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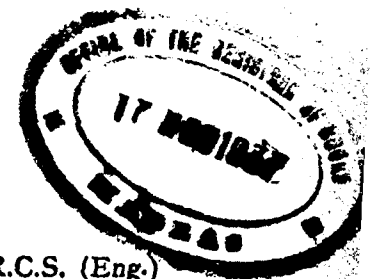
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**Medical Practitioner**  
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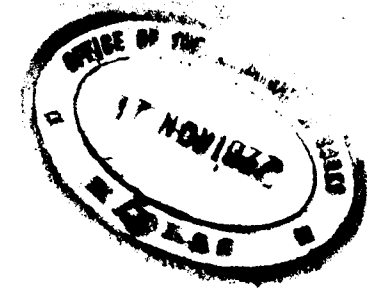
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# THE Medical Practitioner

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## Original Articles.

### SPRUE.

BY

DR. K. NARAYANA MURTHI, M. D.

(Continued from last issue.)

### DIFFERENTIAL DIAGNOSIS.

The principal diseases with which Sprue is likely to be mistaken are (1) hill diarrhoea (2) low country morning diarrhoea, (3) chronic dysentery, (4) Chronic pancreatitis and carcinoma of the pancreas, (5) certain flagellata diarrhoeas, (6) famine diarrhoea and other nutritional forms of diarrhoeas, (7) coeliac disease, Idiopathic steatorrhoea, (8) a diarrhoea common in Indian women during puerperium called 'Sutika', (9) a diarrhoea in young adult Indians often associated with a pernicious like anaemia called 'Asthenic diarrhoea', (10) tuberculous enteritis and lymphadenoma of the mesenteric glands, (11) stomatitis, (12) mucous diarrhoea in infants, (13) Gastrocolic fistula and (14) Addisonian anaemia and (15) pellagra.

The first named disease which has a close resemblance to Sprue is *Hill diarrhoea*. Certain hill stations and sanatoria in India have a predilection to produce diarrhoea in the Europeans. Cases have

been reported from Simla, Darjeeling, Nainital and such hill stations on the Himalayas, but Coonoor and Ooty are comparatively free. History of residence alone at the hill stations with absence of mouth symptoms, and almost immediate relief brought about by a change from the hills, clinch the diagnosis.

Low country morning diarrhoea has been described by Castellain occurring in Ceylon and its symptoms are almost identical with the hill diarrhoea. The loose alluvial soil found suspended in the water might account for the diarrhoea in the people residing in the deltaic areas and in the Indo-Gangetic plain. The same points of distinction pointed above differentiate it from Sprue.

Chronic dysentery, especially the amoebic form, can be diagnosed by the absence of mouth symptoms, by the motions not being typical, by the presence of blood, mucus, vegetative forms of amoebae, if acute or its cysts in chronic stage, Charcot-Leyden crystals, griping and tenesmus and a thickened sigmoid and descending colon. Manson-Bahr says in his Text Book of Tropical Medicine "that there is considerable amount of evidence of the close association between Sprue and amoebic dysentery. The two diseases often co-exist, while on occasions, Sprue appears to be grafted on to intestinal amoebiasis. Possibly too, in the apparent absence of this disease from Central Africa

may lie the clue to its true aetiology. At any rate Sprue is a frequent sequel of amoebiasis". The author in his investigations was led to the same conclusions. Chronic bacillary dysentery is not easily distinguishable from Sprue. The diagnosis can be arrived at by radiological examination.

**Chronic pancreatitis and carcinoma of the pancreas:** The distinguishing symptoms of these diseases are absence of mouth and tongue symptoms, presence of tenderness in the epigastrium and the passing of Cammidge's crystals in the urine. These point out that it is chronic pancreatitis. The presence of Cammidge's crystals is not decisive as they are found in other diseases also. The estimation of urinary diastase, which is always high in chronic pancreatitis, will help in the differential diagnosis. The neutral fats in the faeces predominate in pancreatitis.

**Flagellate diarrhoeas:** Certain flagellates like *Giardia of lamblia intestinalis*, *Chilomastrix mesenili* etc., may produce white frothy stools and fatty diarrhoea. But the identification of the flagellates or their cysts clinch the diagnosis. *Giardia* is now regarded as a harmless commensal.

**Famine and other nutritional forms of diarrhoeas** are caused by a low vitamin content and by a large carbohydrate content in food. If the vitamins are given the diarrhoea is checked. Raw tongue is absent, but other signs as emaciation, bloated abdomen and diarrhoea are present as in Sprue. This is a fairly common condition met with in Indians. History of starvation, fatigue, diarrhoea with mucus and blood and wasting without evidence of tuberculosis clinch the diagnosis.

**Coeliac disease** (Gee's Coeliac diarrhoea or the Gee-Herter syndrome) is described as occurring in Europe, in children under 10 years of age and is also seen in those of European parentage returning from the tropics. This is a fairly common disease among the Indians also between the ages of 1 to 5 years. The etiology of Coeliac disease seems to be entirely different from Sprue. The stools greatly

resemble those of Sprue in chemical composition and in appearance. The disease is characterised by diarrhoea, meteorism, stunted growth and incomplete sexual development. The tongue and mouth symptoms are absent. There is no severe anaemia. The infants improve if they are treated with a fat free diet. The idiopathic steatorrhea in adults is identical with coeliac disease in infants. Possibly idiopathic steatorrhea is the same disease described by Thaysen as 'non-tropical sprue'. Bennett, Hunter and Vaughan described non-tropical sprue having cutaneous lesions, megacolon, lens opacities, gross bony deformities and tetany. From Madras recently Capt. Krishnaswamy reported cases of steatorrhea in adults as quite a different disease from Sprue.

**Sutika:** This disease was first noticed in Bengal. It begins with diarrhoea some 2—3 weeks after delivery. The stools are passed 5—15 times a day. They are watery, frothy and fermenting, but contain no mucus or blood. There is loss of appetite and symptoms of dyspepsia are present. No vomiting, nor griping or abdominal tenderness can be found. There is an irregular fever lasting for months. Oedema of the feet may be noticed as a late symptom. The course of the disease varies. Absence of tongue symptoms, fever and the history of the disease coming after delivery clinch the diagnosis.

**Asthenic diarrhoea** resembles senile diarrhoea. It is very chronic in its course and the patient suffers very little from it. Careful examination for organic disease should be made before concluding the condition as simple asthenic diarrhoea.

**Tubercular enteritis:** Temperature and absence of tongue symptoms and ascitis differentiate it from sprue. At times signs of tuberculosis elsewhere may be found. Guinea pig inoculation with the ascitic fluid, if present, reveals the presence of tubercular bacilli. In *lymphadenoma* the mesenteric glands can be palpated. In *tabes mesenterica* there is diarrhoea.

**Stomatitis:** All forms of stomatitis may be accompanied by diarrhoea. The stools however are not characteristic. e.g., they are not greenish brown, frothy and copious.

**Mucous diarrhoea in infants and pellagra** are other uncommon diseases that have to be distinguished from sprue. The absence of skin lesions and neutral symptoms differentiate pellagra from sprue. In pellagra, the tongue is inflamed and painful all over the whole tongue. But in sprue, the inflammation is confined to certain definite and circumscribed areas on the tongue. Atrophy of the lingual papillae takes place in many diseases where stomatitis occurs. Salivation is another common symptom in all cases of stomatitis.

**Gastro-colic fistulae** may cause symptoms closely resembling sprue. N. H. Fairley and Kilner have described 3 cases with glossitis, fatty diarrhoea and anaemia in which previous gastro enterostomy had been performed.

I am inclined to believe that most of these diarrhoeas, especially the hill diarrhoea, mucus disease in infancy, Sutika and asthenic diarrhoea in young adult Indians often are associated with a pernicious like anaemia and are all probably due to secondary infection of the gut with streptococci as post-flexner phenomenon. These cases improve marvellously under vaccine prepared from the streptococci. These streptococci are often haemolytic and as I have said before can be recovered from urine or faeces.

In conclusion it may be said that Sprue can be distinguished with certainty from other diseases mainly by biological tests and radiological examination of the gut after a barium meal.

(To be Continued)

## \* TUBERCULOUS DISEASE OF THE SPINE.

### PART I

BY

LT. COL. M. M. CRUICKSHANK, M.D.,  
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*Tuberculous disease of the spine* was described by Pott in 1779, who did not of course know that the condition which he so accurately depicted was due to a tuberculous erosion of the vertebrae.

The importance of the disease lies in the fact that it bears a mortality of 40—50% and that its sequelae are, an unsightly deformity in most cases, and a spastic paralytic paraplegia in a certain number of cases.

The method of infection depends on (1) the peculiarities of the vertebral blood supply and (2) on the relation of the Thoracic duct to the vertebrae.

A vertebra has four sources of blood supply:—

1. through the main nutrient artery which enters the body posteriorly and travels forward in the bone marrow,
2. through epiphyseal vessels, two twigs which supply the bone next the epiphysis and the epiphysis itself.
3. through a periosteal blood vessel which enters the body on its anterior surface.
4. through various small branches, which enter the ventral aspect of each transverse process.

As the Thoracic duct passes along in relation to the vertebral column, lymphatics pass from the duct into the

bodies of the vertebrae and thus is explained the condition when many vertebrae are affected with the disease over a wide area.

#### **PATHOLOGY.**

Two types are described, depending on the blood supply of the parts affected.

1. *An osteomyelitis*, found in juveniles (5—10 years), where the organisms enter by the main nutrient artery of the vertebra and settle *nearer the anterior half of the body*. The bone rarefies, caseation and suppuration occur and the body of the vertebra breaks down; the anterior part, lacking the support and buttressing of pedicles, transverse processes, laminae and spines, collapsing with the production of an angular curvature. *Two contiguous vertebrae and the intervening intervertebral disc are affected.*

2. *A periostitis*, found in adults, the organisms entering by the periosteal arteries, that is anteriorly, affect the anterior part of the body and periosteum, *with wide spread superficial caries*, and so producing little in the way of angulation. The disease may attack and spread between the discs and bodies of the vertebrae.

The exciting factor is probably a trauma, resulting in a periosteal tear, from undue traction of the Psoas muscle followed by a subperiosteal effusion, this deciding the site of the lesion, the tubercle bacilli being borne by the blood or lymphatic streams.

*Tubercle may affect any part of the spine*, but is usually confined between D 4 and L 2. With the exception of the atlas and axis, where ligaments are primarily involved, the disease commences in bone.

*The pathological process*, an osteoporosis, is probably the result of liberation of H—substances with a resulting hyperaemia. The myxomatous changes in the bone marrow which precede the actual development of tubercles is due to the toxins circulating in the blood causing an endarteritis obliterans, a late development in tubercle. The osteoporosis is the result of the long continued hyperaemia. The final result is the development of a

kyphosis, the expected support of new bone not being forthcoming as in other forms of osteomyelitis.

This development of Kyphosis is in some degree welcome, for the *consolidation of natural cure depends on this collapse*; a most important point to bear in mind and one which is unfortunately overlooked when treatment is considered.

Paraplegia may appear before there is any evidence of spinal deformity and thus confusion may arise.

Professor Sorrel and Madame Sorrel-Dejerine held that most cases of Pott's paraplegia fell into two groups, *one of early onset*, the other of *late onset* and that two different clinico-pathological types should be recognized which have an entirely different etiology. They mentioned also a third type with a transitory paraplegia.

#### **(1) Early onset of paraplegia.**

It is well to remember that there are non-mechanical factors as well as mechanical factors producing paraplegia and that paraplegia, the result of nonmechanical factors, will not necessarily be retrieved completely by mechanical means.

*Non-Mechanical factors.*—There is only one constant factor; the spread of tuberculous granulation tissue to the epidermal space, where it comes into contact with the meninges.

If the dura could be seen, it would be seen to be covered with shaggy granulations and at first it would appear that a true tuberculous pachymeningitis was present; but this is not so. The dura is not affected with a chronic pachymeningitis and if the granulations was removed, the dura would be seen to be normal. The term chronic tuberculous pachymeningitis is a misleading one, for, far from being affected, the dura acts as a barrier to the spread of the disease.

Well, you ask, "What is causing the paraplegia?"

About every active tubercular lesion a reaction occurs, toxic and vascular, as is

shown by oedema and vascular engorgement. Should vessels of the extradural space be congested and destroyed over a wide area, there is no doubt that the circulation in the cord must be greatly affected. As a result of obstruction of afferent vessels, a simple oedema develops, not a tuberculous "myelitis" as has been described, though microscopically degeneration of myelin sheaths, some degree of perivascular infiltration and some increase in glial tissue are seen.

These toxic and vascular conditions in the cord have to be considered, whatever other mechanical factors may contribute to the paraplegia.

#### **Mechanical factors are:—**

(1) Pressure upon the dura by granulations.

(2) Pressure by the fluid pus of an abscess. The bony canal need not be narrowed; the epidermal space is simply filled with tuberculous tissue and pus. Should such a patient develop a sinus, the paraplegia clears up rapidly, a fact noted by Pott in 1779. Here we have been dealing with a paraplegia of early onset in an early case of Pott's disease. In such cases the paraplegia is complete and tends with treatment to complete recovery. But there are cases of paraplegia of early onset which do not recover (save for 10%) even if the disease becomes quiescent.

Now what major calamity has happened to so change the outlook? Something must have occurred to bring about some degeneration of the cord.

#### **Three factors may be responsible:—**

1. *A pathological dislocation.* The posterior intervertebral joints, pedicles or articular processes have been destroyed, a dislocation has resulted and the cord has been nipped.

So long as the posterior part of the cord remains intact no amount of kyphosis can nip the cord, because the canal space is not encroached upon, nor is it shortened. Here, in pathological dislocation, we have the classical cause of sudden death in

Pott's disease but it must be remembered that before massive destruction of bone has taken place, death may occur suddenly in cervical caries. How does such a disaster occur?

Normally the ligaments of the vertebral column cannot be avulsed without tearing off with them fragments of bone to which they are attached. The tuberculous follicles, however, produce an osteoporosis and the ligaments give way easily.

Greig tells of a case where a rough nurse inadvertently caused the death of a child suffering from cervical caries.

*Collapse of a vertebral body* has resulted from destruction of the posterior inter-vertebral joints, the upper end of the lower fragment or the lower end of the upper fragment pinching the cord.

2. *Loose sequestra or masses of debris* have pushed back into the vertebral canal and compressed the cord.

A rare cause of this sudden compression is "concertina collapse" of a vertebral body.

Of these cases where complete paraplegia is an early feature, 80% will recover while 20% will not recover completely.

Clinically it is important to recognize these cases of early onset of paraplegia, in which recovery is improbable.

What are the clinical features which help one to decide that recovery is improbable.

*A profound type of paraplegia in flexion*, which implies involvement of all the tracts of the cord, lasting more than a very few months, rarely recovers.

3. *Similarly a paraplegia which has become flaccid*, even if spasticity returns, always appears to be irrecoverable.

Sorrel's second type where *paraplegia is of late onset*, coming on even 40 years after a "cure" and where clinical evidence of active disease is hard to find even at its height, the paraplegia is typically

incomplete but in the majority of cases is permanent, but not always so. The etiological factor here is not easily assessed.

The cord is seen to be stretched and attenuated over a consolidated mass of debris which forms the anterior wall of the vertebral canal at the site of angulation.

The canal is quite spacious and there is no compression of the cord against the mass in front. The primary factor would appear to be the pulling of the cord against the mass in front, with stretching, shrinking and atrophy of the cord; again a progressive avascular degeneration, arising from repeated minor circulatory damage by chronic disease dragging on in the vicinity, year after year with very little outward sign.

With pressure on nerve roots we get girdle pains, hyperaesthesias, some muscular wasting, but very rarely are the bladder and rectum affected.

(To be Continued)

## THE GENERAL PRACTITIONER AND COMMON EYE DISEASES

### PART III

(G. J. G.)

#### ACUTE CATARRHAL CONJUNCTIVITIS.

**Syn.**—Catarrhal ophthalmia, sore eyes, pink eye, etc. It is the commonest affection of the eye and is easily recognised and treated, but instances are not wanting where neglect or ignorance on the part of the attending doctor has been responsible for the loss of sight in many cases. The disease affects children commonly, but adults are not free from its infection. It is very common about the months of June to September and occurs more or less in an epidemic form in almost every town and village in South India.

The patient will be seen with heavy discharge on the lids. Discharge in an eye whether light or heavy should attract

your immediate attention before anything else. There will be strong photophobia. The tendency of the patient will be to look down always with the hands over the brows to shut off as much light as possible. Watering is heavy when he attempts to look at anything. The eye lashes are matted together. The lids might be a bit swollen. You will find the eye blood shot, the redness being more marked in the conjunctiva of the lids. There might be small haemorrhages on the bulbar conjunctiva. Besides the discomfort of constant discharge and photophobia, the patient will feel a lot of irritation in the eye as if there were some sand inside the eye and in some cases some pain about the orbit. These discomforts are more marked in the evening and at night, especially under artificial light. Both eyes may be attacked simultaneously or one by one. The same child may get repeated attacks or exacerbations.

In mild cases, there is a light discharge, irritation, itching and watering in the eyes and some shyness to light. In grave cases, however, there is a very heavy discharge. Sometimes, it might be so copious as to suggest Gonorrheal ophthalmia. Tiny, dot-like superficial ulcers on the cornea are not uncommon in severe attacks. You will see them as grey spots, the corneal epithelium there being just raised. These ulcers are very painful but they clear very easily as soon as proper treatment is begun. But if they are neglected, they are likely to develop into the serious stage of corneal ulcers which lead to permanent disturbance of vision.

The chief causative organisms are Koch-weeks bacillus and pneumococcus. Each has a few distinctive symptoms of its own, but it is unnecessary for the general practitioner to bother himself about these. The practical treatment for an acute conjunctivitis is the same whatever the causative organism. The Morax-Axenfeld conjunctivitis will be dealt with separately, as its clinical condition and line of treatment are different.

The mode of infection is not infrequently through dust. It must be

remembered there is generally a yearly epidemic of acute conjunctivitis during the windy season. Probably the infection is not carried in the dust itself. It is likely the irritation caused by the dust helps the activity of the bacteria in conjunctiva. Similarly any physical or chemical irritant can thus be responsible for a conjunctivitis. The small eye mosquitoes also play a large part in spreading the infection. These mosquitoes are seen mostly during the mango and margosa fruit season. Infection also takes place by contact, as our people have not yet realised the need for isolating an infected child or preventing healthy children from playing with a child with conjunctivitis.

Diagnosis is easy. The discharge, redness of the conjunctiva especially of the lids, watering, all these denote an inflammation in the conjunctiva. The clear appearance of the cornea, anterior chamber and iris and pupillary reactions exclude deeper inflammatory conditions. Where the discharge is copious and the lids are swollen simulating Gonorrheal ophthalmia and it is not possible to get the discharge examined under the microscope, it is safer to treat the condition as Gonorrheal ophthalmia. Trachoma complicated with acute conjunctivitis requires in the beginning the same treatment as given here for the conjunctivitis. Diagnosis of that condition will be dealt with when we take up Trachoma. Catarrhal ulcers of the cornea are distinguished by their very superficial nature and their characteristic appearance. They are dot-like, grey in colour and arranged like an arc near the corneal margin. Where the ulcers are deeper and big, they should be treated as regular corneal ulcers. In children, where the parents complain that the child has not opened the eyes for many days, always examine the cornea with the aid of retractors before attempting an examination of the conjunctiva.

**Treatment.**—The sovereign remedy for acute conjunctivitis is Silver Nitrate Solution. But a lot depends on the way it is used. It should always be used as a

two per cent solution. It should not be just dropped into the eye with a dropper. In some mofussil dispensaries I have seen this work being left to the ward attendants. The best effect is got by swabbing the conjunctiva of the lids with a cotton wool swab dipped in a two percent silver nitrate solution. The upper lid is everted and then steadied with the forefinger. With the thumb of the same hand, the lower lid is pulled down to evert it and the exposed conjunctiva of both lids is brushed gently but throughout the surface with the swab. The cornea is protected by keeping the two everted lids together.

This brushing causes a superficial necrosis of the conjunctiva and the uppermost layer of the membrane comes off as flakes of mucus and with it most of the infective organisms also are shed out. There is much irritation, watering and discharge immediately after the brushing, but the same evening, the patient will feel immensely relieved. The irritating action of the drug should not make one to hesitate using it even on delicate individuals. There is no good and effective substitute yet for silver nitrate solution for the treatment of acute conjunctivitis. I have seen many doctors' children suffering unduly long with discharging eyes. Here it is not a case of a physician being unable to heal himself. It is purely a case of hesitation on the part of the father to use an irritating drug on his own child's eyes.

On the other side, there are many doctors who go on using the silver nitrate solution continuously day after day. That is harmful and sometimes dangerous. I have mentioned the caustic action of the silver nitrate solution on the conjunctival membrane. Daily use will, instead of healing the inflammatory condition, cause irritation of the tissues and lead to another form of conjunctivitis with all its bad results.

The plan of treatment will be as follows:—

First day morning: Brushing the conjunctiva with silver nitrate solution two percent.

First day evening: Apply zinc sulph. oint. (*vide* prescription below) to the conjunctiva of the lower lid, with a kucheer or glass rod. This acts as emolient on the inflamed tissues and is a mild antiseptic at the same time. The ointment also helps in preventing gluing together of the lids at night.

Second morning: Swab again with silver nitrate solution.

Second evening: Same as first day evening.

Third morning: Put in two drops Argyrol Sol. 20 %.

Third evening: Same as first day evening.

Fourth morning: If the discharge has stopped or is less, continue the Argyrol drops. If the discharge is not better, another swabbing of silver nitrate solution is indicated.

Fourth evening: Zinc Sulph. ointment.

Subsequent mornings till symptoms subside: Argyrol drops (or Z. B. drops). The evening application may be dispensed with when there is no sticking of lids in the mornings.

In the vast majority of cases, this course of treatment will suffice. If at any time, the discharge starts again, just one application of silver nitrate solution may be necessary to be followed on subsequent days by Argyrol or Z. B. drops. This recrudescence may occur when the child goes again to play in the dust or when the patient exposes himself too much to the sun's glare. Close eye-work also may aggravate the condition. The treatment on the whole will take two to ten days depending on the virulence of the infection and patient's response to treatment.

Presence of the superficial catarrhal ulcers is no contraindication to the application of the silver nitrate solution. There is no deviation from the course of treatment suggested above if ulcers be present. If there be any opacity left on the cornea after the conjunctival symptoms have subsided, application of yellow oxide of

mercury ointment, two per cent, just once a day may be necessary for a week or two.

When there is strong photophobia, people are inclined to wear goggles. It is not good. The eye requires free ventilation. Goggles shut up ventilation and make it a sort of hot chamber around the eyes, which acts so to say as an incubator for the bacteria to multiply. Goggles are definitely contraindicated in acute conjunctivitis. The patient should not also keep his eyes closed to prevent dazzling. There should be a free outlet for the discharge. He may be placed in a room where there is not much bright light and asked to keep his eyes open.

For similar reasons, even if there be ulcers on the cornea, an eye should not be bandaged when there is conjunctivitis and discharge.

The silver nitrate solution should be applied in the mornings only. If you do it in the evenings, the discharge it produces will get locked up inside the eyes during sleep. This should not be forgotten.

Hot fomentation is not good in these cases. If only one eye is affected, the other eye also should be treated as if it had the infection.

Silver nitrate and Argyrol should be used in freshly prepared solution. You should discard a solution more than a week old. In old solutions, a precipitate is formed which is irritating to the eye. Never leave the silver nitrate solution in the hands of the patient to be applied at home. The application of this drug should not be left to the hospital attendants, but must be done by yourself.

Prevention seems almost impossible in this country. You can never convince a parent that the infected child should not be sent to school or allowed to play with other children. But, if every doctor could educate the parent of every child that comes to the hospital, probably in course of time, we may get public opinion round to our side. The doctor should try to insist as far as possible that the child

is not sent to school till eyes are perfectly free from the infection.

If one child gets sore eyes, the rest of the children in the house may be given two drops of argyrol sol. 20% or Z. B. drops in each eye at bed time. But, I am not quite sure whether this helps very much. Isolation is the best way of prevention.

A word about quack treatment will not be out of place. Every grand-mother has a specific for this disease. Many of them are harmless, but some at least are positively dangerous. A common remedy is the application of a black paste on and around the eyes which acts as a counter-irritant. Should this get into the eye, there is destruction of tissues according to the amount of matter getting in. Another remedy is to ask some one to urinate on the affected eyes. The idea of such irrigation with a warm, slightly acid solution is all right, but if that person who is obliging has Gonorrhea, woe unto the irrigated eye.

If every doctor could take it as a matter of religious duty to warn his patients of the risks in quack remedies, many an eye will be saved from destruction.

I owe no apology for dealing at such length with this simple disease. No doubt it is simple but its danger and frequency necessitate detailed notes on its proper care and treatment. Its spontaneous recovery in many cases makes people not to mind it, but where there is no such recovery or proper treatment the risks are manifold.

#### (1) SILVER NITRATE SOLUTION.

Silver nitrate gr. x.  
Aqua Dist.  $\bar{3}$ i

#### (2) ARGYROL SOLUTION

Argyrol grs. 96  
Aqua Dist.  $\bar{3}$ i

#### (3) \* Z. B. DROPS.

Zinc Sulphate grs. ii.  
Acid Boric grs. x.  
Aqua Dist.  $\bar{3}$ i

#### (4) ZINC SULPHATE OINTMENT

Zinc Sulphate ... gm. 0'10  
Tuminal Ammoniate... „ 0'10  
Lanolin ... „ 10'0  
Vaseline ... „ 10'0

#### PHLYCTENULAR CONJUNCTIVITIS.

Under this heading, I just want to say a few words regarding the phlyctenules seen in acute catarrhal conjunctivitis. The regular phlyctenular conjunctivitis as described in text-books are not common in India as in Europe, but many practitioners apply the treatment given for it in the books for the ordinary phlyctenules seen, especially in children and young people with acute conjunctivitis. For example, they dust calomel on these phlyctenules. It immediately causes a flare up of the conjunctival inflammation especially in delicate individuals.

These phlyctenules are seen as small, nodule-like, vascularised elevations looking white or whitish grey at the top. They are present most commonly at or near the limbus. These 'growths' alarm the laity, but there is nothing to fear. The usual treatment for acute conjunctivitis should be applied and should the nodules be present still after the discharge has stopped, then yellow oxide of mercury ointment 2% may be applied for a few days. There is no need for any other drug. Enlarged tonsils and adenoids if present should be attended to. Cod liver oil internally may be advised in cases of general deficiency in health.

It is important to recognise this condition from the regular phlyctenular conjunctivitis. The latter is a chronic disease with a history of weeks. There will be severe photophobia and watering, but no discharge as in acute conjunctivitis. The lids are eczematous, also the skin around the nostrils. The glands in the neck are enlarged and the patient on the whole will give a general scrofulous appearance. On the other hand, in phlyctenules associated with acute conjunctivitis, the patient is healthy (except perhaps for adenoids and tonsils). There is heavy discharge, irritation and all the symptoms of acute conjunctivitis. The

\* Some prefer Z. A. B. Drops adding Alum grs. ii.

history is only of a few days' duration and the whole condition subsides in about a week or two at the most.

I shall deal with the regular phlyctenular conjunctivitis when I take up ocular tuberculosis. This reference is only to warn the general practitioner of the sort of phlyctenules commonly seen in South India apart from what is described in text-books.

### \*HONEY AS A FOOD AND MEDICINE.

#### FOOD VALUE OF HONEY.

By

DR. K. GOVINDAN, L.M.P.

1. *What is Honey.*—Honey is a sweet syrupy liquid collected by the bees from the nectaries of flowers and ripened by them in their hives. Nectar is the excreted sugar solution of the plants at the base of the flowers to attract insects so as to ensure cross pollination.

2. *Chemical Composition.*—Differs with different samples. Specific gravity 1.415, Hygroscopic.

1. Moisture 14.89 to 15.58 %

2. Ash 0.47 to 1.20 %

3. Reducing Sugars 66.53 to 73.96% of average sample.

4. Sucrose 5.84 to 6.51% of average sample.

The reducing sugars consist of Dextrose and laevulose which are generally present in equal quantities.

3. *Difference between honey and sugar solution.*—Though both are sweet in taste, the fundamental difference lies in their chemical composition. Honey contains predigested inverted sugars such as dextrose and levulose which can be easily assimilated by the system without under-

going a further process of digestion, whereas sugar consists of sucrose only and is lacking in the enzymes invertase and diastase which are present in honey. Invertase has the property of converting raw sugars into easily assimilable ones and diastase acts upon the starchy foods and converts them into sugar. I need not dilate here upon the action of these enzymes inside the human body, but it would suffice to say that they play a most essential part in the process of digestion and assimilation of food.

4. *Honey as Food.*—Honey on account of its easily assimilable properties can be taken as substitute for sugar especially in cases where the digestion has been impaired either by old age or disease. For athletes and persons who have strenuous physical exertion in their daily routine it is a good article of diet, since the simple sugars are easily absorbed to replace those in the blood and muscle tissues which might have been consumed by the exercise; for children the use of honey as a general tonic has been known from time immemorial. Granulated sugars and allied products have a tendency, when eaten in more than small amounts, to produce irritation of the digestive tract resulting in flatulence especially in sedentary workers. But honey is remarkably free from this fault as it does not require digestion at all but is readily absorbed into the blood without change. It is especially adopted to small children and people of weak digestion in whom ordinary sugar causes gas and fermentation.

#### COMPOSITION OF HONEY.

1. Proteins 0.11 grammes
2. Fats Nil
3. Carbohydrates 20.21 grammes
4. Caloric value 81 per ounce
5. Vitamins A, B very little.

The caloric value of honey is high. One pound of honey is about the caloric equivalent of 30 eggs; 6 pints of milk; 8 lbs of plums; 10 lbs. of green peas; 12 lbs. of apples and 20 lbs. of carrots. (Dr. Josia Oldfield.)

\* Read by Dr. K. Govindan, L.M.P., Rural Medical Practitioner, Aduthurai, before the meeting of the Tanjore District Medical Association on 29th August 1937, held at Aduthurai.

No detectable amount of Vitamins A, B, C and D were to be found in the honey. It is hygroscopic and demulcent; in America the use of honey in medicine is 50% according to consumers in America. As a substitute for other sweets 22%; food for babies 4%; for certain diets 3%; for malnutrition 2%; for diabetes 1%. Honey is used in America largely in confectionery and bakery. In India from ancient days honey forms an important factor in all the religious functions and is also largely used in temples. Dr. A. K. Kunttalu said that careful examination of the food contents and nutritive value of south Indian foods revealed that the well known dishes handed down to them by tradition and customs, though discarded by the ultra modern South Indians as "crude", were really made according to the scientific principles of a balanced diet. The offering of honey in some of the important temples in Tirupathi, Palani etc., has been an indispensable item in customary style in the form of "Panchamirutham" made from ripe honey, ripe fruits and ghee with unrefined brown sugar added to it.

In this connection it will not be out of place if I were to mention some of the antiseptic and therapeutic values of honey as it is the chief concern of our profession. Pathogenic germs that chiefly invade the alimentary canal have been found unable to thrive in the medium of honey. Therefore it is a powerful antiseptic and a disinfectant. It is freely used by the indigents for sore wounds, scalds and bruises which we notice in our every day practice as a common household remedy. The medicinal properties of honey have been known to our indigenous system of medicine from the earliest times. Our ancestors knew as much about the uses of honey as the present day physicians. The classical works on Ayurveda give the various medicinal uses of honey in a few slokas: what is more important in the above publications is that the difference between pure and heated honey and the use of the latter is not advocated as a medicine. In the light of the present day researches this is quite true; while the fresh form is advocated as a medicine, heated honey is only used for enemas,

emetics etc. The ancient books prohibit the administration of pure honey even along with hot liquids. Fresh honey is a common vehicle for the preparation of several legams (செய்யம்) and tonics.

*Property and Taste of the Honey* differs according to the kind of flowers from which it is being collected by the bees. For, honey collected from lotus flowers is said to be the best for eye trouble. (Lotus Honey). Honey collected from Margosa flowers is bitter. Honey collected from Tamarind flowers is sour. Hence constituents of honey differ according to the sources of flowers from which it is obtained.

Dr. W. G. Sackett, Bacteriologist, Colorado Agricultural College, summarises the finding that the probability of honey acting as a carrier of typhoid fever, dysentery and various diarrhoeal affections is very slight.

1. *B. typhosus* was no longer present in the pure honey after 48 hours.

2. *B. paratyphosus* (A and B) were dead in pure honey after 24 hours.

3. *B. faecalis alkaligenes* was killed in pure honey in five hours.

4. *B. coli communis* died in pure honey on the fifth day.

5. *B. dysenterica*—10 hours exposure in pure honey was sufficient to destroy this organism. The reason why honey is a destroyer of micro-organisms in the vegetative form that afflict the human body is because of the ability of the levulose to extract the water from these germs, for these organisms cannot exist without moisture. In general, summary it may be stated that honey on account of its hygroscopic qualities can never be a carrier of most of the micro-organisms that cause disease in the human family. In this respect honey is decidedly different from ordinary milk which in itself is a food to some of these organisms. In cholera, honey as a portable food is of immense help. In athletic activity the food problem is one that demands close attention. Honey has the following advantages over other sugars that are to be consumed by men who do hard physical work,

(1) It is non-irritating to the delicate mucous membranes of the digestive apparatus. (2) It is assimilated rapidly and easily. (3) It quickly furnishes the demand for energy. (4) It enables the athletes to recuperate rapidly from severe exertion and the men using it show less evidence of fatigue according to standardised medical tests. (5) The use of honey spares the kidneys, lessening tissue destruction, as it goes into the blood stream instantly. (6) It has a natural and gentle laxative effect. (7) Lastly, it is easily obtained and is inexpensive. Cottage industry could be encouraged in this direction.

Dr. Arnold of Carisbad says, honey is the best food for heart that is usually weak in severe diabetic cases as the sugar ingested cannot be utilised and is entirely eliminated in the urine.

In cases of Arteriosclerosis and weak heart, a glass of water with honey and lemon juice is the best food at nights and on awakening in the early hours. Honey dissolves in warm water. Honey not only contains a very pleasant and palatable substance having the same nutritive value as the carbo hydrates, but also it contains small amounts of lecithin. It has a favourable effect on the bowels when taken at breakfast in a vegetarian diet. Owing to its contents of formic acid, honey has also certain curative properties.

Another advantage of honey over sugar is its protein content mainly derived from the pollen of plants. The percentage has been estimated from one to five per cent.

The special honey set aside for the Queen of the hive and known as royal jelly is particularly rich in pollen grains. Her extra size as well as her extraordinary vitality could be directly ascribed to this food.

The general practitioner ought to familiarise himself with a few simple tests in order to detect the grosser adulterations. Thus the specific gravity is a good indication of the amount of water. Genuine honey has a tendency to crystallise or sugar, *i.e.*, to form into a soft granular mass. When dissolved with twice its weight of water it should form a clear solution and not a stringy one, with a specific gravity of not less than 1.099 which is equal to 1.370 of the original honey. It should react acid to litmus paper. 5 grammes of honey dissolved in 20 grammes of distilled water should become faintly opalescent upon the addition of a few drops of silver nitrate or barium chloride, indicating no excess of chlorides or sulphates respectively.

When one part of honey and five parts of water are boiled, allowed to cool and then a little Iodine added, the solution should turn neither blue nor green: if it does, the honey contains starch.

Usually the commercial honey is adulterated with starch and sugar and hence if a general practitioner is acquainted with the above ordinary and handy tests, he could easily detect the adulteration and recommend a good sample of dependable honey.

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" THE BHARATIA MEDICAL STORES, 55/73, Canning Street, Calcutta.  
" DADHA & Co., Madras.

## **Abstracts.**

### **SINUSITIS—SHALL TREATMENT BE SURGICAL OR NON-SURGICAL?**

IRVING WILSON VOORHEES, M.D.  
NEW YORK, N. Y.

To the assertion that "many sinuses get well after all, any, or no treatment," may we not reply that many sinus cases die after all any, or no treatment? The old economic law works here just as it works elsewhere; namely that the *summum bonum* of all human endeavour is to achieve the greatest good for the greatest number.

Is it not true that the fear complex is too much with our sinus patients? Possibly, we, as rhinologists, have been giving them information concerning sinus trouble which is not good for them. A similar thing happened when we talked too much about mastoiditis. Every person who had a pain within an inch of the ear immediately became panicky from a "mastoid complex" had visions of compulsory surgery, and in the words of the newspapers, "death from an operation." Either too much or too little of a certain kind of knowledge can become harmful to our peace of mind, and, therefore, to our happiness. The law of averages is always working, and this law will see to it that none of us is allowed to become too cocksure either of his ability or good fortune.

Many patients with rhinitis have no sinus complications, or at least only a minor involvement in the sinuses, most of the infected mucosa being in the nasal fossae proper, and not in the para-nasal cells. This type of case is surely not surgical and it seems hardly likely that anybody would tear down the sinus walls in such an instance.

Diagnosis, accurate diagnosis of sinus disease, in spite of all mechanical aids, is not uniformly satisfactory. Personally, I do not think much of transillumination save for its effect upon the mind of the patient; for thick bone on one side and

thin on the other may lead to false conclusions. As for X-ray, the only satisfactory pictures are the three dimensional ones viewed stereoscopically. Where definite pathology exists, it will be shown quite well—the only disadvantage is the human tendency to try to read something into the interpretation which is false or of little importance. I have been tricked by pictures but I still think that they are the very best means of making a thorough diagnosis of the size, shape and extent of the sinuses, and determining variations from the normal. But much experience is required both in the making of good pictures, and in their interpretation. When a patient walks in at the first visit with a proud display of "pictures of the sinuses made by my own doctor," I immediately begin to plan what I shall say which will not make a liar out of me or a "monkey" out of the amateur roentgenologist. These single flat pictures are of little value. One is seldom justified in operating upon a patient from a diagnosis determined by them. Even the best pictures are none too good.

The habit of washing out every antrum which seems to show a little cloudiness is reprehensible. Clinical evidence is a much better guide; for if there is little or no pus in the middle meatus or in the nasopharynx, an empyema of the antrum of Highmore is extremely unlikely. Moreover, I do not follow the practice which many excellent rhinologists do, of putting a needle through the naso-antral wall in an acute case, and giving daily irrigations for two or three weeks.

If an antrum is that bad, it is much better to make a small permanent hole in the naso-antral wall and wash through it as necessary. This does no harm, but it does permit of more or less constant drainage even in the absence of treatment. Irrigation through the normal opening is sometimes quite satisfactory, but this is entirely dependent upon the anatomy, whether there are two openings, or one large normal opening. The return flow may then quite readily pass out along the catheter.

Those of us who have forgotten our sinus pathology must retrace our steps and

spend a little time with Onodi or Hajek or Skillern or some other comprehensive authority. I believe that no sinus which contains stinking pus, polyp or necrotic bone can be cured without radical surgery. This is especially true of the antrum and the frontal. Some of the most satisfied patients whom I have ever had, have gone on well after such radical sinus surgery. Many of them had run the entire gamut of tampons and light therapy and visits to Arizona. This is especially true of the antrum cases. Radical antrotomy under block anesthesia can be quickly and skillfully done with destruction of nothing save a button of bone removed from the canine fossa and from the naso-antral wall. Removal of diseased antral contents is followed by nearly complete healing within two weeks, during which time there should be a minimum of washing and spraying and general meddling. If we do a good operation, Nature will usually do the rest. Radical surgery of the frontal is not so simple, but the results are nearly as good if we do not try to do too much in taking away normal bone and soft tissue. It so happens that never yet have I been obliged to remove the superciliary arch for necrosis. The deformity is very unsightly and it is doubtful whether complete obliteration of the cavity is possible by any operative procedure, no matter by what label it is known.

Sinus surgery in children should be relegated to those patients with alarming symptoms or signs who seem likely to die if heroic measures are not adopted. Most children do surprisingly well under conservative management. What we need is more and better co-operation with the pediatricist. Working together we can get most of these little patients well without surgery. However, children with rheumatic fever should not be spared radical operations if we can feel reasonably sure that a focus of infection exists in the sinuses. More often, however, the nidus is in those little islands of infected lymphoid tissue which lie everywhere in the naso-pharynx and on the posterior wall, even after thorough A. and T. removal.

As for non-surgical management, dry suction as advocated and carried out by the late Dr. Lewis A. Coffin still has its uses under certain conditions, but it has been largely superseded by wet suction after the method of Lore and others who have given especial attention to this form of treatment.

For some months I have been using the apparatus recommended by Harold Hays. It is essentially a modification of the well-known Nichols Nasal Syphon, which was invented by the late Mr. H. B. Nichols about 1917.\* For office use, it has the advantage of being uncomplicated by moving parts, and is entirely independent of electric motors or switches, the vacuum created by a continuous flow of water from a faucet being entirely sufficient.

With the patient's head turned toward his shoulder, the middle meatus is sprayed with a dilute cocaine solution (one-half of one per cent) to which a few drops of ephedrine have been added. The ephedrine need not be stronger than ten drops to the ounce. If the meatus is tight, then one should introduce into it a small pledget of cotton soaked with the above, and wait a few minutes for the meatus to open. Unless this is done, no vacuum will be created within the frontal, ethmoid or antrum of the obstructed side. When one has made sure that both nasal fossae are open, the irrigator may be applied. One quart of water at 100° F. containing a teaspoonful of *Alkanos* is poured into the container. This word *alkanos* was suggested by the late Dr. Harmon Smith to describe the formula used by him in his office. The formula is:

|                     |           |
|---------------------|-----------|
| Sod. Bicarb.....    | 16 ounces |
| Sod. Borate.....    | 16 ounces |
| Sod. Chloride ..... | 5 ounces  |
| Sod. Benzoate ..... | 1 ounce   |
| Menthol .....       | 1 dram    |
| Eucalyptol .....    | 1 dram    |
| Bordeaux Red.....   | 8 grains  |

Other formulas may be used according to individual taste or experience. Here are two which may be helpful.

\*Explicit and extended information regarding this method of suction-irrigation can be obtained by writing the maker at 144 East 34th Street, New York City.

#### Dobell-Pyncheon Solution:

|                       |         |
|-----------------------|---------|
| Powdered sod. bibor.  |         |
| Powdered sod. bicarb. | aa 3 ij |
| Thymoline             | Oss     |
| Glycerine (C P)       | Oiss.   |

Mix and triturate two salts, place them in one gallon bottle, adding  $\frac{1}{2}$  quantity glycerine. Let stand 24 hours uncorked with frequent agitations. Add remainder of glycerine and continue agitations another 24 hours with bottle uncorked. Add thymoline and let stand 24 hours. One ounce of this mixture should be added to one pint of water when it is ready for use.

|               |                  |
|---------------|------------------|
| Sodii bicarb. |                  |
| Sodii biborat | aa 3 i           |
| Acidi carbol  | 3ss              |
| Glycerine     | f 3 j            |
| Aqua          | q.s. ad f 3 iv—M |

Sig. Add to quart of water and irrigate.

The irrigator or receptacle should hang from one to two feet above the patient's head, but not too high as it is not necessary to depend upon gravity to "pull" the solution into the nose—that is taken care of by the vacuum. The hard rubber tips or nozzles must completely fill the nasal vestibules or there can be no suction. The physician opens the cut-off, at the same time turning on the water faucet so that about three inches of vacuum are to be read on the indicator or gauge. Of great importance is the retraction of the soft palate by the patient so that a vacuum can be obtained. Some will persistently pull on the palate and thus receive water into the larynx and trachea which is

decidedly unpleasant. Breathing or panting through the mouth will usually relax the palate. When the receiving jar is half full, the rubber tubes may be crossed so that suction is now obtained from the opposite side. Pinching the supply tube creates a stronger vacuum, but one should be careful not to have the vacuum too strong or so-called "vacuum headache" may ensue. One may use separate receiving bottles for each side, and thus observe differences in the quantity and quality of the secretion which comes down.

Suction-irrigation is a helpful means of cleansing the nose, and it often gives relief from pain. It cannot seriously be advocated as a "cure" for all cases of chronic sinusitis, however.

As to ephedrin for home use—it is certainly no boon to the laity. They have gone to great extremes with it. In effect it is evanescent has to be frequently repeated, and is likely to cause undesirable changes in the mucosa and small blood vessels. However, in combination with other agents, it is useful in office treatments instead of adrenalin which gives, at times, an undesirable, rather violent local reaction.

Finally, conservative treatment of the nasal sinuses is to be recommended if one feels reasonably sure that surgery will not be demanded in the long run. If surgery must be done ultimately anyway, then we have merely been wasting time and substance.

*The Eye, Ear, Nose and Throat Monthly September 1936.*

## MENESTRIN CAPSULES

### How do Menestrin Capsules prevent pregnancy?

This question is often asked by some members of the medical profession. The capsules contain Quinine, Iron, Manganese, Ovary and Thyroid and a few other ingredients belonging to the indigenous system of medicine, so combined as to produce temporary hyperæmia in uterine mucous membrane which causes tonic contraction of the uterus and the resulting menstrual flow washes the uterine cavity. This plain answer was put to test by eminent physicians who are to-day prescribing the capsules to their lady patients who dread pregnancy.

To be sure of action the capsules should be taken on the **very day** when the expected menses did not appear.

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## Notes on Therapeutics. Diagnosis and other Medical Subjects.

### COLOURLESS IODINE

Colonel R. J. BLACKHAM (London, E.C.4), in reply to Dr. J. Jackson (*Journal*, May 29, p. 1144), writes: The tinctura iodi decolorata of the B.P.C. is prepared by dissolving iodine in 90 per cent. alcohol and then adding a strong solution of ammonia. The mixture is kept in a warm place until it becomes colourless. The German method of making the preparation consists in dissolving ten parts of iodine and sodium thiosulphate in an equal quantity of water, and then fifteen parts of a 10 per cent. solution of ammonia is added. The mixture is well shaken, and seventy-five parts of 90 per cent. alcohol is added. The preparation is kept for three days in a cool place and then filtered. It is therefore clear that these compounds are not preparations of the halogen, but are ammoniacal alcoholic solutions containing ammonium iodide and ammonium iodate, and consequently possess very little therapeutic value. In order to avoid staining in the treatment of rheumatic and pulmonary affections oily preparations such as unguentum iodi intinctum (Martindale) or iodex should be used.

(B. M. J; 26—6—'37)

### VITAMIN C DIURESIS

M. A. ABBASY (*Biochem J.*, February, 1937, p. 339) reports a specific diuretic effect of vitamin C on human beings. The urinary volume and urinary output of ascorbic acid in children on a constant diet and fluid intake, of whom ten were active rheumatics, ten convalescent rheumatics, and ten controls, were measured before and during the administration of 5 mg. of ascorbic acid a day for each pound of body weight. In all these cases increased output of ascorbic acid and of urine occurred at once in the controls and after two days in the rheumatic cases. In five other controls, maintained under

similar conditions but not given ascorbic acid, there was no change in the urinary volume and urinary output of ascorbic acid. The diuretic effect is therefore ascribed to the ascorbic acid dosage. The delayed response in the rheumatic cases was due to the fact that the children were not in a state of vitamin C. saturation, as was indicated by their low pre-test ascorbic acid output. The therapeutic implications of these findings are discussed, and the author suggests that ascorbic acid may safely be used in those cases in which slow progressive dehydration of the body is desired.

(B. M. J; 26—6—'37)

### ARTIFICIAL PNEUMOTHORAX

S. PUDEK (*Z. Tuberk.*, 1937, 77, 5—6, 321) analyses the answers to a questionnaire which had been sent out to 274 institutions in connexion with their experiences with artificial pneumothorax. From this statistical material the author computes that the number of patients in the whole of Hungary suitable for treatment by this method is about 18,000, while actually it was applied to only 2,183 cases. In the course of the treatment 65 per cent. of those who formerly were unable to work were able to resume their occupations. The average duration of treatment was two and a half years, the average number of refills was thirty, the maximum number 160. The therapeutic results differed from one institution to another. The proportion of patients under treatment whose condition proved satisfactory varied from 10 to 70 per cent. The proportion of patients who improved varied from 30 to 70 per cent. From 2 to 20 per cent. of patients became worse, from 5 to 30 per cent. remained unaffected, and from 1 to 31 per cent. died. The author advises that a national organization under State control for the carrying out of artificial pneumothorax treatment should be set up, and makes a number of practical suggestions for the achievement of this plan.

(B. M. J; 26—6—'37)

# THE Medical Practitioner

Vol. IX ]

OCTOBER, 1937

[ No. 1

## OUR SELVES.

The Medical Practitioner has just completed the eighth year of its existence and may rightly feel that it has justified the purpose for which it was started. Its main aim is to lift the scientific medical profession to a level obtaining in other civilised countries. This has not been possible due to the existence of castes in the profession on account of the different grades in the system of medical education, the British Government in India having originally started medical schools and colleges to train medical subordinates and not medical men to serve the officers of the Indian Medical Service and not the needs of the Indian Nation in regard to the development of scientific system of medicine. Time has been curing almost all the ills from which India has been suffering and as rocks have been slowly and steadily corroding, the vested interests which prevented the British Government to evolve in India an uniform system of medical education, show signs of disappearing at the sharp edge of political weapon. It has now been possible for the Public Health Minister of the unjustifiably nick named benighted Madras Province to announce the burial of caste system in medical education which he did this month. There will be no more Medical Schools for training the licentiates. This announcement synchronising with the month of the birth of The Medical Practitioner we may as well say that the inauguration of this policy of the Government of Madras as the Birth Day present of The Medical Practitioner to the medical

profession. When some attempts were made especially in Madras to ape the system of medical education obtaining in Great Britain by the institution of a College of Physicians and Surgeons as was done in Bombay years ago with little or no effect on the existing castes in the profession, we started an agitation in the columns of The Medical Practitioner against this move and we refer our readers to the Editorial on this subject appearing in the August issue of 1932. We advocated one uniform University standard which exists in all the countries both in the West and the East. Advantage was taken of the position of Dr. V. Rama Kamath as the member of the Madras Council and at his instance a committee was appointed by the Council to revise the standard of education in Medical Schools. This Committee represented all existing interests in medical profession consisting of European, American and Indian members of the Council who in their turn represented all the three groups of practitioners now appearing in Madras Medical Register.

This committee unanimously advocated the necessity of bringing the standard of medical education in schools to a level envisaged in the report of the committee of representatives of all the teaching medical institutions of Great Britain and as such in no way inferior to the Indian University Standard. Though the committee of the Madras Medical Council avoided to tread on the dangerous path of recommending the abolition of medical schools, it did send in the thin end of the wedge and suggested if the schools

should exist at all under the revised curriculum. Nobody could dream at the time the Madras committee wrote this commendable report that Madras along with six more provinces in India would be under Congress Regime much less that Dr. T. S. S. Rajan, himself a Medical Licentiate would be the Hon'ble Minister in charge of Public Health. The Hon'ble Minister must have perused the unanimous resolution of the Madras Medical Council passed recently at the March 1937 session of the council.

Even during the Diarchical System of Government, The Medical Practitioner did suggest the need of having one uniform system of Medical Administration in India as all the Provinces were under one British Rule. The Medical Practitioner did also suggest the necessity of the Provincial Medical Councils working in harmony and co-ordination with each other. We respectfully brought to the notice of His Excellency the Viceroy through these columns to make it possible to have a conference of representatives of the Provincial Medical Councils when His Excellency saw the wisdom of holding an inter-provincial conference for chalking out an All India policy for Public Health. We even went a step further and suggested that if an Advisory Inter-provincial committee of the representatives of provincial medical councils were brought into existence there will be no need for a Medical Council of India and that a huge expenditure of over a lac of rupees now spent for the All India Council could be more profitably utilised for other purposes. We may prophesy that time will not be far when in this country the medical profession would see the unwisdom of having an All India Medical Council of the type now forced on this country. Soon after the Indian National Congress sat on the saddle of provincial Governments, we pointed out the necessity and feasibility of having an uniform policy in regard to medical relief and medical administration in at least six now seven provinces in India and that it was only a matter of time for other non-congress provinces to follow suit. We are glad to read another announcement

from the lips of the Public Health Minister for Madras that a Conference of Ministers of Public Health is to be summoned at Madras during Xmas week and that non-congress ministers have also been invited.

It cannot be reckoned as a matter for pride for one province and humiliation to the rest of the provinces in India, if one province leads others especially at this juncture when the strings of the evolution of a National Government for India is under the control of the National Congress but if the Ministers in all the provinces in India do not take advantage of this most momentous circumstance a thousand and one woes to India.

Though it is a matter of great satisfaction for us and also one of encouragement that some of the pet schemes of The Medical Practitioner are taking a shape and a dawn of reforms could be seen in the cloudy horizon, we cannot take credit of these achievements. For, but for the co-operation of the readers of The Medical Practitioner, we would not have been able to present our views with facts in the way we have been doing. Some readers of The Medical Practitioner from outside this province have been complaining that the affairs of the medical profession of other provinces do not find as much a space in the columns of the journal as do the affairs of the Madras Province. The cause for this is not far to seek. It has not been possible for us to get at our readers in other provinces for necessary help for this purpose through correspondence. Whatever news we could get concerning the profession from elsewhere we did not miss to comment on such news to serve any purpose concerning the profession. Recently we were forced to stay in Bombay for nearly a week on domestic duty and we took advantage of this occurrence and interviewed some of the prominent members of the medical profession in the city of Bombay and also those belonging to the rank and file. We had to limit our visits to a short radius from the place of our temporary residence. We are glad to say that all whom we had the pleasure to see supplied us with a

good stock of information which will be released in the columns of The Medical Practitioner as and when occasion demands in the interests of the medical profession as a whole. Such of those who are attached to the teaching institutions have been kind enough to offer us help in contributing scientific articles to The Medical Practitioner. Dr. S. S. Rao M. D. who has been the subscriber of The Medical Practitioner ever since its birth, has been requested by us to be our Associate in Bombay in charge of Scientific section of The Medical Practitioner. As usual Dr. V. Rama Kamath holds himself solely responsible for the Editorial Policy, News, Comments and the Correspondence Columns of the Journal. Bombay has been the Birth Place of almost all national organisations including the National Congress. It has all the sinews of peaceful war to strengthen the medical profession. Some of the doctors who guide the destinies of the medical profession are strong disciples of Mahatma Gandhi. And is it too much for us to expect help and co-operation from Bombay in our task to serve the profession and bring about communal harmony in the profession and with it contentment and prosperity to the profession as a whole?

Whether it be in the premier cities of Bombay, Calcutta and Madras or else where in urban or rural areas the affairs of the medical profession are identical, the degree of sufferance may perhaps vary due to local conditions. It is our considered opinion as expressed in these columns in season and out of season that the foundation of the uplift of the medical profession has to be built in villages as in the case of other items of national reconstruction.

We therefore appeal to the medical profession in India that the profession as a whole should devote its attention for organising schemes of medical relief to the masses commencing from villages. As in the case of other commodities even medical practice supplies have to come to urban areas from villages and more organisation in villages will always mean more work for the members

of the profession. If organised work is found in villages there will be less congestion in cities and towns. It is true that in Madras Presidency the Government have established subsidised rural dispensaries on a much larger scale than in other provinces but unfortunately the principle of independence is lost sight of and for the petty amount of about Rs. 40 given to rural practitioners, they are treated as menials belonging to an indentured system of labour and the subsidised scheme of medical relief has been converted as yet another department under the Government to the detriment of the evolution of a strong and united independent medical profession. The subsidised rural medical relief has to be introduced in all provinces if the Congress Government is earnest to carry on national reforms beginning from villages. Honorary system, Health Insurance, Medical Inspection of schools and all such schemes of public utility and welfare should start from the villages and the independent medical profession should take a lead with the help of the Government. Otherwise it will never be possible to run these schemes for public good as the Government cannot find funds to run these as additional departments with full time service. If the management of honorary medical service is left to the Government Department even under Congress Regime the medical profession cannot dream of Independence which seems to be the underlying aim of the Congress Government in this country. If any profession could be given Independence without any risk and all round advantage to the public, it is the medical profession. The Medical Practitioner is at the service of the profession. It is not sectarian either in its views or management. It is the only independent organ which has been fearlessly fighting for the rights and privileges of the profession. India has a vast field for the exercise of the medical profession. Full time service under anybody is against the very principle of medical service. The service of the profession should be kept at the doors of the masses by the independent medical service belonging to the scientific system of medicine.

Science is in need of publicity especially during the Congress Government which is directly in touch with the masses. There is danger ahead to the scientific system of medicine if the profession does not organise and give publicity of the benefits of science as against quakery under whatever guise. We keep *The Medical Practitioner* at the service of the scientific medical profession not only in Madras but elsewhere throughout India. Its columns are at the disposal of the profession for not only scientific discussions but also to find fields for the propagation of scientific truths for the relief of human sufferings through those who have to make a life study of science to cure human ills.

### MADRAS MEDICAL ACT.

Dr. P. Srinivasan, a private member belonging to the Congress Party has given notice of his intention to amend the Madras Medical Registration Act. It now transpires that the Government has taken up this responsibility and for this purpose the Hon'ble the Public Health Minister invited a few official members of the medical profession and the Hon'ble Dr. U. Rama Rao, President, Legislative Council to meet him at the Secretariat for discussing the proposed amendments.

Times have been changing very quickly and with it the system of Government, and the Minister in charge of the Public Health shows all round activities of reform. We hasten to discuss not only the necessity of amending the Madras Medical Registration Act, but all other Provincial Medical Acts in India with the hope that the Madras Public Health Minister is likely to lead or at least suggest his brethren in other provinces, the necessity of having uniformity in the working of the Medical Acts in India. We feel justified to make this suggestion as it is reported that the Public Health Minister of Madras has invited a Conference of his brethren from other provinces. We are glad to learn that the Hon'ble Minister has advised the Surgeon-General who is also the President of the Madras Medical Council, to summon the

meeting of a special committee of the Council appointed at the last September Session of the Council to suggest all round amendments to the existing Medical Registration Act to suit the present conditions. Soon after, the Madras Medical Council will have to meet to consider the report of this special committee to be able to send to the Government the opinion of the council in regard to the amendments. From the report appearing in the *Dailies* the amendments suggested by the informal conference summoned by the Minister seem to confine only to the constitution of the Council and the mode of publishing the medical register. The main principles agreed to regarding the constitution of the Council is far from being democratic. It is too much to conceive that even during the Congress regime the officials will be prepared to give up vested interests so long they remained officials. The Medical Registration Act confers on the practitioners who come under the purview of the Act certain rights and privileges. To-day these rights and privileges are a myth to the members of the independent medical profession. The private medical practitioners either in Madras or elsewhere in India have been experiencing to their cost that the most important privilege of issuing medical certificates is a farce. The Heads of the Government Departments are given sole discretion to approve the certificates and in case they do not approve, the certificates are sent to be countersigned by the Government medical officers. In Madras a few years ago at the instance of Dr. V. Rama Kamath a protest in the form of a resolution was passed and submitted to the Government by the Madras Medical Council informing the Government that the procedure of countersigning of medical certificates was against the principles and the spirit of the Medical Registration Act as the countersigning Government officer could not sit in judgment over the discretion of another registered practitioner which he did even without seeing the patient. Since then the Government changed this procedure and the certificates issued by the private practitioners are now being sent to the Government Medical Officers

for a second opinion. The effect of this change of procedure being as objectionable as countersigning, this new procedure was also objected to by the Madras Medical Council but without any effect. If the Hon'ble Dr. Rajan was in the Madras Medical Council during the discussion of this subject he would not have consented to allow an official majority in the medical council. The idea of Dr. Srinivasan in tabling the amendments to the existing Medical Registration Act, is to make the Medical Council democratic. An official may be democratic in his principles, so Major-General Sir Frank P. Connor appeared to us when he was the President of the Madras Medical Council in spite of his being the Surgeon-General with the Government of Madras. His successor Col. Wilson might be showing signs of having in him democratic ideals but an official has to remain an official even under the People's Government. The President of the Medical Council of Great Britain was not an official even in the year 1858 when the General Medical Council for British Isles was first inaugurated. So the decision of the informal Conference presided over by the Minister that the President of the reformed Council should be a Government nominee *i.e.*, the Surgeon-General with the Government of Madras cannot be in keeping with the principles of democratic institutions even though the nomination is to be only for the first four years of the life of the Council. The Conference had decided that the strength of the Council should be 16, *i.e.*, one member more than what the existing Act provides, including the President.

(1) The two Universities are to be represented by two members to be elected from amongst the members of the faculty of medicine by the members of the Academic Councils of the Universities.

(2) Two Medical Colleges of the Madras and Vizagapatam to be represented by two members from amongst the members of the staff who are to elect them.

(3) One member of the staff from all the three existing schools to be elected by

the members of the staff of all three existing schools.

(4) Three members to be nominated by the Government to represent the medical missionary interests or to make up for any deficiency in representation.

(5) Seven members to be elected by the General electorate consisting of all registered practitioners.

The effect of the reform will be that the newly proposed Medical Council will have five officials in all probability as the Medical Colleges and Schools are run by Government and the two returned by the Universities are likely to be officials, the faculty of medicine consisting of members of the staff of the Medical Colleges. The sixth official will be the Surgeon-General who is to be the nominated President of the Council. To this number if three nominated members are added the Council will have nine Government members as against seven elected. This is against the spirit of democracy unless the objection is to be lost sight of at present as the Government is People's Government. The imagination or psychology of the People's Government if stretched a bit more, there may appear to be no harm if all the members of the Council are nominated by the Government. We would certainly prefer nominations pure instead of elections of officials by whichever route. The Medical Profession in India is not what one sees in Great Britain. There, all the teaching institutions are run by the independent members of the profession in private practice. In India the private practitioners and the Government practitioners are two separate communities each having inter castes. The interests of those in service are different from those in private practice, with the result that the rights and privileges conferred by the Medical Registration Act cannot be enjoyed by all equally as in Great Britain and the purpose of Dr. Srinivasan will be defeated if the officials hierarchy is established even though it be under Congress Government. The legacy of castes in the Medical Profession bequeathed by the British Government cannot be lost sight of as the registered practitioners are made to enjoy the rights

and privileges of medical registration depending upon the caste to which they belong. Apart from official and non-official castes there are many more depending upon qualifications. If the caste system did not prevail and if the Medical Registration Act made all those coming under its purview enjoy equal rights and privileges nobody would have thought of the necessity of amending the Act defective as it is. Though the caste of medical licentiates is to be abolished soon, there are over four thousand belonging to this caste in this presidency; all told, India will have at least 20,000. It will take at least half a century for this caste to be extinct even in case all the other provinces follow the lead of Madras.

We trust the Madras Government are aware that their medical colleges and schools have political parties of their own though the politics dealt by these parties is of a different type as is commonly understood. Consequently the staff of these institutions respect a person the leader of a party more than his age and learning. Representation of teaching institutions in the medical council is for the purpose of having expert advice from the learned practitioners who are actually in touch with teaching. Learned members of the profession of ripe experience are not likely to interest themselves in electioneering campaign as such a person would not care to go to his electors with a bowl for collecting votes. The medical colleges here and elsewhere must have experienced the misuse of the ballot box. In India and especially in Madras teachers in medical colleges and schools are all Government officials. So, till the medical colleges and schools are run by the Government, it will be wiser and safer in the interest of representation of teachers in the Medical Council, to depend upon nomination and not on election in the way suggested by Secretariat Conference.

As theory is quite different from practice there should be adequate representation for those who practise medical science by the bed side to judge that the academic teaching is of a kind as to equip the practitioners to treat human beings and not diseases. So taking into consi-

deration all the existing conditions of the medical profession in this country the medical councils should have a solid majority of private practitioners in the Medical Councils as against the Government Officials.

The General Medical Council represents all the teaching institutions in Great Britain without exception. It is not fair not to allow representation to all the existing medical schools in the same proportion as is suggested for the colleges. The Government should also remember that out of the three schools now existing two will be converted into colleges very soon. The teaching bodies in Great Britain are quite different from those in Madras and other provinces. The Universities run their own medical colleges, in the British Isles while in India excepting perhaps, in Lucknow, the Universities do not run medical colleges. Other teaching institutions in Great Britain such as the Royal Colleges, the Society of Apothecaries, have their own Medical schools. In India schools also are run by the Government excepting a few which are under the medical missionaries. So the representation for the teaching institutions should be confined to the medical colleges and schools and there is no need for the Universities to have representation, as those representing the colleges will be in touch with the Universities. And in case the universities are to be represented there is no need for the representation of the colleges. Taking all the above mentioned circumstances into consideration the Medical Council may consist of a representative of each existing teaching institutions the Principal or the Superintendent as the case may be, they being nominated to the Council by the Government and the elected members should be double the strength of officials. That is to say, there should be five members nominated (two from two colleges and three from three schools) and ten members of the independent medical profession. Amongst the five nominated members, majority will be medical graduates of India, and there may be one or two from amongst the European officials. The medical licentiate of India has no chance of representing even the medical schools.

Realities have to be faced and till the caste system in the profession disappears there should be elected representation for one European, three medical graduates and six medical licentiates from the general electorate of registered practitioners, officials being debarred to contest elections. Out of the three graduates one should represent the fair sex so also one from among the medical licentiates. The whole electorate should choose ten members.

The Government being the final authority over the affairs of the Medical Council this authority may be wielded by the Government without special nomination of the Head of the Medical Department in the Council. In future the head of the medical department should occupy the same position in India as the Chief Medical Officer of the Ministry of Health does in Great Britain and should be relieved of all and sundry ex-officio responsibilities which have been hampering the legitimate responsibilities of his office. He can command greater influence over the affairs of even the Council from outside being the chief adviser of the Government. It is better to tumble and learn responsibilities as does a child before it learns to walk. If the Congress Government is keen on safeguards which they once detested, provision may be made in the Act for the choice of the President by the Government from a panel of two names which the Medical Council should choose by ballot. This arrangement should be temporary for a period of 3 or 5 years.

In addition to the reform of the constitution of the Medical Council and the mode of preparing and publishing the Medical Register there are a few more sections of the Act which require to be amended. Sections 13 of the existing Act deals with registerable qualifications and section 20 with reciprocity. As per section 13 (a) any person who is for the time being registered under the British Medical Act, has to be registered automatically. Section 20 prohibits the Government from including in the Schedule of registrable qualifications, medical degrees, diplomas or certificates granted in a country whose Government does not

recognise similar qualifications granted by British Indian Government or University. So whether a country recognises Indian Medical qualifications or not if a practitioner belonging to such a country manages to get into the British Medical Register the Provincial Medical Councils are bound to register him. So section 13 (a) as it exists removes the discretion of the Council in the matter of reciprocity. No harm will be done to those who possess the British Medical qualifications if section 13 (a) is deleted and all the British qualifications are included in the schedule of registerable qualifications.

As in the Bombay Medical Act provision should be made to have a statutory executive committee for carrying on the administrative routine and for dealing with disciplinary cases whose decision should be made appealable to the Council in the first instance. Section 18 dealing with appeal to Government should also remain.

Regarding other amendments, we cannot do better than repeat what appeared in the Editorial columns of the Medical Practitioner in 1933.

"In all democratic institutions, purity in election should be of greatest importance. We have no personal knowledge of elections to the Medical Councils in other provinces, but we can say with authority that in Madras with regard to Medical Council elections there is much room for fraud, deception and many other offences usually committed in elections. The fact that the Returning Officer for the election in Madras is the Registrar and the Election Court is the Council makes matters still worse. In the United Provinces also the Registrar is the Returning Officer and the Medical Council is the Election Court. In Bombay though the Election Court is the Medical Council the Returning Officer is the Surgeon-General or his nominee so also is the case in some other Provincial Councils but in all the provinces excepting Madras, United Provinces and Bombay, the Election Court is the local Government. Affairs of election seem to be more ideal in Bengal where the Returning Officer is quite independent of the Medical

Council being the Registrar of the Calcutta University or his nominee and the Election Court is the local Government.

It is certainly against sound principles to have Surgeon-General or Inspector-General of Civil Hospitals or their nominees as the Returning Officers as the former officers are the nominated presidents of the councils. To have the Registrar of the Medical Council as the Returning officer is most objectionable. He is a subordinate of the Council and hence its creature and as such will not be able to exercise his own independent views. It is very likely he would dance to the tune of his masters who are the Presidents of the Councils or a group of the members of the Councils who are able to guide the destinies of the Council (though not possible in the present councils where the President is the sole monarch) and a particular candidate for election whose entry into the Council is considered not desirable by the President or even by the Registrar himself, such a candidate is likely to suffer most. As mentioned above the medical councils in some provinces are the Election Courts themselves and hence there is no remedy for the aggrieved candidate to have justice at all. So it is desirable in the interest of justice and fairplay that the Returning Officer for conducting election should be a person independent of the council or the President of the Council. A person of the position of the Registrar of an University, as is the case in Bengal, will be most suitable for discharging the responsible duties of the Returning Officer.

It is preposterous that the framers of the Medical Acts in some Provinces should have thought it fit to empower the Medical Councils themselves to sit in judgment about election offences. It is stranger still that the Council could act both as a prosecutor as well as the judge, for, it is mentioned in the rules that the council may, on its own motion, declare any election to the Council to be void on account of corrupt practices or any other sufficient cause. The fact that the decision of the council is final makes the situation most unhearing if not harsh and cruel. Such unreasonable and unjust

authority vested in the council makes the Election Court a farce and not a reality. If a particular candidate is not wanted either by the Registrar of the Council or a group of councillors, his fate is doomed. So, it is highly desirable that the court which sits in judgment about election offences should be a body independent of the Council or any of its office-bearers. Though in some Provincial Councils the election offences are heard by the local Government, this arrangement is not ideal and it can never satisfy the ends of justice. The Government deposes one of its officers in the Secretariat to go through the complaints made by the aggrieved parties and the proceedings conducted by a single officer will never approach a judicial enquiry conducted by a person or persons in the judicial department.

We suggest that the existing sections regarding elections in the Provincial Medical Acts should be amended so as to make provision for a judicial officer to try and investigate election disputes and to declare elections to be void in case the items of disputes have vitiated the results of the election. The judicial officer should not be below the rank of the Chief Judge of the Small Cause Court and in places where such courts do not exist election disputes should be tried by a judge of the High Court on the original side. Provision should also be made for an appeal to the High Court in case the trying judge is below the rank of the judge of the High Court.

If as suggested by us the medical councils are reformed to make them real democratic bodies with an elected President, other reforms which materially affect the growth and prosperity of the profession and the prestige of the councils such as uniform and equal facilities to exercise the rights and privileges conferred by virtue of registration, doing away with the several invidious distinctions now prevailing in the profession, reciprocity in the matter of registration and many such reforms doing away with unhealthy distinctions now prevailing due to defective working of the councils, are bound to follow."

## News and Comments.

**Good News:** The news that the Public Health Minister of Madras has made up his mind to abolish the three medical schools now existing in Madras Presidency and raise them to the status of University Colleges is hailed with joy in Madras by the members of the medical profession including the medical licentiates. The feeling cannot be otherwise in other provinces excepting perhaps in Bengal where there exist some veterans in the medical profession at the top counting amongst them a Knight who, for a long time have been advocating the need of practitioners with inferior training to meet the demands of village practice though from a humanitarian point of view such a mentality of difference of treatment of human ailments is to be condemned. On account of such a feeling amongst the leaders in the medical profession, Bengal has the largest number of medical schools of which excepting the Cambel Medical School, if closed long ago, Bengal would have served the medical profession with less disharmony and more efficiency in regard to practice of scientific medicine. All the same, the medical licentiates of Bengal who have been condemning the ill-staffed and ill-equipped medical schools will join their brethren in Madras and continue their agitation till the Public Health Minister of Bengal sees the wisdom of abolishing the Medical Schools. We also trust that the Hon'ble Dr. Rajan with the help of his medical brethren, the three Ministers in three different Congress Provinces prevail upon the non-Medical Ministers in the other Congress non-Congress provinces especially in United Provinces to introduce the most desirable reform of having one uniform standard of medical education. Such an ideal is quite consistent with Congress principles. It is also hoped that interests of the existing medical licentiates will not be lost sight of by the Madras Minister who, being himself a medical licentiate is expected to treat this class of practitioners with consideration so that as qualified and registered practitioners they enjoy the rights and privileges equally with the rest of the registered practitioners.

**Urban Honorary System:** The Hon'ble the Minister of Public Health announced more than once on public platforms that the future policy would be to stop further recruitment in the medical service on the curative side and replace the honoraries in the place of paid staff as and when vacancies arose. How he would achieve this policy for public good so that the sphere of medical relief in State hospitals is increased without additional financial commitments and without decreasing the efficiency could be judged only after his scheme is released. From the speech delivered by him to the South Arcot Medical Association at Cuddalore one may gather that he intends introducing a subsidised scheme even in urban hospitals, where medical men soon after they qualify themselves will be given opportunities of working as assistants for about a period of five years on a subsidy enough for their livelihood. The Madras Mail seems to have misconceived the principle underlying this scheme and given the scheme a colour of conscription service. To appease any disappointment the Minister told his audience that the young medicoes should not grudge this service when it is known that the Government spends a large amount of public money for the training of medical students and consequently the young medical men should not grudge their service to the public though the return for such service is a humble subsidy. So long such a service is voluntary we fail to see how it can be compulsory conscription service unless the entrants to Medical Colleges and Schools are admitted on condition that they should give compulsory service for a fixed period in spite of their paying the full fees for their education. It is hoped that the Minister will give an opportunity to the profession and the public to discuss his scheme before it is actually launched.

**Rural Honorary System:** If the Subsidised Rural Medical Relief Scheme in Madras Province was styled having the word 'Honorary' in the place of 'Subsidised' the independent practitioners who undertook to do honorary work on a small honorarium would not have been put to the hardships under which they are suffering now. The latest hardship forced

on them in the form of an agreement is that they should not take part in civics and politics. To force this new condition on those who entered this service before the promulgation of this new rule tantamounted to *zulum* to use an Urdu expression indicating illegal threat. Yet on pain of losing the subsidy the practitioners did sign the agreement. When even the full-time paid servants of the Government in high position were suspected to side with the party then in power during elections it may not be impossible to conceive that the independent subsidised practitioners did what they were forced to do in favour or against the election candidates. On this plea a large number of subsidised practitioners were about to be harassed by some District Board Presidents. The Medical profession should be thankful to the Hon'ble Dr. Rajan that the two objectionable clauses debarring these practitioners from taking part in politics and civics will be made to disappear from the agreement. All the same, we advise the rural practitioners to mind their professional activities more than party politics. But if their popularity as professional men is likely to be useful to any civic body they should not grudge to serve the public standing on the plank of welfare apart from professional politics. Though politics is a science for the welfare of the people this science has been unfortunately misused. It is possible for disinterested medical men to reform even the political science.

Deletion of the two objectionable conditions appearing in the new Agreement which the subsidised practitioners have been forced to sign and referred to above, is one of the many other items discussed by the Deputation of the representatives of the P. S. R. M. P's Association with the then Surgeon-General who promised the Deputationists that he would forward his recommendations to the Government soon after. It looks as if the note of the Surgeon-General has not been considered by the Government so far. When a conference of a few Ministers and Heads of the Government Departments with the concerned Secretaries met at the Secretariat last month to consider about Rural Development Scheme, the Hon'ble The

Public Health Minister said that Public Health work, Rural Hygiene, Inspection of Village schools should be entrusted to the Rural Practitioners and this was agreed to by the conference. There are many more responsibilities which could be entrusted to Rural Practitioners in the Rural uplift work. Some of these are embodied in the form of resolutions by the P. S. R. M. P's Association at their conference which met in Madras last July. These resolutions were also subjects of discussion with the Surgeon-General by the Deputationist as referred to above. It is but natural that the Rural Practitioners desire that the popular Minister from whom they expect wholesome reforms regarding Rural Medical Relief Scheme, consults them by summoning an informal conference of their representatives as the Hon'ble Minister was pleased to do in regard to the amending of the Medical Registration Act before the Government decides the future of the Subsidised Rural Medical Relief Scheme.

Before closing we wish to mention a recent event in Trichinopoly District where a subsidised rural dispensary at Pallapatti is converted into a pucca L. F. Dispensary and the practitioner at Pallapatti has been asked to go to Aravakurchi where a L. F. Dispensary existed. The cause of this transformation seems to be that there is more attendance of patients at the subsidised dispensary at Pallapatti and proportionately less at Aravakurchi. Converting a subsidised dispensary into a pucca one is certainly against the spirit of Rural Medical Relief Scheme even if the subsidised practitioner is to be the medical officer of the pucca Dispensary. The purpose of the scheme both on points of economy and interests of the medical practitioners who risk their career to settle in villages will be frustrated. If by the popularity of a subsidised practitioner the village progresses into a small town, additional facilities should be provided to the existing practitioner by way of supply of drugs, instruments, additional servants and even in-patient accommodation. And if the practitioner can depend upon private practice the subsidy may even be stopped and another village be given the benefit of the subsidy. It

is in this way the scope of honorary service should be increased. Then only it may be said that Honorary Medical Service is on a sound foundation.

**Indifferent News :** To enable us to discuss the policy of Medical Administration in different provinces we got the cuttings from the Dailies published in the capital cities of the Provinces in India and we should say we are sorely disappointed. Before the Congress came into power more time was spent in the discussion of budget items than what one sees now. This may be due to three causes *viz.*, excess of success of the party in power or indifference of the opposition due to overwhelming strength of the Government Party or want of organisation in the opposition party. The sprouting process of vegetable kingdom is worth noting by all progressive parties. A seed grows into a powerful plant if at the time of sprouting there is some resistance. So resistance by way of opposition is worth hankering after. The ability and usefulness of a Health Minister could be gauged by the increase in the bulk of medical relief to the masses with the least expenditure. This he could do by throwing open new avenues of welfare to the members of the profession. Unlike other professions the medical is the only one of which honorable advantage could be taken to serve the poor amongst the public by shutting the gates of the charitable institutions against those who could afford to pay. If the Government puts a stop to the hospitals being used as fields for unequal and unwholesome competition by the paid or honorary medical officers the independent medical profession may safely be depended upon to provide for all possible facilities of scientific treatment not inferior to those obtaining in State hospitals. The encouragement promised by the Public Health Minister to the South Arcot Medical Association at Cuddalore that the Government was prepared to co-operate and co-ordinate with independent medical practitioners if they started clinical laboratories and X-ray Institutes on mutual benefit basis will, we hope, receive the serious consideration of the independent medical profession. If the Public Health Ministers released their schemes on the floor of the

Legislative bodies during the Budget Session instead of doing so by bits as is done in Madras by the Hon'ble Dr. Rajan the Public including the members of the medical profession could have had splendid opportunities of judging the policy of the Government.

**Indigenous Medicine :** In the course of a recent tour in the Punjab, Pandit Jawaharlal Nehru stayed at the residence of the late Dr. Ansari. Advantage was taken of his stay at Dehli by the student of the Tibi (Unani) Medical College started by the late Dr. Ansari and the Congress President was requested to open a block for the Indigenous Medicine in the proposed Kamala Nehru Hospital at Allahabad. It is good news indeed that the Congress President did not hesitate to give an answer in the negative saying that the Western system of medicine is more scientifically advanced. We wish the Congress ministers were as bold as the President of the Congress to say what they have in mind regarding running of teaching and treating institutions of pure Indigenous systems by the State at public cost. The Governments in India should endeavour to impress on the lay public that there can be only one system of medicine and that is the scientific system and make it possible to revive the Indigenous Systems of medicine on scientific lines not in separate colleges and hospitals but in the very same buildings where scientific system of medicine is taught and practised. Congress should bring harmony into the medical profession and encourage Science. There cannot be diplomacy in science and if attempts are made to introduce diplomacy in science it will be detrimental to public welfare and public finance. Anatomy, Physiology, Pathology and the intercorrelating scientific subjects such as Chemistry, Physics etc. have to be depended upon for treating human ills scientifically. Choice of suitable treatment for individual patients can be most advantageously made by the votaries of medicine if opportunities are found to combine all scientific truths into one system instead of diverting science into different routes and wasting public funds. The only way to do this is to establish special chairs for

Indigenous Systems of Medicine in the existing medical schools and colleges.

**Dr. Anderson's Report:** A brief summary of the report of Dr. G. C. Anderson, Medical Secretary of the British Medical Association, made to the Executive Committee of that Association and communicated to the lay Press in India by Reuter, has been a matter for adverse and hostile comments in the Indian dailies. Dr. Anderson is said to have remarked that the independent medical practitioners find it almost impossible to make a living owing to over crowding in the profession, low fees and the competition offered by practitioners of indigenous system of medicine and all kinds of quacks. It is also reported that Dr. Anderson opines that the standard of medical ethics is very low in India. He has also minced matters by linking another fact that the practitioners in India use drugs of inferior quality and defective strength.

Dr. Anderson was deputed by the British Medical Association to have first hand information about the medical profession in India. This is what Dr. Anderson told us in person while he was in Madras. We did bring to his notice the strange irony that though in India there was not one qualified practitioner to a population of 20,000 the existing qualified practitioners especially the rank and file are feeling the pinch of poverty. This we said was due to the existing of castes in the profession which had been hampering the growth of the medical profession. For we said it had not been possible and would not be possible for the profession to unite unless the Europeans and Indians at the top of the profession give up vested interests. We also told him that lucrative private practice was cornered in the State Hospitals and that there did not exist powerful filters at the gates of the State Hospitals as in England which could prevent the rich and higher middle class patients getting into the hospitals. We did also tell him that some of the Medical Officers had been entertaining strange ideas of charity and give advice even to the rich, free in their private consulting rooms while their assistants did so by attaching themselves to Chemists in some

guise or other and that instances were not wanting of the full time officers of the Government not only owning and running Chemist shops and Laboratories but also running parallel private hospitals with a team of subordinates under them in State Hospitals. Consequently we mentioned to him that it was not a matter for surprise that there was unwholesome and unequal competition resulting in the deterioration of high ideals. The existing state of affairs we tried to convince Dr. Anderson were the causes of a feeling of overcrowding in the profession with the consequence of 'low fee', which in some instances had dwindled into 'no fee'.

The defective system of Medical Relief and Medical Administration are the main causes which have kept Medical Ethics at a low ebb in India. In addition to the causes result of unwholesome competition referred to above, the system of attaching administrative duties of granting medical certificates etc., to the members of the staff in teaching institutions and the evil consequences of such a system had been the cause of the low standard of Ethics. Corruption and immorality need not be taught and a teacher can propagate his Ethics by mere contact and association. Use of drugs of low standard need not have been mixed by Dr. Anderson with the topic of Ethics. There were other materials before him. We did suggest to him remedies to improve the affairs of the medical profession in India. We wonder if Dr. Anderson had suggested in his report any cure for all the ills he complains in his report. Being the Medical Secretary of a powerful medical association we trust he would have. We await his full report for further comments on this subject. In the meanwhile we wish to tell all concerned that medical practice in India started from State Hospitals and so long there was no difference between Hospital Practice and Private Practice the members of Independent Medical Profession had to follow what was taught to them in the State Hospitals. For all enterprises in independence practice the profession had to look to the enterprise of State Medical Officers. The members of the profession had and have to depend on their teachers for knowledge both Medical and Ethical. Critics either now or in future would do

well to note this aspect of the question of Ethics and morality and see that the Medical Schools and Colleges are staffed with teachers of high qualifications both Academic as well as Ethical. Mere high Academic qualifications without as high Ethical conscience has been a danger not only to the medical profession but also to the public and will continue to be so.

**Bombay Memoranda:** While the medical associations in the Madras Presidency in the city and urban towns make use of social functions to represent their affairs to the popular Public Health Minister, the associations in the city of Bombay have been putting their case before their popular minister in black and white in the form of memoranda. To our knowledge two such memoranda have been submitted to the Public Health Minister in Bombay, one a joint one and the other from a single association. The former has been signed by three associations (1) the Bombay branch of the All-India Medical Association (2) the Medical Association, Bombay North (3) the Bombay Obstetrical and Gynaecological Society; the latter is from the Bombay Medical Union only. The joint memorandum is a well got up document and deals at length 'the more immediate and urgent aspects' of five topics concerning the medical profession. They are:—(1) Reorganisation and extension of Medical Relief in urban and rural areas, (2) The Civil side of the Indian Medical Service; abolition of the post of Surgeon-General and of the entire Civil side of this service, (3) the Public Health Department, Haffkine Institute and the Health Board, (4) the better organisation of Medical Education: Post-graduate teaching and Medical Research and (5) Sickness Insurance.

Judging from the signatories to the joint memorandum from the Bombay City we should say that was the best that could be expected of them. Majority of them are not likely to come in contact with the rank and file of the profession even in the City of Bombay. So it is but natural the memorandum deals entirely with questions of transfer of power from the European in high office to the Indian as such. High officials being exclusively the members of the I.M.S. we might say that the memorandum concerns

itself in displacing the I. M. S. by the B. M. S. The same principle of high appointments is applied with regard to Honorary Service also. We learn that those who were responsible to draft the joint memorandum were anxious to present the same to the Minister in time before the last Budget Session of the Bombay Legislative Assembly met and therefore could not afford to be more elaborate. They have expressed so at the very preamble of the memorandum. As the memorandum is neither final nor complete the signatories will do well to summon a joint conference of three medical associations they represent and try to get at any more associations which wish to join them and make up for the omissions.

The Bombay Medical Union concerned themselves with the only question of the higher Services; as it is said that the union represents the aristocracy of the medical profession in Bombay nothing more could perhaps be expected by the medical profession as a whole from this Union. While the entire profession is agitating to send back the I.M.S. to their legitimate field of Military Service the Bombay Medical Union or at least its President makes a distinction between the Indian and an European belonging to the same service. Such a policy of racial discrimination smacks of personal equation if not want of perception of disinterested sound principles. The fact that blood is thicker than water may justify the reservation of the employment of the European I. M. S. in the civil department but an Indian I. M. S. cannot have any reservation on any account. Some at least amongst the Indian I. M. S. have been showing a great tendency to lose in them the best traditions of Indian life and to the same extent have been imbibing the worst aspect of Western life. Even if the two Indian I.M.S. officers mentioned in the address of the President Bombay Medical Union to the Hon'ble Dr. Gilder are exceptions to the tendency referred to by us, it is not in keeping with the general principles that civil population should have only civil medical men to look after them.

**Absurd Reasoning:** At one of the meetings of the Bombay Corporation held last month (September) the subject of having a whole time officer to be in charge of campaign against Tuberculosis came up for discussion. The Health Committee of the Corporation suggested the name of a doctor already in the service of Corporation and fixed him a salary ranging from Rs. 600 to Rs. 900 with no private practice. It was indeed a matter of surprise that a member of the Corporation belonging to the medical profession should object to the most wholesome and justifiable condition that a whole time medical officer getting a very decent salary, should be debarred from private practice. The surprise is most glaring when the same member justified his objection by saying that if the person was not allowed private practice he, the Tuberculosis Specialist will be deprived of the benefit of additional experience in Tuberculosis. We trust that this specialist appointment was sanctioned by the Bombay Corporation to treat patients in the institutions set apart for the treatment of Tuberculosis. So the reason assigned by this doctor member is most incongruous to say the least especially in Bombay which has the largest number of highly qualified specialists in India who can look after private patients more leisurely efficiently too than a full time doctor can.

**Rural Medical Practice:** It sometimes so happens that what the Government does with one hand it destroys the same with the other. Such a construction cum destruction policy was quite common during the days of diarchical provincial Government in Madras though matters medical were under the absolute control of the popular Minister. Medical Relief in rural areas suffered most on account of changing moods of the Government which again depended upon the methods employed by the Heads of the Local Bodies. The public including the medical profession have been entertaining high hopes that during the Congress Regime interest of the public and not of any individual will weigh more in the judgment of the Government. We do more than hoping and hasten to bring to the notice of the Hon'ble Minister of Public Health some

of the impending dangers to Rural Medical Practice trusting that Government will take immediate action.

During the Justice Ministry under the late Mr. Munuswami Naidu a G. O. was passed that subsidised Rural Dispensaries should not be opened in villages within a certain radius where a qualified practitioners had settled before hand and were practising without the help of Government subsidy. But within a few months of the passing of this order, a subsidised dispensary was started in Kaup, a village in South Kanara District and a medical practitioner who was a relation of the then Taluk Board President was installed as the Subsidised Practitioner in spite of the Government knowing that in that village there existed a qualified registered practitioner commanding decent practice. A similar incident has taken place quite recently in West Godavary District in the village of Tallapudi where a registered practitioner has settled without the help of subsidy. It is reported that in a village called Vegeswarapuram within half a mile from Tallapudi a subsidised dispensary is started and a practitioner from an outside station is put in charge of this subsidised dispensary and that the information gathered by the D. M. O. West Godavary that the practitioner to be appointed at Vegesapuram was practising in that village is not borne by facts. It is possible for the Hon'ble Dr. Rajan to diagnose the ills of party politics in local bodies and we trust a correct diagnosis will be arrived at by him. The aggrieved practitioner at Tallapudi has we are informed appealed to the Government. While deciding this case, the Hon'ble Minister will do well to ascertain how many more subsidised practitioners exist in villages where there are non-subsidised practitioners and transfer the former to villages where the people are in need of qualified medical relief and extend rural medical practice.

The Bezvada District Board is reported to have flouted another sound principle in regard to the location of the subsidised dispensaries to be newly started. We are informed that 25 to 30 subsidised dispensaries have to be newly opened in Krishna District under the jurisdiction of the Bez-

wada District Board and that the Board have pitched upon villages which are in close proximity to villages where subsidised dispensaries exist within a range of 3 miles and in a few cases even a mile and a half. The President of the P.S.R.P.S's Association has suggested to the Government that the Revenue authorities who are the best judges to know the needs of villages depending upon distance and population, should be consulted before any hasty action taken by the Bezvada District Board even on the recommendation of the D. M. O. It may also be mentioned that P. S. R. M. P's Association which met in Madras recently did discuss about this subject and have submitted to the Government their resolution. The Surgeon-General with the Government of Madras whom the representatives of P.S.R.P's Association met on deputation has been apprised about the wasteful expenditure involved if subsidised dispensaries are not located out of the radius of at least 5 miles from each other.

**An Example:** In the Correspondence Columns is published a report of the activities of a Village Sanitation and Development Committee organised by a Subsidised Rural Practitioner in Borigumma a village in Ganjam Dt., till recently in the Madras Presidency now in Orissa Province.

The disinterested and useful services of this practitioner to the village folk should serve as an example to his brethren practising in villages and should also convince the public and the Government about the possibilities of making a rural practitioner a very useful unit of Village Development scheme. As the Central as well as Provincial Governments are very keen in developing villages, we trust they will not fail to reckon the help of the members of the Medical profession settled in villages who if properly encouraged are able to remodel villages with the active co-operation of the villagers themselves financially or otherwise.

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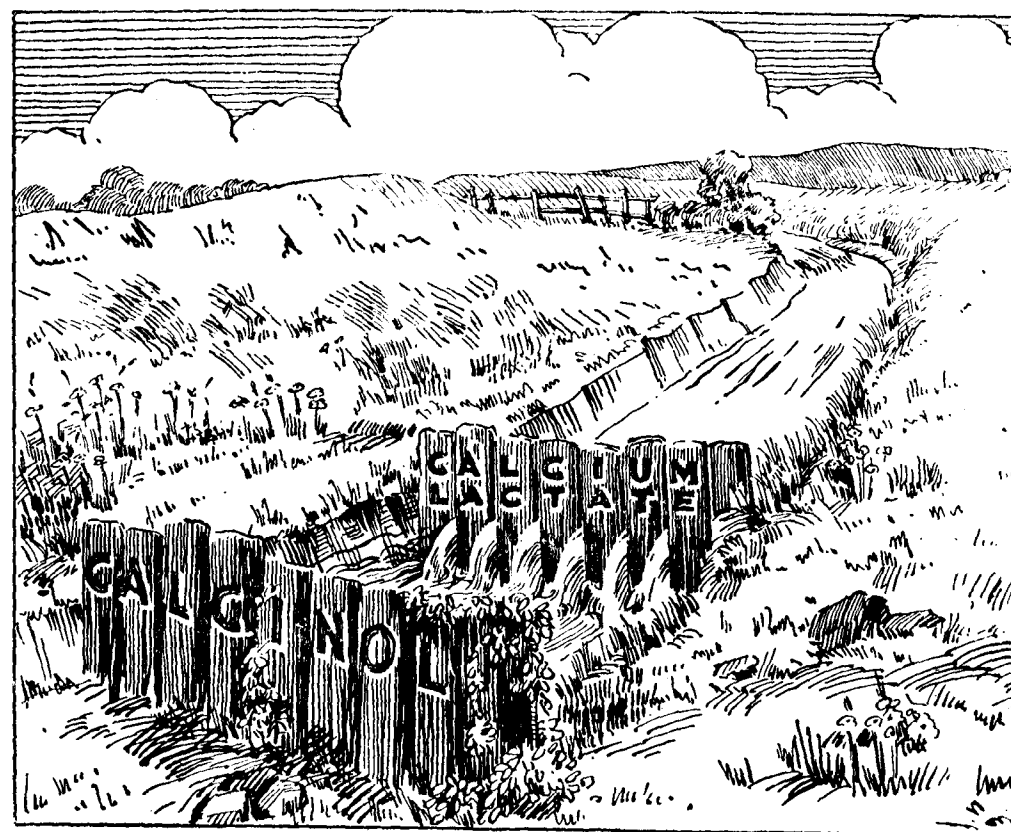
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## Correspondence, Reports Etc.

### The Village Sanitation & Development Committee, Borigumma

To focus public opinion on the importance of Health Propaganda, "The Village Sanitation & Development Committee", Borigumma, celebrated "National Health & Baby Week" this year on 12.9.37. For the successful conduct of the Week, a short and at the same time intensely practical programme was drawn up and gone through. The important features of the celebration are Procession, Baby Show, Sports, Short Lectures on Health Subjects etc.

Short talks on the importance of inoculation and vaccination as preventive measures against Cholera and Small-Pox were given to a large audience by Mr. C. D. Patnaik, Local Amin in Oriya, by Mr. N. Jagannadha Row, C.I. Police, Jeypore, in Telugu and by Dr. K. Ramaswamy M.B.B.S., B.S.Sc., Health Officer, Koraput, in English. The Health Inspector, Jeypore Mr. Kesava Row also gave very interesting lecture in Telugu. The necessity of maintaining a faithful record of Births and Deaths was clearly explained by this Health Inspector.

Prizes in the form of Toys, Jackets, Shirts etc, to the school children and babies were distributed by the President of the day's function, Mr. C. M. Bennett Executive Engineer, P. W. D., Koraput.

Babies from the neighbouring villages were brought and the care of the expectant mother was fully explained to the mothers. Healthy babies were given prizes and all the children present were treated with sweets.

An amount of Rs. 50 was collected from among the local people for the purpose and was spent on the various items of the day.

This is only a small beginning and it is hoped that the coming years would witness greater events.

Advantage was taken of this function and Dr. K. J. Somayajulu, President of the Village Sanitation and Development

Committee gave a short report of the work of the committee in connection with the general sanitary improvements and other civic amenities for the Borigumma Village during the years of its existence since 1935.

The Committee was started in February 1935. Since then steps were taken to create a civic spirit and awaken the sanitary conscience of the people. To this end the Committee made several proposals from time to time to the authorities concerned and thanks to the Agency Surgeon, Dr. J. M. Stirling, and the Taluk Board and the District Board for their kindness in coming to the rescue of the Committee, in sanctioning funds for the improvement of schemes of the Committee, by granting a sum of Rs. 90 per annum for the sanitation and a sum of Rs. 50 per annum for the public street lighting.

The Committee placed on record the very kind co-operation of the public and of Mr. O Pulla Reddi, I.C.S., the Dewan of the Jeypore Samasthanam for donating liberally for the initial expenditure of the lighting scheme of the village with 6 ordinary lights. It is the ambition of the Committee to have a big gas light, 800 C. P., at the junction of the 4 roads opposite to the Police Station. Mr. C. M. Bennett, Executive Engineer, Koraput, had kindly given permission to the Committee to erect the combined lamp and sign post at the junction of the 4 roads. The Committee hoped to finish the work with the co-operation of the public and Government as well.

The Committee at present is only looking after the general sanitation of and lighting of the village. Regarding the protected water supply for the village the President thanked Mr. R. C. S. Bell, I. C. S., Collector and Agent to the Governor and President, District Board, Koraput for having sanctioned the construction of a public well from the "Jubilee Funds." A request had been made to the Collector to get a semirotary pump fixed to the well to ensure full protection of water supply.

The Committee besides looking after the general sanitation and lighting has now taken upon itself to educate the people in matters of Public Health etc., and there has been a good response from the public of the village. It is the earnest desire of the Committee to take up the question of improving the village roads. For this purpose a General Meeting of the villagers was held on the 22nd of last month with the Tahsildar, Jeypore in the Chair. On explaining the benefits of self help, the people readily came forward and on the spot the villagers subscribed Rs. 100. Though the Committee fully realises that "Self help is the best help", it cannot entirely depend upon itself for the execution of the major works in view of its slender resources and undeveloped state of the village.

In this connection the Committee has great pleasure in announcing that Mr. R.C.S. Bell, I.C.S., Collector and Agent to the Governor has been graciously pleased to allot a sum of Rs. 100 through the Rural Medical Practitioner of the village for the improvement of this village roads to augment the voluntary subscriptions of the villagers and the Committee offers its sincere thanks to him.

The most important ambition of the Committee is to convert this village into a "Model Village", and demonstrate to the public practically, how an existing village can be converted into a "Model Village", due to its ideal situation at the junction of the 4 important roads of this Agency of which 2 roads are leading to the independent States--Baster and Kalahandi. For this purpose also the Committee is approaching one and all concerned and hopes that this object of the Committee will be fulfilled during the regime of Mr. R. C. S. Bell, I.C.S., Collector and Agent to the Governor, who is evincing a very great interest in the Rural Reconstruction Scheme.

Regarding the financial help the Committee realises an amount of Rs. 150 per annum from among the local people and an amount of Rs. 140 per annum from the Taluk Board, Koraput. The

total expenditure is about Rs. 280 per annum and thereby the Budget is being balanced so far.

In the interests of the Public Health and the Development Scheme put forward from time to time by the President of the Committee, who is the Rural Medical Practitioner of the village, it is earnestly hoped that His Majesty's Government would come to the rescue of the Committee in the execution of the Rural Development Scheme, which the Committee proposes to undertake.

### 'A Contrast'

DEAR EDITOR,

I read with regret the item "A Contrast" appearing in the August number of your journal in the News and Comments columns.

While professing to fight for unity in the medical profession and to the up-lift of the licentiates—as if they need uplift—the journal very often serves to emphasise the differences between the various classes of medical men. For instance The Medical Practitioner objects to the nomenclature of the licentiates in honorary services and appeals to the Hon'ble Minister for Public Health to put down the 'Injustice' with a 'High hand' as it is the result of "Unwarranted jealousy" who is jealous and of whom and why?

I do not know how the Hon'ble Minister will react your call. But this is how an average individual will react:

The objections must be (1) to the term licentiate (2) to the grades or (3) to both 1 and 2. Regarding (1) I should think the term licentiate is as honourable as the term graduate. If any of the licentiates themselves think less of the term, it is a pity and I can only remind them of the advice of the Hon'ble Minister for Public Health. I can mention several instances where licentiates—at least in Private Practice—have held their own with graduates and sometimes gone on better. Once an English gentleman in an address said "If a man comes to you and says at every opportunity 'I am a pure Englishman' you may

be sure there is something wrong with his pedigree". I commend the wisdom behind these words to The Medical Practitioner. Regarding (2) it is only fair to show what service an individual has put in. You accuse various medical associations for not having protested against this "Injustice" But to me it appears they did not think it necessary to change a nomenclature which is in no way derogatory to the licentiates.

More than once you have objected to the term Sub-Assistant-Surgeon applied to L.M.Ps. The term Sub-Assistant-Surgeon is not confined to licentiates. Let me remind you that there are several graduates as Sub-Assistant-Surgeons. The only reason why there are not more of them is jealousy of at least some of the influential licentiates who saw to it that only a small proportion of sub-assistant surgeoncies were given to graduates, the large majority of posts being reserved for licentiates. You may also be aware that there are a good many licentiates as Assistant-Surgeons. Your argument that a Medical Officer in "Independent" charge of a hospital should not be styled a Sub-Assistant-Surgeon because, according to you, he is sub-assistant to none is not tenable. The District Medical Officer is the Surgeon. He has an assistant or assistants and several sub-assistants. Some of these are posted to places distant from head-quarters but they do not cease to be assistants or sub-assistants of the D. M. O.

The only true ways to abolish "Caste" in the medical profession are as pointed out in a previous letter to you; (1) To abolish the L.M.P. and have only one standard of qualification, i.e., the M.B.B.S. (2) to increase the facilities for existing L.M.Ps. to take the M.B.B.S. Caste will exist so long as medical qualifications are known by different names, even though the standards may be perfectly equal. The argument that in Great Britain different qualifications exist and why not in India is futile. That is one of the evils which need not be copied in India and for which there is no use.

You are trying to prune the top of the tree the root of which is rotten and you know what you are doing, yet you are

not prepared to fight the root cause, i.e., the existence of different qualifications. Why is that? With a popular ministry in office, there are reforms of far greater importance which can be brought about in the profession, reforms which will diminish the appalling death rate, will prevent a credulous public from wasting a great deal of money in pursuing the policy of "penny wise and pound foolish" and will, incidentally, put more money in our pockets. All the energy of the medical associations and medical journals should be turned towards these greater issues instead of towards the petty problems which can be solved with a stroke of the pen.

Koilpatti.

(Sd.) G. DURAIRAJ, M.B.B.S.

(The correspondent is evidently under a misapprehension. Nowhere did we say that the L. M. Ps. should not be called sub-assistant surgeons, though we contend that Registered Medical Practitioners whether in Government service or in honorary service should be designated to indicate the nature of work they are entrusted to do. We wish the correspondent realises the strength of unity for action to solve the bigger problems of the profession. Ed.)

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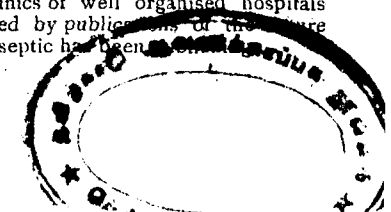
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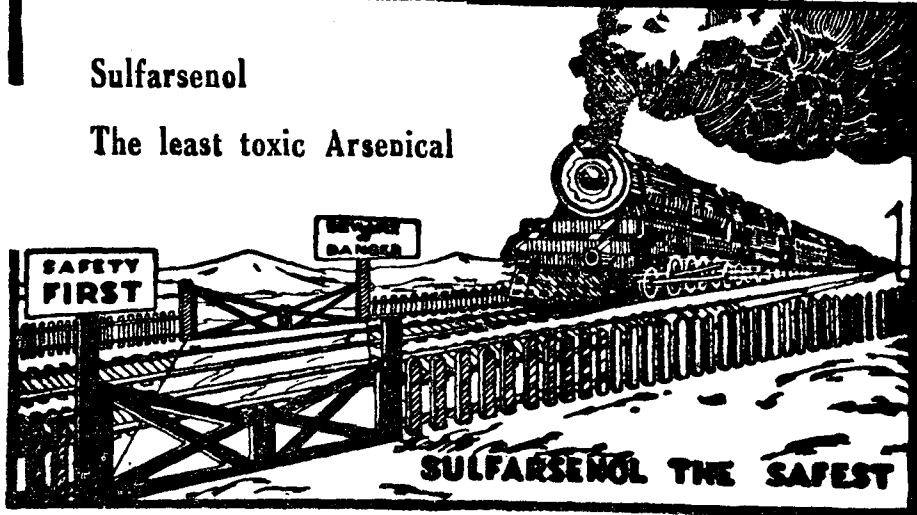
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## Original Articles.

SPRUE.

BY DR. K. NARAYANA MURTHI, M.D.

(Continued from last issue)

### ITS TREATMENT.

From a knowledge of the course and general characteristics of the disease, it is reasonable to anticipate that the treatment of Sprue is often prolonged, difficult and sometimes unsatisfactory. But a timely institution of appropriate measures is almost invariably followed by surprising improvement in the patient. The success of treatment depends upon (1) tackling the disease at an early stage, (2) regulating the diet in accordance with the condition of each individual, and (3) persistent treatment for some months after the last relapse. To secure all the three conditions the patient must be told of the dreadful nature of the disease; for without a complete co-operation of the patient, treatment is difficult to be carried out. The treatment can be roughly classified under four heads:—1. General 2. Dietic 3. Medicinal. This may be subdivided into (a) treatment by drugs, (b) specific treatment, (c) local measures and (4) symptomatic treatment. It is universally and unanimously agreed by all authors who have written on this disease that diet is the most important item of treatment. Erlanger and Hewlett in their experiments on dogs had shown that after removal of a large portion of jejunum and ileum, the dogs developed diarrhoea by diet too rich in fat and undigested food.

*General line of treatment.*—In no other disease co-operation of the patient is so essential as in Sprue. Slight indiscretion in food or drink may undo in a few hours, the good results of months of treatment or flare up a quiescent or unsuspected condition. Therefore it is found always essential to explain to the patient the nature of the disease and the hope of getting over it only if he strictly carries out the doctor's instructions. Every patient with a certain amount of severity of the disease, ought to be put to bed, and the diet is so arranged as to give rest to his digestive apparatus and to leave no residual products which are favourable to the growth of bacteria. Intelligent patients will certainly tell us which particular food agrees and which food disagrees with them, and these patients do improve very well and they contribute towards our successful treatments. If the treatment be undertaken sufficiently early and be thoroughly and intelligently carried out, it is generally marvellously successful.

*Dietetic.*—Endless number of diets have been recommended for Sprue. It is probable that so many "diet cures" have come into existence because (1) the disease has different manifestations in different countries, though the original

infection might have been caught in the Eastern Tropics; (2) there are different stages in the course of the disease where, in a corresponding variation in diet and regimen is to be made; and different people are accustomed to take different diets and the nutritive values of the same food are not constant. Thus the dietetic treatment has to be varied at times in the most essentials and so its management ought to be made to cover the different conditions, under which the disease is met with. Individual patients seem to get well on the most widely different and diverse diets. In prescribing dietary for sprue, one should bear in mind that fats, starches are incapable of being digested and absorbed. As the true etiology of sprue happens to be not definitely known or remains at present in such an uncertain state, it is no wonder that many individual preferences for different lines of treatment are given in different text books.

First let me mention about the milk diet. I have come across in some of the cases intolerance to milk. On trial I found milk aggravating the diarrhoea but these are 10 out of a hundred cases. With a great majority of the cases milk diet agrees, perhaps because the cases were at pre-sprue stage of the disease. When Flexner infection just died out streptococcal infection just commenced, majority of the cases complain of intolerance to carbo-hydrates, but all cases have a good tolerance to a proteid diet. This clinical finding of disagreement of all carbo-hydrates in the patients, lends support to the theory of post-Flexner infection. Manson Bhar, Low, Fairlay and Mackie attach great importance to the milk diet. The milk should not be drunk but sipped. In all severe cases sipping diets ought to be given to begin with and gradually the milk is increased to 5 to 6 pints a day. Every fourth day the total quantity of milk is increased by 10 ounces till the maximum is reached. The total calorific value during the first week may not be more than 1,100—1,500. I do not propose to give tables of different diet, as they can be easily referred to in any text book on tropical medicine. Those diet tables though well

thought of are not suitable and applicable to Indian patients, but may be of some assistance to the doctor to form his own tables of diet to his patient. Since milk happens to be the staple food in cases of Sprue, one has to know the different ways and means by which it can be given. Milk is given in various forms—(1) diluted milk, (2) alkalinized milk—1 to 6 lime water or bicarbonate of Soda 1 gr. to an ounce, (3) citrated milk 1 grain Soda-citras to an ounce, (4) barley water with milk, (5) peptonized milk—this is prepared by boiling 14 ounces of milk with 6 ounces of water and adding an egg spoonful of soda bicarb and two tea-spoonfuls of liquor pancreaticus. The mixture is to be kept for twenty minutes and brought to the boiling point afterwards; by this procedure the albumen and globulin in the milk are converted into peptones. So this milk is easily digestible, but it is repulsive to the patient on account of the bitter taste and bad smell, (6) condensed milk, (7) butter milk—Eledon is a product of butter milk in powder form manufactured by Nestle's Milk & Co., (8) Humanized milk—Frankland method: add to  $\frac{2}{3}$  of a pint of milk, the cream of  $\frac{1}{3}$  pint of milk after stranding for 12 hours, curdle skimmed milk  $\frac{1}{3}$  pint with a square inch of rennet by contact for 10 minutes, break up the curd separating the whey to the boiling point and dissolve 110 grains of milk sugar in it; then add to this  $\frac{2}{3}$  of a pint which has the cream of  $\frac{1}{3}$  in it and lastly add the whey prepared as above. The list of special dietary will not be complete unless another preparation in the market, Sprulac (Cow and Gate Ltd.) is mentioned. This contains 45% of lactose, 34% of protein and 10.6 of fat.

FRUIT DIET.—The Dutch physician Vanden Berg who had an unrivalled experience of this disorder as it occurred in Java claimed excellent results with fruit diet. He considered the indigenous fruits of Java such as mangostans, sapotas, custard apple, papayya, bananas etc. as forming an excellent diet to the patient. It is of the greatest importance that the fruit should be ripe, since by this process of ripening all the remaining

starch is converted into an invert sugar, which is highly assimilable. Bael fruit which is largely sold in the Calcutta market and occasionally at Madras, if given with milk and a small quantity of sugar to taste as a sherbat—is found to check the diarrhoea. Bananas and other fruits mentioned above act similarly. Pine-apples, grapes and other acid containing fruits are not tolerated well by the patients. Strawberries on account of their rarity in India and their cost prohibit their use in our country. In short any pulpy fruit not containing much acid is preferable to stone-contained fruits. Tinned fruits are no good at all. The fruit diet combined with milk diet, and sometimes with meat diet gives very satisfactory results. The good effect of the fruit diet is probably due to its vitamin content, plus the caloric value of its fruit sugar. The patients are tolerant to this form of sugar, since it is a monosaccharide of levo-rotatory nature, which the digestive enzymes need not further split up. A diet of fresh tomatoes is often beneficial.

MEAT DIET.—This is advocated by Cantlie. This suits most of the cases especially in elderly patients with inadequate assimilation who usually suffer from hypochlorhydria and severe anaemia and for whom high protein dietary is indicated. This diet is found to be most suitable for those unable to take milk. In severe cases it is my practice to put the patient first on milk diet and subsequently cut off the milk and then the diet ought to

consist of proteins alone. This protein diet gives immediate relief of some of the symptoms such as diarrhoea and sore mouth. The motions tend to be well formed without any offensive odour and their reaction tends to be alkaline when the meat suits the patients well.

The third method of treatment is medicinal. This can be subdivided into (1) drugs and (2) specific treatment. The preparations that are commonly used are those that are found wanting or defective in the human system, as determined by the bio-chemical methods. The calcium content in blood and the hydrochloric acid content of the test meal in severe cases are found in a few to be low. In these cases calcium lactate 10 to 15 grs. t. d. s., parathyroid 1/10 gr. b. d. and dilute HCl 1 to 2 drachms a day well diluted with water are given after a meal. The intestinal anti-septics such as thymol, menthol, sulphurous acid and astringents like tannic acid, tannalbin etc. are very harmful to the patients and hence should not be given. Salol in five grains dose twice a day, chloramine T and charcoal powders (as ultra carbon, U-carbon etc.) can be given with benefit to diminish flatulence. Depending upon the conception of various theories on the etiology of Sprue vegetable bitters such as gentian, and other preparations like adrenaline, alkalies like sodabarb (to alkaline the system), also ipecac, emetine and bismuth etc., are also administered.

(to be continued).

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## DIAGNOSIS OF COMMON FEVERS

By DR. S. S. RAU, M.D.

This article is confined to the diagnosis of common fevers in Southern India.

The young practitioner sometimes finds it difficult to diagnose a case of fever; if he follows a systematic scheme in the examination of the patient, in the majority of cases, diagnosis is not difficult.

**I. AGE.**—After taking down the name of the patient, the age should be enquired. The fever due to filtrable viruses, *e.g.*, small pox, chicken pox, measles, mumps, acute anterior poliomyelitis, bacterial diseases like diphtheria, whooping cough, coryza, sinus infection, tonsillitis, broncho-pneumonia, empyema infantile diarrhoea, catarrhal jaundice, pyelitis, tubercular meningitis, middle ear disease, and fevers due to metazoa (round worms) are common in childhood.

The eruptive fevers generally occur in epidemics and can be diagnosed by the rash. I do not want to go into the details regarding the rash as their description is found in any text-book. One thing I want to lay stress on, is, the reddening and watering of the conjunctiva which is constantly found in measles even on the first or second day. Koplik's spots are found in a few cases and are worth looking for. In all cases of fevers in children which are not diagnosed by the 7th day, the following examination should always be done.

(1) The bulbar conjunctiva covered by the upper lid should be examined for any yellow tinge suggestive of jaundice.

(2) A few drops of centrifuged urine should be examined for pus cells especially if the child be a female. A positive finding is found in pyelitis.

(3) Signs of weakness or paralysis should be elicited in the extremities. If found the case is most probably one of acute anterior poliomyelitis.

(4) The ear should be carefully examined for otitis media.

(5) The throat should always be examined as a routine in all cases and always once more in all cases of obscure fever to find out diphtheria.

(6) Unilateral nasal discharge with excoriation of the upper lip is in most cases due to nasal diphtheria.

(7) In all cases of obstinate vomiting think of tubercular meningitis and round worms.

**II. SEX.**—There are certain diseases which are most common in women than in men, *e.g.*, pyelitis and cholecystitis. Whenever fever occurs in a woman during pregnancy or after delivery think of the possibility of pyelitis even though there are no urinary symptoms. An obscure fever in a middle aged fat woman of sedentary habits is sometimes due to cholecystitis and the gall bladder region should be carefully examined. Diseases due to generative organs *e.g.*, salpingitis, perimetritis should always be thought of in the female sex, and enquiry should be made whether there is leucorrhoea. A vaginal examination should never be omitted.

**III. RESIDENCE.**—Malaria is prevalent in marshy areas such as plantations. Kala-azar is endemic in certain areas of Madras.

**IV. OCCUPATION.**—Mill hands, knife grinders, stone cutters, and people having dusty occupations are more prone to suffer from tuberculosis of the lungs than others.

**V. FAMILY HISTORY.**—If there be a case of tubercle in a family an obscure fever in any child of the family living in the same house, is sometimes due to tuberculosis.

**VI. PREVIOUS HISTORY.**—Diseases like pneumonia, erysipelas and appendicitis tend to recur, tuberculosis may follow whooping cough and empyema may follow pneumonia. Affections of air

sinuses and middle ear disease follow measles and influenza. Hepatitis may occur after amoebic dysentery. Pyelitis commonly occurs after delivery; septic fever is common after abortions and deliveries.

**VII. HISTORY OF PRESENT ILLNESS.**—1. Enquiry should be made about the prevalence of epidemics like small pox, measles, typhoid fever etc. 2. Onset—whether sudden as in pneumonia or in acute infectious diseases or insidious as in typhoid fever. 3. Symptoms at outset *e.g.*, shivering or rigor is generally found in malaria, pneumonia, acute infectious diseases, septicaemia or pyaemia; convulsions denote that the nervous system is affected except in the case of children where they sometimes take the place of a rigor. Vomiting is generally found in small-pox, gastro-enteritis, appendicitis, and meningitis; diarrhoea if found is suggestive of bacillary dysentery, infantile diarrhoea, typhoid fever, meningitis and influenza.

**VIII. TEMPERATURE CHART.**—This gives very useful information. Fever coming on alternate days or once in two days is suggestive of malaria, double diurnal rise of temperature of kala-azar; a continuous temperature—a step ladder like rise in the first week of typhoid fever; periods of temperature alternating with periods of quiescence, of relapsing fever or rat-bite fever; a number of rigors in the course of a fever, of septic conditions, an inverse rise of temperature, *i.e.*, increase in the morning and fall in the evening of acute miliary tuberculosis.

**IX. PHYSICAL EXAMINATION.**—(a) Have general survey of the patient. A listless position in bed is found in typhoid fever, restlessness is found in acute infectious diseases, pneumonia etc.; patient lying down on the back with legs drawn up is found in cases of abdominal troubles. retraction of the head in meningitis; Rashes, if found, according to the day of their appearance, the places in which they occur and their character are suggestive of certain diseases. I do not want to deal with them here, but secondary syphilis should always be kept in mind. A

number of nodules specially on the lobes of the ears and eyebrows and on the face is suggestive of leprosy. Herpes of the lips is found in malaria, pneumonia cerebro-spinal fever. Conjunctival redness is found in the measles and blood-shot eyes in plague; yellowness of the conjunctiva is found in catarrhal jaundice, infantile biliary cirrhosis, cholelithiasis, black water fever and some cases of malaria. Alae nasi moving is found in pneumonia and should always be looked for. Enlarged glands in the neck are found in septic conditions about the head, face, mouth and throat,—tubercular affection, secondary syphilis, diphtheria, lymphatic leukaemia and Hodgkin's disease. I have seen cases of rat-bite fever with enlargement of cervical glands when the bite has been somewhere about the face. Enlargement of the glands in the groin is found in septic conditions of the leg, filariasis, plague, and climatic bubo. If boils, abscesses or carbuncles are found all over the body examine the urine for sugar. If there is pain and swelling of the joints, think of rheumatism, gonorrhoea, septic arthritis and lastly gout especially if the joint of the big toe is involved. Look for clubbing of the fingers which is very useful in diagnosing bronchiectasis, tuberculosis of the lungs.

If this general examination and the facts gained by history give no clue of the fever, examine the body systematically.

(1) Feel the pulse, if dicrotic it is suggestive of typhoid, if wiry of peritonitis; count it.

(2) Watch the respiration. If Cheyne Stoke's it is suggestive of meningitis; count the number. If the pulse respiration ratio is altered from 4:1 to 3:1 or 2:1 most probably the case is one of pneumonia. If the pulse is slower than what the temperature indicates, it is most probably typhoid, influenza, dengue or meningitis; if more it denotes peritoneal mischief *e.g.*, appendicitis, peritonitis etc.

(3) Examination of the abdomen gives a clue to many fevers whose cause is not obvious at first sight. A distended abdo-

men may be due to the presence of gas, fluid or increase of size of its contents.

*Palpate the liver:* If palpable it may be due to hepatitis, alcoholic or amoebic or due to catarrhal jaundice, kala-azar, chronic malaria, leukaemia, Hodgkin's disease, Addisonian Anaemia. Palpate the gall bladder region at the tip of the right ninth costal cartilage; enlargement and tenderness if found it may be due to cholecystitis and cholelithiasis.

*Palpate the spleen:* It is enlarged in malaria, kala-azar, typhoid fever, septicaemias and subacute bacterial endocarditis.

*Feel for any masses* in the abdomen. If found they are most probably enlarged glands due to tubercular disease. Hodgkin's disease or leukaemia.

*Palpate the kidneys* with one hand in front and the other behind. Tenderness indicates nephritis, pyelitis, pyelonephritis, and if there is enlargement also, pyonephrosis.

*Palpate the right Iliac fossa:* Gurgling is found in typhoid fever. Extreme tenderness and rigidity at the part, especially at McBurney's point is found in acute appendicitis. If the pain be found in women especially if it be a bit in the lower part, pyosalpinx should always be borne in mind. If a mass can be felt, and if the condition be not acute, tubercular caecum or chronic appendicitis is possible.

*Palpate the left Iliac fossa:* Pain and tenderness are suggestive of diverticulitis.

*Palpate the hypogastrium:* Tenderness and pain are due to cystitis or inflammation in the pelvic region especially in women.

(4) *Examine the nostrils* with a speculum in good light. Look for mucous or purulent discharge or membrane. Palpate the frontal bone at the root of the nose, and the body of the maxilla and elicit whether there is any tenderness. Sometimes an obscure fever is due to nasal

sinusitis or nasal diphtheria. In coryza there is only a mucous discharge.

*Examine the throat* for (a) adenoids (b) tonsillitis (c) diphtheria (d) retropharyngeal abscess. The cause of fever is in some cases due to these.

*The lungs* should now be examined in the routine way for the following diseases:—

(a) Bronchitis, (b) Broncho-Pneumonia (c) Lobar Pneumonia (d) Tuberculosis of the lungs, (e) Pleurisy (f) Bronchiectasis, (g) Abscess and Gangrene of the lungs. The last two affections can be known by the foetid character of the sputum. An obstinate cough in a child, not amenable to the usual remedies, and with very few signs either in the throat and lungs is generally whooping cough. Of course when there is vomiting or the whoop the diagnosis is obvious.

(5) *Examine the teeth* for (a) Pyorrhoea, (b) Caries (c) Apical abscess; the last can only be made out with certainty by X-rays. Sometimes an obscure continuous fever is due to these causes.

Ask the patient to put out the tongue. (a) If coated in the middle and raw at the tip and edges is characteristic of typhoid. (b) A clean tongue with a continuous fever is found in kala-azar. (c) A strawberry tongue indicates scarlet fever. Some years ago there was an epidemic of this uncommon fever in Bombay in a mild form. The diagnosis was ultimately confirmed by the disquamation of the skin which occurs in these cases.

A Rectal examination should be made for perineal abscess, ischio-rectal abscess, inflamed piles, prostatitis and visiculitis. In cases of peritonitis a painful tender mass can always be felt per rectum.

(6) There are a few diseases of the circulatory system which produce fever. They are:—

(a) *Acute pericarditis:* Here the patient is generally in great distress; and complains of pain in the precordial region. There is dypnoea and cyanosis.

There are very few signs in the lungs. Examination of the heart reveals the signs of the condition.

(b) *Endocarditis:* Simple endocarditis generally occurs during the course of acute rheumatism. The fever increases and murmurs are heard in the heart region. Septic endocarditis occurs in septicaemia. There are murmur in the heart region, rigors and septic embolism in various organs. Sub-acute bacterial endocarditis due to streptococcus viridans should always be thought of whenever there is a continuous fever resembling typhoid. In this condition in addition to the fever there is anaemia, enlarged spleen, R. B. C. in the urine and small red tender spots occurring over the body specially at the tips of the fingers.

(c) *Coronary thrombosis:* This important disease is fairly common. The patient who is generally elderly complains of severe pain in the region of the chest, the body is covered with cold clammy sweat, the pulse is feeble and the blood pressure low. Within a few hours, there is fever which may not be very high, leucocytosis in the blood and in a few cases a rub may be heard over the precordium. The electro-cardiogram shows the characteristic change in the S. T. interval and T waves.

(d) *Phlebitis:* Here, there is pain and tenderness and in an exposed situation the vein can be felt and the part is swollen. In pyelphlebitis, the liver is enlarged and tender; the disease sometimes follows appendicitis.

(7) Affections of the nervous system also give rise to fever. The chief of them are:

(a) *Meningitis* which may be cerebro-spinal tubercular or septic. In all these cases there are first of all signs of irritation of the meninges, such as severe headache, increase of intracranial pressure causing vomiting and optic neuritis, irritation of the posterior nerve roots causing rigidity of the muscles of the neck and extremities. These can be elicited by Kernig's sign and Brudzinski's

sign. The cerebro spinal fluid is under great pressure, turbid, and there are changes in the cellular content. The causative organism can be recovered from the fluid.

(b) *Encephalitis:* There are signs of paralysis, according to the area of the brain affected, and somnolence. Meningeal signs are not found.

(c) *Acute anterior poliomyelitis* otherwise known as *infantile paralysis* is generally confined to children. After fever for about a week, with pains in the limbs, there appears weakness and finally paralysis of groups of muscles.

(8) Reproductive system should next be examined—In the male the urethra should be examined for gonorrhoeal discharge, which may cause fever during the acute stage, and also on account of the complications, prostatitis, vesiculitis, epididymitis, cystitis, pyelitis, arthritis, and bubo. The penis should be examined for soft sore which also produces a bubo with fever.

In the female Bartholin's glands should be examined for inflammation, and the urethra and cervix for discharge of gonorrhoea. A vaginal examination should be made, and the fornices should be palpated bimanually for pyosalpinx or pus in the pouch of Douglas—the uterus should also be felt for pain and tenderness denoting endometritis.

(9) Skeletal system: Need for examination of the joint has already been mentioned. The bones should be felt for osteomyelitis especially in children; carries of the bone, e.g., ribs, vertebrae, sternum should specially be looked for.

(10) Special senses: The mastoid process should always be examined. Mastoiditis leads to serious complications like meningitis, thrombosis of the internal jugular vein and cerebral abscess.

Inflammation of the eye-ball and dermatitis also cause fever. It is well known that the exfoliative dermatitis follows a dose of Neo-Salvasan or metallic preparations of gold etc.

In all cases where laboratory facilities or other aid like X-rays are available, these should be resorted to, to confirm the diagnosis and also in those cases where physical examination has not been sufficient to diagnose the case. Laboratory or other aids should not be utilised for diagnosing ordinary cases without a careful physical examination.

(1) Blood should be examined for finding out parasites like those of malaria, microfilaria, spirochaete or relapsing fever. Blood count is to be resorted to. Relative polymorphonuclear increase is suggestive of purulent infection. This is specially valuable in finding out appendicitis, amoebic hepatitis and diverticulitis. A big increase in the total W. B. C. count with the present of myelocytes is suggestive of leukaemia. The total R. B. C. count when much reduced with a colour index more than one is found in Addisonian anaemia which sometimes causes obscure fever.

(2) Serum tests: Agglutination tests for typhoid and paratyphoid fevers and bacillary dysentery. Wassermann and Kahn tests for syphilis. Secondary syphilis produces fever and rash which is sometimes mistaken for an exanthem.

(3) Blood cultures should be made for typhoid bacillus in the 18th week, septicaemias and infective endocarditis. Many a time the cultures are negative most probably on account of the paucity of organisms in the blood taken.

(4) Examination of sputum for tubercle bacilli. This is of great help in diagnosing pneumonia, with delayed resolution or bronchiectasis from tuberculosis of the lungs.

(5) Examination of urine for bile pigments in cases of catarrhal jaundice, for albumen and casts in nephritis, for pus cells in pyelitis and for tubercle bacilli, in tubercle of the kidney are extremely useful in clinching the diagnosis. Culture of the urine is useful in finding out the causative organism in bladder and kidney infections.

(6) Examination of the motions. Amoebic cysts are found in cases of amoebic hepatitis. Bacillary and amoebic dysentery can be differentiated in non-typical cases. Round worms are found in typholumbericosis.

(7) Spleen puncture and the examination of the aspirated fluid is used for finding out the K. A. Bodies. Fluid aspirated from the chest is useful in distinguishing simple pleurisy from empyema and for finding out the causative organism. Tapping the abdomen and examination of the peritoneal fluid is useful in diagnosing tubercular peritonitis. Lumbar puncture is useful for diagnosing meningitis from other fevers simulating it, e.g., typhoid, apical pneumonia and also the varieties of meningitis whether cerebro-spinal, tubercular or septic. Fluid aspirated from a nodule of the skin for finding out bacillus leprae.

(8) Swabbings from the various orifices e.g., nose, for diphtheria and leprosy; throat for diphtheria, streptococcal infections; urethra and cervix for gonococci, rectum for amoebiasis. The gloved finger is to be used for taking a smear from the rectum.

(9) Inoculations: Guinea pig inoculations with the pleural and peritoneal fluids and urine is resorted to for finding out tubercular disease. The inoculated animal dies within six weeks from tubercle. Intradermal test (Mantoux). Here 1 c.c. of 1:1000 old tuberculin is injected intradermally. Redness and oedema develop within a few hours and reach a maximum in 24 hours in positive cases. Frei's intradermal test for climatic bubo. This disease is found in Madras.

(10) Biopsy-Histological sections obtained by biopsy are useful for distinguishing tubercular glands from Hodgkin's disease.

(11) Simple X-ray examination of the lungs for tubercle, examination after injection of lipiodal for bronchiectasis, X-ray examination of the roots of the teeth for apical abscess, of bones for osteomyelitis, of the intestines after

barium meal or barium enema for chronic appendicitis and diverticulitis respectively is very useful.

(12) Electro cardiogram is useful for diagnosing cases of coronary thrombosis which also produces fever.

(13) In places where these additional aids are not available, or cannot be resorted to on account of expense one may resort to therapeutic tests after carefully weighing the pros and cons of the case. These are:

- (a) Quinine in verifying malaria.
- (b) Antimony in verifying kala-azar.
- (c) Neo-Salvarsan in verifying syphilis, relapsing fever and rat-bite fever.

(d) Antidiphtheritic serum in verifying diphtheria.

This article does not claim to be complete. The writer has dealt with only with common fevers met with in his practice. The physical examination though appearing long can be done within half an hour. Some of the laboratory tests can be done with the help of microscope within a very short time. The other tests involving heavy expense have been resorted to, by him, only in a few cases. The object of this article will be fulfilled if the young practitioner examines the patient systematically in the above manner. The older practitioner many a time diagnoses the cases quickly on account of the clinical intuition gained by his experience.

## TUBERCULOUS DISEASE OF THE SPINE.

### PART II

BY LT. COL. M. M. CRUICKSHANK, M.D., M.CH., F.R.C.S.E., I.M.S.

*General Hospital, Madras.*

#### THE RITUAL OF EXAMINATION OF A TUBERCULOUS SPINE.

To follow a scheme is necessary if nothing is to be missed.

1. *Observe general appearance and nutrition.*—The one time bright child who becomes dull, feels tired at night, is losing weight,

2. *Observe body attitude and gait.*—*The Spine's attitude.*—The joints of the lower limbs are semi-flexed to lessen painful jars.

*Local peculiarities.*—

In the cervical region—Three positions of the head are noted, the wry neck, flexed or extended position.

In the Upper Dorsal,—a sunken neck. Brevis Collis.

In the Mid Dorsal—a short thorax and apparently long arms.

In the Dorsal-lumbar—the Alderman's gait, where the patient stands on a broad base with prominent abdomen.

In the Lumbar-region, a spondylolisthesis with marked lumbar lordosis—the abdomen projecting forwards, so that the 12th rib touches the iliac crest.

3. *Inspect the spine.*—This will reveal one or more of the following:—

Posterior angulation, a kyphosis greatest in the dorsal, less in the cervical and least in the lumbar region.

Lateral Deviation—a scoliosis sometimes the first evidence of Pott's disease. The Scoliosis is like a simple scoliosis but of rapid onset with spasm and pain.

Boardening or Flattening of spine—This is simulated by very few diseases, and is therefore of great clinical value.

Abnormal degree of spinal Lordosis. The kyphosis is compensated for by lordosis above and below.

4. *Take a permanent record of the Deformity.*—To record Kyphosis—mould a strip of lead  $18'' \times 1\frac{1}{2}'' \times \frac{1}{8}''$  on the spine and trace the outline on paper.

To record scoliosis—Apply a plaster 3'' broad over the spines; dot out spines; remove the plaster; back it with paper and preserve it.

5. *Examination of the Movements of the spine.*—N.B. Muscular spasm and rigidity. Muscular rigidity in the para-spinal muscles affects all movements but especially those in the sagittal plane.

To Test for disease in the :—

Cervical Region.—Place the child on his back, face and sides, and the head will drop to opposite side if no tuberculosis is present.

In older children test nodding, lateral and rotary movements.

Dorsal Region.—Having marked the spines with a coloured pencil ask the child (1) to sit down (2) to pick something off the floor and note how he does it. He will sit down with a stiff back on having picked the object off the floor will work himself up into the erect posture in the same fashion as does a case of hypertrophic muscular dystrophy.

Test extension by placing the child prone, then grasp the ankles, raise the limbs from the couch and spine ought normally to sink in, in a uniform curve.

Lumbar region :—

Spasm of the psoas causes spinal flexion.

6. *Examine for cold Abscess formation.*—

Certain parts of body should invariably be examined.

Pharynx, Sides of neck, Iliac Fossae Loins, Poupart's ligament, Scarpa's triangle.

Mediastinal-prevertebral - psoas abscesses may be suspected by—percussion, X-ray examination and by the rigidity of the psoas muscle preventing hyperextension of hip.

7. *Examine for Paralysis.*—

Motor rather than sensory and most frequent in high dorsal disease.

Bladder and rectum rarely involved.

At first the paralysis is spastic, then flaccid.

Trophic disturbances—induced by bed sores, and Vasomotor disturbances—by persistently cold limbs, and a tendency to free perspiration.

8. *Observation of compensatory changes in.*—

|         |                                                                          |
|---------|--------------------------------------------------------------------------|
| Cranium | } Configuration of ;<br>e.g., "barrel shaped" thorax;<br>tilted pelvis ; |
| Thorax  |                                                                          |
| Pelvis  |                                                                          |

9. *Changes in Heart and vessels.*—Cardiac hypertrophy, Cardiac Dilatation, Valvular Diseases, Investigate the relative potency of large blood vessels.

10. *X-ray Examination of position of Spine affected* will reveal some narrowing of the Intervertebral space ; Will decide the presence or not of a prevertebral abscess—or of tuberculous sequestra or debris.

X-ray examination will also be required to estimate the extent of the disease and to assess progress.

*Differential Diagnosis.*—Having gone through the ritual of examination of the spine, the diagnosis may still be in doubt and these doubts must be cleared away because adequate treatment can only follow a definite diagnosis. In the cervical region one will consider the differentiation from

1. *Brachy-collis* (Keippel-Feil Syndrome) or *congenital short neck*, a condition due to irregular segmentation of the spine in the early weeks of foetal life. In typical cases the X-ray film shows a fusion of the lower cervical vertebrae into a

solid mass. The condition is associated with other congenital defects.

2. Congenital Torticollis, where the muscles are shortened and the head is flexed and bent towards the affected side and rotated towards the opposite shoulder.

In the dorsal region :

1. Rachitic Kyphosis, where the absence of muscular spasm and of pain and the evenness of the Kyphotic curve will rule out tuberculous disease.

2. Simple kyphosis, again the absence of spasm and of pain and the rotation of the vertebrae and ribs producing the characteristic rip hump will decide against tubercle. In simple scoliosis the ribs rotate backward on the convex side while in caries the ribs rotate backward on the concave side.

3. Spinal neuralgia in nervous girls, the pain here is more acute more diffuse, more superficial and rigidity is absent.

4. Kummell's disease (Post traumatic spondylitis), where after a spinal injury, wedge shaped collapse of a single, vertebrae occurs.

5. Scheurmann's disease, (adolescents) a vertebral epiphysitis, which affects the upper and lower surfaces of the vertebral bodies several vertebrae and not necessarily 9 continuous vertebrae being affected, in the thoracic and upper lumbar regions.

The upper and lower margins of the bodies are increased in density and of irregular outline as if eroded.

The width of the intervertebral cartilage is diminished and there may be some wedge shaped deformity. There is tenderness over the spines, but little or no limitation of movement and no muscular rigidity or atrophy.

6. "Calves' disease (5-9 years) an osteochondritis of one vertebral body, the analogue of Perthe's disease in the femoral head. The inter-vertebral disc is not affected".

In the lumbar region we meet with difficulties because here the vertebrae are deeply situated, movements are limited ; the proximity of the psoas muscle is also a source of difficulty ; neither symptoms or deformity constitute a prominent feature of the case. We must consider—in the region.

1. Hip joint diseases—in this all movements of the joint are limited if not abolished but one remembers that coxitis may co-exist with tubercle of the spine.

2. Sacro iliac disease is diagnosed by pain on pressure over the anti-superior spines of the ilium.

If in difficulty ; complete rest will clear up the simpler conditions and give time for further manifestations in more serious states.

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## Abstracts.

### SUNLIGHT AND HEALTH.

The belief that sunlight exerts a beneficial effect on health is at present exceedingly popular. Its general endorsement by the public is visible during the summer months at the beaches and summer resorts. The growing tendency to continue "sun bathing" throughout the year is indicated by the increasing numbers of "sun lamps" available on the open market and the rather large numbers of these devices purchased by the American people for use in their homes. But what is the scientific knowledge regarding the effects of sunlight and of ultraviolet rays on health? Does such information indicate a need for excessive basking in the sun's rays or does it suggest that this practice is unnecessary or perhaps even undesirable? Laurens has recently reviewed the available knowledge in this field.

First, which of the sun's rays actually pass through the outer layer of the skin into the deeper strata? Studies have shown that practically all the rays in the extreme ultraviolet range are reflected from, are absorbed by the outer, horny layer of the skin, whereas a considerable proportion of the longer ultraviolet, the visible and the near infra-red rays are transmitted and penetrate into the malpighian layer, the corium and, in the case of the visible and near infra-red rays, even the subcutaneous tissues. Thus, the horny layer of the skin apparently protects the deeper strata from the shorter ultraviolet rays. Pigment, which is present in the basal layer of cells of the stratum corium, apparently serves as a screen to prevent the "true skin" from receiving too much energy in the form of the longer ultraviolet rays.

The question of the effects of the rays that are transmitted by the stratum corium into the deeper layers of the skin has received wide attention. Certain beneficial effects are well known, as, for example, the favorable influence of the ultraviolet rays on the assimilation of calcium and phosphorus and the resultant prevention or cure of rickets as the results of the formation of vitamin D in the skin.

Favorable effects of moderate amounts of sunlight on the blood and circulation have also been described, particularly in increasing the platelet count in cases of idiopathic purpura haemorrhagica and as an adjuvant to diet and standard therapy in the treatment of secondary anemia. "Sunshine" carbon arc radiation has been alleged to cause a temporary decrease in both the systolic and the diastolic blood pressure in patients with essential hypertension. Natural sunlight, according to a number of authorities, hastens the healing of sluggish, indolent wounds by its local effect on the circulation of the blood and may be of benefit in tuberculosis of the skin (lupus vulgaris). Many believe that heliotherapy constitutes a valuable aid in the treatment of pulmonary tuberculosis. However, perhaps as many equally competent authorities feel that the results are "not likely to be spectacular and its omission not detrimental to the patient's best interest."

Harmful as well as beneficial effects may result from exposure to sunlight. Under certain conditions, as yet none too well defined, photosensitization may occur and the subject so sensitized may experience serious reactions on subsequent exposures to sunlight. A number of skin diseases, such as urticaria solaris and lupus erythematoses discoides, are probably due to this type of sensitization. Likewise it is well known that prolonged exposure to sunlight may cause not only inflammatory and degenerative changes in the skin but also systemic disturbances. One authority has stated that overexposure to sunlight may bring about damage to the central nervous system, especially the brain, as a result of heating of the skull.

Thus it is evident not only that sunlight may exert a beneficial influence on health but also that it may cause serious harmful effects. Laurens believes that the beneficial effects appear to be largely overemphasized. As far as known, man actually requires only a relatively small amount of sunshine for the maintenance of normal health, and the greatest danger perhaps at the present time lies in too much exposure to sunlight rather than too little. Certainly, overindulgence in solar radiation should be avoided because of

known possible ill effects. "Owing to the hypersensitivity of many infants and adults, caution should be used in the use of sunlight, both natural and artificial. Overindulgence, even in the normal, is foolhardy."—*Journal A. M. A.*, June 13, 1936.

### DISCUSSION ON HYPERTENSION.

H. H. SHOOK, M. D. Cincinnati, Ohio.

Perhaps no subject has received more attention during the past ten years than hypertension. To me the subject represents the most important of the unsolved problems in medicine today. And rightfully so, with the ever increasing number of deaths from heart disease, the vast majority of them being directly caused by the effects of hypertension. White has estimated that 70,000 persons die annually in the United States as a result of hypertensive heart disease and an equal number succumb to other consequences of hypertension.

Unfortunately, in spite of the vast amount of experimental work that has been done, the problem still remains unsolved. The ever increasing list of therapeutic agents point only to the fact that, to date, none have proven satisfactory. Fifty years ago blood letting was the chosen method of treatment. Today we use one of an ever increasing list of drugs with which we hope to relieve peripheral resistance in the vascular system. In well advanced hypertension showing clinical evidence of markedly peripheral resistance which manifested in terms of an abnormally high diastolic pressure, I seriously doubt if our therapeutic endeavours are of much more avail today than they were when such patients were bled.

In spite of this pessimistic attitude as it pertains to treatment we have learned to appreciate some consistent pathological features of this condition. Fishberg in seventy-two cases of essential hypertension, examined at autopsy, found arteriolar capillary fibrosis present in all cases. This finding was present not only in the glomeruli but also in the spleen, pancreas and liver. The same findings were present in the terminal arterioles of the skin, skeletal muscles, myocardium, lungs, gastrointestinal tract and thyroid gland. Such findings have been reported so frequently by other workers to establish this fact as an indisputable consistent patho-

logical accompaniment of hypertension. But is this finding the cause of hypertension or is it a protective mechanism on the part of the vessels to withstand the abnormal pressures to which they are gradually subjected? Perhaps at the onset vascular spasm may be a factor but sooner or later organic change takes place. The problem to be solved is by what mechanism are these changes produced. It may well be, as Dr. Herrmann suggests, that there is more than one causative factor involved. While we may not as yet know how to adequately treat the hypertension *per se* we have learned to appreciate its significance and to more properly appraise the ability of the circulatory apparatus to function adequately in spite of its handicap.

Something may well be said in defence of the adrenal glands. While it is possible that they may eventually be shown to play a part in the production of hypertension, such evidence has not been fully brought forth to date. Unfortunately we have no clinical or laboratory test with which to test the functional ability of these glands. To my knowledge hyperplasia of the adrenal glands has not been a consistent finding in hypertension. The analogy between certain rare adrenal tumors with crises of hypertension and the problem under discussion does not hold, as has been pointed out by Dr. Herrmann tonight as well as by others.

Until further evidence has been produced it does not seem that we have produced sufficient evidence to date to place the burden of production of hypertension upon the adrenal glands. Dr. De Courcy has stated that in spite of bilateral resection on the adrenals the blood pressure was only relieved in most instances temporarily. This only again goes to prove that when once high grades of peripheral arteriolar capillary fibrosis is present that the hypertension is certain to continue. Is it possible that the temporary rest as occasioned by a convalescence from a surgical operation was the chief factor in producing the temporary fall in pressure?

Until the time that more incriminating evidence is produced it would seem that interference with the adrenal glands is not justified, especially since recent reports indicate that such interference may not be an innocuous procedure.

## Notes on Therapeutics, Diagnosis and other Medical Subjects.

### ALLERGY AS THE CAUSE OF FREQUENT COLDS AND CHRONIC COUGHS IN CHILDREN. NORMAN W. CLEIN.

Northwest Med. 35: 347 (Sept.) 1936.

The ingestion of foods and the inhalation of certain forms of dust, animal dander and plant pollen may cause frequent colds and chronic coughs in susceptible individuals. This is in direct contrast to similar symptoms that are caused by infection and bacteria. Frequent colds may be interpreted as perennial or seasonal hay fever, the chronic persistent cough of this particular type as a preasthmatic system. That these diseases are due to sensitization or allergy, rather than germs, has been mentioned by many investigators in the past decade. The early recognition of the allergic state in childhood, with proper diagnosis and adequate treatment, may prove to be the chief factor in the prevention of asthma and other major allergic disasters. The diagnosis of these cases is just as definite as that of many other commonly recognized diseases. Certain criteria are present in practically all of these patients, and the allergic history is of paramount importance. The patient has a cold "all the time". He no sooner recovers from one than he develops another. The onset and termination of symptoms may be abrupt lasting a few hours to days. The symptoms may be seasonal. Chronic coughs are frequently preasthmatic manifestations. The diagnosis of asthma in the anteparoxysmal state is justifiable in children in whom there are frequent colds and bronchitis or chronic coughs which do not run a typical course or yield to the ordinary therapeutic measures. There are definite physical findings, but attention is directed to the nose on account of evident obstruction to proper breathing. The geographical tongue or those that have smooth, bare, shiny, round or circinate lesions with raised borders are pathognomic of an allergic diathesis, or present

allergy in any individual. Sinus pathology consisting of an allergic edema may be present. In the diagnosis of acute and chronic rhinitis, croup, paranasal sinusitis, laryngitis, tracheitis and bronchitis the possibility of allergy must be considered. In children acute and chronic infections may obscure a primary underlying allergic condition.

The treatment depends primarily on the results of the allergic study. Dietary management, based on the results of the tests, should be strict. It is highly desirable to substitute foods to provide the proper amount of nourishment and essential food elements for childhood development. Avoidance of allergens present in the inhalant (dust) group is desirable. A dust (allergen) free bed room is desirable. Where the desired effect has not been obtained by avoidance therapy, it is necessary to rely on specific desensitization. Various types of nose drops, iodides, ephedrine, and other drugs may give slight temporary relief of local symptoms. It is very significant that the treatment for pollinosis makes most children less susceptible to common colds during the succeeding winter. The prevention of asthma and other major forms of allergy is the ultimate goal in the treatment of frequent colds and chronic coughs of proven allergic nature. The immediate goal, the relief of irritating nose and throat symptoms, will restore the child to a plane of normal mental and physical activity. This may be attained by rational treatment.

### WATER FILTRATION vs. CHLORINATION

A tendency is manifest in some quarters to advocate filtration of public water supplies as against chlorination. In the interests of public health and clear thinking, it seems worth while to examine the merits of this discussion. The value of chlorination in preventing water-borne infections needs no defence, as shown by the experience of many American municipalities using chlorinated water during the past ten years. Is filtration to be preferred? Filtration of a public water supply cannot guarantee the continued safety of that supply. In point of fact

some of the classic outbreaks of water-borne diseases, such as the Altona Germany, cholera epidemic of 1892, have been caused by supplies supposedly guarded by a filtration process. In most instances today, wherever large water supplies are filtered, it is thought advisable to chlorinate the effluent as an additional or final safeguard. In general, if a community had to depend for health protection on filtration alone for chlorination alone, chlorination probably would be chosen.

Filtration possesses one obvious advantage—it can clarify a turbid water. There is no doubt that clear water makes a strong esthetic appeal. The expense of gratifying this feeling by clarifying the whole public supply is, however, considerable. Crystal clear water is not necessary for all household purposes. Where money is an object, the value of a clear water supply would probably be balanced against the urgency of other community needs.

Any method of water treatment calls for unceasing expert supervision. No water supply, whether it is initially pure or is well purified, can be trusted to take care of itself. Wolman and Gorman have done a great service in pointing out the inadequacy of administrative control over the safety of water supplies in the United States and Canada. Failure to prevent the contamination of initially pure ground or surface water supplies and especially the failure to recognize the danger of cross connections between the pipes of the public water supplies and the pipes supplying water for industrial purposes or for fire protection have caused hundreds of outbreak of water-borne disease. Wolman and Gorman conclude that "defects in collection, treatment, storage or distribution of water for public consumption are responsible for over three-fourths of the water-borne illness reported in the United States during the decade 1920 to 1929. Approximately 40 percent of the outbreaks were due to these defects and not to the pollution of the raw water at its source." The analysis of these waters makes it plain that no method of collection, treatment or distribution is fool proof and that constant checking for defects is highly desirable.

A clear water is not necessarily free from disease germs. Neither is a water that is at times slightly turbid necessarily death dealing. If a bacteriologically safe drinking water is desired, it may be obtained by chlorination. If clarity is essential, filtration may be employed at somewhat greater expense. *Jour. A. M. A.*, October 31, 1936.

### AETIOLOGY OF CANCER OF THE BREAST.

The investigation of cancer by genetic methods has reached an interesting stage. The official publication of the International Union against cancer contains no less than three reviews on this subject, one by Prof. R. Korteweg of Amsterdam, one by Dr. L. Kreyberg of Oslo, and a third by Prof. Leo Loeb of St. Louis. A review on the same subject by Mr. A. P. Gorer appears elsewhere in this issue. What has happened in this field of cancer research to stimulate all this activity? The study of cancer by the methods of genetics had disclosed the remarkable fact that by inbreeding it is possible to produce genetically pure strains of mice in which the mamma will exhibit the development of malignancy in either a uniformly high or a uniformly low percentage of female animals. Until recently this was advanced as an argument to prove that the aetiology of cancer generally was essentially a problem of genetics and could be explained along mendelian lines. This view has never found acceptance by experimental pathologists. On general grounds they have been unable to look upon the highly complex group of biological phenomena, which for the sake of convenience are grouped together under the term "cancer," as if it was homologous to such comparatively simple biological phenomena as body size or coat-colour. Furthermore, in using a different tissue—the skin—as their test object, they found that although the skin of the mouse is very susceptible to the development of malignancy it does not show a high incidence of spontaneous skin tumours and that it was not possible by inbreeding to obtain a genetically pure strain of mice with a uniformly high incidence of spontaneous skin cancer.

The study of carcinogenesis in the skin showed that the development of malignancy in that tissue depends on two main factors: the presence of a carcinogenic substance applied from without and the factor of susceptibility of the skin to that substance. The further study of the development of mammary cancer in genetically pure strains has gradually led to the same conclusion. Thus W. S. Murray found several years ago if the ovaries of mice of a pure strain with a high incidence of mammary cancer, in the females were transplanted into the males of the same strain that mammary cancer could be made to develop in the males. A Lacassagne performed the crucial experiment of producing mammary cancer in the males of such a strain by the prolonged administration of the ovarian hormone—oestrone. He demonstrated further, that oestrone will produce mammary cancer more readily in males belonging to a strain with a high incidence of mammary cancer in the females than in those belonging to strains with a low incidence, and that oestrone will fail to elicit mammary cancer in the males of a pure strain in which no spontaneous cancer of the mamma ever develops in the females. The conclusion that two factors—carcinogenic substance and susceptibility—are essential for the development of mammary cancer in pure strains was thus established as clearly as it had been for skin cancer in mixed strains. The apparent difference between the aetiology of skin and mammary cancer finds an explanation in the fact that in mammary cancer both factors reside within the organism, while for the skin only the factor of susceptibility resides within the organism and a carcinogenic substance has an external origin. The result of inbreeding is to accentuate only the factor of susceptibility or insusceptibility as the case may be. As Mr. Gorer points out, an explanation along mendelian lines may be applicable to the inheritance of the factor of susceptibility but not to the more complex phenomenon the incidence of cancer of the mamma. The term susceptibility to mammary cancer is a vague—a deliberately vague—term, and

it is by no means established that the factor of susceptibility resides entirely within the cells of the mamma. Cramer and Horning found that the adrenals of mice from a genetically pure strain with a high incidence of mammary cancer undergo spontaneously a specific process of degeneration preceding the appearance of cancer of the mamma, and that the same process of degeneration can be induced in mice of mixed strains, in which it does not appear spontaneously, by the prolonged administration of oestrone.

Another new problem is introduced by the remarkable observation of J. J. Bittner, referred to by Mr. Gorer that the fostering of the newly born females from a high cancer strain by mice from a low cancer strain greatly reduces the incidence of mammary cancer. It must be realised that these animals belong to a strain which, according to genetic conceptions, is still genetically pure and ought to have a high incidence of mammary cancer. It follows that in genetically pure strains of mice "some influence," as Bittner calls it, is transmitted through the mother's milk, is of prime importance in determining the incidence of breast cancer. Here again an explanation along genetic lines is not easy to imagine. What is the part played by this factor, transmitted by the mother's milk, in the aetiology of breast cancer? Is it concerned with the susceptibility factor or with the carcinogenic factor? And what is the nature of this "influence"? Is it inanimate a chemical substance, or animate—a virus? The ingenuity with which cancer research workers are unravelling these intricate conditions makes it likely that we shall not have to wait long for an answer to these exciting problems. They may have an important application in the prophylaxis of breast cancer in women. The evidence presented by Cramer in a recent paper on the aetiology of cancer of the mamma in the mouse and in man shows that in the human subject also the mamma is an organ for which the familial incidence of cancer is exceptionally high.

(The Lancet, Aug. 21, 1937)

#### VITAMIN C DEFICIENCY IN PHARYNGITIS.

M. Baer (Disch. med. Wschr., May 7, 1937, p. 741) suggests that in most cases of pharyngitis it is impossible to link it up with some definite aetiological factor such as an infectious disease or a poison (lead, nicotine, alcohol, poisonous gases, dust, etc). Treatment has hitherto been mainly local and symptomatic, and it has not been successful. The case which first made the author associate pharyngitis with vitamin C deficiency was that of a woman, aged 38, who on account of intractable vomiting was kept for several days on a much reduced dietary. There followed a severe and extensive pharyngitis. Suspecting vitamin C deficiency, the author subjected her to the Harris test. The Harris test depends on the identity of vitamin C with l-ascorbic acid, and on the fact that when there is a

lack of vitamin C in the body this acid is retained, and not excreted in the urine until this deficiency has been made good. Since this test proved positive the author prescribed a synthetic preparation of vitamin C by the mouth and by injection, supplementing this treatment by a vitamin-rich diet. Thirty-five other cases of pharyngitis were also investigated and as a result the author attaches more and more importance to the Harris test as a guide to rational treatment in such conditions. He concludes with the generalization that pharyngitis is not a nosological unit but merely as a symptom-complex of the most varied conditions; and he does not consider that his cases are sufficiently numerous yet to justify any dogmatic claim that his therapeutic successes depended entirely upon his aetiological speculations.

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

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## ANDERSON REPORT.

Dr. G.C. Anderson, M.D., L.L.D., Secretary, The British Medical Association has submitted a report to the Central Council of the Association of what he saw and heard regarding the affairs of the medical profession in India. He was deputed for this work by the Central Council of the British Medical Association, on the suggestion of some of its members who visited India in 1935. Dr. Anderson came to India in the winter of 1936—37 and between 11-12-36 to 6-3-37 visited almost all the important cities and towns including the principal medical schools, medical colleges, hospitals (large and small; civil and military) and some dispensaries (rural and urban). Sanatoria, maternity and child welfare centres, research institutions also attracted the attention of Dr. Anderson. In fine, he, "took advantage of every opportunity that presented itself to gain an insight into the conditions under which medical work is being carried in India." For this purpose he had necessarily conversations with a large number of the members of the medical profession of all existing grades in military, and civil service, and in private practice not excluding the members of R. A. M. C. He interviewed also Heads of the medical department, Commissioners and Governors. But nowhere it is said in the report that he met the Public Health Ministers perhaps he thought as a practical man of business that it would not serve any purpose to see the Interim Ministers who were at the time running the show of provincial Governments.

Excepting, one item of information, that "the greater increase" in the numbers of independent medical practitioners "has been on the graduate class" the rest of the information gathered by Dr. Anderson seems to be authentic and faithful too. The report is elaborate and gives an idea of the existing state of the medical profession in India in all its aspects. But it is conspicuously lacking in suggesting remedies to cure the ills from which the profession is suffering. Perhaps Dr. Anderson and more than he, the Central Committee of the British Medical Association wish to entrust this work to the future organisation of a Central Agency in India, representing the British Medical Association. All the same the report is bound to serve as a very important document to bring about necessary reforms in the practice of scientific system of medicine in India. Nobody to our knowledge including the existing sectarian and nonsectarian All India Associations did take the trouble of a survey of the field of medical practice in India in the way Dr. Anderson has done at the instance of the Central Council of the British Medical Association. We wonder if this valuable document has been forwarded to the Public Health Ministers in all the autonomous provinces in India. We wish the Ministers who are keen to introduce drastic reforms in the medical departments read the report.

The crux of the whole situation of medical practice in India and its solution are found in the two paras, 60 and 61 appearing on page 22 of the report. Though the readers of The Medical Practitioner might not find in these two paras

anything new and anything more than what they have been reading in these columns in season and out of season, we have quoted them, as, of late, attempts are made by interested individuals and even associations to mislead the public and the Government that honorary medical service is incompatible with ideals of honest and faithful humanitarian service by saying that even in England there is a tendency for establishing paid service in hospitals.

"Medical practitioners in many parts of India complained bitterly to me that once their patients crossed the threshold of a hospital they never saw or heard of them again. They represent that there is little or no contact between the staff of the hospital and the independent medical practitioner outside. Unless the Government of India and the Provincial Governments are prepared to establish a complete medical service within the reach of all it must remain with the independent medical profession to satisfy in great part the medical needs of the community, and the independent medical practitioner feels that he should not be dissociated from institutional work if this object is to be achieved. The private medical practitioner considers that it is of paramount importance that the disciples of scientific medicine should have the means extended whereby they can keep abreast of the times and become acquainted with the modern advances in medical knowledge. They believe that the only way in which this can be achieved is by admitting them as an integral part of the medical staff of the hospitals and larger dispensaries."

"They recognize that for the administrative and disciplinary reasons certain whole-time appointments are necessary, but they think that the further development of the honorary (or part-time paid) system would greatly improve the existing state of affairs in many parts of India to-day. The honorary system of staffing was advocated by many practitioners, but the part-time paid system was generally believed to be more equitable to those who have to carry out medical work for which the Governments have made themselves responsible. The principle is the same as that to which the Association has given approval in this country."

On medical matters there cannot be a better authority than the British Medical Association and the opinion of the British Medical Association is expressed in the last two sentences in the quotation.

Dr. Anderson's "Survey of existing Medical and Public Health Services" and his "Examination of the existing medical conditions" reveal a state of affairs with which the medical profession in India cannot be unfamiliar. He has been scrupulously

careful not to commit himself either for the statement of facts or opinions basing on such facts excepting in regard to medical ethics. But an intelligent reader cannot fail to grasp what Dr. Anderson has in his mind while he mentions bare facts as reported to him by those whom he interviewed. He states about the differentiation between the pay and emoluments of the Indian and European officers of the I.M.S. and gives reasons (of course as mentioned to him by others) why the I.M.S. should still continue to serve in the civil department for serving the purpose of "War Reserve" and "to afford European medical attendance upon Europeans." Later he draws attention to the view expressed "by another group of persons who believe that the presence of at least a few European officers on the staffs of the medical colleges in India is essential to the progress of scientific medicine. They point out the tendency of the Indian practitioner to blend the practice of indigenous medicine with that of scientific medicine and the influence of caste and religious questions in the appointment of Indians". Excepting the communal bias in regard to appointments the other pleas for retaining the European I.M.S. in the civil service will not be accepted by any group of the Indian practitioners. We may also inform the Central Council of the British Medical Association that the British Government has been mainly responsible for the existence of communal canker even in the medical profession as the Government encouraged the growth of political parties on communal lines especially in the Madras Presidency. While referring to the manifold duties of the medical officers in Government service Dr. Anderson gives an example of the Civil Surgeon at Nagpur, Central Provinces and wonders how one individual can be in administrative charge of a hospital with 230 beds and be one of its Surgeons. The same officer is the administrative Head of a medical school which trains Licentiate, nurses and compounders. This is not all. This Civil Surgeon is the medical adviser to Government officials, medico-legal adviser to the Government and has also to do medico-legal work. The informa-

tion would have been quite complete if the pay and the allowances of this Civil Surgeon were mentioned also. Dr. Anderson must have been surprised the more when he learnt that in addition to all these duties the Civil Surgeon of Nagpur was allowed private practice. It is said that the whole-time medical officers under the Governments in India are allowed private practice if it did not interfere with the official duties. Is it possible to conceive especially for the members of the medical profession who are able to assess the physical possibilities of a human frame that a person entrusted with the responsibilities of the nature which the Civil Surgeon of Nagpur is in charge of, could do justice to his official work when he is allowed private-practice also. Persons with such multifarious duties cannot but attend to their work in a slipshod way with the result that for want of efficient supervision, the institutions under their care deteriorate materially. Such a civil surgeon will not be able to control his subordinates much less himself. The Nagpur Civil Surgeon is a typical example which could be seen on a higher or lower scale in the medical department in India. Dr. Anderson must have known that the Surgeons-General and Inspectors-General in the Indian provinces are harnessed with responsibilities whose number is many times more than that of the Civil Surgeon of Nagpur. In addition to the legitimate official duties they are in charge of not less than 20 more ex-officio departments. The progressive growth of any profession depends entirely on the non-officials who exercise the profession and as the official medical profession has been controlling the activities of the entire profession beginning with teaching and ending in private practice, what is seen about the medical profession in India is the outcome of the legacy of officialdom which cannot undergo any change so long the 'touch me not service' is to continue. The lot of the members of the Independent Medical Profession does not depend upon themselves. Dr. Anderson must know that medical schools came into existence in India primarily not to teach medical science but to train assistants to serve

under the I.M.S. The colleges are the offshoots of the schools and though graduates were trained in colleges the lot of the graduates was also of assistants to the I.M.S. though on higher pay than that given to the Licentiate. Later the graduates have been able to come very near the I.M.S. in official work though not in official emoluments. But the Licentiate subordinates remain where they are as their rise was likely to be a clash with the interests of the higher services though some of them at least have shown capacity for professional work not inferior to that possessed by an average member of the I.M.S. or P.M.S. The official and unofficial members cannot be unaware of such Licentiate. The term 'inferior' and 'superior' are co-relative and depend upon evolution human or divine. The training of graduates in India and in England or of others possessing no graduate medical qualifications must have been very much inferior 20 years ago than what it is now, yet they are not dubbed with inferiority complex and are allowed to practice and compete freely with those who got superior training later. It is possible to conceive that medical men as practitioners learn more themselves than what was taught to them in schools and colleges. It has been so in India. Though the official Licentiate are kept completely under the thumb of superior medical officers it has been possible for them to evolve as successful practitioners. Till about 25 years ago the word Licentiate was unknown in the Indian Medical world, the diploma granted to those trained in medical schools had the Head line "Hospital-Assistant". It is the folly of the British Government to have admitted private pupils in the medical schools which were meant to train Hospital-Assistants. As mentioned in the report there is no overcrowding of the medical profession in India of the nature that exists in England and can never be for at least half a century. India has extensive field for qualified medical service when it is known that on an average there is only one qualified practitioner for a population of 20,000. If the independent medical profession does not thrive and cannot thrive it is due to unwholesome and unequal

competition between the independent medical profession and state-paid profession in India.

At the time comments were made in the 'News and Comments' columns of The Medical Practitioner last month we had to depend upon the extracts of the report of Dr. Anderson telegraphed to the Press by Reuter. We have since received the full report and find that Dr. Anderson did not mince the item of the use of inferior drugs by the members of the Medical profession with the item of his opinion about the "The Independent Medical Profession" where it is said that 'the standard of Medical ethics is very low indeed.' Dr. Anderson is not at all justified to comment upon medical ethics under the heading 'the Independent Medical Profession.' His opinion is likely to reflect only on the independent practitioners in India and the sting will be felt the more when it is seen that the author of the report has avoided to give his views on almost all other topics which are the subject-matter of the report excepting in regard to Medical ethics. All the same the entire medical profession will agree with Dr. Anderson's opinion of Medical ethics but the low standard of ethics pertains to the entire profession including the Government paid medical profession and we would go a step further and say that the authors of Medical ethics in India are those who run medicinal schools and colleges and the members of the profession learn it from their teachers either by association or by precept. In the Madras Presidency there are practitioners may be those belonging to junior section who heard from one of their teachers that crimes cannot be included in the category pertaining to them unless they are detected. The medical profession though the most noble yet is so pliable that saints amongst the practitioners are not known and even if known are not appreciated whereas devils are known but go undetected. The students and upwards the highest officials in charge of medical department may know the undesirable elements in the teaching institutions yet the Government machinery is such that the most corrupt officers continue to thrive so much so that at least a few in the profession doubt if honesty is the best policy at all. Good morals cannot be a

special monopoly of any particular nation, a particular profession or a section of the profession. There are good and bad persons everywhere but in the medical profession there are certain peculiar circumstances which may make the infection of immorality a permanent endemic area if immoral persons are retained in teaching institutions indefinitely. In ancient India and anywhere else the healing art emanated from persons belonging to religious order and in India the Vaidas and Hakims were paid till recently in kind and not in money but even this class after the starting of schools by Government here and there to teach indigenous systems of medicine have been adopting the 'Bill System' for the recovery of their fees, a custom unknown to them once. Vaidas like the priests were always paid in kind. The new machinery of Government schools taught these Vaidas the system adopted by the practitioners of the Western system of medicine. In India especially in Madras, the people even the educated classes flock to doctors who do not demand fee or take whatever given. Some of the Government doctors who have since risen to eminence adopted 'no bill system' or 'no demand'. Independent practitioners cannot afford to have recourse to this system as they have to depend only on what they earn. They have to make money either by visits or sale of medicines at their consultation rooms. Some of the paid doctors in provincial and subordinate service have been openly running dispensaries also as they could not get fees for consultation, while those in service including the members of the I. M. S. started more costly enterprises such as private hospitals and research institutes. It took the Madras Government nearly ten years to be able to judge that running of private hospitals by the full time officers was trade after persistent agitation in which The Medical Practitioner had the largest share. The majority of the hospitals and dispensaries in India are maintained out of public funds and are therefore regarded as free institutions. Domiciliary medical attendance amongst the major portion of the community is relatively small—says Dr. Anderson under the caption, 'The Hospi-

tal Problem'. He adds "There is no almoner system and little or no attempt is made to ascertain whether those people who seek treatment are deserving of the charity for which they ask. The middle classes flock in large numbers to these dispensaries and hospitals, thus avoiding legitimate medical expense, and it is claimed that, as a consequence of this the poorer people who really cannot afford to pay for private treatment are frequently turned away for want of accommodation. Enormous numbers of patients, the majority of whom are unable through extreme poverty to pay the fees of a private practitioner, are dealt with each day, and it is difficult to say how any but the most cursory treatment can be administered with the present staff available. For example in one municipal dispensary I visited which was under the charge of a sub-assistant surgeon, as many as 300 patients were being dealt with daily in a morning of four hours. Undoubtedly many hospitals and dispensaries are insufficiently staffed and insufficient enquiry is made in many instances into the question of the patient's ability to contribute towards the cost of treatment".

In the city hospitals the duties of the almoner are discharged by the medical officer or his immediate assistant and in cases where patients have to pay, the amount to be fixed is left to the discretion of the medical officer and the evils of this system may better be imagined than described. Consequently says Dr. Anderson ".....here again much of the abuse is due to the lack of an adequate almoner system." The system of medical administration in Great Britain being quite different from that obtaining in India the Government has perhaps not been able to appreciate the virtues of almoner system in India though it was pointed to them especially in Madras by The Medical Practitioner when it had occasion to criticise the policy of medical administration in India.

Want of almoner system has been a curse even for the evolution of a healthy honorary service. What is done by the full time officers with regard to admission

of patients and their treatment in State hospitals is being followed by the honoraries both in the higher and lower grades so much so that there is a section of the public including private practitioners who have commenced blaming the honorary system of medical relief. The introduction of honorary system in some provinces such as Madras, Bombay and Calcutta instead of relieving the burden of hospital expenditure shows signs of increase in expenditure year after year so much so that in Madras Province it has reached the zenith of 1 crore of rupees per year nearly 1.16 part of the public revenue according to the statement of the Public Health Minister the Honourable Dr. T. S. Rajan. He also said that this is the biggest amount which any Government spent for Medical relief in India. So if the Government in India do not adopt the almoner system the budget for medical relief is likely to swell year after year.

We are glad that the most unethical procedure of the countersigning of the medical certificates of the independent medical practitioners, by the Government medical officers did not escape the notice of Dr. Anderson. Though the Medical councils came into existence in this country in 1915 none of these councils protested to the respective Governments against this objectionable procedure till at last in 1930 the Madras Medical Council sent its protest to the local Government in the form of a resolution and now this procedure has been substituted by yet as objectionable a procedure of obtaining a second opinion on the certificates of private practitioners from Government Medical officers. This was also objected to by the Madras Medical Council but to no effect. In other provinces the original procedure of countersigning seems to continue still. Counter-signature of vaccination certificates issued to persons proceeding over-seas excepting those issued by a Civil surgeon, a port health officer or a municipal health officer attracted the attention of the Government of India more easily and quickly than the procedure of countersigning of medical certificates as it affected the honour of a large section of Government medical officers.

Even regarding this procedure Madras Medical Council was the first to start the agitation. The effect of the agitation has been that excepting the East and South African Governments and that of Iraq all the rest do not now press for counter-signature of vaccination certificates. It is not known why the Government could not persuade these Governments to give up this procedure. State-paid doctors usually favour the procedure of counter-signing or second opinion. This is our experience in Madras. It is the official position more than qualifications that counts in India for the recognition of medical certificates. Before the statutory medical councils came into existence in India there would have been a justification for insisting on medical certificates from Government medical officers as there was no disciplinary control over independent medical practitioners. But after the medical councils came into existence, corruption in regard to certificates could have been more efficiently checked by the medical councils than by the Heads of the Medical departments. Because the highest the head of the department could do is a transfer, a suspension or dismissal. All the same the punished individual could enjoy the privilege of issuing medical certificates. The monopoly enjoyed by the practitioners in service has brought into the profession more corruption than could be possibly conceived even by Dr. Anderson though the corrupt practices of some of the medical officers are the subjects of open talks amongst the members of the public and also amongst members of the Government.

Medical education did not escape the attention of Dr. Anderson. He sees all round improvement in medical colleges and quite the reverse in the medical schools. Here again the blame is on the head of the Government and not on the medical profession. It is a happy augury that with the advent of the Congress ministry in Madras with the medical port folio in charge of a medical man, the Government of Madras have decided to close down the medical schools and have one standard of University medical education. It will not be long before other Governments in India follow suit.

Want of facilities for post Graduate training and many other defects could only be rectified if medical matters come under the control of medical profession and not under Government control however progressive. It is desirable that the members of the medical profession in Great Britain realise that evolution of a scientific medical profession in a country should depend entirely on the members of the medical profession born and bred up in the same country who alone by actual practice can understand the needs and even the standard of medical education. It is foolish to say that indigenous systems of medicine are unscientific. Before the British people set their feet in India, Indians lived and thrived also. They say that though there was not a machinery to note the death rate and other rates for assessing the welfare of the public, the people lived longer than they do now. So it is preposterous to say that indigenous systems of medicine are unscientific. Their application may be unscientific for want of scientific agencies to handle and develop their systems. At the same time it is waste of funds if the Government were to undertake starting of medical schools of different systems and with hospitals of such systems. All that the Government may do profitably and efficiently is to encourage the votaries of particular systems to run their institutions and have one Medical College to serve as a model where medical education should be imparted on cosmopolitan scientific lines creating special chairs to teach indigenous systems of medicine as special subjects.

Drug control and other subsidiary matters of importance to the medical profession have not attracted the attention of the Government for want of agitation and nobody can agitate about the grievances of the members of the profession than they themselves. So the final question of the purpose of Dr. Anderson's report leads everybody to a query 'Who should control the destinies of the Medical Profession in India?'. There can be only one answer to this question, 'It is the Indian Medical Profession.'

Dr. Anderson has mentioned the names of three medical associations in India,

whose activities are of all-India nature—the Indian Medical Association the All India Medical Licentiates' Association and the British Medical Association. The Licentiates' Association will exist and has to exist so long the Licentiates are not treated as equals by the other members of the medical profession. The growth of the Indian Medical Association has to be encouraged by the lovers of the growth of homogeneous and prosperous medical profession in India. The British Medical Association should be an ally to the Indian Medical Association and not a rival. Its members in India especially the Europeans should enlist themselves as members of the Indian Medical Association and guide its activities to bring it to a level of the scope of the British Medical Association. Those who are at the helm of the Indian Medical Association should be brisk and depend on mass contact in the profession as the National Indian Congress has been doing. When the whole Indian nation has made up its mind to have Indian National Government nobody can entertain the idea of the British Medical Association controlling the affairs of the Indian medical profession. It is true India is not as much advanced as Great Britain. Great Britain of to-day is not what it was a century ago. It is really a difficult problem to bring about unity in India. The division of people on communal and religious basis is an inherent weakness of India. It may be providential. What was the purpose of Providence to create different religions is too much for us to say. But we could repeat this much once again that the castes in the medical profession are the making of the British Government and we can only pray that Providence inspires the British Medical Association to give their brethren in India a helping hand and bring great credit to the most useful and as powerful an organisation without which the British Medical Profession could not have been what it is today.

### News and Comments.

**Dr. Gilder's Haste:** It is reported in news papers that the Hon'ble Dr. Gilder will soon introduce a Bill in the Bombay Legislative Assembly "to regulate the qualifications provided for the registration of practitioners of the indigenous systems of medicine namely, Ayurvedic and Unani". No mention is made of yet another system prevailing in Madras Presidency and recognised by the Government of Madras, called the Siddha system. It looks as if this system is not practised in Bombay. If reciprocity between Bombay and Madras is to be established by the new statute is also not known. Only a gist of the proposed Bill is published in newspapers. A council called the Board of Indian Medicine is provided for with 13 members of which six to be nominated by the Government and remaining seven to be elected by the Vaidas and Hakims. The life of the Council is five years. It is not mentioned if President of the Board is to be nominated or elected. The Board will have a Registrar to be appointed by it and a Register will be maintained. Practitioners of Indian Medicine of not less than 10 years standing are to apply for Registration and before registration they should pass an examination in medicine, surgery and midwifery and they will have the same status as those of the Allopathic Practitioners. It is also contemplated by the Government of Bombay to start a school of Indian Medicine to teach medicine, surgery and midwifery as recognised and taught by the Western system of medicine.

When the scientific system of medicine is clamouring for one uniform standard of Medical Education it is indeed a most retrograde step to develop a hybrid system of medicine of a very low standard. No Indian can deny the importance and efficacy of the Indian systems of medicine but to recognise the existing practitioners of these systems who had no training on recognised scientific lines, will be to encourage quackery. That this is to be done by the Hon'ble Dr. Gilder a practitioner having the highest qualifications of scientific medicine is indeed a most

unfortunate irony. It looks as if politics can change even the cult of an individual. It ought to have been possible for a political party like the Congress to evolve in this country a scientific system of medicine imbibing all that is good in the Indigenous Systems which could have been done by bringing into existence an Indian Pharmacopoeia and establishing special chairs to teach these systems in the existing medical schools and colleges. Instead of giving recognition to the existing practitioners of the Indigenous Systems in a round about unscientific way it would have been enough to establish a Licensing Board to grant License to practise Indigenous Systems of medicine only to such amongst the existing Vaidas and Hakims who could stand the test of the Licensing Board to be established by the Government. Such a step would have not only controlled quackery but encouraged the practice of these systems on ancient lines. We can tell Dr. Gilder, the minister and others like him in the Congress ministry and that without fear of contradiction that 100 per cent of the pupils that pass out from the Government school of Indian Medicine, practise Allopathy and the Indian Medicine on Allopathic lines. Very few of them know to prepare the Indian medicines in the way the ancient Vaidas did. The preparation of Indian Medicines is an art in itself which cannot be learnt with a mere knowledge of weights and measures. There are some preparations like the Bhasmams prepared of organic and inorganic substances like the pearl and copper respectively of which elegant preparations are made without the help of weights and measures and even without the rudimentary knowledge of their chemical composition. For the supply of medicines of Indigenous Systems the votaries of the Government Indian Medical School of Madras depend upon some firms or individuals who manufacture these. A particular preparation which is sold by a particular Vaid or firm for a few annas is sold for as many rupees by another, so one could imagine the state of affairs of the Indigenous Systems especially when it is known that many of these preparations cannot be analysed

scientifically. We wonder if Dr. Gilder knows that there is a large number of Ayurvedic practitioners in Madras Presidency who are not the students or teachers of the Government School of Indian Medicine who have been condemning the method of teaching Indian Medicine in the Madras School and the School contemplated by the Bombay Minister is sure to undermine the Indigenous Systems far from bringing them to the level they were in ancient India.

Science apart, financially the encouragement of Indigenous Systems to appease the sentiments and feelings of the credulous masses will be a wasteful expenditure of public funds. The next step of agitation by the practitioners of Indigenous Systems of medicine will be to ask the Government or Local bodies to establish hospitals and dispensaries as many as those belonging to the Western system. It will be preposterous not to yield to this agitation especially so as these practitioners are given the status of Allopathic practitioners. The Government in all the Provinces find it hard to run the Government machinery at present with the funds now made available to them. Congress is against burdening the people with additional taxation. So hasty legislation on the lines suggested by Dr. Gilder to recognise the Indigenous Systems will lead to wasteful expenditure without appreciable development of Indigenous Systems; for, as in Madras, the students of Indian Medicine in Bombay who are to be taught rudiments of Western Medicine, Surgery and Midwifery are likely to trade on the faith of the credulous masses and bring both the Systems of medicine to disrepute. It was said that the Madras Public Health Minister has summoned a conference of all the Public Health Ministers in Madras. It would be wise for this conference to discuss the ways and means of encouraging Indigenous systems of Medicine and have an All-India plan. Such a plan should be placed before the public for criticisms for a sufficiently long time before legislation contemplated to give effect to the same. Dr. Gilder and his brother ministers in other provinces

know that there does not exist a strong harmoniously organised profession in India whether of Western or Indian system and so it will be a thousand pities if advantage is taken of this misfortune of the learned profession in India to hurl risky and not well thought of Legislative measures concerning medicine depending only upon voting strength on the floor of Legislative bodies. We do not doubt the good intentions of Dr. Gilder and trust our criticisms will only serve as a caution.

**A Demonstration:** Public functions demonstrating gratitude of a patient to his doctor or of a brother to a brother have their own lessons and live impressions on society for moulding its ethical conduct. The impressions will assume the importance of lessons and will guide the society to correct or amend its rules of conduct when persons who could rise to eminence are the participators of such public demonstrations. In case the demonstration is conducted by an important and influential member of a Legislative body the lessons of demonstration assume the authority of law.

A portrait of Lt.-Col. K. G. Pandalai was unveiled by the Hon'ble Dr. T. S. S. Rajan on 5th November at the Rangaswami Iyengar Memorial Hall, Hindi Prachar Sabha, Thyagarayanagar, Madras. The portrait was the gift of Mr. S. Satyamurti to his doctor, Lt. Col. Pandalai who treated Mr. S. Satyamurti in his private hospital and which was originally meant to decorate the walls of this private hospital. But Col. Pandalai preferred to have the portrait exposed in the Hindi Prachar Sabha Hall perhaps to associate his brotherly affection to Dr. Krishna Pandalai the ex-judge of the Madras High Court in whose name Col. Pandalai has endowed Rs. 5,000 for the Hindi Vidyalaya which will be called after the name of Dr. Krishna Pandalai. Nobody would have known these acts of appreciations unless there was a public demonstration of the same. Hindi will be soon introduced as a compulsory subject in schools and the opposition in some quarters on political or other grounds is likely to dwindle when non-brahmin high officials and ex-officials

of different mother tongues, encourage the movement in the way demonstrated at this function. The medical profession will be pleased that eminent politicians do not lag behind to appreciate the services of the members of the profession and would value such appreciation more than money gifts. The profession will also admire the gift inherent in Mr. Satyamurti to make people do what they once determined not to do. But for this gift of Mr. Satyamurti India would not have had Indian National Government in seven provinces though Mahatma Gandhi, Pandit Jawaharlal and even the Prime Minister Mr. C. Rajagopalachari were originally against council entry. There would not have been Dr. Rajan as the Public Health Minister to preside over this demonstration but for Mr. Satyamurti's gift. This is not all. Ever since Dr. Guruswami Mudaliar occupied the place of a Physician in the Government Hospital it was impossible for anybody in Madras to make him take part in any social or public functions. Mr. Satyamurti gift more than the "inseparable" association of Col. Pandalai and Dr. Guruswami Mudaliar must have made the Nestor come out of his cell.

We take this opportunity of expressing our gratitude to Dr. Guruswami Mudaliar and Mr. Satyamurti for having endorsed the view of The Medical Practitioner that the independent medical profession depends upon their brethren in service for encouraging them to start private enterprises for public good and to take lively interest in honorary service. Thanks to the Congress Ministry for inaugurating the policy of freedom of speech even for their Subordinates as could be seen from the maiden public speech of Dr. Guruswami Mudaliar in exposing the pent up grievance of Col. Pandalai which forced the latter to give up his high official position in preference to serving the public in a private capacity. This is a lesson in itself to other officers in similar position who can depend upon their professional skill more than on Government service. This will be yet another lead to honorary service.

The public demonstration has served yet another important purpose. Senior

independent practitioners and even some of the officials have been wondering why a retired official was elected by the Madras Reception Committee of the All India Medical Conference. Dr. Guruswami Mudaliyar's modest appreciation of the services rendered to the profession by Col. Pandalai when he was a Captain, should convince even a doubting Thomas the fitness of choice of Col. Pandalai to lead the profession. An ex-official is the fittest person to demonstrate the difficulties of officials, which have hampered the growth of medical profession in India though as an official Col. Pandalai might not be able to deny his share of the difficulties.

A full report of the demonstration is published in the Correspondence Columns of this issue.

**Ministry Contact:** The vision that Congress has been able to run the Governments in seven out of eleven provinces in India has opened the eyes of official non-official individuals and has made them realise that more could be gained by actual contact than by other means of constitutional and revolutionary agitation. They are now seen vying with each other to come in close contact with the Congress Ministry with the fond hope that they will succeed in realising their heart desires for individual or public good. The popular ministers cannot but be available for conversations, interviews, deputations and parties. The ministers especially in Madras are therefore compelled to have their working hours from 9 A.M. till 6 P.M. ordinarily and more if there were to be parties or meetings of the Legislative bodies. This is really a hard job for the popular ministers harder still considering their pay though it is of their own making.

Teaching institutions medical and non-medical are having a large share of these contacts and as the ministers are sharing responsibility jointly all the ministers are invited by turns to share to see the working of these institutions by instalments. Whatever opinions Ministers gather within themselves the impressions on the public will be something different

from the impressions of the Ministers which again depend upon on the method employed in the expositions before the Ministers at particular gatherings arranged for a particular purpose. The purpose and motive of these group or individual gatherings cannot but be good but taking the world as it is and human tendencies as they exist such gatherings at times cover what is not desirable to own in public and even individual interest. For, those who possess what is not desirable come to publicity and claim popularity which in public interest should not be encouraged. This is one of the dangers of democracy which is now in evidence more than in the days of bureaucratic Government. Leaders of the party in power are also made available for contact with the idea that what they utter during contact will be heard by the ministry most attentively as the leaders outside ministry are at times showing tendencies of power more than the ministry wield with authority. The Congress Prime Ministers are too shrewd not to know what is happening and we wish those who are endeavouring to have too much contact know it as well.

**A Compromise Memorandum:** Almost all the districts in Madras Presidency have District Medical Associations of which excepting in a couple of districts the Presidents are the District Medical Officers. Usually these associations avoid discussion of any subject of controversial nature which are likely to clash with the interests of the official or non-official element in these associations. For the same reason, they avoid discussing problems connected with any particular class (depending upon qualifications). They concern only with professional subjects. The Madura District Medical Association which met the Public Health Minister on 12th November made an exception to the usual routine to take advantage of the Minister's presence in their midst and submitted a memorandum evidently compromising the differences between the members of different grades and qualifications. The Minister did not mince matters and spoke out frankly. We refer our readers to the

Correspondence Columns where the gist of the demands of the Association and the reply of the Minister are published. Regarding restriction of private practice to the Government medical officers in the mofussil towns the Minister's reply that the people cannot be debarred from getting expert advice from the Government medical officers cannot stand the test of sound reasoning. The Minister must have known as a practitioner that mere position in Government service cannot make State-paid medical practitioners as experts. May we ask the Minister with all earnestness whether he, as a general practitioner practising medicine and surgery was found wanting by his patients? All, possessing merit and qualifications of Dr. Rajan cannot afford to be as enterprising as Dr. Rajan was, as a general practitioner to risk their lot in mofussil towns where they have to compete with a D.M.O. This is why very few venture to set up practice in the mofussil. But in case the Government officials are debarred from general practice the mofussil will get the benefit of expert advice from a surgeon and physician like Dr. Rajan and the congestion in the city will be much less. Restriction of general practice to Government medical officers excepting consultation practice will bring about harmony and team work between official and non-official practitioners. If privileges of private practice to full-time medical officers is restricted to consultation and almoner system is introduced in all State hospitals, there will not be much room for corruption in State hospitals and the paid and honorary staff will be getting along peacefully. And really necessitous poor will seek admission into State hospitals.

Elsewhere we have commented upon the best method of encouraging the Ayurvedic and other indigenous system of medicine. If the Government has to yield to the demands of the people, time will not be far when Homopaths, Chromopaths, Osteopaths and many others will press the popular Government to start schools and hospitals for these systems. The Minister has already been approached to keep the Royapuram Government Hospital at the disposal of practitioners of

indigenous system. So long people who pay Government taxes demand free medical aid in systems they have faith, the Government will not be able to refuse such a reasonable demand. So the best thing for the Government to do is to entrust the votaries of particular systems to run their own institutions, the Government taking care that only qualified practitioners of every system are allowed to practice. But this solution may be too drastic in India to be introduced all at once though it has to be the ultimate goal. As far as we know nowhere in other civilised countries have the Government taken the responsibility of running teaching institutions in medicine. Affairs in India being different the best thing for the Government to do is to amalgamate all systems of medicine on scientific lines as suggested by us elsewhere.

Regarding Subsidised Rural Medical Practitioners we will repeat our request to the Hon'ble Minister on behalf of these practitioners to summon a conference of their representatives and discuss with them the future plans of the Government with regard to rural medical relief. The activities of Congress are centred in villages and the rural practitioners may be made to play a very important part in rural reorganisation. The Public Health Minister should necessarily concern more about rural practitioners than the urban as these humble practitioners have nobody else as their Ma.Bap excepting the Government.

**Subsidised Practice Unsafe?:** The news published in these columns last month regarding the conversion of a rural dispensary into a pucca L. F. Dispensary in Trichi District has evidently induced a practitioner from the same district to bring to our notice another conversion already effected of which he is himself the victim. A subsidised practitioner settled in a village called Kadavur in Trichi District about six years ago. It is said that he built up a fairly good rural practice educating the credulous villagers to turn their faith towards scientific treatment though all of

them shuddered in the beginning to have anything to do with a system of medicine which they called "Sircar" medicine. Amongst other things this victim writes, ".....The starting attendance was very poor but it has come to the average of 20 to 25 per day. It is at this stage the above inter-transfer is made without any warning to me". The inter-transfer is to another village, Marungapuri where till then one L. F. Dispensary existed. The cause of transfer is evidently due to slack work at Marungapuri L. F. Dispensary. The L. F. Sub Asst. Surgeon is rewarded for this slack work by transferring him to Vadavur where a subsidised practitioner took over six years to educate the villagers to have recourse to scientific system of medicine as against quackery and the return for such services is the conversion of this popular rural dispensary into a L. F. Dispensary and the benefit of hard work is to be enjoyed not by the person who worked hard but by another person who in spite of all the facilities of a pucca L. F. Dispensary could not put up attendance to justify the expenditure of a L. F. Dispensary. Is it not heartrending that a practitioner who chose his lot to work in a village and settled there for life depending upon the Government who started the Subsidised Rural Medical Relief Scheme—the purpose and the spirit of the scheme being to encourage young practitioners to settle in villages—only to be driven out for no fault of his when he was about to reap the benefit of his hard labour. As per terms of agreement executed by this R.M.P. lawyers will condemn such a transfer as illegal. Illegal action amounts to breaking of law and when this is done by the Government how can Village Subsidised Service be safe? As suggested by us in these columns while commenting on this subject, last month the best course and economic too, would have been to convert the L. F. Dispensary into a subsidised one and find out if a half starving subsidised practitioner is capable of popularising scientific system of medicine when his more fortunate brother in L. F. full time service could not do so. Will the Government be pleased to reconsider their judgment and re-convert the Kadavur

L. F. Dispensary as a subsidised one restoring the aggrieved practitioner to this dispensary? Or else the subsidised practitioners are likely to lose faith in the good intentions of the Government towards Subsidised Rural Medical Relief Scheme.

**Appeal Delays:** Subsidised Rural Medical Practitioners complain that there are inordinate delays in the disposal of the appeals submitted by them to the Government on the adverse orders passed against them by the District Board Presidents. Such delays become most intolerable when the services of the practitioners are abruptly terminated. There is a safety clause in the agreement that the District Board should first get the approval of the D. M. O. before terminating the services of a subsidised R. M. P. but in majority of cases such an approval has been a formal one and at least in one case which has come to our knowledge it was alleged that the subsidised practitioner was a victim to the collusive action of a D.M.O. and a P.D.B. for finding employment for another unemployed practitioner. In such cases the hardships of a subsidised practitioner could be very well imagined. In a village he had to build practice of a hand to mouth living after strenuous labour of several years and he is ordered to quit a subsidised dispensary without even a show of charges against him and no chance of defending himself. Such hardships of a victim amount to cruelty, the practitioner being literally deprived of a humble living. Red tapism which is too much in evidence in Subsidised Rural Medical Relief Scheme prevents the aggrieved practitioner to be heard by the Government without delay. The appeal of a subsidised R. M. P. has to go to the D. P. B. thence to D. M. O. The D. M. O. has to submit it in his turn to the Surgeon-General and the Surgeon-General to the Government. The attitude of the D. B. P. against the practitioner not wanted by him may be imagined. Nobody can question him for the delay in forwarding the appeal to the next channel the D. M. O. This officer is a busy man and has to depend upon his

head clerk to understand the intricacies and complexities of Subsidised Rural Medical Relief Scheme and if village politics and unemployment are at the bottom of the trouble it will be really a hard job even to the Government to find out where the files lie. Even if everything goes on well in the first two channels there is at times delay at the Surgeon's-General office. This office is huddled with responsibilities more than it can manage and if the concerned clerk who has to start the ball rolling does not place it before the Personal-Assistant to the Surgeon-General, it is impossible for anybody to know if a particular file is ever sent to S.G.'s Office. In a few cases which we enquired into, the files of appeals have not reached Government at all and it has come to our knowledge that a District Board President has been sitting on a file from June to November.

Dr. V. Rama Kamath, President, Subsidised Rural Medical Practitioners' Association, in the course of an interview with the Hon'ble Minister, Public Health seems to have gathered an impression that the Hon'ble Minister is of opinion that a subsidised practitioner is not a Government servant and could submit his appeal to the Government direct. But the Secretariat procedure hitherto followed is otherwise, the rural practitioner being treated in regard to petitions to Government as a subordinate of Government. Usually the aggrieved practitioner sends a copy of his appeal direct to the Surgeon-General and the Government with an endorsement "for information". There is nothing to prevent the obstruction in any channel by the authority next to the obstructed channel on the basis of the information received.

The villages were the last items to be noted by all concerned till the Congress sat on the Government saddle. The subsidised practitioner is an important unit of a village and it behoves the Public Health Minister to find out a remedy to prevent delays in hearing the grievances of the subsidised practitioners. It may be stated here that the representatives of the

Provincial Subsidised Rural Medical Practitioners' Association did suggest to the Government through the Surgeon-General whom they met on deputation last July that in case of a dispute between the subsidised R.M.P. and the District Board the services of an aggrieved R.M.P. should not be terminated till the appeal to the Government has been disposed of. If this suggestion is given effect to by the Government, delays in the disposal of appeals will be less cruel. Before closing our comments we feel it desirable to point out to the Government that the agreement which a subsidised R. M. P. has to execute is between the Government as represented by the Governor, the District Board and the R. M. P. and the President District Board cannot legally terminate the services of the R.M.P. unless by a resolution of the Board. From the copies of orders of termination of services, we found that the District Board President punished the R.M.P. on his own accord. We trust the Government will be pleased to note this irregularity also.

## Correspondence, Reports Etc.

### Tributes to Lieut.-Col. Pandalai.

PORTRAIT UNVEILED IN  
THYAGARAYANAGAR.

A portrait of Lieut.-Col. K. G. Pandalai was unveiled by the Hon. Dr. T. S. S. Rajan, last evening, at the A. Rangaswami Iyengar Memorial Hall, Hindi Prachar Sabha, Thyagarayanagar. Dr. M. R. Guruswami Mudaliar presided.

The portrait, a gift by Mr. S. Satyamurti to the Hindi Prachar Sabha, is to adorn the walls of the "Krishna Pandalai Hindi Vidyalaya", now under construction.

Dr. M. R. Guruswami Mudaliar, in the course of his introductory remarks, said that the Vidyalaya had been named after Dr. Krishna Pandalai to mark the gratitude felt by Col. Pandalai for his elder brother, and the portrait of Col. Pandalai had been presented to the Vidyalaya by

Mr. S. Satyamurti to mark the gratitude of a patient to his doctor. He need not say anything about either Dr. Rajan or Mr. Satyamurti, for it would be like painting the lily—they were so well known throughout the whole of India. Many people might not know Col. Pandalai. The healthy public perhaps probably ignored him, (laughter) but the public, who paid attention to problems connected with medical institutions, might have come across the name of Col. Pandalai.

He had known Col. Pandalai since 1904, Dr. Guruswami Mudaliar continued. Col. Pandalai had a keen sense of humour and was a good sportsman. Since 1922 they had been colleagues in the General Hospital. He was the fourth physician then, and Col. Pandalai joined as third Surgeon, and they became inseparables.

When the Lee Commission came to India, the Surgeon-General sent up a memorandum without consulting the Indian Section of the I.M.S. The Indian Section formed themselves into an Association and submitted to the Commission a separate memorandum. Probably it was not a tactful move, and Col. Pandalai as Secretary of that Association had to bear the brunt of the whole thing. Shortly after that, there occurred another of Col. Pandalai's "impetuous actions". He made a famous speech on the medical problems of the province. Many of the reforms suggested by him in that speech had either been effected or were about to be. In that speech, he stressed the need for a Research Institute for the Medical College compound with a properly qualified Indian at its head. That suggestion was about to be carried out. The next point Col. Pandalai raised in that famous speech was the abolition of the L. M. P. course. Unfortunately he used the expression "bottle washers of the old order of things" when referring to L. M. P's in a humorous and colloquial vein. That expression was objected to and Col. Pandalai's head was demanded on a charger. The abolition of the L. M. P. course for which he pleaded then, was about to be done now. Col.

Pandalai also pointed out in that speech, the need for appointing honorary physicians and surgeons, in the hospitals, for raising the general standard of medical practitioners and for popularising the Indian Nursing profession. He desired that the Medical Council should have an elected majority and that the hospitals should be administered by Committees instead of by individuals. Following the example of Col. Bradfield he started a Nursing Home. The number of nursing homes that had sprung up in Madras since then would show to them how popular the idea was, and how necessary such institutions were.

Col. Pandalai had also shown his sympathy with the aspirations of the modern generation by endowing a sum of Rs. 5,000 for the Vidyalaya for the purpose of propagating knowledge of Hindi. Some people were of the opinion that a common language for the whole world would be instrumental in bringing about peace. Whatever might be the merits of that claim, there could be no doubt that a common language for India was a desirable thing.

#### ADDING TO THE STATURE OF THE COUNTRY.

Mr. S. Satyamurti, who spoke next, referring to the evening's function and its association with the names of Col. Pandalai, Dr. Rajan and Dr. Guruswami Mudaliar said that there was an appropriateness about it, because all the three of them had handled him at one time or another. In all the activities of Col. Pandalai for the assertion of the rights of Indian medical practitioners, Mr. Satyamurti said, he had as his right hand Dr. Guruswami Mudaliar. The latter had the reputation of being a silent strong man. By their character and hard work the late lamented Dr. Rangachari, Dr. Guruswami Mudaliar, Col. Pandalai, Dr. Lakshmanaswami Mudaliar, Dr. Tirumurthi, and one or two others earned for Indian medical practitioners a high position. When an Indian made good, in any field of service, he added to the stature of the country. The speaker's

heart glowed with pride to think of the services the great medical men had rendered to the profession and to India.

He was glad, Mr. Satyamurti continued that one of the first acts of the Congress Government had been to appoint the first Indian Principal of the Medical College (Cheers). He was very ambitious and would like to see an Indian appointed as Surgeon-General also.

Speaking about nursing homes, Mr. Satyamurti said that while well-to-do people could go to the nursing homes, the State hospitals should be reserved to the poorest in the land. The problem of medical relief was a vast one. Unless they introduced the honorary system in hospitals and also touched private philanthropy, they could not adequately cope with the problem of medical relief.

Referring to Dr. Rajan, Mr. Satyamurti said that he had "literally eaten out of his hands". Many of them might not know that Dr. Rajan was an excellent cook. He used to prepare nice dishes in the Vellore jail, which all of them enjoyed. He was now in charge of the physical welfare of the people of Madras and also in charge of the religious endowments. Dr. Rajan knew his job. He also knew his mind. The purpose of a Government was to govern, and Mr. Satyamurti had no doubt that Dr. Rajan would be able to give very good account of the departments committed to his charge.

His original intention, Mr. Satyamurti concluded, was to present the portrait to Col. Pandalai's nursing home. But he readily agreed with Col. Pandalai's proposal that it should be presented to the Vidyalaya. That gave him an opportunity to express his gratitude to Col. Pandalai and also to express his appreciation of the work of the Vidyalaya.

#### DR. RAJAN'S SPEECH.

The Hon. Dr. T. S. S. Rajan then unveiled the portrait amidst cheers. Speaking a few words on the occasion, Dr. Rajan said that he came into person-

al contact with Col. Pandalai in London. If Mr. Satyamurti had enjoyed his dishes in the Vellore Jail, he was sure Col. Pandalai should have relished them much earlier in London. Col. Pandalai used to work his way to the speaker's diggings and claim his share of 'paya-sam'. Those were pleasant days and they had lived together, strolled together and spent many evenings together in Piccadilly Circus.

Dr. Rajan, proceeding, said that he happened to be with Col. Pandalai in one of the troublous periods of his life. He would not call Col. Pandalai a great fighter, but he had a knack of getting into trouble always. He got into trouble while in Burma and was sent across the Bay. But, after each trouble he came out better in the end.

The third occasion he came into contact with Col. Pandalai was as a convict. He was brought from Palamcottah to Madras, and Col. Pandalai was instrumental in saving his arm. After the operation he had, with that arm, performed a good amount of surgical work. The scars of that operation were still there, and he had on his person a lasting memorial of Col. Pandalai. It was in fact a pleasure to have known Col. Pandalai and to have lived with him, associated with him and get cured by him. When Mr. Satyamurti suggested that he should unveil the portrait of Col. Pandalai, he jumped at the idea. The function was one in keeping with the traditions of their country. The tradition of brotherly love expounded in the Ramayana was still a living one with them in India. The action of Col. Pandalai in trying to perpetuate the name of his elder brother was one more proof that that tradition lived.

In conclusion, Dr. Rajan thanked Mr. Satyamurti for giving him an opportunity to associate himself with a function connected with one for whom he had a great regard and more than brotherly affection. (Cheers.)

—(The Hindu, 5.11.37).

### Public Health Minister's Speech At Madura

The Madura Medical Association yesterday accorded a reception to the Hon. Dr. T. S. S. Rajan, Minister for Public Health. On arrival, he was received by Dr. M. V. Natesan, Secretary, and conducted to the Victoria Edward Hall, where tea was served. Rao Bahadur S. Padmanabha Sarma, District Medical Officer and President of the Association, welcomed the Minister. The Secretary then presented an address together with a memorandum regarding medical relief. The memorandum stated *inter alia* :

"Non-teaching District Headquarter Hospitals should cease to have an outpatient department dispensing medicines and dressings free, but treat only indoor patients. The out-door poor patients should be treated by municipal dispensaries.

"With the extension of the honorary system, arrangements should be made for admitting a limited number of private patients of the honorary officers.

"Similar facilities should be provided to independent practitioners for admitting their patients in the general wards and for following their progress.

"As many young medical men as possible should be taken as house surgeons and house physicians and a decent allowance paid to them.

"Salaries of those now in service should not be reduced. Men in service may be allowed to retire on proportionate pension any time after completing five years' service.

"The privilege of private practice of the highly paid officers should be limited to consultant practice. The lower paid officers should be debarred from private practice and paid a compensatory allowance in lieu thereof.

"In admitting students to the Medical Colleges other conditions being satisfactory, the sons and dependents of medical men must be given preference over all others."

Dr. Rajan, after thanking the Association for the reception, referred to the good work done by it.

He next explained the principles underlying the honorary medical service which he intended to introduce.

It was his considered opinion that the Medical profession was not overcrowded. They had not even one doctor for every 20,000 of the population.

They had at present a scheme for rural medical relief, with a doctor who would also be the sanitary officer, and deal with all matters of public health.

He did not want the hospitals to be merely in-patient hospitals or to arrange for accommodating limited numbers of the private patients of honorary officers. What they proposed to do was to give training to medical men and make them fit to earn their living by private practice outside and not provide beds in the hospitals for their patients.

As for the present salaries in the service, they should know that Government was spending one-sixteenth of the revenue on medical service and it was time they willingly agreed to a cut. If they did not agree, cuts would be forced on them.

With reference to the private practice of the higher paid officers, they had to admit that these men were the experts. Were they going to prevent the sufferers from getting the benefit of their experience?

As for giving sons of medical men preference in the admission to medical colleges he could not understand how it could be urged. It was different in the case of artisans whose sons naturally had an aptitude and an earlier training for their vocation. That could not be said of sons of doctors. They had the hereditary system in many walks of life, but he was not sure it could be followed in the medical service.

Regarding the Ayurvedic system the Minister appealed to the gathering to bear in mind the traditions of that system and the favour with which it was viewed by the public. Its practitioners were also ambitious and the time would come when each system would accord the other its rightful place.

Referring to a request for grants to Medical Associations for capital and recurring expenditure, the Minister wondered how their members could make such a demand of a Congress Ministry. These associations were for their benefit. If the members asked for grants for running the associations they could also expect to be provided with other luxuries of life for only a contented life was conducive to the best work.

Continuing the Minister referred to the medical profession in general. The private practitioner he said had come to stay. It was an art to get the money from the patient's pocket without increasing his ailments and sufferings. He would like general practitioners to be well fitted to attend to all human ailments instead of making people consult different experts. They should also know the art of tackling the villagers and the lay people and master the art of making them pay handsomely and without grudging.

—(The Madras Mail, 12.11.37.)

### Changes in the System of Medical Education.

FROM AN ESTEEMED CORRESPONDENT

It has been announced that the L.M.P. course (five years) will be abolished and that a second medical college will be started in the present Stanley Medical School which will be affiliated to the Madras University.

I welcome the announcement in so far as it approves of the principal that a certain minimum standard of Medical education is going to be introduced in our province. There appears to have been no definite policy in the past either with regard to the standard of medical education or the location of places of instruction which was not in the best interests of the Province. Government have in the past created several classes of medical men, such as M.B.B.S., L.M.S., L.M.P., Civil Apothecary, Lady Apothecary, Lady Assistant Surgeon and Military Assistant Surgeon. Besides the medical educational institutions in the Capital of the Province, similar institutions were started by Government at Vizagapatam, Calicut,

Coimbatore, Tanjore and Madurai. Those at the last four places have since been abandoned. The institution at Vizagapatam has not yet been recognised by the Indian Medical Council. Institutions started by missionaries at Jammalmadugu and Neyoor have also disappeared. While co-education was and is still in existence in this college, a separate medical school for women was started in the City.

Besides the above, Government have also brought into existence the School of Indian Medicine with its three sections: Ayurvedic, Siddha and Unani. The learned Principal of the school has rightly insisted on Anatomy, Physiology, Midwifery and Surgery being taught to the students of this school, with a view to enable them to assimilate what is wanting in the indigenous system. This has been in existence for a sufficiently long time but we are forced to the conclusion that it does not serve much useful purpose. The abolition of this school also should coincide with the present policy of the Government that there should be only one minimum standard of medical education. Any attempt to lower the standard of medical relief on the plea that ignorant and superstitious people would resort to "truncated" indigenous systems of medicine should be discouraged. Government should legalise the practice of medicine by laying down that only those who possess certain prescribed qualifications and who enroll themselves in a register recognised by Government can practise medicine. It is refreshing to note that Pandit Jawaharlal Nehru, the President of the Indian National Congress expressed his inability to make provision for indigenous systems in the Kamala Nehru Memorial Hospital.

Medical knowledge is international and and we should not be carried away by narrow ideas in matters of medicine.

It is necessary that Government should declare what is best in the interests of the health and welfare of the people and such declaration should be followed to its logical conclusion. It is only then we will be marching on right lines in the matter of prevention of illness and in the raising of standards of health.

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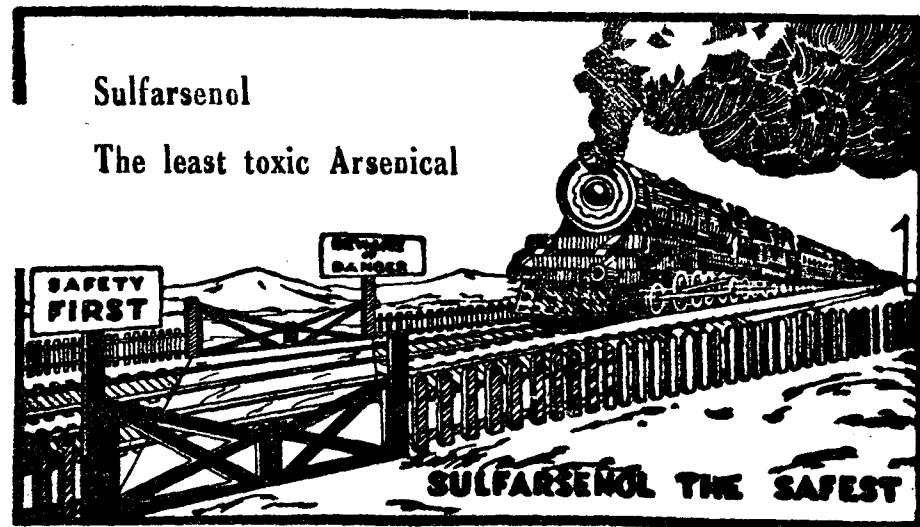
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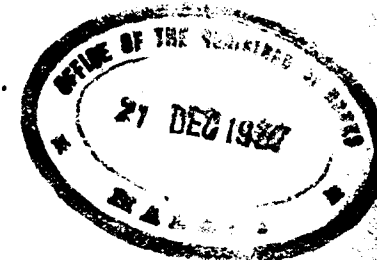
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### THE HANDBOOK OF INDIAN MEDICINE

OR

### THE GEMS OF SIDDHA SYSTEM

IN ENGLISH

With a Foreword by Dr. C. Muthu, M.D., M.R.C.S., L.R.C.P., Associate of King's College, London.

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# THE Medical Practitioner

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## Original Articles.

SPRUE.

BY DR. K. NARAYANA MURTHI, M.D.

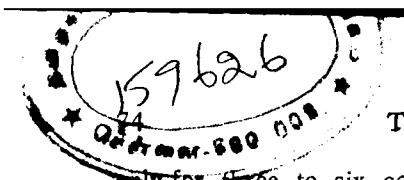
(Continued from last issue)

TREATMENT.

**SPECIFIC TREATMENT:** This depends upon the bacteriological findings. If a case of Sprue is discovered fairly early and the organisms of the Flexener groups or Shiga (of course Shiga is practically never) are found, a bacteriophage prepared for those organisms, proves to be of immense value. But to have the desired effect a suitable local strain of a full potency concerned has to be prepared. This phage can also be used as a prophylactic. The phage can be given by mouth on empty stomach; and during its course of treatment no drugs should be administered, as the drugs destroy the phage. In severe cases, phage can be given as a retention enema; but the purpose served thereby is very little. It is also given as a bowel wash as phages are now available in bulks. Col. Anderson working at Shillong reported very favourable results with the use of the phage given by mouth as well as by enema. But so far the results of my cases concerned at Madras Col. Anderson's phage was found to be very disappointing. I am inclined to believe that the disappointment in the results is entirely due to the phage being not prepared locally. The strain of organisms isolated from a typical case in

a particular locality if used for the preparation of the phage and if this phage is utilized in treatment of the cases occurring in the same locality, the results may be satisfactory. No facilities were available in Madras for me to try the efficacy of bacteriophage therapy. When the phage for dysentery was prepared by d'Herrelle the expectation of a complete cure of Sprue was entertained. After his discovery of the phage, other phages from organisms like Cholera, Typhoid etc., were prepared. The results obtained by treatment with those phages were found to be equally disappointing. Every laboratory connected to a college should prepare its own phage as is done in the Calcutta School of Tropical Medicine and treat the cases belonging to the hospital connected with such institutions. Then the results will not be so disappointing. A description of the preparation of the phage is out of place here, but it is necessary to know how it is to be administered. 2 c.c. of the phage, which is issued in ampoules is mixed in an ounce of cold water, and given to the patient twice daily one hour before food. No intestinal antiseptics are to be used during the whole period of administration of the phage. It is to be administered





only for three to six consecutive days. If the case does not improve the administration of the phage is valueless.

In the absence of Flexener groups of organisms, the other organisms that are most commonly found in my cases were *B. Carolinus*, *B. Pseudo Carolinus*, *B. Enteritidis*, *B. Asiaticus*, *B. Faecalis alkaligenes*, *B. Archibaldi* etc. An auto-vaccine is prepared and administered with an initial dose of 5 millions. The organisms mentioned above are seldom found alone. Streptococci are found more frequently in association with them than *Monilia psilosis* of Ashfordi. When the above groups of organisms are absent *Monilia* is found generally associated with the streptococci. It is at this stage, we meet with cases of extreme anaemia. In still more advanced cases *Monilia* can be isolated in almost cent percent of cases. Though all these organisms are secondary invaders, vaccines prepared from all of them gave excellent results. Vaccines prepared from the streptococci recovered from stools or from the tongue are given intra-dermally every third day. The tongue symptoms clear with the first few injections before the symptoms of diarrhoea subside. If *Monilia* is isolated, it can be autolysed and added to the streptococcal vaccine. Cases which had the benefit vaccine therapy improve to a certain extent and then do not show any improvement at all. The method of preparation of the auto-vaccine from *Monilia* is to be mentioned as it is slightly different from the manufacture of other auto-vaccines. A twenty four hours growth of the *Monilia* strain isolated on *Sabaund's media* is taken. The square area of the growth is calculated with the help of a ruler. An equal number of c.c. of sterile distilled water should be added to the strain. On shaking it an emulsion is formed very easily. The approximate strength of 4 c.c. is equal to 4,000 millions organisms. Next thoroughly emulsify the growth in distilled water. Pipette off the emulsion into a sterile test tube and incubate it at 37°C. for 48 hours. Add 0.5 per cent carbolic acid to kill the growth and dilute it for use to 1 c.c. which is equal to 100

millions organisms approximately. It is necessary, as usual with other vaccine to test it for sterility before use. The initial dose is 10 millions and can be gradually increased to 100 millions.

In cases of severe anaemia, it is essential to institute liver therapy, as an adjunct to the vaccines. In extreme cases no advance in the treatment of Sprue has been so remarkable as a blood-transfusion. The blood-transfusion ought to be made in small quantities repeatedly, rather than doing the transfusion of a large quantity of blood at one time. Two or three transfusions 100 to 200 c. c. of blood at one time, can be done at weekly intervals.

**LOCAL MEASURES :** It is important to clear every kind of focal sepsis. If the patient has a sore tongue, glyco-thymoline or listerine, hydrogen peroxide should be used as mouth wash. Simple salt water mouth wash with a little borax and alum is often helpful to heal the sore tongue. The ulcers on the tongue may be painted with a solution of optochin 1 : 1000 This drug appears to be by far the best. After each mouth wash, feeds are given and the tongue should afterwards be painted with glycerini boracis. If there is severe pain and the patient cannot swallow any food it may be necessary to apply to the mouth cocaine 5 gr. to an ounce in order the patient may take food. For pain due to deglutition 5 to 10 minims of 1 : 1000 adrenaline if swallowed before a meal is found to give relief. If the anus is ulcerated suitable therapeutic measures should be made available. In cachectic cases it is necessary to use a water bed to prevent bed sores. Much better than a water bed is Dunlop's all rubber mattress. It is quite soft and has not the disadvantage of water bed. The patient should not be exposed to chill and should be warmly clothed.

**SYMPTOMATIC TREATMENT.** The most distressing symptoms which are more or less complications, are : acute diarrhoea, intestinal colic, flatulency and meteorism, hiccough, myalgia, insomnia, and mental worry, helmenthiasis, severe anaemia tetany and cramps and rarely haemorrhages.

Acute diarrhoea must be checked by lead or opium contrary to usual experience in other circumstances. Opium when given by mouth checks acute diarrhoea of Sprue more rapidly and more effectively than when it is given hypodermically. Tr. opii 10 minims should be given at one time and repeated if necessary in an hour. It can be continued in small doses 2 to 5 minims at longer intervals. With this a starch and opium enema may also be given. We should discontinue opiates if the motions are solid. In diarrhoea of a less obstinate character Crook's lacto kaolin, in doses of one dram a day is good, while on occasions bismuth and magnesia mixture (bismuth 15 grs. mag carb. pond. 15 grs. with spirit of chloroform 10 minims Aqua ad one ounce) given at bed time is useful in checking diarrhoea during the night. In fatal collapse and heart-failure with diarrhoea appropriate remedies like glucose, brandy, strychnine caffeine, digitalis, and intravenous saline are used.

Tympanites and meteorism are usually associated with some unsuitable element in the diet, and in a mixed dietary it may be due to the milk. Substitute milk with butter milk and give arrowroot gruel without milk sweetened to taste. Apply turpentine stupes to the abdomen and give Tr. asafoetida by mouth or enema. In cases of colonic distension the injection of Pitressin ½-1cc. will give immediate relief. For convalescent patients, the most convenient preparation which can be given by mouth is Kinazyme tablets, (Carnick') one tablet three times a day may be very useful. Allen and Hanbury have put into the market a preparation known as Charkaolin. This has to be taken one tea-spoonful thrice daily. There are also biscuits made with charcoal and these can be used in place of the powder. In some cases a combination of pituitary Pitressin therapy combined with a high colonic lavage with two—of hypertonic saline gives immediate relief when other measures fail.

Myalgia is relieved by massage to the wasted flabby muscles. In bad cases

pilocarpine 1/6 to 1/10 gr. is given intramuscularly three times a day.

Insomnia is to be treated by suitable hypnotics having recourse to morphia and opiates when necessary.

Hiccough is controlled by Liq. trinitrini Spt. chloroform and similar preparations.

Constipation is treated with isphague seeds which give out a good mucoid material when they are in water over night. One or two dessert spoonful of these seeds (2-4 drachms) at a time can be used three times a day. Col. Chopra has studied carefully the therapeutic and pharmacological effect of isphague seeds and he is of opinion that they serve as an excellent demulcent to the ulcerated intestines as they pass out uneffected. The mucilage is colloidal in nature and all the enzymes of the human body as pepsin, hydrochloric acid, pancreatic juice are found to have no effect over the mucoid material. It is found to act mechanically in relieving constipation. This vegetable drug is superior to any other known drug and it is also very cheap and is available in every market. It does not produce any bad effects as liquid paraffin is reported to produce such as eczema ani, paraffin pains malnutrition by preventing absorption and lastly cancer. Castor oil emulsion and soap and water enema may at times be used to relieve constipation.

Mental worry is relieved by admitting the patient into a hospital and not allowing sympathetic relatives and friends to attend on him.

Tetany and cramps are due to calcium deficiency. Calcium lactate grs 10 three times a day or in extreme cases calcium gluconate 5 percent solution 5 or 10 c.c. may be given intravenously. Scott's treatment consists in giving calcium lactate in 10 gr. doses, coupled with the administration of 1/10 gr of parathyroid, thrice a day. This has been found to be extremely beneficial in these cases.

Emaciation is treated with glucose and insulin therapy.

Subsidiary methods of treatment are massage, passive movements. Heliotherapy, ultra-violet radiations to chest and abdomen are all very helpful.

When a case of Sprue does not improve with the methods of treatment chalked down, stop all treatment and carefully search for any co-existing infection, from which the patient may be suffering. Malaria, syphilis, acute amoebic dysentery, helmenthic infection, oral sepsis are the most common co-existing diseases in Sprue. Atebrin, Salvarsan, and Iodides are tolerated by the patient. Ascariasis is treated with yellow santonin and ankylostomiasis with oleum eucalyptus, oleum chenopodium and pelletierin. Thymol should not be given, for it irritates the abraded mucosa, and the drug being easily absorbed produces toxic symptoms. Bad teeth, and pyorrhoea must be attended to after the acute symptoms subside as the debilitated patient will not stand the strain and shock.

#### CONCLUSION.

From my own observation and investigations conducted by me at the Madras Government General Hospital and from the data gathered by me from the books written on this subject by authors of international reputation, I may conclude :

- (1) That Sprue is not a disease peculiar to Europeans living in the Tropics.
- (2) That a large number of Indians have been suffering from Sprue in Madras Bombay and Calcutta.
- (3) That it is not necessary for Europeans suffering from Sprue to go to England and other European countries for the treatment of Sprue on long leave giving up their remunerative occupations.
- (4) That at present, doctors practising in India are sufficiently advanced in their knowledge of Sprue and very encouraging reports are available of successful treatment of Sprue even when the patients were Europeans.
- (5) That there is no need for Europeans to go chasing for strawberries as they

ripe in France, England and Scotland as fruits and other suitable items of dietary are available in India.

(6) That the patients suffering from Sprue may be made to eat any food of their taste chosen on the advice of their medical attendants.

(7) That the criterion of the well-being of the patient does not depend entirely on the improvement in the weight of the patient but on various other factors such as :

- (a) Well formed stools.
- (b) Absence of tongue signs.
- (c) Absence of discomfort or distension of abdomen.
- (d) Good appetite.
- (e) Improvement in the anaemic condition.

(8) That the average duration of treatment was about six weeks (as in my series invariably).

(9) The patients should be warned against relapses and should be advised to be discrete in the choice of their food avoiding always spices, too much sugar and carbohydrates, fats and alcoholic beverages. As anaemia does not improve correspondingly with other symptoms of the disease there is a need for a maintenance dose of liver extract.

(10) Lastly it will be interesting for me to mention that it was my lot to treat a fairly large number of Europeans suffering from Sprue who returned from Home much against the advice of their medical attendants and who improved remarkably under the lines of treatment described above.

I will be failing in my duty if I do not acknowledge the valuable help availed of by me from my teacher Lt. Col. G. E. Malcolmson, I.M.S. who, at the time of my investigations was the Professor, Madras Medical College and First Physician, Madras Government General Hospital.

## TUBERCULOUS DISEASE OF THE SPINE.

### PART III

BY LT. COL. M. M. CRUICKSHANK, M.D., M.CH. F.R.C.S.E., I.M.S.

*General Hospital, Madras.*

*(Continued from last issue)*

#### TREATMENT.

TREATMENT must be

General—fresh air, good food and sunlight, etc., etc.

Local (A) CONSERVATIVE (B) TREATMENT OF DEFORMITY (C) OPERATIVE.

(A) CONSERVATIVE 3 stages :

1. *Complete recumbency*  
No weight bearing.  
No movement.
2. *Ambulation*  
Weight bearing.  
No movement.
3. *Convalescence*  
Weight bearing.  
Movement (regulated movement.)

The keynote of successful treatment is relief of pressure, since pressure maintains the activity of the tuberculous process.

Therefore there are three principles in conservative treatment.

1. Support the back and lessen tendency to ante flexion.
2. Extend the back and lessen tension on diseased vertebrae.
3. Apply traction and so counteract the tendency to contraction of longitudinal spinal muscles.

#### 1. STAGE OF COMPLETE RECUMBENCY.

Every case should pass through this stage, no matter at what stage of the disease it happens to be. For such treatment we have at our disposal :

*The Bradford bed frame*, the width of which is equal to the distance between the shoulder tips ; the length a few inches greater than the patient. The frame is covered with two pieces of canvas with 4" between to allow for nursing.

Two felt pads are placed on the canvas opposite the diseased portion, on each side of the spinous processes, so as to raise and hyper-extend the spine.

The patient is secured by two webbing straps across the chest, shoulder and ankle bands and in children knee bands to keep the legs slightly abducted.

*The Whitman stretcher frame*, which is similar to the Bradford bed frame but bent to carry out continuous hyper-extension. The width of the frame is such that the sides lie opposite the glenoid cavities and acetabula.

The length is 6" longer than the child. Canvas and felt pads are placed as on the Bradford frame and the patient is fastened by an apron over the chest and abdomen.

*Instructions in the use of these frames.*—It is most important to bear in mind that a single relaxation may undo the benefit of months of care.

No pillow is allowed ; harmful pressure is counteracted by small ring pads.

To attend to the hygiene of the back, the patient is strapped to his frame, (in children in hyperextension an anterior plaster cast may be used) the patient is then turned face downwards, the frame removed and the back cared for.

There is no question of the patient being allowed to turn over or sit up. He

must learn to eat and drink with a feeding cup, a procedure which is difficult at first, but with patience and perseverance to which even the child becomes accustomed.

Other methods of recumbent treatment include: Plaster shell posterior and anterior is the best method. In applying these look out for abdominal distension and collapse.

Gauvain's wheel barrow splint.

Double Thomas' splint.

Jones splint frame with headpiece for extension.

Goldthwaite's spinal frame.

Phelp's box.

Pugh's frame.

*The Duration of Recumbency*—till the disease is limited by a fibro osseous barrier. In the cervical region this will take at least six months, but in the middle and upper dorsal areas a minimum of 18 to 24 months is required on account of the tendency to deformity.

## 2. THE AMBULATORY STAGE.

What are the indications which enable one to decide that ambulatory treatment may be commenced?

(1) Pain, local and referred, spontaneous or elicited by pressure, must have disappeared.

(2) The degree of kyphosis shows no increase.

(3) Evening temperature has remained normal for several months.

(4) Weight has increased.

(5) The site of the disease is found to be firm and unyielding.

(6) X-ray examination shows that recalcification is progressing favourably.

(7) The little patient is becoming restless and making efforts to get up.

If conditions are favourable the aim then is to get the patient into the erect position gradually, because on account of changes in blood pressure alarming symptoms may develop.

In this stage movement is still to be prevented but weight bearing will gradually in increasing degree be allowed.

Some form of spinal support then must be provided before ambulation can be permitted, and Fraser lays down certain conditions regarding that support must be fulfilled.

1. A fixed point must be obtained by fitting a pelvic band.

2. The pressure on the spine should be along the transverse processes of each side.

3. The support must not compress the lateral chest wall or interfere with respiration.

4. The posterior pressure must be counter-balanced by pressure to the chest in front.

5. If the disease is above D 10 and below D. 8, the support must extend above and in front of the shoulders.

If the disease is above D 8 then the head and neck must be included in the support.

The plaster jacket properly applied in the erect position is the most efficient immobilizer of the spine which we possess.

*The duration of ambulatory treatment* depends on the region affected, being longest in the mid dorsal—18 months at least—and shortest in the lumbar and cervical regions. The plaster jacket can then be removed in favour of a removable celluloid jacket.

It should be noted that hyperextension is only necessary while there is radiographic evidence of active disease. As soon as activity abates hyper-extension should be discontinued and the diseased vertebræ allowed to fall together.

## 3. THE STAGE OF CONVALESCENCE.

Here the ideal is that while weight bearing and moderate degrees of movement are permitted anything of the nature of harmful movement must be prevented.

*The secret of successful treatment* lies in following the principle of a gradual return to normal function.

*Convalescent treatment begins when the consolidation of the collapsed bodies is complete.* This is usually three or four years after the start of treatment, but the decision rests on something more convincing than the mere lapse of a period of time.

Any unevenness of the bone shadow, any areas of decalcification or of cavitation mean that healing is not yet complete.

*When the lime content has been restored to normal, when pain and muscular spasm have entirely disappeared and the general condition is good the possibility of convalescence may be considered.*

*The stage of convalescence should continue over a period of about 2 years.*

The apparatus is left off for longer periods each day but any return of pain means that the support must be immediately reapplied. During this stage a light celluloid jacket, or a Taylor's or similar brace is worn.

## B. TREATMENT OF THE DEFORMITY THAT IS OF THE GIBBUS

The usual method is that employed by Calot, where windows are cut out in the plaster case one over the kyphosis posteriorly and a larger one anteriorly. A thick layer of vaseline is spread in the skin over the deformity and pads of wool a little larger than the windows and 1 cms. thick are introduced. The bulging material is compressed by means of a plaster bandage. The process is repeated every 4 or 5 days until the desired improvement is obtained.

The risk involved is that a process of separation is induced which delays healing.

## C. THE OPERATIVE TREATMENT.

One might imagine that any method which controls or prohibits the movements of the spinal column would be a reasonable and rapid method of attacking Pott's disease. *But is spinal osteosynthesis indicated in Pott's disease?*

Albee urges operation at all ages, though most authorities would say that such osteosynthesizing methods should find no place in the treatment of children.

Sorrel does not advocate operation in childhood because in the child healing is likely to be complete: in the adult however the outlook under conservative treatment is less hopeful.

Calot on the other hand with the authority of 10 years' experience (he introduced fixation in 1897) has abandoned operative fixation, because he found that purely orthopaedic methods gave as good if not better results than those secured by operation.

In Albee's opinion the main indications for operation are:

- Pain.
- Muscle spasm.
- Increasing deformity.
- Abscess formation.
- Paraplegia.

*The contra indications are*—Secondary infection with high fever because the probability of securing a clean operative field in such cases is slight.

After operation the patient is immobilized in a plaster jacket for six months, after which he wears a celluloid jacket for another six months.

But the results though widely acclaimed in America are not so successful as at first anticipated. The operation

is not free from danger, satisfactory fixation is not always secured and the progress of the disease is not always arrested.

The idea of any fixation operative procedure seems to me unphysiological. Healing of the tuberculous focus depends on collapse of the vertebrae to some extent and this we deliberately try to obviate by the mechanical support and immobilization of a bone graft. Further the stability of the kyphosis mainly dependent on adequate anterior vertebral contact, and posterior spinal fusion does not restore sufficient stability to maintain correction obtained in this manner—(King). The only beneficial result that I can see from the insertion of a bone graft is that we lay down in the region of the lesion a source of an excess supply of calcium, which by the aid of the hyperaemia resulting from the irritation of the graft, will tend to produce a local excess of colloidal calcium which if not simply removed in the body fluids might be utilized in the recalcification of the osteoporotic vertebrae.

When paraplegia complicates the picture, is there then any more justification for operative treatment?

Girdlestone advocates early decompression in adults suffering from paraplegia. The decompression may take the form of a laminectomy, a costotransversectomy or both, but whatever the method of decompression the stabilization of the spine by bone grafting is an essential complement. *B. J. S., XIX.*

Girdlestone operates if the paraplegia advances quickly or if paraplegia progresses with immobilization. Operation is then done to protect the cord from prolonged pressure and the spinal column from further erosion and to promote healing.

He considers that grafting should be done early but that three conditions must be fulfilled before operation can be undertaken:

1. The patient should be comfortably settled on his frame *before, during and after* operation.

2. The period of ill health should be past.

3. Number of vertebrae involved should be known, so that the length of the graft can be correctly judged.

As Girdlestone points out and that wisely, *grafting shuts the door on laminectomy* and therefore in a case of severe paraplegia an adequate laminectomy must be done before grafting. But one asks why not do a costotransversectomy, evacuate a spherical or fusiform prevertebral abscess, and so perhaps eliminate the need for a laminectomy?

This may be done but the danger is that a tuberculous sinus may follow a costotransversectomy and the risk of doing the necessary graft operation later is increased. A sinus however, as Girdlestone points out takes several weeks to appear and during that time the need for a laminectomy becomes evident and the laminectomy graft operation can be carried out some time after the costotransversectomy and before the sinus appears. The formation of a sinus early obviate the necessity for any operative procedure.

We seem, therefore, in those patients who develop paraplegia early, (and paraplegia usually comes on in the first few months of the disease) to have made out a case for operative fixation.

While these are the views of the Oxford school, yet workers in Cambridge are of the opinion that costotransversectomy alone (Menard 1900) is of very definite value in certain cases of paraplegia of early onset and go so far as to state that laminectomy as a routine procedure, is to be condemned.

Steindler and Silver go further and point out that many cases develop a severe paraplegia after so called successful fusion operations have been done, and state that the value of fusion operations has not yet been proved.

From a very small experience of such cases I am afraid I must subscribe to this opinion.

The correspondent of the Hindu makes much by saying that a good number of medical men are employed in Great Britain by the Government and local bodies. On 6th, June 1937 Sir Kingsley Wood made a statement in the House of Parliament on behalf of Ministry of Health that there were only 115 medical men and 16 dentists in the medical staff of the Public Health Ministry. So the Government in Great Britain does not employ more 131 medical men including the dentists whereas in Madras the Government employs nearly 1,200 for medical relief only in addition to those employed in Public Health Department. The British Government has nothing to do with the medical staff employed in Counties and Boroughs as is the case in Madras Presidency where the medical officers employed in Taluk Head Quarter Hospitals are paid by the Government instead of by the local bodies concerned. The public funds at the disposal of the Government cannot permit the Government to have more paid officers. Yet the medical relief of the public should go on. This is only possible if the independent medical practitioners, such of them who could afford it come forward to shoulder the responsibilities of honorary medical service. Honorary service is never meant for people who are in need. Hospitals are never meant to make money. Medical men should give their knowledge free and service in hospitals should be restricted only to the necessitous poor. In every country including America there is honorary service side by side the paid service under the Government but in no country the full time officers are allowed private practice in the way it is done in India. It has been possible in all countries except in India for the independent medical practitioners to evolve as eminent physicians and surgeons and even as research workers. It should be the aim of the Government to help the profession towards this end.

We learn that a memorandum has been submitted to the Minister of Public Health, Madras, on behalf of the Madras Branch of the All India Medical Licentiate's Association suggesting the desirability

of abolishing or restricting the honorary service in the province of Madras as "its further extension is more likely to demoralise the profession and to minimise the chance of efficient and extensive medical relief." At the most, this may be the opinion of the local members of the Association even if all of them attended the meeting when the memorandum was discussed and voted unanimously. It can never be the opinion of the medical licentiates in the province of Madras who will be nearly 4,000 nor of the moffusil members of the Madras Branch of the All-India Medical Licentiate's Association. All the same the opinion of the Madras members of this association has to be considered and causes found out if possible which made those who drafted the memorandum to use the words found in the memorandum and quoted by us above. The probable causes of demoralisation have been mentioned by us at the very outset. If efficiency could be found in paid service only it may be desirable to get the whole lot of registered independent medical practitioners under the employ of the Government and absorb others as and when they are registered. To follow the logic and its sequence as adumbrated in the memorandum the more the pay, the more should be the efficiency. At this rate is it possible to make the paid service as extensive as the need for it demands? If those few who sat at drafting this memorandum were serious and found out the causes of demoralisation in the medical profession and requested the public Health Minister to put an end to these to the extent he can, it was possible to conceive the evolution of a contented and prosperous independent medical profession in the Madras Presidency depending upon only on merit and capacity of service to the public and not under the Government. Such an aim is not only consistent with the cult of the most noble medical profession but also possible to be conceived or at least to be imagined. To compare the Scientific cult of medicine to Police service and other services which cannot be rendered without payment is to forget the high ideals of service and devotion in the medical profession without which world will be a veritable hell

to live in. We will end our comments on the war against honoraries requesting those against the honoraries to wage war against demoralisation in the medical profession whether it be in hospital practice or private practice due to sins of omission or commission by officials or non-officials instead of leading an unholy crusade against honorary system of medical relief.

**An Excise Riddle :** A private practitioner in Hindupur is in a dilemma finding it very difficult to solve a riddle in the Excise rules. His letter addressed to us with the two communications received by him from the Excise Commissioner have been published in the Correspondence Columns of this issue. On a reference, the Excise Commissioner informed this practitioner that a registered practitioner may possess without License opium derivatives containing not more than 120 grs. morphia or diacetyl morphia or both, coca-derivatives containing not more than  $\frac{1}{2}$  oz. of cocaine in aggregate and medicinal hemp 2 drams in the form of extract and one pound in the form of tincture 'for use in his practice and not for sale'. "Use in practice" is interpreted by the Excise Commissioner that the above preparation should be administered "in injections, surgical operations or other emergent cases." "All other issues of the drugs by an approved practitioner from his dispensary shall amount to sale which can be done only under a Licence." The practitioner's scruples made him more cautious than he ought to have been. "Use in practice" covers "emergent cases" apart from the emergency of "injections," and "surgical operations". Excluding the administration of these preparations by skin for their therapeutic use and by the same route in surgery the other only way of administering these in "emergent cases" is by mouth or rectum. The Excise Commissioner is not a medical man and is not expected to know the administration of drugs by mouth and rectum in "emergent cases" and that medicine by mouth or rectum should be in the form of solutions technically called by the medical profession "mixtures" if the solution is to be given by mouth. In our opinion a registered

medical practitioner can with impunity administer these drugs in emergent cases by mouth as he does by skin and charge a fee for such service. But if the practitioner sells these drugs even on a prescription of another practitioner and gets money for such a transaction then only his action will amount to "sales". So in case he does dispensing for others he is bound to have a License. The authority to interpret Excise law and rules framed thereunder is the Government and if law is set in motion is the law court. We shall therefore refer this matter to the Government and the Government's reply will be published in The Medical Practitioner. In the meanwhile the safest course for the practitioners to get out of the clutches of Excise officers is to dispense medicines only to their patients and not to take notice of the additional cost of the preparations which may contain morphia, cocaine or Indian hemp while calculating the cost of a mixture and notify to that effect in the premises where they conduct their business. Excise law requires License only if the products coming under its purview are sold. If these are supplied free these products do not come under the law.

It may not be out of place to mention here that it is not necessary to bring the registered medical practitioner under the control of Excise Department. The medical Acts have provision to punish registered practitioners with the highest and the safest punishment of erasing their names from the medical registers if they misuse their privileges while prescribing drugs coming under the purview of Excise Law. The highest punishment a court can inflict for infringing Excise law is a fine or imprisonment and such a punishment might not necessarily lead to the erasure of the name of the practitioner from the medical register.

**A Fit of Pique in Bombay :** Soon after we read a report in the Bombay dailies, of a "fare-well" function to the old teachers organised by the students of Seth Gordhandas Sundardas Medical College last month, we felt very sorry that an ideal institution teaching the art of healing

sores and curing ills should be made use of for personal bickerings and thus distract the youthful minds devoted for serious study of medical science. We have had personal knowledge of the working of almost all the medical colleges in India excepting one in Lahore and it is our opinion from all points of view not excluding Indianization (if we may use this term to express Indian management and control) that the combined administrative responsibility of the Head of a teaching hospital and of the Head of the medical college in one person the Dean of King Edward Memorial Hospital and Seth Gordhandas Sunderdas Medical College was the best ideal to follow. Depending upon our impartial impressions we did even commend such a combined post of responsibilities to all the Provincial Governments especially the Government of the Madras Presidency when there was a controversy regarding the appointment of a permanent Principal to the Madras Medical College. We refrain from saying who was right and who was wrong either in arranging the 'fare-well' function or in obstructing it. We feel like an innocent child who had a very wicked father and as good a mother. The father could not earn and was a drunkard. It was his behest that he should be served meat at meals on pain of his wife's death. Poor woman could not get butcher's meat one day and she killed a dog and prepared dish out of dog's flesh. The innocent boy has been watching the situation. He loved the good mother as much as he loved the wicked father. He was in a dilemma what to do. He shuddered to speak the truth for fear of his loving mother losing her life. All the same he did not want his dear father to eat dog's flesh. The folk story stops mentioning only the dilemma of the innocent boy. But we cannot stop with the dilemma as the author of that story did.

Our concern is not in individuals but in the institutions of Bombay which train the future members of the noble medical profession. Self-determination and self-respect are now-a-day more misconceived than understood. Result has been most disastrous in schools and colleges and even in domestic life. The tendency

for all is to assert and command but none to obey. It is very easy to create disruption of society even on imaginary grounds but when the causes are bordering on realities, the sores of disruption cannot be cured. A teacher of medical science must learn before he teaches. He knows that bad temper has its physiological and pathological causes and the person displaying bad temper has no control over him and has to be treated instead of punished.

The parties of the unhappy episode are eminent members of the medical profession who are specialists in the art of healing. It could have been possible to prevent bad temper or exposition of such temper. Four retired teachers who were amongst the chief guests one of whom taught Preventive Medicine to the student-hosts, did actually have recourse to praiseworthy prevention. At times doctors should have recourse to curative as well as preventive measures. The remedy suggested for alleged "Despotism", or "Autocracy" might have been applied much earlier instead of allowing of dirty pus to accumulate in a sore and make the sore incurable. The Dean is not a new person. The old teachers must know him more than the new students many of whom might not even know the old teachers. And all concerned before and after the event know that Seth Gordhandas Sunderdas Medical College and Kind Edward Memorial Hospital are under the control of the Bombay Municipality. The Dean is a creature of the Municipality not only after the event but also before. If there was despotism or autocracy in these institutions it might have been cured and the resulting incurable sore prevented if the suggested remedy of an enquiry by the Bombay Municipal Corporation after the fare-well party was thought of and advised to the aggrieved students much before the fateful event. Doctors at times cure diseases the prognosis of which was considered at first to be grave. We wish it be so regarding this event.

**Half-Hearted Reform in Bombay :** It is reported that the Bombay Public Health Minister has framed new rules for

treatment of the public as out-patients and as in-patients in the Government and State-aided Medical Institutions. For the purpose of these rules a "well-to-do" person is defined to be one who has an annual income of Rs. 2,000 or pays annually land revenue to the extent of Rs. 400. People whose monthly income is below Rs. 40 a month in the Bombay City or Rs. 30 a month in the mofussil are considered to be necessitous poor. Well-to-do people or the members of their families cannot ordinarily attend the out-patient department. But they will be entitled for out-patient service in cases of emergency on payment of Re. one for each attendance. The middle class people whose income exceeds Rs. 40 a month in Bombay and Rs. 30 in the mofussil should pay at the rate of one anna per head per day for attendance. These people if admitted as in-patients should make their own arrangements for diet and will not be charged for services in general wards. The necessitous poor will be treated free as in-patients. Charges for private wards will range from one to five rupees according to accommodation and the paying capacity of the patients. The "well-to-do" will be charged in addition for services rendered. But the Government servant will be exempted from paying fees for services as in-patients.

The underlying principle of this reform is to charge the rich and treat the poor free. It is not known if the Bombay Government wishes to introduce Almoner system for admission of patients. In the absence of it hospital abuses are likely to remain as they are or increase, so long the admission of patients into the medical institutions is done by the medical officers treating the patients. This consideration apart, the Government should realise that both the Government as well as the public should depend upon the independent medical profession for medical relief and it should be the concern of the Government to shut the doors of State institutions against the rich and upper middle class people at the out-patient department in places where qualified private medical practitioners are available. This has been possible in Federated Malay States under the British Government ever since these States have been

under the British Government. It must be possible to introduce this reform throughout India. In-patients' admission should be prohibited for the rich and the charges should be rather high even for the admission of the middle class so that independent practitioners may be encouraged to start private hospitals and nursing homes. It is not known why even the well-to-do in Government service should be treated free as in-patients.

**Hopeful Expectations:** In the November issue of The Medical Practitioner we criticised the action of the Government in transferring Subsidized Rural Dispensaries into L. F. Dispensaries under the caption, "Subsidized Practice Unsafe?" A recent G. O. which has been published in the Correspondence Columns of the current issue will put the Subsidized Practitioners in hopeful expectations that the Government is listening to their legitimate grievances. Soon after it was reported to the President, Subsidized Rural Medical Practitioners' Association that in Krishna District a large number of subsidized dispensaries would be started by the Bezvada District Board, he brought to the notice of the Government the desirability of spacing the location of the dispensaries at a radius of at least 5 miles from each other. It was also suggested to the Government that the Revenue Department should be the proper authority to be consulted in regard to the location of the subsidized dispensaries. Comments also appeared in these columns on the subject. The Subsidized Rural Practitioners should be grateful to the Government for their order prohibiting the District Boards in locating Subsidized dispensaries in a haphazard way. The Government have also requested the Presidents of District Boards to examine the question of shifting the existing Subsidized Dispensaries which are within 5 miles distant from each other, in consultation with the District Medical officers, to villages where qualified medical relief is not available. We advise the subsidized practitioners to let the Government know the existence of Subsidized Rural Dispensaries within 5 miles radius from each other. They will also do well to inform the President

P. S. R. M. Ps. Association about such dispensaries.

**Anti-Tuberculosis Fund:** For combating Social diseases such as Tuberculosis India has been always depending upon external help whether in the initiation of the campaign against them or for the agency to work out the details of the campaign including the professional part of it. There is no dearth of philanthropists in India, for, the biggest amount of money for the working of the campaign comes always from within India. The Viceroys or their wives have made it their concern to launch some scheme or other for the welfare of the people in this country. King George Anti-Tuberculosis Fund had its initiation from a Viceroy and Lady Linlithgow, wife of His Excellency the present Viceroy finding that the existing fund is insufficient to combat Tuberculosis on a large scale is now appealing for another fund. A good beginning has been made. It is a strange irony in India that it has not been possible to make the masses take interest in such schemes which are primarily meant for their welfare and it is at times very difficult to make them realise that these schemes are run for their benefit. We wish persons like Mahatma Gandhi evince interest in the personal welfare of the masses as they do in political welfare. We are glad that almost all the Congress Premiers have telegraphed to Lady Linlithgow their hearty support for her efforts to combat Tuberculosis. We would have been happier if he could see as many Premiers or at least persons of public importance in politics adorning the list as Vice-Patrons of the fund. The qualification to be a Vice-Patron does not seem to depend upon the money subscribed, for, we find in the Madras list persons paying a couple of hundreds as Vice-Patrons.

Almost all big schemes launched for combating Social diseases are not also popular amongst the members of the independent medical profession. The Heads of the Medical Departments are usually looked to for professional guidance in such campaigns and they in their turn look to their immediate

subordinates working in special hospitals. The result has been that Special State Hospitals get overcrowded with patients who could afford special treatment outside State Hospitals, and the poor patients amongst the masses remain in their own houses adding to their misery. Unless consulting rooms of qualified independent medical practitioners are made Tuberculosis Clinics, the campaign against Tuberculosis amongst the masses will be a failure. We wish Lady Linlithgow will be pleased to know the importance of general practitioners in combating Tuberculosis.

**In-Road on Medical Profession:** India is a most tolerant country perhaps due to the religious cult of Hinduism which is the religion of the largest section of the people of India. In all other civilized countries manufacturers of scientific medicine desist from advertising their goods in the lay press. But in India the same manufacturers at least some of them not only advertise their goods in the lay press but take the role of Physicians and publish therapeutics of their preparations about which the members of the medical profession have not read in any text books or other books so far published by authors who are competent to write on such subjects. Asperin is one such drug which has been extensively advertised not only in the lay press but also on wall-posters. This is not all, lectures are given by the Agents of the manufacturers in crowded localities, who decorate Motor-Buses with nicely painted posters which demonstrate that Asperin is a panacea for all ills. The credulous people are misguided and have been misusing Asperin with harmful effect on their system.

Some firms have taken the role of Medical Journalists to trade on credulous doctors. It has been possible for them to employ qualified doctors for this purpose. The plea seems to be that medical periodicals are too costly for the practitioners. If manufacturers take to journalism also, the therapeutic uses of drugs and other medicinal preparations will depend upon the skill and ability of the Editors of the

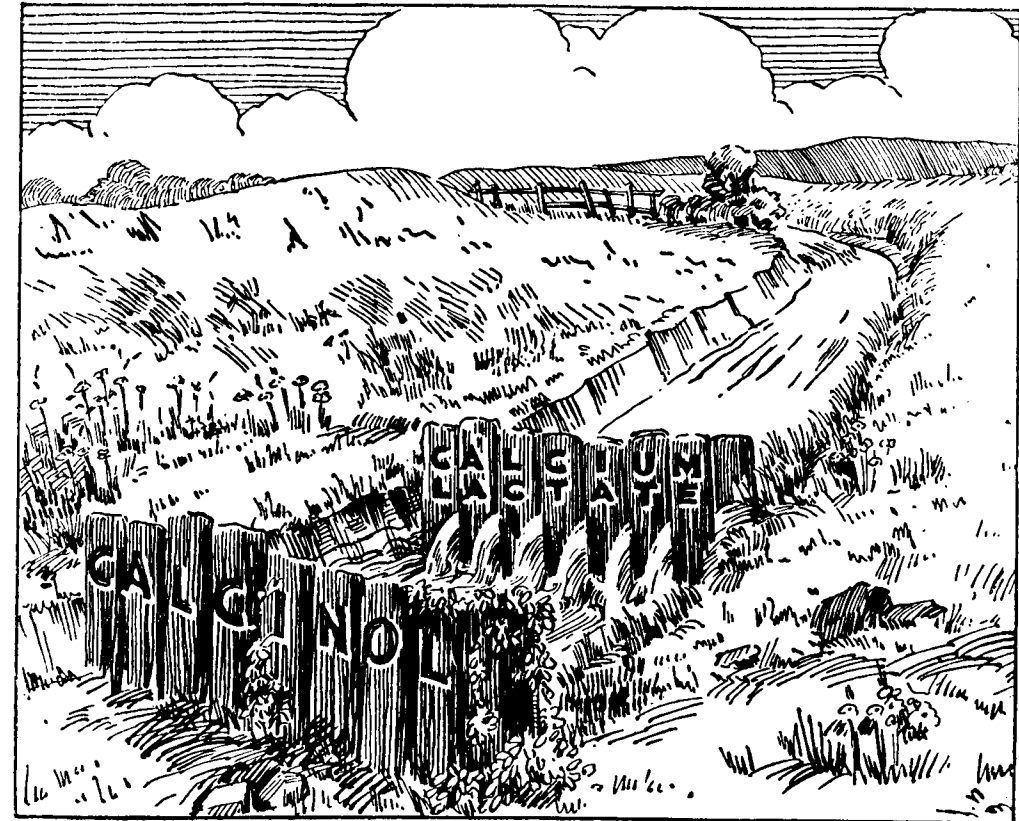
Manufacturers' Medical periodicals and medicine will lose its scientific value. We are glad that at a conference of medical men of United Provinces which met in Benares, October last, the members of the medical profession realised the dangers of advertisements in the lay press and passed unanimously a resolution requesting the Government to control such advertisements not permitting the publicity of proprietary medicines except in the medical press. If the medical press is to be in the hands of manufacturers of proprietary medicines, the members of the medical profession who are capable of diagnosing the evils of such publicity should not lose time in devising most effective measures to prevent such evils. The profession need not apply to the Government for help when there is an effective remedy of 'Boycott.' The medical profession will naturally look to Bengal medical profession to show a lead in boycotting the goods of manufacturers who are insidiously make an inroad on the scientific profession. Bengal knows how to boycott. India depended upon Bengal for this weapon regarding politics. The Boycott talent of Bengal has solved many national problems in the past. Madras was lead in the past by Bengal regarding boycott movement, the picture of the late Bepinchander Pal is still vivid before the eyes of the Madras public. We trust the President of the All-India Medical Conference a prominent leader not only of the medical profession but of the public in general who hails from Bengal will take effective steps to prevent such inroads on the medical profession and prevent all-round danger of unhealthy publicity and as unhealthy growth of medical journalism. The question is also to be seriously considered if qualified and registered medical men can edit Manufacturers' journals, without violating medical ethics.

**Idiocy in the Medical Profession:** Parents usually scold children with expressions which convey no meaning, at times even sense. Some terms of endearment also do not connote the dictionary meaning of the words. Dr. Rajan has given up worldly ambition for service. He assumed the responsibility as a Minis-

ter at an age and at a time ripe enough for the Vanaprasth Ashram. He gives out freely what he has at heart knowing fully well that he will not be misunderstood. It is natural he forgets at times he is the member of the Government of Madras and that his audience are still in the Grahasth Ashram. Recently while he addressed a gathering of doctors and students of medicine at Mysore, he expressed his surprise 'Why medical graduates should only hanker after berths in the State, while there was predominance of diseases in the country.....'

He said, that a medical man who could not get on well in life was the "biggest idiot" going on earth. Idiot is a person with defective mental development and such of the unfortunate medical men who do not get on well in life could not be born idiots unless the Government Medical Colleges were training places for sending out idiots. We request the Hon'ble Dr. Rajan to stretch his knowledge of human psychology and find out why he sees "idiots" not in medical colleges but outside them in spite of the fact that there are extensive fields for medical men to exercise their talent whether it be in Mysore or elsewhere in India. It is worthwhile for the Public Health Minister to find out if the idiocy in the medical Profession is due to defective medical administration and the unwholesome control of the Government over the affairs of the medical profession. At this very gathering Dr. Rajan told his audience that "he had already earned the reputation of possessing the nasty habit of putting his finger in the wrong places. The department under his care had already begun to feel that in a way".

Having done so and having studied the psychology why healthy young medicees appear as idiots he must have been able to draft a scheme of medical relief and medical administration for Madras Presidency which would transform those who have become idiots into useful medical men. The Medical Profession has been anxiously expecting the Hon'ble Dr. Rajan's new scheme of medical administration and medical relief. If affairs of medical profession are allowed to drift as in the past Dr. Rajan is likely to see many more idiots.



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**Correspondence, Reports Etc.****Medical Students Defy the Dean.****EXTRACTS**

FROM THE BOMBAY NEWS-PAPERS.

About two years ago Drs. G. V. Deshmukh, A. S. Erulkar and A. P. Bacha honorary professors of the Seth Gordhandas Sunderdas Medical College Bombay resigned and their resignation was duly accepted. It is said that in the month of June 1936 the students of the college decided to present "Fare-Well" addresses to their old teachers and approached the College Dean, Dr. Jivaraj N. Mehta. In the meanwhile the Dean is said to have received a letter from one of the retired professors Dr. A. P. Bacha which prevented the Dean to take part in the function and that the Dean made known his intention to that effect to the students.

A few months ago five more professors retired; one of them was Dr. Gilder, the present Public Health Minister of Bombay. The Dean wished to present 'Fare-Well' addresses to these and in addition congratulate Dr. Gilder on his having assumed the responsible position. When the students of the College were consulted by the Dean they desired to add to the list the names of Drs. Deshmukh, Erulkar and Bacha. But the Dean did not like the idea and the function was given up.

The students would not yield and held the Fare-Well party outside the college premises last month at the Ram Batt High School, Parel. Seven old teachers were invited as the chief guests, Drs. Deshmukh, Erulkar, Bacha, Purandare, Diwan Bahadur Nerukar, Rai Bahadur Mody, and Khan Bahadur Turner. But only three, Drs. Deshmukh, Erulkar and Batcha responded. The Staff of the College including the Dean did not attend the party so also the Commissioner of the Corporation of Bombay. The Mayor of Bombay Dr. E. Moses presided over the function. The Mayor eulogized the services rendered by the honorary professors and said that the college and the attached King Edward Memorial Hospi-

tal, did bring credit to Bombay, the institutions being run most creditably without Government control. He quoted statistics to verify the steady progress of these two institutions and praised the honorary staff for their selfless services.

Addresses were read and given to the three professors present. The recipients of the three addresses in the course of their replies severely criticised the Dean and described his administration as one of an autocrat. The question then arose as to what should be done with the addresses prepared for the absentee retired professors and the chief student organiser Mr. Chatterjee asked the advice of the Mayor. Dr. Vaidya intervened and spoke in strong terms and suggested that the Bombay Corporation should institute an enquiry about the high-handed action of the Dean in obstructing the students in presenting Fare-well addresses to the three professors who resigned from the honorary staff of the College two years ago.

**An Excise Riddle.**

TO

THE EDITOR,

*The Medical Practitioner.*

*Subject: Minimum quantities of Drugs—Manufactured—to be possessed by Approved Practitioners without licence for "use in practice" and "Not for Sale."*

Sir,

I desire to place before you an urgent and keen aspect of the above problem, and to submit the correspondence thereupon with the Excise Commissioner, Madras, for your early attention and needful action in the interests of the large body of Independent Practitioners.

Being directed by the Surgeon-General, Madras, to communicate with the Commissioner of Excise, the latter favoured me with a list of the Drugs to be possessed without licence, specifying the respective quantities. One of the Drugs is the Extract and Tincture of Medicinal Hemp.

**ANAESTHESIA AFFECTING THE NEWBORN.**

S. H. CLIFFORD and F. C. IRVING (*Surg. Gynec. Obstet.*, July, 1937, p. 23) point out that modern methods of obstetric analgesia, which usually depend on a combination of various agents, though very often successful, are seldom without some unfavourable effect on the foetus. During the past five years the barbiturates have been increasingly used in the Boston Lying-in Hospital with terminal gas-oxygen or gas-oxygen-ether, and the figures for still births and neo natal deaths have both fallen as compared with the previous five years. Since 1931 nembutal has practically replaced amytal. In order to avoid the many other factors which may influence the condition of the foetus at birth the authors have studied comparable groups of normally delivered full-term vertex presentations. A control group of fifty-three received no analgesics, the remaining 410 had one or more of the basal analgesics, and gas-oxygen with often a little ether at delivery. Only two infants died both in the group of seventy-five cases which received omnopon, and the authors stress the danger of opium derivatives, which they consider should not be used here. Of mothers receiving barbiturates 78 per cent. had complete amnesia, compared with 34 per cent. of those who had omnopon or morphine, while in the former group 63 per cent. of the infants were physiologically normal and only 3 per cent. required resuscitation, against 43 per cent. and 23 per cent. respectively for the latter group. No relation could be shown between the time of administration of the barbiturates and any action on the foetus, though with the opiates this effect rose steeply from two hours to a peak at from four to six hours before delivery, falling after eight to ten hours. In contrast again to morphine no relation could be shown between the dosage of barbiturate used and the behaviour of the infant. The addition of scopolamine to barbiturates gave more successful anaesthesia and analgesia than did that of rectal ether or paraldehyde, and none of these combinations showed unfavourable effects on the foetus. Nitrous oxide-oxygen is considered harmless if given for five minute

periods, but dangerous foetal anoxaemia may result if 90 per cent. or more of gas is given for longer periods. The amount of ether used averaged less than one ounce, and it was considered to have no effect on the foetus.

**ANAESTHESIA FOR SPINAL FRACTURES.**

P. MARIQUE (*Scalpel*, Liege, July 17 1937, p. 1023) describes his method of treatment for fractures of the lower dorsal and lumbar vertebrae. The question of anaesthesia for these procedures is fully discussed, and reference is made to Watson Jones, who, in a series of eighty cases, was able to reduce the fracture after an injection of morphine without any anaesthetic. General anaesthesia is not recommended on account of the danger of pulmonary complications, which may develop if a patient lies in a state of narcosis in a plaster jacket. Spinal anaesthesia is only suitable for low fractures of the spine. Various forms of local anaesthesia are discussed, and infiltration of the vertebral muscles with 15 to 20 c.cm. of a 1 per cent. solution of novocain on each side is recommended; this gives an excellent anaesthesia after eight to ten minutes. The solution diffuses over the site of the fracture and reduces relaxation of the muscular spasm, so that reduction can be carried out painlessly.

**HEADACHES AFTER SPINAL ANAESTHESIA.**

M. MARGOTTINI (*Policlinico*, Sez. Prat., July 19, 1937, p. 1385) reviews the literature and records his observations on 3,542 administrations of spinal anaesthetics in the San Giovanni Hospital at Rome from August, 1933, to August, 1936. No deaths were recorded. The anaesthetic employed was a 10 per cent. solution of novocain, which the author regards as the best anaesthetic for the majority of lower abdominal operations. After making a trial of the various methods for the prevention and cure of post-anaesthetic headache, which is much commoner in women than in men, he found that the intrathecal injection of a 1 per cent. solution of glucose after injection of the anaesthetic lowered the incidence of headache to 28 per cent., and reduced its duration and severity.

H. KOSTER L. KASMAN, and A. SHAPIRO (*Arch. Surg.* Chicago, July, 1937, p. 148) classify the various causes of the headache which may follow spinal anaesthesia under three headings: (1) seepage of cerebrospinal fluid after spinal puncture; (2) irritative meningitis, and (3) contamination of the material injected, causing irritation of nerve tissue. In order to obtain information regarding the later experiments were made in which the solution of procaine hydrochloride in cerebrospinal fluid was contaminated by the addition of tincture of iodine and a solution of trinitrophenol. A comparison was also made of the effect of using procaine hydrochloride dissolved in a physiological saline solution tap water, and distilled water with procaine hydrochloride dissolved in cerebro-spinal fluid. The experiment was conducted in five parts with twenty-five patients in each group, and the results showed that neither the addition of tincture of iodine nor the addition of trinitrophenol to procaine hydrochloride dissolved in cerebrospinal fluid had any effect on the development of post-operative headache. Hypotonicity or hypertonicity as occasioned by using tap water, a saline solution, or distilled water did not appear to be a factor in the production of headache. It was seen from the tables of the five groups that five patients had post operative headache, and this figure coincides with that of 5 per cent., which is the ordinary incidence of these headaches.

### CHLOROFORM.

D. KULENKAMPFF (*Schmerz Narkose-anaesth.*, August, 1937, p. 78) states that the dangers of chloroform as an anaesthetic have been exaggerated because unknown concentrations of it have been used, too large doses have been given for the sake of deep narcosis, and the psychological and constitutional side of the problem has been neglected. He points out that experience has long taught that women in labour and accident cases bear the administration of chloroform well, since in both instances there is no fear of an anaesthetic. It is important to set the patient's mind at rest, especially in those cases in which there is a constitutional tendency to spasm and allergy. The dose of chloroform can be accurately determined by the drop method, and local anaesthesia decreases the amount of chloroform required in a major operation. Respiratory disturbances are more dangerous than in ether narcosis, but chloroform may be used with advantage in operations about the mouth. Its non-inflammable properties enhance its value. The author recommends anaesthesia which is begun with ether and small quantities of chloroform, together with local anaesthesia of the skin and deeper structures. When in a major operation deep narcosis is avoided the patient awakes easily, there is no post-operative vomiting, and his recovery is pleasanter.

(*B. M. J.* Oct. 16, '37.)

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# THE Medical Practitioner

Vol. IX ]

DECEMBER, 1937

[ No. 3

### NEW YEAR GREETINGS.

Due to a happy domestic occurrence (the wedding of Dr. Kamath's daughter in Bombay) we have to be absent from Madras from the 15th December till perhaps the first week of January 1938 and therefore send our New Year greetings now instead of on the eve of the New Year. Our kind readers are not only our well-wishers but the actual feeders of *The Medical Practitioner* with whose generous sympathy, *The Medical Practitioner* has been able to grow a sturdy child, now in its ninth year. This month, last year, saw us in the Chief Presidency Magistrate's Court gazing at the face of the Magistrate with a mighty prosecutor opposite, in the person of a Lt. Colonel trying his best to make the Magistrate believe that our comments against the system of examinations of Medical Licentiates' course was defective, defamed him. A trying Judge has to depend on facts and law. He cannot know the conscience of the accused much less that of the prosecutor who in this case was an officer of the Government holding high position. Our sympathisers and wellwishers could not gaze at the face of the trying judge as we could do and consequently were more anxious than ourselves—quite naturally too. As for our part our anxiety was growing less and less as each defence witness got into the box and came out glorious in spite of tedious cross examination and a large number of them belonging to the fair sex. The art of judging things from the face is a necessary qualification of a medical man and this art helped us a good deal and kept us all through our

ordeal less anxious than our sympathetic readers. The delay in delivering the judgment added to their anxiety. We realised the joy of our readers by the volume of the congratulatory messages received from them after the judgment was delivered in our favour. In spite of our short comings during our ordeal when we could not devote much attention to the Journal, our readers have been most tolerant and did put up with all our irregularities of omission commission. The popularity of the journal has been not only maintained but also increased by them. Our indifferent health bordering on infirmity must have been yet another factor for the considerate sympathy of our readers and all that we can do in return is to pray for their health and prosperity all through the coming year, serve them as faithfully and as sincerely and make them realise the effect of our fervent prayers.

We have not been misplacing the confidence of our readers. Even the official section is made to realise that the motto of *The Medical Practitioner* is "Service" to the entire profession. We never hesitated to serve the official medical profession when we found its members had a real grievance against the authorities. "Independence" is our goal and there cannot be a more opportune and as auspicious an occasion than the present one when the Indian National Congress is on the saddle of the Governments of seven out of eleven provinces aspiring for political independence. It cannot be difficult for the Congress Ministries to conceive that the medical institutions owned by

the British Government and which are now owned by the Congress Governments are the legitimate belongings of the scientific medical profession and the medical profession and not the Government should be in sole charge of these institutions. Such a conception is not possible to be entertained in regard to the other learned professions as the entire public including the members of other learned professions know that free service is expected from and is given only by the members of the medical profession. India is a land of ironies more than other civilised countries due to her subordination and it may not be strange that the Congress Governments may do things which the British Governments have been doing in India. The Indigenous Systems of medicine have been so far to a large extent independent of the Government but the Congress Ministries instead of maintaining their independence and teaching them how to be independent, are absorbing them as the British Government had absorbed the Allopathic System. Narer in Orissa Province the Ministry has gone a step further and is showing a tendency to bring Homoeopathy under its control. The history of the growth of any science in all countries except in India should convince all right thinking persons that independence was at its root. If medical science has not made rapid progress in India it is due to the medical science being under the control of Government. Hospitals, dispensaries and other medical institutions were brought into existence in India by the British Government primarily to look after the army and when there was no need of active war service, the medical officers brought to India on high salaries were employed to look after the Civil population. Native medical subordinates were created to serve under the Army Medical Officers and out of these subordinates evolved the medical practitioners. In Great Britain and elsewhere where one nation is not ruled by another, the history of the growth of medical science is quite different. Because the Allopathic system was patronized by the British Government which they did not so much in the interests of the

public or the medical profession to begin with but in the interests of the Army, because later the Allopathic medical officers have been thriving on medical practice and because the British Government built hospitals, dispensaries and other medical institutions and filled them with full time officers with unrestricted privileges of private practice, the Allopathic practitioners have been entertaining an idea that without Government service medical science cannot be recognised by the public. The practitioners of Indigenous system of medicine are now following suit, the Homoeopaths are agitating for recognition and others will follow.

The legitimate duty of the Government and Local bodies is the prevention of diseases and the curative part of it should be entrusted entirely to the medical profession. Financially, it is an impossible proposition for the Governments or the Local Bodies to socialise medicine. It is against medical science itself, Government can not force any particular system on any particular individual or on a particular locality. The best thing to do will be to allow medical science to grow independent of Government control.

Lethargy and indifference cannot bring independence. Nor will pious resolutions passed by the provincial or All-India conferences move any Government; deputations and memorials cannot take the profession anywhere near the goal of independence. The profession has to agitate in the way the Congress has been doing. Sacrifices have to be made by those who could afford.

Apart from the affairs of the profession the members of the medical profession should take keen interest in the development of society. Social diseases such as Leprosy, Tuberculosis and Venereal disease etc. should receive their earnest attention. The agency at the head for combating against these diseases should be members of the medical profession. They should disabuse from the minds of the public that they are a trade union. Hospitalisation and not mere dispensing should be their aim in the exercise of their pro-

fession. Groups of individuals in a locality should organise team work in alleviating the sufferings of the public. If a large number of the members of the medical profession copy the example of foreign missionary medical service, independence will not be far off and the servile desire of service under the Government either as paid or honorary officers will disappear. Self-help is the greatest help and if the members of the profession realise that God helps those that help themselves, the future of the medical profession will be much brighter in the coming year and years to follow. May God guide the destinies of the healing profession and lead them to paths of righteousness and glory is our sincere prayer now and for ever.

"In the world's broad field of battle  
In the bivouac of Life  
Be not like dumb, driven cattle!  
Be a hero in the strife."

"Trust no future howe'er pleasant!  
Let the dead Past bury its dead!  
Act, act in the living Present!  
Heart within, and God o'er head!"

### DANGER AHEAD.

Under the caption, "Task Ahead" there appears an Editorial in the October number of the official journal of the Indian Medical Association wherein suggestions have been made to the Provincial Governments of a programme for "a new orientation to the public health policy." Reference has been made to a previous Editorial appearing in the August issue of the same journal where responsibilities of the new autonomous legislatures was the subject under discussion. During the course of elections to the reformed Councils, The Medical Practitioner discussed about responsibilities of the medical profession to the public welfare under the caption, "Reform and Responsibility" and suggested to the contending political parties especially the Congress Party, the desirability of having at least a minimum of

ten members of the medical profession in the Legislative Assemblies in the major provinces and five in the minor. It was said amongst other things that Government existed for the welfare of the people and no other profession could speak with authority about the welfare than the medical profession. Politics having assumed the role of yet another profession, the politicians as such are not likely to realise the need of a good contingent of the members of the medical profession in the Legislatures unless the medical profession as a whole asserts its legitimate right to be in the Legislative bodies. There are a good number of the members of the Indian Medical Association at its helm who could, through the Association, press the claims for the representation of the medical profession in the Legislatures. The annual conference of the members of the profession held under the auspices of the Indian Medical Association is the proper place to voice forth the need of representation of the profession in the Legislative bodies so as to enable the public and the Government to take advantage of expert medical advice. Thanks to the sagacity of the Hon'ble Mr. C. Rajagopalachari in choosing as his lieutenant the Hon'ble Dr. T. S. S. Rajan to be in charge of Public Health Department of the Government of Madras. Dr. Rajan seems to have drawn up almost all the schemes suggested by our contemporary in the "Task Ahead," excepting the scheme of Natation Health Insurance which Dr. Rajan declared in one of his utterances would be difficult to launch in the existing difficult conditions in India. He did not say what difficulties he had in his way for this scheme which while insuring the health of the poor people would have brought employment to the rank and file in the profession. As for ourselves we could see only one formidable difficulty and that—the existence of different systems of medicine in India which Congress Ministers feel, have to be recognised by the Congress. It is really most unfortunate that instead of unifying the existing systems of medicine in India on scientific basis there are signs of the Congress Governments creating factions in the medical science either out

of fear of public or medical opinion from the Western point of view.

So in the "Task Ahead" The Indian Medical Association would do well to discuss the desirability of unifying the indigenous systems of medicine and the so called Western system of medicine into one or else there is grave danger ahead to the medical science as a whole especially so as it is the opinion of the Indian Medical Association that Public Health should always be one of the first charges on the revenues of every civilised State. It is said by our contemporary that "It is undeniable fact that nation building activities occupied a secondary place in the programme of work of the previous Governments." The tendency of the present Governments seem to be to launch "nation-building activities" on a large scale without consulting public opinion on the assumption that the opinion of the public is entrusted by the public through the electorate to the M.L.As. and M.L.Cs. Government does things which the public deserve; and it cannot be otherwise now. The mass contact of the Congress has been able to make the Congress Government take the role of dictatorship. Even if the word dictator, is too harsh to be used in case of Congress Premiers, and even if the word Kings may be a suitable term the ideals of Ramraj will be most suitable to India than of any other king modern or ancient. Those who had the pleasure to read the Ramayana would remember that King Rama after he slew the Rakshasa King Ravana for having kidnapped his beloved wife Sita, sent her to exile as King Rama heard that a dhoby blamed the king for having brought Sita back though she was alone with Ravana for a pretty long time. It was too much for Rama to tolerate this insinuation though he could not for a moment suspect the chastity of his life partner and though it came from a humble washerman. He was a constitutional monarch not of modern times yet he thought he should take note of public opinion. Though the Congress Government with a Mahatma at its head would give India the benefit of Ramaraj it is desirable in a far advanced materialistic world to have

strong organisations to voice public opinion for guiding those who rule. This is indeed a very difficult task in the Indian Medical Profession as it is constituted to-day. If the Indian Medical Association concentrates all its attention to achieve unity in the profession and organises itself into a mighty union as the British Medical Association is in Great Britain, it would have solved all the difficulties in launching schemes for building a healthy nation. Provincial autonomy must be amenable to public opinion or else it cannot be an autonomy. So it is desirable to have a strong united organisation and the first concern of the Indian Medical Association is to concentrate its activities in organising itself into a harmonious united body. It will be not out of place for us to signal, "Danger". The U. P. Branch of the All-India Medical Association has been circulating a mandate not only to its members in U. P. but throughout India calling upon the medical Licentiates to boycott the Indian Medical Association for reasons which the Indian Medical Association should know. We do not wish to say anything further about this event at a time when the united action of the whole profession is needed for making the All-India Medical Conference to be held in Madras a great success. Yet as there cannot be smoke without even a small spark of fire and as at times a small spark would do to bring about destruction, it is worth the while of the leaders of the Indian Medical Association to quench even this smallest spark in time. The leaders of the Indian Medical Association many of whom are Congress men themselves, should realise how Congress has come to power by preaching and adopting mass contact. The Indian Medical Association has to do what Congress did to have an Indian National Profession. The Indian Medical Association has done well in enrolling as its members all registered practitioners in the way the British Medical Association did. But whatever the leaders may have at heart the Association has not shown tangible signs of protecting the interests of the masses in the profession whether they be Graduates or Licentiates. Mere

high sounding schemes or long drawn pious resolutions will not do. It is action coupled with self sacrifice that should come into play; then only shows of Conferences can shine as realities. We have been always mentioning that the independent medical profession, evolved as it is from the official medical profession has been always depending upon the officials to lead them even in private enterprises. We are most happy that Lt. Col. K. G. Pandalai who was till recently the seniormost medical officer in the City of Madras next to Surgeon-General has been elected by the Madras Medical Profession as its leader to run the All India Medical Conference. We did suggest to him to lead the profession much earlier than the date of the meeting of the Madras Reception Committee. We

trust under his guidance a most healthy, congenial and cordial atmosphere will prevail and await the guests coming from outside in spite of tropically situated Madras. Even elements will be in favour of such an atmosphere due to the salubrious climate of December and the merry festivities of Christmas. The election of Dr. B. C. Roy, as the President of the Conference will be hailed with joy by the entire profession in India. He is a staunch Congress man and knowing as he does the strength of the Congress as well as its weakness, he will be able to guide successfully the activities of the All-India gathering. We hope the New Year will have a much brighter record of work of building up the profession on national lines, by the Indian Medical Association.

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### News and Comments.

**War Against Honoraries:** Ever since the Congress came to power and Dr. T. S. S. Rajan took charge of the Medical Portfolio in Madras the Hon'ble the Minister has been giving expression to the policy of the Government to replace paid medical officers by honoraries. Later he announced that the honoraries will be paid a living wage. To us Dr. Rajan's scheme looks like a subsidised urban scheme at least in regard to assistant honoraries. Whether the honorary Physicians and Surgeons will also be subsidised is not known.

What the honorary scheme is actually to be has not been made quite plain though the Minister has been referring to the scheme wherever he was entertained by the medical associations. It is also not known if the scheme is to be published after its adoption by the ministry or before, for public criticisms. The repeated utterances of the Minister on honorary medical relief scheme without even the skeleton of the scheme not being exposed seem to have put some interested people in suspended animation. The increase in the number of free dispensaries in the City of Madras and other bigger towns in the mofussil with no restriction to those who go to such dispensaries for medical aid and abuse of hospital practice by those working in them whether they be State paid practitioners or honoraries has materially decreased the scope of work of the private medical practitioners with the result that the honorary system of medical relief gets the brunt of adverse criticisms instead of the persons who are licenced to work in the hospitals either as paid or honorary medical officers. Another serious defect in the honorary system is that the stipendiaries and honoraries are made to work in the same institution both being allowed to admit their private patients into their wards in spite of a standing order of the Government to the contrary. If hospitals cannot be used for the treatment of the middle class and the rich but are utilised to do service only to the necessitous poor there would be less applications for hono-

rary service and no room for hospital abuses by paid staff of the hospital. Strictly speaking the war is against the honoraries and not on the system of honorary service. Occasionally there appear letters in the columns of the lay press from correspondents against the honorary system but almost all the authors prefer not to publish their names. The letters seem to be from medical men or at least written under their inspiration. It could have been possible to assess the value of the criticisms if the authorship was known. Cowardice and intrigues are against the cult of the medical profession which is considered to be noblest. The nobility of the profession cannot deteriorate in spite of its ignoble votaries. So also the system of honorary medical relief cannot be made to appear dishonorable in spite of those who take up honorary work as a means of livelihood, the money being earned inside the temples of service *i.e.*, the hospitals. We refer to one such letter which appeared in the Hindu early in the month of September last. The Hindu gave a prominent place to this letter by publishing it in the form of an article and not in the correspondence columns. It cannot be from a private practitioner nor can it be from a lay man. The datum on which this correspondent depends in making an attempt to make it appear that there are more medical men under Government service than in honorary service in England and America is wrong and is likely to misguide the public. As mentioned by the correspondent in the Hindu the 19,000 medical men serving in the panel system cannot be reckoned as Government paid officers. They are certainly private practitioners who have chosen to serve the poor on a contract system, the Government taking the role of the bill collectors serving the members of the medical profession under authority, compelling the capitalists and the workmen to share the medical fees along with the Government. The same authority has thus created a vast field for private practice, the workmen being at liberty to select a doctor of his choice. So the doctors on the panel system cannot be brought under the category of Government Medical Officers.

The correspondent of the Hindu makes much by saying that a good number of medical men are employed in Great Britain by the Government and local bodies. On 6th, June 1937 Sir Kingsley Wood made a statement in the House of Parliament on behalf of Ministry of Health that there were only 115 medical men and 16 dentists in the medical staff of the Public Health Ministry. So the Government in Great Britain does not employ more 131 medical men including the dentists whereas in Madras the Government employs nearly 1,200 for medical relief only in addition to those employed in Public Health Department. The British Government has nothing to do with the medical staff employed in Counties and Burroughs as is the case in Madras Presidency where the medical officers employed in Taluk Head Quarter Hospitals are paid by the Government instead of by the local bodies concerned. The public funds at the disposal of the Government cannot permit the Government to have more paid officers. Yet the medical relief of the public should go on. This is only possible if the independent medical practitioners, such of them who could afford it come forward to shoulder the responsibilities of honorary medical service. Honorary service is never meant for people who are in need. Hospitals are never meant to make money. Medical men should give their knowledge free and service in hospitals should be restricted only to the necessitous poor. In every country including America there is honorary service side by side the paid service under the Government but in no country the full time officers are allowed private practice in the way it is done in India. It has been possible in all countries except in India for the independent medical practitioners to evolve as eminent physicians and surgeons and even as research workers. It should be the aim of the Government to help the profession towards this end.

We learn that a memorandum has been submitted to the Minister of Public Health, Madras, on behalf of the Madras Branch of the All India Medical Licentiate's Association suggesting the desirability

of abolishing or restricting the honorary service in the province of Madras as "its further extension is more likely to demoralise the profession and to minimise the chance of efficient and extensive medical relief." At the most, this may be the opinion of the local members of the Association even if all of them attended the meeting when the memorandum was discussed and voted unanimously. It can never be the opinion of the medical licentiates in the province of Madras who will be nearly 4,000 nor of the mofussil members of the Madras Branch of the All-India Medical Licentiates' Association. All the same the opinion of the Madras members of this association has to be considered and causes found out if possible which made those who drafted the memorandum to use the words found in the memorandum and quoted by us above. The probable causes of demoralisation have been mentioned by us at the very outset. If efficiency could be found in paid service only it may be desirable to get the whole lot of registered independent medical practitioners under the employ of the Government and absorb others as and when they are registered. To follow the logic and its sequence as adumbrated in the memorandum the more the pay, the more should be the efficiency. At this rate is it possible to make the paid service as extensive as the need for it demands? If those few who sat at drafting this memorandum were serious and found out the causes of demoralisation in the medical profession and requested the public Health Minister to put an end to these to the extent he can, it was possible to conceive the evolution of a contented and prosperous independent medical profession in the Madras Presidency depending upon only on merit and capacity of service to the public and not under the Government. Such an aim is not only consistent with the cult of the most noble medical profession but also possible to be conceived or at least to be imagined. To compare the Scientific cult of medicine to Police service and other services which cannot be rendered without payment is to forget the high ideals of service and devotion in the medical profession without which world will be a veritable hell

to live in. We will end our comments on the war against honoraries requesting those against the honoraries to wage war against demoralisation in the medical profession whether it be in hospital practice or private practice due to sins of omission or commission by officials or non-officials instead of leading an unholy crusade against honorary system of medical relief.

**An Excise Riddle:** A private practitioner in Hindupur is in a dilemma finding it very difficult to solve a riddle in the Excise rules. His letter addressed to us with the two communications received by him from the Excise Commissioner have been published in the Correspondence Columns of this issue. On a reference, the Excise Commissioner informed this practitioner that a registered practitioner may possess without License opium derivatives containing not more than 120 grs. morphia or diacetyl morphine or both, coca-derivatives containing not more than  $\frac{1}{2}$  oz. of cocaine in aggregate and medicinal hemp 2 drams in the form of extract and one pound in the form of tincture 'for use in his practice and not for sale'. "Use in practice" is interpreted by the Excise Commissioner that the above preparation should be administered "in injections, surgical operations or other emergent cases." "All other issues of the drugs by an approved practitioner from his dispensary shall amount to sale which can be done only under a Licence." The practitioner's scruples made him more cautious than he ought to have been. "Use in practice" covers "emergent cases" apart from the emergency of "injections," and "surgical operations". Excluding the administration of these preparations by skin for their therapeutic use and by the same route in surgery the other only way of administering these in "emergent cases" is by mouth or rectum. The Excise Commissioner is not a medical man and is not expected to know the administration of drugs by mouth and rectum in "emergent cases" and that medicine by mouth or rectum should be in the form of solutions technically called by the medical profession "mixtures" if the solution is to be given by mouth. In our opinion a registered

medical practitioner can with impunity administer these drugs in emergent cases by mouth as he does by skin and charge a fee for such service. But if the practitioner sells these drugs even on a prescription of another practitioner and gets money for such a transaction then only his action will amount to "sales". So in case he does dispensing for others he is bound to have a License. The authority to interpret Excise law and rules framed thereunder is the Government and if law is set in motion is the law court. We shall therefore refer this matter to the Government and the Government's reply will be published in The Medical Practitioner. In the meanwhile the safest course for the practitioners to get out of the clutches of Excise officers is to dispense medicines only to their patients and not to take notice of the additional cost of the preparations which may contain morphia, cocaine or Indian hemp while calculating the cost of a mixture and notify to that effect in the premises where they conduct their business. Excise law requires License only if the products coming under its purview are sold. If these are supplied free these products do not come under the law.

It may not be out of place to mention here that it is not necessary to bring the registered medical practitioner under the control of Excise Department. The medical Acts have provision to punish registered practitioners with the highest and the safest punishment of erasing their names from the medical registers if they misuse their privileges while prescribing drugs coming under the purview of Excise Law. The highest punishment a court can inflict for infringing Excise law is a fine or imprisonment and such a punishment might not necessarily lead to the erasure of the name of the practitioner from the medical register.

**A Fit of Pique in Bombay:** Soon after we read a report in the Bombay dailies, of a "fare-well" function to the old teachers organised by the students of Seth Gordhandas Sundardas Medical College last month, we felt very sorry that an ideal institution teaching the art of healing

sores and curing ills should be made use of for personal bickerings and thus distract the youthful minds devoted for serious study of medical science. We have had personal knowledge of the working of almost all the medical colleges in India excepting one in Lahore and it is our opinion from all points of view not excluding Indianization (if we may use this term to express Indian management and control) that the combined administrative responsibility of the Head of a teaching hospital and of the Head of the medical college in one person the Dean of King Edward Memorial Hospital and Seth Gordhandas Sunderdas Medical College was the best ideal to follow. Depending upon our impartial impressions we did even commend such a combined post of responsibilities to all the Provincial Governments especially the Government of the Madras Presidency when there was a controversy regarding the appointment of a permanent Principal to the Madras Medical College. We refrain from saying who was right and who was wrong either in arranging the 'fare-well' function or in obstructing it. We feel like an innocent child who had a very wicked father and as good a mother. The father could not earn and was a drunkard. It was his behest that he should be served meat at meals on pain of his wife's death. Poor woman could not get butcher's meat one day and she killed a dog and prepared dish out of dog's flesh. The innocent boy has been watching the situation. He loved the good mother as much as he loved the wicked father. He was in a dilemma what to do. He shuddered to speak the truth for fear of his loving mother losing her life. All the same he did not want his dear father to eat dog's flesh. The folk story stops mentioning only the dilemma of the innocent boy. But we cannot stop with the dilemma as the author of that story did.

Our concern is not in individuals but in the institutions of Bombay which train the future members of the noble medical profession. Self-determination and self-respect are now-a-days more misconceived than understood. Result has been most disastrous in schools and colleges and even in domestic life. The tendency

for all is to assert and command but none to obey. It is very easy to create disruption of society even on imaginary grounds but when the causes are bordering on realities, the sores of disruption cannot be cured. A teacher of medical science must learn before he teaches. He knows that bad temper has its physiological and pathological causes and the person displaying bad temper has no control over him and has to be treated instead of punished.

The parties of the unhappy episode are eminent members of the medical profession who are specialists in the art of healing. It could have been possible to prevent bad temper or exposition of such temper. Four retired teachers who were amongst the chief guests one of whom taught Preventive Medicine to the student-hosts, did actually have recourse to praiseworthy prevention. At times doctors should have recourse to curative as well as preventive measures. The remedy suggested for alleged "Despotism", or "Autocracy" might have been applied much earlier instead of allowing of dirty pus to accumulate in a sore and make the sore incurable. The Dean is not a new person. The old teachers must know him more than the new students many of whom might not even know the old teachers. And all concerned before and after the event know that Seth Gordhandas Sunderdas Medical College and Kind Edward Memorial Hospital are under the control of the Bombay Municipality. The Dean is a creature of the Municipality not only after the event but also before. If there was despotism or autocracy in these institutions it might have been cured and the resulting incurable sore prevented if the suggested remedy of an enquiry by the Bombay Municipal Corporation after the fare-well party was thought of and advised to the aggrieved students much before the fateful event. Doctors at times cure diseases the prognosis of which was considered at first to be grave. We wish it be so regarding this event.

**Half-Hearted Reform in Bombay:** It is reported that the Bombay Public Health Minister has framed new rules for

treatment of the public as out-patients and as in-patients in the Government and State-aided Medical Institutions. For the purpose of these rules a "well-to-do" person is defined to be one who has an annual income of Rs. 2,000 or pays annually land revenue to the extent of Rs. 400. People whose monthly income is below Rs. 40 a month in the Bombay City or Rs. 30 a month in the mofussil are considered to be necessitous poor. Well-to-do people or the members of their families cannot ordinarily attend the out-patient department. But they will be entitled for out-patient service in cases of emergency on payment of Re. one for each attendance. The middle class people whose income exceeds Rs. 40 a month in Bombay and Rs. 30 in the mofussil should pay at the rate of one anna per head per day for attendance. These people if admitted as in-patients should make their own arrangements for diet and will not be charged for services in general wards. The necessitous poor will be treated free as in-patients. Charges for private wards will range from one to five rupees according to accommodation and the paying capacity of the patients. The "well-to-do" will be charged in addition for services rendered. But the Government servant will be exempted from paying fees for services as in-patients.

The underlying principle of this reform is to charge the rich and treat the poor free. It is not known if the Bombay Government wishes to introduce Almoner system for admission of patients. In the absence of it hospital abuses are likely to remain as they are or increase, so long the admission of patients into the medical institutions is done by the medical officers treating the patients. This consideration apart, the Government should realise that both the Government as well as the public should depend upon the independent medical profession for medical relief and it should be the concern of the Government to shut the doors of State institutions against the rich and upper middle class people at the out-patient department in places where qualified private medical practitioners are available. This has been possible in Federated Malay States under the British Government ever since these States have been

under the British Government. It must be possible to introduce this reform throughout India. In-patients' admission should be prohibited for the rich and the charges should be rather high even for the admission of the middle class so that independent practitioners may be encouraged to start private hospitals and nursing homes. It is not known why even the well-to-do in Government service should be treated free as in-patients.

**Hopeful Expectations:** In the November issue of The Medical Practitioner we criticised the action of the Government in transferring Subsidized Rural Dispensaries into L. F. Dispensaries under the caption, "Subsidized Practice Unsafe?" A recent G. O. which has been published in the Correspondence Columns of the current issue will put the Subsidized Practitioners in hopeful expectations that the Government is listening to their legitimate grievances. Soon after it was reported to the President, Subsidized Rural Medical Practitioners' Association that in Krishna District a large number of subsidized dispensaries would be started by the Bezawada District Board, he brought to the notice of the Government the desirability of spacing the location of the dispensaries at a radius of at least 5 miles from each other. It was also suggested to the Government that the Revenue Department should be the proper authority to be consulted in regard to the location of the subsidized dispensaries. Comments also appeared in these columns on the subject. The Subsidized Rural Practitioners should be grateful to the Government for their order prohibiting the District Boards in locating Subsidized dispensaries in a haphazard way. The Government have also requested the Presidents of District Boards to examine the question of shifting the existing Subsidized Dispensaries which are within 5 miles distant from each other, in consultation with the District Medical officers, to villages where qualified medical relief is not available. We advise the subsidized practitioners to let the Government know the existence of Subsidized Rural Dispensaries within 5 miles radius from each other. They will also do well to inform the President

P. S. R. M. Ps. Association about such dispensaries.

**Anti-Tuberculosis Fund:** For combating Social diseases such as Tuberculosis India has been always depending upon external help whether in the initiation of the campaign against them or for the agency to work out the details of the campaign including the professional part of it. There is no dearth of philanthropists in India, for, the biggest amount of money for the working of the campaign comes always from within India. The Viceroys or their wives have made it their concern to launch some scheme or other for the welfare of the people in this country. King George Anti-Tuberculosis Fund had its initiation from a Viceroy and Lady Linlithgow, wife of His Excellency the present Viceroy, finding that the existing fund is insufficient to combat Tuberculosis on a large scale is now appealing for another fund. A good beginning has been made. It is a strange irony in India that it has not been possible to make the masses take interest in such schemes which are primarily meant for their welfare and it is at times very difficult to make them realise that these schemes are run for their benefit. We wish persons like Mahatma Gandhi evince interest in the personal welfare of the masses as they do in political welfare. We are glad that almost all the Congress Premiers have telegraphed to Lady Linlithgow their hearty support for her efforts to combat Tuberculosis. We would have been happier if he could see as many Premiers or at least persons of public importance in politics adorning the list as Vice-Patrons of the fund. The qualification to be a Vice-Patron does not seem to depend upon the money subscribed, for, we find in the Madras list persons paying a couple of hundreds as Vice-Patrons.

Almost all big schemes launched for combating Social diseases are not also popular amongst the members of the independent medical profession. The Heads of the Medical Departments are usually looked to for professional guidance in such campaigns and they in their turn look to their immediate

subordinates working in special hospitals. The result has been that Special State Hospitals get overcrowded with patients who could afford special treatment outside State Hospitals, and the poor patients amongst the masses remain in their own houses adding to their misery. Unless consulting rooms of qualified independent medical practitioners are made Tuberculosis Clinics, the campaign against Tuberculosis amongst the masses will be a failure. We wish Lady Linlithgow will be pleased to know the importance of general practitioners in combating Tuberculosis.

**In-Road on Medical Profession:** India is a most tolerant country perhaps due to the religious cult of Hinduism which is the religion of the largest section of the people of India. In all other civilized countries manufacturers of scientific medicine desist from advertising their goods in the lay press. But in India the same manufacturers at least some of them not only advertise their goods in the lay press but take the role of Physicians and publish therapeutics of their preparations about which the members of the medical profession have not read in any text books or other books so far published by authors who are competent to write on such subjects. Asperin is one such drug which has been extensively advertised not only in the lay press but also on wall-posters. This is not all, lectures are given by the Agents of the manufacturers in crowded localities, who decorate Motor-Buses with nicely painted posters which demonstrate that Asperin is a panacea for all ills. The credulous people are misguided and have been misusing Asperin with harmful effect on their system.

Some firms have taken the role of Medical Journalists to trade on credulous doctors. It has been possible for them to employ qualified doctors for this purpose. The plea seems to be that medical periodicals are too costly for the practitioners. If manufacturers take to journalism also, the therapeutic uses of drugs and other medicinal preparations will depend upon the skill and ability of the Editors of the

Manufacturers' Medical periodicals and medicine will lose its scientific value. We are glad that at a conference of medical men of United Provinces which met in Benares, October last, the members of the medical profession realised the dangers of advertisements in the lay press and passed unanimously a resolution requesting the Government to control such advertisements not permitting the publicity of proprietary medicines except in the medical press. If the medical press is to be in the hands of manufacturers of proprietary medicines, the members of the medical profession who are capable of diagnosing the evils of such publicity should not lose time in devising most effective measures to prevent such evils. The profession need not apply to the Government for help when there is an effective remedy of 'Boycott.' The medical profession will naturally look to Bengal medical profession to show a lead in boycotting the goods of manufacturers who are insidiously make an inroad on the scientific profession. Bengal knows how to boycott. India depended upon Bengal for this weapon regarding politics. The Boycott talent of Bengal has solved many national problems in the past. Madras was lead in the past by Bengal regarding boycott movement, the picture of the late Bepin-chander Pal is still vivid before the eyes of the Madras public. We trust the President of the All-India Medical Conference a prominent leader not only of the medical profession but of the public in general who hails from Bengal will take effective steps to prevent such inroads on the medical profession and prevent all-round danger of unhealthy publicity and as unhealthy growth of medical journalism. The question is also to be seriously considered if qualified and registered medical men can edit Manufacturers' journals, without violating medical ethics.

**Idiocy in the Medical Profession:** Parents usually scold children with expressions which convey no meaning, at times even sense. Some terms of endearment also do not connote the dictionary meaning of the words. Dr. Rajan has given up worldly ambition for service. He assumed the responsibility as a Minis-

ter at an age and at a time ripe enough for the Vanaprasth Ashram. He gives out freely what he has at heart knowing fully well that he will not be misunderstood. It is natural he forgets at times he is the member of the Government of Madras and that his audience are still in the Grahasth Ashram. Recently while he addressed a gathering of doctors and students of medicine at Mysore, he expressed his surprise 'Why medical graduates should only hanker after berths in the State, while there was predominance of diseases in the country.....'

He said, that a medical man who could not get on well in life was the "biggest idiot" going on earth. Idiot is a person with defective mental development and such of the unfortunate medical men who do not get on well in life could not be born idiots unless the Government Medical Colleges were training places for sending out idiots. We request the Hon'ble Dr. Rajan to stretch his knowledge of human psychology and find out why he sees "idiots" not in medical colleges but outside them in spite of the fact that there are extensive fields for medical men to exercise their talent whether it be in Mysore or elsewhere in India. It is worthwhile for the Public Health Minister to find out if the idiocy in the medical Profession is due to defective medical administration and the unwholesome control of the Government over the affairs of the medical profession. At this very gathering Dr. Rajan told his audience that "he had already earned the reputation of possessing the nasty habit of putting his finger in the wrong places. The department under his care had already begun to feel that in a way".

Having done so and having studied the psychology why healthy young medicoes appear as idiots he must have been able to draft a scheme of medical relief and medical administration for Madras Presidency which would transform those who have become idiots into useful medical men. The Medical Profession has been anxiously expecting the Hon'ble Dr. Rajan's new scheme of medical administration and medical relief. If affairs of medical profession are allowed to drift as in the past Dr. Rajan is likely to see many more idiots.



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## Medical Students Defy the Dean.

## EXTRACTS

FROM THE BOMBAY NEWS-PAPERS.

About two years ago Drs. G. V. Deshmukh, A. S. Erulkar and A. P. Bacha honorary professors of the Seth Gordhandas Sunderdas Medical College Bombay resigned and their resignation was duly accepted. It is said that in the month of June 1936 the students of the college decided to present "Fare-Well" addresses to their old teachers and approached the College Dean, Dr. Jivaraj N. Mehta. In the meanwhile the Dean is said to have received a letter from one of the retired professors Dr. A. P. Bacha which prevented the Dean to take part in the function and that the Dean made known his intention to that effect to the students.

A few months ago five more professors retired; one of them was Dr. Gilder, the present Public Health Minister of Bombay. The Dean wished to present 'Fare-Well' addresses to these and in addition congratulate Dr. Gilder on his having assumed the responsible position. When the students of the College were consulted by the Dean they desired to add to the list the names of Drs. Deshmukh, Erulkar and Bacha. But the Dean did not like the idea and the function was given up.

The students would not yield and held the Fare-Well party outside the college premises last month at the Ram Batt High School, Parel. Seven old teachers were invited as the chief guests, Drs. Deshmukh, Erulkar, Bacha, Purandare, Diwan Bahadur Nerukar, Rai Bahadur Mody, and Khan Bahadur Turner. But only three, Drs. Deshmukh, Erulkar and Batcha responded. The Staff of the College including the Dean did not attend the party so also the Commissioner of the Corporation of Bombay. The Mayor of Bombay Dr. E. Moses presided over the function. The Mayor eulogized the services rendered by the honorary professors and said that the college and the attached King Edward Memorial Hospi-

tal, did bring credit to Bombay, the institutions being run most creditably without Government control. He quoted statistics to verify the steady progress of these two institutions and praised the honorary staff for their selfless services.

Addresses were read and given to the three professors present. The recipients of the three addresses in the course of their replies severely criticised the Dean and described his administration as one of an autocrat. The question then arose as to what should be done with the addresses prepared for the absentee retired professors and the chief student organiser Mr. Chatterjee asked the advice of the Mayor. Dr. Vaidya intervened and spoke in strong terms and suggested that the Bombay Corporation should institute an enquiry about the high-handed action of the Dean in obstructing the students in presenting Fare-well addresses to the three professors who resigned from the honorary staff of the College two years ago.

## An Excise Riddle.

TO

THE EDITOR,

*The Medical Practitioner.*

Subject: Minimum quantities of Drugs—Manufactured—to be possessed by Approved Practitioners *without licence* for "use in practice" and "Not for Sale."

Sir,

I desire to place before you an urgent and keen aspect of the above problem, and to submit the correspondence thereupon with the Excise Commissioner, Madras, for your early attention and needful action in the interests of the large body of Independent Practitioners.

Being directed by the Surgeon-General, Madras, to communicate with the Commissioner of Excise, the latter favoured me with a list of the Drugs to be possessed without licence, specifying the respective quantities. One of the Drugs is the Extract and Tincture of *Medicinal Hemp*.

The first enclosure refers to this, and explains also the term "use in Practice."

I wrote to the Commissioner again asking whether the administration of the Drugs through Mixtures or otherwise than under the category of "Use in Practice," amount to 'sale,' and if so, as to how the inclusion of the tinctures of Hemp in the list can be appropriately interpreted. For, the tincture can only be dispensed through Mixtures. I therefore requested him to clear the dilemma. The second enclosure is the reply to my request.

I need hardly dilate upon the apparent inconsistency between the two enclosures, and the consequent ambiguity it produces to the General Practitioners regarding the possession of a licence or otherwise. I do not know how many Practitioners are silently suffering, like myself, under this enigma.

Under the circumstances, I request you, on behalf of the Independent Medical Practitioners in the Presidency, to dispel this too apparent an inconsistency by taking necessary action and solving the puzzle one way or the other. I am sure that the independent profession, as a whole, will be indebted to your successful efforts in the matter.

HINDUPUR, } (Sd.) T. NARASINGA RAO L.M.P.  
12-11-37.

## ENCLOSURE I.

Letters received by Dr. T. Narasinga Rao.

Dated 4th October, 1937.

FROM A. H. A. Todd, Esq., C. I. E., I. C. S.

Third Member, Board of Revenue and Commissioner of Excise and Separate Revenue.

SUBJECT:—Drugs—'Manufactured'—possession by approved Practitioners without licence—Limits—

READ:—Letter from Dr. Narasinga Rao, dated 17-9-'37.

MEMO:—

Dr. Narasinga Rao is informed that an approved practitioner may possess for use in his practice but not for sale the following quantities of manufactured drugs:—

(i) Opium derivatives (other than prepared opium) containing in aggregate not more than 120 grains of either morphine or diacetyl morphine or both.

(ii) Coca derivatives containing not more than  $\frac{1}{2}$  oz. of cocaine in the aggregate.

(iii) Medicinal hemp up to 2 drams (54.6 grains Avoirdupois) in the case of extract and 1 lb. in the case of Tincture.

The expression 'use in practice' covers only the actual direct administration of the drugs in injections, surgical operations or other emergent cases by or in the presence of an approved Practitioner. All other issues of the drugs by an approved Practitioner from his dispensary shall amount to sale which can be done only under a licence to be obtained from the Collector.

P. K. R. MENON,

Assistant Secretary.

## ENCLOSURE II.

READ—the following:—

Letter from Dr. T. Narasinga Rao, L.M.P., Hindupur, dated 15-10-'37.

MEMO:—

Dr. T. Narasinga Rao is informed that the expression "use in practice" covers only the actual direct administration of the drugs in injections, surgical operations or other emergent cases by or in the presence of an approved practitioner. It does not include the dispensing of mixtures containing manufactured drugs from the dispensary and such issues by an approved practitioner from his dispensary shall amount to sale for which a licence has to be obtained from the Collector.

P. K. R. MENON,

Assistant Secretary.

## The All India Medical Licentiates' Association, (Madras Branch.)

A general body meeting of the above association was held at No. 57, Thambu Chetty Street, Madras, at 5-30 p.m. on 24th October '37 under the presidency of Dr. R. Ramanujulu Naidu, and the following resolutions were passed unanimously:

- (1) Resolved that the Madras branch of the All India Medical Licentiates' Association, while appreciating the abolition of the L.M.P. course and with it the cadre of sub-assistant surgeons congratulates the Minister of Health, Madras, for the desirable steps taken by him in this connection.

- (2) This branch approves of the proposed change of the Stanely Medical School into the status of a College and its affiliation into the University of Madras.

There was however, some heated discussion about the conversion of the course from the diploma into a degree especially in view of the recent speech made by the Health Minister, Madras, at the entertainment given to him by the students of the Stanely Medical School.

- (3) That this branch of the All India Medical Licentiate's Association requests the Minister of Health, Madras, to give the existing medical licentiate, concessional facilities to qualify themselves for the M.B.B.S., degree of the Madras University, and to absorb senior sub-assistant surgeons in the subordinate medical cadre into the provincial medical service.

The memorandum on the subject Honorary Medical Service drafted by the Executive Council of the Association was read and passed unanimously with instructions to the Secretary to forward the same to the Minister of Health, Madras, through the Surgeon-General with the Government of Madras.

The gist of the memorandum was as follows:

- i. that it was wrong on the part of the State to declare that a particular set of persons shall work in a particular department without any kind of remuneration for the services rendered, though such services are voluntarily offered.
- ii. that it singles out the medical department for a parsimonious treatment.
- iii. that it is no solution of the problem of acute unemployment of medical men which we know, exist in fact and which is the duty of the Government to remedy as far as possible.
- iv. that it will bring in more corruption and engender indiscipline, irregularity and inefficiency.

## Government of Madras

EDUCATION AND PUBLIC HEALTH DEPARTMENT

(Public Health)

G.O. No. 3066, 15th November 1937

Medical institutions — Rural (subsidized) — Location at short distances — Prohibited — Selection of villages for opening new dispensaries to be made in consultation with Revenue Divisional Officers — Instructions issued.

Order—No. 3066, P.H., dated 15th November 1937.

It has been brought to the notice of Government that in certain districts, especially in Kristna, some subsidized rural dispensaries are located within five miles of each other and consequently a few villages only have the benefit of qualified medical relief and the rest are left unprovided for. The Government consider that as a rule no new rural dispensary whether subsidized by the Government or by the local board should be opened within a radius of five miles from an existing dispensary and that in the case of rural dispensaries which have already been opened within short distances of one another, the question of shifting such of them as are considered to be superfluous, to other suitable centres where medical relief is more urgently required, should be considered. Presidents of District Boards are accordingly requested to examine the question in consultation with the District Medical Officer and to submit proposals for shifting the superfluous subsidized rural dispensaries to other centres.

2. Before submitting proposals for the opening of new rural dispensaries in future, Presidents of District Boards and District Medical Officers are requested to obtain the opinion of the Revenue Divisional Officers concerned, through the Collector, in regard to the suitability of the villages selected by them for the opening of new rural dispensaries and to submit a copy of the opinion given by them, along with the proposals for the opening of new rural dispensaries.

(By order of His Excellency the Governor)

C. H. MASTERMAN,  
Secretary to Government.

To all Presidents of District Boards.

- .. all Collectors (except Madras).
- .. the Surgeon-General.
- .. the Principal Indian Medical School.
- .. the Revenue Department.
- .. the President (Subsidized) Rural Medical Practitioners' Association, Vepery, Madras.

## Review.

### The Administration Report of the King Edward VII Memorial Hospital and the Seth Gordhandas Sunderdas Medical College, Bombay, For the Year 1936—37.

The report of these two institutions is reviewed in these columns year after year and we find that though the main headings under which the report is spread remain with little or no change, the matter appearing under these heads give the valuable information for those interested in the utility and growth of medical institutions especially those which train the medical students.

The Dean has been repeatedly complaining in his reports that the K. E. M. Hospital worked much in excess of its full complement of 354 beds and bringing to the notice of the Bombay Corporation about the necessity of the expansion of the out-door department to meet the demands of the extension of the Bombay City in the North where K. E. M. Hospital exists. We are glad to read in the report that the Bombay Corporation approved the suggestions of the Dean and have sanctioned an expenditure of Rs. 15,16,000 for providing 106 additional beds and additional organisation of the out-door department. Half the sanctioned amount will be met by the Governor's Hospital Fund. This will not only relieve the over-crowding of the hospital but give additional training facilities to the medical students. Under motor accidents the Dean suggested in the previous report the desirability of compulsory third-party insurance so that the Insurance companies may be compelled to pay the cost of treatment for accident-cases admitted in the hospitals. The Dean is naturally gratified that the Bombay Road Committee has recommended to the Government a scheme for meeting the hospital charges in treating motor accident cases. The Dean has suggested in the report under review that the Courts while levying fines in road accident cases should take also into consideration "the question of reimbursing the hospitals for the expenses incurred by them in treating accident cases." We trust this valuable suggestion will have the desired effect and will be noted by Courts even outside Bombay City.

A good amount of Social activities could be seen in the institution under the administrative control of the Dean. There is a Nurses' Welfare Fund which is contributed by the ladies and gentlemen outside the hospital and special mention has been made in the report for the help the Fund received from Messrs. Mackinnon Mackenzie & Co. and Messrs. Killick Nixon and Co. The Fund provides a Library to which periodicals English, Marathi, Gujarathi are supplied free by the proprietors of these periodicals.

A social clinic is run for the welfare of the children attending the Municipal Primary Schools. 6,951 cases old and new were treated in the K. E. M. Hospital and in the General and special departments.

There is a Poor Box Charity Fund to help poor patients with spectacles, crutches, artificial limbs and travelling expenses. The fact that the

Dean was able to spend Rs. 19,923 from the collections made in the Poor Box should testify to the popularity of the Box. It is most praiseworthy that the honorary staff of the hospital in the Casualty Department pays the fees collected for medical certificates to Poor Box Charity Fund.

Bhagini Samaj an organisation of the members of the fair sex has been helping the labour staff of these two institutions in various ways. In addition to the teaching of 3 Rs, the womenfolk of the labour staff are given training in needle work, embroidery, etc. Three co-operative credit societies are continuing their good work for the benefit of the labour staff and it may be conceived how useful these societies are when it is learnt from the report that a ward attendant who borrowed Rs. 34 in March 1933 from a Pathan had paid Rs. 204 as interest and "still owed the whole of the principal, plus the good will of the Pathan as an excellent and regular payer."

The Dean has also a good record of work in the college under his charge. In 1935 the Bombay Corporation which runs both the institutions restricted the admission only to candidates coming from the City of Bombay and Bombay Suburban District. It looks as if the Dean reported to the Corporation that such a restriction prevented the admission of promising candidates. It is now laid down that only 75 per cent of admission should be reserved for Bombay and Bombay Suburban District. 5 seats are reserved for students coming from Central Provinces for which the C. P. Government pays a subsidy of Rs. 500 for each candidate and the individual candidate pays his fees with Rs. 40 more than what the native of Bombay pays. 20 seats are thrown open for candidates applying from outside the City of Bombay and its Suburban District.

An educational, a social, and a welfare survey of each student is maintained. The Dean keeps a record not only of the health of the individual student but knows how many of them are married, how many unmarried and how many betrothed. Out of a total strength of 454 students 244 were placed in the "A" class, 165 in "B" class and 6 in the "C" class regarding their health. There were 3 married and 5 betrothed students. The College admits students belonging to both sexes. There were 411 men students as against 43 women.

There is hostel to accommodate only men students and the Bombay Corporation have recently provided funds for a separate hostel for the women students.

Though the teaching and the hospital work in the college and the hospital is mainly turned out by the Honorary Staff the results of examinations compare favourably with the Government teaching institutions imparting University education in the City of Bombay or elsewhere. We have great pleasure in congratulating the Dean Dr. Jivraj N. Mehta and his Honorary colleagues for the good work turned out by them. We have to appreciate the decision of the Bombay Corporation in having extended the services of Dr. Jivraj N. Mehta till the 55th year of his age and thus guaranteed the continuity of sound medical education and discipline in the Seth Gordhandas Sunderdas Medical College and King Edward VII Memorial Hospital.

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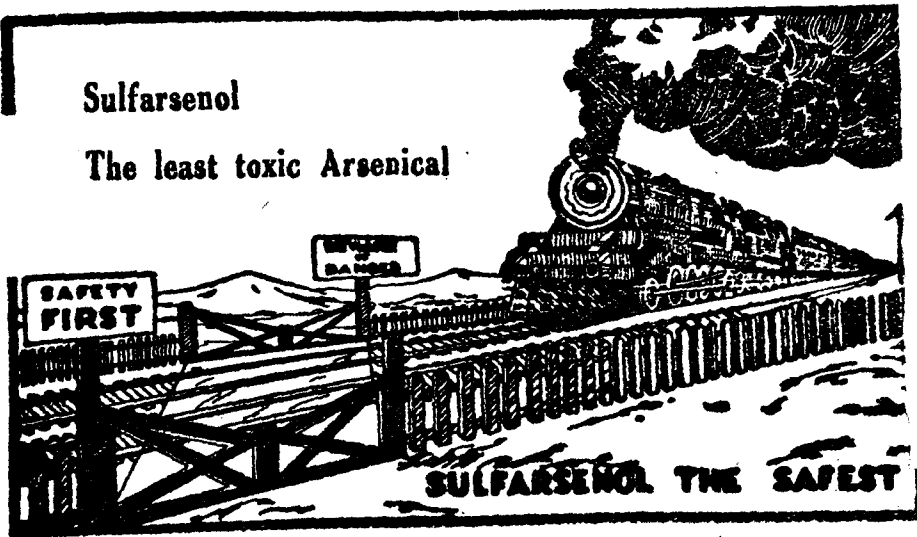
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