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MEDICO-SURGICAL SUGGESTIONS

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CONTENTS

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MEDICO-SURGICAL SUGGESTIONS

VOL. VII — JULY 1938 — NO. 7

Original Article.

"LEUCORRHOEA."

BY DR. S. K. GUPTA.

Laboratory Clinic (Analyst), Railway Road, **Pasrur** *(Dist. Sialkot).*

This disease, being commonly known by the name of *the Leucorrhoea*, appears in the form of a discharge from the vagina, varying both in colour and quantity. Leucorrhoea is the term applied when there is excess in natural secretions.

Leucorrhoea is one of the symptoms of many diseases and it is not a disease. Hence, the name, whites, is given to it.

Secretions from the *Bartholin glands* is clear, colourless and slightly acidic. It could be at times seen swelling up from the openings of the duct on Vaginal examination.

Vaginal Secretions:—Varies in character. It may be white, yellow, greenish, or colourless, and the quantity may be so small as to be barely appreciable, or as much as half a pint a day.

It is white, semi-solid and acid in virgins and nulliparous. It is opalascent and either alkaline or neutral in parous women. Cervical secretion is abundant, viscid and is alkaline. Endometrium and Tubal Mucosa secrete very little and the discharge is watery.

Anyhow, the discharge is in itself very annoying, and causes much discomfort, and the constitutional symptoms are more or less severe.

Types:—(1) *Excess of natural secretion* :—In normal women increases during pregnancy and before onset of menses due to increased pelvic vascularity.

(2) *Chlorosis and Anaemia* :—It is due to inflamed patches in cervical mucosa.

(3) *Serous discharge* :—It is rare except during pregnancy in certain cases of prolapsus, late in puerperium, intermitent hydrosalpinx, in early cases of malignant disease of uterus, rarely in tubal papilloma or carcinoma and urinary incontinence.

(4) *Muco Purulent* :—It is due to (*i*) Inflammatory changes in genital tract. (*a*) Acute Gonorrhoeal discharge is yellowish green

and very irritating. (*b*) In Chronic Gonorrhoeal discharge it is paler. (*c*) If inflammation be due to septic germs it is whitish and pus like. (*ii*) Pelvic abscess may open into uterus.

(5) *Purulent*:—It consists of large amount of serum and pus cells and mucus, if examined under the microscope. It stains linen yellow. It is due to sub-acute gonorrhoea with Erosion of Cervix, deep cervical laceration or Ectropion of cervix.

Causes:—It depends upon debility and an inflammatory condition of the parts, and a long list of causes might be enumerated. All such influences as have a debilitating effect upon the system may give rise to whites or Leucorrhoea. It seems to be constitutional in some women, and the intimate connection between the uterine system and the nerve centers, and in fact with almost every organ of the body, lengthens the list of causes beyond all ordinary limits. Some of the numerous causes are as follows:—

(1) Dirty personal habits.
(2) Foreign body in vagina *e.g.*, retained and neglected Pessaries.
(3) Ulceration in tumours *e.g.*, Sloughing Fibroid.
(4) Cancer of cervix, rarely cancer of body.
(5) Sloughing of genital canal.
(6) Senile Endometritis with Pyometria.
(7) Rupture of Pelvic abscess into uterus.
(8) Putrefaction of products of conception.
(9) Urinary or faecal fistula.
(10) Veneral Diseases *e g.*, Gonorrhoea or Syphilis.

Clinical Types:—

(1) *Little Girls* suffer from Vulvo-vaginitis due to either Gonococci or other pyogenic organisms. Discharge is muco-purulent.

(2) *Young Virgins*:—Slight excess of normal discharge due to depressed general health.

(3) *Virgins or Nulliparous*:—Muco-purulent discharge due to Erosion, Gonorrhoea.

(4) *Parous women below fifty*:—Due to (*a*) Gonorrhoea. (*b*) Laceration of cervix with ectropion. (*c*) Erosion.

(5) *Women past Menopause*:—Due to (*a*) Senile Endometritis with Pyometria. (*b*) Cancer of uterus and cervix.

Diagnosis:—

Inspection:—(*a*) Vulva inspected to note condition of urethra and Bartholin's glands. (*b*) Cervix inspected by speculum examination. (*c*) Speculum examination also reveals fistulae if present.

Treatment :—As whites is a symptom and not a disease, the cause should be attacked to cure it. As for example, whites due to chlorosis or anaemia, should be treated with extensive liver therapy and Iron and Copper.

There are certain cases which require local treatment together with the general treatment of the causal factor.

In the treatment of whites, it should always be remembered that the mere drying up of the discharge does not always cure the disease. A wide variety of constitutional disorders may in different cases need correcting, and the first thing to be ascertained in any case, is, obviously, the *cause*, and then again, if possible, this should be removed. In the acute form, when the discharge is profuse, and there is a good deal of inflammation and some constitutional disturbance, everything heating and stimulating in the food must be carefully avoided, and the drinks must be mucilaginous, as flaxseed tea, or such as lemonade barley water and simple cold water. The bowels should be kept open, and different purgative may be useful, by exciting the mucous membrane of the bowels and thus relieving the womb and vagina.

After the inflammation has subsided some what, the diet should be made more nutritious, and simple astringent injections, such as acetate of lead, alum or sulphate of zinc, be employed. About three grains of the lead, or zinc, to the ounce of water, is the usual strength used. Another very good injection is two parts of port wine to one of water.

Septic Vaginitis clears up in two or three days by douche and 15 per cent Protargol pessaries. I have found in such cases Neem Bark douche. Levico water douche and insertion of suppository Leuco by Avon & Co., efficacious.

Erosion:—Levico water douche is given after clearing mucus by application of liquor potash; next is to cauterize cervix with either Iodized Phenol, saturated Picric acid or 10 per cent Formalin. Erosion clears up in four to six weeks.

Cauterization of eroded area by Paqualin's cautery. First clean the eroded area, dry it and apply cautery at dull red heat taking care also to cauterize the follicles and margins of the cervix to prevent secondary erosions ; later, insert suppository Leuco by Avon Chemical Works into cervix.

Ionization of the cervical canal:—

Endometritis:—Intra Uterine douche of either Iodine or Dettol followed by Intra uterine application of iodized phenol.

Post natal or post abortal discharge should be treated by evacuating uterus followed by Intra uterine douche of any anteseptic such as Iodine, Lysol or Dettol to clear the surface. Glycerine is injected into uterine cavity after douching to clear up sepsis. At times, glycerine with 4 per cent mercurochrome acts much better in clearing up the sepsis.

Whites during early pregnancy yields well to low cold levico douche. It tones up and cleans the mucosa.

Internal Remedies:—As internal remedies, turpentine, copaiba or cubebs is often used with good effect. A very useful prescription is the following:—

Sulphate of iron	...	... gr. xx
Aloes	...	... gr. xxxv
Turpentine	...	... Enough to mix.

Mft. Divide into 20 pills.

Sig. One pill three times a day.

Iron in some form is usually beneficial in these cases, and very often curative, and can be made still more effective by alternating with it some of the bitter tonics, as tincture of cinchona or tincture of gentian.

Whites or Leucorrhoea is regarded as infectious, and has been known, in married persons, to produce in the husband a disease very similar if not altogether like Gonorrhoea.

WELLCOME ADDRESS

Delivered at the 4th Madras Provincial Conference of the All-India Medical Licentiates' Association, Vellore, on the 18th June 1938

BY DR. E. VIJAYAM NAIDU,

Chairman, Reception Committee.

Brother Delegates, Ladies and Gentlemen,

I deem it a proud privilege and honour conferred on me by the Reception Committee of the Fourth Provincial Conference of our Association as its Chairman. I am connected with our organization as a member for more than two decades, and have done my humble best in my capacity as the Secretary, of the Madras Branch, Joint Secretary of the All-India Conference held in the year 1916, and Provincial Secretary for some time. It is superfluous to narrate now the history of our ancient organisation which has been existing for the past 32 years with, at present, 168 branches all over India. Thus it can be said to be the biggest organisation in this country, showing vivid activities for the uplift of our class in particular and the profession in general. It would be treading but the old path with which you are familiar if I dilate on this point. But now, new developments have arisen, a great change has come over, and the class for which we have been fighting for its *extinction* or *distinction* has achieved, in a way, its end and aim, in at least so for as our Province is concerned. For the *extinction*, the Hon'ble Minister of Public Health shares the credit, and for the *distinction* we claim it

with the rest of the profession by virtue of our merit successfully tested in season and out of season. I boldly affirm, Ladies and Gentlemen, that in this noble profession it is ridiculous to have any class or caste distinction. In fact, our Association was started specifically with a view to establish equality of status and fraternity among the members of the profession, and it has been continuously working in this direction for the last 32 years against much opposition from the vested interests.

Before touching the vital interests of our class, I take the opportunity of welcoming you all to this historic city of Vellore, which has played no unimportant part in the history of Southern India in that it has to its credit a mutiny, and the scenes of valour and courage exhibited in the four Mysore wars. The relics of the old times are found as you go about the town where you will find a fortress without a king and in which there is a temple without an idol and above all, near by, you come across a big river with plenty of sand but no water. Modern times have brought forth improvements and we have educational institutions about which we are justly proud, such as the Mahant's High School and the Voorhee's College, the premises of the latter being the venue of our present Conference. The Mission Hospital of this place is a popular institution which attracts a number of patients from far and near, and where the sick and suffering get relief. To this hospital is attached a Medical School which is now undergoing the same transformation as the one in Royapuram, but it is rumoured that this institution is intended to impart medical education to the fair sex exclusively as a discretionary measure under the changed circumstances. The Police Training School, Vellore, is a long-standing and noted institution where the soldiers of peace, from Constables downwards up to the Superintendents, are trained. The Central Jail of Vellore is well known for the manufacture of carpets and fabrics, and for holding in custody in its four walls many a political prisoner of whom the present Minister of Public Health was one of its distinguished inmates amongst others. There are also other places worth mentioning which I would leave to the visitor to see during the short sojourn he makes here. Once again, on behalf of the Reception Committee and on my behalf, I extend to you all our most hearty welcome to this great city of ours which is none the less inferior in its intensity of the solar heart which made us a fortnight back, the less fortunate residents, to take shelter indoors whilst the more fortunate ones hastened to some cooler places in the hills. Even the Sun God has now become favourable to us, apparently in the interests of our class.

It is customary in Conferences of this kind to discuss about our grievances and pass resolutions with the idea of getting redress from the Government. In course of time, with the extinction of our

class, the usual grievances will also become extinct but may give rise to fresh ones based on new environments which the Minister of Public Health seems determined to bring about. It therefore, behoves each and every member of our class to fight his way out through the changed circumstances in which he is now placed. Since our organization is the only one through which we have to show our strength and influence we have gathered here under its auspices to examine our position in the profession and to see how far we will be able to serve the public in the matter of medical relief.

I am not going to give you any elaborate account of our grievances which are but a few and which can be counted on our fingers' ends. Though we applauded the Minister over his bold act of abolishing the L.M.P. course and expected a great many improvements for this gradually disappearing class of medical men, the subsequent developments unfortunately show that we are no better than what we were, probably worse. If by an act of Providence the existing L.M.Ps. were to be blotted out of existence, then only their grievances would come to a stand-still. But the L.M.P. is a tenacious man and makes his existence felt. The united strength of the Association is one that cannot be thwarted, for, numerical strength counts in warfare as well as in welfare. We form the majority of the profession not only in this presidency but all over India, and our cry must be heard. What we want is that our legitimate claims should be recognised by treating us on a par with the rest of the medical men in so far as we possess qualifications which are statutorily recognised. This means that equal opportunities should be given for all who possess registrable medical qualification—be it a diploma or a degree. Mere letters after one's name have already lost the glamour not only in our profession but in others also. What the public want is merit, capacity and efficiency. We feel badly that we are not given legitimate and fair chances. We feel we are given a bad name and hanged without a trial. Now that a popular ministry representing the masses is holding the reins of the Government, we ask them for the necessary relief. Even with the present alleged inferior qualification, which I do not at all accept as true, the Licentiates have shown to the public at large their mettle and their worth, for, in my experience I have known very many of the L.M.Ps. leading in the profession and making a mark. In fact the majority of the L.M.Ps. in this province hold the palm in private practice, in towns as well as in villages. The President-elect of this Conference is a living example in our midst. The daily attendance in his clinic is by far greater than in the Out-Patient Department of the Madras General Hospital. I do not wish to make any invidious or odious comparision, but facts must be told for what they are worth. Hence I appeal to the L.M.Ps. not to depend upon any

body's favour. I would also offer my candid advice to such of those L.M.Ps. who desire higher education and University degrees to put up with any test imposed on them, because I know they would come out gloriously in the end, and there are instances of some of the L.M.Ps. coming out with distinction even in their career at the University course.

I now come to the subject of the Honorary Scheme about which there is a storm of protests by way of opposition, amendments and alterations. I frankly tell you, Ladies and Gentlemen, that I have not yet understood what this Honorary Scheme means. We are at a loss to know what it is going to be and where it is going to end. The Hon'ble Minister in his enthusiasm to reform the medical department has, perhaps, with the best of intentions evolved a scheme with which none seems to be in agreement. Though the Minister has made utterances that he is not infallible and that mistakes would be righted, would it not be still better if he gives up the Honorary Scheme altogether, as it is unsuitable to conditions prevailing in our country—and it has been stated as such by many distinguished medical men and representative Associations. Many of us seriously apprehend it as not conducive to efficient medical relief. If the Honorary Scheme is to work well, men of experience must be chosen who have got time, money and aptitude for public work and with whom the reputation and the proper conduct of running institutions and hospitals would be unsullied and safe. But the difficulty is: how and where such men are to be found? This is an ideal project but whether it can be successfully put into practice or not I am not sanguine. Having studied the several systems of medical relief obtaining in the world, my opinion is that the Honorary Scheme of the Government of Madras cannot succeed in the long run, though there may be a craze for it in the beginning. I say this, Ladies and Gentlemen, because I know the majority of the independent medical practitioners, barring a few, are on the verge of starvation. How can one think of an honorary job when the stomach is pinching? The problems of unemployment and starvation are staring us in the face. Why on earth the Honorary Scheme should be hurled on the medical profession only? It is, I consider, the most unkindest cut of all and I send my earnest appeal to the Minister to so modify his scheme as to keep us above starvation. The honorarium—to say the least of it—is paltry even in these days of financial stringency and economic depression all round. I would suggest, instead of a whole hog Honorary Scheme, that the medical men may be started on an initial pay of Rs. 100 going up to a maximum of Rs. 200 per mensem. This would involve getting rid of the top heavy medical administration and, which I think, is already over-due.

The labourer is worthy of his hire—and more so in our profession. I can never believe, as the Hon'ble Minister is not tired of repeating, that paid service is slavery. If service is slavery, private practice is nothing short of robbery. In truth, neither service is slavery nor practice, robbery. But private practice is a job for which all are not suited. It requires great commonsense, skill, diplomacy and what not. It is, in reality, an art which is difficult to acquire. Even here it is only the lucky few who get on, and the majority are on the brink of starvation. Getting rid of the top heavy salaries of the civil surgeons and levelling up of the profession in other ways, will go a great way to bring contentment, peace and efficiency in the profession. I dare say, the Minister, a shrewd politician that he is, will rise to the occasion to give the profession redress in these desirable directions.

Lastly, it is my prayer, Ladies and Gentlemen, that you should not mistake my candid statements. I am certainly one with you in the common aspirations of the profession. Our endeavours should be to get rid of the angularities and wipe out the differences in the profession so that, whether one is a graduate or a diploma-holder, we may all stand shoulder to shoulder and share the responsibilities devolved upon us for the proper disharge of the duties in rendering relief to the sick and suffering humanity. Suffering knows no Degrees or Diplomas and hence I appeal to you all, in the name of the noble profession—the independent profession in particular—not to care for such differences but to fight the ravages of disease and rid our land from famine, pestilence and epidemics.

Honour and shame from no condition rise,
Act well thy part, there all the honour lies.

PRESIDENTIAL ADDRESS

Delivered at the 4th Madras Provincial Conference of the All-India Medical Licentiates' Association, Vellore, on 18th June, 1938.

BY DR. U. L. NARAYANA RAU, MADRAS.
President Elect.

Friends,

It is not in the language of mere convention I confess to you that I am not worthy of the honour which you have conferred on me by electing me to preside over this 4th Madras Provincial Conference of the All-India Medical Licentiates' Association. I really do not know why this choice has fallen on me. I have not taken any active part in the working of our Association. I believe that your

choice has not been made on the criterion of my worthiness and of service rendered, because, I know there are people worthier than I who have made great sacrifices and rendered life-long service to our Association, and who, therefore, deserve this position much better. And if I am here to day as the President of this Conference it is solely on account of your choice which I have found difficult to resist, and of my desire to tell you that I am with you in your efforts to redress your legitimate grievances and to find out ways and means for an extensive and efficient medical relief to the people of our Province.

The New Political Dispensation.

Since the advent of the Government of India Act 1935, the administration of the Provinces has mostly passed into the hands of the elected leaders of the people. We are particularly fortunate in Madras that the Cabinet of Ministers is composed of persons noted for their ability, character, and responsiveness to public opinion. So far as the Medical and Public Health policies are concerned they are entirely in the hands of the Public Health Minister, and not in the hands of the department as before. Notwithstanding this inevitable change, I shall not be truly voicing your feelings and opinions if I do not avail myself of this occasion to state publicly that the medical licentiates of this Province, as in other parts of our country, owe much to the officers of the Indian Medical Service whose sympathetic help has made them what they are to-day—self-respecting and self-confident, ambitious and aspiring, united and persistent in their resolve to establish a recognised standard of medical education in the medical schools of this country. It was Col. Bryson who so improved the Royapuram Government Hospital that it is now found fit and suitable to be converted into a College-hospital. His great hope and vision have now been fulfilled, and the Hon'ble Dr. T. S. S. Rajan, our Public Health Minister and one of the alumni of school-hospital, has converted the old school into a new college which is expected to begin its first session this year. It was Col. Bryson who wrote in 1916:

> "Efficiency, patience, loyalty, devotion to duty and a dozen other attributes belong beyond question to the S. A. S. The great mistake of mistakes is that he is underrated and undervalued."

The other names that easily come to my mind are Col. Bannerman, Col. Giffard and Col. King whose solicitude for the welfare and progress of our class had been practical, genuine and sincere.

The times have now changed, and the effect of this change, so far as we are concerned, is that we now look forward to the elected Public Health Minister for help and guidance in the realisation of our ideals and for the achievement of the objects of our Association. The political significance lies in the fact that the Public Health

Minister is in direct contact with public opinion, and has got the necessary constitutional powers to shape his policy in the light of this opinion. Our immediate duty, therefore, is to intensify this public opinion in our favour, convince the Minister of the reality and the legitimacy of our grievances and demands, and continue to serve the popular Government and the public with increasing zeal and devotion.

Abolition of Medical Schools.

The first fruit of this political change has been the abolition of the medical schools in this province. The honour and pride of having done it goes to a medical licentiate who now happens to be the Public Health Minister—I mean the Hon'ble Dr. T. S. S. Rajan—of this province. It is an act of supreme statesmanship and none but Dr. Rajan, of all the Public Health Ministers in India, would have been so bold to conceive and bolder enough to execute it immediately. I assure him on behalf of the licentiates of this Province that there is not one amongst them who has failed to appreciate this reform. When I say this, I am not unaware of the opinion of some of our Branches and colleagues in Northern India who believe that this change is detrimental to the interests of the medical licentiates. The one great argument they advance is that this change may bring about the extinction of the class for whose welfare we have all been working for the last 40 years. They adduce the British model and say that a medical diploma and a medical degree may co-exist on equal terms and with equal opportunities for State and public service. The second argument is that if this change be permitted or tolerated, the position of the existing licentiates would become intolerably miserable. The third argument is that if our Association welcomes this change it would but mean going against the very objects with which it was started.

I do not for a moment question the seriousness of or the motives behind this opposition. But on ultimate analysis you will find that abolition of the medical schools is the inevitable and natural culmination of the aspiration and work of our class and our Association.

What is meant by the dubious words: "the extinction of our class"? The *Dressers* of the East India Company became extinct when the *Hospital Assistant* was created. Then the class of *Hospital Assistant* became extinct when the *Sub-assistant Surgeon* was ushered. He in turn became partially extinct when the diploma of *Licensed Medical Practitioner* was introduced. And along with these changes in designation, the institutions which trained them also underwent corresponding changes. "Extinction" therefore is not, in my opinion, the proper term to be used in this connection. On the other hand, it really denotes progress and reform. We have now reached a stage when the *Licensed Medical Practitioner* has to be designated in such a manner as would be appropriate to the raising

of the course of studies in medical schools to five years and to the raising of the general educational qualification to the Intermediate in Science of an Indian University which we have been asking for during the last 15 years.

This leads me directly to answer the main issue: Whether to have a medical diploma equivalent in all respects to a medical degree but separate from the latter, or to have only one university minimum medical degree, namely, the M.B., B.S. If these two designations mean one and the same thing, as they are intended to be, and if the rules for admission and the courses of study in a medical school and a medical college are to be on the same basis of Intermediate in Science and five years' course, as they have to be under the regulations of the Indian Medical Council, I fail to understand the significance, the importance or the necessity for two separate, but equivalent, minima with different appellations. The British model cited in this connection is, it seems to me, entirely out of point. In the United Kingdom all the diploma granting Bodies are private Bodies following the regulations of the General Medical Council, whereas in India almost all the medical schools are owned and conducted by the Government and follow the regulations of the Provincial State Medical Faculties or the Board of Examiners which are not recognised by the Indian Medical Council. In the United Kingdom healthy conventions have grown with regard to the current diplomas and degrees, whereas in India the Government, ever since the beginnings of modern medical education, have imposed and perpetuated a differential status, value and treatment to the diplomas of the medical schools and the degrees of the University Medical Colleges. It is also useful and important to note that in every other civilised country, except in Great Britain, medical diplomas do not exist, and M. D. alone is laid down as the minimum medical qualification for legal registration. I, therefore, urge my friends in Northern India to choose the continental model. That, I believe, would pave the way for orderly medical progress and efficient medical and public health service to the people of our country. That alone would result in homogeneity in the profession. That alone would put an end to the existing class differences among registered medical practitioners.

The next point of contention is that, if such a change is permitted, it will go against the interests of the existing licentiates This is no doubt true to an extent, but I contend this is inevitable. Even if a new diploma registrable by the Indian Medical Council is inaugurated with corresponding changes in the curricula of studies in the medical schools, it would still leave the existing licentiates unrecognised by the Indian Medical Council. That is a problem which I would deal with presently, and which, I hope, would form a chief item in your deliberations. What I want to point out to you now is

that whether the medical school is reformed in such a way as would gain the recognition of the Indian Medical Council, or whether it is abolished and converted into a college under the University, the status of the existing licentiates cannot materially be altered, because in either case they would not be recognised by the Indian Medical Council. Nor is it within the power of the Provincial Governments to compel the Indian Medical Council to recognise their present qualification. Some of our friends may say that since the earlier Hospital Assistants and the Sub-assistant Surgeons were allowed to use the designation of L. M. P., when it was introduced by the Government of India on the 6th November 1911, they may be similarly treated now and that they should ask for similar treatment. This is an impossible claim at present, because the control of recognised medical education is now entirely and statutorily vested in the Indian Medical Council, and it is not at all likely that this Council would go back upon its own standards to satisfy our claims and demands. We must understand this constitutional position clearly and adjust our demands accordingly. And in doing so, we should take care not to jeopardise the integrity, the efficiency and the consolidation of medical education and medical profession of the future in our country. Our zeal should not overrun our discretion.

The last argument against abolition is that it will contravene the objects of our Association. I submit this is an incorrect and incomplete appreciation of the chief objects of our Association which are, as stated in the Rules and Regulations of our Association, "to work for the abolition of the present compartmentalism in medical education, medical service and registration in this country," and "to urge for and obtain statutory equality of status for the medical licentiates in respect of entry into State Service and higher appointments therein". I admit that these two objects can be attained either by reorganising medical school education in such a manner as it would be recognised by the Indian Medical Council, or by converting the medical schools into University Medical Colleges. But I have already discussed the manifold advantages of having only one kind of minimum medical education and one type of minimum medical degree, *viz*, the M.B., B.S. I need not, therefore, repeat the same arguments but urge my North Indian friends to give a close thought to the subject, discuss it without passion and self-interest, and evolve a solution favourable to the future consolidation of medical education and medical profession in this country. And I have no doubt in my mind that they would come to the inevitable conclusion, *viz*., that to abolish the medical schools and to have only one standard of medical education under the control of the Provincial Universities is more profitable ultimately than to have two minimum standards with the intrinsic and extrinsic possibility of class differences and preferences in the profession. So far as Madras is concerned, we are glad that we have done away with the medical school for good.

The Problem of the Existing Licentiates.

There are about 5900 registered medical practitioners in this Province (1937). Out of these, about 4260 are medical licentiates. They are approximately distributed as follows:

In Subordinate Medical Service	...	493
,, Municipal, Railway and other services	...	200
,, Subsidised Rural Medical Service	...	390
,, Private Practice	...	3077

The only existing facility for higher medical education of the licentiates is the one that is offered by the Madras University which, according to its latest decision, requires Intermediate in Science with preregistration subjects as general qualification, and 2 years' course in the Madras Medical College. These conditions are indeed too hard to be easily taken advantage of by a large number of medical licentiates, and there is also no provision at present for the admission of more than ten such candidates per year, even if the licentiates possess the necessary preliminary qualification needed. In fact the Principal of the Madras Medical College, while speaking on the occasion of its centenary celebration, brought out this point clearly when he said:

> "Although preference was given to Madras L.M.Ps. in the matter of admission, the course was not confined to Madrasis but was thrown open to all who held the necessary preliminary qualification for admission as required by the rules. As only very few seats were allotted by Government for L.M.Ps., numerous applicants with good qualifications, not only from Madras but from all over India, had had to be refused admission".

After all, under the present arrangements only 28 licentiates were able to acquire the University degree during the last 7 years. At such a rate it will take more than 25 years to have at least 100 L.M.P. graduates. I would therefore appeal to the Ministry of Health, Madras, to provide for at least 15 seats in the Madras Medical College and another 5 seats in the contemplated new medical College at Rayapuram.

This, I am afraid, by no means fully meets the needs of the licentiates for a higher medical qualification. The present Minister of Health may not be unaware that there is a wide-spread and insistent desire among them to acquire such a qualification. I, therefore, appeal to him to consider ways and means of attaining this end, and myself take the liberty to suggest the following plan which he may adopt with suitable modifications, if necessary:

Institute a diploma of L.M.S. to replace the present L.M.P.

The same Board of Examiners who are now in charge of L.M.P. examinations may be continued and empowered to examine candidates for L.M.S.

The L.M.Ps. with matriculation and 4 years' medical course may be allowed to undergo one year extra course of studies with a suitable syllabus.

The L.M.Ps. with a five years' course may be allowed to appear for the L.M.S. examination without any extra course.

Those who hold this L.M.S. diploma may be treated on a par with medical graduates so far as this Province is concerned.

It may be argued that this suggested new diploma is not of any value or usefulness, because such a qualification will not be recognised by the Indian Medical Council. But it is not the desire of the licentiates that the Government of Madras should take steps to influence this Council to give recognition. They will be satisfied if the Government declare that this new "L.M.S." and the M.B., B.S., are equally entitled for entry into paid or honorary medical service without the handicaps imposed on the present L.M.Ps. I may say that since the medical school and the subordinate medical service are abolished—and abolished rightly—it is but just and necessary that the Government should thus come to the rescue of the existing licentiates and help them in all reasonable ways to gain public status and recognition equal to those of the University graduates. It is only a temporary arrangement which the Government should not grudge or be parsimonious about, in view of the acknowledged merits of the class and the services it has rendered so far to the Government and the public of this Province. I appeal to the Minister for Public Health to recognise the discontent of the medical licentiates of this Province in this respect and to remove this discontent on the lines I have suggested, or by any other means which he may adopt in our interests.

The Existing Members of the Subordinate Medical Service.

I may be permitted to thank publicly, on your behalf, our present Minister of Health for having promoted a good number of Sub-Assistant Surgeons with higher medical qualifications to the Provincial Medical Service, and for having reinstated in the Subordinate Medical Service some of the Sub-Assistant Surgeons retrenched by the Orissa Government as a result of re-alignment of provinces. And in this connection I would be failing in my duty if I do not thank also Dr. D. V. Venkappa, our Provincial Secretary, who made these things possible by frequent representations to and interviews with the Minister, and I would not be wrong or exaggerating if I say that it was he who was mostly responsible for convincing the authorities of the expediency and the justness of these measures, subsequently sanctioned by them.

The next objective of our Association is to see that the present members of the Subordinate Medical Service are absorbed into the Provincial Medical Service, not necessarily on the pay of the Assistant Surgeon, but with the designation and other privileges of the

Provincial Medical Service. This, I believe, is not an unreasonable demand since out of the total of 493 S. A. Surgeons, over 418 have put in more than 15 years of service and are drawing the scale of pay between Rs. 155 and Rs. 209 per month. This question may naturally form part of your deliberations, and I hope that you would arrive at a resolution agreeable to you and acceptable by the Government.

Honorary Medical Service.

It would serve no useful purpose at this juncture to discuss the merits and demerits of the system of Honorary Medical Service as in vogue in this country, particularly in Madras, as opposed to socialized medicine which aims to employ every doctor available and to give efficient and timely medical relief to all the citizens of the State. I agree entirely with the observations of Dr. M. R. Guruswami Mudaliar whose long experience in the Medical profession entitles his remarks to close attention and thorough consideration. He said recently :

> "I wish you all to look forward to a condition wherein every medical man would be paid by the State and every person would have a claim on the State for his or her ailment being treated without payment. The State collected taxes and provided for the necessities of life. Similarly the State should also provide free medical aid. But meanwhile, on that account, no medical man should be asked to render service free and go without employment."

But the policy of the Government seems to be, as expressed in their communique on this subject dated 23rd December 1937, to replace gradually the stipendiary by the honorary service. Whether this would ultimately benefit our profession and our people I do not know, and for the present we have no other alternative than to agree to this scheme of the Government and help, as far as it lies in our power, to work it out successfully.

Apart from this general view, the original scheme was thoroughly distasteful to the medical licentiates from another point of view also. It deliberately excluded them from seeking honorary appointments even as Assistant Medical Officers and limited them to the field of House Surgeons only. This was followed by an unfortunate statement by the Hon'ble Minister of Health at the Stanley Medical School that "no Government order can ever make a licentiate equivalent to M.B., B.S., and create opportunities equivalent to all of them." These events created a great stir among the licentiates in this Province at that time. The Madras Branch sent a strongly worded memorandum against this attitude of the Minister, and other Branches followed suit. Dr. D. V. Venkappa, Provincial Secretary, had an infructuous interview with the Minister. He toured round the province and created a favourable public opinion on this subject.

And the result is that the Government have removed some of the objectionable features of the honorary scheme. The medical licentiates are now, under this amended scheme ordinarily eligible for appointment as honorary assistant medical officers. I hope that what the Minister acceeded to them in principle will not be whittled down in practical application. I may assure him that the licentiates will prove worthy of the trust he has reposed in them.

Amendments to the Madras Medical Registration Act of 1914.

You are all aware that our good friend, Dr. P. S. Srinivasan, M.L.A., had been kind enough to give notice of moving in the Madras Legislative Assembly an amending bill drafted by the Madras Branch of the All-India Medical Licentiates' Association with the consent of other Branches, and that the Hon'ble Minister for Public Health has approved of the same with some necessary alterations. The main provisions as finally agreed upon by the Government are:—

The Medical Council shall consist of 16 members constituted as follows :—

(*a*) the Academic Councils of the two Universities shall return each one candidate by election amongst themselves,

(*b*) each medical college staff will return by election one member, that is, the staff of the Medical College, Madras, and the Medical College at Vizagapatam shall, by election, return one member each,

(*c*) the staff of the three medical schools, viz., the Stanley Medical School, the Lady Willingdon Medical School and the Medical School for Women at Vellore, shall return one member,

(*d*) the Government will nominate three members just to make up the absence of representation, particularly, with regard to women, missionary bodies and such other groups of practitioners who may not be returned by the general electorate,

(*e*) the general electorate shall return seven members,

(*f*) the President shall be nominated by Government for the first four years after which he may be elected by the Council itself, and

(*g*) the Vice-President shall be elected by the Council.

We are further thankful to the Government for taking up the responsibility of introducing the Bill themselves which shows the sincerity and the responsiveness of the Public Health Minister to public medical opinion in this matter, and we do hope that he will have it piloted successfully in the next session of our legislature. With the passing of this Bill we will have, for the first time in our country, a Provincial Medical Council really worth its name and worthy of our Province, and made efficient and popular to discharge its duties and functions in the best interest of the profession.

The only objectionable feature in these proposals is the nomination of the President. I do not know why the Congress Government should fight shy of an elected president. The Madras Medical Council is not a new one of its kind and has been in existence for the last 23 years with nominated President, and there is no justification for repeating this procedure. I sincerely hope that the Minister gives a more favourable consideration and suitably alters the Amending Bill in this respect.

Post-Graduate Courses.

It is sad to note that our Province cannot boast of any great facilities for post-graduate studies and diplomas in various special subjects. Consequently our men have to proceed to foreign countries for such a purpose. This means an avoidable drain of money from our country. With such first class general and special hospitals in our city and with teachers of great experience and ability in our midst, it is not at all difficult for the Government to organise suitable post-graduate courses for both specialists and general practitioners, and those can be made even self-maintaining by levy of fees on the post-graduates who will willingly pay for such facilities. Post-graduate training is the greatest need of the profession to-day in view of the growing advances in medical science, and without such a periodical training medical relief will naturally suffer from lack of completeness and efficiency. It may be argued that this is the essential function of the medical associations and the Universities in this country, as indeed they are in other civilised countries in the West, and not of the Government. But the Government seem to ignore the fact that in the United Kingdom almost all the hospitals are under private management and the trustees of this management make arrangements for post graduate courses, whereas, here, all the big hospitals are entirely under the Government. As such, it should be their primary duty to open post-graduate courses and thus help the profession in the efficient discharge of its duties. Nor need this cost much to the Government, if cost is their consideration, because it can be made self supporting by charging fees—even high fees if necessary—from the candidates. I appeal to the Government to consider this question early.

Public Health Act.

I may assure the Minister of Health, on behalf of our Association, that it will heartily co-operate with the Government in successfully working this Act which he intends to introduce in this province. It is needless for me to add that this Act is a great desideratum and that it will, in course of time, materially improve the state of public health in this Province.

Rural Medical Relief.

It is gratifying to note that the Government of Madras have a genuine desire to extend rural medical relief, and consistent with

their budget limitation, they have set apart a reasonable sum for further extension during the year 1938-39. It is also equally gratifying to note that the Public Health Minister is sympathetic towards the grievances and demands of the Subsidised Rural Medical Practitioners as set forth by their Association in a recent deputation to the Minister under the leadership of our able friend and colleague, Dr. V. Rama Kamath. Many of their grievances are easily remediable and will cost the Government neither money nor loss of prestige. That they are smarting under barbed-wire restrictions is beyond question. The meagre provision for sick leave, the insecurity of tenure, absence of provisions for study leave, too many masters to serve and too may duties to perform are some of their sore grievances. It was far from the original intention of the scheme that these practitioners should behave and conduct themselves as full-fledged Government servants. In practice, however, it has degenerated into a form of enlightened slavery. The restrictions imposed on them have become increasingly severe, worse than in actual Government Service, and their independence has become a mere myth. Many a willing recruit has, to my knowledge, been scared away by these restrictions.

Already the Minister for Public Health has shown some signs of generous attitude towards them, and may I hope that he will pursue a policy which will make this Service happy, contented and efficient?

It may be noted in passing that there are at present 400 subsidized practitioners in this Province, out of whom nearly 394 are medical licentiates. If only the Government take such steps as would make rural medical practice comfortable, decent and worth undertaking, the problem of the personnel of rural medical relief and its further extension may be easily solved in the near future.

Admission of the Licentiates to the University Medical College, Madras.

Thanks to the efforts of Dr. M. R. Guruswami Mudaliar and Dr. A. Lakshmanaswamy Mudaliar on our behalf, the University of Madras decided in 1931 to admit the licentiates to a course of 2 years at the Madras Medical College provided they possessed the general qualification of the Intermediate in Arts of any Indian University or a Cambridge Senior Certificate with three distinctions. The licentiates have been complaining against this needless restriction about the general qualification, not merely because it is unnecessary but also because such a restriction disables an appreciable number of them to qualify for the M.B., B.S. degree. That this is true is proved by the fact that only 28 L.M.Ps were able to obtain the University degree during the last 7 years. As if this restriction is not sufficiently hard, the University is now considering, at the suggestion of the Indian Medical Council, to modify the existing regulations in such a manner as would virtually prevent the licentiates from

acquiring the M.B., B S. degree. I understand that in the last meeting of the Syndicate held in April, 1938 it was decided to accept only Intermediate in Science of an Indian University with pre-registration subjects as a minimum necessary general qualification to entitle the licentiates for admission. This suggestion is awaiting the ratification of the Senate. Meanwhile, the licentiate candidates who have applied for recognition on the basis of previous regulations have been asked to wait for the final decision. There seems to my mind no real necessity for tightening the regulations further, because such regulations will be a negation of the original purpose for which this concession to the licentiates was shown, namely, to help them to acquire University medical degree on reasonable and practicable conditions. If these new regulations come into force, it would virtually mean closing up of all avenues for higher medical education to the licentiates in the country. Besides, they are untimely, coming as they do at a time when the medical schools and subordinate medical service in this province are abolished. I fervently appeal to the University of Madras not to stiffen the regulations further which will deprive all reasonable chances to the licentiates to acquire the M.B., B S. degree, and thus stifle their legitimate ambitions. It is the function of an University to offer a full scope for higher education without any arbitrary exercise of authority or domination of vested interests. As Mr. Syama Prasad Mukherji, Vice Chancellor of the Calcutta University, said:

> "The University ideal is to provide extensive facilities for education from the lowest grade to the highest, to mould our system in such a way as to unify our educational purpose and to draw out the best qualities that lie hidden in our youths and to train them intellectually, physically and morally, for devoted service in all spheres of national activity in villages, in towns and in cities."

I hope that our University will consider our appeal, encourage the licentiates to have higher medical education on reasonable conditions, and refuse to submit to an arbitrary authority like the Indian Medical Council, particularly when its directions are contrary to the policy of a liberal higher medical education, and ultimately prejudicial to the interests of efficient medical relief in this province.

Indian Medical Council.

I think it is the General Secretary of our Association, Dr. U. B. Narayan Rao, who said that the Indian Medical Council Act was worse than the Rowlatt Act, and therefore characterised the former as the BLACK ACT. And he is right. Rowlatt Act stifled the civil liberties of the people. The Indian Medical Council Act has stifled the rights and privileges of 30,000 medical men who are statutorily recognised by all the Provincial Medical Councils. Rowlatt Act was still-born and therefore harmless. But the Indian

Medical Council Act still lives, but lives as a hand maid of the General Medical Council of Great Britain and as a tool to carry out its imperialistic designs. It is needless to go into the history of events which culminated in the enactment of the Medical Council for India, since all of you are familiar with them. You may also be familiar with the fact that long before the passing of this Act Dr. Lohokare proposed a similar Bill in the Imperial Legislature in June 1925, and my revered uncle the Hon'ble Dr. U. Rama Rao in the Council of State in February 1926. This Bill, unlike the one sponsored by the Government of India in 1933, received the universal support of the profession and the public in this country, and even the *Indian Medical Gazette*—the organ of the officers of the Indian Medical Service—welcomed it as one eminently suitable and satisfactory. But the Bill had to be dropped, because the Hon'ble Dr. Lohokare died in December 1926 and the Hon'ble Dr. U. Rama Rao resigned, in the same year, from the Council of State on the mandate of the Swaraj Party of which he was a distinguished member. Compared to this Bill the Indian Medical Council Act of 1933 is a mere parody. Every one of its provisions reveals the hidden hand of the General Medical Council of Great Britain and the betrayal of Indian interests. The meagre representation of the independent medical profession, the packed up official majority, the partial terms of reciprocity and the exclusion of the medical licentiates, who form the bulk of the medical profession in this country and who are recognised as duly qualified medical men by Statutory Acts of Provincial Medical Registration, from within its purview, are features which no self-respecting medical man will ever accept and which no Government except a foreign Government as that of India would have dared to enact. The Government conceded only one thing at that time—the abandonment of the Indian Medical Register. It was conceded because even the bureaucratic Government of India could offer no plausible excuse for the exclusion of the licentiates from such a register, of whom a large number were employed under its own service.

Five years have now elapsed since the passing of this Act, and we are yet to experience any benefit accruing out of it. "Efficiency at home and honour abroad" was the slogan with which the Government of India ushered it in 1933. It has now been proved to be a slogan without substance or sincerity. The Indian Medical Council has not, till now, made any serious attempt to improve the alleged low standard of medical school education in this country, and its excuse has been that it is beyond the preamble of the Act. Thus it may be said to have failed to make the 28 medical schools of India, which supply the bulk of the medical personnel for medical relief in this country, efficient according to its standards. As for honour abroad less said the better. Italy, Germany, France, and other countries have

refused to recognise the Indian Medical Council unless endorsed by the G.M.C. of Great Britain. Sir Cuthbert Sprawson in his review of the working of the Indian Medical Council, addressing the members of the Council at its 7th Session on 12th Feb. 1937, narrated the mournful story that :

> "As regards reciprocity with countries other than those in the British Empire the opinions so far received indicated that only those of our Indian Degrees that have received the recognition of the G. M. C. would be recognised."

It will not be far from the truth, therefore, when I say that the present Indian Medical Council has created neither efficiency at home, nor honour abroad. The results cannot be otherwise, because the Indian Medical Council is neither Indian in intention nor medical in its purpose. It is in reality a political gift by the Government of India to the General Medical Council, and this is obvious from the fact that between the years 1933-38 this so-called Medical Council for India was faithfully and obediently carrying out the orders and wishes of the G.M.C., proving thereby its real origin and its real purpose. Dr. T. S. Tirumurthy resigned his membership of the Council last year as a protest against the non-recognition of the Vizag. Medical College, in spite of its own Inspectors' report that its standard of teaching and equipment was efficient and satisfactory, because the Council counted the bricks and not the brains which composed the college. "Two types of mentality" said Dr. Tirumurthy "prevail in the Indian Medical Council, one the official red-tape mentality, and the other the mentality governed by a subconscious fear of what the G.M.C. may say in regard to any matter."

Not only in the matter of recognition of the Vizag. Medical College, but also in the matter of admission of the licentiates into the Madras Medical College, has this Council been exerting its influence in the wrong way. I have referred elsewhere to the fact that at the initiative of this Council, the Madras University intends to modify its regulations regarding such admissions in a manner which will strangle once for all the desire and the right of the licentiates for higher University medical education. I may inform you that the Indian Medical Council has passed a resolution directing the Madras University to revise the rules of admission of the licentiates so as to conform to the standards set up by this Council. It is on the insistent demand by this Council that the Madras University is now compelled to restrict the present concessions, and probably it has no other alternative but to obey these instructions. This, again, is an instance of its unwanted and unnecessary interference, particularly at a time when the medical schools in Madras are abolished, and when the Government of India have called for a conference of representatives to discuss the future of medical school education this December, about which I will be speaking to you presently.

The question, therefore, arises: how to change the scope and the provisions of the existing Act? Already our Association and the Indian Medical Association are considering how to effect this change. But the political conditions at present are unsettled. There is no prospect of an amending Bill getting through the present Central Legislature. In fact, an Amending Bill drafted by our able and versatile editor of the *Indian Medical Journal*, Dr. A. Viswanathan and approved by our Association was sent to some members of the Central legislature with a request to move the same in one of its early sessions. It was twice ballotted successfully, but the Government, not being very anxious about it, have relegated it to the limbo of neglected bills. We have therefore to await our chances in the coming Federal Assembly, if it ever comes, and I hope that our leaders will spare no pains to amend this Act suitably at the earliest favourable moment. *Unless this Act is amended properly, the profession in India will have neither peace nor safety under the regime of the present Indian Medical Council.*

"A Bill to Regulate the Import of Drugs and Medicine into British India."

A bill with the above caption has been accepted by the Central Legislative Assembly during last year and it is now referred to the Select Committee for final consideration. This Bill is intended to control only the imports, and leaves out completely the question of controlling the standards of local manufactures, and adulteration of food-stuffs. The excuse is that these are within the jurisdiction of the Provincial Governments and that the Central Government is not justified in encroaching on their powers by a central legislation. I do not think the Provincial Governments will refuse to submit to central legislation if a comprehensive Bill is enacted to control the standards of all drugs and foods on a rational basis. In fact, it is my considered opinion that such a bill should have an all-India application and usefulness in order to avoid piece-meal provincial legislation and provincial conflicts. The recent communique by Dr. B. C. Roy, President of the Indian Medical Association, brings out the intrinsic dangers of the Bill under contemplation, for, as he rightly points out, the certification of imported drugs and foods will act as a stimulus to foreign trade in the absence of similarly certified drugs and foods of local manufacture. The Bill, as it is, will be a death-blow to Indian manufacturers, and I cannot imagine any valid reason to split drugs into *imported* and *local* when what we want is a proper control of all drugs, Indian and foreign, so that only standardised drugs and foods may be in circulation in the Indian market, and so that the public may have the benefit of pure drugs and foods. Chopra's Drug Enquiry Committee published its recommendations in 1930, and this report revealed the deplorable state of adulteration of drugs and food-stuffs, both foreign and Indian, current in the Indian market, and the disastrous consequences on the health of the nation. The Government of India had accepted this report and I think it is their duty to act upon it fully. Though the present Bill is obviously based on Chopra's report, it is yet incomplete and narrow in its provisions and will not really help to remedy the hopeless conditions of drug adulteration even as reported by its own Committee. May I draw the attention of our Government to the narrow provisions of this contemplated Bill and request them to advise the Central Government to make it more comprehensive, to frame it on an all-India basis, and to include under its purview all drugs and food-stuffs — Indian or foreign?

Friends, I have almost finished and I hope I have touched upon all the important subjects that affect the licentiates and the profession in general. Still there are matters which I have left out, not because they are unimportant but because you are already too familiar with them.

Reorganisation of the Indian Medical Service.

One of them is the recent reorganisation of the Indian Medical Service by the Government of India. The three important effects of this reorganisation are: (1) the reduction of the Indian personnel of the I. M. S. in the general total strength and in military and civil appointments; (2) the reservation of civil appointments to British I. M. S. officers only; and (3) apparent reduction in the emoluments of the Service being made up by an increase in the overseas allowance. There has been a country-wide protest against this action of the Government of India. For my part, not only do I protest against this one-sided justice of the Government of India, but I also do question the necessity for continuing the Indian Medical Service at all, and, if continued, the necessity of imposing this Service on Civil Medical Administration. I consider that the time has now come for the medical department to be wholly Indian in composition, Indian in character, and Indian in outlook. This should be our objective in future.

Allopathy and Indigenous Systems of Medicine.

Another subject of topical interest is the so-called conflict between allopathy and indigenous systems of medicine. You may be aware that the new Provincial Governments are attempting to consolidate and recognise the various systems of Indian Medicine. The votaries of Indian Medicine are now brought into a separate register by the Government of Madras. In Bombay there is a pending Bill in its legislature for the registration of indigenous medical practitioners. In the United Provinces, the Hon'ble Mrs. Vijaya Lakshmi Pandit, Minister for Public Health, is said to have a scheme which will replace small allopathic dispensaries by ayurvedic and unani dispensaries. What this movement will ultimately result in it is difficult to foresee. Probably, when the political conditions of India become

normal, what is best in these systems of medicine will be absorbed into one scientific system. Medical science is neither Eastern nor Western—it can only be interpreted in terms of usefulness and truth. Patriotism, prudence and the demands of true science require that the votaries of various systems of medicine should shed off their prejudices which, I believe, are more based on sentiments than on facts. Our leaders should see that the science and art of medicine is not divided into compartments of past and present or into systems working against one another. There should be no quarrel in doing a good thing like saving human life and in mitigating the sufferings of disease. What is wanted is really a scientific system of medicine to prevent and cure the ills to which the flesh is heir and not to indulge in controversies which are futile and meaningless. At the same time, I would appeal to our popular Government to re-organise the indigenous systems of medicine on a scientific basis. One of the best means of doing this will be to create a chair for Indian Medicine in our University and make it an essential part of University medical studies. I entirely agree with Lt. Col. Pandalai when he said :

> "The modern medical student should also be told about Ancient Medicine, otherwise he will develop into a man without a national background."

This is too true to be ignored.

The Conference of Representatives to discuss the Future of Medical School Education

Probably you may be aware of the proposal of the Government of India to hold a conference, at the end of this year at Delhi, of representatives of Provincial Governments, Medical Councils and Examining Bodies to discuss about the future of medical education in the medical schools of this country. I am glad that the Government of India are showing some anxiety to arrive at some solution with regard to the vexed, and hitherto much-neglected, problem of medical school education. It is difficult, even hazardous, to foresee the probable results of this Conference. I can only hope that its deliberations may find a way out for the unification of medical standards and for the consolidation of medical profession in this country. Meanwhile, I am surprised to note that while the Government of India have called for representatives of the Provincial Governments, the State Medical Faculties and the Provincial Medical Councils, they have not cared to call for similar representation from the All-India Medical Licentiates' Association which is directly as much interested in the future education of medical licentiates as any other Bodies, Government or private, in this country. This is a mistake which ought to be rectified early—and there is time enough to make good this omission. I believe such a representation is indispensible if the recommendations of this proposed

Conference are to be acceptable to the medical licentiates. There is no use of deciding things without consulting them, because they are the persons who will be involved in the effects of any decision, favourable or unfavourable. I say deliberately that, because the licentiates have been given poor representation in the Provincial Medical Councils, State Medical Faculties and other Examining Bodies, because they have never been actually and seriously consulted by the Government in matters touching their interests as if they had no voice in their own education, and because their voice of caution and advice, of progress and probity was drowned in the din of vested interests, and brushed aside as too contemptible to be heard, the medical school education is what it is to day—ill-defined, ill-adjusted and incomplete. The Government, as any body else, know that our Association has been demanding from the very first year of its inception to affiliate all the medical schools to the respective Provincial Universities, so that there may be one medical standard and one medical degree. But the Government consigned these resolutions to the waste-paper basket. Then, as an alternative, the Association suggested to raise the course to five years and to fix Intermediate in Science as the minimum general educational qualification for admission into the medical Schools. This again was not heeded to. Thus the standards of the medical schools were kept deliberately low, ostensibly on financial grounds but really to please certain vested interests and to propitiate the superiority complex of the socalled "superior grades" of medical officers. What more proofs do the Government of India want than these verifiable facts that the licentiates have been made the scape-goats of expediency and selfish interests? The tragic irony of the situation is that while the medical licentiates are condemned as possessing inferior medical qualification, the system which produces such men are connived at and condoned. I therefore, say on behalf of the licentiates that they ought to be heard at least this time, and that no plans should be foisted on them which would injure their status and dignity in the profession. May I hope that Col. Wilson, our popular Surgeon-General, who is going to Delhi as the Director-General of Indian Medical Service will set right this serious omission and thus do justice to the licentiates' claim of representation in a Conference which is intended to discuss their future medical education?

Our Association, our Work and our Duty.

Our Association, to-day 32 years old, has been growing from strength to strength, and has now attained a position which for strength of members, for a wide ramification of its Branches throughout this country, for spontaneous and ready offers of men, money and service during times of famine, earthquakes and wars, and for conducting a first-class medical journal with a leading circulation in India and abroad, has no parallel among the medical associations in

this country. First, our Association began with Service people, because, then, there were practically no private practitioners. They served as members of the Subordinate Medical Service, a service which has come down from the days of the East India Company, which has served the successive governments with rare loyalty and devotion and with a rare sense of self-sacrifice and patience, and which has stood the test of time, the test of work and the test of sacrifice. During the last 20 years private medical practice has grown to large dimensions in India, and even here the medical licentiates have taken the field and form the main bulwark in medical relief through private practice. These licentiate private medical practitioners have been joining the Association in yearly increasing numbers and enthusiastically helping their service brethren in the redress of their grievances. That is a singular feature of our Association, almost unique and without a parallel in this country. I, therefore, appeal to all the licentiates of this Province who have not yet joined the Association to do so, because it will continue to serve them with its characteristic zeal, efficiency and thoroughness. I hope that my appeal may not go in vain.

The Hon'ble Dr. T. S. S. Rajan while opening the recent conference of the Indian Medical Association gave expression to the opinion that, since the medical school and the subordinate service are to be abolished,

> "the Association may not increase in numbers; on the contrary their membership would come to a stand-still and in course of time, will gradually dwindle."

Now that the abolition of medical schools and subordinate medical service has become a *fait accompli*, as envisage by the Hon'ble Minister for Public Health, it may be presumed by you, as he did, that the membership would decline and that there is no necessity for joining this Association. On the other hand, I may inform you that since the Minister spoke on this matter there has been an actual increase of 150 members from this Province alone and that the membership is increasing, on an average, by 10 per month. This shows that the licentiates realise the utility in joining this Association. I will reiterate that the object of looking to the needs of the subordinate medical service has never been its only object, though at times it was put in the forefront of its activities. Its other important object has been to safeguard and promote the interests of the private practitioners of whom the medical licentiates form the greatest number in this Province, as elsewhere. You may take it for granted that this Association which has been adjusting itself since its inception to the changing times, will like-wise adjust itself in future and appear in a new garb to suit the coming times and circumstances. There is no danger of its dissolution even were the licentiates cease to be as such, now or

in near future. The duty of the licentiates is, therefore, clear : they should join the Association in greater numbers, work out their ideals under its auspices, and make it useful to themselves, to the public and to the Government.

It may be that the subordinate service is abolished. It may be that you are not allowed generous entry into the new fangled honorary medical service. About these you need not get disheartened. But none can prevent you from engaging in private practice. That is a field in which academical preferences play a very insignificant part, and in which your own ability, honesty and integrity are the sponsors of your prosperity. I therefore appeal to all the licentiates of this Province to take to private practice, intensify and augment it by devotion to duty, by service to the suffering public, and by discharging their obligations to the country and her people in all possible ways open to them and to the extent of their full capacity. Let a few of you in each city start co operative clinics which will enable you to equip these clinics satisfactorily and thus render efficient and perfect medical service without unnecessary mutual competition between individual members of the profession It is but right that practice should be shared by all practitioners and thus avoid unhealthy competition and actual starvation. The present position is that a few get on well, some are on the border line of subsistence, and most are pining away for want of sufficient practice to enable them to live at least with minimum comforts. We should not allow this state of affairs to continue any longer and thus deprive the large mass of practitioners of the means to live honestly and to share the duty of medical relief to the sick. In this way only lies the progress and prosperity of the large mass of private medical practitioners in this Province. By this way only they will be able to equip their clinics and extend their services to the public in an efficient and satisfactory manner. By this way only unhealthy competition can be avoided. In America particularly, such co-operative clinics are common and popular. Col. Mirajkar, Professor of Surgery, Lahore University, is sanguine that the system of co-operative private clinics would thrive well in India as the Indian doctors are either lacking in talent nor in efficiency. He believes that this would be one of the efficient means of rendering medical help to the people as well as relieving the medical practitioners from the embarrassments of continuous unemployment. What is immediately required of us is team-spirit. To live in personal selfishness is no glory or credit to the one who has taken up this noble profession. I would therefore urge on you all to cultivate this team-spirit in an ever-increasing degree, and utilise it in forming co-operative private clinics, and thus help yourselves and the suffering public. This is a subject which is worth a detailed discussion in this Conference, and I hope you will do it and arrive at such plans and programmes as would make the starting of co-operative private clinics possible in at least a few centres in our Province.

I shall now close my address with an appeal for unity. It will be a bad day for this Province if we the members of the medical profession think in terms of medical licentiates and medical graduates. Our primary duty is to think in terms of service to the people of our Province. A large majority of them are without any kind of medical relief and before this stupendous work, every other thing looks small and silly, personal and profitless. Let us evolve a plan of medical relief which would save our people from premature death and avoidable suffering, let us ask the Government to take the initiative in this matter and let us help them in their undertaking. By all means work for the consolidation of the profession which is only a means to an end. By all means fight for and acquire your rights and privileges, but this again is only a means to an end. And the ultimate end is efficient and satisfactory medical service to the people. As the Hon'ble Premier of the Central Provinces, Dr. N. B. Khare, said while addressing the 4th Provincial Conference of the Licentiates of that Province, *these castes and compartments in the profession are a part of the imperialistic design which are bound to disappear when India attains her freedom to manage her own affairs.* Let us all, licentiates and graduates, band together and work in the cause of relief of human suffering.

Extracts.

FEVER THERAPY IN RESISTANT GONORRHEA: WITH ESPECIAL REFERENCE TO ITS RELATIONSHIP TO SULFANILAMIDE THERAPY OF GONORRHEA.

E. C. Elkins, M. D., Fellow in Physical Medicine, The Mayo Foundation and F H. Krusen, M.D , Section on Physical Medicine: One year ago from twenty to forty patients who had gonorrheal infections were being given fever therapy at the Clinic each month. With the advent of the drug, sulfanilamide, the use of artificial fever in the treatment of gonorrhea immediately declined. It almost seemed that in so far as the treatment of gonorrhea was concerned, fever therapy might become just one more therapeutic measure relegated to the past. Since the dangers of artificial fever are definite, the discomfort to the patient is great, fever therapy departments are few and the expense to the patient is considerable, any chemotherapeutic agent, acting with reasonable rapidity, efficiency and safety, can be considered a great advance over fever therapy.

However, since there is a certain percentage of failures with sulfanilamide therapy of gonorrhea, various investigators having

reported failures in from 15 to 50 per cent of cases, we have continued to treat a small number of patients by artificial fever. Likewise it should be noted that some patients who have been classed as failures in fever therapy have responded promptly to sulfanilamide.

SUCCESSFUL RESPONSE TO SULFANILAMIDE FOLLOWING FAILURE OF FEVER THERAPY.

We have had two cases of gonorrheal infections in which response to treatment by means of artificial fever therapy did not occur but sulfanilamide therapy was successful. The first was that of a young woman who had gonorrheal urethritis and cervicitis. She was given three ten-hour sessions and one eleven-hour session of artificial fever with bodily temperatures maintained in each instance at 106.5° F. During two of the sessions local pelvic heating by means of pelvic diathermy was employed for varying periods.

The second patient was given a choice of artificial fever therapy or sulfanilamide therapy. Since she was anxious to eradicate the infection quickly, she chose fever therapy. She received one ten-hour session but continued to have positive cultures. She was advised to return home and take sulfanilamide under the supervision of her family physician. She later reported having been "cured."

SUCCESSFUL RESPONSE TO FEVER THERAPY FOLLOWING FAILURE OF TREATMENT BY SULFANILAMIDE: COMBINED TREATMENT.

In a group of ten cases in which fever therapy was employed sulfanilamide had failed previously to eradicate the gonorrheal infection. All of these patients had had what was considered to be an adequate amount of sulfanilamide therapy. The drug had been administered either at the Clinic or by the patient's family physician. Six of the ten patients were men, all of whom had gonorrheal prostatitis and urethritis. One also had an associated epididymitis and a perineal abscess which had been incised elsewhere and was still draining at the time of treatment at the Clinic. Five of the six men responded satisfactorily to artificial fever therapy. From three to five negative cultures were obtained the treatment, and they were dismissed as having complete clinical remissions or as being markedly improved.

The possibility that combined treatment with sulfanilamide and artificial fever might give added assurance of eradication of the infection was kept in mind Hence all of the patients treated were kept on the saturation maintenance dosage of the drug, or were given 80 grains 5.3 gm.) of the drug for two days prior to the treatment by artificial fever. The amount of artificial fever therapy given varied. Three of the six males had one ten-hour session with bodily temperatures maintained at approximately 106.7° F. One patient was given an eight hour session, the treatment being terminated early due to the fact that he had a convulsion which promptly subsided on removal from the fever cabinet Another patient was given two five-hour

sessions of artificial fever with the bodily temperatures at 105.5° F., and 106.7° F., respectively. The treatment was terminated early because the patient exhibited a rapid pulse rate.

The only man in this series for whom artificial fever therapy failed had the most complications. He had had the infection for more than five months and had been given large doses of sulfanilamide over a long period of time. He received one five-hour, one six-hour and one ten-hour session of fever therapy with bodily temperatures maintained above 106.5° F. Cultures remained positive, little or no improvement occurred and it was necessary to hospitalize him later.

Of the four women in this series treated by fever therapy all had had adequate treatment by sulfanilamide. For these, varying amounts of artificial fever therapy also were necessary. Two had one ten-hour session of artificial fever with bodily temperature maintained at 106.7° F. They were dismissed as having complete clinical remissions. Another had one ten-hour session of artificial fever combined with five hours of local pelvic heating by means of veginal diathermy during which the rectal and vaginal temperatures were maintained between 107 and 110° F. Following this treatment two cultures from the cervix were negative and then the cultures again became positive. She was given a twelve-hour session of artificial fever with six hours of local pelvic heating. Her cultures from the cervix and urethra became negative and have remained negative.

The fourth woman patient was aged fifty-seven years. In the course of treatment with sulfanilamide she was given eight hours of local pelvic heating by means of pelvic diathermy during which the rectal and vaginal temperatures were raised to between 107 and 110° F. She was given a five-hour and a six-hour session of artificial fever, during which the oral and axillary temperatures were elevated to 103 and 104° F. and her rectal and vaginal temperatures were maintained by means of local pelvic heating with vaginal diathermy between 107 and 110° F. Following these treatments, cultures became negative.

Recently some workers in this field have taken into consideration the possibility that sulfanilamide therapy combined with artificial fever therapy might give added assurance of the eradication of gonorrheal infections in the complicated cases. Ballenger, Elder and McDonald made a preliminary report on the treatment of gonococcic infections by means of sulfanilamide and thermotherapy. He stated that his experience with a group of patients who received artificial fever in combination with sulfanilamide had convinced him of the value of such a plan of treatment. At first, the cases chosen for thermochemotherapy were those in which artificial fever therapy had failed or the treatment with sulfanilamide had failed.

Later, since the combined treatment was found to be efficacious in cases of a resistant infection, he decided to employ it for patients who for domestic or business reasons had urgent need for immediate cure.

Ballenger's plan of treatment was to administer to the patient 80 grains (5.3 gm.) of sulfanilamide for two days preceding artificial fever therapy. The bodily temperatures were then elevated to 103 or 104° F. and maintained in this range for three or four hours. The fevers were administered every other day until three treatment were given. In ten consecutive cases so treated he had only one failure, and this failure, he thought, was due to the fact that the patient, since he had had a gastrointestinal upset, had not taken a sufficient quantity of sulfanilamide Ballenger suggested, that since treatment by sulfanilamide had failed in these cases and since the moderate amount of artificial fever administered and the low bodily temperatures maintained were not sufficient to cure gonorrheal infections, the hyperpyrexia activated the sulfanilamide or increased the defensive bodily reactions in a manner not attained by separate administration of these agents.

In contrast to Ballenger's report Kendell said in a recent personal communication that he was still treating the usual number of gonorrheal complications in spite of the advent of sulfanliamide. Although he did not mention the number of patients he had treated, he did say that in all of his recent cases sulfanilamide therapy had been given without bringing about a remission, prior to the fever therapy. He had nevertheless been administering sulfanilamide therapy (approximately 60 grains or 4 gm. a day) for two or three days preceding fever therapy. In this group of cases after the initial session of three hours of artificial therapy with a bodily temperature at 105° F., one eight-hour session of artificial fever was administered with bodily temperatures maintained at 106 2° F. rather than at 106. 7° F. One patient was given two eight-hour and one ten-hour sessions of artificial fever with bodily temperature maintained at 106.2° F. Cultures in this case continued to be positive and it was only after a ten-hour session of fever with bodily temperatures at 106.6° F. was given that the disease finally disappeared. Kendell mentioned another patient who had received many types of treatment, including local irrigations, for nearly a year and who was sent to him because of epididymitis and a persistent active urethritis. This patient was given one eight-hour session of artificial fever with bodily temperatures maintained at 106.2° F. Three days after treatment there was no evidence of activity. Then an acute exacerbation of the urethritis occurred. One ten-hour session of artificial fever with bodily temperature at 106.6° F. was given and all evidence of gonococci disappeared from the urethral and prostatic fluid and the patient has remained well.

Kendell further stated that he had had several other cases similar to the ones mentioned and that it appeared to him that the combination of fever therapy and sulfanilamide therapy was little more effective than fever therapy alone. He stated that he had had only one case in which he had used sulfanilamide and fever therapy together as the initial treatment. In this instance the sulfanilamide was given daily for three days prior to treatment by artificial fever at which the bodily temperature was maintained at approximately 106.3° F. rather than the usual 106.7° F. This procedure had entirely eradicated the gonorrheal infection.

In our series only two patients who received five-hour sessions of artificial fever at 106.7° F. obtained clinical remissions. Seven of the ten patients required eight to twelve-hour sessions of fever and two of these required more than one long session with high bodily temperatures in conjunction with sulfanilamide therapy before the infections were eradicated. In one case, which was not included in the series, a five-hour session of artificial fever was given at approximately 106.3° F. and cultures continued to be positive.

Although the findings in this study might suggest similar conclusions to those of Kendell, nevertheless, in our series, no attempt was made to change the routine, that is, to lower the bodily temperatures or to shorten the session of fever. Also the whole group was made up of very resistant cases. Therefore, we do not feel that any definite conclusions can yet be drawn concerning the combination type of therapy.

In conclusion, however, we feel that since there is a certain small percentage of failures with unfortified sulfanilamide therapy, and since in a high percentage of these cases the infection can be eradicated by means of unfortified artificial fever or by the combination of artificial fever and sulfanilamide therapy, fever therapy will continue to be an important therapeutic adjunct in the treatment of certain more resistant cases of gonorrhea.

ANESTHETIC PROCEDURES USED AT THE MAYO CLINIC

I. GENERAL CONSIDERATIONS OF LOCAL, INHALATION AND INTRAVENOUS ANESTHETIC AGENTS AND METHODS AND PREMEDICATION.

E. B. Tuohy, M. D., Section on Anesthesia: The purpose of this series of reports is to discuss various anesthetic procedures which are used for certain types of surgical operations. It is not my intent that whatever procedures are in current use for certain types of operations are by any means the only accepted methods by which such procedures may be done, nor is it assumed that the methods which we are using at the Clinic at the present time for an individual operation may continue to be indefinitely the methods of choice. The usual methods of anesthesia which we employ for various surgical operations will be described. The administration of premidication and basal sedatives will be discussed later in the paper. I shall write not of "my methods" or "my choice" but of "our methods" and "our choice," for the experience to be reported here is that of the Section on Anesthesia rather than that of a single individual.

GENERAL CONSIDERATION OF LOCAL ANESTHETIC AGENTS

Procaine (novocaine or neocaine) is considered by us to be one of the most valuable of all local anesthetic agents, because it seldom produces untoward reactions. Another local anesthetic agent which differs markedly, chemically, from procaine and one which we consider may be satisfactorily substituted for procaine is metycaine. It produces local, topical, regional or spinal anesthesia of longer duration than does an equivalent dose of procaine. The use of metycaine for certain types of regional anesthesia will subsequently be elucidated further.

Certain of the vasoconstricting agents are used with local anesthetic agents in order to produce a more lasting effect. Chief among these are epinephrine, ephedrine, cobefrin, and neosynephrin. These agents are all similar structurally and in their physiologic effects. Epinephrine produces a quick vasopressor and vasoconstrictor response which lasts fifteen to twenty minutes. Cobefrin likewise produces the same effect as epinephrine, but the effect lasts definitely longer (twenty to thirty minutes) than does that of epinephrine. Neosynephrin may be used interchangeably with epinephrine. Ephedrine produces the largest vasopressor effect of these four drugs (forty-five minutes), but it has one disadvantage in that it does not give adequate hemostasis for local anesthesia. The long duration of its pressor effect, however, makes ephedrine most useful in spinal anesthesia. In general, cobefrin, epinephrine, and neosynephrin are the most valuable hemostatics in local anesthesia. Incase shock of marked degree occurs, these agents may be administered intravenously and in milder cases they may be administered intramuscularly or subcutaneously.

When either procaine or metycaine is used for regional anesthetic procedures, the usual concentrations will vary from 0·5 per cent to 2 per cent, except when metycaine is used topically and then the concentration of this agent is 0·25 per cent to 4 per cent. For the various types of regional block, however, the exact concentrations of either of these agents will be mentioned.

GENERAL CONSIDERATIONS OF INHALATION ANESTHETIC METHODS.

Nitrous oxide is the most widely used gaseous anesthetic agent for inhalation and it is usually employed in combination with ether vapor and oxygen. It is relatively one of the safest gaseous anesthetic agents for administration by inhalation that is available, and in combination with ether little difficulty usually is experienced in obtaining adequate surgical anesthesia.

Cyclopropane has more or less taken the place of ethylene in our hands, because we feel that the former agent has advantages which ethylene does not possess; namely, smoother induction for the patient and production of greater surgical relaxation; moreover, it can be combined with high percentages of oxygen and still maintain adequate anesthesia. Cyclopropane, like ethylene, is explosive and inflammable but since it does have certain advantages we prefer to use cyclopropane. From an economic standpoint it is definitely advantageous to administer all anesthetic agents that are given by inhalation with a gas machine which allows the carbon dioxide absorption technic to be employed. Without this method of circle breathing, it is not particularly desirable to employ relatively expensive gases such as cyclopropane. The increase in potency which cyclopropane possesses, in contrast to nitrous oxide and ethylene, arouses the caution of those who are not familiar with its administration. It should be administered slowly and in not too concentrated a mixture. During induction, careful attention should be paid to the character of the pulse and respiration. Any sudden cardiac arrhythmia, or a sudden change in the character of the respiration, should be adequate warning to the anesthetist to discontinue administration of cyclopropane and to resort to some other type of anesthetic agent. It is alleged that in certain Concentrations, and with certain patients cyclopropane may produce certain cardiac irregularities, the most serious of which is ventricular fibrillation. We feel that careful induction, with particular care being paid to pulse and respiration, will help to detect those patients who are perhaps sensitive to this particular agent.

INTRAVENOUS ANESTHESIA

"The short acting soluble barbiturates, such as pentothal sodium and evipal soluble, are useful agents for producing anesthesia for short operative procedures. In contrast to the intravenous administration of other barbiturates, such as pentobarbital sodium and sodium amytal, pentothal sodium and evipal soluble both have rapid induction and recovery periods, produce fair surgical relaxation and a minimum of postoperative restlessness. However, the control of certain agitated psychoses, convulsive or manic states, is more satisfactorily accomplished by the intravenous administration of pentobarbital sodium or sodium amytal than it is by the intravenous administration of pentothal sodium or evipal soluble because the duration of the effect of the former is longer than that of the latter.

"The details of the administration of pentothal sodium have been described elsewhere, but in general it may be said that either pentothal sodium or evipal soluble, or any short acting barbiturate, should be administered intermittently, slowly, and not according to body weight. In this respect the intravenous administration of soluble barbiturates resembles closely that of administering ether by the drop method.

"Children who are less than twelve years of age for the most part do not tolerate the intravenous administration of barbiturates well because of respiratory depression. Likewise, certain adults who have dyspneic conditions sach as asthma or congestive heart disease do not react favourably to intravenous anesthesia. It is absolutely essential that a free airway be maintained in any case in which intravenous anesthesia is administered and it is wise to have a competent person hold the patient's jaw forward so that the tongue cannot fall back into the pharynx and interfere with the exchange of air. In the event that respiratory depression occurs, oxygen and carbon dioxide should be available and administered in the usual manner. Occasionally, it may be necessary to introduce a Magill intratracheal tube in order to maintain an adequate airway in the event that there is marked interference with respiration. The usual methods of nasal or oral intubation are used."

PREMEDICATION

The derivatives of barbituric acid are extensively used as basal sedatives to allay preoperative fear and apprehension on the part of the patient. It has been the custom to administer the derivatives of barbituric acid, especially pentobarbital sodium, as premedication for both regional anesthesia and for anesthesia by inhalation. The role which the barbiturates play in regional anesthesia is one of antagonism, to balance any untoward effects of local anesthetic agents. In particular, the barbiturates serve to protect against untoward reaction from procaine, metycaine and cocaine. The sedative effect is also of definite benefit to patients who must undergo regional anesthesia. Barbiturates are used freely as preoperative medication prior to anesthesia by inhalation, chiefly to assure the patient of rest and to allay fear as much as possible.

Pentobarbital sodium is administered in doses of 1½ to 3 grains (0·1 to 0·2 gm.) the evening before operation. In addition, on the morning of operation this drug is given about forty-five minutes to an hour before operation. Also 1/6 to ¼ grain (0·01 to 0·016 gm.) of morphine sulfate and 1/150 grain (0·004 gm.) of atropine sulfate are given hypodermically. To certain patients it may not be necessary to give a hypodermic injection of morphine sulfate if sufficient sedation has been produced by the pentobarbital sodium. If the respiratory center is depressed too much by the barbiturate and

morphine, it may be difficult, in certain instances, to induce satisfactory anesthesia by inhalation.

It is debatable whether atropine sulfate should be given as a routine preliminary to anesthesia by inhalation when the patients are children, inasmuch as atropine may act as a metabolic stimulant and sometimes will produce rise in temperature of children.

Pentobarbital sodium in doses of 1 ½ to 3 grains (0·1 to 0·2 gm.) plus 1/6 to ¼ grain (0·01 to 0·016 gm.) of morphine sulfate are used practically routinely as basal sedatives for regional anesthesia, and in most instances atropine sulfate is withheld unless there is considerable likelihood that in addition an anesthetic agent may be administered by inhalation. We do not use avertin fluid routinely as a basal sedative, chiefly because we feel that we can obtain the desired effects more simply with the derivatives of barbituric acid.

Medical News & Notes.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(*Tinnevelly Branch of the Indian Medical Association.*)

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 25th of June 1938, at Papanasan one of the most sacred places of the District, noted for wild scenery and most charming waterfalls.

Members numbering 42 gathered from all parts of the District. All the members had an early bath in the Falls which was followed by light refreshments.

The meeting began at 10 A.M. under the Presidentship of Lieut. Col., T. S. Shastry, I.M.S. The Secretary read the minutes of the last monthly meeting held at Mangalagiri near Tuticorin, on Saturday the 14th of May 1938, which were passed.

The proposal of the Ramnad Branch of the Indian Medical Association that a Presidency Branch of the Indian Medical Association should be formed in order to be able to speak in the name of the Presidency in regard to the Indian Medical Association, was discussed, and the following resolution was unanimously passed :—

"The Tinnevelly District Medical Association is of opinion that the question of forming a Provincial Branch of the Indian Medical Association for the Madras Presidency may be considered when an adequate number of District Branches of the Indian Medical Association have been formed in the Presidency."

The letter from the Secretary, Indian Medical Association, Calcutta, regarding the All India Anti-Medical Council Act Day was read out and discussed. The following resolution was passed *nem: con* :—

"The Tinnevelly District Medical Association is of opinion that the time has come when the All India Medical Licentiates Association and its Branches together with its membership, Funds. and Journal should be entirely amalgamated and merged with the Indian Medical Association, thereby facilitating the formation of a united front for the redressal of the legitimate grievances of the Licentiates and to unify the Allopathic Medical profession as whole."

The following resolution was also passed unanimously :—

The Tinnevelly District Medical Association is of opinion that the Indian Medical Association subscription may be reduced from Rs. 3 to Rs. 2 in as much on the membership of the Indian Medical Association has increased appreciably since its formation and as there is every likelihood of more Medical Associations joining the Indian Medical Association if the subscription is reduced and that this suggestion may be sent up to the Central Council of the Indian Medical Association."

It was also considered necessary to discuss the above subjects at Courtallam meeting on the 23rd of July 1938, where the Medical Associations of the Travancore State, Ramnad, Madura and Tinnevelly District meet together.

Thereafter Dr. T. K. Nilakanta Iyer, Selection Grade Sub-Assistant Surgeon of the Government Headquarters Hospital, Palamcottah, read out the following interesting cases which were successfully operated and treated at the Government Headquarters Hospital, Palamcottah :—

1. A case of Stab Injury of the neck.
2. A cae of Liver Abscess.
3. Two cases of septic knee-successful treatment with proseptasine and Soluseptasine.
4. Three cases of Erysipelas-successful treatment with prontosil.
5. A case of Fracture of femur attended with haematomyelia.

After detailed discussion by the members Colonel Shastry, summed up the salient and important features of all cases. He offered his cordial thanks to all those members who helped towards the success of the function and thanked Dr. T. V. Gopala Menon, M.B.B.S. for the excellent arrangements. He congratulated Dr. K. R. Vekoba Rao, L.M. & S., B.S.Sc., one of the members of the Association on his selection for the Health Department of Madras.

All had an excellent Dinner at 1 p.m. Thereafter an enjoyable musical entertainment brought the happy gathering to a close at 3 p.m.

HEALTH EXHIBITOIN.

At 5 p.m a very enthusiastic Health Exhibition was held at the Thirthapathi High School, Ambasamudram. It was opened by Mr. Jayarajan, I.C.S., Sub Collector, Sermadevi. Dr. T. C. Sankara Iyer, L.M.P. of Kallidaikurichi, presided over the function.

Lieut Col., T. S. Shastry, I M.S., the President, welcomed the guests and requested Mr. Jayarajan, to open the Health Exhibiton. Mr. Jayarajan, I.C.S. in declaring the Exhibition open said that such exhibitions are very useful and beneficial to the masses.

The President, delivered his speech in Tamil which was very intersting. He impressed the necessity for such Exhibition and its usefulness and urged the people to practise the ways of Health and to create a health conscience and stressed how our personal habits should improve in regard to our latrines, and water courses.

The Exhibition was thrown open to the public and school children till late in the evening. The Exhibits consisted of posters relating to Cholera, Tuberculosis, Malaria, Small-pox, etc. This was very much appreciated by the gathering which consisted mostly of School boys and Teachers—about 300 strong from the whole of Ambasamudram area.

Leiut. Col., T. S. Shastry, I.M.S, offered cordial thanks to the Head Master, Thirthapathi High School, Mr. Jayarajan, I C S., and Dr. T. C. Sankara Iyer, for their kind co-operation for the success of the Health Exhibition.

MEDICAL ASSOCIATION—A meeting of doctors employed in the Government hospitals of Trichur and those practising in the town was held on 3rd July '38 in the local C.M.S. School hall under the presidenentship of Captain A. R. Poduval, Director of Public Health and Panchayats, when a new medical association for Trichur was organised. It was resolved to conduct monthly meetings and hold discussions on matters of medical interest.

Captain A. R. Poduval was elected the President, Dr. E. Rama Warrier, the Vice-President, and Dr. M. V. Parameswaran the Secretary and Treasurer.

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