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THE PROBLEM OF MEDICAL RELIEF IN INDIA.*

BY

CAPTAIN E. S. GOPALAN, M.B., M.S., A.I.R.O., COIMBATORE.

The subject I have chosen for this evening's discussion is timely. Only last week the Director-General of the Indian Medical Service has published a bulletin, extracts of which were published in the daily papers. Some of them wrote leading articles also, on the subject. Apart from this, the actual medical administration in the British Indian Provinces is in the hands of popular ministries responsible to totally elected legislatures on a wide electoral franchise. It is natural, therefore, that medical relief, in all its aspects, should be anxiously considered by the popular ministries.

Not alone India, even advanced countries such as Great Britain, United States of America, Australia and New Zealand, have yet to perfect their system of medical relief. In Great Britain, the bold experiment of National Health Insurance for the working classes is being subjected to critical study. The profession in the United States of America, if we have to judge from the views of the American Medical Association, is against the British plan, though President Rosevelt in his plan of the "New deal", may experiment on some such system to fulfil his promises. The Labour party in power, in New Zealand, is about to introduce a system of National Health Insurance. Russia has solved the problem in its own way. Unprejudiced British observers have reported that Medical relief in Soviet Russia has no comparison with its state in the Czarist regime.

It is no wonder that politico-social ideologies are discussed in India and with increasing political consciousness of the masses, the system of medical relief should also undergo revolutionary changes. The system of medical relief has never been and will never be, static. It is bound to undergo changes due to evolutionary or revolutionary changes consistent with the contemporaneous changes in the system of society called the Government.

*A lecture delivered at a meeting of the Coimbatore District Medical Association held on 12th November 1938.

But in the changing and future India, the men at the helm of affairs should not forget certain fundamental factors which have a lot to do with human affairs. So far as medicine is concerned, mechanization and regimentation of doctors, should be normally avoided, though in exceptional situations like a great national calamity, it may be permissible. Medical relief should have its pivot in the family practice system. I am omitting purposely the case of the specialists who are in a minority against the large army of general practitioners. No patient, rich or poor should be deprived of medical attention, at the hands of the doctor he chooses on the criterion of richness or poverty alone. Any system of medical relief to the masses must be based on this vital point. The general practitioners collectively must be responsible for the health and welfare of the masses. Is it possible ? one may ask. I say it is not only possible but inevitable and equitable.

The Services of Medical Men are not Utilized Properly.

Men in power say that the number of qualified medical men working out roughly at 1 for 10,000 of inhabitants, is inadequate. True: But I ask, are the services of these 35,000 to 40,000 qualified doctors, fully utilized by the State? It is a deplorable fact that while on one side the masses are crying for medical relief, doctors and more doctors, a good percentage of medical men are languishing for want of professional work and taking to such questionable practices as representing manufacturing firms, travelling representatives, insurance agents and vendors of patent medicines. What is the use of manufacturing more doctors, if, at the end of a strenuous obstacle race, the society has no need for them? Any well-wisher of the masses must take into account the vital problem of how to utilize the potential energy of the unemployed medical men to the services of the ailing public and to the public who want to prevent ailments. The problem is simple. The problem is difficult. The problem is simple for those who like myself, want a re-orientation of the whole Medical policy. The problem is difficult for those who want to do patch-work here and there for a structure which is declared unsafe by competent authorities. An unsafe building must be demolished even as an incompetent system of medical relief must be scrapped.

Preventive Medicine.

In the field of preventive medicine, there is ever only a lip sympathy for the role of a private practitioner as the man on the spot. The private practitioner, I can say from experience, is not fully trusted. To take one example, Government is anxious to eradicate venereal disease and has started clinics in the bigger hospitals. Is it going to solve the problem say of the

satisfactory cure of syphilis? Even the poorest has some delicacy in going to a public institution for the cure of venereal disease. But he cannot afford to go to his private doctor, because of the costliness of the drugs. But I dare say, if the practitioner is trusted with free Salvarsan and free Wassermann reactions to be utilised for absolutely indigent only, the venereal problem will be solved more satisfactorily. You can open any number of venereal clinics but the problem will be only solved when you utilise the services of the independent profession in full. As in the case of venereal diseases, so also, in all the aspects of preventive medicine, the private practitioner can be given greater responsibilities. Personally I am against the bifurcation of the preventive and curative aspects of medicine into two water-tight compartments. Fully paid medical men in the preventive section, are needed only for research, and not for carrying out the routine duties in municipal and other administrations.

Consider for example, the public health administration of a Municipal town like Coimbatore. Its population may be roughly a hundred thousand, and there are no less than eighty or ninety qualified practitioners. The work of the health officer can be done by a Health Committee chosen from the practitioners. The members of the Committee need not be elected Councillors. A senior sanitary inspector may be the executive officer for health, responsible to the health committee. When an epidemic threatens the whole medical profession of the town, if not the district, can be utilised to do preventive and educative work to combat the menace. Given responsibility, the medical profession will rise to the occasion. If you treat the profession as an outside body, completely ignorant of health problems, but still requiring their services when you condescend to have them you cannot expect their co-operation and their services to society are lost.

So far as prevention in the rural parts is concerned, the village subsidized medical practitioners can be entrusted with the work and also any private practitioner unsubsidized.

The offices of the District Medical and preventive officers may be amalgamated. The combined officer, deprived of the professional work in the headquarters hospital, which can be managed by the local practitioners themselves, may be free to tour the district and look after the medical administration in the preventive and curative aspects.

The Problem of Ancient Indian Systems of Medicine.

I have dealt with this problem fully, elsewhere, and I have concluded that a synthesis of the ancient systems with the scientific system, must be

achieved soon, by intensive pharmacological research on all the reputed Ayurvedic, Unani and Siddha drugs and incorporation of them into an Indian Pharmacopoeia. It may take quarter of a century or a half century but it has to be done before the present generation of Vaidyars and Hakims die out.

Inadequacy of Medical Relief.

It is accepted that the medical relief is inadequate at present. Can the State go on building more hospitals and dispensaries and staff them? Even if the professional services are rendered honorary, *where is that to end?* The honorary system implies that there is scope for remunerative practice outside the State hospitals and public dispensaries. If the state goes on building more hospitals and dispensaries and expects men to work honorarily, the scope for private remunerative practice will gradually dwindle and medical men cannot live on air. Even such multiplication of hospitals and dispensaries, at the expense of the State will be very costly and Government cannot cope with the situation.

If the State contemplates to have a fully paid system of medical relief, even that will be still more impossible for obvious reasons. The bulk of the revenue will be spent away in the up-keep of institutions and salaries of medical officers.

If the State cannot undertake complete relief out of its own resources, what then should it do? There is an army of medical men who are only waiting for opportunities to utilise their hard-won professional knowledge and skill. Why not utilise their services?

How to utilise the private doctors' services.

The honorary system may solve the problem to a limited extent and I am of the view that the honorary system should be restricted to treating poor in-patients in the existing state and public institutions and should not be utilised to staff outpatient departments of hospitals and dispensaries. The distinctions between out-patients and in-patients, I consider fundamental and on this distinction I am going to construct my plan on the solution of the problem of medical relief. The honorary system should not be strained to deal with every aspect of medical relief.

Family Practice System.

I should enlarge the scope of the family practice system even to treat poor and indigent patients. I do not see why the State should not pay some

subsidy to private practitioners if the latter volunteer for the same and maintain a satisfactory register of poor patients treated. The scheme of the subsidized rural practitioners is a valuable step in the right direction and the subsidized system may profitably be employed in every aspect of medical relief and prevention. This subsidized system is also in vogue in the department of education. Directly or indirectly the State derives its revenue from the masses of tax-payers and it is incumbent on the State to utilize it to the benefit of the masses through the army of medical men.

The panel practice system obtaining in England is based on this essential principle of utilizing the family doctor to treat indigent people for a small contribution. England has built up a system suitable to its genius and its peculiar conditions. Even the unemployment dole of an English Labourer will be ample for a middle class family in India. It will not be practicable to copy the English model since the taxable capacity of the Indian masses is negligible. Moreover the machinery for the working of the English panel system is said to be complicated. For India I should propound a single system of subsidy based on the annual attendance of the poor patients at the office of the subsidized practitioner. The district medical and preventive officer may inspect the registers periodically and certify to their proper upkeep.

In order that there may not be overcrowding with a particular doctor, the maximum subsidy must be fixed. This provision will tend to distribute the work among many doctors.

Incompetency of the present State and Municipal dispensaries.

However much one may admire the popularity of dispensaries by a census of the crowds attending them, I am very sceptical, having had experience of out-patient work of a specialized nature in the leading hospitals of the Presidency for more than 8 years, about the quality of the work turned out. If in a premier teaching institution, there is scanty scope for work of a high quality in the out-patient department, we can very well imagine the conditions in the other state hospitals and Municipal dispensaries. The doctor has no time to think and has to dispose hundreds of cases in a couple of hours. The patient may be satisfied with a bottle of coloured medicine, but can the doctor make bold to say that he is practising a reasonable standard of scientific medicine. But for the utter helplessness of the masses and their grinding poverty these medical booking offices, miscalled dispensaries, would have ceased to attract such crowds. I wonder if, in a busy Municipal dispensary, it is possible to take the temperature of a patient complaining of fever, or to

make an examination of the chest in the proper manner. Yet there is a cry for more dispensaries and the elected councillor pleads for greater expense for dispensaries, drugs and low-paid doctors. I ask is it fair to spend public money on the unscientific practice of scientific medicine? Instead of two or three doctors disposing 400 or 500 out-patients in an unscientific manner; why not the work be distributed among 50 doctors at the rate of ten patients for each doctor for a nominal subsidy? The subsidized doctor can at least spend 5 minutes over a case, and is not likely to miss any important feature of the case.

So I should unhesitatingly abolish all the Municipal dispensaries, in places where there are competent private practitioners of the requisite number and utilise the saving for not only subsidizing the practitioners but also for starting a public clinical Laboratory in co-operation with the State for doing clinical service to the practitioners in general and subsidized practitioners in particular. I would even have a public X-ray department with provision for physical therapy to serve the local needs.

In towns where there are a large number of private practitioners, public dispensaries doing third rate work are a menace to public health and to the profession. I can understand the existence of specialised out-patient departments in first rate public hospitals, where cases are referred by private practitioners for substantial reasons. But I cannot see why we should continue to fool the public by pretending to attend to them as scientific men. 95 per cent. of the work done by these dispensaries are of a nature that can be more efficiently done by subsidized practitioners. The time spent in dismissing hundreds of patients with mixture alba, mixture influenza, or cough mixture etc., may be spent in examining 10 to 20 cases referred by practitioners by competent specialists in each particular line. So the time has come not only for the abolition of the Municipal dispensaries but also for the State hospitals to confine themselves to works of specialised nature referred only by private practitioners, and the real emergencies.

Private Practitioners and Poor Hospitals for In-patients.

If public dispensaries are abolished and the out-patient work of poor hospitals are restricted to the necessary minima, I do not see why the private doctors should not have facilities for treating their poor patients in public hospitals as in-patients. When a private doctor is competent to treat, say, a paying enteric case in the patient's house, he can easily treat a poor enteric

case in a poor hospital. Where a private doctor is admittedly competent to treat a particular case, he must be given full facilities to treat it in the public institution, or must be allowed to share in the treatment along with a competent specialist. People who are inclined to make a fetish of so-called administrative difficulties, may object to this innovation. It is no innovation either. Such a system obtains in Canada where a big hospital of about two-hundred beds, belongs professionally to all the private practitioners of the locality and any private practitioner is at liberty to treat his case in the hospital. Under such a system the so-called paid system, and the much criticised honorary system, may be replaced by the rational method of the family practice system.

This ideal of public poor hospitals to be managed by the local practitioners, may not be completely practicable, because the nature of the services rendered by such hospitals is likely to be of a specialist type. If such be the case the specialists ought to be recruited from private practitioners either on an honorary basis or for a small honorarium. If the work turned out by these poor hospitals is not of a high quality than that obtained in general practice, I would freely allow the practitioner to treat their own cases in the hospital.

Fetish of Specialities.

While specialities on a broad basis such as medicine, surgery, obstetrics and gynaecology, oto-rhino-laryngology, ophthalmology etc., must be welcome, I cannot understand the usefulness of such a splitting of the specialities as leprosy, tuberculosis, proctology, chest surgery, venereology etc. True — a few may be allowed to be proficient in such a small subject as bronchoscopy or gastroscopy but these should be exceptions. The treatment of tuberculosis or leprosy can as well be managed by a private practitioner in occasional consultation with an accredited specialist but the tendency to send all cases to the so-called tuberculosis or leprosy specialists, is surely the limit. The tuberculosis or leprosy problems are not going to be solved by appropriate sanatoria or colonies respectively, alone.

Socio-economic factors, play a large part in these problems and in evolving a more equitable distribution of the world's materials, the private medical practitioners must play their part nobly. Is it the object of sanatorium life to keep the tuberculosis patients perpetually in their midst? Surely not. If that were so, every taluq should have a sanatorium on the lines of Madanapalle and Perundurai. The sanatorium must be a temple of education in the methods of correct living. The sanatorium ideal must

become the national ideal and tuberculosis or no tuberculosis, every family in India must be made to lead a life as is obtained in a sanatorium, so the best approach is to bringing the conditions of a sanatorium to the very door of the citizen of India. And to accomplish this a thorough re-ordering of society is necessary. I do not want to pursue the matter further. My object in this little digression from my main theme is to bring before the profession that there must be a limit to the splitting of medicine into the specialities. The general practitioner should not be merely an R. M. S. sorting clerk but must take courage in his hands to treat all reasonable cases medical or surgical, including tuberculosis, leprosy, venereal diseases etc. I do not know if in the scheme of the King George V anti tuberculosis fund, the general practitioners has any part to play but, I should warn my brothers that they should not be a party to commit suicide by listening to the cry that only specialists should handle tuberculosis at all times. But I am certainly not against timely consultations with reputed specialists. The general practitioner must try to retain in his hands all cases which he is reasonably expected to treat.

Private Hospitals and Clinics.

In India hitherto the State had to shoulder the burden of medical relief to the poor. A few missionary institutions are a notable exception to this general state of affairs. Perhaps the State circumstanced as it is cannot afford to open more institutions. Even if it does, it has to find money from the tax-payers. But I strongly believe that there is a great scope for private enterprise. India is said to be the land of charity but I know from experience that this is a land of misplaced charity. I know of many sincere souls who have burnt their fingers in noble causes for want of reasonable charity. In another municipal town noted for its monumental temples, there was a time when money was spent like water in municipal and taluq board elections, but a natural primary school for girls, is even to this day under artificial respiration. It wanted a few thousands and there have been no donors so far. Judging from numerous past instances, I can say that charity has left India to find congenial soil in England and America. The amount spent by unofficial agencies in England and America for medical relief to the poor, must stagger even the most charitable-minded Indian.

But we need not despair. If the medical profession as a body is charitably inclined, we can expect reciprocal charity from the public. If we combine together and offer our services to the poor we can ourselves build any number of institutions and need not compete with each other for all and sundry jobs in the State hospitals. To build an institution, proper men are

wanted and not mere materials alone. We can even treat patients in thatched sheds or tents in an extensive open space. What is wanted is co-operative effort. If once the public realise that we are sincere, we really want to serve the poor public, we can tap their pice if not their rupees, and simple arithmetic tells us that one rupee from an unwilling hand is equal to 64 pice from willing hands.

I am sure that the State, though it may not be able to finance institutions fully, may yet be willing to give reasonable subsidies for philanthropic institutions not working for profit. Judging from this standpoint, I must say that the examples of Madanapalle and Perundurai are meritorious. And I must congratulate our President in this connection, that he is an able and lucky beggar in the Perundurai affair. I wish him still more luck in his beggary in the future. And may I not appeal to him, in this connection that once he settles the Perundurai on a satisfactory footing, he should seriously work for a private general hospital for the poor in our very city of Coimbatore.

Nursing Services.

An important auxiliary to medical relief is the nursing facilities for the sick. Nursing in sympathetic and competent hands may mean the difference between success and failure in the management of a case like enteric fever or post-operative management after a serious operation or the management of a normal labour. A good number of patients are high strung and nervous, more so when they are in pain and physical distress. A nurse who combines in herself or himself sympathy, tact and firmness may tide over crises.

The State and missionary hospitals have qualified nurses, though even there, there is a great scope for marked improvement. But when we come to nursing in private practice, we are woefully in the pre-Florence Nightingale period. And it is a paradox also that, more often, the fees for the doctor is comparatively less prohibitive than the fees for the private nurse. It is so because private nursing, barring mid-wifery nursing, is not yet given the importance it deserves. I have encountered in my former general practice, cases of acute bacillary dysentery insisting on walking to the latrine 50 to 60 times a day. You can well imagine the amount of exhaustion this to and fro walking might cause in an already exhausted patient. The Government may solve the problem in its institutions by forming a cadre of male nurses, which by the way, is a very commendable measure not deserving of the adverse criticism from vested interests. But how are we to provide nursing in private practice? Are we not losing cases

by admitting even paying cases into public hospitals for want of nursing facilities? I have dealt with the subject of private co-operative nursing homes elsewhere. The only way of properly tackling this problem is to pay subsidy to qualified nurses enabling them to set up private practice. Only if the nursing is made cheaper will it become popular among doctors and patients.

In this connection I want to impress on all that certain elementary things in nursing such as (1) giving a sponge bath (2) giving an enema (3) taking temperature and (4) preparing a bed etc., must be taught to every able-bodied adult male or female. Just as Air Raid precautions are taught to masses of people, so also these are essential nursing aids.

First-Aid Measures and Hygiene.

Elementary lessons in human physiology, Hygiene and first aid must be taught to all students of the III or IV or V Form.

The Curse of Proprietary Medicines.

We must restrict the use of patient medicine to the minimum. Most of the diseases are very amenable to single medicines in the pharmacopoeia. The indiscriminate prescription of numerous tonics, this cure and that cure has only a demoralising effect on the practitioner. The claims put in by certain manufacturers for certain of their so-called specifics are spurious. We should never be a party to the abdication of genuine pharmacological products, in favour of patent frauds. We can profitably copy the methods adopted by the American medical association.

Maternity Aid.

Women welfare clinics may well be managed by subsidized medical practitioners and full time nurses. For patients requiring maternity aid at their homes, subsidized midwives may be employed.

Laboratory Facilities.

As I have already indicated some of the amount spent in managing useless State and municipal dispensaries may be utilised in establishing district and taluq clinical laboratories where free laboratory service can be given to poor patients under the subsidized practitioners. The figures quoted by Guindy, Madras Medical College, and Pasteur Institute, Coonoor are staggering for even the middle class patient. An indigent patient, under a private practitioner, has to shell out Rs. 10 for a serum reaction, before he could purchase a neosalvarsan tube for Rs. 1—4—0. A private indigent patient has to shell out Rs. 20 or so for Widal and blood culture before he could purchase milk for preparing whey. Under this system a patient may have faith in a particular doctor, but the conscientious doctor has to send the patient to the nearest hospital. It is here that the hospital doctor paid or honorary is at an advantage and it is this which has led to a lot of questionable tactics adopted by the practitioners attached to such institutions from the General Hospital, Madras down to the taluq board dispensary. This must go and I have every reason to hope, it will go in the near future. I need not add, that, in addition to laboratory facilities, we should have X-ray facilities for our poorer patients.

Military Medical Services.

Last, but not the least in importance, I come to the much debated Military Medical Services. I have no hesitation in characterising it as an expensive anachronism. These services might have had some justification in the mid nineteenth century and immediately later. If there had been progress in medicine, in India, it is not on account of the Indian medical service but in spite of it. But look at the progress of medicine in India and compare it with Japan, U. S. A., Australia etc. We are quarter of a century behind even these later civilizations. This service, paid by the Government and a host of other subordinates has been a dead-weight to the rational development of modern medicine and to the genesis of a cultured independent profession. I am not going to dilate on the topic except to say that this essentially Military Service on such a large scale, stifling the independent medical profession every minute of its existence, must be given up in favour of (1) a minimum number to cater to the health of the army on a substantially reduced scale of pay (2) clearing the civil side of the service of all the military service officers (3) creating a large reserve of civil medical practitioner for purposes of national emergencies and (4) making the civil hospitals of the State cater to the treatment of the sick and injured from the military in return for a subsidy from the federal Government funds. Even at the present moment serious cases are transferred to the Civil hospitals, and if so, why need we have such a costly institution as the Indian Medical Service and hospitals like the military hospitals, in peace time.

Conclusion.

These are my views on this important problem of Medical relief in India and you can take it from me, that my criticisms are against the system and not against individual officers past or present who have been or are in this soulless machinery.

I propose, briefly, to discuss three measures which the Madras Government have introduced or about to introduce in the matter of Medical relief,

as appendices to this paper. They are (1) The re-organization of the provincial medical services (2) Alterations of conditions of the subsidised rural medical practitioners and (3) Re-organization of the nursing services.

APPENDIX A.—RE-ORGANISATION OF THE PROVINCIAL MEDICAL SERVICES.

The proposals taken as a whole, are well-intentioned and if successfully worked, in the proper spirit, will be a great blessing to the people of this province, and a splendid opportunity for practitioners with a zeal for service for its own sake, irrespective of rewards. But there are some details which are bound to be irksome in Practice and some aspects which in my view require re-consideration. My criticisms will be under following heads (1) who is to determine the number of officers needed for the institution? (2) The grading of officers (3) The scheme in respect of the teaching institutions (4) Tenure of appointment (5) Honoraria (6) Study leave on allowance.

(1) NUMBER OF OFFICERS FOR INSTITUTIONS.

According to the present scheme, the initiative for settling the number of posts for institutions is left vague. For the Madras City Hospitals, the Minister himself seems to have taken the initiative after frequent visits. What about the district and taluq hospitals? You can never expect a reasonable initiative from District medical officers. They will always be content with the existing state of affairs. And so the Government must proceed on certain principles depending on the bed strength and out-patient attendance. In the absence of such a clear-cut policy, the opinions of individual district officers will vary a good deal. Personally, as I have indicated elsewhere, I should have on an average, one officer, for every ten beds and one officer for every 25 to 30 out-patients,

(2) THE GRADING OF OFFICERS.

These grades are necessarily not based on class distinctions but based on experience. I should have the former grading (1) clinical assistants (2) assistant medical officers (3) physicians and surgeons. The first grade must be meant for newly passed out graduates and licentiates. The second grade must be for those who have matured out of the first grade. The third grade must be given to men who have passed through the first two grades and possess exceptional merit or higher academic qualifications. The art and science of medicine is perfected by experience and study. Junior men should not be straightaway be made responsible assistant medical officers. In the English Voluntary hospitals, the post of an assistant physician or surgeon is never attained so easily as in India. In this respect the scheme is not practical.

(3) THE SCHEME IN RESPECT OF TEACHING INSTITUTIONS.

So far as pre-clinical subjects such as, Anatomy, Physiology, Pathology, Pharmacology etc. are concerned, the honorary system should not be introduced. The teachers in these subjects must be full-time and paid adequately private practice being debarred. For clinical subjects honorary professors and lecturers may be appointed on a suitable honorarium which should not be less than Rs. 100 per mensem. In big institutions such as the Medical College, Madras, the chair of each clinical subject even may better be held by a full-time professor, who must be deprived of any sort of private practice. The principle must be either adequate pay with no practice or no pay with unrestricted scope for practice. It is well that the local Government is seized of this important matter now.

(4) TENURE OF APPOINTMENT.

This five years' tenure is a disappointment in the otherwise far-reaching scheme. The Government will not be well advised to lose the services of experienced men. The tenure for each grade of officer in each grade must be at least 5 years making a total of 15 years service. A new entrant to the cadre of clinical assistant, provided his work is up to a reasonable standard, must be assured of 10 to 15 years of service. Particularly in regard to teaching institutions, this small tenure is unjustifiable.

(5) HONORARIA.

In my view the honoraria proposed in the scheme is not conducive to the healthy development of the honorary system. For honorary work why should there be grading of honoraria? The honoraria offered especially for the lower grades smacks of the cooly system. It does not speak well of the giver or taker. Better it is abolished altogether. When the service is done for the love of service, this ridiculous pittance must be considered as an unintentional insult to the profession. But I should certainly pay an honorarium of not less than Rupees Fifty per mensem to the clinical assistant cadre if that is established. The other grades need not be paid except part time lecturers in clinical subjects who must be paid not less than Rupees One hundred per mensem for special preparation of the subjects.

(6) STUDY LEAVE ON ALLOWANCE.

Medical officers who want to make special studies in India or abroad must be given leave with a subsistence allowance on conditions they undertake to serve the institution for 10 years after return. Frequent post-graduate studies are very important to maintain a high standard of practice.

APPENDIX B.—SUBSIDIZED RURAL MEDICAL PRACTITIONERS.

It is unfortunate that just when rural medical relief, should be established on a satisfactory basis, the Government propose to throw cold water on

the scheme by proposals for retrenchment. I am afraid this poor honorary system is likely to be overworked. The honorary system can be worked successfully only so far as specialized in-door treatment is concerned, where the honorary men can expect to get private practice outside the state hospital To mis use this sytem for village dispensaries or even for municipal dispensaries, will discredit the system altogether. But the rules may be amended in such a way that in addition to a fixed subsidy, the rural practitioners may be offered extra subsidy depending on the annual attendance. By adopting such a method the allowance for medicine may be dropped. In no case should the pay of the midwife be withheld.

APPENDIX C—RE-ORGANIZATION OF THE NURSING SERVICES.

The Government have done well to institute the system of male nursing. The pay offered is reasonable considering the grinding poverty of the masses. And if there is agitation from some interested quarters against the proposals, we can well understand it. A man enjoying certain privileges does not like to lose even a job for the benefit of the community. It is human nature. The system of assessing human values by graded salaries is responsible for this state of affairs. Maximum good to the largest number must be the motto of any Government by the people. It is true that the privileged classes, in all services, cut their coat according to the cloth by giving up numerous luxuries which are not needed for a biological existence.

ADDENDUM: THE PROPOSED PUBLIC HEALTH ACT FOR MADRAS.

Only this morning I read a summary of the provisions of the proposed Act and I should say that its advent is not a day too soon. Some of the details may be unpopular to begin with, but I hope the date of enforcement, after the passage in the legislature, will be preceded by province-wide propaganda among the people to observe the provisions. In this propaganda medical men should lead.

So far as provisions for the control of venereal infection is concerned, I am sorry that the private doctor is not given his proper place. He should be trusted, helped with medicines and free laboratory tests and the privacy and secrecy between patient and doctor should not be disturbed except when the patient is incorrigible. The provision that chemists and pharmacists should disclose the names of persons, for whom anti-venereal drugs are purchased, is better dropped. The medical practitioner should be trusted to give confidential information to the health department, for action in case of the incorrigible only.

TREATMENT IN MEDICAL PRACTICE

By

P. S. VARADARAJAN, M.D., M.R.C.P., (Lond).

Hon. Physician & Cardiologist, Govt. General Hospital, Madras.

Preamble :—The employment of drugs in the relief from disease is, by no means, the most important item of treatment. Physico-Therapy, immunotherapy, dieting etc. have each a very specific role to perform in the amelioration of symptoms, if not in the cure of disease. Prophylactic measures are now viewed rightly too, as an integral part of the treatment of diseases though, some years ago, preventive medicine and public health were scarcely referred to, in books pertaining to treatment of diseases.

Choice and care of the sick room should receive prime consideration. Good ventilation without draught is essential. Overcrowding with, either animate or inanimate objects is highly undesirable. On the hills and in the colder zones, question of heating the room will arise - 65° to 70° is considered to be the optimum temperature. Likewise, in hot weather, question of cooling will arise—Electric fans, if available would serve the purpose —kerosene fans are undesirable. The old fashioned Punka is quite good.

The furniture should be few and must be of the type that can easily be washed. Cots if possible should be made of iron to permit the destruction of bugs which are apt to collect and disturb the nocturnal rest of the patient. Dark corners when they do exist, should receive careful notice to prevent the accumulation of dust and dirt.

There is no effective substitute to good nursing. Some diseases like enteric fever run a smooth course mainly through good nursing—the converse is equally true in this case.

Diet of the sick is now claiming so much attention of the medical intelligentia that volumes have been written on the subject. "Rest is half the treatment and Diet the rest of the treatment" is a slogan worth memorizing. Often times, some diseases need no drug at all if suitable dieting is carried on. Further, certain forms of diet like the Ketogenic diet, the diet of sprue—high protein, low carbohydrate and low fat, should now be deemed as therapeutic advancements. A more detailed reference will be made under the respective diseases.

(Treatment in general of Fevers including specific treatment of certain fevers will form the subject of the next article.)

NOTES ON PUBLIC HEALTH.

(Issued by the Principal Information Officer, Government of India.)

CONTROL OF DRUGS IN INDIA.

Stringent Measures Needed.

Stringent measures are needed to deal with the chaotic situation in regard to the profession of pharmacy in India and to the manufacture, sale and import of drugs in the British Pharmacopœia as well as those which are 'known and approved'.

The report of the Drugs Enquiry Committee in 1930—31 drew attention to the ineffectiveness of existing legislation to control the drug industry and prevent the sale of impure, adulterated and misbranded pharmaceutical products.

Existing Acts Ineffective.

Mere adulteration of drugs is not, by itself, prohibited throughout British India by any enactment. Apart from the Commission of the offence of cheating, adulteration which renders the drug 'noxious' or 'lessens the efficacy' or 'changes its operation' alone is controlled by the Indian Penal Code. Nor is the sale of a drug of insufficient strength or improper standard punishable otherwise than on the basis of misrepresentation and fraud. The non-existence of fixed standards or methods of analysis, the absence of any precise definition of adulteration, the difficulty of proof and the fact that intention or knowledge is of the essence of these offences, as well as of cheating, complicate the situation and render the provisions ineffective in practice.

Hydra-Headed Misbranding.

In penalizing false marks and false trade descriptions, the Indian Merchandise Marks Act and the Sea Customs Act merely touch the fringe of the problem of misbranding which is hydra-headed. Strict proof of difference in the nature or quality of the goods or the falsity of the description is often beset with impediments. The Cantonments Act is also of limited scope and efficacy. The Indian Sale of Goods Act, 1930, which is merely concerned with obligations of a civil nature is also inefficacious in securing food and drugs of the opposite standard of strength, purity and quality.

As regards the profession of pharmacy, there are practically no restrictive laws of general application except certain perfunctory provisions in Municipal Acts of some of the provinces relating to the registration and licensing of retail shops and the employment of compounders.

VALUE OF INDIAN INDIGENOUS DRUGS.

Only Limited number deserve Attention.

Only a very limited number of indigenous remedies deserve the reputation they have earned as cures and quite a large proportion of them are absolutely worthless and have probably crept in through tradition and folklore.

This is one of the results of an important research undertaken to investigate on scientific lines the claims of the rich materia medica of the Ayurvedic and Unani systems of medicines which was financed by the Indian Research Fund Association.

International Recognition.

During the last twelve years this enquiry has done a considerable amount of work which has not only received local appreciation but international recognition. The Departments of Pharmacology and Chemistry of the School of Tropical Medicine, Calcutta are now considered an authority on all questions in connection with the chemistry, pharmacology and therapeutic uses of the Indian indigenous drugs.

It has been found that many of the pharmacopocial drugs or allied species grown in India which could be used in the manufacture of pharmacopotial preparations are in common use.

DRUG MANUFACTURE IN INDIA.

Medical Stores Departments Pioneer Work.

It is not widely known that the Medical Stores Department has done pioneer work in the manufacture of drugs in India.

There are many preparations which are made exclusively by the Department. For example, in Madras are made the four preparations of Oleum Hydrocarpus, used in the modern treatment of leprosy, and it is believed that this is the only source in India from which these preparations can be procured at a reasonable rate.

There are four Medical Store Depots located at Madras, Bombay, Calcutta and Lahore, administered by the Director-General, Indian Medical Service, on behalf of the Government of India, Defence Department.

Up-to-Date Factories.

The depots were originally established to ensure the supply of drugs, instruments, and appliances, of uniform quality and pattern for the Army in India. In course of time their sphere of activity was extended and the civil medical institutions turned to them as the most reliable source of supply.

The stores were, at first, only distributing centres. It was, however discovered that some of the drugs could be more economically manufactured in India than imported from abroad and in consequence Depots undertook to do pioneer work in manufacturing. The number of items manufactured gradually increased, especially during the War, and now there are at the Madras and Bombay Depots two modern and up-to-date factories, employing Indian labour capable of supplying all Government institutions in India with drugs and preparations of British Pharmacopoeia standard.

At each of these factories there is employed a highly qualified advisory chemist, whose duties include the analytical examination of every preparation made in the Depot factory and all supplies received from outside to see that they are up to the prescribed standard.

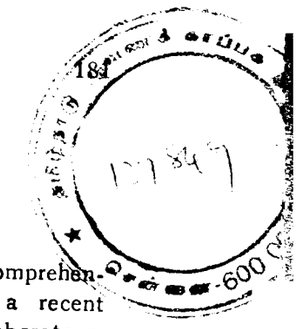
Purchases in India.

Further, as soon as it is found that a preparation of the required standard can be obtained in India at a rate of not more than the cost of manufacture in the Depots, the manufacture of that particular item is discontinued and it is purchased locally. More than half the amount provided for purchase of stores is in this way spent on purchases made in India. Stores worth Rs. 11,52,131 were imported in 1936—37, while stores worth Rs. 14,14,796 were purchased in India during the same period.

A Vital Function.

It is not the policy of the Government to compete with private enterprise, nor is it the intention to make a profit from the Medical Stores Department although it is desirable that it should be as nearly self-supporting as possible. Private institutions are not encouraged to obtain their supplies from the Depots, but the experience of the past has proved that the Department was able to make good the deficiencies required for civil purposes and which were due to the failure or irregular supply of imported drugs.

The Medical Stores Department therefore fulfil a useful and necessary function, which may in time of crisis become vital.



DRUG CONTROL IN INDIA.

POOR QUALITY OF ERGOT PREPARATIONS.

BIOLOGICAL LABORATORY'S INVESTIGATIONS.

All-India Drug Survey.

The urgent need for proper drug standardization and for a comprehensive scheme of drug control has been painfully brought out by a recent investigation undertaken by the Biochemical Standardization Laboratory, Calcutta, into the liquid preparations of Ergot sold in the Indian market and in common use for medicinal purposes. The Laboratory, which was established by the Government of India in Calcutta in 1937, as a first step towards tightening of control over the manufacture, importation and distribution in the Indian market of drugs inferior in quality and spurious in character, has since its inception been engaged in an All-India survey of the quality of drugs. Some of the findings recorded in this Laboratory reveal a serious state of affairs regarding the quality of Ergot preparations that are daily being used in India.

Chiefly used to stop post-partum haemorrhage, an emergency condition where energetic treatment with fresh and potent Ergot preparations is essential to save the life of a mother, the poor quality of Liquid Extract of Ergot which is the commonest preparation employed in hospitals and private obstetrical practice in India constitutes, therefore, a grave menace to maternal health, and is possibly also a contributory factor to maternal morbidity from a subinvoluted and imperfectly contracted uterus.

Inferior drugs imported.

Of 130 samples of Ergot preparations of different types, *e.g.*, Liquid Extract of Ergot, Ammoniated Tincture of Ergot, Solid Extract, Ergot Powder etc., tested in the Laboratory, 112 samples or 86·15 per cent were found much below strength, and in 58 or 44·61 per cent no active principles whatever could be detected.

Of the samples examined 103 were of indigenous manufacture and 27 of foreign make.

The causes underlying this state of affairs are not clearly understood. While the deterioration of the active principles of Ergot in the hot and humid climate of India may be an important factor in bringing about the poor quality of Ergot preparations, the opinion is expressed that it seems probable also that an inferior quality of both crude and finished preparations of Ergot, unsaleable in their countries of origin due to stringent drug laws, are being purchased in India at a cheap price.

General low quality.

That the results obtained from these investigations are representative of the general quality of Ergot preparations all over India, will be evident from the fact that the samples subjected to analyses were obtained from practically all the Provinces of British India through the Surgeons General, Inspectors-General and other Heads of Medical Public Health Departments. A few were obtained direct from the Customs office, within a few days of their importation, while another group of preparations were picked up at random from the open market.

The standardization of the Ergot preparations were carried out by pharmacologists and pharmaceutical chemists working in close co-operation. The 'Colorimetric Method' of assay described in British Pharmacopoeia, 1932, with the modification subsequently described in the Addendum to the British Pharmacopoeia 1936, was generally employed, and wherever necessary the results were checked by the "rabbit uterus" method of biological assay.

Results analysed.

The following is a tabular statement of the analysis of the quality of Ergot preparations on the Indian market:—

Analysis of the Quality of Ergot Preparations on the Indian Market.

Nature of Preparations tested.	Total No.	Origin.		Preparations Below Strength.			
						No Active.	Principle.
		Indigenous.	Foreign	Total No.	Per Cent.	Number.	Per Cent.
1. Liquid Extract of Ergot ...	108	86	22	96	88·88	54	50·0
2. Liquor Ergot Fortis ...	8	8	...	5	62·5	...	..
3. Ergot Prepared ...	8	5	3	6	75·0	...	...
4. Ammoniated Tincture of Ergot ...	2	2	...	2	100·0	2	100·0
5. Ergotinine Citrat ...	2	1	1	2	100·0	2	100·0
6. Ergot Powder ...	1	1	...	...	...	...	...
7. Solid Extract of Ergot ...	1	...	1	1	100·0	...	...
	130	103	27	112	86·15	58	44·61

ASSOCIATION NOTES.

The Medical Practitioners' Association, Nuzvid

An ordinary meeting of the above Association was held on Sunday the 20th November '38 at Nuzvid in Dr. Mrs. Seshagiri Rao's dispensary premises at 3 P.M. when Dr. P. Anjaiah Naidu presided.

Refreshments and tea were offered to all the members by Dr. N. Rama Rao, Secretary of the Association meeting the cost from the Association money. The Secretary then read the minutes of the previous meeting which were duly adopted. The following case reports were made and discussed.

1. A case of early sarcoma of the thigh and one of Criminal abortion that ended in septic temperature of 106° F and tetanus and ultimately death. Medico-legal opinion was called for in the latter case.

2. A case of sudden and acute intestinal hæmorrhage and vomiting of blood resulting in collapse, by Dr. N. Rama Rao who had to take recourse to speedy measures by Glucose and saline administration, anti-hæmorrhagic remedies and cardiac stimulants to resuscitate the patient. He said the patient was an adult male of 33, well built and quite healthy and any history of digestive disorder prior to this was not given. Discussing over the probable causes, the members mentioned acute gastric ulceration or of Duodenum erosion of an Abdominal Aortic Aneurysm and Ptomaine poisoning and lastly the possibility of rupture of the distended anastamosis of the oesophageal branches of the thoracic aorta and those of the Subclavian artery as a result of a congested lever.

3. A case of Apoplexy with hemiplegia of recent origin, by Dr. V. Ananthari, L.I.M.

4. A case of Ascites treated by Neptol and Decholin injections, by Dr. S. Hanumantha Rao, L.I.M.

The members then passed unanimously the following resolution :

"As this Association is of opinion that the Honorary scheme now proposed for the Rural Medical Practitioners by the Government in their Memorandum No. 34730—1—D2 P.H. dated 30th September '38 will mar the prospects of the practitioners who have not been able to reach the expectation of the Government to stand on their own legs without present emoluments, it resolves to request the Government to drop such an idea and to allow the Rural Practitioners as at present."

The meeting came to a close by 6 p.m.

The Tinnevelly District Medical Association, Palamcottah.

(Tinnevelly Branch of The Indian Medical Association).

TENTH ANNIVERSARY.

The Tenth Annual Gathering organised by the Tinnevelly District Medical Association commenced at 4-30 P. M., on Saturday, the 3rd of December 1938, in the Subrahmanya Karayalar Public Library, Palamcottah. Members numbering 75, including 7 women doctors were present. Two members of the Independent Medical Practitioners' Association, Tinnevelly also attended the function.

After Tea party and music the Business meeting commenced at 5-30 P.M., under the Presidentship of Lieut.-Col. T. S. Shastry, I.M.S. The Secretary Dr. K. Rama Ayyar, M B.B.S., (Andhra), read the minutes of the last monthly meeting held at Tuticorin on Saturday, the 29th of October 1938 and also the minutes of the Special Meeting held at Vannarpet on the 16th of November 1938.

Then the election of Office-bearers was proceeded with :—

1. *President* :—Lieut. Col., T. S. Shastry, I.M S., (re-elected)
2. *Vice-President* :—Dr. T. N. Govinda Iyer, M.B, & C.M., (re-elected)
3. *Secretary & Treasurer* :—Dr. K. Rama Ayyar, M.B.B S., (Andhra) (re-elected)
4. *For Women members* :—Dr. Mrs. E. Bernard Carr, (re-elected)
5. *For the General Body* :—Dr. L. Mahadevan, M.B.B S , (Madras) D.O.M.S., (London) (re-elected)

   Dr. N. Isaac, Retd. Selection grade Sub Asst. Surgeon. (elected)

   Dr. K. S. Subrahmanyam, L.M. & S., (elected)

Member - Auditor :—Dr. K. V. Muthiah Pillai, L.M. & S., (re-elected)

Resolved that the following be the Programme of Meetings for the year 1939 :—

1.	January	...	Nanguneri (Temple)
2.	February	...	Headquarters.
3.	March	...	Tiruchendur (Sea Side)
4.	April	...	Headquarters.
5.	May	...	Srivaikuntam (Temple)
6.	June	...	Papanasam (Waterfalls) (Ambasamudram)
7.	July	...	Courtallam (Waterfalls)
8.	August	...	Headquarters (President's Function)
9.	September	...	Sankarankoil (Temple)
10.	October	...	Headquarters (Anniversary)
11.	November	...	Koilpatti (Mills)
12.	December	...	Headquarters.

The following resolutions were passed unanimously.

1. Amending Rule No. 19 as follows :—

To have the power to alter the constitution at any one of its meetings after previous notice has been given where not less than one half of the number of members on the roll are present and three fourths of the number present are in favour of the proposed change in the constitution.

NEW RULES.

2. Members whose subscription is in arrears for six months shall cease to be members, but they may continue to be liable to pay the arrear.

3. Members who have lost their membership under the bye-law shall not be re-admitted unless they pay all the arrears due from them.

4. A non-residential membership shall be instituted as follows :—

(1) " It is resolved that the Association may institute a non-residential membership for the benefit of those members of our Association who get transferred or who have to move out of our District in the course of the Journal Year (1st of October to 30th of September following).

(2) This non-residential membership applies only to such members as are residing and working in a District which has no branch of the Indian Medical Association.

(3) It is proposed that the Annual subscription for the non-residential members should be Rupee One for the membership plus a Journal subscription of Rupees Three per annum for the Journal. But since he has already paid Rupee One towards the Journal he should pay only Rupees Two for it for the current year.

(4) Before he leaves the District he should pay all the subscription and other dues due to the Association : and when he applies for non-residential membership he should pay in advance the subscription of Rupees Three for the current year.

(5) For the next year onwards he should pay Rupees Four in advance. If it is not paid in advance his name shall be removed from the list.

(6) His applications should be accepted by the Managing Committee and he should be enrolled as a non-residential member before he gets the benefit of it, and the Secretary of the Indian Medical Association, Calcutta, should then be informed to continue to send the Journal to such a member to his new address".

5. The " Association Year " shall be from the 1st of October to 30th of September the following—to come into line with the Indian Medical Association.

Then Lieut.-Col. T. S. Shastry, I.M.S., offered a hearty welcome to all the members and guests.

ANNUAL RE-UNION.

Lieut.-Col. T. S. Shastry, I.M.S., opened the proceedings of the Conference as the Chairman of the Re-union.

Dr. K Rama Ayyar, M.B.B.S., (Andhra)read out the messages of Good wishes for the success of the Conference received from the following :—

1. The Hon'ble Dr. T. S. S. Rajan, L.R.C.P., M.R.C.S., etc., Minister in charge of Medicine & Public Hetalh

2 Rao Bahadur C. B. Rama Rao, M.D., Bangalore.

3. Dr. K. Raman Tampi, M.D., President, The Travancore Medical Association, Trivandrum.

4. Dr. P. Rama Rau, Radiologist, Madras.

5. Dr. Noble, M.D., F.A.C.S., Nagercoil.

6. Dr. K. R. Menon, L.M. & S., President, The Malabar District Medical Association.

7. Dr. D. V. Venkappa, Madras, President-elect of the All-India Licenciates Medical Practitioners' Association.

8. Rao Bahadur T. S. Tirumurti, B.A., M.B. & C.M., D.T.M. & H., (London), Principal, Stanley Medical College, Madras.

9. Telegram from Dr. U. Krishna Rau, Joint Secretary, The Indian Medical Association.

10. Telegram from Dr. P. S. Srinivasan, Dhanushkodi.

Dr. M. Venkatachalam Chetty, Sub-Assistant Surgeon, read out the following interesting clinical cases which were successfully treated and operated at the Government Headquarters Hospital, Palamcottah :—

(1) A case of Tumour (Right shoulder) (Not operated)

(2) A case of perforating wound (Abdomen.)

(3) A case of undescended testis (Left side).

(4) A case of Traumatic dislocation hip (Left side).

Dr. Mrs. A. Brown, Woman Apothecary of the Government Women and Children Hospital, Vannarpet read out a case of Tumour on the left side of the neck.

A discussion of these cases followed, the Chairman of the Re-union contributing to the discussion and elucidating the Therapeutics of the cases.

The grand Banquet was brought to a happy close at 11 P.M. after a grand dinner party.

K. RAMA AYYAR, M.B.B.S., (Andhra),
Secretary & Treasurer.

CONTENTS

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