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OVERCROWDING IN MEDICAL PROFESSION

INADEQUATE SUPPLY FOR VILLAGES

INDIAN MEDICAL REVIEW.

It is estimated that there are 35,000 to 40,000 qualified doctors now practising in India, and although a proportion of one doctor to roughly 10,000 of the population would appear to be very inadequate, it is a fact that unemployment has become a serious problem among the younger members of the profession. Careful enquiries, however, show that in many towns the proportion is as high as or higher than one to 1,000 and that it is the disinclination of members of an educated profession to settle in rural areas, which is responsible for this apparent overcrowding.

This statement occurs in the comments on the medical profession in India, made by the Director-General, Indian Medical Service, in the " Indian Medical Review ", a publication just brought out, which gives, for the first time, in a compendious collection useful information bearing upon science and practice of medicine in India, and the facilities available for training and treatment.

While the Central Government has responsibilities for medical research, port quarantine, higher medical education, and for medical and health affairs of areas under its direct administrative control, medical and health subjects are the concern of the Provincial Governments. Despite the fact that there are numerous hospitals and dispensaries in the country, rural areas are still without adequate medical provision. Want of adequate funds is, no doubt, the principal cause to which the existing state of affairs may be attributed, but absence of facile means of communication and disinclination of the qualified medical men to settle in rural areas is also another reason.

DISINCLINATION TO SETTLE IN VILLAGES.

This disinclination of the private practitioner to settle in rural areas is not peculiar to India, but is common to all agricultural countries. A professional man, who has passed successfully through an arduous and pro-

longed scientific education, is not generally willing to reside in a remote country area, where amenities are few and earnings meagre.

Provincial Governments are doing their best to lessen as much as they can the sufferings of the millions living in villages. Medical men are being encouraged to settle in rural areas. They are being given subsidies for the purpose and are allowed private practice. Rural medical relief is at present afforded through the agency of fixed and touring dispensaries, subsidized medical practitioners, unqualified village school-masters, practitioners of indigenous systems of medicine and Missionary doctors.

Advisory Committees for hospitals function in almost all provinces. Their activities are confined to giving advice and making suggestions and also to looking after the welfare of the patients, the Committee thus forming a very useful liaison between the Government and the public.

Hospital Service.

The following is a tabular statement of the average area and population served by each hospital or dispensary :—

PROVINCES.	Total number of hospitals and dispensaries in province.	Average area served by each hospital or dispensary. (sq. miles)	Average population served by each hospital or dispensary.
Madras ...	1,134	126	41,217
Bombay ...	429	180	41,940
Bengal ...	1,449	540	34,585
United Provinces ...	597	176	81,087
Punjab ...	896	111	26,318
Central Provinces ...	343	291	45,212
Bihar ...	528	131	61,310
Assam ...	343	160	25,138
Sind ...	108	429	35,991
Orissa ...	164	145	32,355
Delhi ...	24	24	26,510
North-West Frontier Province ...	114	118	21,272
Baluchistan ...	41	1,327	11,305
Ajmer-Merwara ...	10	271	56,029
Coorg ...	11	145	14,848

Expenditure on medical relief in the various provinces was as follows :—

PROVINCES.	Expenditure on Medical Relief during 1936.	
	Per Capita.	Per Square mile.
	Rs. A. P.	Rs. A. P.
Madras ...	0 2 7	53 2 5
Bombay ...	0 4 9	65 7 0
Bengal ...	0 2 1	84 0 0
United Provinces ...	0 1 0	29 0 4
Punjab ...	0 5 7	51 12 9
Central Provinces and Berar ...	0 1 5	13 11 10
Bihar ...	0 1 3	35 11 8
Assam ...	0 1 8	14 5 5
Sind ...	0 4 0	20 15 3
Orissa ...	0 1 6	23 5 8
Delhi ...	1 2 5	1,272 0 0
North-West Frontier Province ...	0 6 3	70 0 0
Baluchistan ...	0 8 8	4 9 9
Ajmer-Merwara ...	0 4 11	63 0 10
Coorg ...	0 11 2	71 9 7

The total number of beds available for maternity cases in the various provinces during the year 1937 was about 8,000.

As against this, nearly three million women are disabled temporarily or permanently every year as a result of pregnancy and labour, while maternal deaths arising out of pregnancy number over 160,000 and the tragedy is that probably 80 per cent of these deaths were preventable.

X-ray facilities are also by no means adequate, there being in India only 83 major and 47 minor sets in the hospitals reported on.

Facilities for radium treatment exist to a very limited extent, the total quantity of radium available being about 5131 m gms. available only in Madras, Bombay, Bengal, Punjab, Bihar, Assam, Orissa and Delhi, besides the small quantities in the hands of the private doctors.

Free Treatment for the Poor.

Poor and indigent patients, both indoor and outdoor, are given free medical and surgical treatment in all provinces in India. A complaint frequently made against the administration of Indian hospitals, is that large number of patients who can really afford to pay are treated free of charge. The problem is not simple, because modern scientific medicine is costly, and although a person may not be indigent as regards the ordinary necessities of life, he often is in respect of even minimum requirements when sick. On the whole the revenue obtained from the payments of ordinary patients, says the Director-General, is not large, but fees paid by patients occupying private or paying wards should cover the cost to Government or the Hospital Management and in general do so.

Few private Nursing Homes exist in India, except in Calcutta, Madras and Bombay. In Bombay a legislation on the lines of the Nursing Homes Registration Act of Great Britain to provide for registration and inspection of Nursing Homes is under contemplation. When passed into law this measure should considerably improve the situation.

Nursing in India.

There is considerable dearth of the right sort of material for training as nurses. The caste Hindus have for decades looked with disfavour upon nursing as a profession, though the prejudice is slowly breaking down.

Since 1934 a considerable change has taken place in the outlook of the Central and Provincial Governments. Nurses ' and Midwives ' Registration Acts have been passed in Madras, Bengal, United Provinces, Central Provinces, Punjab and Bihar.

In practically all the nurses ' training schools in British India, the three years ' period of training for nurses has been adopted and most hospitals work very closely on the comprehensive syllabus laid down by the Central Nursing Council of England and Wales. Where this syllabus is adopted, there are two examinations. The preliminary one can be taken at any time after the completion of one year's training, but is usually taken at the end of eighteen months and the Final one on completion of three years' training.

Indigenous Medical Systems.

For sometime past there had been a demand from the public of the Bombay Presidency for the recognition by Government of the Ayurvedic and Unani systems of medicine. There is accordingly now under consideration

in the Bombay Legislative Assembly, a Bill which provides for the establishment of a Board of Indian systems of medicine and for the recognition by law of certificates given by registered practitioners of these systems. The Board is to prescribe the course of training and qualifying examinations, and no person shall be eligible for registration unless he has passed such an examination.

The Madras Government have already given a certain amount of recognition to the practitioners of the Indian systems of medicine, by appointing holders of the diploma in medicine of the Government Indian Medical School, Madras, as subsidized Medical practitioners in rural areas.

The Punjab Government have appointed a Committee to suggest means by which necessary protection can be given to such practitioners.

The United Provinces contemplate adopting a system of Vaids and Hakims, and a scheme for subsidizing Vaids and Hakims is under consideration.

Medical Training Facilities.

Medical Colleges built at Government expense were established in India at Calcutta and Madras in 1835, but it was not until 1906 that the need for higher teaching of a university standard was generally recognised. There are now ten University medical colleges, including one exclusively for women, established in India, while post-graduate training is imparted at the School of Tropical Medicine, Calcutta, the All-India Institute of Hygiene and Public Health, Calcutta, and at the Malaria Institute of Karnal.

While the Lady Hardinge Medical College, New Delhi, is meant exclusively for women students, in most of the other colleges, a few seats are reserved for women, and there are 322 such students at these other colleges.

Though at the Lady Hardinge Medical College, Delhi, students are admitted from any part of India, at other medical colleges seats are primarily reserved for local candidates. This Provincial preference means that students of many areas cannot obtain a higher medical education in India. Residents of Indian States, Central Provinces, North-West Frontier Province, Delhi and the centrally administered areas are especially affected, and the time has come, says the Director-General, Indian Medical Service, when the establishment of a new medical college in Delhi or at some other central place must be seriously considered.

Plea for High Standard.

The first medical school in India was established in Calcutta in 1822. There are now 18 Government and 9 non-Government schools in British India, training a class of medical men and women known as Licentiates or Sub-Assistant Surgeons. Several schools began as Unani and Ayurvedic teaching institutions, but all of them have abandoned this system.

The considerations, says the Director-General, which have prevailed so far in continuing the licentiate course of studies no longer exist. Higher scientific education has become popular and there is not likely to be any dearth of well qualified candidates for admission to the Medical Colleges. The time has, therefore, arrived for adopting a uniform standard of medical education. The Government of Madras have already decided that with effect from 1938 fresh admissions to the Stanley Medical School, Madras, and the Lady Willingdon Medical School for women, Madras, should be stopped. The former institution will be converted into a medical college for men and women.

Standardizing Medical Education.

The Medical Council of India was brought into existence by the Indian Medical Council Act of 1933, which placed on it responsibility for the maintenance of uniform minimum standard of higher qualifications in medicine for the whole of British India. The Council carried out a detailed inspection of all the Indian Medical Colleges and their examinations, and as a result the medical qualifications of all the Universities, except those of the Andhra University, have now been reorganised.

The Medical Council of India has also framed a series of recommendations for professional education, which now govern the requirements and standards of University medical education in India.

The furtherance of the recognition of the Indian medical qualifications in countries outside British India, with its corollary, the reciprocal recognition in this country of approved qualifications of such countries, is another function of the Council. Non-Indian qualifications recognized by the Council till now, are only those which have been accepted on a basis of reciprocity. The General Medical Council of Great Britain has accepted for registration in the United Kingdom all the degrees granted by the British Indian Universities, which have been approved by this Council.

There are also various Provincial Acts of Medical Registration which provide for the formation of a Medical Council in each province, where such

legislation obtains, and the registration of qualified medical practitioners. The functions of these Councils include, in addition, the supervision of medical education, inspection of examinations, exercise of disciplinary control over medical practitioners and that of advising the Local Government in regard to the recognition of the various medical qualifications.

Profession of Pharmacy.

A close study, says the Review, irresistibly points to the pressing need for immediate improvement of the situation in regard to the profession of pharmacy in India and to the manufacture, sale and import of drugs included in the British Pharmacopoeia as well as of those which are known and approved.

Both Bengal and Madras have instituted advanced courses in Pharmacy, but they are not popular, mainly because the prospects for future remunerative employment are meagre. The probable solution, says the Director-General, would be to insist upon a reasonable standard of general education, such as is guaranteed by passing the Matriculation examination of an Indian University, an adequate course of training, including apprenticeship of not more than 9 to 12 months, and properly organised Provincial examinations.

"GREYNESS AND BALDNESS OF DENTAL ORIGIN"

By

Dr. C. S. RAMAN,

Assistant, Dental Dept, Government General Hospital, Madras.

One result of dental irritation may be a localised greyness or whiteness of the hair, the distribution being identical with that of alopecia and in definite relation with particular groups of teeth. Leaving out of consideration cases with suppuration, instances in which greyness of the moustache follows treatment of the upper incisors with arsenic are specially worthy of mention. Hyperthyroidism is demonstrable in almost all cases as a predisposing factor.

As against circumscribed changes of colour and alopecia such as is seen in chronic affections of the teeth, diffuse baldness is observed in acute oral lesions. In such cases, the falling out of the hair of the head and the beard is usually preceded by marked hypersensibility of the skin and the scalp, which makes combing impossible.

With regard to localisation, alopecia appears in the beard and the hair of the head when the disease is in the upper jaw; in the beard and the nape of the neck when the disease is in the lower jaw. In fact, it ranges from the front to the back, according to the group of teeth affected thus: for the upper incisors and canines, the moustache and forehead; for the premolars, the temple; for the 1st molar, the vertex; for the 2nd molar, the lower vertex and the upper part of the back of the head; for the 3rd molar, the occipital region. The relations in the lower jaw are: for the incisors and canines, the region of the chin, for the premolars, the maxillary and sub-maxillary regions, for the 1st molar, the angle of the jaw, for the 2nd molar, the occipitomastoid region; for the 3rd molar, the back of the head and the nape of the neck.

Ten per cent of the cases represent the figure for the frequency of the participation of the teeth as a determining cause in falling out of hair. In twenty-five per cent the teeth act in conjunction with irritation in the area of distribution of the trigeminal nerve, through which other causes, such as hypotonia, may suddenly become operative.

Treatment varies with the case; in emotional types, extraction may be recommended; in more sensible persons, conservative treatment.

IS A NATIONAL LANGUAGE NECESSARY FOR SCIENTIFIC EDUCATION AND EXPRESSION IN INDIA?

By

Captain E. S. GOPALAN, M.B., M S., A.I.R.O., Coimbatore.

Though this is not, strictly speaking, a topic of medical interest, medical practitioners of India, will, nevertheless, have to grapple with this problem, in common with others claiming to be scientific, if not in the coming decade or two, at least a quarter of a century hence. If I venture to prophesy, in the manner I am going to do in this article, I do so after studying and, feeling also, the contemporary tendencies of the Indian national life. Whether a group, like the medical profession, wills it or not, the changes that are going to take place in the national education all over India, will have their influence on scientific education, including medical education. India is sure of having a national language, a lingua franca, and that language is surely Hindustani, a language born of the fusion of Sanskrit, Persian and other languages. That Hindustani is really the lingua franca of India, is practically recognized by the British Government in India, for, every officer of the Indian Medical Service has to learn Hindustani compulsorily and he has to undergo an examination for competency in that language. From my very limited experience as a medical officer in the Army in India Reserve of Officers, I can certify, to the absolute necessity of learning Hindustani, if we want to get a reliable history from patients from the Army, and, to the greater confidence such patients place in the medical man who can deal with them in their own language. Even my very meagre and elementary knowledge of the language stood me in good stead when I had to deal with the army patients. If, at the present moment, English, is the common medium for scientific education, and expression, in India, we cannot be sure it is going to be so for all time to come.

The need for a national language

India is a vast continent in which one-fifth of the human race live. It is a geographical entity. Culturally it has been, is, and is going to be one in spite of the apparent diversities in religion and provincial languages. When countries like France, Italy, Germany, Denmark, Norway, Sweden, etc., which, considering the extent and population, may be compared to our provinces and states, have expressed their highest researches and discoveries

in their own languages, India, with its 350 millions, must find it a very simple affair, to use its lingua franca, for scientific expressions. There is nothing unnatural about this. The unnaturality is in artificially transplanting a foreign language and compelling all and sundry to learn it. The theory that Indian languages cannot be made to express scientific thought is an exploded myth. Any Indian language, as a matter of fact, can express the highest scientific thought. If practical proof is needed, I can state that in the Oosmania University at Hyderabad, all medical subjects from the 1st year chemistry to the final year subjects like medicine, surgery and midwifery, are taught in Urdu which is Hindustani itself. I am indebted for this information to my friend Dr. Mir Abdul Basir, of the Vizagapatam Medical College, who is an examiner for Physiology in the University.

Future of Hindustani.

Hindustani is sure to be virtually the national language in the future Indian federation, whether medical men want it or not, or whether some Tamilians want it or not. In learned societies it is going to occupy the place which English, at present, occupies. With the adoption of it as a compulsory language all round India, and with the increasing use of the provincial languages for education, even in the University classes, the present standard of English is bound to go down, even among the very well educated communities. When that time comes, is it necessary or is it even wise, to have English only as the medium for learning mathematics, physical sciences, natural sciences, medical science, engineering, etc. ? All the basic sciences will be taught in the Indian languages or the Hindustani. Then medical subjects also will have to fall in line and rightly so. But I am afraid, there may be strong influences working in the linguistic provinces, for making the provincial language, as distinct from Hindustani, the vehicle for even advanced scientific education. Nobody can reasonably object to such a move in the case of secondary education and in the arts subjects of university education. But I should urge Indian scientists and medical men, to have the national language as their language, because Indian scientists must meet together as often as possible to compare notes, should publish their theses and articles in the common language, and should have a united front and common platform.

Advantages of the national language.

(i) It is an admitted fact that there is considerable wastage of Indian life in acquiring a reasonable standard of proficiency in English. If the time we devote to English is devoted to Hindustani, I can boldly say

that every one of us will be no mean scholars in the language. Even as the ancient Ayurvedic and Siddha systems of medicine were written in Sanskrit and Tamil verses respectively, some of us, politically inclined, can express our knowledge in verses.

(ii) At present India has to depend on foreign publications for scientific education. When all the sciences have to be taught in the Indian national language, there will be great impetus to the publication of all scientific books in the language resulting in a vast expansion of Indian authorship, Indian publication and Indian Book trade. So even commercially we stand to gain.

(iii) A liasion will be created between the Ancient Sanskrit Ayurveda and the Urdu Unani systems. My impression is that there are treasures in our ancient systems which have to be unearthed and utilized not only for the benefit of Indians but also for the whole mankind. A knowledge of Hindustani will facilitate research in such a direction.

Place of English.

In order to have academic and cultured contact with the outside world, it is necessary that a good number of the scientists, if not all, should learn English. Of all the foreign languages from the scientists' point of view English is the best, as it is handled by the largest number of people in three continents. It should be a very valuable optional for all who are really anxious to have contact with the trend of scientific thought in Europe, America and Australasia. But it should not be forced on all.

Conclusion.

Hence, I sincerely believe, that it would be profitable even for the present generations of Scientists, including medical men, to get into touch with the language and acquire proficiency. Things are moving very fast, and what is a dream today, may be a grim reality tomorrow and scientists, at any rate, should not be taken unawares. A good number among even the present-day scientists, must be competent to take up the responsibilities of authorship in the lingua franca of India. Where suitable terms in the language, are not available, we can freely transliterate to the enrichment of the vocabulary.

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JOURNAL OF SOUTH INDIAN MEDICINE.

NOVEMBER, 1938.

GOVERNMENT MEDICAL SERVICES AND PRIVATE PRACTICE.

The proposal of the Government to restrict the private practice of its paid medical officers has given rise to much controversy. We have refrained from entering into this controversy for many reasons. For one thing, once the Government makes up its mind about a particular matter, it goes about its work apparently unaffected by criticisms, destructive or constructive. But the more important reason for our silence is this. The present Government has been responsible in the short space of a year for many schemes of re-organization of Medical administration. The immediate result of all the contemplated changes has been a feeling of despair and helplessness among all ranks of the medical profession. And we do not wish to worsen this feeling by engaging in further controversy.

There is resentment and disappointment among the members of the Indian Medical Service, European and Indian. This has been a great and powerful service. The members may therefore be trusted to look after their own interests successfully. Till now, the impression has been growing that the (Provincial) Madras Medical Service was the pet of the successive Ministries of the department of Public Health in the Government. The members may therefore be pardoned if they have come to believe more and more strongly that they were to inherit the good things of this world to an increasing degree. Its career could well be likened to a stream with a negligible origin which meanders long in the wilderness as a tiny little streak of water. Suddenly this narrow stream has a great access of water, flows down with a swell, breeching bounds and inundating the surrounding country to a great extent on either side. Just at the moment when oblivious of its very humble beginnings, the

river is rushing on, proud of its weight and volume, contemptuous of any small stream that might seek entry into its course, she is blocked by rocks, the size and force of which is difficult to gauge. The rocks might divert the course, but they may also break the mighty river into a number of insignificant streamlets again. That is how the Madras Medical Service feels now. The goddess is in sulks, notwithstanding the camphor burnings and other assuaging peace offerings that still go on.

When the honorary scheme was first introduced the members of the various services exhibited much concern and then affected great contempt. When it was given out that that appointments in the Schools and teaching hospitals may be thrown open to honorary medical officers, they were not much disturbed, because they were still certain of their influence to prevent the realization of such ideas. But when the privilege to engage in private practice is sought to be restricted they are greatly perturbed. We fully sympathise with them in their moment of anguish. We have never suggested that the paid Medical Services should be prevented from engaging in private practice. But we have always insisted that the abuse of the privilege should not be tolerated. Reference to the back numbers of this Journal will bear testimony to this effect. We are sure that the members of the paid Medical Services appreciate our attitude.

We have already referred to the feeling of bitterness and resentment that exists among all ranks of profession. The members of the profession who are outside the services form the great bulk of the profession. It is well known that on the whole their economic plight is anything but pleasant to contemplate. The members of the paid Medical Services know this as well as anybody else. And the better minds among them also know the extent to which the abuse of the privilege of private practice by State Medical Officers has contributed to the sad plight of the practitioners.

We have appealed to these officers frequently, but in vain, to work for a position of importance and usefulness in the profession.

By force of circumstances many of them have abundant opportunities of being well equipped in the theory and practice of the various departments of medicine. The practitioners whose lot is cast in very difficult environment and whose time is taken up in keeping the wolf from the door has not the atmosphere nor the opportunities for keeping abreast of the rapid advances in the science and practice of his profession. They would therefore welcome their service colleagues if they would be glad to be their honoured consultants. Instead of this, they have been content with ever increasing self aggrandisement. Whether it be school medical inspection, issuing of vaccination certificates, or Insurance Medical work, they are ever on the alert to muster all their intelligence and influence to get these duties for themselves, all the time completely ignoring the fact that there are others among their profession who find time hanging heavily on them for want of anything to do. One of the main arguments at present used against the proposal to stop this privilege, is that the suffering public is denied the freedom of choice of their Medical attendants. Whether this grievance is real or not, surely the work that we have instanced above do not affect the freedom of the public. Do the members of the paid Medical services believe that there are not enough men among the practitioners who can do these duties as efficiently as themselves?

There are some among the members of the paid services who in their excessive zeal to condemn the honorary medical officers attribute base motives. We also come across honorary officers and other members of the profession who frequently refer to the many lapses from integrity of the paid medical officers. There can be no end to this mutual recrimination unless the members of the profession realise that honesty is not the monopoly of any one class. A medical man who is not paid by the Government is not likely to be any more dishonest than his brother who is a paid servant. The honesty of the independent practitioner and that of the paid medical officer cannot be any less than the average honesty of the Indian nation as a whole. No man has a right to expect any more, nor to presume any less of the members of the independent profession.

be fighting the proposals of the Government, when they propose to cut down their pay or curtail their privileges. The Service Medical men are not the only guilty ones. There are their counterparts in the fast disappearing "independent" profession. But the fortunate ones are much larger in number among the services. Their responsibility is therefore great for the existing state of the profession. Do they yet realize this truth?

POST-GRADUATE COURSES.

By

P. S. VARADARAJAN.

At no stage of medical practice can knowledge of recent advances in the diverse branches of medicine be dispensed with; but the time left for acquisition of such knowledge in the daily routine of a successful practitioner is totally inadequate. Unless and until the existing facilities for enriching his knowledge are altered or improved upon so as to suit the practitioner it is futile to hope for a higher standard of work. Eventually, it is the public that suffer, in so far that a lack of knowledge of the recent progress would result in poorer medical service. These remarks do not refer to that small group of persons who by dint of self-help acquire the necessary skill and knowledge and are able to employ the same in their service to humanity. Exceptions merely prove the rule.

A brief reference to the existing facilities may be of help in appreciating the changes suggested. Two main types are discernable. They are:— 1. In the metropolis and in towns

with clinical institutions. 2. In the mofussil, the formation of medical associations, for the purpose of periodic readings of papers of scientific interest and demonstration of clinically interesting cases constitute the main activities of this group of practitioners. A few of the more enterprising associations endeavour to build up a small library with facilities for circulation. In the metropolis and in the towns with medical schools, a greater degree of facilities exists in the shape of University extension lectures, reading of papers constituting the work of the research scholars, and regular courses of studies extending over a few weeks or months like the one for the study of tuberculosis that exists to-day.

It must be admitted that the above enumeration impresses one as being adequate and sound; but any one who has seen the working of it knows the hollowness of it all. The writer of this article on his first appearance to speak at one of these meetings was pathetically convinced of the soporific value of his own voice. Since then there has been no occasion to alter that conviction though three years have lapsed.

Considering the fact that an enormous amount of clinical material is available in most of our hospitals and that the type of work done is by no means inferior to that done anywhere else, short refresher courses would be very popular. The Clinical teachers could be requested to concentrate upon making the demonstrations as practical as possible. Temptation to exhibit clinical anomalies and curiosities should be curbed. For example, a broncho-pneumonia case should be preferred for demonstration to one with a cerebellar tumour. Surgical operations should be shown, and the talk should be limited to the explanation of the operation shown. The duration of these intensive refresher courses may be limited to 48 or 72 hours. These courses may be repeated every three months. If it is deemed necessary to levy a fee, it should be negligible. In the earlier stages, levying a big fee would make the course very unpopular.

To cater to such of those practitioners who contemplate acquiring a higher grade of proficiency in any one branch of

medicine, a prior drawing up of syllabus is absolutely necessary in many of the departments. Within reasonable limits, post graduate courses should be arranged in most branches of medicine. By way of tuition-fees, a small honorarium may be given to those who are not in the pay of the Government. As the accommodation is limited, the selection should not savour of favouritism. To avoid such a comment, it is best to vest that power in people outside the institution (it is of course understood that they know the nature of the work they are doing).

Courteous reception of old boys of the respective medical schools—By no means the least important item in any scheme of postgraduate studies, is the treatment accorded to the old boys on their visit to their *Alma Mater*. It is a pity that a good deal remains to be done in this direction. A large majority of the old boys who are unconnected with the institution have expressed to the writer that the least bit of love they might have entertained towards their *Alma Mater* was killed by the chill reception both at the college and the hospital. Further, the official "red tape" surrounds them to the extent that they are compelled to shorten their visit to minutes instead of hours or days. Dreams of intellectual relaxation, contact with high spirited youth, renewing pleasant memories of old times etc. are shattered to the ground. Though it is not so very essential to beseech the aid of "the old school tie", it must be possible to pick out and treat our elder brethren in the profession in such a way that they may get over their initial shyness and enjoy their visit to the *Alma Mater*. This "walking the hospital" should need no permission from any one. The "old boy" may just call on the superintendent and the principal and mention to them the fact that he intends "walking" the hospital during his sojourn in Madras. It would be very unfair to demand from the practitioner a permit from the Surgeon-General etc.

In conclusion it is universally felt among the practitioners that the vast clinical knowledge that passes through the teaching hospitals may be made available within reasonable limits to the practitioners as well without any complicated process of permits.

ASSOCIATION NOTES.

The South Indian Medical Union, Madras.

Minutes of the meeting of the Council of the Union held on Monday the 14th November 1938 at 6-15 p.m. at 32, Broadway, Madras.

Members present :—

Dr. E. V. Srinivasan.
„ T. Satakopan.
„ P. S. Varadarajan.
„ C. R. Krishnaswami.
„ B. M. Sundaravadanam.
„ M. Krishnamurthi.
„ J. A. S. Masilamany.
„ V. C. Sudarsanam.
„ U. Venkata Rao.

Dr. P. S. Varadarajan was in the chair.

1. The minutes of the last meeting were read and confirmed.

2. The financial Statements for the months of August, September and October 1938 were presented and approved.

3. The following practitioners were enrolled as members of the Union,

1. Dr. K. Venkata Rao, L.M.P., Madras.
2. „ S. T. Narasimham, L.M.P, Madras.
3. „ Nanduri Narasimhachari, M.B., B.S., Madras.
4. „ Miss P. K. Pancharatanam, M.B., B.S., Madras.
5. „ A. M. Srinivasan, L.M.P., Madras.

4. The letter of resignation of Dr. Mrs. L. Jacob was considered The Secretary was requested to write to her to reconsider her attitude.

With a vote of thanks to the chair the meeting terminated.

The South Kanara District Medical Association.

A special meeting of the Executive Committee of the above association was held on 6-11-38 in the Wenlock Hospital with Dr. K. Vittal Shetty, President in the Chair to consider Memo. No. 34730/1 D2 P. H. dated 30th September 1938 regarding the future pay and prospects of Rural Medical Practitioners.

A large number of Rural Medical Practitioners who are specially invited for the meeting to give their considered opinion were present. The following resolution then moved from the Chair was passed unanimously.

I. (*a*) " Resolved that in view of the arderous, prolonged and expensive course that Medical Practitioners have to undergo ; and the fact that the Rural Medical Practitioners have to settle down in remote villages with absolutely few amenities ; and the fact that the villager is so poor that he cannot possibly pay anything tangible for the services rendered which naturally led the Government to grant subsidies and free medicines, though admittedly meagre ; this Association is emphatically of opinion that in the best interests of Rural Medical Relief, the Rural Medical Practitioners should not be forced to work under the new scheme, Memo. No. 34730/1 D2 P. H. dated 30th September 1938 which is sure to cause hardship to the Practitioners, and considerable difficulties to the obviously poor suffering villagers."

(*b*) " The meeting authorised the Honorary Secretary to communicate the above resolution to the Hon'ble the Minister for Public Health, the Government of Madras, the Surgeon-General, the District Medical Officer, the President, District Board, South Kanara and the Medical and Lay Press."

The Krishna District Subsidised Rural Medical Practitioners Association.

A Special meeting of the above association was held at Bezwada in the Government Hospital at 3 P.M., on Sunday 6-11-'38 when Dr. H. C. Halge of the Local Hospital, presided. Dr. N. Rama Rao, the secretary read the minutes of the previous meeting which were passed and the address by Dr. V. Rama Kamath, President, P. R. M. A. was read over to the members who was invited for this meeting, but who could not go over there on account of unavoidable domestic inconveniences.

The meeting then passed unanimously the following resolutions :—

(i) This association expresses its deep sorrow on the death of Dr. K. Venkaiah, R. M. P. Chennur and resolves to convey its sympathies

to his family in bereavement and authorises the secretary to communicate the same to the deceased's family.

(*ii*) This association resolves that the Krishna District S. R. M. P. Association be converted into the Krishna Branch of the Provincial Subsidised R. M P. Association, and that Dr. S S. Rama Rao of Kanumole be elected as the representative to the Provincial Committee of the P. S. R. M. P. Association.

(*iii*) This association views with great concern, the Government's move as per their memorandum 34730—1—D. P. H. dated 30th September 1938 to curtail or abolish the subsidy and medicines now given to the R.M.Ps. and requests the Government to drop it forthwith as such a step would be ruinous both to the R.M.P. as well as to the poor village patient whom he is expected to serve.

(*iv*) This association is of opinion that the honorarium fixed for the R. M. P. doing Public Health work in G. O. No. 2639 dated 21-7-'38 is too low when compared to the loss of private practice and the amount of work to be done and requests the Government to so alter the G. O., as to fix the honorarium, not lower than Rs. 30, per mensem, with a vaccinator to assist him. It further requests the Government to give the usual subsidy while on Health training in addition to the proposed honorarium of Rs. 25 for the period.

(*v*) Resolved to request the D. M. O. Kistna to afford facilities to R. M. Ps in the District to attend operations and study cases in the Head Quarters Hospital during Sundays and public holidays not exceeding four days in the month and also to arrange for bedside clinics and post-graduates lectures on the penultimate Saturdays.

(*vi*) Resolved to request the District Board Kistna to uniformly sanction a fixed contingency of Rs. 5 per month for each dispensing and do away with the present practice of granting of actual expenses incurred and that too up to Rs. 3, and qualified by vouchers and certificates as such a procedure is most cumbersome and time-consuming.

(*vii*) This association brings to the notice of the Government the delay and irregularity in the supply of medicines and the resulted dislocation of work and requests the Government to so arrange the supply as to reach the R. M. P. not later than a date fixed and also see that all medicines indented for are supplied in one time without instalments as is at present done.

(*viii*) This association thanks the Government for having done justice in reinstating the R. M. P. Pakevada who was unduely thrown out of service for no fault of his and resolves to request them to sanction his subsidy for the intervening period.

(*ix*) Resolved to request the Government to give effect to the resolution No. 18 of the P. S. R. M. P's conference passed on 10-7-'37 as such a course would create an atmosphere in which the R. M. P. would be able to do more useful work.

The Tinnevelly District Medical Association, Palamcottah.

(TINNEVELLY BRANCH OF THE INDIAN MEDICAL ASSOCIATION)

The monthly meeting of the Tinnevelly District Medical Association was held at S. A. V. High School, Tuticorin on Saturday, the 29th of October 1938. Members numbering 27, including two women doctors were present at the meeting. 15 members of the Tuticorin Medical Union were also present.

After Tea Party and sweet music the meeting began under the Presidentship of Dr. P. Janardhana Rao, L.M. & S.

The Secretary and Treasurer read out the Minutes of the monthly meeting of the Association held on 24th of September 1938, which were passed.

Dr. D. Kirubaimani, read out the following cases which were operated and treated at the Government Hospital, Tuticorin :—

1. Two cases of Diphtheria in extremis treated and cured by Tracheotomy and serum injections.
2. A case of Adenomatous Goitre operated in the Hospital.
3. A case of Meningitis due to Chronic Otorrhoea

Dr. G. Manuel, L.M.P. of Tuticorin delivered an interesting lecture on " Excerpts from General Practitioner's Memoranda ".

Thereafter Dr. P. Janardhana Rao, L.M. & S., summed up the salient and important features of all the cases and their differential diagnosis in detail. He thanked Dr. G. Manuel, L M.P. for his interesting address and also thanked the School authorities for lending the School premises to the Association for holding the meeting.

Thereafter an excellent Dinner Party brought the happy gathering to a close at 10-30 p.m.

HEALTH EXHIBITION.

Under the auspices of the Tinnevelly District Medical Association in connection with the monthly meeting, a Health Exhibition was arranged at the S. A. V. High School, Tuticorin on the 29th of October 1938 at 10 a. m.

Dr. P. Janardhana Rao, L.M. & S., welcomed the guests and requested Sri Duraiswami Nadar, M.L.A., to open the Exhibition.

Sri Venkateswara Ayyar, Chief Sanitary Inspector, Tuticorin, delivered an interesting lecture in Tamil regarding Sanitation, Cholera, Tuberculosis etc., for the benefit of about 300 boys and girls.

The Exhibition was kept open till 12 noon. The Exhibits consisted of Posters on Tuberculosis, Small-pox, Flies, Mosquitoes and Cholera, etc. The Exhibits of the Tuticorin Municipality were also exhibited.

Ayurveda Prachara Sabha.

Dr. A. Lakshmipathi suggests that at the 17th Andhra Provincial Conference to be held at Gudivada, demonstrations, and lectures should be arranged to emphasize the importance of the "external methods" of treatment according to Ayurveda.

NOTICE.

ALL INDIA OPHTHALMOLOGICAL SOCIETY.

The Sixth Conference of the All India Ophthalmological Society will be held in Bombay on the 19th, 20th and 21st December 1938.

The Subject for a symposium will be "Uveitis."

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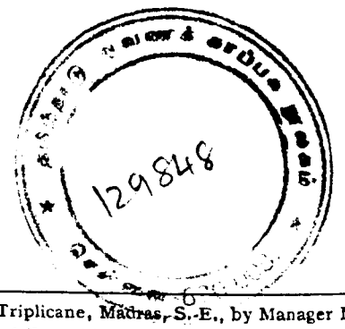

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