either the second phase or the third phase of the disease. It is very difficult to say which of the chronic diarrhoea cases pass on to a clinical condition of sprue. Yet one can say this much. That all neglected and improperly treated cases of Flexner and Morgan infection of the gut are likely to develop the clinical syndrome of sprue. Allergy seems to play a great part in the determination whether a case of simple diarrhoea can pass on to the stage of sprue.

The diagnosis of sprue from its clinical standpoint is to be based upon the following cardinal symptoms.

1. Morning diarrhoea with frothy, clay coloured stool, acid in reaction, the colour of the stool in an Indian often being brown or greenish yellow, partly due to less quantity of the fat intake and partly due to the absence of the leuco-bases.

2. Boggý, blown-out abdomen.

3. Glazed and ulcerated tongue.

4. Progressive emaciation with anaemia but without any temperance.

5. The disease being marked with remissions and exacerbations.

All the above symptoms and signs may not be found in the same individual. But I am sure one can make out all of them in the third phase of the disease, which is a late stage when we can do very little by way of treatment. These made a certain school of thought to think that if a case of sprue is diagnosed, it must die and the diagnosis is confirmed by the pathologist. We do get such cases in the third stage of the disease and it is not far wrong to label them as 'Malignant Sprue'. But all the same we should not be missing the disease when it is at its beginning. For such a diagnosis, we can't wait for the development of all the symptoms aforesaid. Therefore we require the assistance of some laboratory methods. The laboratory investigations that are to be made to clinch the diagnosis are the following:—

1. X-ray examination after a Barium meal. This method, the author and Dr. Pillai employed not only for diagnostic purposes but also for treatment purposes as well. This method serves (a) in checking the diarrhoea, (b) the X-ray radiations have a soothing and curative effect on the ulcers and (c) the radiations bring about a change in the flora and fauna of the intestinal tract. In a majority of cases, the patients reported to us a great relief from this treatment, though the process of taking the photographs is often tedious and irksome to the patient. I prefer to have the X-ray photographs taken at the following hours. The first photo is to be taken almost immediately after Barium meal, in prone and supine positions. The other pictures are taken at intervals of 15 minutes, $\frac{1}{2}$ hour, 1 hour $1\frac{1}{2}$ hours, $2\frac{1}{2}$ hours, 3 hours, 6 hrs, 12 hrs, 24 hrs and 48 hrs. In sprue cases, it was found that the contents of the stomach passed into the small intestine in less than

three hours. The duodenal cap in a few cases was found to be indistinct. The process of digestion, I suppose, to a great extent, takes place in the small intestines; especially it is found to be so in the case of a vegetarian, where there is no need for peptic digestion to take place in the stomach. This extra amount of strain over an exhausted system brings about first an atrophy of the mucus membrane which rapidly desquamates. Finally the whole of the small intestines become atrophic and the X-ray photographs show a rapid emptying of its contents. Such a condition may possibly be due to (1) undigested particles of food irritating the small intestines. (2) undue strain thrown over this portion of the intestines and (3) the small intestines sharing the general emaciation of the whole body. In the large intestines, we find ptosis, distension, diverticulitis, diverticulosis, stasis and ulceration of the gut. The distension is most probably due to excessive gas formation due to fermentation and partly due to the atony of the musculature of the gut. The circular muscle fibres seem to be more affected than the longitudinal ones. Stasis may be at the caecum or at both the flexures or at the sigmoid. The distension in the whole of the colon is so great that it is mistaken for Hirschsprung's disease (Megacolon). The food remains in the large bowel for a much longer time, than in the stomach or small intestines and so fermentation and distension takes place. The large intestines lose their normal haustrations and in some cases they may look like a tube. At other positions, the bismuth may be found as if hanging in a hammock. The large intestines rapidly empty in gushes as it were during morning hours and so the motions are frothy and contain much gas. The motions stop of their own accord if the large intestines become empty. In the hospital cases, since the patient is put on a restricted diet and undergoing treatment, the characteristic morning diarrhoea during the earlier stages of the disease may not be noticed. We can definitely divide the disease into acute, sub-acute and chronic cases with the help of the X-ray photographs after Barium meal. Thus the Barium meal photographs give us a clue to the diagnosis of the disease. In many of these cases, when other positive evidences were lacking,

a bismuth meal greatly facilitated the diagnosis. The ulcers revealed therein favoured the post-flexner theory of infection.

To be brief, I may quote from Manson-Bahr's Text Book on Tropical Diseases, 1935 edition, regarding our work. The Radiographic findings in sprue: "According to the Editor's experience and that of Pillai and Murthi, in acute incipient cases there is no loss of tone in the stomach or intestines. The stomach is emptied in two hours after the Barium meal, the hepatic flexure of the colon is reached in three hours and the intestines are empty in 6-8 hours. In sub-acute cases, there is slight loss of tone and vigour of peristalsis of stomach. In chronic cases, there is some ballooning of the large intestine, with some delay in the caecum and colon".

2. The second thing to do is an agglutination test with the serum of the patient against Flexner and Morgan group of organism. In a majority of cases, where the history of dysentery was lacking, I had positive results by the above test, giving a strong agglutination reaction to a titre 1:160 against Flexner. Thus this test gives information, when it is lacking in the history of the case. I suggest that this test can be adopted as a routine in the examination of all cases of sprue.

3. The third laboratory method of diagnosis is to do a fractional test meal. This is a very important test and perhaps the only test which greatly helps to distinguish sprue from a case of Addisonian anaemia. Very often Addisonian anaemia is indistinguishable from the severe anaemia in sprue. It can be done as a routine. The total acids, as well as the free hydrochloric acid were found to be remarkably diminished but the chloride content was found to be progressively higher. This high chloride content is due to pyloric atony and consequent regurgitation of the duodenal contents into the stomach. Fairly, Mackie and Malandkhar had similar results and they called this condition as "Neutralization Achlorhydria". Mc Lean Griffiths and Williams showed in their experimental dogs that the chlorides and hydrochloric acid were secreted by the stomach, the former being lower at a time when the latter was high. When this is the case it is important to devise a method by

which one can find means of differentiating true achylia gastrica from "Neutralization Achlorhydria". The best method so far known is to inject subcutaneously 1 c. c. of 1:1000 solution of histamine hydrochloride and estimate the total acidity after an Ewald test meal. Out of 17 cases, (Gompertz and Vohans) which showed no hydrochloric acid, in 59% of them free hydrochloric acid was detected after histamine injections. In 5 of my cases where there was achlorhydria, I found free hydrochloric after histamine injections. After the usual test meal, histamine stimulates the oxyntic cells, if they lie dormant and do not show the free hydrochloric acid in the stomach.

This test is important in the sense, that it gives roughly an idea as to what extent the free hydrochloric acid is defective. In a majority of the cases, hypochlorhydria was found. In most cases there was complete absence of hydrochloric acid after histamine injections and both of them had the blood picture of pernicious anaemia. A few cases did not show the presence of bile in the stomach contents, yet they showed a high value of the chloride content. The converse was also true, viz, where the bile was found in the stomach, there was no high chloride content in the sample of the meals. It does not seem to me that there is any relationship regarding the existing of the chlorides, the free hydrochloric acid and total acids. Why this is so it is not easy to explain.

The fourth method is the estimation of the total fat, neutral fat and fatty acids in stool. This test does not throw much light on the diagnosis of the disease. In an Indian the fat content of the stool is very low. The estimation of fat in the stool of such a case is found to be very much less. Personally I do not advise fat estimation in stool as a routine measure because (1) of the technical defects in the methods of fat analysis (even with Saxon and Holt methods), (2) of the erroneous results that we are likely to get in the patients that are fed on milk diet, which diet was necessarily to be given before the investigations are made and a satisfactory diet is prescribed and (3) it is of no assistance by the way of diagnosis and treatment. Sokhey and Malandkhar attached no importance to this test, as they had found the fat contents of the patients suffering from other diseases and were on milk diet, was almost the same

as that of the stool in cases of sprue. Yet it is possible that this test is of value in determining the prognosis of the case, if we know that the total intake of fat, since the fat in the stool is found to decrease in proportion to the improvement of the case.

The fifth important laboratory investigation is the bacteriological examination of the faeces. I outlined in my previous paper the findings that were got at different stages of the disease and the different media that could be used with benefit for the identification of the micro-organisms. Repeated examination of stool is often necessary to arrive at correct diagnosis. In some of the cases examination of stool 6 to 8 times became necessary before pronouncing the diagnosis. In all cases of sprue as a routine the faeces ought to be examined for these three groups of organisms (1) Flexner (2) Streptococci and (3) Monilia.

The other laboratory investigations that have to be necessarily made to gauge the prognosis are (1) a complete cytological examination of the blood (2) the Vanden Bergh test (3) the inorganic and organic calcium content of the blood serum and (4) the blood cholesterol.

No cytological examination is complete without finding the following: the percentage of haemoglobin, the absolute count of the R. B. C. and the W. B. C., the colour index, the average diameter of the corpuscle, the abnormal cells,—the degenerative and the regenerative forms—and lastly a reticulocytic count. The blood picture of a case of advanced sprue is indistinguishable from that of a case of Addisonian anaemia. Both have an identical blood picture with a high colour index. The other anaemia which simulates sprue is the anaemia in the sub-acute degeneration of the cord. Therefore the three diseases, Sprue, Pernicious Anaemia of Addison and Sub-acute combined degeneration of the cord form the triad. The word Pernicious Anaemia is a misnomer, as in several other diseases as well blood picture of Pernicious Anaemia may be seen. Therefore the terms primary and secondary anaemias are obsolete and they must go from all text books. There is nothing like Pernicious Anaemia. It is better to use the term severe grade of anaemia in the place of Pernicious Anaemia. All the changes in the nomenclature of these terms

are fast taking place in view of the great advancement of the cytological studies made with vital staining in the recent years.

Price Jones curves are elaborate and tedious, but one with the Eves halometer can read more or less accurately the diameter of the corpuscles in less than a half a minute. In severe cases of anaemia the average corpuscle diameter is found to be high. If the diameter of the corpuscle is getting smaller, it means the patient is progressing. With this instrument the normal diameter is found to be 7.6 microns in the dried unstained film.

A graph can be prepared to show the curves of the R. B. C., the percentage of haemoglobin and the reticulocytic count. The reticulocytes are found to decrease progressively as the R. B. C. and haemoglobin increases. Therefore a graph of this nature is essential to be made with each of the cases.

The Vanden Bergh reaction varies with the condition of the blood. If the blood picture is one of Addisonian anaemia, it is found to give an indirect positive reaction and bilirubin content of more than 2 units. Mc. Nee considers that 0.6 units of bilirubin is found in normal individuals. Schiffs is of opinion that 1.2 units of bilirubin in blood is indicative of some pathological change in the body. Thus Vanden Berg test is not of much significance except for the fact that it shows the presence or absence of haemolysis.

The test for serum calcium does not very much help in the diagnosis. The author determined the calcium content in the South Indians; and it was found to vary from 7.8 to 12.5 mgm. This variation is roughly about the normal. On the whole the average South Indian has less amount of calcium than an European. But in those cases of Sprue wherein depletion of calcium is noticed, calcium lactate, parathyroid, phosphorus and vitamin D can be given. Calcium lactate cannot be absorbed into the system without the other constituents as the phosphorous and vitamin D being administered. These seem to assist the calcium metabolism. Linder and Harris have shown that calcium salts and Ergosterol were without effect in treatment of sprue, until the fat in the diet is reduced.

The next investigation of the cholesterol content of the serum is of some importance,

if we know the cholesterol content of the food taken by the patient. Fairley reports a rapid rise of cholesterol in the serum occurring in cases fed on a high proteid diet or on liver extract. But Newham, Morris and Manson Bhar found hypocholesterolaemia which had no relation to the degree of anaemia. In some other diseases as in pernicious anaemia we are likely to get a low cholesterol content.

The above four tests have to be done as a routine, since they help partly in prognosis and partly in instituting the right kind of treatment. From the point of view of differential diagnosis, these investigations do not very much help.

The last investigation which is of very doubtful value is the blood culture. Mackie and Gore reported to have isolated a pleomorphic organism allied to *B. Mallei* from blood in one case and in another from the duodenal content. The authors themselves are silent about this observation later on, and therefore the test is of no sequence.

The value of sigmoidoscopic examination of the rectum for diagnostic purposes does not compare as favourably as do the results obtained by a Barium meal examination. Not only is this of any value in lesions situated far above the reach of the sigmoidoscope, but also there is a definite risk attending this examination. Whereas the Barium meal tends to heal and soothen the ulcers, the instrumentation leads to unnecessary irritation and exacerbation of symptoms caused by trauma and its consequences.

There has been a case where sigmoidoscopy, right enough revealed the ulcerative lesions in the lower bowels, but unfortunately the trauma induced thereby resulted in peritonitis with a fatal result. This one fatal case could have given a direct objective evidence of the ulcerative lesions with concomitant factors relative to the abdominal organs in particular but unfortunately a post mortem examination could not be made as no amount of persuasion to lend the body for post mortem examination was effective with relatives concerned.

Therefore sigmoidoscopic examination in cases of sprue must be discouraged. The whole of the descending colon with fibrous adhesions and thickening as a result of chronic amoebic or bacillary infections

becomes so friable that instrumentation however gently done will surely lead to tearing of the gut wall with its undesirable effects.

A Barium enema in sprue is not of much consequence in as much as the condition of the caecum and the colon could not be visualised by this procedure in their natural state. The extra pressure induced by the injected Barium enema increases the calibre of the colon and obliterates the finer pathological changes which we would like not to miss.

Therefore sigmoidoscopy and Barium enema should never be used for the diagnosis of cases of sprue.

*DIET OF THE INFANT AND TODDLER.

BY

DR. (MISS) M. K. M. ALEXANDER,
M. B. Ch. B.,

Rainy Hospital, Madras.

To-day I have been asked to speak to you on "The Diet of the Infant and the Toddler" and I think it well worth while to devote a short time to the infant, as the foundations of a good digestion are of inestimable value to the toddler.

A right beginning is essential, and I feel sure all my colleagues will agree that natural feeding is every baby's birth-right, and that practically speaking, the breast feeding of babies should be and could be universal. There are one or two very rare exceptions, such as tuberculosis in the mother, or some temporary acute infectious disease where the doctor feels there would be undue risk of infecting the child in the course of nursing.

Properly and efficiently carried out, breast-feeding is best for the mother's health and figure, as well as best for the baby, and so I want to impress on all here that "failure in nursing is almost always due not to failure of nature, but to failure to live in accord with natural laws and requirements, and failure in management." The many alluring advertisements for baby foods are extremely harmful, but even if some of these foods build bonnie babies, how much bonnier are the babies who receive their natural and perfect food.

* Lecture delivered at the Conference on Maternity and Child Welfare organised by the Madras Health Propaganda Board.

Breast-feeding is really an art, and we must learn by observation exactly the right length of feeds to allow each individual baby. Some mothers fail in nursing not because they have too little milk, but because they have too much in the early days. The baby is stuffed during the first few weeks, and being overfed he suffers from indigestion and becomes a crying fretful baby, and the mother becomes worried, finds her milk going, and begins on a bottle. On the other hand if the milk is delayed, so many mothers give artificial food in too great quantities, and the bottle becomes a serious rival to the breast, and between the two the digestion is ruined. For every baby there must be a normal routine, and the ideal is to feed by the clock on a 3 hourly system changing gradually to 4 hourly after 6 to 8 weeks. Personally I find this very difficult to carry out with uneducated mothers unless they are in hospital, and yet I have been told by other educated mothers what a difference regular feeding has meant for them. With previous children they had crying difficult babies, and with this regular system of feeding they don't know there is a baby in the house, and both mother and baby have been so much happier and healthier.

Any baby that is 4½ lbs. or under should be treated as a premature one; and though the care of such demands more thoroughness and devotion, with knowledge and a good share of common sense, the very tiny baby who is really completely alive and healthy at birth, can be safely and successfully brought up in an ordinary home. The great danger to the premature baby is loss of heat. It has little available fuel stored up in its body, and the heat regulating power is undeveloped. So immediately the baby arrives it should be wrapped in warm cotton-wool, and put into a deep nest so that moving currents of air may not reach it, and the temperature should be maintained constant. Incubators are sometimes used, but unless in hospital cannot be considered, as they need skilful handling to see an even temperature is maintained, and that the baby is also getting plenty of fresh air.

The premature baby is certainly more difficult to feed, and finds it hard to assimilate his food, and so it is most vital that there is a supply of breast milk. Yet there is a widespread idea that if the baby comes

too soon it will be impossible to breast feed, though all that is necessary often is to give artificial stimulation for the first few days. The breasts must be stimulated and massaged, and milk drawn off by hand, or by breast pump. A really tiny baby may only have plain boiled water for the first 24 hours, and then the milk such as it is must be expressed 6 times daily. The baby should be fed by pipette very slowly, and the greatest care should be exercised in moving the child after a feed or he will return all the food that has just been patiently given. This is due to the muscles of the stomach not yet functioning.

Another of the difficulties of feeding the little premature, is due to the fact he is a very sleepy little person; certainly this is good, as the more he sleeps the better, but it does complicate feeds, and these we must keep regular. Then he has not the strength to suck very long, and yet we must see he gets enough. Every effort should be made to feed the premature baby on mother's milk, but if there is nothing at all at first, the ideal plan is to get a nursing mother nearly to give 3 or 4 ounces of breast milk each day, which should be diluted with boiled water according to the baby's body weight. The first few feeds can hardly be too weak. Once he is sucking the interval and time at the breast must be gradually lengthened, till he receives the same treatment as the normal baby.

The diet of the mother who is nursing her baby is also important, and overfeeding is just as harmful as underfeeding. The ordinary mixed diet of health is the ideal one. Hot curries and spices and pickles and tinned food and alcohol must be avoided, while plenty of fresh fruit and fresh vegetables should be given. It is here, however, that the economic problem comes in. Fresh fruit is expensive, and fresh green vegetables are almost unknown at least in the villages I am familiar with. I feel there is a whole field here that needs development, for if the village folk ate less polished rice and took whole rice, ragi, wheat and dhal and tried to cultivate some simple green vegetables or tomatoes there would be vast gain to the health and physique of their children. The lack of mineral salts and vitamins in the diet of the South Indian woman during pregnancy and lactation is responsible for so much constipation, bad

digestion, anaemia, acidity of the blood, and appalling pyorrhoea that the power of resisting diseases such as dysentery, malaria, tuberculosis, cholera, leprosy is greatly lessened, and so many babies are left motherless due to these. As Colonel McCarrison points out in his excellent little book on food, which all parents should read and digest, diets which contain the necessary nutrition as well as the essential vitamins to suit all races, and castes, and religions can be arranged from the common classes of food stuffs, but the mother in the village needs a great deal of education on this subject. Simple meals which include whole grains, fruits and salads, and which must be chewed and masticated well, will safeguard the mother's health as well as that of the baby.

Some mothers have not enough milk to satisfy their babies, but this should not be decided by the mother or her neighbour, but only after careful enquiry by the welfare centre or doctor and by test weighing. In such cases there is no necessity to wean the baby, but a supplementary feed of cow's milk or other artificial food may be given and such should be given immediately at the end of the breast feed so that it mixes with the breast milk in the child's stomach. Many mothers believe that cow's milk or other artificial food disagrees with the baby, but although cow's milk may disagree with the baby, it never disagrees with breast milk or makes breast milk disagree with the baby.

It cannot be too strongly impressed that artificial or unnatural feeding is only second best, and that there is really no such thing as humanised milk, in spite of all the marvellous advertisements we read. Human milk can be copied in composition so that the baby can be offered a food which will give the benefits of breast milk, but its inherent qualities such as immunity-conferring powers, freedom from germs and the natural link it forms between mother and child cannot be copied in any laboratory, however scientific or up to date.

Nature has provided mother's milk for every baby, and the most experienced nurses and complete sterilizing outfit and all the riches in the world will not compensate the child who is denied this food. Artificial feeding is a tragedy, but for the sake of the

baby who loses its mother at birth, or has a diseased and delicate mother, or where circumstances necessitate the mother parting with her baby, artificial feeding must be considered. The choice of food is definitely an economic problem, and looks as if it will remain so for a considerable time. In this country cow's milk mostly must be used either whole or diluted or as a foundation for making humanized milk mixtures. Yet I could name to you several villages near my village dispensary where cow's milk is not available, and where the infant whose mother cannot feed it often perishes. Where cow's milk is unobtainable, goat's milk may be tried. The one great advantage of goat's milk over cow's milk is that it is less likely to be infected with tuberculosis, though in composition it is richer in fat, and is often not so well tolerated. The common objection to goat's milk in our country is its smell, but this is merely prejudice, and in no wise interferes with its value. Asses' milk might be occasionally used if cow's milk cannot be tolerated. The casein in it is less than in cow's milk, and the curd is therefore more flocculent and almost as fine as that of human milk. On the other hand it is very deficient in fat, and should only be used to tide over a period of digestive trouble. It should not be diluted and does not require sugar.

We must recognise the difference in composition between human and cow's milk. Roughly the percentages are as follows:—

	Sugar	Fat	Protein.
Human milk	8	4	2
Cow's milk	4	4	4

So cow's milk is deficient in sugar, and contains double the amount of protein, and because of this milk mixtures are used to suit the human baby.

The advantages and disadvantages of fresh boiled cow's milk are:

ADVANTAGES	DISADVANTAGES.
1. It is cheaper	Alteration in taste.
2. Easier to obtain	Loss in vitamine value.
3. Boiling makes the curd more digestible.	Composition may vary.
4. Germs are destroyed.	Possibilities of carrying disease, e. g., Typhoid & T. B.

DRIED MILK

ADVANTAGES	DISADVANTAGES.
1. Sterility	1. Cost.
2. Easy to make mixture.	2. Loss in vitamine value.
3. Curd more easily digested.	

I shall merely mention the names of the best brands of proprietary dried humanized milks: Cow & Gate, Sunshine Glaxo, Allenbury's, Lactogen, Trufood, as these are for the rich only, and in them even there is a deficiency in the supply of vitamins. These vitamins must be made up by giving orange juice or tomato juice, or if that is too expensive raw sunde juice and spinach juice, and these must be given even from birth if there is no mother's milk.

The ideal to be aimed at is 8 to 9 months complete breast feeding, and normal weaning should take place during the 10th month, and in the interests of the mother and the baby should be a gradual process. Babies do not take kindly to changes, and though it may be easier to wean on a bottle, it is with a view to the baby's own interests to use a spoon and cup. If the giving of water and fruit juice has been by spoon and cup, then the baby will take more kindly to it. At least one to two months before weaning, it is good to teach the baby to bite a hard baked crust or rusk. The first change may be carried out as follows: 4 breast feeds in the day at 6 A. M., 10 A. M. and 6 P. M. and 10 P. M. and one artificial feed on a milk mixture at 2 P. M. for a few days. Then 3 breast feeds at 6 A. M., 2 P. M. and 10 P. M., and two artificial ones at 10 A. M. and 6 P. M.

The third change means two breast feeds at 6 A. M. and 10 P. M., and 3 artificial feeds at 10 A. M., 2 P. M., and 6 P. M.

The last change one breast feed at 6 A. M. and the rest artificial feeds, and lastly drop the 6 A. M. breastfeeding and the baby is weaned.

The management of weaning is most important, and here it is that the European mother so often scores over the Indian mother, because her powers of discipline is much more developed. If the mother struggles for a little and then gives in, there is bound to be trouble, and even if the baby refuses, he must be put down firmly without food. It will not hurt him to miss a meal,

but will impress upon him that it is this new food or nothing. If some one else than the mother can give these first feeds it is often helpful, and also to give the feed in a different room and with different surroundings will distract him, but during weaning the mother must keep very calm, and the giving of humanized milk mixtures puts the least possible strain on the digestion.

By the end of the 10th month weaning ought to be complete, and now the introduction of solids begins. There is however one school of thought chiefly in America, which maintains that milk alone is the proper food for a child up to 2 years. They give up to 2 pints of milk per day, together with orange and fruit juice and the juices of vegetables only, and they deprecate giving egg to a child under 3 years, or meat under 6 years. I just mention that to show you that milk is really a perfect food, and I remind you again of the villages within 15 miles of Madras where ordinary cow's milk is unobtainable even for a sick child with typhoid, much less for the average healthy infant. There is on the other hand, a very much smaller school of thought who believe that it is against nature to give milk to a child once it is weaned, but I feel the more correct path lies between the two, and that there is a lot of truth in the old custom of letting a child have a little of what is going in moderation, after it is safely weaned. If babies are used to biting hard baked crusts just before and during weaning, a boiled scraped mutton or chicken bone may be introduced. It is more important here to learn to masticate and use the little jaws, than actually to get nourishment from the bone or crust. During the 10th to the 11th month, additions such as ground rice, rice congee, oat flour or oat jelly, ragi, or wheat congee, or milk pudding may be introduced. Starch is so cheap that it is very difficult to withhold it, but we must also remember proteins are the body-building foods, and a sufficiency of them is essential at this stage of rapid growth. Egg yolk on alternate days starting with a teaspoonful, and a little meat soup or gravy are next additions, and milk mixtures should be included in the diet up to the first year. At 11 to 12 months potato, plain boiled rice, bread and butter, egg in the form of custard are added.

The place of fruit is one of the problems of the nursery, and here the wise mother

must exercise her own judgment. Baby must have enough vitamins, and though we believe in the value of oranges and apples, the immature power of digestion and tiny stomach must be kept in mind. If a mother says orange juice doesn't agree with baby she must be advised to dilute it more, or try another brand of orange, and sugar should not be added to it. An apple is best introduced about a year old, but the baby should never be left alone with it. Partially peel the apple, and hold it for baby's teeth to work at it for a little, and then take right away. It is the exercise and the cleansing properties obtained by working the teeth and jaws on the solid side that counts. About 18 months the morning milk may be replaced by a peeled apple or other fruit juice. Prune juice or the juice of other dried fruits is very good for constipation. Bananas are rather indigestible and are better left till the child is older. After the first year in the early morning orange juice and water may be given, varied with a whole peeled apple by the 18th month. During this time breakfast may consist of bread and butter, strained oat-meal, barley, ragi or wheat congee, and whole milk. The midday meal may consist of plain boiled rice or boiled rice with buttermilk, egg or gravy and potato or vegetable soup, stewed fruit and rusks, or milk in the form of pudding. The evening meal, bread and butter, congee, rusk or biscuit and milk. At this time steamed fish or pounded chicken can be introduced.

Good-bye to baby-hood arrives when the little one can stagger to his feet alone, and begin a voyage of discovery for himself. He has emerged from the helpless babe to the intelligent independent little toddler, with a personality of his own, which should be recognised and respected. It is here that right habits must be encouraged, for all the little actions being practised are forming character, and how difficult it is for a child to grow out of a bad habit. Of all things that are necessary to a child, such as cleanliness and bodily hygiene, fresh air, exercise, proper clothing, discipline, and love, there is one essential, namely, nutrition. An ideal diet is not an easy thing for the average mother to provide without some knowledge of food and food values. Besides, the care of the toddler demands every ounce of her patience and self-control.

For the tiny baby a simple routine is

sufficient, but environment and management complicate the routine of the toddler. Apart from the actual diet itself, there are several principles that must be laid down, and here are some of the most important:—

1. The food must be fresh; no re-heated, tinned, preserved, or over-cooked food should ever be allowed.

2. The food must need mastication and give work to the teeth.

3. The interval between meals must be kept regular, and must be a minimum of 3 to 4 hours at least. Eating between meals should never be tolerated, and the giving of sweets between meals and at bed time is definitely wrong. Sweets such as barley sugar or plain boiled ones may be allowed occasionally, but only immediately after or with a meal.

4. A child may be taught to take almost any food and through usage grow fond of it.

5. No tea or coffee should ever be given to a child under 5 years.

The choice of food may be very wide and varied, provided these rules are observed. So many mothers make the mistake of mincing and mashing and soaking food, so that the child takes more than is necessary, and neglects to use the sharp little white teeth. Other mothers imagine the child needs sweet things, and the giving of sweets and snacks at all times not only gives rise to indigestion, but also to lack of appetite for the proper nourishing food. Sweets and sweetened foods are responsible for so much of the dental caries from which even little children suffer. We Scotch people always flavour our oat meal porridge with salt, and in all well-regulated households every little toddler began the day, and still begins, I hope, with porridge and milk. It is invariably the child who won't eat the ordinary food who is the one who has been pampered with sweets. Speaking generally the variety of foods for the toddler include whole meal bread, good butter or dripping, milk, eggs, fish, rice, ragi, wheat, dhal, cheese, fresh fruit, green vegetables, especially lettuces and spinach, root vegetables (especially carrots), fresh meat, twice a week, is quite sufficient, and in South India the toddler can easily dispense with meat till he is five years old.

According to Colonel McCarrison the caloric value of common articles of diet

in this country show that the ordinary mixed diet of the poor contains too little protein and fat, and too much carbohydrate, and that it is sadly lacking in all the vitamins. Even the diet of the better class is badly adjusted. Although the caloric value of polished and unpolished rice is the same, the vitamin content of the polished rice is nil, and diet can be greatly improved by substituting unpolished rice for polished, and by the addition of milk and milk products, green vegetables and fruits which contain all the vitamins and mineral salts so necessary for the bodily health and building up of resistance to disease.

Here is an ideal menu for a European child of 2 years, and I should be very grateful if some of my Indian colleagues will give a similar menu for an Indian child of 2 years. Morning meal or breakfast—Toast or brown bread with butter or a little dripping, Porridge, milk or cocoa, raw apple or stewed fruit. Midday meal or dinner, chicken or meat twice a week, fish twice a week, with gravy, potato, and vegetables. Milk pudding or stewed fruit varied with baked custard or light steamed pudding. Evening meal bread with butter or dripping, biscuit or plain cake occasionally, salad, milk.

Children should always be encouraged to drink pure water, half an hour before meals preferably. The last meal of the day should be given at least an hour before bed-time, and after the teeth are cleaned there must be no giving of a sweet or a little drink of milk. Under no circumstances should a child be coaxed and pressed into eating. If food is only offered three times a day, with no bits and pieces in between, there will be no need to create an appetite. A romp before breakfast, and rest before dinner are aids to a good normal appetite, and children who are kept up too late at night are sometimes too nervous and listless to eat. Meal times should be quiet and restful; little toddlers must be in good moods for good manners at meal times. It is always wise to calm an excitable, irritable child, or cheer up a sulky one, before sitting down for food. Proper feeding and good habits at meal times will have far-reaching effects in the days when the toddler becomes full grown.

THE GENERAL PRACTITIONER AND COMMON EYE DISEASES

II

(G. J. G.)

METHOD OF EXAMINATION

In examining eye cases, close observation is essential. Unlike diseases of the general system, history of the case may not be very much necessary in all cases, especially in external diseases of the eye, but if you can make note of every little detail, you will get the diagnosis almost by intuition. Till you get into that habit of being able to note everything that matters, it is necessary, in the beginning at least, to adopt a systematic method of examination.

I propose to confine myself to an examination of the anterior segment only of the eye (about 80% of curable diseases of the eye are of the anterior segment). The equipment that is required is not very much. It is not necessary that one should have an electrical installation or any special dark room lamp. The modern electric torch serves the purpose very well. But it should be of a focussing type to give you a concentrated beam of light at a focus of four to six inches. The torch with a narrow dial is better than that with a broad one. The button should be such that you can press or release it with a slight touch. The light is shown at an angle of about 45 degrees to the surface of the eye. If you show it directly against the eye, the dazzling will prevent the patient from opening his eyes. If it is directed from the extreme sides, there will not be a well focussed beam on the field of examination.

For examining minute details, a magnifier will be helpful. Any binocular loupe will do. I prefer Bishop Harman's. The advantage with that is, it leaves your hands free and it does not shut off your vision outside the field of examination. The way to wear it is to pull down its bridge to very nearly the tip of your nose—as an old school-master is usually depicted in caricatures—and then get at your focus, with the light at the same time thrown on the parts you have to examine.

No special dark room is necessary. Many of the external diseases of the eye could be

examined in your consultation room itself. When any fine details have to be seen, especially on the cornea or iris, the windows and doors might be closed. That amount of darkness is sufficient to give you a clear view of the torch-lit field.

For examining children and in some cases adults also, retractors may be necessary to pull the lids apart to have a view of the eye. I use generally Desmarres' eyelid retractors. They cause the least injury to the tissues and are handy. You will require two of them, one for each lid.

I am against the use of local anaesthetics for the examination of an eye. Where there is a severe photophobia and it is practically impossible for you to have a look at the eye, you may use just one drop of Pantocaine, one per cent solution. But don't use it indiscriminately for all cases.

A rough knowledge of the anatomy of the eye is necessary to detect and understand the clinical symptoms found, but more important than that, the examiner should have a clear impression of what is normal in an eye. To gain perfection in that knowledge, I should advise every one to start with studying a number of normal cases repeatedly in the order of examination I am giving below. When you get a clear impression of what is normal, any change will be apparent immediately on inspection.

The examination of a patient begins from the time he enters your room. Observe whether he is entirely blind and has to be led by others or whether he feels his way, whether he has a vacant look or whether he tries to peer through with screwed up lids, whether he is in agony with pain in the eyes or head, whether there is photophobia and all that. Even as the patient sits on your examination stool, you can have a rough idea of his sight if it is defective.

Seat the patient in such a way that he is facing the light of the window or the door. You should be seated in front of him with your back to the light and the height of your seat should be such that your eyes are about the level of his.

Before you proceed to examine the eye, a general survey of the face will be helpful. Facial paralysis, ptosis of the upper lid, squint, motility of the eyes, swelling, general or local, prominence or sunken nature of the eye—all these may be noted.

Then follows a general inspection of the eye. Note whether the eye is red and there is discharge. If there is a discharge, is it profuse or only just at the medial corner of the eye? What is its nature—is it purulent, muco-purulent or mucous? Is there a photophobia? Is there any watering from the eye? Are the eye lashes matted together or are they free? Are they in regular order or are some of them turned in? Is any of the lid margins inverted or everted? Is the curvature of the lid, especially of the upper one normal or distorted? Is there any puffiness of the lids? If it be a case of injury what are the lesions?

Going down to details start with a close observation of the lid margins. Look for small crusts at the hair roots. The margins of the lids may be inflamed. Note whether it is general or whether it is confined to the angles only. Patches of scanty or no eye lashes or a double row of eye lashes are easily perceived.

Before you go to the examination of the conjunctiva, the condition of the lachrymal sac may be noted. Where the sac is inflamed, the swelling and pain will attract your attention immediately but in chronic dacryocystitis, a careful examination is necessary. Note whether there is any small swelling about the area of the medial canthal ligament and if present, whether it is above or below the ligament. Even if no swelling is perceivable you must see whether the sac contains pus or retained tear. To find it out, draw the lower lid down to bring the lower punctum in view and with the thumb of your other hand (the other fingers of the hand resting on the other side of the face) apply gentle pressure on the area of the sac in such a way that the fluid regurgitates out through the punctum. The pressure is directed towards the lachrymal fossa and slightly to the inner side and upwards. Take care to see that you are not pressing on the passage itself.

The tests for obstruction in the lachrymal passages will be taken up later in connection with dacryocystitis.

Proceed to examine the inside of the lids. First draw the lower lid down with the bulb of your thumb flat on the skin, asking the patient at the same time to look up, and you get a full view of the conjunctiva of lower lid. Note the colour of the conjunctiva and the presence, if any, of follicles, localised

or general redness or swelling, sticky discharge, adhesions, etc.

The examination of the conjunctiva of the upper lid requires a bit of practice. I am sure most of the doctors who are reading this can evert a lid easily, but a short description of the technique might be helpful to those who experience any difficulty. Ask the patient to look down. If you are examining the left eye of the patient take a good grasp of the eye lashes close to their roots with the thumb and forefinger of your left hand and pull the lid down and a bit forward. Place a glass rod or a small kuchee or pencil or your own right forefinger horizontally over the lid behind the tarsus, that is well away from the lid margin and using that as a fulcrum pull the margin of the lid up with the left hand and lid is everted. After the eversion, the rod used as fulcrum may be removed and the eversion can be steadied with the help of the left thumb on one side and the left forefinger on the other side of the everted lid, leaving the right hand free to throw the torch light on the field or to pull the lower lid down, when there will be a clear picture of the conjunctiva of the upper and lower lids together.

Don't attempt this eversion when there is any deep ulcer on the cornea or any perforating injury.

A careful study of the normal conjunctiva of the upper lid will be helpful in discerning early pathological changes. You must have a clear idea of the appearance of the conjunctiva, its blood vessels, the size and thickness of the tarsus, etc. The magnifying loupe will be helpful here. What you may have to note in a patient will be the presence, if any, of a foreign body, follicles or granules, generalised or localised hyperaemia, ciccatrical areas, condition of the tarsus, etc. The fornix also requires examination at the same time, but that will be taken up when we come to Trachoma.

We then come to the bulbar conjunctiva and the sclerotic. The colour of the conjunctiva, general congestion, localised redness superficial or deep, inflammatory swelling, nodules, haemorrhages, general congestion, whether it is more marked around the cornea of the conjunctiva of the lids, whether any fleshy growth from the conjunctiva is encroaching or spreading over the cornea—all these may be noted.

Pericorneal and conjunctival congestion, may conveniently be dealt with in connection with the respective diseases.

The examination of the cornea and the deeper structures will require the aid of focussed illumination and at times magnification.

The size of the cornea whether it is small or big may be made note of first. Then examine for any foreign body, abrasions or ulcers, presence of vessels growing over the cornea or deep into its substance, haziness, deposits or opacities superficial or deep, and everything that affects the clear transparency of the cornea and the smooth shininess of its epithelium.

The condition of the anterior chamber and iris will be clear if the cornea is transparent. You must learn to note the depth of the chamber, whether it is normal, shallow or deep. For this a study of a number of normal eyes is essential. Muddy or turbid chamber will not show a clear picture of the iris. You must train your eye to note the smallest collection of pus at the bottom of the anterior chamber and also dots or deposits at the back of the cornea. The aid of the magnifying loupe is essential in these examinations.

Any inflammation in the iris will be evident as loss of its usual lustre. A practised eye will not miss it. The normal structure of the iris with its crypts can be seen best with the help of the loupe. Any coloboma of the iris will need your enquiry whether it is artificial or congenital. This will be explained later. Note whether the iris is adherent to the cornea or to the lens and whether the pupil is irregular and closed. The margin of the pupil also must be examined closely for any sphincter atrophy and other changes. The colour of the iris will give an interesting study.

The examination of the pupil is very important. Such serious diseases as glaucoma, optic atrophy and some retinal diseases have an effect on the reaction of the pupil to light and if this is detected, the patient will get an opportunity to be warned of his condition and to consult a specialist in time.

First note the size of the pupil. Is it equal in both eyes? What is its shape? Is it regular or irregular, round or oval, dilated or contracted? In young people especially,

the pupils might appear wide and dilated when you begin to examine them without getting into their confidence. The dilatation here is only from fright and if you wait for a minute and then examine after the patient is re-assured, you will find the pupil in normal size.

The reaction of the pupil to light is very important. Throw the light suddenly, switch it off and then put it on again and watch the reaction of the pupil. The electric torch is very handy and good for this purpose. The button should be such that you can press or release it quickly without any special effort. The focus must be well on the pupil. In normal eyes you will find the reaction of the pupil to the light clear and active. An immobile or a sluggish pupil denotes a serious lesion inside. Test the reaction of the pupil in each eye separately having the other eye covered. It is an important point and must not be forgotten.

In the lens there is not much to see from an external examination, except opacities. If there is a mature or traumatic cataract it will be evident with the light on, but in immature or incipient cataracts, before a definite opinion is formed it is always safer, for beginners especially, to confirm the diagnosis by an examination with the ophthalmoscope. I shall not be dealing with that now. It is an important point to know whether a lens is present or not and whether it is in its position or is dislocated. The special tests for these will be explained later.

The examination of children requires much tact. Don't use force unless it is necessary. Many children could be examined when they are on their mothers' shoulders. Try to have a look at the eyes without your touching the head or the eye of the child. Sore eyes—a common affection in children will be easily recognised from the discharge,

redness and all that. But if the lids be swollen and the child cannot open the eyes, put the child on the table, have somebody to steady the head and hands, separate the lids gently with the aid of the Desmarres' retractor and then examine the bulb with a light. If there be nothing worth, the conjunctiva of the lids may be examined and treated. Mere attempt to separate the lids with your fingers will give the necessary eversion of the lids for a view of the conjunctiva.

The reader should not be scared away by the voluminous details that I have catalogued for an eye examination. In fact I have left out certain details which I have reserved for later description. I have not also given the significance of the steps enumerated. All these will be dealt with in detail with the clinical appearance of particular conditions. Later, it is my intention to revert back to the method of examination to discuss the clinical symptomatology and general hints at diagnosis. This paper, however, is only to give you the line of examination, for if you do not know what all to note, you are very likely to miss some details—details which will have a strong bearing on the diagnosis. But, if you get into the practice of examining item by item, the chances of your overlooking anything of importance is nearly nil. I have no doubt given a long list of points to be noted, but after a little practice you will not find it a tedious examination. To get into the habit of a particular order of procedure and also to have a thorough impression of the normal condition, I want you first to examine not less than half a dozen normal eyes every day just for a week. You will find then that you can without any special effort examine the anterior segment of the eye within probably a minute, thoroughly exhausting the process of examination mentioned in this paper.

Scientific Optical Accuracy Guaranteed

AT

MANILAL M. MEHTAS

Wholesale and Retail Optician.

8, Broadway, Madras.

Abstracts

LEPROSY

While travelling in India one occasionally hears a peculiar sound uttered by one of the natives, this begins in a low guttural tone gradually increasing in crescendo to end in a short piercing cry.

This manner of giving warning of the approach of a leper has been substituted in India for the implacable "Unclean, unclean," of the leprous as recorded in the Bible.

This warning is made imperative in India by legislative enactment, and must be given by each leper when approaching another person at a distance of not less than seventy feet.

In those far off days when Moses was giving proclamations, with all the intransigent of an Oriental potentate, he issued an ukase which enjoined upon the populace the following restrictions: "When a man shall have in the skin of his flesh a rising, a scab, or a bright spot, and it be in the skin of his flesh like the plague of leprosy; then he shall be brought unto Aaron or unto one of his sons the priests."

After a physical examination the suspect was placed under strict quarantine regulations for a period of one week, at which time the patient was re-examined and in the event of doubt concerning the diagnosis the patient was detained in quarantine for another week. The result of a final examination was transmitted by his mentor to Moses who then issued this warrant:

"He is a leprous man, he is unclean: the priests shall pronounce him utterly unclean: his plague is in his head.

"And the leper in whom the plague is, his clothes shall be rent, and his head bare, and he shall put a covering upon his upper lip, and shall cry, unclean, unclean. All the days wherein the plague shall be in him he shall be defiled; he is unclean; he shall dwell alone, without the camp shall his habitation be."

These excerpts are taken from the most complete work on sanitation and health measures extant in the records of the ancients—the book of Leviticus.

Subtleness in the prodromal symptoms of leprosy cause this stage of the disease to escape detection in by far the greater number of instances, usually the disease is far advanced before the victim is brought to book and registered as a leper.

In the earlier stages of leprosy the diagnosis is difficult owing to the striking resemblance of the skin and mucous membrane manifestations of leprosy to those of lues, tuberculosis, and trypanosomiasis.

Expert laboratory technicians are still experiencing difficulty in differentiating the causal agents of these pathological conditions. With only a rising, a scab, or bright spot in the skin of his flesh as a peg upon which to hang his diagnosis, is it not highly probable many sins of omission were committed in Aaron's clinic?

The tragedies of faulty diagnosis on the part of this clinician must have involved many innocent victims in the Holy Land.

Leprosy was regarded as the most hideous disease in the entire range of human misfortunes, for a period of over four thousand years the sufferers of this disease were shunned, feared, detested as persons having committed an unpardonable sin. The page of history tells no other story comparable in cruelty to that of man's inhumanity to the leper, he was forsaken by relatives, abandoned by friends, cursed by the public and condemned by legal authority to live in exile, there to be destroyed by the all-devouring pitiless tooth of time.

This insufferable state of the leper continued, nay increased in abhorrence, each succeeding generation, vying with the preceding in heaping restrictions, ignominy, shame, disgrace and hardships upon the unfortunate leper until the middle of the nineteenth century.

No attempt had been made in all these centuries to discover the cause of the disease, relieve the sufferings of those affected or mitigate the harsh conditions imposed upon the leprous by an unsympathetic public.

In the year 1848 Danielssen and his co-worker Boeck, set about investigating leprosy and published the results of their findings. This, no doubt, is the first accurate scientific account of the disease.

Some years later, 1873, another Norwegian, Hansen, discovered the bacillus

leprae, since which time much progress has been made in knowledge of the symptoms, diagnosis, pathology, course and duration of leprosy.

Publication of the work of Danielssen and Boeck attracted the attention of humanities and shortly thereafter there appeared upon the scene a messenger of mercy, whose name has become a household word in every civilized country on the face of this globe.

Joseph de Veuster (1840-1889) was of Belgian birth, he attended the famous University of Lovain, took up religion, entered the priesthood and engaged as a missionary. His name in the order of priesthood is Father Damien. At the age of thirty-three he became interested in the problems of leprosy and thereafter devoted his remaining life, energies and talent to the care of those suffering of leprosy.

Heroes of Thermopylae Pass, the Light Brigade, the Alamo, whose names are emblazoned upon history's page as the acme of physical courage pale into insignificance when placed beside the work of this intrepid priest, who lived with lepers and spent his days in giving aid and succor to those unhappy mortals.

Father Damien was undoubtedly a man possessed of great force of character, an indomitable will and dauntless moral courage.

He went to the Hawaiian islands where thousands of lepers then existed and still exist, and through his intercession succeeded in obtaining legislative regulatory measures for the betterment of lepers and funds for establishing a leprosarium on the island of Moliki, one of the Hawaiian group. Through the same source Father Damien secured funds with which he revolutionized physical conditions then existing among the lepers, water and food supplies were regulated, clothing, medicines and other essentials for these much neglected people who hitherto had been relegated to isolation, misery and contempt.

In the Biblical account of leprosy one is led to infer the ancients believed the disease is highly contagious, but not hopelessly incurable, dubious phases of the malady which still exist in the mind of those well versed in the clinical course of leprosy.

Our former townsman, Dr. Eric Fennel, now located in Honolulu, informed the writer of these lines he had been able to recover the B. leprae, almost without exception, from tissue of patients discharged as cured of leprosy, thus giving supporting evidential value to the supposition of many non-leprous patients having been observed in Aaron's clinic and erroneously diagnosed.

The art of physical diagnosis was not then, nor even unto and including this day and generation, infallible.

It has been forcefully written and vocally proclaimed: "By their works ye shall know them," judged by this token Father Damien's name is indelibly written in the roster of the immortals and will dwell in the hearts of men as long as the written page survives.

In a world cruise one sees evidence of the humane work inaugurated by this great pioneer in almost every country. Leprosaria, staffed by doctors of medicine, nurses, missionaries and other attendants, wherein scientific research and care of the leprous are fully carried on, these conditions are in damning contrast to the inhuman management to which the leper was brutally subjected in a former day.

In the aggregate lepers are computed at from three to five millions now living, the wide variance is due to the vast horde of lepers living in the backward countries where reliable statistics are not available.

In one of the far-flung possessions of our country, the Philippine islands, there is a leper colony in which splendid work, scientific and managerial, is being accomplished.

The late Major General Wood, a real doctor of medicine, formerly Governor General of the islands, working in conjunction with Dr. Wade and his daughter Dorothy, organized a memorial for the eradication of leprosy. On one of the islands, Culion, which is resplendent of tropical flora agremens, there is situated a well equipped leprosarium, and there are approximately five thousand persons on the island suffering of leprosy.

In the past endemic scourges of leprosy have invaded many localities, this disease ravaged the inhabitants of Great Britain for thirteen successive centuries, beginning in

the year 600 A. D., and one writer says: "Burnt itself out about the beginning of the nineteenth century," however, there are sporadic examples of leprosy still existing in England.

Although leprosy is more frequently encountered in hot climates than in the temperate zone, no region on earth is exempt, this disease now exists in all countries from the scalding tropics to the frozen north. Asia and Africa with their teeming millions of human beings have an uncountable number of lepers. Japan, China, Indo-China, India, Ceylon, Java, the Straits Settlement, the Malay Archipelago and the numerous islands which stud the Pacific and Indian oceans are badly infested with leprosy. Numbers of these sufferers may be seen in South America, the Caribbean islands, Central America, Mexico, and a few in North America, but one must travel in the Orient in order to fully visualize the extent and ravages of leprosy.

The abject, piteous appearance of some of the unconfined lepers one sees in these countries cause him to shudder and commiserate their hapless condition, their utter helplessness, and their studied neglect.

The skin of those affected is thick, pudgy, dotted with numerous plum-colored excrescences, sloughing ulcers and white scales, with nails, fingers, toes, ears, nose and other members undergoing a deadly destructive process or absent. A clinical observation is to the effect, leprosy is less severe and patients live longer in a mild climate than near the equator.

A leprosarium located at Carville, La., is the only institution of the kind in continental U. S. A. There are about one thousand lepers in our country, four hundred of them are confined and under treatment at Carville, thus it comes to pass some six hundred lepers, perhaps undetected, wander aimlessly through the streets, complaining and begging like unto those in the Land of Sudden Death—India.

With the subject of contagiousness of leprosy still in doubt we submit this situation as being intolerable, demanding correction at the hands of our public health officials.

Of the several standard works on internal medicine examined, preparatory to writing

these comments, practically all maintain leprosy cannot be transmitted by inoculation.

Osler, however, cites an instance where in this disease was presumably reproduced by inoculation. A convict under sentence of death was inoculated, four weeks later neuritis and painful swelling of the ulnar and median nerves and nodules in the skin followed. Three years later leprosy was fully developed and the patient died of the disease, six years having elapsed between the time of inoculation and death.

Commenting, the author says: "The case is not regarded as conclusive, as he had leprosy relatives and lived in a leprosy country." (Hawaii)

A case history given by the same author markedly tends to confirm belief in the contagiousness of leprosy: "In 1860 a girl who had hitherto lived at Holstferhschhof, where no leprosy existed, married and went to live at Tarwast with her mother-in-law, who was a leper. She remained healthy, but her three children (1, 2, 3), became leprosy, as also her younger sister (4), who came on a visit to Tarwast and slept with the children. The younger sister developed leprosy after returning to Holstferhschhof. At the latter place a man (5), fifty-two years old who married one of the younger sister's children acquired leprosy; also a relative (6), thirty-six years old, a tailor by occupation, who frequently visited the house and his wife (7), who came from a place where no leprosy existed."

The duration of life varies from eight to twenty years after the inception of the disease, death takes place in the leprosy like unto death from other diseases, not from the original malady, but from some intercurrent affection.

The prognosis, formerly hopeless, is now being improved by means of modern medicinal and hygienic measures.

In the half century just past much has been attempted to banish this all-time scourge of the human race, but many eons will come and go before the last cry, "Unclean, unclean," is heard on the face of this globe.

The Journal of Medicine, August, 1937.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

BRITISH MEDICAL ASSOCIATION

SECTION OF DISEASES OF CHILDREN

At a meeting of this section, with Dr. H. Morley Fletcher (London) in the chair, a discussion on

ENURESIS

was opened by Dr. Robert Hutchison (London), who said that this condition, as Bacon said of medicine in general, is a "a subject which has been much laboured but little advanced," for we are still very ignorant of its causes and mechanism and largely helpless in its treatment. He limited enuresis to bed-wetting and did not regard it as pathological until the age of three. The functional characteristics are important although he maintained that the children show no recognisable psychoneurotic peculiarities and generally come from normal homes. He dismissed high acidity of the urine, phimosis, threadworms, enlarged tonsils, and adenoids as contributory causes, although he agreed that removal of the adenoids might be a deciding factor in terminating the condition. He called attention to the group of cases with nocturnal polyuria and wondered whether they were due to a functional disability of the kidney or to a vasomotor instability. Enuresis usually disappeared before puberty although it might persist much later. He summed up the essentials of prognosis in the words of a French writer; the enuretic is "socially dead". Dr. Hutchison's advice on treatment followed classical lines as to general management; sphagnum moss or a rubber urinal counteracted unpleasant effects. Belladonna has fallen into wrongful disuse, as it improved the condition clinically, although its mechanism was not understood. Ergot, ephedrine, pituitary extract, and other endocrines had proved of little help. The passing of sounds has no justification. There remained psychotherapeutic methods; suggestion and hypnotism might prove useful in certain cases, but more severe practices, such as Freudian analysis, were disproportionate to the object.

Dr. S. Graham (Glasgow) emphasised the importance of excluding organic disease,

notably pyuria, chronic interstitial nephritis, diabetes mellitus, and diabetes insipidus. The evidence that spina bifida, calculi, acidity, phosphaturia, and phimosis lead to a bed-wetting was not substantial. There was no typical mental make-up among enuretics, and their sleep characteristics varied, although the wetting usually took place soon after sleep began. Psychological treatment held out the greatest hope and should produce an increasing number of cures.

Dr. R. Marshall (Belfast) asked what caused the persistent occasional enuresis in a boy when he goes away from home, in contrast to the effect on the average enuretic of admission to hospital; and whether there was any recognised connexion between this type of enuresis and epilepsy. In his opinion enuresis was connected with two types of bad mother: (1) too fussy, (2) too careless.

The President did not agree with Dr. Hutchison's age limit, holding that control of the bladder should be established before three years of age. He advocated inquiry into the day habits of an enuretic; should frequency be a factor the child should be taught to hold urine in the bladder for gradually increasing periods of time, up to three hours. If this training was done well, the night habits would also improve. He mentioned the onset of enuresis in adolescence which he attributed to development of puberty, and also called attention to enuresis following severe measles and typhoid. Belladonna was the only useful drug, but must be used in sufficient doses.

Dr. E. A. Bennett (London) outlined the psychological point of view. He asked that the total personality should be taken into account and that the parental relations should be reviewed. These children absorbed "upsets" in the home and then developed enuresis. The child must be taught to take his own responsibilities and should keep a diary, in which he initialed his own reports. Hypnotism was often used but was superficial. Freudian analysis should be reserved for the exceptional child. Adler's methods were preferable and the attitude of the child towards his parents should be changed towards independence. Explanation of dreams might be of use and any method whereby the child was made to see that no

guilt was involved but only an emotional state would finally produce the desired cure.

Dr. R. E. Steen (Dublin) associated himself with Dr. Bennett as regards the "blame factor". He advocated the cutting down of solid food at tea as well as fluids and belladonna as the most useful drug.

Prof. S. Barling (Birmingham) also agreed with Dr. Bennett. It was important for the child to take his own responsibility. Close co-operation with the psychotherapists was desirable.

Dr. W. R. F. Collis (Dublin) asked that a greater interest should be taken in the cause of the condition.

Dr. A. A. Moncrieff (London) said that babies nowadays are overtrained and that parental interest in psychology frequently produces untoward effects.

Dr. H. K. McKernan (London) asked what could be done for the child from the poor home who cannot be induced to attend a child guidance clinic.

Dr. T. H. Crozier (Belfast) agreed that the most difficult cases come from poor homes, and that the parents need treatment as well as the child.

Dr. D. C. R. R. Jenkins (Belfast) described the distress of the boy who suffers from enuresis on entering his public school. The condition frequently disappeared as he gained in importance. He had found the use of a diary and the administration of belladonna gave the best results.

Dr. Hutchison, in reply said that in persistent occasional enuresis a return in an almost cured case might be due to any mental or physical upset. He did not approve of the attempt to produce early dryness and believed that the final issue was thus only evaded. He welcomed Dr. Bennett's remarks but did not himself believe that parental disharmony had anything to do with the condition; in his opinion exaggerated weight was attached to this factor. Psychotherapeutic treatment would stand or fall by its results.

There was danger that the use of a diary would lend too much importance to the condition in the child's mind; rather should it be realised that if a child is unhappy his bladder may become out of control. Dr. Hutchison welcomed Dr. Steen's suggestion of cutting down the food intake and agreed

with Dr. Moncrieff that the modern child has been too much studied.

Prof. Barling read a paper on the diagnosis and treatment of

TUBERCULOUS CERVICAL ADENITIS

He pointed out that not only the incidence of this condition but also the severity had diminished during the last thirty years. Clinical experience had shown that this disease caused much ill health but was rarely lethal, and it was unusual for generalised tuberculosis to follow. Under the age of two years prognosis was more grave, and the excision should be avoided where possible, except with extensive involvement of the skin. In older children the outlook was better, and once the local condition was mastered reassurance might be given as to generalisation. He held that a combination of tuberculous and septic infection, both of low grade, resulted in an essentially localised lesion. In the early stages the condition differed little from simple chronic adenitis, but as time progressed matting of the glands made a tuberculous diagnosis more probable. Softening of the glands or involvement of the skin made the diagnosis almost certain. In the early stages pain might be present, but later was absent, unless secondary infection or the skin involvement occurred. Aetiology included bad environment, poor nutrition, and local foci of infection in tonsils, adenoids, teeth or skin. Rarely, infection resulted from a case of open pulmonary tuberculosis in the household. Infected milk more usually produced infection of the thorax or abdomen. Treatment by various physical agents had been increasingly used in the post-war years, and advocates of radium, X-rays, and various forms of light therapy all claimed a high percentage of successes. Prof. Barling usually treated the early cases, with unbroken skin, with a mercury vapour lamp in increasing dosage; to achieve complete cure might take a year or more, but in most cases resolution might be expected. Especially good results were obtained between the ages of 2 and 10. Among these the younger the patient and the more recent the infection the greater were the advantages of non-operative methods. Cases in adolescence did best with light treatment before operation, especially where sinuses were present. Light lessened the local oedema and infection in

and around the glands, and when used after surgery had a favourable effect on missed outlying glands, thus guarding against recurrence. Aspiration might suffice for a tiny area, followed by prolonged light treatment, but repeated aspiration usually ended in sinus formation and deep sepsis. Surgery was indicated for (1) extensive glands breaking down; (2) when glands appear for the first time in adolescence; (3) when non-operative treatment has been carried out and no further improvement had taken place. A high degree of surgical skill was needed for this type of case.

Dr. Marshall raised the question whether the decreased incidence of abdominal tuberculosis had not coincided with that of cervical adenitis.

Dr. Hutchison agreed that infected tonsils were frequently an early cause of this condition and advocated tonsillectomy, followed by six weeks at the seaside. Should the glands not disappear, then excision should be advised. In his opinion light treatment was time-consuming and probably as expensive in the long run as more drastic measures.

Prof. J. Morley (Manchester) advocated complete excision. He deprecated curettage as this predisposed to re-infection of adjacent groups of glands.

Prof. Barling, in reply, agreed that the pendulum against surgery had swung too far, but wished to emphasise the necessity for the best surgical skill.

Dr. Moncrieff read a paper on the USE OF THYROID FOR PREMATURE BABIES.

He had followed the suggestion of Dr. E. Pritchard that thyroid might speed up the maturation of premature babies, as it had done experimentally in tadpoles. It was not given to replace a deficiency. He showed charts to illustrate the effect on weight, mortality rate, and temperature. In a controlled experiment, the mortality rate in premature babies receiving daily 1/20th grain of thyroid extract per lb. body-weight was a third that among the untreated babies. A full report on this work would be published in the near future. Dr. Collis had also found thyroid useful for premature babies.

(*The Lancet*, August, 21, 1937)

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AN ILL-CONCEIVED THREAT

It is very unfortunate that neither the Government who enacted Medical Acts nor those who have been entrusted to wield the authority of the Acts seem to have realised the purpose and scope of these Legislative measures. From about the year 1914, one provincial Government or other brought into existence Medical Councils and with them the Medical Registers. The main purpose of the Medical Act is to help the public by means of Medical Register, to know who is qualified to practise Medicine. The most important function of the Medical Council is to guard the public safety in regard to the exercise of the medical profession by those who are in the Medical Register. So the Medical Councils have been given statutory powers to control medical education and to wield disciplinary control over the practitioners whom the Council registers so that such practitioners do not misuse the rights and privileges enjoyed by them by virtue of their being registered.

But in spite of the existence of the Medical Acts and the powers conferred by these Acts, the Heads of the Medical Department in provinces have been permitted by the executive authority to usurp most important and responsible functions of the Medical Council in regard to the control of medical education. When the Medical Councils informed the Government about the necessity of raising the standard either of entrants to medical schools or the course of medical studies, the recommendations instead of being given effect to, were safely confined to the waste paper baskets. Regarding University medical education, the Universities never cared to consult the Medical Councils and the Councils did not dare to approach

the University as the prevailing conception was that the University medical education was the highest possible. The only work the Provincial Councils have been doing was to record the G. Os, and try practitioners for infamous conduct. Even in this respect, the ideal followed seems to be, the humbler the practitioner in regard to his qualifications, the more serious view is to be taken about the breach committed by the practitioner. Even in the matter of the rights and privileges conferred on the practitioners there is no uniformity though all the practitioners paid a uniform fee for registration. The registered practitioners are not treated alike by the Government and by the departments under the Government; the degree of the enjoyment by them of the privileges of registration depended upon the order of the group in which the practitioner appears in the Medical Register, the official position of the practitioner counting the most.

When the affairs of the existing Medical Councils were looming in this way in all provinces a thunderbolt was hurled from Great Britain by the General Medical Council that the University medical education in India had been deteriorating and that the Government of India should appoint and pay an Inspector to be approved by the General Medical Council who was to report about the efficiency of the University medical education. Such an action by the General Medical Council synchronised with the appointment of Indians in the teaching staff of some Medical Colleges. When the Central Assembly turned down this demand the General Medical Council as a protest withdrew recognition of the University degrees already recognised by it. A compromise was effected by the India Government and the result

was the birth of Medical Council of India. The existence of the type of the All India Medical Council has no parallel in any other civilised country. It does not maintain a register to enlighten the public who is qualified and who is not. It does not confer any rights or privileges on those who come under its purview, excepting recognition of the qualifications by the General Medical Council. It is devoid of disciplinary control even over the practitioners with whom they are concerned. Its only function is to recognise such medical qualifications as approved by the General Medical Council. In fine it is a creature of the General Medical Council though born in India and maintained by Indian tax-payer. It has no authority of its own, its existence does not serve any of the purposes for which Medical Councils exist. It has been borrowing the inspiration for recognising higher medical qualifications from the General Medical Council, Great Britain. Even the foreign countries with whom the Medical Council of India has been corresponding for reciprocity seem to know that for the recognition by this Council of the foreign qualifications it has to depend on the General Medical Council, so much so that almost all the foreign authorities conferring medical qualification on their nationals, are reported to have replied to the Medical Council of India that they would reciprocate in case the medical qualification recognised by the Medical Council of India has the recognition of the General Medical Council. We state these facts to convince the Provincial Governments that there is no need for them even in the interest of higher medical qualifications to be dictated by any other Medical Council outside their jurisdiction. The authority of the Medical Council of India over the autonomous Provincial Governments is so humiliating that the Provincial Governments which would not and cannot brook the control over them by even the British Parliament should lose no time to protest against the existence of a Medical Council which is not wanted.

It is reported to us that our comments on the news of the then threat by the Andhra Medical Students to boycott the Vizagapatam Medical College appearing in the last issue of *The Medical Practitioner* under the caption "A false Alarm" have not been understood by the interested parties in the

spirit they were made. The cause of the alarm came from the Medical Council of India and we said that Alarm was not real. What is not real is really false though the Alarm may have such an effect on the nerves of those who are immediately affected. We attempted in our comments to suggest to those that were alarmed to take advantage of a situation brought about by the Medical Council of India and strengthen the hands of the Madras Government to establish autonomy in regard to medical education. The threat of non-recognition of the M. B. B. S. degree of the Andhra University is not only unreal but also unsustainable and therefore not justifiable. Sections 15 and 16 of the Indian Medical Council Act in which the control of the Medical Council of India is contemplated run thus:—

15. Every medical institution in British India which grants a recognised medical qualification shall furnish such information as the Council, may, from time to time, require as to the courses of study and examinations to be undergone in order to obtain such qualification, as to the ages at which such courses of study and examinations are required to be undergone and such qualification is conferred, and generally as to the requisites for obtaining such qualification.

16. (1) The Executive Committee shall appoint such number of medical inspectors as it may deem requisite to attend at any or all of the examinations held by medical institutions in British India for the purpose of granting recognised qualifications.

(2) Inspectors appointed under this section shall not interfere with the conduct of any examinations, but they shall report to the Executive Committee on the sufficiency of every examination which they attend and on any other matters in regard to which the Executive Committee may require them to report.

(3) The Executive Committee shall forward a copy of any such report to the medical institution concerned, and shall also forward a copy, with the remarks of such institution thereon, to the Governor-General in Council.

As required by these two sections the Executive Committee of the Council deputed Inspectors to test the sufficiency of examinations conducted by the Andhra University for M.B.B.S. degree. It is not known if the Executive Committee directed the Inspectors to report 'on any other matters'. Even if they did this additional reference cannot vitiate the issue of the test of the sufficiency of the Examination. For it is known as a matter of fact that two inspectors out of three reported quite favourably about the sufficiency of the Examination and also of

Examiners. The inspectors recommended some addition to the existing staff and the recommendations have been given effect to. The object of sections 15 and 16 was to ensure that the students of a particular teaching institution are taught and examined so as to secure to persons possessing the medical qualification skill to make them competent to practise medicine. As the majority of Inspectors appointed by the Executive Committee of the Medical Council of India had reported favourably regarding sufficiency of knowledge both of the medical students and the teaching staff, the Executive Committee in the ordinary course of events ought to have approved the majority report.

Section 17 quoted below is clear on this point. Nowhere it is said in this section or in the whole body of the Act that the recognition of the qualifications depended entirely on the equipment of buildings to a teaching institution. Para (2) in section 16 of the Act quoted above, no doubt, makes it obligatory on the teaching institutions to supply information 'on any other matters in regard to which the Executive Committee may require them (Inspectors) to report,' the actual purpose of this detail being to guarantee the sufficiency of the knowledge of the students and the staff and as regarding these items two Inspectors out of three did report favourably. The Council is therefore not justified in withholding recognition on the plea of want of equipments. It is rumoured that when the subject of recognition of the Andhra M.B.B.S. degree came up for consideration before the Medical Council, at its last session, Major General Sir Frank Connor, the then Surgeon-General with the Government of Madras, an eminent Surgeon himself, suggested to the Council that the Council should concern itself mainly on the quality of the students and the staff and not on the quality of the building and said more or less to the effect that it was much safer to have a good surgeon operating on patients under a mango tree than a bad surgeon performing operations in grand buildings. It looks as if the Medical Council cared more for the prestige of the Executive Committee than the hardships of the medical graduates and medical students of the Vizagapatam Medical College. It is most astounding that the Medical Council of India did not mind

even the prestige of the Madras Government when the Government assured the Council that the necessary buildings would be supplied as and when funds were available. From the reports so far published in the newspapers it looks as if the Medical Council of India deals with the Andhra University direct and not through the Governor-General in Council as is required by Section 17 of the Act which says:—

17. (1) When, upon report by the Executive Committee, it appears to the Council that the courses of study and examination to be gone through in any medical institution in British India in order to obtain a recognised medical qualification or that the standards of proficiency required from candidates at any examination held for the purpose of granting such qualification are not such as to secure to person holding such qualification the knowledge and skill requisite for the efficient practice of medicine, the Council shall make a representation to that effect to the Governor-General in Council.

(2) After considering such representation, the Governor-General in Council may send it to the Local Government of the province in which the medical institution is situated, and the Local Government shall forward it, along with such remarks as it may choose to make, to the medical institution, with an intimation of the period within which the medical institution may submit its explanation to the Local Government.

(3) On the receipt of the explanation, or, where no explanation is submitted within the period fixed, then on the expiry of that period the Local Government shall make its recommendations to the Governor-General in Council.

(4) The Governor-General in Council, after making such further inquiry, if any, as he may think fit may, by notification in the *Gazette of India*, direct that an entry shall be made in the First Schedule against the said medical qualification declaring that it shall be a recognised medical qualification only when granted before a specified date.

It is seen from the wording of all the four paras of section 17 that the Medical Council should base their objection on the "standards of proficiency required from the candidates at any examination held for the purpose of granting such qualification". When the Medical Council does not raise any objection on this ground, the Governor-General in Council should favourably consider any application for the recognition of medical qualification granted by any medical institution in British India. It

is also mentioned in section 17 that the Governor-General in Council should deal with such applications through the Local Government which in turn is required to communicate with the teaching institution. It is not known whether these formalities were gone through in regard to the Vizagapatam Medical College. If gone through, we fail to understand why the Local Government did not intercede. We trust the Madras Government under the regime of the Indian National Congress will take a serious view of what the Medical Council of India has been doing in regard to a Medical College which is in no way inferior to the Madras Medical College and other Medical Colleges recognised by the Medical Council of India as could be judged by the standard of education. The final authority to decide about recognition is the Governor-General in Council. When the provincial Governments have been able to let loose all sort of political prisoners whom the older Governments considered to be dangerous to public safety, it is possible for us to conceive that the Madras Government would not find any difficulty to convince the Governor-General in Council that there is absolutely no harm to public safety if the Governor-General in Council overrides the decision of the Medical Council of India. The entire medical profession not only in this Presidency but also elsewhere in India are watching the events and expect the Hon'ble the Minister in charge of the Medical Portfolio will take up this matter and deal with it as expeditiously as is consistent with the prestige of the Government under the Congress regime.

News and Comments.

First Step for Reorganisation: Recently it was announced in newspapers that the Hon'ble Minister in charge of Public Health had prepared a scheme for re-organisation of the Medical Service and the Minister gave out on the floor of the Legislative Assembly on 15-9-37 that the re-organisation of the whole medical department was going on. This statement from the Minister was in reply to a question regarding private practice by Medical officers. So it is certain that this subject for which the old diarchical Government could find no solution in spite of the various questionable practices in the rights and privileges

of private practice by the full time medical officers. We have been repeatedly mentioning in these columns and elsewhere that from the history of medical services under the British Rule it was clear that the full time officers of the Government were allowed private practice not as a special privilege of service but to popularise the scientific system of medicine as at the time the hospitals and dispensaries were first brought into existence into this country there were no private practitioners, to practise the scientific system of medicine recognised by the Government. But with the growth of independent private practitioners, the Government did not curtail the privileges of private practice by the State paid officers due to clashing of vested interests, the result being unequal and unwholesome competition in private practice between private practitioners and Government Medical officers. The medical officers in charge of hospitals and dispensaries have a distinct advantage in private practice. In addition to these facilities, skilful surgeons in the Madras City Hospitals thought of running private nursing homes which they thought was a special privilege and ran such institutions under the very nose of the Government. Those working in teaching and other institutions whose work was not in hospitals and dispensaries provided for themselves chemist shops and laboratories or worked on profit or commission basis in recognised chemist shops. Apart from the privileges of private practice the state paid officers enjoyed special privileges by virtue of their official position. Certificates of physical fitness and of good health for commuting pensions are the special privileges of Civil Surgeons. The Government have not realised the dangers of allowing such privileges to a special class of their officers in spite of what has been happening. Before the Medical Registration Act came into existence there might have been an excuse for the Government that the privileges of granting certificates might be abused by those on whom they had no control. But there could be no justification to entrust this work only to Government medical officers, after the inauguration of the Medical Council which has statutory disciplinary control over registered medical practitioners both in Government service and private practice. The Medical Council could punish registered medical practitioners including those in service more effectively than the Government

can for infamous conduct in a professional respect. It might be argued that the Government servants were entitled to get certificates either for physical fitness, commuting pension or any such purpose from the Government officers free of charge. But we ask, "Do all Government Servants get such free service even in genuine cases of illness?". There may be justification, certainly, not based on morals that non-genuine cases have to be paid for. But in cases of such payments, Government suffers the most, the healthy servants of theirs being made unhealthy in cases of sick certificates and unhealthy being made healthy in cases of commutation of pension. Monopoly of privilege granted to a class of registered medical practitioners is most risky to the Government both financially and morally. It is a psychological truth not requiring arguments for proof that usually a human being has temptations to do a work which pays him amply without exertion. So it will not be a surprise to the Hon'ble Dr. Rajan if he hears or knows that such tendency may exist in Government medical institutions due to faulty administrative system.

Stories of these dangers are as difficult to be detected as they are difficult to prove. The medical profession, noble as it is, is pliable to the extreme with the result that the entire profession whether in service or in private practice suffers in its reputation on account of a few undesirable elements. The rigour of discipline and law is such that without proof nobody can be punished and punishment is not the only means for bringing about reformation. Fixity of tenure of office is considered not wholesome even in the case of Governors and Viceroys who retire after a term of five years. Whereas, in the medical department, once an officer gets into the city of Madras, he continues to be there till the rest of his life. There are some amongst them who do not wish to get out of city even on promotion. The Madras atmosphere has been very conducive to them. Usually the professional skill possessed by a particular officer or interests of medical education is put forward as an excuse to keep these officers permanently in Madras. The skill and proficiency of all those who have been in the city was known only after their having worked for some years in the same institution. Many of them

got higher qualifications on account of their stay in Madras which is denied to others in service. The city of Madras has to accommodate itself to other medical officers after any in the present batch retires or has to leave service due to unforeseen circumstances not excluding death. The present policy of keeping medical officers in a particular station is certainly baneful and against public interest. The only effective remedy for the above ills is not allowing Government Medical officers to be in a particular station for not more than three years. It is not known why this policy which exists in all other departments of Government Service has not been made applicable to the medical department. It is most flimsy to say that transfers once in three years are likely to interfere with efficiency in teaching institutions when it is known that the Government has more than two teaching institutions in this province. The students are changing every year and with them the teaching staff may change without any deterioration of their fund of knowledge, if any body is to be transferred to another teaching centre. So the first step in reorganisation should be transfers and this has to be done before the reorganisation scheme is published or else we are afraid that the scheme is likely to be disturbed even before it takes a shape.

Public Health Minister's visits to City Hospitals: The local dailies have been publishing news this month that the Public Health Minister has been visiting the City Hospitals very frequently, the Government General Hospital being visited for three days. The visits do not seem to be formal when it is said that the Minister went to every department existing in the hospital. It is not known if the Minister does this to help him to re-organise the Medical Department or whether the first visit he paid to any of the City Hospitals prompted him to lose no time in re-organising the whole system of medical relief. Whatever the purpose of the visits may be, we request the Hon'ble the Minister to have at least a cursory glance of a book published under the authority of Government in two volumes. We are in possession of the IVth Edition of this book which is called "The Madras Civil Medical Code". The volume I deals with "the Administrative and Professional Functions of the Officers of the Civil Medical Department of the Madras Presidency

and embodies such rulings as have been issued by the Government and the Surgeon-General for the administration of the department and the management of medical institutions". We draw the attention of the Public Health Minister to para 284 appearing on page 149 of Volume I of the Civil Medical Code, which deals with private practice. This para seems to be a copy of the Proceedings of the Surgeon-General, No. 247 A, dated 6th October 1925. It was slightly modified by a G. O. dated 24th January 1930 Ms. No. 148 P. H. The para runs thus:

"284. Medical Officers who are entitled to take private practice should not treat private cases, for which they have received fees, in the hospitals or dispensaries to which they are attached. Medical officers in charge of Hospitals who are allowed the privilege of private practice and registered medical practitioners in general may be given the loan of Hospital instruments and be supplied with dressings from the hospitals for use in connection with their private cases subject to the following conditions:—

(i) That the instruments and dressing can be spared without detriment to the hospital work;

(ii) That the Medical officers and practitioners shall be responsible for the safe custody of instruments and shall make good any loss or damage from whatever cause; and

(iii) That they shall pay the following charges, namely:—

For instruments.—Five per cent of their value per diem (the value being taken to be the value as entered in the current priced vocabulary of the Madras Medical Stores Depot) subject to a minimum of Re. 1 and a maximum of Rs. 10 per diem.

For dressing.—The actual cost of the dressing supplied subject to a minimum of Re. 1 and a maximum of Rs. 3 for the dressing supplied on each occasion. A register of such transactions should be kept in each hospital and dispensary and should be shown to Inspecting medical officer. (G. O. Ms. No. 148, P. H. dated 24th January 1930)".

We may state without fear of contradiction that this G.O. has been rigidly followed in breach whether it be in City hospitals or mofussil hospitals and dispensaries, the only

difference between the City and mofussil being that the patients seeking admission into the City hospitals paid a fee not less than Rs. 15 for consultation before they sought admission into the hospital whereas in the mofussil, patients got medicines and surgical dressings free. The existence of this G. O. must be a surprise to the entire Civil Medical Department; so also to the Public Health Minister. We have reasons to believe that its existence must have been forgotten by those in office of the Surgeon-General. The non-observance of this rule seems to have affected the morale and discipline in state hospitals and poor patients complain that even menials demand money for services. It is also alleged that ignorant patients in their anxiety about their welfare offer fees for extra care in the hospitals. We know of at least a few officers who resisted such temptations. Even after experiencing the surprise, some may ask what to do with patients who desire or deserve to be in the hospitals especially when sufficient number of nursing homes do not exist? The answer is very simple. There is no rule that admission to Government hospitals should accompany with a chit from the officers in charge of hospitals or wards. Regarding want of nursing home facilities, the existing policy of the Government in managing hospitals is wholly responsible. The public and the profession will hail with joy the re-organisation of hospital administration if it were to prevent rich and well-to-do people getting into charitable hospitals meant primarily for the poor and if such a restriction finds a place in the new policy of administration, nursing homes and private hospitals will sprout out very soon and will suit to the paying capacity of patients. As there will be demand, there will be a supply. There is no dearth of doctors nor the necessary enterprise will be wanting. The policy of the Government was such that even in a private enterprise, the independent profession could not compete with their brethren in Government service with the result that a few private practitioners who had the courage to run nursing homes did so on account of the legacy of the Government medical officers who started the nursing homes. The first to start a nursing home in Madras was an eminent member of the Madras Medical Service. He was followed by an European member of I.M.S. who again gave the lead to an Indian member of the same service. To our

knowledge, excepting one honorary medical officer, none of the members of the independent medical profession had the courage to start nursing homes on their own accord. Years ago, a prominent private practitioner in George Town ran a nursing home for a short time and perhaps had to close it for want of encouragement. Another started a private hospital in Puraswalkam, Madras and had to abandon it for similar reasons. If the existing G. Os, circulars etc appearing in the Civil Medical Code had been observed, the private practitioners and the Government Medical Officers would have been able to do good team work to the public with mutual benefit and good will and the morale and discipline in state hospitals could have enhanced; at least not so deteriorated.

An Appreciation: Major-General Sir Frank P. Connor, Surgeon-General with the Government of Madras retired on 15th September 1937 after serving the Madras Government nearly four years during which period he acted as Director-General of Indian Medical Service from 29th October 1935 to 20th March 1936. Major-General Sir Frank P. Connor succeeded Major-General (now) Sir C. A. Sprawson. There was inordinate delay in announcing the name of the successor of Major General Sprawson and soon after the name was published, we welcomed Sir Frank P. Connor, giving details of his service after he joined the Indian Medical Service on 1st September 1902. While commenting on the service rendered to this Province by Sir Frank P. Connor, suffice it to say at present, that the various appointments held by him in Civil Medical Service from the post of Resident Medical Officer (Surgeon and Physician) Calcutta Medical College Hospital, to that of permanent Professor of operative and clinical surgery, Calcutta Medical College and Surgeon, Calcutta Medical College Hospital from 1919 to 1933 were a sufficient guarantee to his subsequent elevation as the Head of the Madras Medical Department. He has had enough administrative experience apart from professional attainments. He served as a Civil Surgeon both in Bengal as well as in Bihar and Orissa. He had training in X-ray as early as 1907 and there was to his credit Public Health work also though for a short period. So it could be said of Sir Frank

P. Connor that he had versatile knowledge of medical science in all its aspects.

Our knowledge of the old Surgeon-General Sir Frank P. Connor being one that was heard and our old impressions of Military Medical Officers doing surgery in civil department being one of awe, we were rather nervous just before we sought an interview with Sir Frank Connor soon after he assumed office as Surgeon-General with the Government of Madras. The very moment we saw Sir Frank Connor we were so pleased to be impressed much against our apprehensions that Sir Frank Connor was most civil, polite and courteous. Even on the first day of our meeting there were discussions on some serious topics concerning the medical profession and Sir Frank Connor kept smiling all the while and did not resent our criticisms which poured forth in quick succession taking advantage of his smiling face. We did feel that the very first interview was rather a long one but from the face and the talk of Sir Frank Connor we could not say that he felt it so. We had had several occasions to see Sir Frank Connor and for various purposes and never did we feel we were talking to a Bureaucrat. This was also the experience of many others including his subordinates who had anything to do with him.

We mention these facts to show that it is possible for a Bureaucrat even with military training to be most democratic and as civil too, qualities which the brown Bureaucrats, without military service, might as well aspire. Sir Frank Connor was just the same when he conducted the meetings of the Madras Medical Council of which he was the ex-officio President. On the very first day he presided over the meeting of the Council he said that he would have very much liked to be an elected President instead of being a nominated one. He said that his position as a nominated President was very delicate; he had to treat the Council more courteously than the elected President could do as the latter was there by virtue of the confidence of the members of the Council who elected him. He never made the Council feel that he was the Surgeon-General with the Government of Madras.

We could not see eye to eye with Sir Frank Connor in some of his views, but all the same we appreciated his frankness as

denoted by his very name. He knew who is who and who is what both in the Department and outside, but none who met him could say Sir Frank Connor was bitter in his words. It could be truly said of Sir Frank Connor that his smiling face was a mirror of his heart and he did what his heart dictated him to do. Heads of administration whose terms of office did not exceed three years at the most—in the case of the Surgeons-General of this province the period of actual service did not last at times even three continuous years—had to depend, to a great extent, upon the experience of their immediate assistants or else there would be little or no peace in any office, these days, especially if the Head of the Department is a European and the immediate assistant is an Indian belonging to Superior Service. Policies emanating from the Government of Madras were till recently the initiations of the Heads of Department moulded not on popular views, as the old Government could not be said to be peoples' Government. If the Madras Provincial Medical Association be stirred on behalf of its members belonging to Madras Medical Service and if the other Medical Associations run by the members of the medical profession did their part towards its members, the policies of the old bureaucratic Medical Department would not have been as inconsistent as some of them were during the regime of Sir Frank Connor. He was himself a victim of a grievance that his seniority was not counted to make him the permanent Director-General of Indian Medical Service though he acted as such. It is said Sir Frank Connor did console some senior assistant surgeons who have been superseded by their juniors by not being promoted as Civil Surgeons, quoting his own case. There are lot of undercurrents in service which those aggrieved cannot see, yet they are to be taken notice of to run the wheels of Government machinery. Many a time a good and honest administrator has to be a slave to a defective system though there are certain individuals who are capable of changing or shaking the system for good or bad either in individual or common interests. What Sir Frank Connor did was with the best of motives. He is incapable of hatred. He has been as good as he has been frank. We wish him a long and healthy life of usefulness during his retirement.

Reports of Meetings. We apologise to all the moffusil medical associations for not having published the reports of the meetings which they have been sending us. Many such reports are published in the local dailies at times more elaborately than the extracts sent to us indicate. Excepting the names of the medical diseases and surgical operations and the persons who performed the operations, usually nothing more that is likely to interest a practitioner for gaining scientific knowledge, is mentioned in the reports. To give an idea of the usefulness of the reports of the meetings of the members of the medical profession, we have published in the current issue in the "Therapeutics Columns", a report of the meeting of the British Medical Association as published in one of the recent issues of the Lancet. We have to cut our coat to the cloth that is available. The rate of subscription of The Medical Practitioner of Rs. 2 a year does not permit the management to use more pages of reading matter than 32 to 40 which are usually published excluding advertisements. Other journals may look more voluminous but the bulk of the volume is advertisement. Even with slender finance which comes only from subscribers and not from advertisers we devote more pages than we can possibly afford and these pages have to be used discretely so that we could supply our readers really useful matter by publishing scientific articles and Editorials and News and Comments, the latter two items being the speciality of The Medical Practitioner. We are strongly of opinion that we should help the members of the profession, especially the rank and file, to live decent lives of usefulness though not one of affluence. We are therefore concentrating our activities more on topics concerning the prosperity of the profession. We have to request all the Associations to send us the reports of their meetings on the style referred to above.

Hopeful Expectations: The Medical Practitioner has been doing its best in ventilating the grievances of the Subsidised Rural Medical Practitioners ever since it came into existence. After the Congress formed the Madras Government and the Hon'ble Dr. Rajan was entrusted with the Medical Portfolio, the Subsidised Rural Medical Practitioners along with the rest of the members of the independent medical profession having been entertaining hopes,

not without reasons, that good days are dawning for them. Just on the eve of the Congress coming to office, the Subsidised Practitioners met in a conference. The then Surgeon-General, Sir Frank P. Connor and some prominent members of the medical profession encouraged them by their presence. Their Association which was inactive on account of the sudden death of their secretary Dr. Ramasubbu, is now revived and put on sound basis. The Medical Practitioner has been made the official journal of their Association with Dr. V. Rama Kamath as President. Complaints are now pouring in the form of copies of appeals to the Government, letters to the Editor, The Medical Practitioner and to Dr. V. Rama Kamath as the President of the Association. Dr. Kamath in his double capacity will soon see the Public Health Minister to discuss some of the problems of rural practitioners. We have published in the Correspondence Columns some of the most important grievances requiring the immediate attention of the Government so as to enable the Public Health Minister to send for the concerned files from the offices concerned. Red Tapism and other causes on the way of the transit of these complaints to the Government, are hampering their disposal to the detriment of the aggrieved practitioners. The cumulative effect of the delays, will certainly have undesirable effect on the welfare of the village folk as the zeal for honest service is likely to decrease for want of interest shown towards the subsidised practitioners by the authorities concerned.

Leprosy: We draw the attention of the readers of The Medical Practitioner to the Editorial Comments on this subject appearing in the August issue of "The Journal of Medicine" an esteemed American monthly journal, which comments we have published in full in the Abstracts Columns of this issue. The members of the medical profession in India including the English and the Americans will be startled at the prevailing ignorance in America about India when they read the following first three paras in the Editorial Comments:

"While travelling in India one occasionally hears a peculiar sound uttered by one of the natives, this begins in a low guttural tone gradually increasing in crescendo to end in a short piercing cry.

This manner of giving warning of the approach of a leper has been substituted for the

implacable "Unclean, Unclean", of the lepers as recorded in the Bible.

This warning is made imperative in India by legislative enactment, and must be given by each leper when approaching another person at a distance of not less than seventy feet".

We trust that our American contemporary is aware that India is under British Rule for over a century and it is a matter of surprise that our contemporary could conceive that such harsh Legislative measures could be possible under British Rule. We wonder if our American contemporary is aware that India is not governed by the Indians and that the eleven provinces which constitute India got Provincial Autonomy with safeguards only in April 1937 and what the condition of the lepers will be, at least in the Madras Presidency, may be judged from the speech made by the Hon'ble the Public Health Minister on 15-9-37 at a meeting of the autonomous Madras Branch of the British Empire Leprosy Association. Our American contemporary will be glad to know that the Public Health Minister of Madras is a medical man and will correct the impressions about India, especially regarding leprosy when he reads the most pithy sentence in the address delivered by the Hon'ble Dr. Rajan at the inaugural meeting of the Madras Branch of the British Empire Leprosy Relief Association. The Minister said amongst other things "We believe that coercive legislation of any sort is not the right approach to a solution of this problem. What we want is to create public opinion which will take note of the conditions prevailing among lepers in this Province and to get hearty co-operation rather than coercive submission to law". The other thought provoking valuable comments of our American contemporary, are in all respects most useful reading especially to the members of the profession who should make up their minds to play their part admirably in the campaign against social diseases like Leprosy, Tuberculosis etc. There is at present a tendency to make medical men a tool of a few fussy, though well meaning Social and Health workers. Are medical men not capable of conducting preventive propaganda of these and other social diseases themselves? Surely they can. In Madras, Bombay and Central Provinces the profession has a special opportunity of serving the country in all possible ways. It need hardly be said that

when the members of the profession devotedly serve their country, the country will surely serve them in turn. No other profession can take care of the welfare of the public in the way the medical profession can. We trust the Governments will not be found wanting when true gestures of national service are made by the members of the profession, at least a few here and there till, with the help these few, the Hon'ble Ministers in as few provinces build up a medical profession while building the Government on sounder foundation than they exist now. The fact that the Congress rules seven out of eleven provinces should not be lost sight of by the medical profession and they should make the best of the present position occupied by three or their brethren in the provincial Government of three provinces.

Supersession again: Quite recently 4 or 5 Civil Asst. Surgeons have been appointed as officiating Civil Surgeons, one of whom is 51 in rank in the Civil List of Asst. Surgeons and out of those who are superseded one occupies the 18th place in the same list. For a casual observer these supersessions look like somersaults though in the past the height of such feats was much more. In the early part of this year, there was a similar feat and about a dozen Senior Asst. Surgeons who were affected memorialised to the Government. Three or four of these were since promoted as Civil Asst. Surgeons. A few did not want to memorialise at all and did not covet the position of a Civil Surgeon, out of Madras. Official positions are now counted by some occupying junior appointments, though qualified to be posted to Civil Surgeon cadre, in rupees, annas and pies and not by the elevation to a higher rung in the official ladder. A few lucky can fortell their horoscopes in the immediate future and do not mind to displease official Gods, while many feel that their claims are unjustly overlooked, when such supersessions take place. The result of all this is discontent in service. It is a pity that the Government have not recognised that a contented service is an asset especially in the medical department as the officers in this department are entrusted with the lives of the public.

It is said that the Surgeon-General had advised senior Civil Asst. Surgeons that seniority alone did not count while promoting them to Civil-Surgeon cadre. Record

of service and good health are the guiding factors and military service is taken into account as additional qualification. So far so good. In the past, most astonishing supersessions did take place and even a temporary Civil Asst. Surgeon was installed as a Civil Surgeon. But all this was done in the name of teaching institutions. Regarding administrative appointments as Civil Surgeons, such high jumps over seniors were not so common as it is now. There are instances when persons whose claims were not considered in the past are now found in the Civil-Surgeon cadre. If once the claims of an officer were not taken into consideration for a higher appointment and the same person was appointed to the higher post later, it has to be conceded that there are certain ways and methods by which the once neglected officer could be recognised. Nobody questions the *Bona fides* of the Government but it is desirable in the interest of public service that its officers should know the ways that guide the Government in their selection so that those that are not fortunate may reform themselves, not necessarily for aspiring to the posts once refused to them but to help healthy evolution of human society. The discontent is so heavy and is likely to affect the good name of the Government unless a method is found by the Hon'ble Dr. Rajan to allay the same. What is possible for him now would not have been possible in the past for obvious reasons, chief amongst which is the fact that the Public Health Minister is a medical man and is in a position to weigh past and present records quite dispassionately.

New Surgeon-General: We welcome Colonel Norman Methven Wilson, O. B. E., M.R.C.S., L.R.C.P., D.T.M. & H. (Lond.) I.M.S., the new Surgeon-General with the Government of Madras. He took charge of office on 15-9-37. After entering the Indian Medical Service and undergoing special training, Col. Wilson came to India in 1905 and was in Military Service till about the year 1920. During the Great War he went to France with the Expeditionary Force and served in Mesopotamia and Persia till the end of the war. Later for one year from 1919-20 he did military duty in Afghanistan and Waziristan. Col. Wilson's entry into the Civil Medical Department was in the Punjab Province where he served as District Medical Officer at Lyapur till 1926. He was later

posted as Civil Surgeon, Simla, and after serving for 4 years in that capacity, he became the Medical Officer of the Delhi Province. In 1933 he was promoted as Inspector-General of Civil Hospitals in Central Provinces which position he occupied till March 1937 when he went home on long leave and returned to India and was posted as Surgeon-General with the Government of Madras.

Col. Wilson assumes charge as the Head of the Medical Department in Madras at a time when the Government is run by the Indian National Congress having a Minister in charge of Public Health belonging to the medical profession, a general practitioner as we presume. Col. Wilson was before he took charge of the Medical Department in Central Provinces. In this way the affairs of the Medical Department will be quite safe as the Minister as well as his chief adviser, the Surgeon-General, will not have predilections to any special branches in Medicine and Surgery or to their devotees. As there is no uniformity maintained for the administration of medical departments in provinces, though the Government is one under the British Rule, the Surgeon-General will necessarily take some time to compare and contrast the details of medical departments as he saw them in the two provinces, the Punjab and the Central Provinces and as he now sees in Madras. There are always good and bad things about administration as judged from the peoples' point of view and we hope the experience of Col. Wilson as a member and as a Head of Medical Departments in two provinces would be availed of by the popular Minister, Dr. Rajan, who is now keen in reorganising the medical department in this province. This is a distinct advantage to the new order of things as there will be little or no prejudice, conscious or sub-conscious. This will also to a great extent counter-balance the discontent prevailing in certain quarters that the Surgeon-General with the Government of Madras hails from a distant province. A good and conscientious administrator will continue as such wherever he does his duties, dictated by his conscience. There need not be any alarm on this account. On the eve of the departure of Major-General Sir Frank P. Connor we were inquisitive to ask him "How is Col. Wilson?" Sir Frank Connor answered promptly "I know him; he is a very nice

man." We never knew at the time that Connor and Wilson were co-medical students at London and conducted dissections of human bodies in the Anatomy Theatre on the same table. Modesty or something else must have prevented Sir Frank Connor to tell us that he knew Col. Wilson as a co-medical student. We fervently hope that Col. Wilson will co-operate with the Hon'ble Dr. Rajan and both will earn the gratitude of the noble profession to which they belong and that the re-organisation scheme that is to be launched in Madras will serve as a model to other provinces.

Correspondence Reports, Etc.

Subsidised Rural Medical Relief Scheme.

As decided upon by the Conference of the Provincial Subsidised Rural Medical Practitioners' Association, which met in Madras on 10-7-37, a deputation consisting of the members of the Interim Managing Committee of the Association waited on the Surgeon-General with the Government of Madras in his office on 7-9-37, led by Dr. V. Rama Kamath, the President of the Association.

A memorandum was submitted to the Surgeon-General along with the copy of The Medical Practitioner containing the proceedings of the Conference in detail, including the resolutions passed. The Surgeon-General was requested to forward a copy of the memorandum with the journal to the Government along with his recommendations.

Till the whole scheme is remodelled to suit the village uplift work in which the Provincial Government and also the Central are very much interested, the deputationists state that the new agreement that they are now forced to execute should be immediately modified so as to enable the Subsidised Practitioners to take a part in social and civic problems of the rural areas, without which their responsibilities to the village folk cannot be complete as many of the human ailments were due to the breach of good sanitary and social laws.

They therefore placed before the Surgeon-General a draft of the agreement in the form they wished to have in the immediate future. The most important modifications were:—

1. Deletion of paras 8 and 9 in the new agreement form (which did not find a place in the old one) and which prohibited the Subsidised Rural Medical Practitioners to take part in "aid of any political movement in India, any political movement related to Indian affairs" or in any "election or appointment as a member of any local authority."

2. Compulsory supply of a building or a rent therefor for the location of the Subsidised Dispensary; a ward boy on Rs. 12 a month; a midwife on a salary usually paid to midwives by local bodies and surgical, midwifery and dental instruments and an outfit for the midwife.

3. If Public Health work is to be entrusted to the practitioner it should be at his option and he should be paid a monthly allowance not less than Rs. 30. Necessary assistance by way of servants etc., should be given to the practitioner, the area of the work being within five miles radius from which the dispensary is situated. Regarding vaccination, the practitioner should have the help of a vaccinator for the actual operation, he being responsible only for the verification of the vaccination.

4. The Subsidised Practitioner should be entitled to 30 days' leave, including holidays, with full subsidy, he being permitted to accumulate his leave for a period of three months in case he wishes to undergo special course in any branch of medicine. Leave should be granted without waiting for previous sanction, in case of illness. No previous sanction should be demanded for leave for 8 days or lesser period. In case leave is required for more than 8 days, previous permission should be taken, but in case the permission is not communicated to the practitioner within 5 days from the date of the application for leave, the practitioner can leave the station in anticipation of sanction.

5. For Leprosy work, the practitioner should be paid Rs. 10 for a daily average attendance of 20 patients at the clinic and for each additional patient at the rate of 4 annas. A separate building should be provided for this work and the practitioner should be paid for all other contingent charges.

6. Regarding closure of the dispensary on account of want of finance by the Local

Bodies or alleged misconduct or breach of the terms of the agreement, the previous sanction should be taken from the Government before the dispensary is to be closed or the practitioner is discharged.

7. In the matter of correspondence and payment of Travelling Allowance and Batta for attending Courts on behalf of the Government, Local Body or a private individual, the practitioner should be entitled to the rights and privileges of a Gazetted Officer of the Government.

The Surgeon-General was very sympathetic and said that majority of the grievances were modest and real. He felt sorry that his term of office was to come to a close very soon and that he would not have time to write to the Government at length about them, but promised the deputationists that he would meet the Hon'ble Minister of Public Health and tell him in person what should be done in the immediate future in regard to the grievances of the Subsidised Rural Medical Practitioners.

Dr. Kamath thanked the Surgeon-General on behalf of the deputationists who wished the Surgeon-General a long life of health and happiness during the days of his retirement.

MEMORANDUM

Submitted to the Surgeon-General with the Government of Madras on 7-9-'37 by the Deputation consisting of the members of the interim Managing Committee of the Provincial Subsidised Rural Medical Practitioners' Association led by the President of the Association.

Sir,

At the outset we have to express to you the gratitude of the Subsidised Practitioners of this province for the impetus given by you for rejuvenating the Association, by your company at the last conference of its members which met in Madras on 10-7-37.

Before the last conference met, it was not possible for the Association to know the exact number of its members on the roll, as the records in possession of the late lamented Secretary, Dr. S. Ramasubbu were not available. We are glad to inform you that the Association has now on its roll 175 members and applications are coming in

daily for admission. It is our ambition to have on the list of the members the whole strength of the Subsidised Rural Medical Practitioners.

The Association has recognised The Medical Practitioner as its Official Organ and we therefore present to you the July number of The Medical Practitioner which contains the full proceedings of the Conference. We refer your kind attention to these proceedings and also to the Editorial on the Subject.

We should say that the Conference met at a very auspicious moment just on the eve when the Indian National Congress decided to run the Government of this Province along with five more Provinces in this country. Rural reconstruction has been one of the most important themes in the programme of national work to which the National Congress is pledged. It was indeed a very good omen also that just before the Congress entry into the provincial Governments, India should have as its Viceroy and Governor General in the person of Lord Linlithgow who on the very day he set his foot in India made it known that agricultural India has to depend upon the villages for its prosperity and well-being and that therefore the first concern of the Government of this land should be the uplift of the villages.

You, Sir, as the Head of the Medical Department of this Province know more than we do, the magnanimity and the usefulness of the scheme of village uplift which, the most loyal Representative of His majesty the King Emperor has at heart. This ambitious scheme to be successful has to be worked out practically by non-official agency with the help and co-operation of official experts. The whole programme for village reconstruction being for the welfare of the village folk, there cannot be better agents to carry out the scheme than the members of the medical profession. Apart from the knowledge of scientific treatment of human ailments, in both the aspects of prevention and cure, a member of the all pervading medical profession should have working knowledge of all other arts, such as Engineering and even Law. There is nothing which a medical man does not know (or is expected not to know) to make him understand the cure of human diseases or their prevention. Therefore the members of the medical profession should form the pivot of village welfare work.

Need we say, Sir, that it behoves the Government to encourage the members of the medical profession to settle in villages in large numbers. The best and cheapest way of doing this is to remodel the Subsidised Rural Medical Relief Scheme in a way best suited for the national programme of village uplift.

Sir, we can say without fear of contradiction that you were the first Surgeon-General of this province who has a soft corner at your heart for the much talked of, but the least considered, Rural Medical Practitioners. It is really our misfortune that when you were about to make practical demonstration of your sympathies to the most neglected class of medical practitioners, called on paper as the "independent" but actually treated as "the meanest of the menials in service", your term of office should come to an end.

We do not wish to take undue advantage of your kindness just at this moment. We hasten to keep before you a modified draft of the *agreement* which we have to execute and we fervently hope that the modifications suggested in the *agreement*, if recommended by you, will be given effect to by the present Government, the medical portfolio of which is under the charge of a medical man who till recently was one amongst the really independent Medical Practitioners. Most of our suggestions are in keeping with the spirit of the public utterances recently made by the Hon'ble Minister in charge of Public Health who is of opinion that the Subsidised Practitioners are "Independent" and "if by a recent contract they were made quasi-service men, it is high time that we revise their status".

Soon after the Subsidised Rural Medical Practitioners are made to feel by the peoples' Government that they are *independent*, we hope to put before the kind consideration of the Government, a scheme of rural medical relief making it an integral part of any future scheme of village uplift work without embarrassing the Government with any unwieldy financial commitment.

We request you, Sir, to forward a copy of this Memorandum to the Government with the suggestions made by us modifying the *agreement* to be entered into between the Government, the District Board and the Subsidised Rural Medical Practitioner.

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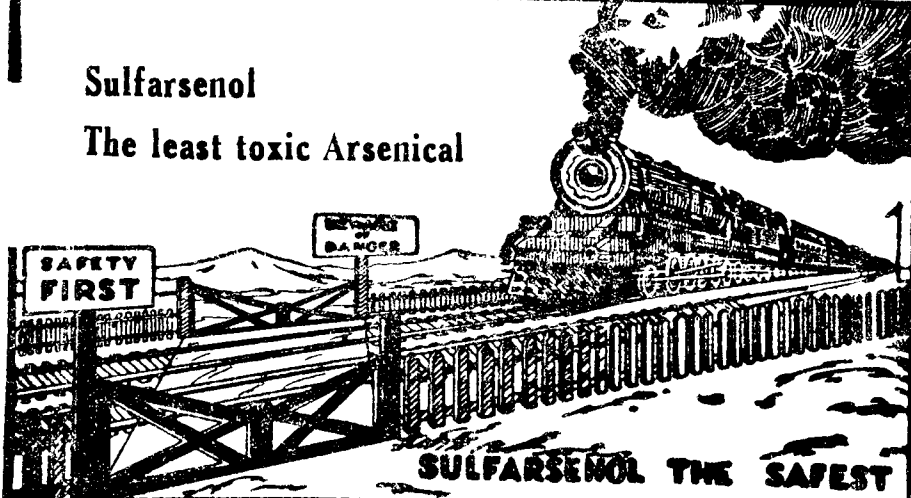
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The
Medical Practitioner

A Monthly Medical Journal

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

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VOL. VIII.]

AUGUST, 1937.

[NO. 11

Original Articles

SPRUE.

By

DR. K. NARAYANA MURTHI, M. D.

(Continued from last issue)

SIGNS, SYMPTOMS, TYPES AND COURSE:
The signs and symptoms of Sprue vary as infinitely as their combinations. Each case varies also in its progress whether it be towards recovery or untoward termination. In some instances it may start as an acute process, the patient rarely recovering from the attack. In sub-acute cases the course of the disease might run for an year or two; in chronic cases, the course may drag on for years—20 to 25—the signs and symptoms becoming quiescent at intervals alternating with periods of ill health. The cause for such infinite gradations in the course and the attendant signs and symptoms seems to depend upon the age, the intelligence of the patient and finally his co-operation, not to mention the rationale in treatment adopted by the physician.

The general symptoms in a typical case of Sprue are soreness of the mouth, distension of the abdomen, morning diarrhoea, marked emaciation and severe anaemia. Loss of memory, extreme irritability of temper and inability to concentrate are the chief nervous manifestations of the disease. To have good grasp of the nature of the disease, it is essential to describe some of the chief symptoms associated with the

mouth, the abdomen, the nature of the diarrhoea, and anaemia.

MOUTh: The mucus membrane is raw, red and painful. The lesions are superficial and their intensity varies from day to day. Minute vesicles with a white surface covering over them appear over the edges of the tongue, inside the cheeks and the lips. The tongue becomes fissured and the filiform papillae disappear. On either side of the frenum of the tongue aphthous like patches may be seen. Sometimes erosion of the lips and palate may also be seen. The soft palate, including the uvula is raw and the gullet may be felt sore while swallowing any food. As a result of ulceration of the whole mouth saliva may be dribbling from the mouth. It is almost impossible for the patient to take hot or even slightest irritating foods. Even bland diets may cause intense pain and burning in the mouth, with the result that the patient is afraid to take any food though he may be ravenously hungry. After taking the food the patient may complain of sub-sternal pain. All spices, strong wines, sour food and even salt irritate the mouth lesion. At no stage of the disease the tongue is found coated. It is found always either raw or smooth and yellowish in colour depending upon the anaemic condition of the patient. Apparently the tongue conditions will be the only symptom for years together without any trace of diarrhoea. The chief characteristic symptoms at this stage of the disease are severe anaemia and achlorhydria and these precede frothy, foul-smelling motions of Sprue.

DYSPEPSIA: The patient, on account of the raw condition of the mouth, is afraid to chew any food. He simply gulps down the food without masticating. The food is not digested and therefore the patient feels a sense of weight and oppression in the chest, and distension of the abdomen. The abdomen gets ballooned as it were with gas, and it makes a striking contrast with the general emaciation of the body. Gas is felt as if moving, making such noises which at times can be heard at a distance. In early cases the secretion of Hydrochloric acid is not diminished; but in chronic cases it is invariably absent even after injection of Histamine (achlorhydria). Achlorhydria often precedes the development of severe anaemia and at this stage, Sprue is indistinguishable from Pernicious Anaemia or the Addisonian Anaemia.

ANAEMIA: Anaemia is very much marked and pronounced in certain variety of Sprue, even at an early stage of the disease. The anaemia seems to have a bearing upon the condition of the mouth and the stomach. If Achlorhydria develops early, either on account of infection of the mouth with streptococcus haemolyticus or something in the unmasticated food which inhibits the 'internal secretion' of Castle, Townsend and Heath, a severe anaemia in the patient develops long before the symptoms of true diarrhoea are seen. Probably in these early cases, anaemia supervenes, and as a result of which diarrhoea starts. It is generally agreed that there are cases of Sprue without diarrhoea, the rest of all the symptoms being present in the same case. The anaemia in Sprue is so profound that the blood picture is almost indistinguishable from Addisonian Anaemia. The colour index is well over 1. These cases are invariably fatal. There is no increase of leucocytes and on the other hand there is marked leucopenia. At times a high grade of eosinophilia is found. This change is considered by the author to be a good prognostic sign. The eosinophilia count is made in relation with the absolute count and the differential counts of the W. B. C. Anything over 250 eosinophiles per c. c. of blood is a good prognostic sign. In a few cases the author noticed aplastic anaemia, which is usually associated with severe diarrhoea. These cases don't respond well to treatment and die very early during the course of the disease.

DIARRHOEA. Diarrhoea may be the first symptom at an early stage of sprue, the tongue and mouth symptoms being entirely absent. The diarrhoea often occurs during the morning hours, the number of motions varying from 2 to 4 and during the later part of the day the patient is not being disturbed at all. Each motion brings comfort and relief and the patient often has the false idea in him that only the undigested food is passed out. These motions are not at all associated with pain. The motions are always copious, frothy, pale, acid and foul-smelling. Abnormally large amount of fat and other oils are passed out. Since the diarrhoea in a quiescent stage of the disease is not severe, the patient goes about his work without worrying himself with the disease. His appetite and weight are not lost. When the diarrhoea becomes severe, the patient then thinks that something is materially wrong with his system. Severe diarrhoea brings about emaciation and debility which confine the patient to bed. Later on anaemia, sore tongue and other associated symptoms develop.

TYPES OF SPRUE, THEIR COURSE AND TERMINATION: The author and Dr. Pillai described two varieties of Sprue, basing their finding on their radiological study. One, they described as "Ascending variety" and the other as "Descending variety" the gall bladder acting as the centre of infection. In the Descending variety the first symptom they noticed was diarrhoea which is often of the Flexner type. In the Ascending variety the first symptoms were glossitis, stomatitis and severe anaemia. Dr. Flora Innes working independently at Vellore in South India came to recognise the two varieties of Sprue aforesaid by the author, but she named them in different terms as the "Excretory type" and the "Non excretory type". The 'Excretory type' corresponds with the Descending variety of Pillai & Murthi and the 'Non-excretory type' corresponds with the 'Ascending variety' of the same authors. Manson Bahr's classification into types, as 'Sprue without diarrhoea' and 'Tongue and mouth Sprue' really correspond to the two varieties of Murthi & Pillai and also to the two varieties, though differently named, of Dr. Flora Innes. Manson Bahr makes mention of a few more varieties classifying the types under two heads. 1/ Protopathic and (2) Incomplete Sprue. Under incomplete Sprue

he describes gastric and intestinal cases in addition to Sprue with diarrhoea and mouth Sprue. This classification is cumbersome and not at all based on pathological evidences in the body. From clinical signs and symptoms alone infinite varieties and types can be described but, for intelligent understanding and rational treatment the two varieties described above will serve the best purpose.

In an uncomplicated case we often hear the history that the patient is having morning diarrhoea for months or perhaps for years without interfering with his avocation and not appreciably interfering with his general health. Later sore mouth is noticed with increase in the number of motions. The motions begin with, contain bile and the patient is likely to attribute the diarrhoea to the 'bilious type' of diarrhoea occurring in the tropics. Gradually the stools become pale white in colour. Distension of the abdomen and other dyspeptic symptoms appear. These become pronounced as time passes by, the general health is impaired, marked lassitude, emaciation and inability to get through day's work result in permanent invalidism. With the indiscretion in diet or lack of treatment, the diarrhoea continues throughout the day and night, now no longer confined to the morning hours. Severe anaemia develops and the patient is confined to bed. The feet become oedematous, the skin becomes dry and scaly, the patient often dying either from an intercurrent disease, from inanition or from choleraic diarrhoea.

SEQUELAE: Anaemia with sub-acute combined degeneration of the cord is described in text books to be a common symptom. In Indian patients, particularly the South Indians the author had not seen a single true case of sub-acute combined degeneration of the cord. As to why it is so rare here, it is difficult to say. In the western countries, the triad, Pernicious Anaemia, Sprue and Sub-acute combined degeneration of the cord is often noticed. Neuritic signs as pins and needles in the arms and legs are often complained of by the patients. Purpuric rash, irritable dermatitis, oedema, cramps and tetany have also been described to occur as sequelae in Sprue.

Having described the signs, symptoms, varieties of Sprue and their sequelae, the author proposes to deal with 'Investigation

and Differential Diagnosis of Sprue in the next issue of The Medical Practitioner.

THE GENERAL PRACTITIONER AND COMMON EYE DISEASES

(By G. J. G.)

INTRODUCTION

The extent to which blindness prevails in India is perhaps gradually being realised, thanks to propaganda by people interested in the campaign against blindness. But in spite of that, no organised action is being taken to remedy the evil. A few associations here and there or the opening of some ophthalmic hospitals do not touch even the fringe of the problem. The need for relief is extensive.

It is a sad fact that much of this blindness in India is preventable—even excluding cases of curable blindness as Cataract. Those of us who work in eye hospitals know how many distressing cases one has to meet almost every day—cases which have gone incurably blind, but which need not have gone blind if they had been properly attended to in time.

Why they are not attended to in time is known to every one in the field, but the remedy available is not in one man's hand. The causes one has to combat are manifold—superstition, ignorance, quackery, procrastination and in many of the cases poverty.

To lay out a plan of action to meet all these is a problem which has not been seriously tackled. We cannot possibly expect the Government to bestow concentrated attention to it, when they have yet to tackle the equally serious problems of Cholera, Small-pox, Malaria, Maternity relief, etc. Nor can private bodies alone achieve much by their own efforts. Sometime back, an attempt was made by the authorities in the Swedish Mission Hospital at Tirupatur to draw up an ambitious scheme to rid the Ramnad District of all curable and if possible preventable blindness within a certain period, but without official aid they were simply helpless to do anything. The Bijapur Blind Relief Association in Bombay is a voluntary organisation depending on public gifts and grants-in aid but its work has to be very limited for want of direct official help. The Bengal Association for the Prevention of Blindness seems to be in a little more fortu-

nate position, though not to the extent one would wish it to be. As it is, I think, it is the only organisation in India where we have exemplary co-operation between officials and non-officials in an organised attempt to prevent blindness. We except that association to do some real good work. But one such association alone will not do. Unless we have a similar well organised body for each and every district, we shall not be doing much.

While the work to be done is extensive, we should not forget, it is urgent. Organised relief work will take time to come, but can not we medical men do something in the meanwhile? The object of this paper is to draw the attention of the medical men, especially in the rural areas, to their responsibility. How many cases which come to the general practitioner in the early stages could be saved if he only diagnosed and treated or advised them properly. I know a number of people who have gone permanently blind on account of the advice given by their doctors that they should wait till they cannot see anything, on the assumption it was cataract. Corneal ulcers, Keratomalacia, Gonorrheal Ophthalmia, if treated properly and in time, would save India from many a wasted life of blindness. For want of an eye hospital nearby or for want of funds to go to one, it is to the local general practitioner that many of these cases turn up and if he only knew what to do in such cases, he would be rendering a real humanitarian service to the patient, his family and the country at large. It might be argued that very few eye cases attend a local fund dispensary. It is so, in some places, because very little eye work, even of the most ordinary type, is undertaken there.

It is proposed therefore in this paper to give just an outline of what should be done in eye cases which resort to a general practitioner. We all know the training given in practical eye work during our medical course is, to say the least, inadequate; it scarcely fits us for doing any real work. There are a number of eye books in the market, but none of them - except perhaps Kirkpatrick's - is of much practical help to the busy practitioner. Even if one consults a book, the various drugs and varieties of treatment for one single condition causes confusion. I know a doctor who was trying on a patient

one drug after another in the order given in the book till the eye went blind.

As desired by the Editor of The Medical Practitioner this 'serial' on common eye diseases is undertaken with the idea of giving some simple, practical hints as to what should be done in eye cases which go to the general practitioner, particularly in village and remote areas, where there is no facility for consulting any body, least of all a specialist. An attempt will be made to give just one line of treatment for a particular condition which one can safely employ. It is not my intention to follow any regular order according to anatomical conditions as given in the books. I shall take up as far as possible such eye conditions in the order of frequency as seen by the general practitioner, and shall deal mainly with clinical symptoms, method of diagnosis and a safe line of treatment. I must also make it clear at the outset these series will have no pretension for originality or exhaustiveness and as such, it will not be of any interest to specialists in the line, but it is hoped it will be of some use at least to the general practitioner and the poor patients going to him.

(To be continued.)

TREATMENT OF BOILS AND CARBUNCLES.

By

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

Hon. Surgeon, Govt. General Hospital, Madras.

A boil arises as a small red pimple which is indurated and painful to the touch and is the result of infection of a hair follicle. Rarely, resolution may occur without any actual pus formation, in which case, it is known as a "blind boil". As a rule, however, a yellowish centre forms which begins to exude pus. A hair can often be seen protruding from centre of this area and after the yellow necrotic mass is discharged, healing occurs rapidly. The constitutional effects of a boil vary, the patient often feels unwell, and a furuncle on the ala nasi or the tip of the nose may produce very severe symptoms and considerable fever. In situations where there is loose connective tissue the oedema may be widespread. Boils are frequently multiple.

The treatment consists in protecting the hair follicles in the surrounding skin from

becoming infected. This is best done by avoiding friction of the clothes and by not using hot boric fomentations, which make the skin moist and sodden. Sterile vaseline or some antiseptic ointment as Ung. Hydrarg can be smeared around the boil to prevent this auto-inoculation of the hair follicles.

The boil should be incised, the pus with the central core evacuated and the wound dressed with sterile gauze. This can be done without any pain with the aid of an ethyl chloride spray. A small incision relieves the tension and the pain is eased immediately and healing occurs very rapidly. Deeper furuncles should be treated conservatively by dry heat and incised only after pus has formed.

General constitutional treatment is important. The urine should be tested for sugar and albumin. Generally, the patients are in a run down condition and a holiday should be advised and change of climate is also indicated especially from the heat of a place like Madras. Regular daily evacuation of the bowels and a generous diet are essential. Vaccine treatment is of definite value in cases where the boils are multiple or when they occur in crops. Autogenous vaccine is preferable to stock vaccine but the latter is also quite useful. Small doses of vaccines starting with 10 or 20 millions are more beneficial than larger doses. Iron containing tonics are often of value. Colloidal manganese 1 c. c. given intramuscularly gives good results in certain cases. Where there is considerable oedema, especially in deep furuncles Protosil album or Proseptastine tablets are distinctly beneficial, and bring about early localisation of the infection.

CARBUNCLES.

Carbuncles generally occur in people who are suffering from Diabetes or Albuminuria although one meets with a fair number of cases of carbuncles in whom neither of the above conditions are found to be present. The prognosis in the latter group is much better than in the former ones. Prognosis is also not good in cases where the carbuncles are multiple or when they occur on the face, especially on the upper lip. Prognosis is bad once Pyaemia occurs. A subnormal temperature and nocturnal delirium are also bad signs.

GENERAL TREATMENT: The concomitant conditions whether diabetes or renal disease,

should receive appropriate treatment. In the former condition the urine should be examined to determine the amount of sugar it contains and also to detect the presence of acetone bodies. Injections of Insulin with regulation of the diet by diminishing the fats and allowing a fair amount of carbohydrates are indicated. Patients can be allowed to take large amounts of water. If the temperature is high, a mixture containing Sodium Salicylate and Sodium Bicarbonate is administered. Anaemia is best counteracted by injections of liver extract. Autogenous vaccines are also useful. It is very important to increase the general resistance of the tissues to the infection and to cause increased phagocytosis; this effect can be produced by daily intramuscular injections of Gemenol. To alleviate the pain, even opiates can be administered provided there is no albumin in the urine; otherwise the patients feel very much exhausted.

LOCAL TREATMENT: This depends on the stage at which it is first seen by the Surgeon. Very often a large percentage of carbuncles are neglected or improperly treated until a deplorable involvement of tissues has occurred. Great judgment is required in deciding as to when to operate in these cases. An operation performed too early may cause a spread to the blood stream of a germ to which the body has not already erected efficient local barriers. It is not wise to wait too long also before removing the focus as the latter may itself bring about a blood stream infection.

In the very early stages when there is only induration present, hot dry fomentations with dressings of gauze soaked in a solution of anhydrous Magnesium Sulphate in glycerine are very helpful. Auto-haemotherapy is of distinct value in these early cases, sometimes bringing about a subsidence of the carbuncle. This consists in injections of about 3 to 5 c. c. of blood at the periphery of the carbuncle at three or four equidistant points, using a fresh needle each time. In carbuncle of the face or scalp in very early stages, dry cupping is of value and may abort them altogether.

EXCISION is the ideal treatment when possible. But this is to be limited to cases in which the general condition of the patient is good and the carbuncle is not too extensive. All the tissues right down to the deep fascia are removed and a clean raw

area is left to granulate. Skin grafting can be performed in the later stages to hasten healing.

CRUCIAL INCISION with removal of all slough is employed when complete excision is not possible. The flaps are reflected and the slough removed completely. The cavity is packed with Iodoform gauze and the flaps are allowed to fall back. If the superficial skin is also gangrenous, then the affected part of it is also removed. The wound is cleaned with hydrogen peroxide at subsequent dressings and packed with Eusol gauze.

The experienced surgeon can give the exact prognosis after making an incision into the carbuncle. Prognosis is bad where there is only a large mass of slough without any attempt at formation of pus, showing that the reaction of the tissues is very poor. The best anaesthetic in all these cases is gas and oxygen.

SIMPLE CRUCIAL INCISION is to be hinted to bad cases where it helps to relieve the tension. But the sloughs are not removed and there is a tendency for the infection to spread in these cases.

Boils and carbuncles on the face should not be incised but treated conservatively by hot fomentations and Magnesium Sulphate and glycerine dressings. The great danger in these cases is the spread of infection into the intracranial sinuses.

INFANTILE ECZEMA

By

CAPT. S. THAMBIAH, M.C., M.R.C.P.,
D.T.M. & H., F.D.S.

Lecturer in Dermatology, Madras Medical College.

Definition:—This is a catarrhal inflammation of the skin with a variable duration and subject to remissions and acute exacerbations. This catarrh may be latent when retained intercellularly, or patent when it appears as exudation or weeping. It is non-contagious and also, non-microbial. The aetiology of the disease is not well-understood, though a certain measure of sensitiveness to proteins derived from foods can be established.

* Lecture delivered at the Conference on Maternity and Child Welfare organised by the Madras Health Propaganda Board.

Vernacular synonyms:—In Tamil it is called *karuvilai* or *karuvilai*. When it reaches the eczema rubrum stage, it is called *karuvilai* and *Sithirai*. In Malayalam it is known as “*Thodu*”.

Signs and symptoms:—The earliest manifestation of the disease shows itself as a reddening or roughening of the prominence of the cheeks very much akin to windburn or simple chapping. On close inspection it will be readily evident that the reddened area is not dry, but moist; clear serum is seen to ooze from the irregularly fissured and thickened skin. This serous discharge later dries into crusts of variable thickness. The borders of the lesion are indistinct and shade off into the normal skin. In a few fortunate cases the process stays more or less at this stage and then clears up under soothing protective applications. The disease may from the start be acute with a fiery red appearance, gradually making a peripheral extension of the original lesion and also fresh lesions of a minute vesicular or vesiculo-papillar character may appear. The latter types on evolution weep and crust in the same way as the original reddened type. A note-worthy point is the ever present *itching*, and to secure relief the child resorts to scratching with the finger nails, and rubbing against the dress and bed clothes. Thus the disease spreads slowly or rapidly to other parts of the body as the forehead, the chin, and the ears and neck. In much neglected cases, the wrists, the knees and the flexor and extensor surfaces of the extremities may become involved. On the face, the circum-oral, circum-nasal and circum-orbital areas remain free throughout the disease, while the cheeks, chin, forehead and ears are badly affected. So the distribution of the lesions on the face may have the characteristic mask-like spread. It may be noted that the palms and soles also escape.

The intense itching and scratching keeps the child as well as the members of the household awake for the greater part of the night with the consequent deterioration of their general health. It is also worthy of note that the child maintains a good general condition during the earlier months of the affection.

Aetiology:—No other disease has had such numerous theories as to etiology, and hence to the methods of treatment. Babies between the ages of 6 months to two years are often affected; at the end of the two years, most of the children become free even without treatment. Teething, vaccination, food irregularities—events of importance present at this period have been blamed without much foundation. A good many dermatologists of eminence in England are inclined towards an external irritation as the main factor in its causation. A strong hereditary tendency can be demonstrated. Patient inquiry will reveal the presence of eczema, asthma, urticaria, angio-neurotic oedema, migraine, etc., in other members of the family. Children with infantile eczema on reaching adolescence, very often suffer from eczema or asthma.

Professor White in England made a study of the stools in obstinate cases of infantile eczema and showed the presence of excessive fat in 60% of cases and excessive starch in 40%; preponderance of sugar in 20% and 10% of proteins. He also concluded that excessive starch was associated with a dry type of eczema and excessive fat with a moist type—points of practical clinical importance.

From the dietetic point of view, different items as the fat, starch, sugar and of late protein have been indicted and eliminated from the menu with varying effects on the progress of the disease. Excessive starchy food causes fermentation: the stools are mushy or loose, green and acidic with a sharp penetrating odour.

A more or less similar effect is produced by sugars. The combined action of fats and protein produces an intense sensitization and aggravation of the pre-existing eczema. The fatty acid, split off from the neutral fat consumed, irritates the intestinal mucous membrane making it more permeable to the protein and other substances, which, when absorbed, may cause the eczematous process. “There is evidence to show that proteins particularly may be absorbed and digested through the intestinal mucous membrane and may give rise to sensitization. This form of sensitization to products of protein is termed “allergy.” Its presence to various substances can be demonstrated by intracutaneous, percutaneous and patch tests, em-

ploying a large range of allergens. But unfortunately, protein sensitization does not solve the problem of all cases of infantile eczema; yet there appears an intimate relationship between infantile eczema and protein sensitization, the exact nature of this is not determined.

There is also a certain amount of racial peculiarity in this disease; children of coloured races are less affected by this malady. In South India I have not seen so many children with infantile eczema at the out-patient clinic of the General Hospital, as I have seen at Leicester Square. Perhaps over-feeding is not seen among the hospital class of children.

TREATMENT.

Mild cases may be treated at home; severe ones require hospitalization and efficient nursing. To prevent scratching and rubbing, restraining devices have to be used. The Edinburgh device or the method proposed by White of Boston may be adopted. Soap and water aggravate the lesions. Saturated solution of boric acid may be used for cleansing purposes. Starch bath is comforting to the patient. Crusts may be efficiently removed by means of olive oil, or cold cream.

From the dietetic point of view, and the assumption that the protein of milk caused the eczema or aggravated it, L. W. Hill of Boston proposed a protein free diet and introduced a preparation under the name of “Sobee” (Mead Johnson & Co.). It is made up of Soya Bean flour (67.5%), barley flour (9.5%), Olive oil (19.0%), sodium chloride (1.3%) and calcium carbonate (2.7%). Olive oil supplies the fat and the last two items, the mineral deficiency of Soya Bean (calcium, sodium and chlorine). Sobee is not sweetened and sugar may be added according to the tolerance of the patient. Cod liver oil and orange juice may supplement the vitamin deficiency in older children. A level table-spoon of Sobee added to an ounce of water will provide the full strength mixture giving a caloric value of 17. For weaker children a dilution less than indicated above may be used. This diet has yielded much satisfaction in very severe cases. In less severe cases evaporated milk and milk heated, varying from 6 to 8 hours, have been advocated and used with good results. The protein of the milk is altered or “dena-

turized" in such a way that no injurious effect can arise to a sensitized child.

Local Treatment:—Any external application which is soothing and protective will answer the purpose quite well. If weeping is predominant, an ordinary calamine solution or $\frac{1}{2}$ aluminum acetate in water is all that is necessary. When drying becomes marked cold creams may be substituted. An efficient cold cream can be prepared by adding 3 to 4 drachm of zinc oxide to an ounce of well-prepared cotton oil. It is better to incorporate a dram or two of lanoline or laceranum to keep the cream in a homogenous mass, and this also will be of help if any acid preparations have to be added. Among the proprietary preparations I have found Crooks Colossal Lacto—calamine and ordinary calamine solution to answer the purpose. The former can be diluted with an equal quantity of warm water without lessening its efficacy. Lassar's paste without salicylic acid is a better protective in that the paste when applied will stick better and cannot be easily dislodged. If scaling is predominant, 2% calomel in Ung. Aqua Rosae or 20 minims of Liq. Carb. Diterg. in an ounce of Laceranum is all that will be required. Steam distillate of tar under the trade name of tara-alba may be used in refractory cases.

In spite of the above figuring and planning as regards treatment, a few cases remain without being benefited in the least by treatment. In these cases, it is wise and proper to improve the general health of the child, so that growth may not be interfered with. The physician should remember that this is a self-limited disease and when treatment of the eruption is not yielding to external applications, it is better to treat the individual as individual without imposing much dietetic restrictions.

Abstracts

THE PHYSICIAN AND THE CANCER CONTROL PROGRAM

FRANK L. RECTOR, M. D., EVANSTON, ILLINOIS

Field Representative American Society for the Control of Cancer New York, New York

There are four tests of a community's intelligence: Religion, education, civic government, health. The first three of these are not germane to our discussion tonight, so I am saved the possible embarrassment of assigning to them their positions of relative importance. Such assignments would, of course vary with the ideas, the intelligence, and the interests of those consulted. We can all agree, I hope, that one important measure of community intelligence is the status of measures for controlling those health factors affecting its citizens. This test has a more scientific basis than the other three.

The health of any community is the sum of the individual health of its citizens. With communicable diseases largely brought under control, others have taken their places as important health problems. This latter group, known as degenerative diseases and represented by heart disease, cancer, nephritis, and apoplexy, to mention but a few of the more important, must depend for control on what the individual does rather than on any community measures that may be employed. The application of preventive and control measures to these diseases is an individual problem of the patient and his physician, although their results may profoundly affect the community welfare.

The history of the great disease scourges of mankind have all followed the same general course, Plague, cholera, tuberculosis diphtheria, syphilis, name them as you will, you will find three stages in the development of measures for their prevention and control. Briefly these stages may be described as follows:

Stage 1—Characterized by mystery and fear. A new group of symptoms, almost universally fatal or at least devastating to large numbers of the population, makes its appearance. Its origins are shrouded in mystery

which engenders fear in the minds of its victims and a greater or less degree of consternation in the medical profession.

Stage 2—Concerned with fact finding. As clinical experience accumulates and the disease is studied from all angles, a less fearful attitude is developed, more lives are saved, and an increasing degree of optimism appears. The cause may have been discovered and, if this is true, it stimulates a bolder approach to a study of ways and means for controlling it.

Stage 3—Devoted to prevention and control. A stage is finally reached where the cures approach, equal, or exceed the deaths and with the cause known, preventive and control measures can be applied.

During the first and second stages, the problem lies largely in the medical and related scientific fields. Fundamental problems in biology, chemistry, physics, hygiene and sanitation, must be solved. The physician must enlarge and perfect his clinical experience and technique as rapidly as this fundamental information becomes available. It is only in the third stage, where the full force of scientific knowledge and the layman's cooperation can be brought into play to minimize the effects of the disease, that preventive work can best be done, work to ward off the disease, or its early cure if it has already found its victim. In the last analysis this is the practice of medicine carried to its highest plane of service.

Where does cancer fit into this picture? What are the questions surrounding this disease that are of interest to the medical and allied professions and to the public? Can the three stages of the history of disease just described be applied to cancer?

Answering the last question first, we can safely say that the history of cancer fits easily into our classification. Cancer is one of the oldest known diseases and was recognized by the earliest student of medicine. It is world-wide in its distribution, so there has been opportunity for its simultaneous study by scientists during all ages. It is as ubiquitous as life itself and is easily understood when we realize that it is primarily an expression of biological activity, and only secondarily does it assume the characteristics of a malignant tumor.

Since the dawn of history cancer has been known and recognized as a serious medical problem. For centuries it was considered a fatal disease from the time of its appearance in the patient's body. Cures were almost unheard of and were deemed practically impossible. A great mystery surrounded the disease and many fallacies came to be believed. People would not seek medical help until driven by pain or discomfort, so physicians seldom saw the disease in early stages when they were able to offer hope of cure.

Gradually, however, earlier stages of the disease were encountered and some palliative treatment was found effective. Study of the problem was taken up by workers in the related sciences of chemistry, biology, and physics, and information began to appear from these quarters. Physicians learned from their clinical records that the earlier the patient was treated after the appearance of symptoms, the longer he lived. Three-year cures were reported in increasing numbers, then five-year cures. Today there are thousands of cured cancer patients, many of them unknown to their closest friends. The American College of Surgeons has reported a list of more than 25,000 cancer patients who have remained free from cancer for five years or longer since treatment.

For thousands of years the public has been an important, but almost silent participant in this drama. The commendable conservatism of the medical profession in refusing to claim too much for the progress being made in cancer research has left the public wondering and speculating about many aspects of the disease that should be freely discussed with it. Cancer is now, almost four thousand years after its earliest recognition, entering on the third stage of our classification—that of prevention and control. Some physicians who have not kept pace with developments in this field still would keep cancer in the second stage and refuse to admit that the public has anything to gain from or contribute to a program of cancer prevention and control.

What are the facts about cancer as we know them today? Simply these:

1. Cancer is no longer considered a single disease. It is rather a large group of diseases with a similarity of symptoms, especially that of uncontrolled of growth.

* Read at a meeting of The Academy of Medicine of Cincinnati, January 5, 1937.

More than five hundred types of malignant growths have been identified.

The exciting cause of all forms of cancer is not known. It is believed that chronic or prolonged irritation is the most common factor associated with production of malignant growths. Many causative factors are known. Some forty-five different chemicals have produced cancer when injected into laboratory animals. About fifteen species of parasites have been identified as cancer-producing when they become encysted in internal organs, principally the liver. Prolonged exposure to high temperatures or to the sun's rays is conducive to cancer growth in some persons. Hormones from certain glands, particularly from the ovary, when present in excess, stimulate tissue growths that closely resemble cancer.

3. There is no conclusive scientific evidence that cancer is hereditary in the human family. Students of genetics now say that a constitutional susceptibility to cancer may be transmitted from parent to offspring, but not the disease itself. This susceptibility needs the added contribution of chronic irritation in order for cancer to develop. It has also been found at times that a certain type of cancer occurring in a parent at a certain age occasionally occurs in a child in the same organ at or near the same age as it occurred in the parent; but such cases are few compared to the number of families in which none of the children of a cancerous parent or parents has died of the disease, or in other families where but one or a very few cancer deaths occur in several generations.

4. Cancer is not caused by a germ, therefore it is not contagious. It is not a blood disease, nor is it acquired by immoral practices. You cannot develop cancer by thinking you have it. It is not cured by faith healing, salves, or other medicines. All these fallacies and many more are firmly believed by many people.

5. The only effective methods of treatment are surgery, X-rays, and radium. The medical profession should appreciate that in cancer, more than in any other disease, their skill alone spells the difference between cure and death. In most other diseases the problems of infection, tissue resistance, and other factors determine largely the outcome of a particular illness. In cancer the

patient always dies unless treated adequately in early stages.

6. Cancer is a disorderly growth of cells of the patient's own body, caused by an overstimulation of the growth function inherent in all living cells.

7. Enough is known about controlling cancer that, if this information were fully utilized by the medical profession and the public, a reduction of thirty to forty per cent in the number of deaths could be brought about in a few years, and for cancer in some sites, this reduction would range from seventy to ninety per cent.

8. The cancer patient cannot learn to live with his disease as he can do with other conditions as heart disease, diabetes, or even tuberculosis.

9. There are early signs of cancer, "danger signals," which should be familiar to every intelligent person. Briefly these are a lump that persists, especially in a woman's breast; a sore that does not heal, particularly about the mouth, face, or lips; an unnatural bloodstained discharge from a natural body opening; persistent indigestion; change in size or color of moles or warts. Physicians should consider each of these early symptoms as evidence of cancer until proved by careful examination to be due to something else.

The putting into effect of a program of cancer prevention and control waits largely on the willingness of the medical profession to make this information available to the public and to provide facilities for carrying the program into effect. To this part of the plan the public can and should contribute liberally, as it is for its own good that this be done. The public should support all educational efforts, such as lectures, exhibits, radio broadcasts, and literature distribution. The provision of funds to make these services available through the medical profession to the entire population is one example of ways in which the public can contribute to the control of this disease. The public must become better informed about cancer, less fearful of the subject, and seek medical advice at the first suspicion of danger. After he knows what cancer is and how it behaves, the initial responsibility is the patient's.

As soon as the patient seeks medical advice the responsibility for that case rests

in large measure on the physician. The first physician seeing the patient determines largely the ultimate fate of that patient. The steps he takes for diagnosis and therapy are the determining factors in the outcome of the individual case. If the physician procrastinates, if he indulges in a period of watchful waiting to see what will develop in the next few weeks or month, he has probably doomed his patient to an early death. If he is alert to the possibilities of cancer and employs every possible means to get the answer to his patient's problem, he will have done all he could to prolong that patient's life. It is doubtful if any physician today justified in waiting more than a week in seeking an answer as to whether a suspicious condition is cancer.

I am certain that no physician is justified in pursuing such a policy as was recently reported by a lady who said that when she went to her physician with an appreciable lump in her breast, he proceeded to take her bust measure periodically for several weeks to see if the growth were enlarging. When it is realized that at least 70 per cent of breast cancers are curable when competently treated in early stages, and that a patient's chances for surviving five years decrease about four per cent with each week's delay in starting treatment, the value of prompt diagnosis and therapy is readily understood.

If the physician has not immediate access to facilities for getting the answer, he knows or should know where such facilities exist. The desire to keep complete control of a patient's treatment in the face of inadequate facilities for such treatment should not be countenanced by medical groups with power to influence the physician in such matters. For instance, no physician should perform a partial or complete hysterectomy for cancer of the cervix because he does not have immediate access to irradiation facilities, or experience in this form of therapy. Few cases of cancer are of such an emergency character that the patient cannot wait a few more hours in order to be placed in contact with proper therapeutic facilities.

Another phase of the physician's relation to the cancer patient is that of acquainting the patient with the fact that he has cancer. Repeatedly people who have had cancer say to me: "If my doctor had only told me the truth about my condition, I would have felt

so much better satisfied and could have helped him so much more in my treatment."

The average layman still is very fearful of cancer. This fear is based largely on ignorance of the character of the disease and methods for controlling it. When this ignorance is replaced with knowledge, the channels of control are open. It is then a matter of sympathetic cooperation between the public and the medical profession to see that cancer does not obtain a fatal foothold before it is discovered. Such cooperation implies frankness on the part of both parties to this service. Laymen must go to their physician at the first sign of trouble, withholding nothing that would aid the physician in reaching an accurate diagnosis. The physician should be frank with his patients and speak plainly of cancer as he does of other diseases. No longer do people dread to hear the word smallpox or tuberculosis mentioned, and yet in the memory of some of us this condition once prevailed. The longer the word cancer is spoken in an undertone or camouflaged by meaningless terms, the longer will the public hold to its senseless fear of the disease.

Cancer should be called cancer and the patient advised by his physician that early and adequate treatment is the only hope for a cure. Give the harrassed cancer patient all the hope possible, but tell him the truth. While it may stagger him at the time, he will cooperate much better in his treatment if he knows the true situation. This is the report made by those hospitals and physicians who routinely tell their cancer patients that they have the disease. The wagging tongues of friends and relatives often do more to break the patient's morale than does the knowledge that he has cancer. We might add that the wagging tongue of some thoughtless colleague, who indulges in innuendo or open criticism of the treatment given, often causes more trouble than anything else.

Physicians who are the logical teachers of health should take some pains to enlighten the public about these matters. Under no circumstances should a seeker after health information be made to feel that he is asking too much of a physician when asking for such information. For instance, the periodic medical examination of an apparently well individual constitutes the first line of defense in the war to prevent and control cancer,

How many physicians, in the absence of some rather definite pathology, are willing to give an examination complete enough to enable them to pass an intelligent opinion on the presence or absence of signs and symptoms of cancer? Daily I am told by intelligent people that they have been laughed out of the physician's office for asking for an examination in the absence of evident illness. My answer to that question is for those so treated to go to some other physician who will make the requested examination and to advise the first physician that they are doing so and why. From the standpoint of the physician's income alone, thousands of dollars are being thrown away annually because he has not either the interest or the ability to determine the physical condition of an apparently well person.

Coupled with the problem just discussed is that of the physician who, through disinterestedness or worse, does not keep informed of advances in medical practice, and very soon assumes a pessimistic attitude toward the whole cancer problem. His philosophy may be summarized in seven statements that have been discussed in considerable detail elsewhere. *Bulletin, American Society for the Control of Cancer*, v. 18, No. 10, October, 1936. We will enumerate them here and discuss them briefly.

1. *Efforts to enlighten the public about cancer only stimulates morbid fears about the disease.* There are a few confirmed neurotics in every community who will momentarily grasp at cancer information for a vicarious thrill; but this will satisfy them only until their attention is directed to some other condition which will give them something else to worry about. Such persons comprise not more than two to three per cent of the population. Should they be allowed to determine or influence what should be said to the other 97 to 98 per cent who will profit from the knowledge about prevention and control of cancer? It should also be remembered that cancerphobia never kills as does the real disease.

2. *Cancer education drives the public to quacks.* I cannot agree with this statement for the simple reason that there have been cancer and other quacks so long as there has been a science of medicine. Because of general health education, these charlatans have not flourished as they did previously. It is largely because reputable physicians

have been unwilling and, in many cases, are still unwilling to give their cancer patients any appreciable amount of hope that these distracted people turn to those who will promise all they ask for, regardless of the fact that such promises cannot be fulfilled. If cancer education drives the public to quacks, it is because their salesmanship is more inviting to the public than is the reticence of the ethical profession. Is not the implication clear for the profession to adopt a more hopeful attitude toward this problem?

3. *The medical profession has no cure or even hope to offer the cancer patient.* This statement is so obviously misleading as to need no defence before this audience, yet I have heard it many times from physicians in active or should we say passive practice.

4. *Treatment often increases the patient's suffering.* Again this statement is without foundation. Some people who are ultimately benefited by radiation therapy have a temporary reaction that is most unpleasant, but of comparatively short duration. The number of such patients is lessening as improvements in therapeutic technique are brought about. The number of swollen arms following radical mastectomy is growing smaller as improved surgical technique is employed. Knowing the terrible suffering the cancer patient must face towards the termination of his illness, temporary inconveniences like those just mentioned should not be of importance in determining on measures designed to save or prolong life.

5. *By telling the cancer patient the truth, his condition is often aggravated.* This argument has already been answered earlier in this paper and needs no elaboration here.

6. *The patient will not cooperate in treatment.* According to my observation and information, cancer patients will cooperate in treatment as well as other types of patients once they know their true condition. So long as they are kept in ignorance, they cannot be expected to appreciate the significance of their disease or the necessity for the prolonged treatment that is so often necessary.

7. *A watchful waiting attitude on the part of the physicians often the best policy to pursue.* The seriousness of procrastination by the attending physician has already

been discussed. It is inexcusable, unnecessary, and positively detrimental to the patient's welfare.

Time will not permit of further discussion of these points, but they might well be designated as "seven steps to the undertaker" when followed to their logical conclusion.

It should be appreciated that the diagnosis and treatment of cancer is a group problem. No one physician is competent in all diagnostic and therapeutic procedures in this field. The pathologist and roentgenologist should largely determine the diagnosis. The surgeon, radiologist, and radium therapist are concerned with treatment. In this group should be included, of course, any other specialist in whose field a cancerous lesion might lie. Each should respect the contributions his colleagues can render in this field. Dr. James Ewing recently said that cancer is no longer a condition to be handled by the general surgeon as a part of his day's work with fractures, appendicitis, and gall-stones. Cancer requires a careful cooperative study by those specialists mentioned above, and in many cases by the internist also.

The American College of Surgeons has recognized the importance of the group study of cancer by formulating a plan for an organization within the hospital staff and standardized procedures for the diagnosis and treatment of this disease.

It is important that cancer patients be followed for a five-year period at least after the initial treatment. A useful follow-up schedule might be stated as follows:

Monthly visits for the first six months.

Bimonthly visits for six months.

Quarterly visits for one year.

Semiannual visits for three years.

Annual visits thereafter, preferably for life.

There is no harm in having a monthly or bimonthly follow-up for a much longer period than the first year if it is practicable. Some physicians try to see their cancer patients monthly for an indefinite period.

The physician who does not follow up his cancer patients after treatment cannot be considered as rendering the best service to them. Contact with these patients is only begun when the first treatments are finished. The excuse so often given that patients will

not cooperate in a follow-up program suggests that they have not been fully satisfied with their experience in the first place. There is abundant evidence that most patients will cooperate in any reasonable program once it is presented to them in the proper manner and the physician makes it worth their while to cooperate.

The chief function of any health undertaking is that of prevention. The main factors working against prevention of any disease are ignorance and fear, and education is the best antidote for them. Cancer education must be directed to all intelligent groups. It must be a continuous process as people forget easily and younger groups are always growing older. Today in many cases it is easier to prevent cancer deaths after the disease has become established than it is to prevent development of the disease. This situation will change as knowledge of prevention and control increases. If other diseases were neglected as is cancer, their death rates would be proportionately high.

The time is propitious to extend the cancer educational program to include all groups of high school age and over. For the past twenty-five years the public has been exposed to all sorts of health information until today it is eager for the facts about cancer. In many cases patients are indisposed to accept the opinion of one physician as to whether or not they have the disease. For this reason they consult a number of physicians before concluding to take action. Recently I talked with a lady who had consulted twelve physicians during the past year, and by the delay had probably sacrificed her life. Each physician recommended the immediate removal of a painless lump in the breast which, by the time she talked to me, had begun to give pain in the axilla and elsewhere, symptoms very suggestive of advancing and probably hopeless cancer.

To meet the public demand for factual information about cancer, the American Society for the Control of Cancer is organizing the women of this country into a group known as the Women's Field Army Against Cancer with the object in view of bringing to the entire population known facts about the prevention and control of this disease. The organized medical profession is being invited to assume the direction and control of this educational program in each

state. By this means it is hoped to arouse the interest of all intelligent groups to the end that deaths from cancer may be materially reduced.

With cancer causing 10 per cent of all deaths in the United States, with certain types offering a 70 to 90 per cent chance for cure, if taken in time, with a possibility of reducing the total number of deaths by one-third or more by the application of known methods of control, it requires no great stretch of the imagination to realize that cancer is now entering the third stage of its history, the stage of prevention and control, and awaits the active cooperation of all social groups undertaking.

The medical profession has a unique opportunity and a heavy responsibility to see that practical scientific methods are used in the diagnosis and treatment of cancer, and that accurate information on its prevention and control reaches the public. The responsibility of the layman is to provide facilities for the scientific care of cancer patients and aids for the physician to use in his educational work. Planning and working together more closely than ever before, both groups should make real contributions to the control of this disease.

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

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Rhinolaryngological Clinics

ROBERT F. RIDPATH, M.D., Sc.D., F.A.C.S.
CLINIC 1—HISTORY OF A CASE OF FRONTAL SINUSITIS:

It had been intended that a radical frontal sinus operation be demonstrated to the class at this period; however, this was not possible because of the death of the patient—this from the spread of the infection to the frontal lobe of the cerebrum. Nevertheless we will discuss the case in association with the general symptomatology of frontal sinus disease. The following salient features were present in this case:

The patient (P.G.) was a man 53 years old a native of Russia, who had had a productive cough of twenty years duration; this had gradually been getting worse. He expectorated a profuse amount of thick mucous, greyish in color, with no odor or

blood. No dyspnoea or desphagia. No pain in chest, no night sweats and little temperature. There was a profuse post-nasal (very unusual in Frontal cases) discharge. Following a severe coughing spell he became hoarse as he also did from talking for any length of time.

The family history is negative as to the present condition. His past history reveals the fact that he had pneumonia when fifteen years of age. He also states he was treated for syphilis when a young man. Tonsillectomy by Electro-Coagulation several years ago. Pleurisy at thirty years of age and a history of always having trouble with his nose. The resume of the medical examination notes an extremely obese man who appears older than his chronological age. His face is somewhat pasty and flabby. Eyes—pupils react sluggishly to light and accommodation. No jaundice of the sclera is noted. The ears appear negative. The examination of the nose reveals residual pathology of a septal abscess on the right side where patient had removed a polyp. Septum deviated to the left and on the right side of the septum anteriorly some piled up tissue is noted which is suggestive of healed ulceration as patient gives no history of having any nasal operation. The mucosa appears redder than normal. No pus or secretion is found at this examination. The throat shows marked pharyngitis. Tonsils large and cryptic with exudate despite history of having had electro-coagulation done. A heavy thick tenacious postnasal discharge is noted. The larynx is congested and irritated by constant coughing. The vocal cords are of normal motility and are fairly normal in appearance. The chest reveals a chronic bronchitis, some thickening of the pleura in the right lateral chest wall. The heart is enlarged transversely. Aortic dullness wider than normal. Myocardial tone flabby. The heart sounds are poor.

The symptoms of which the patient complains are:

1. History of influenza for ten days.
2. Persistent pain over the right frontal region, radiating to the vertex and parietal areas. This pain increased by assuming a prone position.
3. Edema of the upper eyelid and sclera.
4. Malaise; anorexia; vertigo; fever.
5. Discharge of pus from nose and post pharyngeal space.

If, after proper examination it is decided frontal sinus disease is present, the following treatment should be employed: Cocainize the mucus membrane with 4 per cent cocaine. Wait 5-10 minutes. Then wash out the entire nasal chamber with warm normal saline solution. If pus is obtained by this method the treatment should be continued. The most satisfactory results are procured with the patient's head in a vertical position. In order to liquefy the pus in the frontal sinus, applications of hot pads, fomentations or a hot water bag should be applied, or infra red treatment given. After the pus has been evacuated a solution containing glycerine as a base and incorporating such agents as argyrol, silvol or neosilvol, metaphen—1 to 5,000, etc., can be used. The following are splendid local applications:

(a) Silvol (25%) in equal parts of glycerine and water applied warm.

(b) Ichthyol (5%) in equal parts of glycerine and water applied warm.

The general constitutional effects, however, deserve careful attention *since the conditions is accompanied by toxicity*. Remember the use of digitalis, caffeine and strychnine for general stimulation to the cardiovascular system. Saline purges are important for the intestinal constipation which is usually present. Alkalinize the probable condition of acidosis. Salicylates, urotropine and biniodide of mercury are frequently indicated. Aconite to reduce temperature is very useful. It is very important to go further than the local condition and for this reason you must treat the symptoms as they present themselves. Hot baths may be tried.

If local methods are unavailing, two other treatments may be resorted to:

(1) *Protez Method*—vacuumizing the nasal sinus with instillation of $\frac{1}{2}$ of 1% Ephedrine in normal saline.

(2) Internasal opening of the frontal sinus by rasping.

In summing up this case, it must be stated that the history, symptoms and signs were very definite, and the subsequent results might have been avoided, if we had had the patient earlier. Never forget that "Swollen upper eyelid, edema of the sclerotic coat, fever and pussy discharge from the nose," are very indicative of frontal sinus disease. Edema of the lower lid may be maxillary or ethmoidal in origin. In this case although the symptoms at time appeared to be im-

proved, the general condition became suddenly worse and frontal abscess was diagnosed. It seems proper here to mention the other symptoms of frontal sinus disease:

1. Dull sickening pain over the frontal area when in lying position.
2. Patient may even fall on stooping forward.
3. Smoking and alcohol irritate and increase all the other symptoms.
4. Pressure over frontal area increases pain.
5. Influenced by weather and humidity.
6. White discharge at times during the day.
7. Pain on arising due to movement of body.
8. Lack of ambition, some melancholia.
9. Inability to concentrate.

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

Therapeutic Notes.

By

DR. T. V. MUTHUSWAMY CHETTIAR
TIRUPPATTUR.

INFANTILE TETANY AND SPASMOPHYLIA.

The relation between rickets and tetany and the disturbance in the calcium-phosphorus metabolism in these conditions have already been discussed by me in my article on Rickets. In both these conditions Vitamin D is an effective remedy in that it corrects the underlying disturbances responsible for these conditions. As the action of Vitamin D is slow (it takes a week or two for its effects to become manifest), calcium chloride (10 to 15 grains in milk given every four hours) may, with advantage, be given by mouth. Calcium chloride gives relief within 18 to 24 hours. To control the attacks, sedatives may be given.

NON-SPECIFIC VITAMIN DEFICIENCY.

Infants and children fed for a long time on a purely milk diet which is poor in quality and quantity, develop certain signs and symptoms which are not indicative of any one of the conditions so far discussed. The symptoms are not due to the deficiency of any one factor but it is due to a combination of several factors as for example deficiency of more than one vitamin, inorganic salts, inadequate protein intake and excess of carbohydrates in the diet.

Symptoms are chiefly gastro-intestinal: viz. dyspepsia, loss of appetite, constipation, diarrhoea, listlessness, absence of increase in weight or actual reduction in weight and wasting.

These cases must be carefully kept under observation for sometime, their dietary must be examined and treatment should be begun early.

PEPTIC ULCER.

Based on a study of the experimental animals, it has been shown that ulcerations of the gastric and duodenal mucosa are associated with a deficiency of vitamin A in the diet. Hence it is that the patients suffering from peptic ulcers are put on diet rich in its vitamin content especially vitamin A.

In cases of peptic ulcers associated with a deficiency of vitamin C, haemorrhages may occur. To prevent this, bananas and scraped raw carrots may be given.

Their high acid-content prevents certain fruits rich in vitamin C being used in these cases to their best advantage.

DEFICIENCY OF INORGANIC SALTS.

The growing child requires a sufficient amount of salts especially iron, phosphorus, and calcium for the growth of strong bones and for enriching the haemoglobin content of the blood. The infant's liver contains enough iron (obtained from the mother's blood during intranterine life) to last for six months, as such a deficiency of iron in the diet becomes manifest only during the latter half of the first year. When the child is fed on a diet containing only milk (which is poor in quality and quantity) for a long time, and when it loses considerable quantities of inorganic salts by vomiting, diarrhoea, or perspiration, it is liable to suffer from a deficiency of salts in the tissue fluids. If the deficiency is great, it may be sufficient to cause death. Administration of sodium chloride alone is insufficient. Potassium, calcium, magnesium, iron, enough of manganese and copper should be given to the children between the ages of 2 and 12 years.

Therapeutics

The Eye, Ear, Nose and Throat Monthly Dec. 1936
ECZEMA OF THE EYELIDS

This affection is greatly helped by the following:

Plumbi acet.	0.06
Morphine Sulf.	0.06
Aquae Dest.	30.00

And the same solution may be dropped into the eye for the relief of eczematous conjunctivitis.

ACUTE TONSILLITIS

The following prescription has much to recommend it in this condition:

Tinct. Aconiti Rad.	m. xvj
Tinct. Ferri Chlor.	dr. j
Potass. Chlorati	dr. j
Glycerin	dr. vj
Aquae Dest. q. s.	oz. ij

A teaspoonful every two or three hours.

NASAL LAVAGE

The Late Dr. Lake recommended the following powder for this purpose:

Sodii Chloridi	
Sodii Biborati	
Sodii Bicarb.	aaa dr. j
Sacchari Albi	oz. iij

One in ten teaspoonfuls of tepid water.

SYMPATHETIC OPHTHALMIA

The old method of treating the acute stage has still much to recommend it, namely, bathing the eye with hot water at frequent intervals, instilling atropin, and applying leeches to the temple at the orbital margin, permitting the bites to bleed freely; hot baths and free sweating.

DIPHTHERITIC CONJUNCTIVITIS

Avoid strong applications to the swollen conjunctiva during the acute stage. Use solutions of 1:5000 bichloride of mercury or 1:6000 permanganate of potassium at frequent intervals to remove the discharge. After the membrane has been thrown off, weak astringents should be applied once daily.

FOLLICULOSIS

A collyrium of zinc sulphate, 1 gr. to the ounce, daily applications of glycerite of tannin, 30 grains to the ounce, silver nitrate 2 grs. to the ounce, boroglyceride, 40 per cent, and the occasional touching of the follicles with copper sulphate, constitute the most useful remedies.

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AN OPPORTUNITY.

The individual members of the Medical Profession and all the existing Medical Associations in the Madras Province including the Medical Students' Associations are seen vieing with each other to honour the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister. The Congress Ministers here as well as elsewhere have been advising the public and the statutory local bodies against public receptions and addresses telling them that there is no need to spend money on this account and that they are prepared to meet even a humble individual and listen to him whenever any legitimate help is needed from the Government either in public or individual interest. The Hon'ble Dr. Rajan said at one of the functions that the object of such functions was plain, and that the organisers naturally expect something in return. This is too true to be considered otherwise. The real practical and even psychological effects of these functions have left on society such impressions that in spite of mild protestations from the recipients of these honours, the social functions are more in evidence and have been yielding tangible good results.

The Medical Practitioner is so happy that the views and ideals which the Hon'ble Dr. Rajan is placing before the members of the medical profession who have been honouring him ever since he became the Public Health Minister are just the same to which he gave expression as a practitioner. The extracts from his speech delivered in his capacity as Chairman, Reception Committee of the Trichinopoly Medical Conference held under the auspices of the Trichinopoly District Medical Association in 1933 and

published in the columns of The Medical Practitioner in the July issue should convince all concerned that Hon'ble Dr. Rajan holds the same views and maintains the same ideals in his public utterances as expressed in the past by Dr. Rajan, the medical practitioner. Soon after Dr. Rajan entered the Central Legislative Assembly, he contested the seat to represent the independent profession excluding the Medical Licentiates, in the Medical Council of India consequent to the death of Dr. T. Krishna Menon. Just at that juncture the then Madras Government went out of the way and nominated a person to the Madras Medical Council who was at the time in the field of competition to represent a graduate in the Madras Medical Council. The Medical Practitioner protested against this nomination and soon after this nominated graduate contested the vacancy against Dr. Rajan, The Medical Practitioner warned the electorate against the choice of a person who was the nominee of the Government in the local Council. But our suggestion fell on deaf ears. If Dr. Rajan had a chance to see for himself the affairs of the Medical Council of India, the profession would have given him an excellent opportunity to judge that the Medical Council of India was not at all for the benefit of the medical profession in India but served the purpose of only placating the General Medical Council, Great Britain. Such an experience gained by Dr. Rajan of an all India Act would have served the profession splendidly now when Dr. Rajan is in power to enable him to use his influence in the interests of the rank and file of the profession so that the all-India Act might be made beneficial to the medical profession throughout India. This

episode we are reiterating so that the independent medical profession might get wiser even after such events and realise that it pays even the individual interests if fearless independent practitioners represent the profession wherever and whenever such representation is needed. It was indeed a very pleasant sight to see Dr. Rajan honoured by the graduates and would-be graduates on the Medical College grounds on 10-8-37 when the Madras Medical College Students' Association gave him a grand reception, almost all of them even the Officials being decorated with tiny tricoloured Congress flags. The joy of the gathering was all the more to see the first Indian Principal in the person of Dr. A. L. Mudaliar receiving the Congress Minister and eulogising him in glorious terms on behalf of the Students' Association and requesting him to address the new graduates.

The social functions so far arranged and responded to by the Hon'ble Minister of Public Health in the person of Dr. Rajan augur a most unique and an enviable confidence which the entire medical profession has reposed in the Public Health Minister. It is no exaggeration when we say that either in this province or in other provinces in India an opportunity similar to the one that has arisen in Madras will never occur. The fond hopes Dr. Rajan has been able to create in the bosoms of the members of the medical profession belonging to all grades (it will be more correct to say, 'all castes') is not due to his being a Congressman only though it has to be said that the political school to which he belongs has served the purpose of adding lustre to the golden hopes. The fact that Dr. Rajan began his life as a medical man soon after he passed out of the Royapuram Medical School and eventually was able to be a member of the Royal College of Surgeons, a Licentiate of the Royal College of Physicians and was a very successful general practitioner in a mofussil town commanding a practice not less lucrative than that enjoyed by his City comrades, is the secret of the hopeful expectations the whole profession is entertaining about Dr. Rajan as Minister of Public Health.

The Hon'ble Minister is not ashamed to own his past humble position nor is he too proud of the position to which he is elevated by the Prime-Minister. To him, his present position is a sacrifice if his services are to be reckoned in the shape of the salary he is now

getting, but he cannot deny nor has he attempted to do so that he has an unprecedented opportunity of service to the medical profession and through the profession, to the people committed to the care of the Government without any strain to the paying capacity of the rate payer including the unfortunate starving peasant.

The down trodden subsidised practitioner has been able to see a bright line in the horizon of darkness in which he is living at present. The fortunate well paid Medical Officers in Government service have been assured by Dr. Rajan that they need not entertain any doubts of even of a passing cloud in the bright sky under which they thrive at present.

The Medical Licentiates have been exhorted by him to throw away the inferiority complex and he demonstrated his own example. His advice to the Medical Graduates was not less encouraging. He has told them that there was extensive field for service though not under the Government and he gave them examples as to how money could be earned more than the salaries that are given by the Government to its officers. He advised them to take to private practice as there was extensive scope for such service in India where there was not even one qualified medical man to a population of 25,000. Whatever grievances the profession has, as a whole, or a particular section of it, the Minister had assured, would receive the sympathetic attention of the Congress Government. But he had warned all concerned not to be inactive and that they should try to get public support for any reform in the right direction and press such reforms through their popular representatives in the Legislative bodies which have a solid majority to ensure success for any programme for the welfare of the public. The Medical profession cannot afford to lose an opportunity of rendering service to themselves and to the public. Nor can the Public Health Minister lose sight of the opportunity of the confidence of the profession. Then only his personal sacrifice will be a boon to all those who are taking a pride to own the Minister as their own, nor will the Minister feel sorry either now or in the future for recognising the privilege of hopeful expectations entertained by the members of the medical profession from the bottom to the top.

LEGITIMATE CUTS TO HELP CONGRESS PROGRAMME

We feel glad that in the six provinces in India, the Government are keen in stopping the evils of Drink and intend making these provinces dry within five years. Gandhiji has declared that an attempt to make India dry is within the scope of practical politics as majority people in this country are not addicted to alcohol. We are afraid if the Mahatma is aware that there is a tendency for India to get more wet than America or other countries in the West and the members of the medical profession who are expected to know the evils of Drink more than their brethren in the other professions are at times more lax than they ought to be. There is another danger in Indian society especially amongst sections who are prohibited from drinking by the religions they follow. If members of these sections take to drink on account of association either here or during their sojourn in foreign countries they forget the limit in drinking and many a time are the objects of laughter and pity combined to those whose religion or social customs do not prohibit drink during social functions. We have to mention this fact with great reserve and reluctance just to convince our readers that the medical profession should give its whole hearted support to the Drink Prohibition campaign inaugurated by the Government either here or in other provinces.

The Prime Minister of Madras is easily made available for all functions and he does not grudge presiding over any of them in spite of his multifarious duties. He has been making use of almost all the functions and somehow or other manages during these functions to talk about his own programme not excluding prohibition. He has been appealing everywhere about voluntary cuts in the pay of officers of the Government so as to enable him to carry on the Government with its programmes for the amelioration of the conditions of the poor. So far no department of the Government has come forward offering cuts. All the same we read in the news papers that Madras would have a surplus Budget in spite of the loss of Excise Revenue from one of the Districts where the prohibition campaign is to be launched in the near future. So far so good and we congratulate the Prime Minister on his ability as a financier. The work of the Con-

gress Government has just begun, they have a very ambitious and as laudable a programme to see that the poorest person has at least one meal a day and a cloth to wear. This will indeed be a difficult job when the government is bent on giving relief to the ryots by reducing land revenue to the utmost limit and forego altogether the Excise Revenue by making the country dry. We wonder how it was possible for the Prime Minister to have surplus budget unless he has made cuts in the salaries of superior services. He does not wish to surprise these officers perhaps: this is why he has been appealing for voluntary cuts in season and out of season so that any cuts appearing in the Budget will not have a startling effect.

Unlike the other Government Departments the Medical Department has been enjoying liberty of action not only in the matter of creating new appointments but also in regard to their emoluments. A glance of any of the old Medical Budgets may convince the Prime Minister that payments made to a large section of the Medical Officers in the form of special pay and allowances cannot be justified when it is known that all such officers who have been the recipients of special emoluments which are denied to others in the same department, are full time officers. Any work these officers are expected to do they do within the limit of hours of whole time service. A large majority of the medical officers in the City hospitals work from 10 A. M. to 1 P. M. or at the most till 2 P. M. i.e. 3 to 4 hours a day excepting the present Superintendent of General Hospital who, on his own accord, has fixed his hours of attendance from 6-30 A. M. till 4 P. M. while in the mofussil, officers in the same superior cadre are expected to work from 8 A. M. to 12 Noon, also 4 hours. We will not be far wrong if we say that at least a few manage to finish their work within the above limits both in the City as well as in the mofussil. Some Officers teach students or treat patients within the full time of 3 to 4 hours. The full time service in other departments is from 11 A. M. to 5 P. M. and it is a matter of surprise why the Superior Officers in the medical department cannot work for six hours a day when even their present chief, the Surgeon-General, can be seen in his office from 11-30 A. M. to 5 P. M. It is said in the Civil Medical Code that private practice is permitted to the medical officer, not at the risk of official

duties. So, any special allowance given in lieu of loss of private practice, as a teaching allowance or in any other form cannot be a legitimate claim on the Government. The District Medical Officers and their Assistants in the mofussil attend to their official work for as long a period a day or perhaps longer than their more fortunate brethren in the City Hospitals. Yet it is not known why there should be special treatment to those in the City. The fact that almost all those in the City enjoy appointments as specialist and are commanding much heavier fees for private consultations cannot be lost sight of. The invidious distinction shown to those in the City institutions has been the cause of discontent in the Medical Department and if the Prime Minister makes cuts in these special emoluments he will be doing a double duty: contentment in Service and a saving to the Government. The Hon'ble Minister of Public Health being a medical man would be able to point out the fairness of these cuts with the help of which he will be able to co-operate with his Chief in the campaign of Prohibition and other programmes not excluding enlarged scope for Medical Relief.

If the Minister for Public Health goes through the latest Civil Medical list, he will come across many surprises where many Asst. Surgeons who in the ordinary course of service would not have been promoted to the Civil Surgeon's grade. There may be at least a dozen such assistant-surgeons who are officiating as Civil Surgeons, though there is no place for them in the cadre of Civil Surgeons which should contain only 43 members of the Madras Medical Service. Yet they are drawing a salary of the Civil Surgeon ranging from Rs 600 to 900. Their legitimate salary could not have been more than Rs. 450, the maximum pay to which an Assistant Surgeon could aspire after fifteen years of service. Such transformations took place when the Vizagapatam Medical College came into existence and when a large number of junior assistant-surgeons were made Civil-Surgeons with an excuse that the professors of a Medical College should be Civil-Surgeons. In 1931 when a Special Officer was deputed for effecting retrenchment in Government service, he brought to the notice of the Government for the first time the unjustifiable promotions effected in the Medical Department and later it was

found possible for an assistant-surgeon with foreign qualifications to teach any subject in the Vizagapatam Medical College without being transformed into a Civil-Surgeon.

Even after such a glaring mistake being brought to the notice of the Government by their own officer, there have been at least four instances where junior assistant-surgeons were promoted as Civil-Surgeons and in one case a new Civil Surgeoncy was created much to the discontent of many of the senior assistant-surgeons in service. If assistant-surgeons with foreign or special qualifications could do the work for which purpose assistant-surgeons were transformed by mistake into Civil-Surgeons, it is not known why such mistakes are being repeated and the cost of administration increased. If the Hon'ble Minister in charge of Public Health finds out what these appointments are, it is possible for him to effect a saving of at least five to eight thousand rupees a year. We are told two of such officers are still acting. If a careful scrutiny on the lines suggested above is made, it may be possible for the Madras Government to effect a saving of at least a lakh of rupees, in the current budget without affecting either the efficiency or the safeguards of service. On the other hand, the Minister would be guarding the interests of all in service and bring about contentment so that the members of the medical profession in Government service would be glad that during the regime of Congress ministry all will be treated alike. If such a contentment is brought about, a sense of justice will prevail in the Medical Department and it may be possible in the near future for the Ministry to persuade Government Medical Officers, especially those belonging to the provincial service, for adopting permanent cuts in their salaries.

We are sure the Hon'ble Minister in charge of Public Health who, we are now told, is engaged in the organisation of work in government hospitals will soon be able to find out ways and means of curtailing unnecessary expenditure for medical relief and will be able to curtail expenditure in his department not only in the interest of medical relief to the masses but to effect general economy for carrying out the Congress programme, the most important of which being the Prohibition of Drink in the province.

News and Comments.

The All India Medical Conference: A circular under the signature of the presidents of four medical associations in the Madras City which was sent to us for publication appears in the 'Correspondence Columns' of the current issue. The four presidents represent the local branch of the All India Medical Licentiates' Association, the South Indian Medical Union, Madras Provincial Medical Service Association and the local branch of the Indian Medical Association. The All India Conference is to be held in Madras during Christmas under the auspices of the Indian Medical Association. Our information is that none of the three associations other than the Branch of the Indian Medical Association is affiliated to the Indian Medical Association and the magnanimous gesture shown by these three associations to join the activities of an All India gathering to be held under the auspices of the Indian Medical Association is very laudable indeed. It is not known if the gesture was spontaneous or the result of an invitation from the Sister or the Mother Indian Medical Association. From what we know, the strength of each of the four local Associations as calculated from the actual paid list of members cannot be over a hundred. Yet the responsive gesture just at this juncture when the provinces in India are enjoying Provincial Autonomy would have strengthened the medical profession as a whole if the three associations affiliated themselves to the Mother All India Medical Association without risking their sectarian or provincial interests. If the gesture shown by the three Associations is an outcome of an invitation, the Provincial Subsidised Rural Medical Practitioners' Association which has now on its roll over 130 members and which is in need of help and encouragement from all the existing Associations is likely to feel whether the village outlook of this Association has anything to do for this Association not being in the list of the Associations that intend going into a Reception Committee on 20-8-'37. All the same we trust that in consideration of larger interests especially of funds, the rural practitioners will individually receive the circular from the presidents of four Associations and such of them who can afford to pay Rs. 10 (rather a big amount indeed for rural prosperity) will make up their minds to join the

Reception Committee or affiliate their Association to the Mother All India Medical Association to watch their interests if not for anything else.

It is indeed a very fortunate coincidence that the first All India Medical Conference is to be held in Madras when for the first time in the annals of the history of the Provincial Governments, Madras has a medical practitioner as its Minister for Public Health. It is expected that the existing sectarian Medical Associations and the individual members of the medical profession give up their differences and complexes in the interest of the medical profession as a whole and help the Provincial National Government to have the benefit of a National Medical Service. The Madras Public Health Minister wherever he made public speeches has been sowing the seeds of the future Government Policy regarding medical relief, both curative and preventive. It is for the profession to water these seeds, supply manure when these seeds sprout into healthy robust plants and later help the growth of the plants to fine trees bearing fruits worthy of the seeds. And all this should commence in the villages as it is the established policy of the Governments, including the Central under the present Viceroy, that nationalism must have its foundation in rural areas. Madras has an exceptional opportunity of leading other provinces if the organisers of the All India Medical Conference are such as are able to feel the pulse of the future national life.

Social Functions have their own Lessons: The Hon'ble Dr. Rajan's past career beginning from the Royapuram Medical School which qualified him to serve the Burma Government as a Hospital-Assistant, his resignation of Government service and subsequent life as a practitioner at Rangoon which enabled him to soar higher and go to England for qualifying himself as M. R. C. S; L. R. C. P., followed by a brilliant career as a private practitioner in a mofussil town, coupled with his extreme views of Congress school of Politics which enabled him to love the life of a convict dearer than the life of one deprived of civil liberties, has been responsible for so many functions in the city of Madras and in mofussil towns. Of course, political power which Dr. Rajan is now enjoying as

the Minister of a very important portfolio, the grades and castes now prevailing in the Medical profession and Dr. Rajan's belonging to more than one caste has been the cause for the variety of these functions as well as the different venues where these functions have been taking place. From the humble Midwife, the depressed Sub-Asst. Surgeon, to the well-off Matron and the all powerful and the safe guarded Lt. Colonels have been either the hosts or the patronizers of these parties and the Congress having rightly created an atmosphere of freedom of thought and action, the hosts in whatever position have been able to express themselves in terms which till recently would have incurred the wrath of those at the head of the Government Departments. The Hon'ble Minister, Dr. Rajan's identifying himself as the servant of the public and not its master, though both these attributes are co-relative to one enjoying his position has enhanced the value and scope of these social functions. The public and the medical profession see that each party given to the Hon'ble Minister has its own lesson quite different from the other. The master who has been teaching lessons may have but one principle underlying these lessons. The hosts interpret or wish to interpret them in the light and in the colours conducive to them. The power of politics is such that inveterate foes are seen as intimate bed-mates and vice versa depending upon purpose and not at all on any principle. Accordingly contemptuous familiarity is made to appear as cordial friendship to misguide and even threaten the public and unless the recipients of the honours in the form of functions are shrewder than the hosts such functions at times lead on to untoward guesses and even serious events. Nothing of this sort is likely to happen in the case of the Hon'ble the Public Health Minister whose success in life as a competent and capable medical practitioner has given him exceptional opportunities of study of human ailments which in themselves cannot be successfully treated unless the medical attendant is a master of human psychology. The Minister is therefore able to diagnose the troubles of those who meet him. He does not make a secret of his prognosis and utters it at times in language likely to shock those who approach him for treatment.

We wonder if any of the hosts of the Hon'ble Minister of Public Health at Modern Cafe on 30-7-37 have noted the remarks of one amongst them who is reported to have said, "that the chief guests knew their difficulties and grievances and would certainly try to redress them. They should represent their grievances to the Government at the right time and in the right manner and not at such a dinner."

This note which was a warning to all concerned might have fallen either on deaf ears or those who heard this note might have felt it was very discordant on such occasions. Opinions usually may differ and some may suffer. Yet the author of this note being an L. M. P. himself we highly appreciate his remarks which is a lesson in itself. Dr. Rajan made it clear that night at the Modern Cafe where we presume there were none except the medical licentiates as guests and hosts that the hosts themselves entertained the inferiority complex and he emphatically said that the Licentiates should shake off their inferiority complex. He advised the hosts to follow the example of the chief guests of that night. It is very unfortunate that the Medical Licentiates are bred up in an atmosphere of false safety and the sooner they know it the better not only for themselves but the entire profession. The guileless innocent lambs are seen kissing the feet of butchers who in the interests of their trade are rearing and making the lambs appear so nice with the only purpose of having a good bargain by the sale of their flesh which the butchers—not minding all the while that the lambs have been kissing their feet—slay them mercilessly. The life of the Licentiates has not been otherwise. Everybody wants them for a purpose and soon after the purpose is served they are thrown away or even sacrificed. The Hon. Minister whom the Licentiates rightly claim as one of their own (and the Minister himself is proud of his being one of them) did give them valuable advice to throw away the inferiority complex and we take this opportunity of warning the Licentiates to know who is what and what is what. We doubt if the persons who carry the Licentiates on their heads at a particular place and throw them to the wolves at another, know that there are others amongst the Licentiates who could see the scenes of both such occurrences. The theory of evolution is such that those who have to be

evolved have themselves to take part in the evolution. The Licentiates will be doing a great harm to their class if they recognise persons as their patrons who favour a Licentiate here or a Licentiate there for their own selfish and individual purposes. If there is today a Dr. Rama Rao who has been able to make a mark in this city as a practitioner and as a public man who has been enjoying representation in all known councils local, provincial and Central and if there is another L. M. P. in the person of Dr. Rajan who has attained the highest position of being a unit of the Executive Government of this province and if there are others, amongst the Licentiates, who have been shining in the profession and as public men either in this province or outside, these facts themselves should be a beacon light for the licentiates to be self-reliant and get themselves evolved, depending upon their own activities and not on the pseudo-sympathies of others outside their fold, which far from doing them any good will be a great hindrance towards natural evolution.

A Contrast: The hon'ble Dr. Rajan, the Public Health Minister might have noticed why only three medical licentiates, a solitary group of individuals from a particular hospital in the city of Madras should have waited on him on 10-8-37 to represent the injustice done to a class of practitioners to which these practitioners belong, on account of the Government passing a G. O. to the effect that the Honorary Medical Officers amongst the licentiates should be styled as Licentiate Honorary Medical Officer 3rd grade, after 3 years service as Licentiate Honorary Medical Officer 2nd grade and after 10 years service as Honorary Medical Officer 1st grade, in contravention to the G. O. No. 1610 P. H. dated 29th July 1932 where all the honorary medical officers were styled as (1) Clinical Assistants, (2) Honorary Assistant Physicians or Surgeons and (3) Honorary Physicians or Surgeons without any distinction to the qualifications they possess, excepting in the case of those to be appointed as honoraries in teaching institutions. Soon after the rumour was current in September 1935 about the new G. O., Dr. V. Rama Kamath moved a resolution at the October 1935 session of the Madras Medical Council pointing out to the Government that the new G. O. was against the spirit of the Medical Act and that the

Government should stick to the G. O. passed by them on 29th July 1932. The helplessness of the medical profession especially the Licentiate section of it might be gauged when it is known that since 1932 till the date of passing of the new order no member of the medical profession, official or non-official, complained against the nomenclature of the honoraries recommended to the Government by a committee consisting of official and non-official medical men presided over by the then Surgeon-General with the Government of Madras. It looks as if in 1935 the initiation of the special nomenclature for the Licentiate Honoraries started from the office of the Surgeon-General. So far, in all matters medical, the Surgeon-General with the Government of Madras was the Government itself. We do not blame the Surgeon-General, much less the old Government, but the system which prevented the Government to consult non-official medical profession in matters concerning them. The Government is aware of the existence of at least District Medical Associations presided over in majority of Districts by the District Medical Officers, if they did not want to recognise the existing association in the city of Madras. Perhaps the Government knew that there is no spirit of comradeship in the Medical Associations in this province, as is evidenced by the fact that not a single association took up the lead given by the Madras Medical Council. The despair of the Medical Licentiates is all the more that the local branch of the All India Medical Licentiates Association did not concern itself about the invidious distinctions shown to the licentiates regarding honorary titles. The South Indian Medical Union nor the All India Medical Association, both of which have the Licentiates as members, were also silent on the matter. The Medical Practitioner wrote two leaders on the subject last year and Dr. V. Rama Kamath wrote twice in his review of the work of the Medical Council, but to no effect. Under such circumstances it is no wonder that the Government was adamant and did not take any notice of the resolution passed by the Madras Medical Council against the new G. O. At the last March session of the Madras Medical Council, when the order of the Government to the effect that the Government did not find their way to consider the resolution of the Madras Medical Council was read, Dr. Kamath moved yet another resolution requesting the Government to re-consider

their judgment and the resolution was passed in spite of the opposition by a few official members. One of the Medical Licentiate Honoraries was recommended by the Surgeon of the Government Royapuram Hospital, Surgical Unit, to be promoted as Hon. Asst. Surgeon as he had served as an honorary in the lower grade for over six years. The Hon'ble Minister would do well to call for all the concerned files regarding this episode. Though the Sectarian Medical Association of the Licentiates and others, non-sectarian, had not the heart to back the Honorary Medical Licentiates, when a gross injustice was done to them, we trust the Hon. Minister would take into his consideration that the Madras Medical Council, a body, representing the entire profession in this province with a large majority of officials and nominated members of the Government, was against the new G. O. as could be evidenced by the fact that Dr. Kamath's first resolution in October 1935 was passed by the Madras Medical Council by a large majority if not unanimously and that when the G. O. to the effect that the Government did not find its way to consider the resolution of the Madras Medical Council on this subject was about to be recorded at the last March session of the Madras Medical Council the same Council stuck up to its old resolution in spite of opposition from one or two officials. It is also to be noted by the Hon'ble Minister that the Madras Medical Council is presided over by the Head of the Medical Department, the Surgeon-General with the Government of Madras from whose office the initiation for the promulgation of the new G. O. started. The attempt to call the Honorary Licentiates as 1st grade, 2nd grade and 3rd grade Honorary Licentiate Medical officers smells nothing less than an unwarranted jealousy and it is expected that the Public Health Minister will put it down with a high hand. The Government will do well to call its stipendiary Medical officers who are in independent charge of medical institutions as 1st grade, 2nd grade and 3rd grade Medical Officers. Styling them as Sub-Asst. Surgeons and Asst. Surgeons is a misnomer. The Medical Officers whether stipendiary or honorary should be designated so as to indicate the nature of work performed by them in the hospitals. It is awkward to call an L.M.P. working as an honorary under a Surgeon or Physician as Licentiate honorary medical officer of any

grade. It is also meaningless to call a paid medical officer an L.M.P. or one possessing M.B.B.S. or equivalent qualification as a Sub. Asst. Surgeon or Asst. Surgeon respectively when both such officers do not work under an Asst. Surgeon or a Surgeon.

Apart from any other consideration this incident cannot fail to impress on the Minister that Medical Associations, sectarian or even the provincial and all-India ones, do not wield a spirit of comradeship though tales of grievances are pouring forth at public functions organised by these Associations for some purpose or other. Is it not a strong unseemly contrast of feelings expressed at the social functions celebrated to honour Dr. Rajan, the Public Health Minister by all the existing medical associations? The popular Minister is certainly capable of reforming the medical associations by installing in them public spirit and the spirit of comradeship without which they will look like bodies without souls.

Has L. O. Diploma a Market Value? The L. O. Diploma which indicates that the practitioner possessing it is a Licentiate in Ophthalmology, is granted by the Madras Government to the medical Graduates and Licentiates both of whom have to put in a prescribed course at the Government Ophthalmic Hospital, Madras. They say it is rather a hard test. It is also said that the Government levies as hard a fee. It is expected that the possessor of this special Diploma should have special knowledge of Ophthalmology whether he be a Licentiate or Graduate in medicine. It may also be said that both have to be treated alike in regard to their special knowledge in Ophthalmology at least.

A Licentiate Honorary Medical officer who is in sole charge of the Ophthalmic Clinic in a District hospital and who till recently granted certificates to candidates for Public Service has been recently deprived of this privilege. It is also said that an attempt is made to place the ophthalmic clinic under the charge of a stipendiary medical officer who is not an L. O. Does this mean that the L. O. Diploma cannot itself have any market value if the possessor thereof is a medical Licentiate? This is another new problem which the Hon'ble Minister of Public Health will have to tackle in the near future lest he should be bothered with similar or more astounding ones. Who

thought or even dreamt that a medical man and that possessing an L.M.P. Diploma would ever be the Public Health Minister? The Hon'ble Prime-Minister of Madras has worked a wonder. It is hopefully expected that many mysteries in the Medical Department will be solved by a wonderful Minister.

A Wolf and a Lamb Story: If a compilation is made about the grievances of the Subsidised Rural Medical Practitioners, an interesting book of stories could be written to serve as parables. News comes to us from a village that a subsidised practitioner was suddenly served with a notice that his subsidy is stopped, that he should hand over charge of his dispensary to some other practitioner who was said to have arrived just then from Madras. No reason being assigned for this sudden termination of subsidy, the aggrieved practitioner ran up to the D. M. O. to be told that in case he did not obey orders immediately, he would be severely dealt with. The practitioner was aghast to see at the office of the D.M.O. the father of the practitioner to whom the D. M. O. ordered him to hand over charge. As this person, (the father) is said to be also from Madras employed in an important office, the subsidised practitioner trembled, not knowing what to do. As soon as we got this news, we wrote to the D.M.O. suggesting to him that it was not fair to terminate the services of the subsidised practitioner who had a satisfactory record of work certified not only by successive D.M. O's. but by the President, District Board also. The next scene as reported to us was that one or two medical men working under the D. M. O. went to the subsidised practitioner searching him in several places, as at that time the practitioner took leave and left the village, and persuaded him to see the D. M. O. They strongly advised him also not to listen to anybody excepting the D. M. O. and hand over charge of the Dispensary to the son of the person whom the practitioner recognised a few days ago as one belonging to an important office. The medical officers who escorted the practitioner warned him that in case he did not hand over charge, the consequences would be serious as the D. M. O's. word would be relied upon at the Surgeon-General's more than that of anybody else. The practitioner was hesitating what to do. In the meanwhile it is

said that the D. M. O. put himself in communication with the Dt. Board President whose secretary saw the D. M. O. and it was finally settled that the discharged practitioner was to be put in charge of another subsidised dispensary and was asked to go to that village which he did but only to be told by the Dt. Board President that there was no vacancy. The practitioner naturally lost hopes in all and is said to have appealed to the Government.

When the story of the second scene was narrated to us, we wished to make certain of its veracity and we wrote to the concerned D. M. O. though, by that time, he was transferred elsewhere. We also addressed a letter to the present D. M. O. of that District, requesting him to let us know if the part alleged to have been played by his staff under the advice of his predecessor was played by them at all. The former has not replied to us so far but the latter, after a reminder, did not directly deny the allegations and said if these medical officers did anything at all, it was on the advice of the D. M. O. It now transpires that the aggrieved subsidised practitioner has been asked to act for another subsidised practitioner and that he has consented to act, on the distinct understanding that he does not relinquish his claim to continue as the subsidised practitioner of his old village in case the Government is pleased to pass orders in his favour. We made honest endeavours not to publish this story but the red tapism and the consequent sufferings of the innocent subsidised practitioner were such that we thought that the Government and the Medical profession should know this story which is a parable in itself.

A Cock and a Bull Story: Almost the very day when the Public Health Minister of Madras declared at a function at Trichinopoly that the subsidised Rural Medical Relief scheme should be free from political influence and that the subsidised practitioners were independent practitioners, news comes to us from a district not far off from Trichi, that a subsidised practitioner has been threatened to resign. In the preamble of the order it is mentioned that the practitioner was discussing politics with his patients. The order ends by saying that the new agreement prohibits subsidised practitioners to be members of Panchayat Board and as the practi-

tioner is the elected president of the Panchayat Board, he should immediately resign his position in the Panchayat Board as per conditions in the new agreement. It is a surprise that such an order should pass through the office of the D. M. O. without protest. The new agreement form came into existence in January 1937 and the very next month a reference was made to the Government by the President, District Board, Malabar whether in view of the conditions in the new agreement, a subsidised practitioner could be an elected member of the Panchayat Board. The Government was pleased to say that the subsidised practitioner could be a member of the Panchayat Board as this body was under the District Board. This order was communicated to all the D. M. Os. The cock and bull story will not be complete unless we tell our readers that the subsidised practitioner is not in the good books of a petty politician in the village who disfavours the popularity of the subsidised practitioner. Those who love village uplift work will be most happy to learn that this subsidised practitioner is an ornament to the village, being the President of the Panchayat Board, and not a thorn. But the village politician thinks otherwise. It will be most painful if this person belongs to the Congress school of politics.

A False Alarm.—The students of the Vizagapatam Medical College have been raising false alarm and threatening to boycott the college on account of a false rumour that the Government intends closing the college as they could not find 24 lacs of rupees for capital and running expenditure to meet the demands of the Medical Council of India which did not recognise the M.B.B.S. degree granted by Vizagapatam Medical College on account of the defects in equipment of the College. The amount for the necessary additional equipment demanded by the Medical Council of India was originally 16 lacs which swelled up to Rs. 24 lacs on account of some additional plans brought into the original estimate of Rs. 16 lacs by the ambitious permanent Principal of the Vizag Medical college. The Surgeon-General went to Vizagapatam recently and in consultation with the staff of the College and the Vice-Chancellor of the Andhra University, is said to have brought down the estimate to the original figure of Rs. 16 lacs. It is rather hard to conjecture why the

medical students appear to be most uneasy imagining a situation which has not arisen or likely to arise and that even after an assurance from the Public Health Minister to the effect that the Government had no intention of abolishing the college as rumoured. This assurance was followed by a communique issued by the Publicity Minister confirming the assurance given by Public Health Minister on behalf of Government and making a further assurance that the College would be equipped in the manner demanded by the Medical Council of India. As mentioned in the Government Communique the fears of the medical students seem to be rather exaggerated; so also the demands of the Medical Council of India. The Inspectors that visited the Medical College, Vizagapatam, did certify that the present staff of the college is quite qualified and efficient to do the teaching work and the results of the examinations confirm this testimonial as these results compared very favourably with that of the Madras Medical College which had been recognised by the Medical Council of India without any fuss. In spite of all this, it is most annoying that the Andhra Medical students who are expected to be extra-nationalistic should childishly threaten the authorities knowing as they do that the present Government is run by National Congress. The national outlook of the Andhradesa would have been more appreciated if the medical students requested the Madras Government to see that the Vizag Medical College was not bullied by the Medical Council of India which cannot be said to serve Indian national interests and initiate an agitation to make India autonomous in regard to Medical Education. Not even one per cent of the medical graduates who pass out of the Indian Universities are likely to settle in foreign countries. As for foreign medical qualifications many at least from the Madras Province got them not so much due to a thirst for knowledge but to get better recognition in government service. The Indian medical graduates can improve their scientific knowledge by attending special clinics outside Great Britain as in Vienna and make the Government recognise such special training. It is more creditable to suffer and get national rights established than to submit to sell national honour at a cost of 24 lacs while the finances of the Government are required for more urgent national demands. If the

Government either here or elsewhere have real regard for the authority of Medical Councils they should demonstrate it in regard to such Councils established by statute in the Provinces which they govern. If these Councils are made to function with the same authority as the Medical Council of India and if Andhra medical students turn their activities towards this end rather than trying to embarrass the local Government they would have done better service to themselves and to the country as a whole. It is most astounding that Dr. C.R. Reddi, the Vice-Chancellor of the Andhra University should wire to the Madras Government suggesting that the Medical Council of India should be informed about the intention of the Government to make a token cut at the next session of the Legislative Assembly with the purpose of assuring the Council of the bona-fides of the Government. There are three representatives from Madras in the Medical Council, one of whom being the Surgeon-General with the Government of Madras. It is their duty to tell the Medical Council what had happened at the Vizag Medical College and the Madras Secretariat. It is ridiculous if not humiliating for the Madras Government to petition to the Medical Council in the way suggested by the Vice-Chancellor. If Dr. Reddi was really anxious, he could as well send a telegram to Simla.

Is Preventive Medicine Effective?

The Cholera Epidemic in Guntur District and the visit of the Minister for Public Health to Guntur Town on 18-8-37 must have agitated the Minister to ask within himself "Is preventive medicine effective?". The Minister addressing a group of Health Staff and private medical practitioners at Guntur bluntly said "You should feel ashamed that in a place like Guntur, where there are a large number of private practitioners and sufficient Health Staff, the epidemic could not be controlled even after 23 days of its outburst". If this is the state of affairs regarding the prevention of Cholera Epidemic in an important town having a Municipal Health Officer and his staff and also the Head Quarters of the District Health Officer, what would be the state of villages in Guntur District where the infection seems to have travelled from the town? The Public Health Minister was till recently a private practitioner himself and should know the degree of cordiality that exists

between private practitioners and Government paid practitioners including the Public Health Staff. He should also know that prevention of Epidemics is not felt to the extent of the existence of a Separate Preventive Staff under the Director of Public Health though it has to be conceded that the Government has been spending fabulously and proportionately more money for curative department. The Director of Public Health has four Assistants under him, every one styled as a specialist in a special branch of Preventive Medicine. All are having their offices in the same building where the office of the Director of Public Health is located. A few years ago we made a suggestion to the Government in these columns that it would be a cheaper yet more efficient arrangement if the whole province was divided into convenient divisions where the Assistant Directors should be in direct charge so that they could have a better control within easy distance instead of controlling the preventive activities from Madras. It is said that for some time past the Assistant Directors are put in charge of divisions in the way suggested by us without prejudice to the special work of which they were in charge before but all the Assistant Directors have their Hd. Quarters in the Madras City itself. If the departments like the Engineering, Forest, the Agricultural etc. require the immediate presence of the Deputies of the Heads of their departments in the Hd. Quarters of their circles outside Madras, the necessity for the Deputies of the Preventive Department to be also in their respective circles in readiness for combating and controlling the Pandemics like Cholera, should be much more. Half-hearted reforms in Preventive Medicine are more risky than no reforms. We trust the Public Health Minister will note the usefulness of our suggestion in the spirit it is offered. We trust also that the Guntur experience should convince the Minister about the necessity of the Health Staff working in team with the private practitioners who should always be in readiness to give their services ungrudgingly when an epidemic is beyond the control of the preventive staff. Curative and preventive medicines are correlative terms and one cannot exist without the other; so also those who exercise these two branches of medicine. The cordiality should always proceed from the paid to the unpaid service and the position a paid officer occupies

should not be a barrier for closer relationship which is far too uncommon in these days when the official false ideas of prestige and status predominate.

Obituary: It is with a deep sense of sorrow that we have to publish the very sad news of the passing away of Mr. John Pius Pinto, M. A., Manager, the office of the Surgeon-General with the Government of Madras and Registrar, Madras Medical Council at an early hour on 7-8-1937. Till the 5th evening, the late Mr. Pinto was in the best of health. His illness began with a slight rise in temperature attendant with diarrhoea and the illness took a sudden serious turn late at night on the 6th August when Mr. Pinto was admitted in the Government Royapuram Hospital where he succumbed, in spite of best medical aid. Mr. Pinto graduated himself from the St. Aloysius College, Managalore and entered the Registration Department and after serving there for some years joined service in the office of the Surgeon General in December 1921 and was promoted as the Senior Superintendent in 1926. Early in 1934 he was appointed as part time Registrar of the Madras Medical Council and a couple of months ago when Mr. H. Theodore, the Manager of the office of the Surgeon-General retired Mr. Pinto succeeded him.

The late Mr. Pinto was an honest and a very diligent and zealous officer who loved his official work as much as he loved his religion and he was as regular in attending his church as he was in attending his office and one could see him the earliest to be at the church and equally so in his office and the last to return home. He had passed all the tests required for the highest office in the Revenue Department and if he had been lucky to enter the Revenue Department or the Secretariat, he would have risen to the rank of at least a Dy. Collector at the time of his death and would have certainly done

justice to the work of a Collector of a district. He was very good at accounts and was in sole charge in the preparation of the Medical Budget which work he did most methodically.

Our readers are aware of the black days of the office of the Madras Medical Council and of the fact that it was during the regime of Mr. Pinto as the part time Registrar of the Madras Medical Council that it was possible for that Council to publish the Medical Register for the first time on the due date, a statutory duty which the previous Registrars failed to do. He made the Medical Registers so attractive on account of the accuracy of the addresses of the practitioners and in other details that there were good sales of the Registers and with them a good income to the Medical Council. He prepared the agenda for the meetings of the council so orderly and later published the proceedings so intelligently that it was really a pleasure to read and understand them.

He was perfectly thorough in details with any work that was entrusted to him either in the office of the Surgeon-General or the Madras Medical Council. His modest unassuming behaviour made him attractive to all who had anything to do with him. When Mr. Theodore retired, we could say that the whole medical department was so glad that in Mr. Pinto they had as capable and industrious a manager as his predecessor. Alas! the sudden passing away of Mr. Pinto shocked all that knew him. Nobody could dream that Mr. Pinto's life was to be so brief. His death has created a void which will be very difficult to be filled whether it be in the office of the Surgeon-General or that of the Medical Council and in both these offices, Mr. Pinto will be found missing ever and for ever.

May God rest his soul in peace.

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XIV. All-India Medical Conference

CIRCULAR

It has been decided to hold the 14th session of the All-India Medical Conference, this year, at Madras during X'mas week (probable dates being 26th to 31st December '37). The aim of this conference is to bring together medical men from all over India on a common platform to discuss and formulate their views on matters of vital importance to the medical profession.

The Conference will have three sections

1. *The General Section:* In which matters relating to Medical Education and Medical Relief, Public Health and Sanitation, Medical and Medico-social legislation etc. will be discussed.

2. *The Scientific Section:* In which purely professional and scientific papers will be read and discussed, thus affording an excellent opportunity to members to exchange views with their medical brethren from all over India.

3. *The Exhibition Section:* In which, firms dealing in Surgical goods and Hospital requisites, Drugs and patent medicines, Health and sanitary wares etc. will be afforded an opportunity of displaying their goods.

It is our ardent desire that this Conference, which is the first of its kind to be held in Madras, should be an unqualified success. To achieve this end, we appeal to all medical men and medical Associations, in the city and in the mofussil, to join the Reception Committee in large numbers and to contribute scientific papers on general subjects or on their specialities. For this purpose, it is proposed to hold a meeting of all medical men of Madras and mofussil on the 28th Aug. '37 at 5-30 P.M. at "Gana-Mandir" No. 10 Thambu Chetty Street,

G. T. Madras. At this meeting, the Reception Committee will be formed. Members wishing to join the Reception Committee are requested to send to The Secretary, Indian Medical Association (Madras Branch), 20 Thambu Chetty Street, their names and membership fee of Rs. 10 before the 21st Aug. '37. The election of the Chairman and other Office bearers of the Conference, will take place at this meeting and only those who are members of the Reception Committee will be entitled to vote for these elections.

The various medical Associations are requested to send in their representatives to be present at this meeting and express the views of the respective Associations.

M. SUBRAMANIA IYER, M.B., C.M.,
President, South Indian Medical Union.

U. RAMA RAU, M.L.C.
President, All-Indian Medical Licentiates' Assn. Madras Branch.

V. D. NIMBKAR, F. R. C. S.

President, Indian Medical Assn. Madras.

A. LAKSHMANASWAMI MUDALIAR,
B.A., M.D., F.C.O.G.

President, Madras Medical Association.

Circular

P. S. R. M. P. ASSOCIATION

As it was not possible for the Interim Committee to meet after the Conference was held, the President is still in charge of the funds of the Association. Though the receipts acknowledging subscription are issued under the flaccimele signature of the Secretary and Treasurer, the responsibility is owned by the President till the subscriptions so far collected are audited and handed over to the Treasurer.

V. RAMA KAMATH
President.

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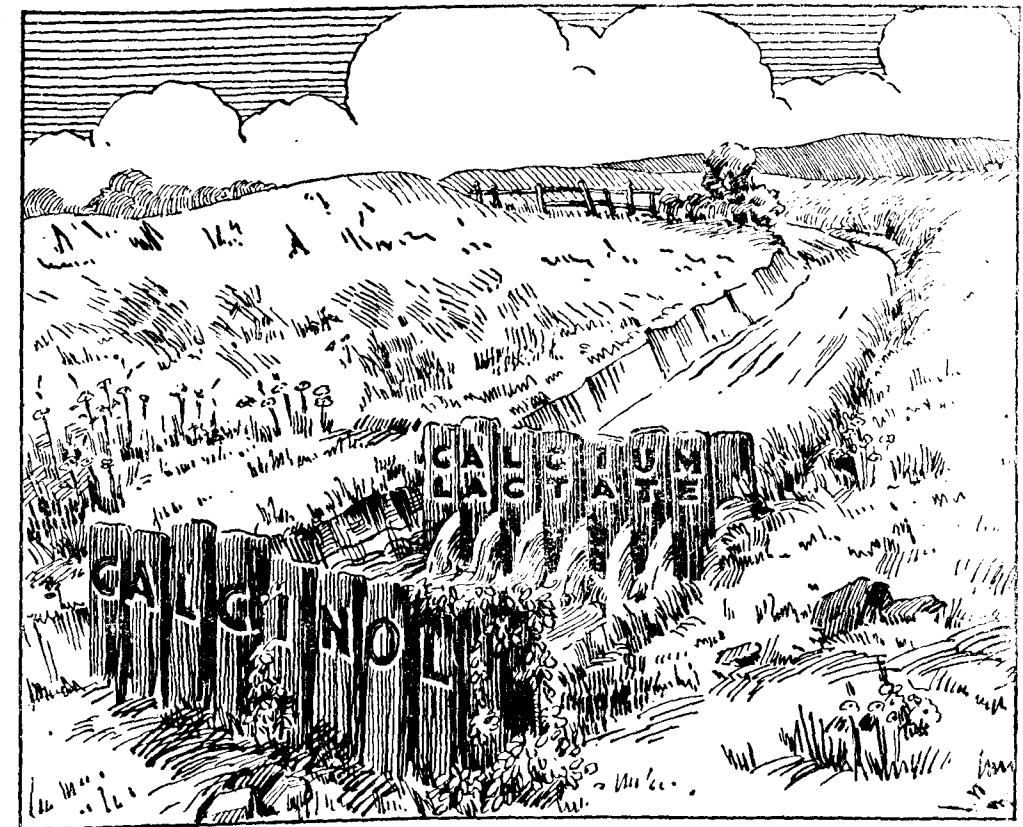
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List of Postings of Sub-Asst. Surgeons for the month of June, 1937.

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. P. Srinivasa Prabhu	L. F. Dy., Watrap	Govt. Hl., Virudunagar.
2	„ A. M. Krishnan Nambiar	Leave	L. F. Dy., Suler.
3	„ Miss. A. Janaki Ammal	Leave	Govt. Hl., Manjeri
4	„ Mrs. Kaveri Krishnamurthi	Govt. Hl., Manjeri	Govt. Hl., Madanapalle.
5	„ K. Vanamaraju	Govt. Hl., Amalapuram	Govt. Hl., Palacole.
6	„ N. P. Ramanujacharyulu	Govt. Hl., Parlakimedi	L. F. Dy., Kongi, Bellary.
7	„ Miss. A. K. Verghese	Victoria Caste and Gosha Hl., Madras	Victoria Caste and Gosha Hl., Calicut.
8	„ K. V. Narasimha Rao	Govt. Hd. Qrs. Hl. Guntur	L. F. Dy., Ponnur.
9	„ R. Sivaramamurthy	L. F. Dy., Ponnur	L. F. Dy., Darai, Nellore.
10	„ K. Pichu Iyer	Govt. Hd. Qrs. Hl. Salem	Govt. Hd. Qrs. Hl. Palamcottah
11	„ Miss. M. Verkkey	Leave	Govt. Hl., Nand-gama.
12	„ M. Lakshminarayana	Govt. Hl. Tanuku	Central Jail, Rajahmundry.
13	„ Mrs. Daniel Kirupakaram	Govt. Hd. Qrs. Hl. Masulipatam	Govt. Hl. Tiruvannamalai.
14	„ C. Manicka Mudaliar	Kosigai, Bellary	Special Police Dy., Sivakasi
15	„ P. K. Kumaran	Govt. Hl., Villupuram	Reserve duty, Cuddalore.
16	„ P. Palaniyandi	Leave	Govt. Hl., Kumbakonam.
17	„ P. S. Sankaranarayana Iyer	Govt. Hl., Kumbakonam	L. F. Dy., Vellore.
18	„ K. Simhachalam	Govt. Hl., Kavali	Agency duty, E. Godavari.
19	„ C. Ramachandra Iyengar	Police Hl., Coimbatore	Pasteur Institute, Coonoor.
20	„ B. V. Venkatakrishnan	Govt. Hd. Qrs. Hl. Salem	Govt. Hl., Tiruchengodu.
21	„ K. V. Krishnan Nair	Govt. Hl., Tiruchengodu	Reserve duty, Govt. Hd. Qrs. Hl., Salem.
22	„ Kuruvetti Narayanan Nair	Leave	Stanley Ml. School, Madras.
23	„ M. V. Suryaprakasa Rao	L. F. Dy., Porumamilla	Govt. Mental Hl. Madras.
24	„ K. V. Krishnan Nair	Govt. Hl., Tiruchengodu	Group Leprosy Officer, Vellore.
25	„ K. Satyanarayana Rao	Govt. Hd. Qrs. Hl. Nellore	Govt. Hl., Palacole.
26	„ K. V. Narasimha Rao	His posting to Ponnur cancelled	R. No. 2323/15-6-37.
27	„ Mrs. I. S. Devadasan	Leave	Reserve duty, Salem.
28	„ A. Rajagopala Rao	West Godavari Agency	L. F. Hl., Atmakur.
29	„ M. V. Gopalan	L. F. Hl., Atmakur	Govt. Hl., Kavali.
30	„ P. K. Kumaran	Govt. Hd. Qrs. Hl. Cuddalore	Govt. Hd. Qrs. Hl. Salem.
31	„ D. Maduranayagam	L. F. Dy., Ottapidaram	L. F. Hl., Srivaikuntam.
32	„ P. Ramalinga Nainar	L. F. Hl., Srivaikuntam	L. F. Dy., Ottapidaram.
33	„ P. Adinarayanaswamy	Group Leprosy Officer, Chittoor	Group Leprosy Officer, Peddapuram
34	„ N. Manjunath	do. Bezwada	do. Vellore.
35	„ T. R. Subramania Iyer	do. Coimbatore	do. Villupuram.
36	„ V. Gnaniah	L. F. Dy., Aravakurichi	Group Leprosy Officer, Vellore.
37	„ Miss. R. P. Chacko	Govt. Hl., Tellicherry	Govt. Hl., Udipi.
38	„ Mrs. C. H. Selvanayakam	Govt. Hl., Srirangam	Govt. Hd. Qrs. Hl. Trichy.
39	„ A. Rajagopala Rao	East Godavari Agency	L. F. Dy., Nayudupetta.
40	„ M. Murthi Sarma	L. F. Dy., Nayudupetta	Govt. Hl., Kavali.
41	„ R. Venkatakrishnayya	Govt. Hl., Rajamundry	L. F. Hl., Pithapuram.
42	„ K. Pichu Iyer	Govt. Hd. Qrs. Hl., Salem	Municipal Dy., Walajpet.
43	„ S. Seshagiri Rao	Municipal Dy., Walajpet	Agency duty, Vizagapatam.
44	„ K. V. Narasimha Rao	Govt. Hd. Qrs. Hl. Guntur	Govt. Hl., Gurzala.
45	„ K. Sriramamurthy	Govt. Hl., Gurzala	Agency duty, E. Godavari.
46	„ S. Sitarama Sastri	Leave	Govt. Hl., Rajahmundry.
47	„ P. Chockalingam Pillai	Govt. Hd. Qrs. Hl., Trichy	Govt. Hl., Palamanar.
48	„ P. V. Subba Rao	Govt. Dy., Chintapalli	L. F. Dy., Srungavarapukotta.
49	„ L. V. Jagannadha Rao	L. F. Dy., Srungavarapukotta	Reserve duty, King George Hl., Vizagapatam.
50	„ M. Lakshminarayana	Central Jail, Rajamundry	L. F. Dy., Kovvur.
51	„ M. Jagannadha Rao	L. F. Dy., Kovvur	Reserve duty, Govt. Hd. Qrs. Hl. Cocanada.
52	„ T. Sitaramayya	Central Jail, Salem	Raja Sir Ramaswamy Mudaliar's Lying-in-Hospital, Madras.



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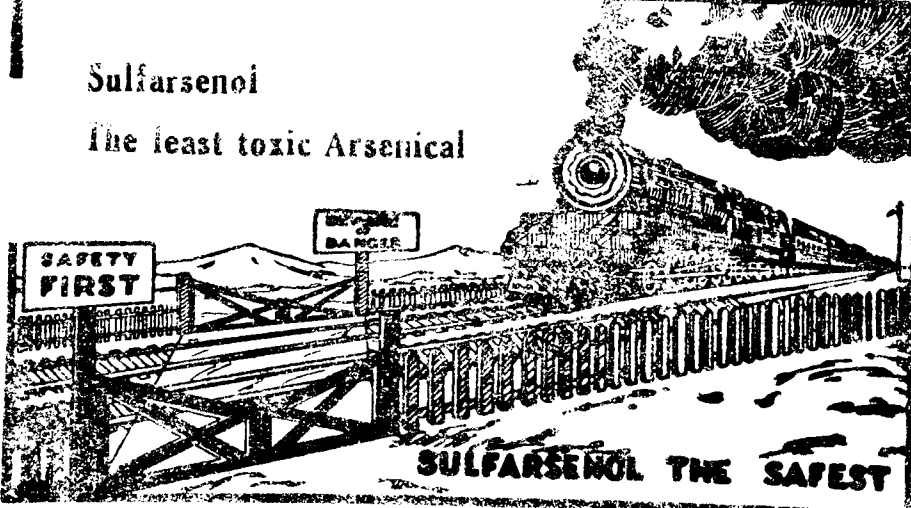
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The Medical Practitioner

A Monthly Medical Journal 226

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

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VOL. VIII.]

JULY, 1937.

[NO. 10

THE PROVINCIAL SUBSIDISED RURAL MEDICAL PRACTITIONERS' CONFERENCE Madras, 10-7-1937.

A provincial conference of the subsidised rural medical practitioners was held on 10-7-37 at the Y.M.C.A. Auditorium, George-town, under the auspices of the Provincial Rural Medical Practitioners' Association. Dr. V. Rama Kamath, Editor of the *Medical Practitioner*, and member of the Madras Medical Council, presided and Major-General Sir Frank P. Connor, Surgeon-General with the Government of Madras, opened the conference.

WELCOME ADDRESS.

By DR. K. VITTALDAS PAI,

(Subsidised Practitioner.)

On behalf of the Provincial Rural Medical Practitioners' Association, I welcome most heartily, Major-General, Sir Frank P. Connor and other guests who have been kind enough to attend the conference today even at this inconvenient hour in spite of your multifarious duties and I earnestly hope by your conjoined efforts and counsel, this conference of ours will be a success and will help us to ameliorate our conditions.

About twelve years ago, the late lamented Raja of Panagal, seeing the conditions of our villages without proper medical aid and finding the ranks of the unemployed medical men increasing day by day, started the Rural Medical Relief Scheme, to help the villagers with the scientific medical aid as well as to solve the unemployment problem to a certain extent. The Scheme was inaugurated when the finances of the Government were not bright and at the time it was agreed to give a small subsidy to the practitioners who settled in the villages and treated the necessitous poor free and the practitioners were considered independent. Now, when the finances are better and plenty of money is spent on Rural Reconstruction, the Government can certainly increase our subsidy and make our lot better.

Some years later on, our Association was started with the sole efforts of our late, indefatigable, lamented secretary, Dr. S. Ramasubbu, who practically single-handed, fought for our cause organising such conferences and got us some concessions and tried his best to raise our status to a certain extent in the eyes of the public as well as the Government. May his soul rest in peace and be a guide to us always. Very few practitioners gave him support and for want of encouragement, the Association could not get us relief to the extent we deserved and ever since he was snatched from our midst by the cruel hands of Death, the activities of the Association practically came to a standstill; now after some time, some of us thought that our lethargy must be shaken off and the Association must be revived, and the present conference is the outcome of that natural spirit which is lurking in the bosom of every R.M.P. to see that his position must be secure as well as safe under the onslaught of any and every District Board Head or the Government Head, so long as he works conscientiously with the sole idea of ameliorating the conditions of the villagers.

Now after the inauguration of reforms, if we look into the agreement forms which we were forced to sign under penalty of stopping of our subsidies, we find that our lot has become completely hopeless; there is not even a shadow of independence that is assigned to us and the subsidised independent practitioners have been converted into most, dependent, suppressed and depressed service practitioners. If we peruse carefully the agreement, we find that we cannot take part in politics or civics and we must do what the Government order us to do; is this independence, Gentlemen, that was thought of when the Scheme was first started? Apart from working from 7 to 12 in the mornings in the dispensary, the Government expect us to treat all emergent cases at all hours of the day or night; does this mean that we should be always at our village head quarters and not stir out even after 12 noon to distant villages to give medical aid to those who are in need? Is the rural dispensary meant only for the village where it is situated or is it meant for the surrounding villages for an area of 10 miles around? If the practitioner is forced to fix himself in the village throughout, where are the chances for the villages in the surrounding area to get scientific medical aid? Certainly this was not the original spirit of the scheme. Coming to the duties in the conditions of the agreement, we have to maintain registers and write returns as much in detail as the full time medical officers do subject to the scrutiny of various authorities. It is only a farce that we are called 'independent'.

Excepting the post-mortem work, we are doing all the duties of a regular paid service men without enjoying privileges of paid-service. We do not have a compounder and many of us not even a ward attendant. There is not even a decent building for the dispensary in some villages and in some places there is not a decent house for the practitioner to live in.

The original idea of the independent, rural medical service has been completely ignored and now after the present agreement has come into force, our conditions is just like that of regular service men with all the defects but no advantages.

If the Government is keen to see that ours must be a pucca service, let them pay us at least a minimum of Rs. 100 per mensem providing us with a decent dispensary building, a ward attendant, better leave regulations and fixity of tenure in the village; then let them bind us under all the restrictions that they contemplate in the present agreement; but we must not fall into that snare and lose in the whirlpool of those ideas. We want to go by the original idea of independent subsidised medical practitioners and if that be the Government scheme originally contemplated, let them give us the liberty to practice anywhere we like in the afternoons provided we come back to the station in the night; let them provide us with a dispensary building or at least pay the rent thereof. Let each dispensary be given at least a ward attendant. Let us be allowed to take part in politics and civics as independent medical men; let there be fixity of tenure for every one of us in the village; and on our behalf let us solemnly promise that we will treat the necessitous poor free, and do our best for the rural uplift.

Let us have an opportunity for free discussion of any topic concerning not only our scheme but concerning village reconstruction also with the official or non-official agencies who are concerned in the work, and let the Government and the local authorities realise our situation and difficulties fully and try to do their best for us and let them really assign the independence to us in matters of our taking part in civics and politics so long as we do our duty enjoined on us. If the Government is keen on rural uplift, let us be permitted to co-operate with all those official or non-official agencies interested in rural uplift work.

I must now appeal to you my brethren, present here, to serve the poor in the villages in the spirit of service and try to do some real good to the villagers; let us do our work conscientiously without giving room for complaints; let us stick to the terms of the agreement and let us trust in God, being content that "service is prayer" and "service is its own reward" and lastly let us stand united shoulder to shoulder and organise and strengthen our Association.

Gentlemen, I have now got a most pleasant duty of requesting Major General Sir Frank P. Connor to open the Conference. It is really our good fortune that Major General Sir Frank P. Connor has encouraged us by attending this Conference in spite of his multifarious duties. I crave your pardon Sir, for our inability to approach you with a request to open the Conference earlier than we did a couple of days ago.

Gentlemen, Major General Sir Frank P. Connor has by his act of kindness kept us all under a deep debt of gratitude by evincing his interest in us, the humblest practitioners of this province. Sir, though myself and my brethren had no chance of seeing you at close quarters, we have been reading your concern about the medical profession as a whole, in the columns of *The Medical Practitioner* which reaches many of us.

The state of affairs of our Medical Council was far from satisfactory before you took charge of it. Some of us found it even difficult to get ourselves registered in time in spite of our paying the required fee. Even the Medical

Register was published for the first time on the due date, demanded by Statute, after you took charge of that office and we learn that while conducting the affairs of the Council, as its head and as the head of the whole profession in this Province you never remember your official position though you are the President of the Council by virtue of your position as the Surgeon-General with the Government of Madras. You are an example, Sir, of an official who weilds office not as a bureaucrat but a true democrat. Whenever you had opportunities of addressing medical associations in the mofussil, during your tour, you had always a kind word to say about us. I had the privilege of dining with you on that memorable day of the 'Pan-Schismatic' Dinner at Conmemora Hotel and knew at close quarters your kind heart. It is our association with you and other seniors of the profession at the Dinner that encouraged a few of us to conceive the idea of reviving our Association and remodelling it to suit the present conditions and we hope, Sir, that with your blessings we will steer clear of our difficulties and be able to put before the Government a scheme which while removing our hardships, will make us render service to the village folk with zeal and sincerity worthy of our noble profession. I now request you Sir, to declare the Conference open and invoke your blessings.

SURGEON-GENERAL'S SPEECH.

Sir Frank Connor said that he realised how difficult it was for many of them to come to the city from the mofussil to attend the conference. They must all be aware, he continued, that ever since he came to this presidency he had a very soft corner in his heart for the rural medical practitioner and rural medical practice. He knew the necessities of the countless numbers of people living in rural areas, most of whom received no medical aid. It was a very difficult thing for Government or the Surgeon-General to grapple with such a big problem. They had in this Province a huge population a great many of whom were poor, and it was not possible for many years for any Government to give free medical aid to all the poor people in the rural areas. And that problem had been exercising his mind very much.

Whenever he went in the rural districts he attended the associations there and always wanted to know how the rural medical practitioners were getting on. They would at the present conference pass many resolutions and these would have his best attention. He would say that the chief function of the conference should be for the medical practitioners to meet one another, and discuss their problems, and to find out in what reasonable ways their difficulties could be removed and their conditions ameliorated. In other words, the object of the conference should be to take stock of their conditions and make wise plans for the future. He would certainly help them. The Government would also help them.

He met many rural medical practitioners when he went to the rural areas and obtained first-hand information about their conditions. Most of them, when he asked how they were getting on, replied. "Not too badly, we do not make much money, we are pulling along." That was something.

Spirit of Service.

They must remember that if they chose the rural medical practice, and that too for a certain number of years, it entailed a certain spirit of service which they could not get away from. Anywhere in the world doctor, fortunately or unfortunately, had to do a great deal for nothing. They had to work for small fees. That might seem hard, but they were learning something by doing such work. It was invaluable in that it inculcated in them from the very beginning that spirit of service without which a doctor was very poor indeed.

Until the individuals in rural areas became more prosperous they would not be in a position to produce much in the way of fees. That was a stern fact. But every indication was present that the time had come when the conditions of the rural areas and of the people living there would be looked into more fully than before. He thought the rural medical practitioners were intimately connected with the Economic Councils which had been started in rural districts.

Comparative Success in Madras.

Sir Frank P. Connor next said that in this province there were over 400 rural medical practitioners of whom the majority had the L.M.P. qualification, a few were graduates and others were licentiates of the Indian Medical School. He would point out that the whole service of rural medical practitioners was an experimental measure. This was the only province in India where up to now the service had proved a comparative success. He would not say, however, a complete success as many of them, rural practitioners, said they were "pulling along." In Bombay they had just tried the service formally, and in Burma they started it three years ago but said it was so hopeless that they were going to give it up. It rested with the rural medical practitioners to make the experiment a success or not in the Madras Presidency.

Referring to the grievances of the rural medical practitioners, the Surgeon-General said that if they said there were too many grievances the Government would say the scheme was a failure. Such submission would not lead them to success. He remembered five previous conferences of rural medical practitioners were held—two in Madras, one in Trichinopoly, one in Tanjore and one in Bezwada—and the present one was the sixth. Some good had resulted out of those conferences.

Many of their grievances were just. Grievances could be redressed only if they were reasonable. In all their former conferences they made a great point of the independence of the general practitioner. There was a fallacy in their argument when they said they wanted little control.

Question of control.

Perhaps they felt they were more controlled than they liked for the comparatively small subsidy they got. Possibly they felt that the triple control by the District Boards, the District Medical Officers and the Government made their position difficult, particularly in these political times. He would say that politics was likely to come into many matters and without control over them

they would be affected. Government were not likely to give them something without exercising control. So also were the District Boards.

They should not harp upon grievances too much. They must take advantage of conferences such as the one they were holding now to find out ways of improvement and also the best way of getting medical relief for the people in the rural areas. They, doctors had been taught to give medical relief for nothing and they knew that the spirit of service must never yield. A certain amount of sacrifice on their part was always essential to solve the problems of this country. Until individuals gave a great part of their time, leisure and service for the country, it could get on only very slowly.

Concluding the Surgeon-General observed that thousands and thousands of young men were working hard like coolies in other countries. In labour camps and elsewhere, for the sake of their countries and turning marshy lands into cultivable ones. With that sort of spirit they must go a head. When that happened in India this country would be happier and they the rural medical practitioners, would have a fair share in the picture.

PRESIDENTIAL ADDRESS

BY DR. V. RAMA KAMATH.

You are all aware that The Medical Practitioner was brought into existence by me with the help of my late revered colleague Dr. M. S. Krishnamurthi Iyer, to ventilate the grievances of the medical profession in this country and both of us did not lose a single opportunity of criticising either the inherent defects in the Scheme or the hardships brought to bear on the unfortunate Rural Practitioners. For this purpose, we invited an article on the Subsidised Rural Medical Relief Scheme from the late Dr. S. Ramasubbu, the Secretary of the Madras Provincial Rural Medical Practitioners' Association, in the very first issue of The Medical Practitioner. My address this day to you is only a compendium of the criticisms appearing in The Medical Practitioner since 1929 including the views expressed by the late secretary Dr. Ramasubbu. I shall only attempt to find out how far the past criticisms are profitable and justifiable, taking into consideration the existing conditions and circumstances.

A few months before the inauguration of the guarded Provincial Autonomy, India had the good fortune of having as its Viceroy and Governor-General in the person of, Lord Linlithgow, a parliamentarian of eminence, who had exceptional opportunities of knowing the conditions existing in the villages of this country having occupied the position of the Chairman of the Royal Agricultural Commission and who has had as good exceptional opportunities of knowing the nature of the new constitutional machinery set on foot and which our Rulers say is for the good of this country. On the very day Lord Linlithgow took charge of his responsible office as the representative of the King Emperor, he broadcasted his ideas of good Government, and ever since has been busy to make the various Government departments and the public realise that good Government is not mere balancing of budgets or raising taxes to balance the budgets but consisted in making the people live healthy lives. The experience gained by Lord Linlithgow as Chairman of the Royal Agricultural Commission has stood him in good stead as the Viceroy had realised more than the Heads of the various departments, his immediate advisers, that the prosperity of the agricultural India depended entirely on her villages and reforms in

every direction should start from the villages. And as the village prosperity depended mainly on animal husbandry, His Excellency has been keen to take active steps for the healthy growth of human and animal kingdom, constituting the villages with a view to ensure the health and prosperity of the urban areas. Soon after Lord Linlithgow took charge of his office as Viceroy, he called a conference of the Heads of all departments concerned with the health, human and animal, including those who are in charge of research in nutrition of animal as well as vegetable kingdom and impressed on them the necessity of their working in close co-operation. His recent attempt in the direction of health and welfare of those under his care was the inauguration of a Central Advisory Board, the individual units of which were not to rival in authority as was the case till now, but to co-operate and co-ordinate with each other to make the people of this country realise that, "Good health is the greatest of all blessings".

It is indeed a great relief to me and must be so to others interested in public welfare that Lord Linlithgow was able to detect with surprise the neglect of the Public Health Commissioner since 1930 in not mentioning a word in his annual reports regarding urban sanitation and housing. The Madras Mail aptly remarked regarding the first surprise of the Viceroy, in its Editorial column on 24th June, "We do not doubt if His Excellency extends his researches into other branches, he will experience many more surprises, for it is remarkable how routinism dominates administration". I would be justified in substituting the word, 'callousness' for 'routinism' in the above quotation. I am having at times many unpleasant experiences in getting ordinary routine information with regard to subjects concerning the public from the Government Departments. My recent experience was with regard to a request to all the Heads of Medical Departments in India to supply me information about Rural Medical Relief Scheme in their provinces. Anticipating the nature of response a humble individual like myself was likely to get, I approached an officer in high position at the Central seat of Government who has authority over these Heads and requested him to put in a word to such of those whom he knew, to comply me with my request. The latter was most courteous and replied to me by return of post, assuring me that I would not have any difficulty in getting the information asked for. But as apprehended by me, I could get information only from four provinces viz., United Provinces, Assam, Bihar and the Punjab. This must be yet another surprise to the Viceroy and to his adviser whom I approached for help, trying to prevent such a surprise.

Everywhere in India, all of us are discerning signs of a growing consciousness for the uplift of our villages. For this purpose, economic councils have been brought into existence in this province and other agencies under different nomenclature have been working in other provinces. From the persons constituting these bodies, their functions and other activities so far evident, one is led to smell politics more than the welfare of villagers. The officials who run the show of these councils, mind newspaper reports more than actual results. So far, either here or elsewhere those constituting these councils or even those who brought them into existence have not shown signs that the result of these schemes of Village Reconstruction should be an increase in the health and welfare of the village community. In the neighbouring state of Hyderabad, even the officials in charge of the village councils did not make a secret of the fact that the success of the running of these schemes depended upon the zeal of the non-official element. In a far off province, the Punjab, the Hon'ble Minister in charge of the Medical Portfolio openly

declared in a conference that the Government must depend upon non-official agency for the administration of Rural Medical Relief and Rural Sanitation. It is a pity that His Excellency the Viceroy who (and not the Advisory Heads working under him) has been responsible for the initiation of a very sound policy of good administration, did not even after his surprise, conceive the idea that his all ambitious and all useful a scheme of public welfare must depend entirely on non-official agency for its successful working. The Madras Mail which usually breathes the official atmosphere in a different way from its national contemporaries, has gently warned His Excellency in its Editorial columns on 24th June, in these words, "His (Viceroy's) sincerity is patent to all; but we fear that at the end of five years he will find that little has been accomplished, unless and until he can organise not Government Departments, but volunteer organisations fired with like ideals eager to lift the masses from the sordid environments in which they now live and willing to labour unceasingly to instil into all classes an attitude of greater social responsibility, 'I am my brother's keeper' might well be the motto of such a corps."

Before I speak to you about the actual state of affairs of the existing Subsidised Rural Medical Relief Scheme, I thought that it was necessary to impress you with some authority, the paramount necessity of making all realise that Subsidised Rural Medical Relief Organisation should be made free from all official and non-official embarrassments, and be made an integral part of any scheme of Village Reconstruction to be started for the welfare of the village folk. With all respect at my command to the departed Rajah of Panagal, the first Chief Minister of this province, who inaugurated the Subsidised Rural Medical Relief Scheme, I am compelled to say that the end results of the working of the scheme so far, have been quite the reverse of what was expected of it.

The G. O. regarding the scheme No. 1522 P.H. dated 22-10-1924 states "that Government strongly feel that some amelioration of the masses is urgently called for, and that for want of unlimited funds at their disposal, encouragement of private practitioners (Allopathic) to settle down in villages for practice by the grant of money subsidies and supply of medicines from public funds, as being the cheapest and at the same time the best from many points of view and thus to divert to the villages the large number of unemployed medical men who now congregate in towns for private practice as also tend to solve the problem of unemployment to a material extent". According to the Scheme, a Registered Medical Practitioner has to practise in a village selected by the then existing Taluk Board in consultation with the District Medical Officer, the practitioner agreeing to treat professionally and supply medicines to all the necessitous poor of the locality (who are defined as persons or members of the families of persons whose monthly income does not exceed Rs. 30) who shall apply to him therefor: such treatment being given and medicines supplied free of all charges at the residence of the practitioner (Clause 2 of the agreement to be executed by the practitioner and the Taluk Board: G.O. No. 1994 P. H. dated 28-9-25). In return the Taluk Board will pay to the medical practitioner a sum of Rs. 400 per annum if an L. M. P. (since enhanced to Rs. 500) or Rs. 600 if a medical graduate and an additional subsidy of Rs. 100 per year (since raised to Rs. 300) if he shall engage, maintain and employ a qualified midwife, as also supply him free of charge with medicines to a value of not less than Rs. 360 per year. (Clauses 6, 7 and 8 of the agreement amended by G. O. No. 2185 P. H. dated 3-11-27 and 942 P. H. dated 6-4-29. Such an agreement shall be subject to termination on giving to either of the parties 6 calendar months' notice in writing to that effect. But the

Taluk Board shall not be entitled to terminate the agreement under this condition unless it finds itself unable to maintain the dispensary on account of financial stringency. (Clause 10 amended by G. O. 1756 P. H. dated 27-8-28). "The Taluk Board shall however terminate the agreement at any time without notice on the event of an alleged breach by any practitioner of any agreement on his part, an appeal against which will lie to the Government of Madras whose decision will be final and binding on both the parties. (Clauses 11 and 12 of the agreement amended by G. O. No. 2185 dated 3-11-27.) Subject to the above conditions, the medical man is an independent practitioner and he was entitled to practise for his benefit. He was expected to settle in his village and in no case can be transferred from place to place. (G. O. No. Press 1154 P. H. dated 14-2-27); nor do such extraordinary duties as inoculation, festival or polling work, formed part of the ordinary duties of the practitioners (Government Memorandum No. 29417-2 D.P.H. dated 26-10-27). The object of the scheme, therefore, was to provide some sort of employment to the unemployed medical men, and at the same time afford some degree of skilled medical aid to the necessitous poor.

The Taluk Boards did not realise the real object of the scheme and those constituting the Board in many taluks made use of the scheme to serve private selfish purposes.

To an audience which consists largely of Subsidised Rural Medical Practitioners, I need not repeat the stories of their sufferings in one form or other, in detail. Many such incidents were on a par with the stories of 'a cock and a bull' or 'a wolf and a lamb', the aggressive party always being a president of a taluk board or some prominent member of the Board or of the Local Body who had influence over the taluk board president. Series of such incidents have been reported in The Medical Practitioner with Editorial comments. The comments, though they prevented a similar act of wilful tyranny commented upon, gave rise to new incidents of unbearable sufferings to the practitioners. Even in simple affairs such as forms of correspondence, some of the taluk board presidents desired that they should be addressed as if the Rural Medical Practitioners were menials under them though as a matter of fact, as per terms of the scheme, he was an independent practitioner who took upon himself the lot of practising in rural area with little or no prospects of even a hand-to-mouth living. The treatment meted out to these unfortunate practitioners seriously affected their prestige and status as members belonging to a noble profession, so much so that they materially suffered in not being able to command faith and respect from their patients.

No thought seems to have been bestowed in the choice of villages for supplying subsidised medical relief. In many instances, the selection of a village for medical relief was made not depending upon its population, its situation and other circumstances which if carefully considered would not only have served the purpose of the scheme but would have brought some income by way of private practice to the practitioner, so as to encourage him to settle in a village permanently. The selection of a village depended upon its vicinity to the house of a member of the taluk board or his relations or friends so as to enable them to get free medical aid from the subsidised medical practitioner. This was evidently done not in the interest of the scheme to supply the necessitous poor in the village the services of a qualified practitioner but to serve a rich taluk board president or his lieutenants in the board, their relations and friends.

Apart from attending to the necessitous poor, free of charge, the practitioners were forced to do the duties of the Public Health Department with regard to festivals, inocu-

lations and were even asked to do work at the polling stations during local or legislative council elections, and for all the work they were not paid any remuneration. There have been instances where undue and uncharitable advantage was taken by those in authority in taluk boards of the popularity of some of the subsidised medical practitioners who were able to command good practice. Such dispensaries were suddenly converted into pucca taluk board dispensaries, in spite of an existing G. O. that in the newly converted taluk board dispensary, the subsidised practitioner of that particular station should be made the medical officer of the taluk board dispensary; such a converted subsidised dispensary was put in a charge of a new medical man who was either a relation, a friend or the relation of the friend of those in power in the local bodies. Such an action on the part of the local bodies set at naught the very principles of the scheme and the Government many a time, perhaps on political grounds, did not interfere with the high-handed action of the taluk boards.

The Government has had its share of the violation of the principles of Rural Medical Relief Scheme, nay, they did not even mind cutting at the very root of the scheme, at times swallowing their own orders. A few self reliant private practitioners here and there did not wish to sell their prestige and honour for a mere pittance of a subsidy and started practice in the rural areas of their own accord. In such places, subsidised practitioners were appointed by the taluk boards though there was a G. O. to the effect that in a village where a Registered Medical Practitioner has settled, the taluk board should not start a subsidised rural dispensary. Here again Government valued political expediency more than their prestige and honour and when the aggrieved independent rural practitioner appealed to the Government, they did not interfere.

It is true that some of the petty grievances of these unfortunate practitioners were rectified after persistent agitation and they are now paid for festival and inoculation duties, and in a few selected districts, they are made to assist the Public Health Department on a monthly remuneration of Rs. 15 for executing work for which the Government must have employed subordinate staff on a pay thrice as much as the remuneration they are now given.

There have been indications in the past as adverted to above, not without evidence, that the rural medical relief scheme, was utilised by the unscrupulous politicians to serve their political ambitions.

The recent changes brought about by the Government in the agreement to be executed by the Subsidised Rural Medical Practitioners, if gone through even by a casual reader will convince him that the past activities of those who were responsible to run the scheme did culminate to such an extent that the scheme was utilised or is likely to be utilised in future for political purposes and not for purposes of serving those for whom it was meant.

The new form of agreement which the subsidised practitioners are forced to sign has been given the force of an indenture depriving the practitioner of even the elementary rights and privileges of citizenship. They have been converted to a class of menials having no rights and privileges of service which are enjoyed by even the most humble subordinate either under the Government or local bodies. All the return the practitioner is entitled to by the indenture is a subsidy ranging from Rs. 500 to Rs. 600 a year (the former for licentiates and the latter for graduates). Even the coolies booked by the old Kanganies for labour in the rubber estates in far off lands in the F. M. S. or

of the Tea Estates in Ceylon enjoy better privileges comparatively depending upon their status. They had at least a protector apart from the Almighty Protector. The subsidised practitioners have yet to find one to protect them.

In old days the practitioner had to bind himself only once by the agreement for the whole period of the subsidised service as per the spirit of the scheme. The new agreement gives a security of service for a year only and the continuity of his service depends only on the sweet will of the President, District Board or Panchayat Board. The hours of attendance at the Dispensary or his presence in the village were left to the discretion of the practitioner in the old agreement and later due to the laxity of work on the part of a few practitioners and various other causes, hours were fixed. The practitioners were at liberty to go to adjoining villages to serve the villagers there. Later, though they were permitted to go, permission had to be obtained from the President of the local body. He is not permitted to have an additional dispensary at his own cost in an adjoining village even without prejudice to his work at the subsidised dispensary. The latter prohibition, though not specifically mentioned in the agreement seems to be in effect in actual practice. The new agreement insists on compulsory attendance of the practitioner at the dispensary in the mornings and the presence of the practitioner in the village throughout day and night. In fact instead of encouraging the scope of private practice, the agreement curtails it in all possible ways. The framers of the agreement seem to have lost sight of the fact that even to obey the stringent conditions of the agreement the practitioner must be able to live.

The maximum aggregate leave to which the practitioner is entitled is only 15 days a year. In case the practitioner requires leave for a longer period on account of ill health, he is bound to keep a substitute to be paid out of the portion of the subsidy. Government and local board servants enjoy 15 days' casual leave and leave with full pay for one month in a year and could accumulate their leave for any period till recently, but now for 3 months. Whereas an honorary who cannot be treated as a servant of the local body or of the Government is treated worse than the meanest servant with regard to leave. The worst and the most humiliating new conditions are the following :

1. The practitioner shall not take part in, or subscribe in aid of any political movement in India or any political movement relating to Indian affairs. When there is room for doubt whether any action which he proposes to take will contravene this provision, he should refer the matter to the Local Government through the President, Dt. Board.

2. The Practitioner shall not stand for election or appointments as a member of any Local authority. He shall not be canvassing or otherwise interfere or use his influence in any way, in an election to a legislative body constituted under the Government of India Act or any local authority, except that he may record a vote, if he is qualified to do so. In that case, as far as possible, avoid giving any indication before hand or the direction in which he intends to vote.

It looks as if the old Ministry which was responsible for the new form of agreement was desperate, knowing as it did, that even the subsidised practitioners had lost confidence in the Government. It is also equally evident that the Ministry was more conscious than the subsidised practitioners that the latter craved for freedom.

The higher services under the District Boards, such as the Engineers are now under the disciplinary control of the Government after persistent agitation. Their immediate assistants are now agitating for the same. I have been receiving requests from L.F. Sub. Asst.

Surgeons and Asst. Surgeons to agitate for provincialising their services also. If any body has grievances against the local bodies more than anybody else for bad treatment, it is the Subsidised Rural Practitioner and he deserves the sympathies to the fullest measure. All the same, I wish to tell you more than I would do so to others that inspite of your sufferings you should not fight shy of the local bodies. On the other hand you should even at the risk of your own interests train people in the art of Self-Government, which if it is not a reality in villages, India can never be free nation.

I am quite conscious why you and others working under Local Bodies prefer to be directly under the control of the Government. It has been the experience of everybody under British rule that an Indian whether he be an official or non-official has more faith in justice and fair play in the European when the quarrel is between two Indians. This is unfortunately the feeling throughout India. This feeling is on account of our being a subject race. An Indian in whatever position while judging things cannot forget easily that he has to mind his masters while being a judge so that his judgment does not prejudice the interests of these masters. Local Self-Government has been a failure so far. Those constituting the local bodies usually do not know the purpose and functions of Local Self-Government. Education and Medical Relief are the main items about which Local Bodies should concern themselves. But unfortunately both are being neglected by these bodies. Soon after the Local Self Government Department became a transferred subject all the Local Boards, Municipalities in this Province gave over their major medical institutions to the Government with a false idea of economy and the Government took them over as irresponsibly as if the money spent by the Government is not peoples' money. The Government as well as the Local Bodies have been forgetful that all their departments exist for the welfare of the people under their charge. You village practitioners who are in direct charge of the welfare of the villagers should take the credit of creating a real conscience of Self-Government in the villages as all Governments exist only for the welfare of the people. The old village Panchayats and not the present ones were ideal centres of Self-Government. I come from a village where my father took great interest as a village Panchayatdar. He acted as a judge, civil as well as criminal and even administered forest laws and all without any statutory authority. His judgments had no appeals. The village folk may be quite different from what they were before, but it is not possible for them to forget the instincts of their forefathers, that is, faith in good leadership for their welfare. You should lead the villagers by example and not by precept. You should make them realise that you have settled in the village for their good and once you create faith in them by rendering them sincere disinterested service, you will be able to command their unrestricted confidence.

Almost all the missionary medical institutions in India were started in small huts. The men or women medical missionaries who began the work in these huts had the initial difficulty of language and want of knowledge of habits and temperaments of the village people. They got only a living wage but their devoted service to the village folk could be seen now in grand well equipped hospitals, some of which have since become teaching institutions. Though the missionaries have been able to get into most modern buildings with equipments of which even the Government medical institutions should be ashamed of, the missionaries who began their lives in huts have not forgotten the village folk and you will find elderly missionaries like Dr. (miss) Ida. S. Scudder going out on

ambulance car to serve the villagers as regularly as she would go to the class rooms of the hospitals and the college of which she is the Principal. If such work is possible for those who come to India from far off lands, why not for the Indians themselves? Many foreign missionaries have adopted India for doing selfless service. Why not some of you at least be as selfless? It is likely you may be whispering within yourselves that the missionaries are serving us for evangelistic purposes. Why not you too do the same? If they have a Son of God through whom and for whom they love humanity, why not you have Lord Krishna as your ideal in the place of Jesus Christ—Or a Mahomed or a Buddha?

Many of you must have been experiencing lot of hardships one way or the other from those who wish to lord over you and even from those whom you have been serving to rid them of the diseases they suffer. You have been in an atmosphere of humiliation and intimidation with little or no appreciation, for the services rendered by you. You belong to a noble profession and can afford to be scientifically tolerant, as all that you see in others who do not reciprocate to your feelings of whatever description may be explained as scientifically to be due to deficiency diseases, due to want of endocrines, vitamins, organic or inorganic chemicals. You also know how to deal with such persons by the study of psychotherapy. Many of you my friends know that I have not been keeping normal health for the past few years. Some of you here and others outside have been asking me how I managed to keep much better health now which they see in my face though not in the body. My answer to all my friends was that I am making a study of human deficiencies in whatever form and trying to correct myself and this study has been keeping me to increase my sphere of love in all directions. I am now able to love or at least not to hate those who cannot love me. You all know that I usually disagree with the officials and that in the medical department, including the Head of the Medical Department who has been so kind to encourage you by his presence here. You also know that those whom I criticise have been showing towards me more sympathies than those for whom I am fighting, incurring the displeasure of officialdom. I am frank to a fault and in spite of my recent sufferings it has not been possible for me to be otherwise. So I advise you my brethren in the profession, serving the village folk that you will do well to undergo the study of human weakness, not forgetting yourselves. I began my study at the fag end of my life but you will be benefitted more than myself, for you have a longer span of life than I am destined to have.

With the study of the human mind along with the causes of the bodily ailments in the villages you will be excellent doctors of whom our province if not the whole of India may well be proud of. There is no need to go abroad to study human ailments peculiar to tropical India, at least for such of those who are general practitioners. If you cultivate the study of human ailments in the way indicated by me, people from foreign countries will go to you to learn your methods of treating human ailments and keeping villages free from not only human ills but human strifes also.

After such a training you will be able to govern the health of your village and the villages surrounding the sphere of your activities and will be in a position to dictate health laws to those who govern you by virtue of authority. Love humanity and love your profession and the spirit of this love will take care of you all.

Those in whom the ideals put forth by me are latent, may be pacified at least for the time being at the sermons preached by me. Others who have come at tremendous

sacrifices to their poor or empty purses are likely to be exasperated as your sufferings in the villages have been as keen as they are real, and I will not be doing my duty and will be throwing mud and cold water over your anxious expectations if I do not tell you something more real. The times are not only most auspicious but most opportune also to draw the attention of the public and the Government to the villages as both are determined to make the villages centres of attraction in the interests of the villagers and more in the interests of the urban areas. All that the villages could produce themselves have been sucked to the bottom and unless and until the villages get substantial help for reproduction, the Government machinery is bound to fail one day or other. Whether the Village Reconstruction is viewed with the object of rendering help to the rural areas or for the preservation of health and welfare of those in urban areas, it is certain that the question will materialise into something different from what it is now. Thanks to the selfless activities of the Indian National Congress, this mighty organisation has been able to convert a well guarded Provincial Autonomy into a Government, for the people and by the people, at least to the extent of day to day administration. Those who have the reins of Government in future cannot have excuses for running schemes of vital importance for the welfare of the public. The Rural Medical Relief Scheme being the most integral part of any schemes launched now and to be launched in the future for the village uplift cannot be ignored. The representative of His Majesty, the King Emperor is keen on building the health of Indian Nation, and has impressed the Heads of the departments working under him and those working in provinces that the welfare work should begin in villages simultaneously with the work in urban areas. The Viceroy who is always surrounded by officials or non-officials in high position should be made to realise the gentle warning given to him by the Madras Mail and quoted by me a little while ago. The Viceroy cannot start public non-official organisations of the type the Madras Mail has in view to help the Viceroy to realise his ambition. The organisation of Rural Medical Relief Scheme is the legitimate responsibility of the medical profession and not of one person in the medical department. Public utility services should have non-official control and cannot be one man's show though it is true that all public activities are the outcome of the brain of a public leader who frames and adjusts his activities to suit public demand. There is no medical profession worth its name in India as in other civilised countries and all work of public-health activities, preventive or curative, are run by individual officers of the Government. This state of things cannot last long and for ever. Even the activities of the independent medical profession should begin in the villages. This is my experience as a member of the medical profession for the last thirty years. The experience of the younger generation cannot be otherwise. Those who began their lives with me or earlier as independent practitioners did not feel that we took a wrong step by not entering Government Service. But a large majority have been hankering after it now as they find service more lucrative than independent practice.

No Government throughout the world can afford to give free medical aid to all the necessitous poor with the help of only the paid staff. The population of the Madras Province according to the census of 1931 is 47,193,602. There are at present 1363 institutions belonging to Government, Local and Municipal Bodies, Missionaries, Private aided and non-aided bodies, Railways including 435 subsidised dispensaries, as seen from the latest Administration Report of the Surgeon General with the Government of Madras. The total number of paid officers, honoraries including the subsidised medical practitioners

who are in charge of 1363 charitable institutions including the subsidised dispensaries are 1963. These figures in multiples of ten roughly work at one medical man for 24,000 of the population. From the authenticated statistics collected by the late Dr. Krishnamurthi Iyer, retired sanitary commissioner of the Travancore State and the late senior Editor of The Medical Practitioner, it is found that in America and Japan there is one qualified practitioner for a population of 1600 in rural and for 800 in urban areas. I have no idea of the rural population of this province as against the urban. There are at present 5860 registered practitioners in this province including 1963 paid and subsidised. These figures work roughly at one medical practitioner for a population of 6000. As there are proportionately a very large number of practitioners in urban areas than in rural areas, there may not be even one for 20,000 population in the rural areas, a most deplorable state of affairs. There is yet another difficulty in this country and that is the existence of indigenous systems of medicine, in addition to the other western systems, such as Homoeopathy, Naturapathy, Hydropathy. Signs are not wanting for the people who have faith in these systems to press the Government to give medical relief in the particular systems in which they have faith. The Ayurvedic, Unani, Sidha systems have been able to get themselves recognised by the Government not only in this province but in a few others. At the last session of the Central Legislative Assembly a resolution was passed by a narrow majority asking the Government to recognise Homoeopathic system of medicine and the representatives of this system did already approach the Ministry in the Punjab offering the services of Homoeopathic practitioners for Rural Medical Relief in villages. These representatives have been asked by the Punjab Government to formulate a scheme and submit the same for the approval of the Government. I have put before you all aspects of medical relief with which the popular Government will be confronted, and you as members belonging to the scientific profession should show the way to the Government, not forgetting your public responsibility as citizens when you put before the Government a constructive scheme of medical relief for the rural population. This is really a very tough question, rather knotty too, and not easy of solution unless you depend upon self help and your own resources. Everybody knows that you cannot depend upon resources in the shape of money. But there are ways and methods by which a powerful organisation united in strong bonds of comradeship can put forth its unlimited resources in the shape of knowledge. If such an organisation is assured and if a spirit of real union prevails in that organisation, the Viceroy down to the peasant will open their eyes and ask the help and co-operation of such organisation in the uplift of the village. Now you know to your cost that you are made the tools for services either preventive or curative and thrown away soon after the use of the tools is over.

As the scheme is at present worked in Madras there is not much difference in the principle of working a local fund dispensary maintained at a public cost and a subsidised dispensary maintained from the public revenue. The Rural Medical Relief Scheme is made yet another department under the Government but maintained at a cheaper cost than the regular medical department. In olden days in India when the village communities were in a more flourishing condition, the village physician popularly known as Vydian existed in each and every village and these were regarded and actually occupied the position of family physicians. The necessity of having family physicians at present is certainly more than it was years ago. In any rural reconstruction scheme family physicians should occupy an important place. None can diagnose diseases nor cure them as effectively as a family physician does, who being the permanent resident of the locality

possesses accurate knowledge of the local conditions and having had varied opportunities of coming in contact with the inhabitants in every day life knows well their constitutions and the diseases to which they are predisposed. This knowledge can greatly facilitate not only the diagnosis and treatment of diseases but will help the village practitioner to prevent diseases with the help of the special departments which His Excellency the Viceroy intends to organise in his programme of village uplift.

It is therefore essential that the Rural Medical Relief Scheme is run in such a way as to encourage the growth of family physicians. This could be done only by making private practice more attractive. The existence of state paid medical service with unlimited privileges of private practice which has been hampering the growth of independent medical profession in urban areas has similarly handicapped the rural practitioners who wish to settle in villages independent of the subsidy. In urban areas, the state paid practitioner is much better off in competition with his brethren in private practice. It is not the case with the Rural Subsidised Practitioner who, though in a better position than his unsubsidised brother cannot hope much or at least as much as his more fortunate brother in Government or local board service as he is treated not as a medical man but as a menial belonging to the local board service. It is the existence of paid medical service that is responsible for the non-development of Rural Medical Relief Scheme also. The idea of subsidising rural practitioner would not have arisen at all if there did not exist paid service. As things are to-day, it is not possible to get out of the vicious principle of pay or subsidy with regard to medical relief and you have to make the best of a bad situation. Though the principle of the Government paying a subsidy in the way it is done now, is against the growth of family physicians, it will not be possible to induce qualified medical men to settle in villages so long as state paid doctors exist, unless the rural practitioners are shown some encouragement. The salvation of India entirely depends upon village reconstruction and no work of village uplift will be complete unless right sort of medical men take part in it. For, there is nothing which a medical man cannot tackle if he is properly trained and put in the way. If the Government is sincere in the welfare of this country and if they believe that the prosperity of India is in her villages, the first charge on public revenue should be Village Reconstruction work. The Government should realise, more than anybody else, that 90% of the revenue comes from the villages. There is no need for the Government to tap further resources for the extra expenditure. I have been repeatedly pointing out to the Government through the columns of The Medical Practitioner that the opening of the dispensaries distinct from hospitals, by the state, out of public funds, is objectionable and prejudicial to the interests of the patients and the profession. It is very doubtful if the patients attending the out-patient dispensaries in the cities and towns, where on an average, over 200 patients are disposed of within a couple of hours or perhaps a little more, by a couple of doctors utmost, are benefitted at all, knowing as all of us do that on an average not even a minute is spent on the examination of a patient. As serious illness requires constant attention, rest, diet and treatment and as the large majority of those who attend the out-patient Department cannot have them in their own houses, the duty of opening and maintaining hospitals only should fall on the Government until philanthropic gentlemen come forward to assist or relieve them of their responsibility. So the unit of medical service should be hospitals and not dispensaries as is the case in Federated Malaya States where the death rate cannot be more than in India though not a single out-patient dispensary can be found either in the Federated Malaya States or in

the adjoining Native States. The treatment of out-patients should be left entirely to private practitioners in the urban areas where exist today a large number of private practitioners. The Government should close down the out-patient departments wherever they exist and money saved should be utilised for the Rural Medical Relief. The Government are recognising, though slowly, the utility of honorary medical officers, but vested interests do not permit them to replace their paid officers by honoraries who are made to work as supernumeraries. If the Government make up their mind, which I hope they will, under Provincial Autonomy, and utilise the services of honoraries and substitute them in the place of the paid staff there will certainly be a large saving which could with advantage be utilised for real service of usefulness in the villages and by doing so the village will be healthier and happier and the Government not poorer.

Even in villages the ideal to aim should be the institution of cottage hospitals in convenient centres in charge of local practitioners who should give assistance in an honorary capacity not only in curing diseases but also in preventing them, for, no scheme of Rural Medical Relief is complete without the consideration of the measures for the prevention of diseases.

At present, want of prestige and status in the Subsidised Rural Practitioner, more than want of knowledge that makes the officers belonging to the Preventive Public Health Department entertain unfavourable ideas of their proficiency in any programme of preventive medicine. These high paid officers and even those who are the products of the medical schools or colleges of this province, conveniently forget that there are rural practitioners possessing qualifications similar to those possessed by such officers. The Officers of the Public Health Department do at present very little work requiring physical labour. Their duties consist more at the desk in writing reports. The actual work during the epidemics falls on those doing curative work in the profession which work the officers of the preventive side of the Public Health Department expect the rural practitioners to do for wages which a skilful labourer doing menial work would refuse to undertake if labour alone and the time required for the labour is taken into consideration. The Government is at present grudging these poor unfortunate subsidised practitioners to pay more than Rs. 15 a month for doing sanitary work without the assistance of even a peon which a sanitary inspector can command. A deffadar in the Public Health Department gets a pay more than Rs. 15 a month. If any one of the subsidised practitioners has the sense of prestige and honour and refuses the work forced on him, he stands the risk of losing even his subsidy and getting out of the village. If any work should be done on the preventive side of the Public Health by the subsidised practitioner, he must not only be paid an honorarium worth the status of his profession and treated with consideration his position demands.

I do not wish to lead you in the task of remodelling your scheme. I have placed before you some facts and figures and some important happenings with regard to village uplift work, it is for you to formulate a scheme to suit the circumstances of the villages taking advantage of the new system of Government which, I hope, cannot afford to treat you in the way you have been treated in the past though there was a popular Minister in charge of the Medical Department. You should now go into subject Committee and if you have time today, draft a scheme worthy of the ideals of the profession to which you have the honour to belong, not forgetting the ideals I have placed before you in the brief period allotted to me. You will be well advised to take advantage of your

elders in the profession, wherever they are and I shall render you all help that I can possibly do. You should remember while drafting your scheme that you should be independent of all official influence. The Government will be well advised to entrust the control of your scheme to the District Economic Councils giving the representatives of your organisation a place of equality. You should make provision in your scheme to have for you a professional non-official guardian, preferably one for each district, from amongst experienced senior practitioners or retired medical officers who can afford time and little money also to be in charge of the cottage hospitals which you should start with the help of the villagers in the way the medical missionaries have been doing. The Government is bound to give you grants as they do to all recognised educational and medical institutions.

You should disabuse the minds of the public and the Government that the rural medical practitioner is one with little knowledge. It is essential that you should be far above the average of a general practitioner as you have to depend upon your resources in villages where you cannot afford to have the help of senior consultants. Every one of you should be an up-to-date physician, surgeon and obstetrician and should be able to treat common diseases of eyes, ear, nose and throat. Provision should be made in your scheme for post-graduate training either in well-equipped District Hospitals or City Hospitals.

Maternity and Child Welfare work should be part of your activities and you should have a working knowledge of nutrition with regard to the food available in your villages.

Leprosy, Tuberculosis and even venereal diseases were considered once as social diseases prevalent only in urban areas. But the present knowledge of these diseases is quite different and these diseases seem to be prevalent in villages to the same extent as in towns and cities. It is therefore necessary that you should be well up in the treatment of these diseases also.

Apart from the routine sanitary duties you should interest yourself with school hygiene. In addition you should teach elementary hygiene and physiology to school children enough to make them understand domestic and personal hygiene; you should be in the village councils and other councils where the interests of those under your care are at stake.

The popularity of any system of medicine depends upon the person who practises the particular system. You who belong to the scientific system of medicine cannot have any difficulty to absorb in your system medicines and drugs from whatever system which are rationally indicated for the treatment of your patients. So you should not feel nervous of competition with the other systems of medicine but always keep an open mind and try to understand other systems and make use of them if found scientifically rational. The future Government of India being under the control of the popular Vote it will not be a surprise if the Government is forced to recognise all the systems in which the people have faith and the Government will be bound to carry out popular demands so long the people contribute to Government taxes from which the doctors are paid. The Government will have a very difficult task as no Government however rich can afford even to dream of the Utopian task of rendering free medical aid to all whom they govern. The best and the only policy the Government will have to adopt under those circumstances is to leave the medical relief of the general public to

the private medical profession of whatever system as is done in other countries. So you must be prepared for any future exigency and it therefore behoves you to establish your usefulness and popularity always remembering, 'I am my brother's keeper.'

RESOLUTIONS.

After the Presidential Address, all the practitioners went into a committee and discussed at length many problems concerning the Subsidised Rural Medical Relief Scheme in detail, with the object of finding out reasonable ways and methods to improve the scheme. They took stock of their present grievances with the object of finding solution for many of them. Dr. V. Rama Kamath presided over the Subjects Committee meeting and also at the open session of the Conference which commenced its sitting at 7 p. m. The following are the resolutions unanimously passed by the conference:

1. This Conference records the noble and selfless service rendered to the Provincial Subsidised Rural Medical Practitioners' Association by the late Dr. S. Ramasubbu, L. M. & S., its secretary; feels very much grieved at his sad, sudden and premature death; expresses its deep sense of sorrow and conveys the same to the members of his family.

2. Resolved that Drs. K. Vitaldas Pai, B. K. Shenai, M. R. Bhat, S. Viswanathan and K. Govindan, the organisers of this Conference, form an interim committee for management and organisation till the Memorandum of the Association is prepared by them and kept before the Association for its approval, at its next Conference.

3. Dr. V. Rama Kamath was elected as the President for the year and Dr. Vitaldas Pai as the Secretary and Treasurer.

4. Resolved to request the members of the interim committee, to prepare an agreement form, consistent with the spirit of the Scheme, within the first week of August 1937, the committee taking into their consideration the letters so far received from the subsidised practitioners by the President and to be received by him within 15 days from the date of publication of the resolutions in the Madras Dailies; and taking also into consideration other resolutions passed by the conference concerning some of the conditions of the agreement.

5. Resolved to request the Government to enhance the subsidy, to be paid from provincial funds as the subsidised practitioners are not able to earn enough to maintain themselves and their family on account of the existing economic conditions prevailing in the villages and also to request the government to advise the local bodies to do like wise in case of subsidised practitioners working under them.

6. Resolved to request the Government to permit the subsidised practitioners to be absent from their villages for 30 days in a year without loss of subsidy and that it should be made possible for them to leave their villages for a maximum period of 8 days or a lesser period without waiting for sanction from the President of the Local Bodies under whom they serve; in case the practitioners have to absent themselves for a period more than 8 days, previous permission should be obtained and such sanction should be communicated to the practitioners within 5 days from the date of their applications, failing which the practitioners may leave the villages in anticipation of sanction; but in case of absence on account of illness, mere report of the illness should be made sufficient to permit the practitioners to absent from duty without waiting for sanction. Resolved also to request the Government to pay the subsidised practitioners the full subsidy during the period of leave for 30 days in the year and in case a substitute is found necessary during the period of absence of the subsidised practitioner, the authority paying the subsidy should pay the same subsidy to the substitute also and that the subsidised practitioners should be permitted to accumulate their leave for a period of 3 months during the period of their service in case they wish to undergo any special training in Medical Science.

7. Resolved to request the Government to permit the subsidised practitioners to enjoy the privileges of the gazetted medical officers with regard to the form of correspondence, travelling, daily allowance and the battas while attending courts either on behalf of the Government or the private parties.

As it was found very inconvenient to continue the session after 8 P. M., it was resolved to authorise the President to draw up the resolutions on other subjects with the help of such of those who could stay in Madras on the 11th and the Conference was dissolved at 8 P. M. after thanking the President. Accordingly such of the subsidised practitioners who stayed on 11th met at Kamath Buildings in the afternoon and continued the unfinished work after framing the following resolutions depending upon the authority and the understanding arrived at during the open session on the 10th.

8. Resolved to request the Managing Editor, The Medical Practitioner, to permit the Provincial Subsidised Rural Medical Practitioners' Association to use the Medical Practitioner as its official organ.

9. Resolved to increase the yearly subscription for membership from Rs. 2 to Rs. 2-8-0 out of which As. 8 being earmarked to be paid towards the funds of The Medical Practitioner.

10. The Conference considers that writing separate returns in three forms on the work of midwives attached to the subsidised dispensaries is unnecessary as each dispensary maintains a register to record the work done by the midwife as the writing of such returns interferes seriously with the daily work of the subsidised practitioners; and for the same reason the Conference is of opinion that submitting of quarterly returns is not necessary as the practitioners submit yearly returns under the same headings as in the quarterly returns, and therefore the Conference requests the Government to do away with the unnecessary duplicate work in the interest of professional work to be done by the practitioners. The Conference, in addition, requests the Government to direct the Local Bodies to supply the subsidised practitioners with necessary forms in print to prepare any return required by them.

11. As the yearly allotment towards medicine is a lump sum of Rs. 360 for each subsidised dispensary, the conference is of opinion that maintenance of a stock book is done away with; in case where a subsidised practitioner leaves a particular dispensary for any reason, he should be made to refund at the rate of Rs. 30 a month out of the sum of Rs. 360 given to him for a period of one year towards the cost of medicines and that instead of supplying drugs worth Rs. 360 let the subsidised practitioners be paid a lump sum of Rs. 360 per year.

12. The Conference requests the Government to direct District Boards not to dislodge subsidised practitioners who have settled in the villages by the newly passed stipendiaries belonging to the particular District Boards as such an action will be a hardship to those who had already settled in the villages and will make the scheme very unpopular.

13. The Conference considers that it is quite consistent with the spirit of the scheme in case a subsidised practitioner settles in a village permanently for life, without any subsidy, after some period of subsidised service, and if any such practitioner makes a request to the Government to direct the Local Bodies not to start either a subsidised or pucca L. F. dispensary within a radius of 10 miles from the place where such practitioner wishes to settle such a request should be complied with.

14. As some District Boards maintain subsidised dispensaries, allopathic or the Indian system of Medicines, within a range of 2 miles from each other, or from a pucca L. F. Dispensary, the Conference requests the Government to find out the places where such dispensaries exist at present and order the Local Bodies to fix strictly to the principle of restricting the location of the subsidised or pucca L. F. dispensary to a radius of 10 miles except in cases where the population of the particular area justifies the location of such dispensary within a radius of 10 miles.

15. The Conference reiterates the resolution passed at the 4th Provincial Conference of the Subsidised Rural Medical Practitioners regarding Leprosy work and requests the Government that the practitioners be given a minimum of Rs. 10 every month in addition to separate accommodation, necessary medicines, equipment and contingent charges for treating 20 lepers a month and if he has to treat more than 20 a month the practitioner should be paid at the rate of 4 annas per patient per month.

16. The Conference requests the Government to employ Rural Medical Practitioners to be in charge of Medical Inspection of schools in the area of their activities and also to teach

lessons in Hygiene and Physiology to the school children in case these subjects are made part of the curriculum in the schools.

17. The Conference requests the Government to make arrangements in the Head Quarters or the City Hospitals to give post graduate training to the Rural Medical Practitioners free of charge and arrange to have such a programme as early possible.

18. As Rural Sanitation and Medical Relief should be an integral part of any Village Reconstruction Scheme, the Conference requests the Government to bring the scheme under the control of the existing Economic Councils or such councils to be brought into existence in the future for village uplift work, making provision for the representation of Rural Practitioners, which representation should be made in consultation with the Executive of the Subsidised Rural Medical Practitioners' Association.

19. Resolved to request Dr. V. Rama Kamath the President, to lead a deputation consisting of the members of the managing committee to wait on the Surgeon-General with the Government of Madras to discuss about the necessity of re-modelling of the Subsidised Rural Medical Relief Scheme.

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Original Articles

SPRUE.

By

DR. K. NARAYANA MURTHI, M. D.

(Continued from last issue)

Having acquainted the Readers of The Medical Practitioner about the definition, history, climatic influence, of Sprue in the last issue, the Bacterial Theory alone has been discussed in the current issue of the journal to make the discussion on Etiology of sprue complete, the other causes so far recognised having been mentioned already some of which being as obsolete as they are improbable.

BACTERIAL THEORY.—To have a clear grasp of the Etiology of sprue it is desirable that the three phases in the course of the disease should be clearly understood. The first phase very much resembles the symptoms of Flexner type of dysentery. The second phase is more less a picture of secondary infection of ulcerated mucus membrane of the intestines, the organisms being the streptococci in association with the organisms usually found in the intestinal flora such as bacillus faecalis, alkaligenous, bacillus carolinus etc. The third or the last phase is the infection by the fungi such as Monilia psilosis of Ashford. All the three phases have been discussed in the following pages the first phase being the post Flexner bacillus infection as referred to above. It is to be remembered that mild Flexner infection does not cause severe dysentery. It may be a simple diarrhoea often mistaken for indigestion. It frequently starts as a diarrhoea resembling the "Hill-Diarrhoea" or "Low Country morning diarrhoea". On the other hand, the bacillus Shiga is as a rule a very toxic organism, producing very powerful toxins, which give rise to the severest types of dysentery associated with fever and other constitutional symptoms. The toxins of Shiga are three-fold in nature. They are an exo-toxin, an endo-toxin and pressor bases. Col. Acton, Chopra and Boyd (1923) have shown that these pressor bases are formed from the amino-acids of the protein molecules in the intestines and these are very toxic to man. Therefore Shiga bacillus is found to be not

the causative factor in Sprue, since we do not find these toxic symptoms developing in Sprue. Quite contrary to the infection of Shiga, we find in Flexner infection less toxicity giving rise to much less severe forms of dysentery. It has also been found that Flexner group of organisms produce an endo-toxin, but no pressor bases. Therefore in the treatment of dysentery, anti-toxic serum is no good in Flexner infection. If given, it is not only a waste of serum but a source of danger associated with the administration of any sera, such as anaphylaxis, serum sickness, urticaria, arthritis etc. Use of the anti-toxic sera in the treatment of cases of Shiga infection, gives marvellous results. I have seen cases with Flexner infection of a severe kind almost resembling Shiga infection. Herein also the use of anti-toxic serum often fails; as there is no exo-toxin elaborated by the bacillus Flexner.

Subsequent to the infection with the Flexner group of organisms, infection, with secondary organisms like B. Asiaticus, B. Carolinus, pseudo-Carolinus, which ferment many sugars with the production of irritating acids (Archibald products) takes place.

Therefore I am inclined to call early stages of Sprue as post-flexner bacillus phenomena because (i) the serum taken from those patients give a positive agglutination reaction with B. Flexner to a titre 1 : 160 (ii) a number of chronic diarrhoea cases with infection with B. Flexner passing on gradually to one of the stages in Sprue. Shiga bacillus practically never causes chronic diarrhoea. It kills or is killed, by producing strong anti-bodies.

It may be pointed out here that there is a great difficulty in isolating the B. Flexner group of organisms in all those cases where there is secondary infection. This difficulty is either due to (i) the original infection of B. Flexner completely disappearing or lying latent in the mucus membrane leaving behind the ulcers which get secondarily infected with a haemolytic streptococci or (ii) B. Flexner lies dormant for some time when the secondary organisms find time to get in. In all chronic cases of dysentery, we fail often to get at the flexner organism.

The second phase of the disease is the occurrence of streptococci on the tongue and also in the stools. With the occurrence of these we find a change in the symptoms

of the disease. Rogers and Nichollas in 1914 as a result of successful treatment of Sprue cases with autogenous streptococci isolated from the tongue, suggested that Sprue was due to the infection of the oral cavity, particularly the tongue with the streptococcus viridans. This streptococcus from the tongue and mouth passes down the alimentary canal giving rise to some more symptoms. Absence of hydrochloric acid in the stomach which is a frequent phenomenon in Sprue favours the growth of the Streptococci. But in a majority of cases there was no achlorhydria. In cases where hypochlorhydria is noticed, histamine injections are given and there is the return of hydrochloric acid.

X-ray photographs are taken after a barium meal showed a hurried action of the contents of the stomach into jejunum and ileum owing to the condition of the atony of the pylorus. Regurgitation of the alkaline contents of the duodenum took place into the stomach and so the chloride content of the stomach would be higher. Therefore it is important to estimate both the free hydrochloric acid and the chloride content of the stomach in cases of Sprue. It is not sufficient to find if the patient is hypo-chlorhydric or achlorhydric. We must always find the chloride content in Sprue as there is pyloric atony.

The organism isolated from the tongue was found to be non-haemolytic, but gave positive compliment deviation with patients sera. Nichollas believes that there are two factors operating on Sprue: one the infection with the bacteria and the other is the dietary factor. The streptococci isolated from the tongue are very delicate and are very difficult to be cultured. Vaccines were prepared from them and were used successfully in the treatment of Sprue by Sir Leonard Rogers at the Calcutta School of Tropical Medicine. His method of isolating the streptococci and the preparation of the auto-vaccines for treatment is only feasible in cases of Sprue with the affection of the tongue. But in cases with no lesions of the tongue streptococci can be isolated from the stool by using Conradi-Drigalski medium. These streptococci are found to be either haemolytic or non-haemolytic. The former variety is responsible for the severe anaemia in Sprue. From these streptococci, vaccines are prepared and injected intra-dermally. The

patients who had had this method of treatment are reported to have progressed satisfactorily. Now we have given up Sir Rogers' treatment with the streptococci grown from the tongue in the treatment of cases of Sprue, because (i) cases of Sprue without tongue symptoms are often seen. (ii) of the difficulty of isolating the streptococci from the tongue, even if there is ulceration and (iii) it is far easier to isolate the streptococci from the stool by the use of the above media.

The third phase in the disease is the phase of the infection with *Monilia psilosis*. Kohlbrugge in 1901 found in Java this fungus in cases of sprue which he called *Monilia albicans*. His observation was speedily confirmed by several other workers. Castellani in 1912 described several other species of the same fungus. In 1914 Manson-Bahr in Ceylon isolated the fungus from the tongue scrapplings and from the stool. Ashford in 1915 working at Port Rico isolated a fungus which he named as *Monilia psilosis*. He produced in his experimental rabbits, gaseous diarrhoea, gradual emaciation and death by the injection of the cultures of the fungus. He proved that such cultures are intensely toxic to white mice, guinea pig and rats, when they are injected intra-peritoneally. Michael in 1918 using emulsion of *Monilia psilosis* as an antigen obtained complement deviation in the sera of not less than 400 cases of Sprue. Anderson in 1917 made a thorough study of the normal and abnormal fungi in the intestinal tract. He says that "wild yeasts are present in normal individuals, but the fungi obtained from sprue cases entirely differ from the normal forms". He named these as para-saccharomyces of Ashford. Dold and Fischer in 1918 claim to have experimentally produced a Sprue-like condition by feeding white mice and monkeys with cultures of these fungi.

On the other hand, Manson and Bahr in 1923 recorded failure of producing Sprue in dogs fed on *Monilia psilosis*. Further he recorded failure of isolating *Monilia* from cases of sprue, seen in London. Hence he is inclined to think that *Monilia* is only an accidental or a secondary invader into the gut. He further recorded cases of non-tropical sprue. Recently he is inclined to think that *Monilia psilosis* though not the cause of sprue occurs as a terminal infection,

In a majority of cases of sprue occurring in Madras, *Monilia psilosis* has been isolated by me. I used a special media, *Monilia* grows best in Sabraud's media. The colonies occur either as chalk white, cream colour or transparent. These are, in my opinion, only secondary, the prime cause being the Flexner group of organisms. Mackie and Chitre were invariably led to the same result. They were unable to produce sprue-like symptoms in animals by inoculating them with *Monilia*. Lt.-Col. Knowles at Shillong isolated *Monilia psilosis* of Ashford from three cases of sprue. These strains were found to be non-pathogenic to white rats and guinea pigs on feeding as well as by intra-peritoneal injection. Two of those cases were treated by autogenous vaccine prepared by autolysing cultures of this fungus and both patients recovered.

Mackie and Chitre in the Indian Journal of Medical Research Memoirs 1928, August, studied 252 strains of yeast-like fungi isolated from stools from typical sprue and in other cases they divided the strain into two main groups, A and K. Class A are all maltose fermenters and usually ferment glucose, laevulose and galactose. These are of the type of *Monilia psilosis* of Ashford. Class K are non-fermenters of maltose and this type is *Monilia Krusei* of Castellani. The yeast-like fungi commonly regarded as pathogenic are of the A type. None of the strains are found to liquify gelatin and none are found to be haemolytic. Therefore this fungus is not responsible for the anaemia. The distribution of the different types of yeasts is found by them to be similar in sprue and other diseases as well and no type is particularly frequent in either a diseased or healthy condition. Consequently they adduced no evidence that yeast has a causative relation to sprue. In 1929 April, in the Indian Journal of Medical Research, experiments were reported of compliment fixation with *Monilia psilosis* isolated in sprue cases which all gave negative results. Therefore, there is conclusive proof so far that the fungus *Monilia psilosis* is not a causative factor in Sprue.

(To be continued.)

THE TYMPANIC MEMBRANE AND ITS PATHOLOGY.

BY

DR. T. S. SHETTY, Z.L.O., D.O. (VIENNA.)

One of the commonest ailments a general practitioner comes across and yet often one of the toughest diseases to deal with is pus from the ear technically called otorrhea, acute or chronic. Though this may be due to various minor causes in the external ear, in this and a series of following articles it is my desire to acquaint the reader with the commonly met middle ear disease.

To know the details of the disease it is necessary to know something of the anatomy and physiology of the structures of the middle ear. As the drum membrane is the one structure which is of paramount importance from the examiner's point of view in order to locate the lesion and correctly diagnose its location for chalking out the line of treatment and give out the prognosis to the patient, it is necessary to have clear vision of the normal appearance for the drum membrane. The following structures constitute the middle ear:

1. Membrana tympani.
2. Eustachian tube.
3. Tympanic cavity and its contents.
4. Antrum.
5. Mastoid cells.

Of these, the tympanic membrane can be called the mirror of middle ear disease. It consists of three layers, the outer blending with the skin of the external canal which consists of flat epithelium with cylindrical cells - the inner layer is a reflection of the mucous membrane of the middle ear with cuboidal cells. In between these is the middle layer itself composed of two layers - an outer with radiating fibers and an inner circular layer with non-elastic fibers.

It is almost oval in shape being 8-9 mms. transversely and 9-10 mms. vertically. It has two parts - the pars tensa and the pars flaccida otherwise called Shrapnell's membrane. The pars tensa forms part of the outer wall of the middle ear. The whole membrane is semi-transparent. It is attached to the sulcus tympanicus to the extent of the membrana tensa but the portion of the circumference forming membrana flaccida is devoid of annulus tympanicus and hence the membrane is loosely attached.

Without a reflecting head-mirror it is almost impossible to correctly examine the eardrum. When so examined the drum presents when normal, bluish grey appearance and the most prominent part of it is a protrusion at about 1 o'clock in the right drum and at about 11 o'clock in the left drum to the observer's eye. This prominence is the short process of the Malleus. It is important to note its landmark. Extending downward and slightly backward up to almost the centre of the drum is the manubrium at the termination of which is the umbo slightly flattened. Extending downwards and forwards from the umbo is a cone of light indicated as a bright area with its apex at the umbo and the base at the circumference between 3-5 o'clock in the right drum and 7-9 o'clock in the left ear. In pathological changes this cone of light (C. L. N. Fig I.) may be elsewhere, blurred, broken or absent.

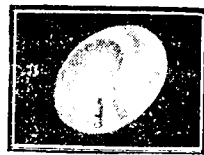


FIG. I.
(Actual size)

Two folds extend—one longer (L. P. Fig. II) the other shorter (S. A. Fig II) from the short process. These folds separate the superior flaccid Shrapnell's membrane from the inferior membrana tensa.

To facilitate description the membrane may be divided into four sections by two imaginary lines—one passing directly downward from the umbo and the other through the umbo perpendicular to the 1st line. These divide the membrane into four quadrants.

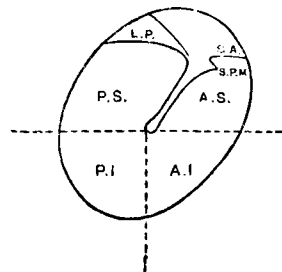


FIG. II.

Name of Quadrants Structures near Quadrants

1. Postero-superior.
(Fig. II, P. S.) Stapes, long process of incus, chorda tympani-nerve, pyramid with stapedius muscle.
2. Postero-inferior.
(Fig. II, P. I.) Mastoid cells, antrum and a little away jugular bulb.
3. Antero-superior.
(Fig. II, A. S.) Opening of Eustachian tube, canal of tensor tympani.
4. Antero-inferior.
(Fig. II, A. I.) Internal carotid.

It is necessary to know the different structures of the middle ear and the neighbourhood in relation to these imaginary divisions of the membrane so that one could diagnose many lesions of the ear in relation to the perforations and other pathological changes in the drum head.

Various changes are produced in the appearance, contour thickness, mobility and intactness of the membrane due to diseases in its neighbourhood as well as systemic.

As the Eustachean tube is the window and ventilator of the middle ear, it helps drainage to a certain extent and also keeps equilibrium of air pressure in the middle ear. When this tube is closed due to any reason, there will be retraction of the membrane. The short process and the two folds starting from it look more prominent and the cone of light is irregular or absent. If air is blown through Siegle's Otoscope the membrane may bulge uniformly. Should however adhesive changes have occurred in the middle ear, the membrane bulges irregularly when inflated due to areas of adhesion not moving.

Acute inflammations due to direct injury of drum-head may occur as well as due to middle ear disease. It is not unusual to see in India at any rate amidst poor class people rupture of the drum membrane as a result of sudden compression of air in the canal due to a blow on the ear. Of the 13 cases that came to me for treatment within a year 11 were females who had rupture of the drum membrane due to blows by their husbands; 2 were men. Of the eleven cases one developed mastoid complications and had a very bad time of it.

In all acute inflammations of the drum-head, the chief part affected is the upper at the level of the handle of the malleus. From the glistening bluish grey appearance it becomes yellowish red and the inflammatory infiltration causes indistinctness of the handle of the malleus. The chief symptom of acute inflammation of the drum head will be ecchymotic condition of the membrane scarlet red in colour and may appear bulged towards the observer. There may be a blister like appearance on the surface. If noted a few days later it may be the whole thing has resolved or a seropurulent discharge is present with a perforation in the area of the original bleb.

In chronic inflammation, the drum head may be retracted due to adhesions to the interior tympanic region. Here the cone of light will be irregular and broken and may be visible as one or two spots of bright area. The membrane may have undergone fibrous changes due to chronic inflammatory process. If so, thickened portions look whitish, lustreless, opaque and dull; chalky white areas may be present where the membrane is adherent. Due to increased thickness of the membrane the handle of the malleus is indistinct, the cone of light is short and irregular.

PERFORATIONS OF THE DRUM-HEAD AND THEIR IMPLICATION.



FIG. III.

(Double Actual Size)

The most important examination is for perforations of the drum-head. The patient comes with a history of slight deafness or with a history of pus from the ear. After cleaning the external ear thoroughly, so as not to have anything in the way of a clear vision of the membrane, one may notice a perforation of varying size in the membrana flaccida, or membrana tensa or in the margins or in the centre around the umbo. It is

very important to locate the perforation, for on this, to a large extent depends the line of treatment for the cure of the otorrhea. Though not pathognomonic, generally speaking, the marginal perforations indicate affections of the bone in the neighbourhood—hence the condition is more serious and treatment needed should be more thorough than if the perforation is more central which may be comparatively called simpler as more often than not, the bone is not involved.

The central perforation (Fig. III P. C.) is mostly due to tubal infections from adenoids, tonsils, ethmoid or sphenoid sinus diseases and where these perforations are present it is no use operating on the mastoid. The treatment is directed to the nasopharynx.

Should the perforation be in the inferior margin of the drum head (Fig. III P. I. M.) it may suggest necrosis of the inferior wall which is in relation to the jugular bulb mostly separated from it by a thick layer of bone. To treat this condition one has to curette the floor but it is not without danger as the bony wall separating the jugular bulb is often so thin that meddlesome surgery may prove dangerous.

The margin of the posterior quadrants (Fig. III P.S.M.) may be the seat of a perforation if so the antrum-mastoid cells and incus may be affected and the treatment is simple or radical mastoid operations after the necessary tests have been made.

There is what is called the attic perforation (Fig. III P.A.) immediately above the short process close to the superior wall. Of all the perforations this is the most difficult to locate and a careful examination is to be made sometimes with the help of a magnifying lens as the perforation may be as small as a pinhead and escape detection. When this is present it indicates necrosis of the tegmen tympani.

If there is a perforation of the membrana flaccida, (Shrapnell's membrane Fig III P.S.) it may be the head of the malleus that is necrosed as it is in immediate relation to the area.

There are cases where the entire membrane may be absent. Though theoretically speaking it gives better facility for drainage and helps a cure, this condition is to be taken as equal in its seriousness to a marginal perforation.

Though by themselves not sufficient, the findings of a proper location of the perforation are a great guide for the line of treatment to be chalked out for individual cases.

It is therefore no exaggeration to say from the foregoing that the appearance and its position, color, integrity and luster of the membrane is an index to the location of disease proper and to the line of treatment to be followed.

(To be continued)

Abstracts

Views of the Health Minister.

IN 1933 AS A PRACTITIONER.

Extracts from the Address of Chairman Reception Committee, Dr. T. S. S. Rajan Annual conference, Trichinopoly District Medical Association.

"Times are changing rapidly. Trained medical men are increasing in numbers and it is a welcome relief to see rural areas are being dotted with them. Cities have ceased to be the pocket boroughs of one or two leading practitioners. We are having scores of them even in small towns, leave alone cities where they are in hundreds. The increase in numbers and consequent competition has brought in specialists in the field and they have become a welcome addition to medical practice. Besides these there is fast growing a set of practitioners who have got trained and qualified in indigenous system of medicine and who are trying to carve out a place for themselves in the medical profession in this country. We shall soon have to recognise them as one of us.

In spite of numerous additions to our numbers I for one do not believe that the profession is over-crowded. Perhaps there may not be much room for more in towns but the rural areas still want practitioners. Thanks to the late Rajah Sahab of Panagal, we are today having a system of aided rural medical relief in our Province. Though there are many defects in its working, still none of us can deny that it is fulfilling a longfelt want and I hope you would agree with me in saying that the scheme must be worked up still more elaborately till at last there is one medical man available for every thousand of the population in the rural parts.

It is not in our hands to prevent the growth of Medical Practitioners nor is it at

all desirable even if we have the wherewithal to do so. In our country, with a threatening problem of the unemployed and unemployable English educated middle class it is impossible to shut out the one or two outlets of professional studies for them. But for the heavy cost of a professional education in a poor country like ours, we should have by now been cramped with medical men.

There is the tradition in our country that medical service was not paid for as is understood and practised in the West. No doubt there have been distinguished Vaidyas in connection with ancient Royal House called Raja Vaidyas who were richly endowed by the Kings of their time but even they were rendering free service to the poor. The feeling of making a demand at a time when a man is in pain is undoubtedly none too pleasant and if we could only render unconditional service to those in need and allow the relief afforded to speak for itself we would have attained the ideal.

In a National State the health of the citizen is a concern of the Government. Just as any civilised State provides for unemployment and old age to all her citizens, it must provide for relief during illness also. Every healthy human life is an economic asset of no mean value and wisdom demands the preservation of this asset both for the benefit of the individual as well as of the State. The question to be decided is how should this necessary consummation be worked out. England has solved it in a way by the National Health Insurance Act whereby the average poor man is enabled to get medical relief in times of need. But here in India not even a beginning has till now been attempted in this direction. With the growth of Medical Practitioners, the question will soon make itself felt. It will no longer be possible to say that there are not enough medical men in the country to inaugurate a scheme of universal medical relief. No one can deny the fact that there are not enough free hospitals in the land to cater to the needs of our ever growing poor population. Though nature finds her way out by an enormously high death rate, such a process neither redounds to the credit of the Government nor to the skill of the medical profession. Till compulsory universal state relief is provided for, the only way in which the remedy lies is in multiplying free hospitals rapidly all over the land.

This can be done in one of the three ways. Firstly the Government may provide for more hospitals by reducing the expenditure in the present ones. This can be done by replacing all the paid staff in Civil hospitals with Honorary men. That there are some difficulties in the initial stages should not deter them in adopting the plan in its entirety at the earliest possible moment. Such honorary service must be made attractive and dignified enough to draw in the best men available in the profession. It is no sin if a young practitioner by his sterling merit in honorary service aspires to establish his reputation with the public and makes it pay. In fact honorary service is meant for it. Only while you are doing honorary service, you should not degrade it by unworthy acts which might make it stink in public estimation. Given fair treatment, convenient hours of work and sympathetic supervision, the scheme is bound to become very popular. Even under the existing irksome conditions, the scheme is attracting a large number of our young medical practitioners both in cities and the mofussil.

Secondly the growth and development of private philanthropy amongst the public by providing endowments for hospitals and Sanatoria would go a long way in utilising the services of the medical practitioners. Such institutions are yet rare in our Province. Bombay with her rich Commercial Magnates has a number of such institutions and the growth of an intelligent, strong and independent medical profession in that city is no doubt due to this fact. These endowed private hospitals have unhesitatingly utilised the free services of the practitioner and in turn he has made himself reliant, resourceful and reputed.

Thirdly, the over crowding in the profession may be utilised by diverting the energies of the more enquiring of us into channels of research and investigation. The research worker unlike the practitioner cannot hope to live by his profession. Science is a jealous mistress and shall permit of no tinkering by his devotees. While she would want the best of us for her service, she will not let us degenerate into the tempting lure of wealth and consequent luxury. I once used to wonder why big commercial houses in Europe and America gave large sums for research work in medicine and science. I am in a way able to understand it now. Any

new discovery is worth the nation all the riches of the world put together. If the life of the individual could be prolonged by as much as five to ten years, imagine what a great economic value the life becomes to the state. If we reduce the man-power of our nation into rupees, annas, pies, we can easily understand the value of such discoveries. If trade in the West is responsible for ninety percent of her wars, it may with equal truth be stated that trade is responsible for ninety percent of her benefactions to science. Scientific discoveries are commercialised. They add to the nation's wealth in two ways firstly by adding to the longevity of the life and thus increasing the man-power value to a state and secondly by the commercial sale of the discoveries of science to the rest of the world.

Nature does not yield her secrets for the mere asking. She bestows her favours to her most devoted ones after years of patient toil and worship at her shrine. But even so a single find is a priceless treasure worthy of the sacrifice of a legion of us. Through it we should have carved out a deserving place for ourselves and our nation under the sun and would have earned the gratitude of posterity. The law of the survival of the fittest is an eternal truth and the fittest are those that have, in their life done something to make this land of ours a better place to live in for generations to come. Today research work in this great sub-continent of India is yet in its infancy and a paltry sum of five lakhs spent by Government last year is all the help it has had. Even this meagre amount is being threatened with emergency cuts and no one need despair if the results are only proportionate. But the fact remains that not much money comes in the way of the medicine research work in this country. We must by our service create enough enthusiasm in the minds of the few well-to-do amongst us for the cause and thus provide the needed support. Medical men are men of science and the merit of the art consists in the practical application of their knowledge to the suffering humanity. In that way it is a real live science capable of appealing even to the lay public.

It is not my desire to enter into a big exposition of the merits of modern science. I have just sketched out a few common place suggestions for your consideration as possible remedies against over crowding in the pro-

fession, for I have often heard it said by our comrades that our profession is getting over crowded. Even over crowding may be made to bring good provided it is diverted into useful channels. Increased efficiency and skill is bound to come as the result of competition and the public will have the benefit of it. Medical service can be had at competitive rates without deterioration in quality and thus even the moderate poor can summon the services of the doctor to his door with due regard to his sense of self-respect without waiting at the crowded gates of a charity hospital".

Subsidised Rural Dispensary Borigumma.

EXTRACTS FROM VISITORS' BOOK

I was very glad to have a chance of visiting the Dispensary at Borigumma and seeing something of what is a very interesting development. Evidently good work is being done here by Dr. Somayajulu. I shall be glad to give something from my discretionary grant for instruments or other purpose, if the Agency Surgeon will kindly put up a proposal through D.H.P.S.

Sd. J.A. HUBBACK, 11-11-36.
Governor of Orissa.

I visited the Rural Dispensary, Borigumma with the Agency Surgeon, Koraput on the 30th May 1936, at 10-30 A.M.

Dr. Somayajulu has been in charge of the Dispensary for the last five years.

The Rural Medical Practitioner Dr. Somayajulu seems to be taking very keen interest in his work and he is doing very good work here. A type of man like him is the best fitted for such work in Rural areas. He gets a subsidy of Rs. 50 per month from the Government and Rs. 360 for the purchase of Medicines. He treats people free of charge. The Local Board contributes, in addition, a small honorarium of Rs. 10 per month for the Dispensary work and Rs. 15 per month for public health work over an area of five miles radius. Amongst the large number of ignorant people he is the only man who is looked up to with some amount of confidence for help and advice. Of course due to his enthusiasm and persuasion he has succeeded in promoting the co-operation of

the local people to a great extent in improving the general Sanitation of the village. He has established a local informal committee of the people resident in the village of which he himself is the President. He has undertaken renewal of the public health activities such as improving the drains, conservancy, water supply, street lighting, etc. Small subscriptions are being raised by the committee from among the people for meeting the expenses for improving the health and Sanitary condition of this village. I am told that the informal committee will shortly extend their activities with regard to anti-malarial measures. The Dispensary appears to be fairly popular with the villagers and the daily average attendance was about 25 which was not bad for a small village like this. The reason is due to the fact that the Doctor is available at the spot for rendering medical aid at all times of the day to the people of the village. He is also available for epidemic work whenever required within five miles radius of his village.

This is the type of young Doctors that we require for settling down in the Rural areas of this Province where Medical advice and aid are difficult to obtain. I hope to persuade a few young Doctors of the L.M.P. Class who are ever after me for Government Jobs to go and settle down in some Rural areas and follow the example of the Rural Practitioner in the far remote Borigumma Village, they may earn a decent livelihood for themselves and be light guide to the poor and ignorant villagers in such areas.

Sd. G. VERGHESE, MAJOR, I.M.S.
*Director of Health and Prison Services
Orissa.*

Visited the Dispensary this morning along with Dr. Stirling the Agency Surgeon.

Since my last visit in May last year considerably more improvements have been effected both to the Dispensary Building as well as in the general sanitary improvements of the village. I am pleased to find that the reputation of the dispensary is being well maintained.

Sd. G. VERGHESE, LT. COL., I.M.S.
D.H.P.S. 22-1-37.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

An Unusual Pituitary Syndrome.

Since Simonds described in 1914 the syndrome produced by destruction of the anterior lobe of the pituitary further confirmation of the wide-spread influence of this gland has been obtained, especially during the last decade. The possible relationship, direct or indirect, of the anterior pituitary and blood formation has so far not attracted a great deal of attraction. I. Snapper, J. Green, D. Hunter and L. J. Witts* now describe a remarkable syndrome of anterior pituitary and gonadal insufficiency associated with achlorhydria, anaemia and subacute combined degeneration of the cord. They present six patients, four men and two women, between the ages of 42 and 58 all of whom had had symptoms of anterior pituitary insufficiency for a number of years and one of whom had signs of a chromophobe adenoma. Insufficiency of the gonads considered to be secondary to hypopituitarism, was shown in these patients by lack of physical vigour and sexual interest or desire, amenorrhoea, and in two cases by small size and imperfect descent of the testis. The facies was dull and expressionless, the movements lethargic, sexual hair was absent, and the hair of the scalp and eyebrows was scanty or absent. The basal metabolic rate, in the four patients in whom it was estimated under suitable conditions, was considerably depressed, but there was no reason to believe that they were suffering from true myxoedema. The skin was soft moist and elastic, there was no subcutaneous oedema, the appearance of the patients bore no resemblance to that of a patient with myxoedema, and the basal metabolic rate, unlike that of myxoedema, was raised by the administration of thyrotropic hormone. All the patients had hypochlorhydria and five complete achlorhydria; anaemia developed relatively late in the course of the disease. In three there were symptoms of subacute combined degeneration of the cord: in one the anaemia was hypochromic and responded to iron, and in two it was of the Addisonian type and responded to liver treatment. The authors consider that the anaemia was essentially gastrogenous and hence an indirect effect of insufficiency of

the anterior lobe of the pituitary. They postulate that anterior pituitary deficiency is followed by achlorhydria, and that the achlorhydria may induce after a long interval an iron-deficiency anaemia, a liver-deficiency anaemia, subacute combined degeneration of the cord, or a combination of these conditions.

(B.M.J. 19th June '37.)

Prevention of Urinary Calculi.

In patients who suffer from some disease of bone needing prolonged immobilization and who at the same time have retention and infection of urine, the presence of calculi in the urinary tract is an unpleasant and not infrequent complication from which every effort should be made to guard them. The patient undergoing prolonged orthopaedic treatment needs protection from this complication just as elderly immobilized patients do from hypostatic pneumonia. The urinary problem has recently been studied by Higgins and Schlumberger of Cleveland, who point out that in patients undergoing orthopaedic treatment several of the known aetiological factors associated with the formation of urinary calculi are aggravated either by their disease or by its treatment. These factors are infection (either local or focal), stasis, hyperparathyroidism, nutritional deficiency, and phosphaturia. Investigations have shown the great importance in these immobilized orthopaedic cases of the nature of the diet and the reaction of the urine—two factors intimately related. Diet, however, is of more importance than its effect on the hydrogen ion content of the urine, because it is known that adequate amounts of Vitamin A are necessary to maintain the integrity of epithelial structures. When a deficiency of Vitamin A exists stratification of the transitional epithelium of the bladder, ureters, and renal pelvis occurs, and this change apparently favours the formation of calculi. As the calculi in these orthopaedic cases are found to consist of phosphates and carbonates of calcium and magnesium, it is important to prevent the precipitation of these salts. The urinary reaction should therefore be kept on the acid side (pH of 5 to 5.2) by an appropriate diet with a high vitamin content and, if necessary, also by the use of acidifying agents such as ammonium chloride. Details of suit-

able acid-forming and high vitamin diets are given in Higgins and Schlumberger's paper, which may profitably be consulted by those who have to treat these patients. It is important to examine the urine frequently in all recumbent orthopaedic cases, to give an appropriate diet, and, as a safeguard, to make an x-ray examination before their discharge from hospital in order to rule out the possibility of a silent renal calculus.

(B. M. J. 19th June, 1937.)

Extracts

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

Otitis Media.

The use of phenol and glycerine in suppurative otitis media is permissible in the early stages. However, its prolonged use produces desquamation of the epithelium of the meatus, and coats the drum membrane. Moreover, its use is apt to mar the symptoms and thus interfere with proper diagnosis.

Burns in the Eye.

The instillation of acids and alkalis to "neutralise" alkaline and acid burns respectively is largely fallacious, besides the possibility of doing more harm than good. The action of the offending substance is too rapid to be thus "neutralised". Nothing is

better perhaps, than the free use of distilled water with a view to dilution.

Tonsillitis.

Bismuth therapy is said to reduce the duration of acute tonsillitis by about one-half. After twenty-four hours of the intra-gluteal injection of bismuth the temperature subsides to normal, the coatings are cast off, and the edema disappears. The dysphagia disappears within six to eight hours.

Q. What advance has been made in the treatment of tobacco amblyopia?

A. Besides the orthodox procedures emphasis is now laid on the value of acetylcholine administered by intramuscular injection. Orr. (Brit M. J. 2: 69 (July 11 1936) treated four patients, giving from 0.1-0.2 gm. daily for about a week; then twice weekly for two to three weeks, and in one case once weekly for six weeks. The patients had central color scotomas and reduced visual acuity which began to clear within a week after the first injection. In one case the return was in six days, in another on the ninth, in a third on the eleventh, and in the worst case on the fortieth day. Vision was 6/12 in two cases, 6/9 in one case and normal in the fourth. The author is enthusiastic about the results and advises the treatment in all cases of tobacco amblyopia. He is also using it in cases of retinitis pigmentosa, but is not ready to report on the results.

THE MEDICAL BULLETIN

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THE Medical Practitioner

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RURAL MEDICAL RELIEF.

It has been a very happy augury that a few Subsidised Rural Medical Practitioners conceived the idea of rejuvenating the Provincial Subsidised Rural Medical Practitioners' Association and the Subsidised Practitioners held a conference in Madras just two days after the leaders of the National Congress made up their minds to accept office in the six provinces where they had absolute majority. After Mahatma Gandhi became the accredited leader of the Congress, this national movement took quite a different turn and the practical lead given by the Mahatma to Village Uplift forced the Governments in different provinces to realise the necessity of diverting their attention to what the Mahatma has been doing to alleviate the forlorn conditions of the villages. It is true that Economic Councils and organisations bearing similar names have been brought into existence by the Governments. But as mentioned in the Presidential Address at the Provincial Subsidised Rural Practitioners' Conference "from the persons constituting these bodies, their functions and other activities so far evident, one is led to smell politics more than the welfare of the villagers. The officials who run the show of these councils, mind Newspaper reports more than actual results. So far, either here or elsewhere those constituting these councils or even those who brought them into existence have not shown signs that the result of these schemes of Village Reconstruction should be an increase in the health and welfare of the village community". The Government of this province and of five more provinces is now in the hands of Congressmen who have made it plain beyond any doubt that the village reconstruction

will be their first concern. The Prime-Minister of Madras declared on the very day the Conference met that, "The first result of this identification of the Congress with the Provincial Administration should be that in every village there should be a Congress Sabha which functioned in reality". The public expect that the congress as a political party would mind its most lofty ideals and not the forms and will be tolerant to co-operate with those who cherish these ideals as honestly as those who are now on the saddle of the Government whether it be in rural or urban areas. There may be at least a few here and there who do not wish to identify with any political party but are second to none in their zeal 'for raising the status of India to that of a completely free country.' They may not have the nerve to be congress soldiers though their hearts are with congress ideals. They may be too weak to wear the congress armour yet their hearts may be full with patriotism. The electorate that backed the Congress during the elections not only in this province but in other provinces also, are not all congress soldiers wearing the congress uniform. Those not wearing the congress uniform are in absolute majority in the electorate than the very few who wear them yet they did solidly vote for the congress even knowing that all that glitters is not gold. We are sure that the Prime-Minister can diagnose the condition of the hearts of the villagers more than medical men may profess to do. The public know that he gave up the urban materialistic life and chose to live a life of service and contentment. He has led a life of sacrifice in the true sense. He never dreamed nor did the public think that he would be at the Head of the Government of this province. He has been able to com-

mand influence and authority without worshipping Mammon. The spirit of tolerance has been amply demonstrated by the Prime-Minister who did not mind going a bit out of the way in selecting as his Lieutenant Dr. Rajan, taking advantage of a very fortunate circumstance that His Excellency kept two seats vacant in the Upper House without nominating anybody till the Congress assumed office. It was indeed a very very pleasant and as welcome a surprise hailed with joy by the medical profession. We are delighted that the fond hope of The Medical Practitioner given expression to in the Editorial appearing in its September 1936 issue under the caption "Reforms and Responsibility" has been realised though not in the form we wished. We did send this issue to Mr. C. Rajagopalachari with our best compliments and wonder whether he had read the article, so also to Dr. Rajan who is on our complimentary list ever since The Medical Practitioner came into existence. The Prime-Minister did also demonstrate that politics is a science of good Government for the welfare of the people and that all departments of the Government exist for the welfare of the public only, by choosing as his Lieutenant a tried Congress medical man to take charge of the Public Health Portfolio. The party of which the Prime-Minister is the Head having chosen Dr. U. Rama Rao as the President of the Council the shrewd and as vigilant Prime-Minister took advantage of nomination and had Dr. Rajan in his team. There is yet another fortunate event which we wish to mention and that is the choice of the Parliamentary Secretary to the Public Health Minister. The public might not know as much as we and the medical profession does how useful Mr. A.B. Shetty has been in the past not to allow the medical department to drift more than it had been drifting under the old Ministry. It looks as if Mr. Rajagopalachari has been noting the activities of Mr. A.B. Shetty as the popular representative in the old council. We may safely say that the interests of the profession and the public are safe under the new Government unless something unexpected happens.

It has been recognised by all including the right royal Representative of His Majesty King Emperor that the foundation of good Government are the villages. The fact that Mr. Munuswami Pillai a Harijan leader who

though a nominated member in the old Legislative Council, was always with the people unlike his other Harijan comrades least expecting he would be a Minister under the peoples' Government, is the Hon'ble member in charge of Rural Development, is another happy incident to be noted with great satisfaction. The judicious selection of Mr. Giri who is known for his devoted concern for the poor himself not being amongst the unfortunate, as the Hon'ble Minister to administer subjects connected with labour and co-operation, is hailed with acclamation not only by the poor but the rich as well. It is said that Hon'ble Mr. Gopala Reddi trained as he is under the most imaginative yet as practical a Poet and Sage of India will be an ideal person to be in charge of Local Self Government in spite of his youth. Finance and Revenue are under the charge of two inseparable comrades who know the value of money and also its limitations. With a team whose record of work for the country has been measured, the future of Rural Medical Relief and Rural Sanitation may be said to be secure. The Head of the Medical Department who has been virtually the adviser to the Government in the past, will soon receive a deputation of the representatives of the Subsidised Rural Medical Practitioners who will suggest the need of immediate reforms in the Rural Medical Relief Scheme to be placed before the Government with the hope of evolving an ideal Scheme in the near future. Though nurtured under the bureaucratic Government, Major General Sir Frank Connor has shown during his administration democratic tendencies at least in matters unconnected with official interests. That the organisers of the Conference were justified and rightly so in requesting him to open the Subsidised Rural Medical Practitioners' Conference could be seen from the few sentences appearing in his address. Sir Frank Connor said amongst other things:

"The rural practitioners must all be aware that ever since I came to this presidency I had a very soft corner in my heart for the rural medical practitioners and rural medical practice. I know the necessities of the countless numbers of people living in rural areas most of whom received no medical aid. It is a very difficult thing for the Government or the Surgeon-General to grapple with such a big problem. You have in this province a huge population a great many of whom were poor, and it is not possible for many years for any Government to give free medical aid to all the

poor people in the rural areas. This problem has been exercising my mind very much. Whenever I went in the rural districts I attended the associations there and always wanted to know how the rural medical practitioners were getting on. You will, at the present conference pass many resolutions and these would have my best attention. I would say that the chief function of the conference should be for you to meet one another and discuss your problems, and find out in what reasonable ways your difficulties can be removed and your conditions ameliorated. In other words, the object of the conference should be to take stock of these conditions and make wise plans for the future. I would certainly help you. The Government will also help you."

Later in the concluding remarks of Sir Frank Connor is found the following sentence:

"Many of your grievances are just and could be redressed only if they are reasonable".

When the Head of the Government which was bureaucratic till the 7th July certifies that at least some of the grievances of the Subsidised Rural Medical Practitioners are just these unfortunate members of the medical profession settled in villages, can certainly hope that under the present Government by the people for the people, with a team of tried leaders of ideal democracy whose foundation of good Government will and has to be built in villages, that the Rural Medical Relief scheme will be an integral and most important part of the activities of the Government serving as key-stone of the arch of the foundation of good Government.

At the Conference of the Subsidised Rural Medical Practitioners, Major General Sir Frank P. Connor did not stop his address by merely saying that the grievances of the rural practitioners are real and just but placed before them the true spirit of service. He said.

"We doctors have been taught to give relief to the poor for nothing. The spirit of service must never leave us. But we are not all missionaries. I think the predominant note must always be that of a certain amount of sacrifice on your part towards the problems of India, and I say that until individuals, young individuals, give a great deal of their time and leisure and service for the country, the solution of problems will get on very slowly. Thousands and thousands of young men in other countries as in Germany are working like coolies in labour camps, to turn marshy lands into cultivable ones. That is the sort of thing that makes a country go ahead. When that happens in India, India will go ahead and you have a share in that picture".

The President of the Conference exhorted the Subsidised Rural Medical Practitioners to work the Scheme in a missionary spirit with a motto, "I am my brother's keeper." All the same he pointed out that so long as a paid medical service existed, the village practitioners should be given subsidies sufficient to encourage qualified practitioners to settle in villages. The President pointed out how without additional financial commitments Government can divert public funds for village uplift work in regard to medical relief and sanitation.

The immediate reform demanded by the Rural Medical Practitioners is the deleting of the most objectionable conditions in the agreement form between them and the Government which prohibit the practitioners from taking part in civics and politics. Regarding their urgent grievances, they demand simple structures for the location of dispensaries and for their habitation, a compounder or at least an attendant, a midwife, both of whom under their control, a substantial increase in their subsidies to enable them to have a bare living. They are prepared to shoulder any responsibility in curing or preventing human ailments but wish not to be treated as menials or tools. They claim that they should have holidays at least for 30 days in a year and should be treated as independent practitioners which they really are. They would avoid official or non-official interference with their work except to the extent that the subsidies paid to them are not misused. They will soon prepare a scheme of Rural Medical Relief and Rural Sanitation to be an integral part of existing or any future schemes of village reconstruction consistent with the spirit and principles of those schemes. Gandhiji who influenced the Working Committee of the Congress and other Congress men to accept office did place before his disciples through the columns of the Harijan, the ideals of service to be followed by those who had to run the future Government. He says amongst other things that "attention should now be devoted more to the villages and the peasantry than to the Cities". Hon'ble Dr. Rajan has given the medical profession including the Medical services an opportunity of having a vision of his aims and policy. The Minister knows that free medical aid including free supply of medicines should be diverted exclu-

sively to the Rural Dispensaries and that the words 'free medical aid to the necessitous poor' appearing in the agreement of the Subsidised Rural Medical Practitioners should be deleted from that agreement and made to appear in bold types on the walls of all the Government Medical Institutions in Urban areas, where excepting a bare minimum of medical officers for administrative work, all the staff should be honoraries. That members of the medical profession are capable of administering or initiating any scheme of public utility needs no mention. The Hon'ble the Minister in charge of the Medical Portfolio and the Hon'ble the President of the Legislative Council are living examples before the public and the Government. The humble and down-trodden Subsidised Practitioners here and there have demonstrated that in spite of the humiliating position they are kept under, it is possible for them to do useful village uplift work in addition to their legitimate duties. We know of at least two such practitioners, one in Trichi District running an elementary school where even Harijan children are admitted, the school being run by villagers themselves, very near a Brahmin Temple. Another subsidised practitioner in a village called Borigumma, Vizag Agency now in Orissa Province, is an ideal to be followed not only by his professional brethren residing in other villages but also by the lay public. Elsewhere in the Abstracts Columns we have published the opinions expressed by the Head of the Medical Administration in Orissa and also by the Head of the Government of Orissa, His Excellency J. A. Lubbock regarding the village uplift work turned out by this subsidised practitioner.

Subsidised Rural Medical Relief Scheme was first started in Madras Presidency. United Provinces is another province where few subsidised practitioners of the Madras type exist. We trust Hon'ble Mr. Rajan will soon be able to launch a scheme of Rural Medical Relief with the active co-operation of the Subsidised Practitioners and show a lead to the other provinces in India, at least to five of them where peoples' Government has been established.

PRINCIPAL, MADRAS MEDICAL COLLEGE.

Delay in filling the vacancy of the post of the Principal, Madras Medical College, caused by Lt. Col. Plumptre going home on leave for four months, has given room for speculations in the medical circles. Some say that the Interim Minister then in charge of the medical portfolio suggested that a senior Medical Officer belonging to P.M.S. was in his mind but he preferred the question to be settled by his successor. Others say that the suggestion appearing in The Medical Practitioner in the January-February combined issue and repeated in May 37 issue is likely to be favoured as an experimental measure as the Head of the Medical Department had the same view and wished to try the experiment when Lt. Col. Croly was Superintendent of the General Hospital. The present Surgeon-General was once the professor of surgery, Calcutta Medical College. It is likely that the Surgeon-General got the idea from Calcutta as the Superintendent of the Calcutta Medical College Hospital is the Principal of the Calcutta Medical College. It is now rumoured that the chances of combining these posts into one are very few and that His Excellency who is the final approving authority, has before him two names belonging to P.M.S. The suggestion appearing in The Medical Practitioner in its two recent issues is not a novel one. The same suggestion has been made more than once in the past. As was mentioned in the Medical practitioner, years ago the Administrative Head of the Government General Hospital was styled as Senior Medical Officer and he did not do professional work in the Hospital. He was also the Principal, Medical College. Later the ambition of individual medical officers in the I.M.S. was responsible for splitting one appointment into two though till then, one senior most I. M. S. officer carried out the duties of two posts quite efficiently. Both these officers were allowed the benefit of private practice with the result one could see now in these institutions, especially at the General Hospital where the chances of efficiency of administration depends upon the officer and not on the responsibility of the post itself. There was also a time not far when the Principal of the Medical College was a very busy practitioner and he could hardly find time to do justice

for the two administrative posts as Principal medical college and Superintendent of a special Hospital. One can very well imagine the state of disruption in medical institutions where the administrative officers do not find it possible, due to multifarious duties, to fix regular hours of attendance. So when occasions arose The Medical Practitioner pointed out to the Government the necessity of reverting to the old order of things.

The present occasion when there is a temporary vacancy of the post of the Principal, Medical College, was considered by us as a very suitable opportunity for suggesting to the Government the desirability of entrusting the administration of these two institutions to one person, the present Superintendent of the General Hospital. The fact that this officer has been found to enter the hospital gate first, early morning at or about 6-30 and is seen on his administrative chair till about 4 p. m. and is also popular with the staff, persuaded us in public interest and in the interest of medical education, to have recourse to old order of things and to combine the two offices into one and style this officer as the DEAN of both the institutions. Such a step will be in accordance with the principle followed in the medical institutions at Calcutta, Patna, Mysore, Hyderabad, Lucknow and a few other places. The old ideal that existed in Madras is the ideal followed in all medical teaching institutions in other civilised countries where the Head of the teaching institution is a whole time officer not enjoying the privileges of private practice. In this respect no medical teaching institution in India comes to a level of those in the west or in America excepting the Seth G. S. Medical College, Bombay and the hospital attached to it both being under the charge of one Dean. The Medical Practitioner is second to none in its zeal for Indianisation of services. Want of discretion should not frustrate the purpose of Indianisation. To have a superintendent of a special hospital which is two miles away from the Medical College as its principal is not a sound administrative policy in itself. It is more objectionable if the person in charge of the two administrations is a busy practitioner. Selection of an officer to be in charge of an administration should not depend upon an artificial seniority alone. The one to be selected must have previous

administrative experience either in a teaching institution or in any other responsible office. An administrator should be a whole time officer and should not have private practice at all. It is also desirable that the popularity of the officer should be taken into consideration. Communal bias should be out of consideration. This seems to be possible in Madras under the regime of the present Government. The Hon'ble member in charge of the Medical Department is fortunately a medical man having had professional training both here and in the West. He knows that in Great Britain, all university and non-university medical colleges and schools have as their administrators eminent medical men who gave up extensive private practice to covet the honorable and onerous responsibilities as the Head of the teaching institutions. The policy of vested interests should be put an end to for higher purposes. His Excellency the Governor knows the ideals followed in his own country and is expected to encourage such ideals in Madras if his popular colleague in charge of the medical portfolio points them out. The senior most member in the medical department who is qualified for the post and who is willing to devote himself entirely to the Administration of the General Hospital and the Medical College may be offered the combined post. Such a post will ensure economy and efficiency, the patients in the hospital will be happier than they are now and the medical students will have the benefit of much better training. The medical profession and the public will gratefully admire the new government for the first forward step towards reform which far from affecting any safe guards will ensure the safety of cordial and harmonious relationship between two institutions, the Madras Medical College and the Government General Hospital. While going to the Press we learnt that Rao Bahadur Dr. Lakshmanswami Mudaliyar had been appointed as the Principal, Madras Medical College. We congratulate Dr. Mudaliyar. He is the first Indian to deserve this honour and trust that the first Indian Principal will justify the trust the Government have in him by encouraging the realisation of the ideal referred to in these columns to have one Dean in charge of two teaching institutions, the Hospital and the College.

MEDICAL BUDGET.

The entire medical profession in India is rejoicing that a disciplined political party which has solid majorities in the six provinces, has assumed office. The profession rightly entertains hopes that will soon take its legitimate place in the affairs concerning the teeming millions residing in India. The fact that the Ministers in the two major provinces of Bombay and Madras are medical men and the Chief Minister in the Central Provinces is in charge of medical portfolio must have also strengthened the high expectations in the minds of the members of the medical profession. The uniformity of administration of different departments of the Government which is expected to prevail in the six provinces, during the Congress Regime, is yet another feature to be noted with great satisfaction not only by the medical profession but also by the public as a whole.

Madras being the centre of activities of The Medical Practitioner, we had much more opportunities of studying the Medical Budget and watching the interests evinced by the popular representatives on the floor of the Madras Legislative Council. We had occasions to read the proceedings of the Bombay Legislative Council for the past few years. Amongst a few that sat opposite to Treasury Benches who took keen interest in discussing the policy of the past Government in regard to Public Health, Mr. A. B. Shetty is the only popular representative who has been returned to the council on the congress ticket. There are two or three more in the new Legislative Assembly who were also sitting along with Mr. A. B. Shetty but these two concerned themselves more about the representation of their communities in the Provincial Medical Services than in topics of general public interest. Mr. A. B. Shetty concentrated his attention to build up a strong medical profession in this province; for he must have realised, as we have, that the first concern of the profession is to have an organised medical profession. He might have rightly thought that other big problems concerning Public Health could be efficiently solved soon after there was an independent medical profession. The Medical Department has been active so far to afford facilities to the officers of the department to make themselves felt in the medical pro-

fession at the cost of unpaid and independent medical service. Under the old Dyarchial System of provincial Government the privileges of private practice enjoyed by the paid whole time medical officers extended to the running of chemist shops, laboratories private hospitals not to mention of agency service to chemists either in the very building where the chemist business was conducted or in an adjacent building. Though Mr. A. B. Shetty was able, to a certain extent, to close down some of these activities of whole time officers of the Government in the city of Madras, these trades are being run surreptitiously by at least a few in the medical department as the Government have not so far adopted the sound principle of transfers of City Medical Officers which has been made applicable even in the case of high officers in the Government Secretariat, knowing as they do that even Governors and Viceroy's can hold office for only a period of five years. It took the Government several years to decide that running of private hospitals by the whole time officers of the Government was a trade, though this trade was run in more than one place by the Heads of Administration of Government Hospitals with a team of subordinates working under them. The Government could not see or hear the activities of these trades though members of Legislature had the benefit of such activities in the past.

So the discussions on the floor of the Local Legislative Council centred round the grievances of the members of independent medical profession and of the public, especially the poor amongst them who complained through their representatives that they could not get the benefits of medical relief in State Hospitals. Consequently it was not possible for the popular representatives to conceive the higher fundamentals of justifying the existence of the Public Health Department under the Government. The order of things will be or has to be quite different during the Congress Regime. Out of six provinces under the supreme sway of the Congress there are at the Head of the Medical Administration medical men of eminence in three provinces and Madras is exceptionally lucky to have a Minister who has a knowledge of the Medical Department and the Medical Profession from the bottom to the top. We

AN APPEAL.

We refer our readers and the members of the Legislative Bodies to the views expressed by Dr. T. S. S. Rajan in 1933 as a private practitioner and the recent speeches made by him during the congratulatory functions arranged to honour him soon after he assumed office as the Public Health Minister. These public utterances should guide the people's representatives even sitting on seats opposite to the Treasury Benches that the Public Health Minister under the Congress Regime knows well what is going on inside and outside state hospitals and all concerned should concentrate their attention on bigger problems such as medical relief in villages, population welfare problems such as housing, overcrowding, general nutrition, maternity and child welfare, combating of social diseases such as tuberculosis syphilis etc. The Health Minister knows that all the above problems cannot be solved by the Government however rich and that the independent medical profession should be requisitioned for helping the Government to enable the public under their care to live healthy lives. He also knows how to secure medical relief to the masses. For this purpose his ideal seems to be not the Out-patient Departments, but the inauguration of National Health Insurance through the panel system. He had publicly announced that real medical relief is to be found in hospitals. He had a plan that even charitable hospitals should be the concern of the rich philanthropic citizens. More than anything else, he is of opinion that the members of the medical profession have splendid opportunities of persuading the people to own medical institutions of their own. We trust Hon'ble Dr. Rajan will give expression to his views by practical work in this province to be followed in other provinces where the attention of the popular members of the legislature has been directed so far to implant a brown bureaucracy in the place of white one. We trust the Medical Profession here and elsewhere will immediately begin to make hay while the sun shines. The implication of this adage, we hope, will not be lost sight of by the members of the profession in all the provinces.

We trust the readers of The Medical Practitioner will realise that even for the building up of a solid independent medical profession in the country, the work should begin in the rural areas. The rural medical relief scheme will be a failure if it is meant only for finding employment for members of the medical profession. If the medical profession desires to have a legitimate share to build a nation in India worthy of her ancient ideals, it is the rich and well-to-do amongst the members of the profession that should girdle up their loins and be prepared to shoulder the responsibilities of village uplift without which it is impossible to have an Indian Nation worthy of its past. We have been endeavouring to encourage the Rural Medical Relief Scheme with a much higher vision than that of finding employment to a few unfortunate medical men in the rank and file of the profession. We therefore appeal to the readers of The Medical Practitioner to go through the proceedings of the Conference of the Provincial Subsidised Practitioners' Association and suggest to us ways and means of remodelling the Rural Medical Relief Scheme to serve as a sound foundation for the building up of a strong medical organisation in India. Madras, though nicknamed 'the be-knighted' is far advanced in its ideals of medical relief. The Subsidised Rural Medical Relief Scheme is an example and if this is worked on sound principles to help village reconstruction, other provinces will naturally follow suit. With all the inherent defects of medical administration, Madras has been harbouring ideals of democracy in the medical profession which is not so much in evidence in other advanced provinces. The rank and file in the medical profession have been evincing more interest in public welfare in this province. The last elections to the Legislative bodies in Madras province have proved this fact. Madras has a Public Health Minister who rose from the rank and file of the medical profession; so also the President of the Legislative Council and the Legislative Assembly has at least to our knowledge three more such members in addition to the Minister. One amongst them belongs to the fair sex.

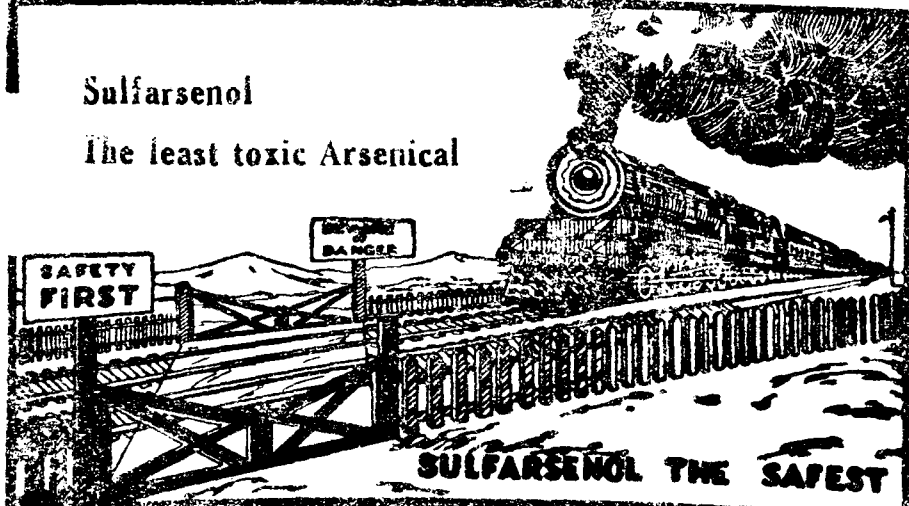
It is needless to say that the medical profession is grateful to the Congress leaders for having recognised the need of medical men

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in the Cabinet. We trust that the medical profession will rise up to the occasion and begin the uplift work both of the profession and the society in the villages and make India an independent country, not for waging wars but to establish world peace.

held by him at the time of his retiring was the Superintendent, Government Royapettah Hospital Madras.

The late Dr. Kamath was a kind sensitive man, his didactic private utterances and his swiftly formed opinions might have belied his true character; but those who knew him intimately and the members of the medical profession who consulted him even for the first time were rarely deceived. Though an uncompromising critic, he never gave expression to his views unless forced to do so by circumstances beyond his control. Dr. Kamath was a person who interested himself with all problems of human welfare and society but never showed a desire to mix himself anywhere except with the hospital patients and staff and the members of his household. He was a capable medical man though known only as an eminent physician. He was an ideal medical officer whose character was unimpeachable. His official career was exemplary and may be followed with benefit by the old and young generation in service. It is not exaggeration to say that Dr. Kamath's knowledge was of encyclopaedic type, both as a teacher and a doctor.

A wide circle of the members of the medical profession, students and patients feel that an eminent medical guide and a sage has gone from amongst them for ever. May his soul rest in peace.

OBITUARY

With deep regret we have to announce the death of Dr. M. L. Kamath, B.A., M.D.C.M., retired Civil Surgeon of the Madras Medical Service, which took place early morning on 7-7-37 at his residence in Madras.

Dr. Kamath was the Arts graduate of the St. Aloysius College, Mangalore. He joined the Madras Medical College soon after he left the Arts College and passed the M. B. C.M. degree in 1904 and entered service as a teacher in the then Medical School, Vizag. After serving in various capacities as a medical officer in the position of Asst. Surgeon in the mofussil, he was for some years teacher of medical schools in Vizag, Calicut, Madras and then served in Madras, as a Physician, General Hospital, and Professor of Physiology. A few years later he was the Professor of Physiology, Vizag Medical College and afterwards was appointed Superintendent, King George Hospital, Vizag and Professor of Medicine, Medical College in the same place. The last appointment

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