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JANUARY, 1938

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Original Articles.

THROMBO-ANGIITIS OBLITERANS.

BY DR. ARTHUR, E. DE. SA., F.R.C.S., (ENG.)

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INTRODUCTION : An article on Thrombo-Angiitis Obliterans needs no apology. Since the awakening of Thrombo-angiitis consciousness in this city of late, we have come to realise that the disease is much commoner in Bombay than was heretofore imagined, and that many cases that were in the past diagnosed as Peripheral Neuritis and Flat Foot were probably missed cases of Thrombo-Angiitis Obliterans.

I propose in this article to give a brief account of what is known to date with regard to the disease and to assess the value of the conservative treatment of Thrombo-Angiitis Obliterans by intravenous Hypertonic Saline, a method of treatment so ardently championed by Saul Samuels.

HISTORY : The first important contribution to the pathology of Thrombo-Angiitis Obliterans was made in 1879 by Von Winiwarter who, in describing a leg amputated by Billroth, gave a complete account of the Endarteritis and Endophlebitis.

Laveran, in 1894, drew attention to the migrating Phlebitis which is so charac-

teristic of the disease. He emphasised the essential difference between Arteriosclerosis which is a disease of the arteries alone, and Thrombo-Angiitis Obliterans, which affects both the arteries and the veins.

Beurger, from whom the disease takes its name, described in great detail, in 1908, the gross and microscopic findings in Thrombo-Angiitic legs.

ETIOLOGY.

1. *Race.*—Sustained investigation has shown that the disease is not, as was formerly thought, confined to Russian Jews. The disease is very common in India. It is found in all European races and in the Chinese and Japanese. However it is predominantly a Jewish disease, over 75% of cases occurring in Semites. (Samuel).

2. *Sex.*—The curious fact that the disease is almost confined to the male sex has led to numerous speculations as to the pathology of the disease and has been reflected in the many forms of therapy that has been suggested, such as Blood Transfusion from women donors and administration of female hormones.

3. The disease shows a tendency to familial incidence.

4. *Age*.—The common age period is 15 to 45 years. If a patient presents symptoms and signs of vascular occlusion for the first time after 45 years, it is essential to exclude Arteriosclerosis.

5. *Ergot and Tobacco*.—Both these are aggravating but not etiological factors. The profound influence that tobacco has on the course of the disease, will be stressed later in the course of the article. It has been suggested that the disease is in the nature of an allergic response to tobacco, or the products of cigarette combustion.

6. *Glands*.—These bear no relationship to the disease and Adrenalectomy, once suggested and practised, is valueless.

7. *Organisms*.—Rabnowitz has isolated gram negative bacilli from the blood of Thrombo-Angiitis patients; whereas at the Mayo Clinic, Streptococci have been grown from the phlebotic patches and the blood.

The etiological significance of Syphilis is now wholly discounted.

SYMPTOMS AND SIGNS: In the diagnosis of the disease, signs are more important than symptoms, which are comparatively unreliable.

A burning sensation in the foot, and even actual pain in the foot, is quite a common symptom. Sometimes, these take the form of shooting pains in the calves like the lightning pains of Tabes. These cases are often treated as cases of Flat Foot with arch supports.

Numbness and paraesthesiae in the foot may occur, especially after walking.

Symptoms appearing after walking are very suggestive. 'Intermittent Claudication', a severe cramping pain in the leg appearing on exertion, is not pathognomonic. It is only a symptom of muscular ischaemia. There is the characteristic cycle of walking and rest.

Shooting pains down the back of the leg may occur, simulating Sciatica. It has been suggested that it might be due to spasm of the Inferior Gluteal Artery.

With continued progress of the disease, pain is felt even apart from exertion "rest pain". This is, a diffuse pain over the whole extremity, or localised to areas like the ankle or forefoot leading to loss of sleep. When the pain is localised to the nail-bed of the Big Toe, "Ingrowing Toenail" is often diagnosed. Operation under this mistaken diagnosis is often the cause of a spreading gangrene.

The rest-pain of Thrombo-Angiitis is a peculiarly diffuse pain of complex origin. It is not relieved by Neurectomy or Sympathectomy. Only the comparatively severe procedure of Spino-thalamic Cordotomy gives relief.

In the *Upper Extremities* pain is always of the rest type. Subjective coldness in a single or several fingers, as in the toes, or in the entire extremity, is a common symptom. Occasionally the patient, if he is intelligent enough, may note a complete cessation of perspiration in the affected foot, especially if he is accustomed to shoes.

All these symptoms are merely suggestive of Arterial obstruction and are not pathognomonic of Thrombo-Angiitis.

SIGNS: These are much more important than symptoms. It is essential always to compare the two limbs. Muscular Atrophy is a common sign. It is difficult to say whether it is due to the ischaemia or to disuse.

The Bony atrophy is well seen in Radiograms.

Trophic changes are often marked. The skin becomes dry and parchment like, or transparent, glossy, and like tissue paper. There may be an absence of hair on the affected limb and they may grow again with treatment.

The Nails become dry and brittle and their rate of growth slower.

Colour changes. With moderate arterial occlusion, no change is observable in the colour of the limb on assuming the horizontal position. With severe occlusion the limb may be pale and cadaveric or dark and cyanotic. If the limb is cold in addition to being cyanotic, gangrene is impending, especially if the cyanosis does not disappear on pressure.

Ischaemia is accentuated by elevation of the limb, thus adding the effect of gravity to that of arterial occlusion. With muscular contraction in addition to elevation, e.g., plantar and dorsi-flexion of the ankle, or opening and closing of the fingers, the palm or sole may become very pale. The pallor may be limited to a couple of fingers or toes, indicating that the disease may be very local. Radial pulsation is obviously a bad guide to the condition of the digital circulation.

With normal arteries these manouvers cause no colour changes. *Rubor on pendency* is a peculiar manifestation of Thrombo-Angiitis for which there is no adequate explanation. It is not diagnostic of the disease as it also occurs in arteriosclerosis; but the colour in Thrombo-Angiitis is naturally more cyanotic.

Cyanosis in the extremity indicates a severe circulatory upset especially if it does not disappear on elevation or pressure.

Surface temperature. The palm of the hand may be trained to detect minute variations in temperature. The limb affected by Thrombo-Angiitis is invariably colder than its normal fellow. The best method of determining changes in skin temperature is with the aid of a sensitive skin recorder, a Copper Constan Thermocouple. There are two kinds of skin electrodes, one for recording surface temperature and another for the subcutaneous tissue.

Digital palpation of the arteries gives a crude estimate of the state of the arterial circulation. The arteries to be palpated are: In the Lower Extremity. *i.* Dorsalis Pedis. *ii.* Posterior Tibial, *iii.* Popliteal (very difficult to feel normally) and

iv. Femoral. In the Upper Extremity, *i.* Radial. *ii.* Ulnar (more prone to abnormalities than the radial), *iii.* Brachial, *iv.* Axillary.

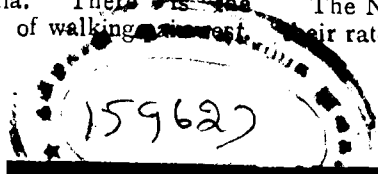
There are certain fallacies in the method of estimating the extent of the disease or in coming to a diagnosis. A strongly pulsating artery does not exclude Thrombo-Angiitis as the digital vessels may be affected; conversely, an impalpable artery does not prove the existence of the disease. It may be deeply situated or abnormally placed, especially the dorsalis pedis.

For accurate records of arterial pulsation, instrumental methods are desirable, viz., Oscillometry with a Pachon Oscillometer. Arteria tenderness is an occasional sign of Thrombo-Angiitis. In 40% of cases attacks of superficial phlebitis occur. These are characterised by localised, red, tender areas along the superficial veins anywhere from toe to groin and finger tip to axilla. They may disappear rapidly from one area to reappear at another, hence the name Thrombo-phlebitis Migrans. These attacks are characteristically afebrile and without leucocytosis. The moral is,—examine the peripheral arteries in every case of phlebitis in a young man.

ACCESSORY METHODS OF INVESTIGATION OF ARTERIAL EFFICIENCY.

1. *Arteriography* is the radiological delineation of the arterial circulation after the injection of a radio-opaque substance, such as, Thorotrast, or Uroselactan B, or Sodium Iodide. It is a valuable adjunct to the experimental investigation of the disease, but unnecessary in its diagnosis or treatment.

Technique: A blood-pressure cuff is placed on the limb proximal to the point on the artery that is to be injected. The artery is exposed by the open method or punctured through the skin, commonly the Brachial at the elbow, or the Femoral in the Scarpa's triangle. In the latter case since the application of a sphygmomanometer cuff is impracticable, digital pressure has to be resorted to.



The cuff is pumped to above systolic pressure and the radio-opaque substance injected. If Uroselectan B is used, about 12 c.c. are necessary. An X-ray of the limb distal to the injection is taken immediately. The pressure in the cuff is now lowered to zero and two or three arterial beats allowed through. The cuff is again pumped to above systolic pressure and the X-ray of the limb repeated. The purpose of lowering the pressure to zero is to permit the arterial pressure to open up the collateral stream, but the purpose of the procedure will be utilised if too much time is taken in raising the pressure again to above systolic, as the Uroselectan is so quickly washed out of the peripheral circulation through the veins. A comparison of the two X-rays will furnish some idea of the extent of the collateral reserve.

2. *Oscillometry*.—Furnishes a precise and permanent record of arterial pulsation. The thigh or arm are "cuffed" high up and connected to the oscillograph. The cuff is pumped to above systolic pressure, and the pressure is slowly released. Small movements of the recording needle are observed above the systolic pressure—"Supra-maximal pulsations." The maximal excursion of the needle occurs at the systolic pressure. The maximum number of divisions traversed on the scale furnishes the 'oscillometric index.' Normally there is a decrease of the oscillometric index from the centre to the periphery.

Oscillometry finds its special field of usefulness in the location of the site of embolic obstruction. If the cuff is worked steadily downwards there is a sudden drop of the oscillometric index below the site of obstruction.

PATHOLOGY.—Fundamentally there are two elements in the disease,

1. An acute inflammatory process in the arteries and the veins and occasionally in the nerves.

2. A thrombotic occlusion of these vessels.

Arteriosclerosis, by comparison, is a degenerative, non-inflammatory affection of the arteries which may lead to obstruction.

Thrombo-Angiitis is essentially a disease of the whole of the vascular system, and therefore it is not surprising that attacks of superficial phlebitis occur. It is probable that these superficial nodules hold the secret of the disease.

The incidence of the disease has probably some bearing on its etiology. 60% of cases occur in the lower extremity alone. 38% of cases occur in both upper and lower extremities; and 2% of cases occur in the upper extremity alone.

PROGNOSIS: Jefferson maintains that 25% of Thrombo-Angiitis come to amputation before the age of 30 years if they are not subjected to a timely sympathectomy, and that only 5% of patients so treated come to amputation before 30 years. It would probably be truer to say that very few patients need to have a high amputation done, if they are subjected to early and intensive Saline treatment, and it is the one purpose of this article to show that such severe and mutilating operations are practically unnecessary.

A great number of Thrombo-Angiitis suffer from coincident Coronary or Mesenteric arterial disease, and thrombosis of these vessels is a complication which is necessarily fatal.

TREATMENT: Any treatment must stand or fall by its results and the following should be the criteria on which the value of any therapy is to be judged.

- (i) The extent of Sympathetic relief.
- (ii) Healing of Ulcers and Gangrene.
- (iii) Increase of Pulse Amplitude.
- (iv) Rise of surface temperature.

The crux of modern conservative therapy is the encouragement of the formation of collateral circulation to counteract the tendency to gangrene. Normally, collaterals develop side by side with the occlusive process which is comparatively

slow; gangrene implies a failure of the compensatory collaterals to keep pace with the occlusive process.

Not long ago the prognosis was considered gloomy from the beginning and early amputations were performed for minor ulcerative lesion of the toes.

TREATMENT IN PRE-ULCERATIVE AND PRE-GANGRENOUS STAGE: It must be emphasised to the patient that objective improvement is more important than subjective. This is very necessary because the patient is often induced to discontinue treatment from a mere cessation of subjective manifestations. Treatment must be continued till a reserve of collateral circulation is established. The object must be over-treatment rather than under-treatment of the disease. The fundamental factor in the treatment of the disease is rest, especially if there is impending gangrene. A foot that is swollen, puffy and cyanosed, will, after a few days rest in bed, become warmer and pinker and show a wrinkled skin. The leg must be kept horizontal and not dependent. The latter position aggravates the oedema and pain.

WHERE GANGRENE THREATENS: Complete rest in bed with the feet horizontal for at least 15 days or more, varying with the severity of the disease, is essential. Hospitalisation is preferable, so that the patient will not be tempted to break away from the routine.

In the milder cases with numbness, pain and coldness, the patient may continue at work but the other parts of the treatment must go on. However, the patient must abstain from using his legs as much as possible for the 1st few months. When not at work the legs must be kept horizontal. Long walks are to be avoided. As the collaterals fill out, short walks may be indulged in, but walking must be slow, and never carried to the point of fatigue. The object of this mild exercise is to overcome the tendency to muscular atrophy. Complete cessation of smoking is perhaps the most important single factor in the

treatment. Rest pain that has disappeared with treatment may reappear with smoking. In healing gangrenous ulcers the gangrenous process may reappear and spread apace. Persistence in even a few cigarettes a day will utilise any therapy.

Heat must be used with caution because diseased limbs are easily damaged. Hot sitz baths for about 10 minutes with immersion up to the hips and the water comfortably hot, are a useful therapeutic measure.

Contrast baths are dangerous with a seriously compromised circulation and are to be avoided in the presence of ulceration or gangrene.

Diathermy is sometimes useful. It is contraindicated in the presence of ulcers, gangrene and phlebitis. It may however lead to increase warmth of the feet and disappearance of pain on walking. Also there may be improvement in nail growth. Diathermy finds a special field of usefulness where salines cannot be administered due to Cardiac or Renal disease.

Baking. This is a dangerous method of treatment. It precipitates gangrene in devitalised areas and encourages spread of ulcers and gangrene.

Postural Exercises are useful as an adjunct to the other methods of treatment, especially where there is severe rest pain and claudication.

The cycle of elevation, pendency and rest of the limb, is repeated four or five times. The period over which each phase of the cycle must be maintained is determined by the time taken for the appearance of blanching or rubor of the limb. This is done twice a day. The good effects of postural exercise are enhanced by a hot sitz bath following the exercise. The exercises are to be kept up for a long time after the patient is apparently cured.

Contraindications to this treatment are the presence of ulcers and gangrene.

Intermittent Negative Pressure applied to the diseased extremity with machines of the "Pavex" type is dangerous and to be avoided as a routine measure.

Intravenous Saline Therapy was introduced by Koga with the object of decreasing the increased blood viscosity in cases of Thrombo Angiitis, a phenomenon first observed by Mayesima. In the earliest cases marked improvement occurred resulting in healing of ulcers, disappearance of rest pain and demarcation of gangrene.

Silbert in 1926 suggested the employment of 5% Saline now in use. The rationale of the newer method with hypertonic Saline is somewhat different from that originally postulated by Koga. The injection of hypertonic solution into the blood stream is supposed to raise the blood pressure by an osmotic transference of fluids from the tissue spaces, and thus helps in the opening up of the collateral circulation. Repeated injections keep up a repeated stretching of the smaller vessels, and thus opens up a new pathway for the passage of blood towards the periphery. Curiously enough, though the treatment is responsible for a striking improvement in the symptoms and the healing of ulcers and gangrene, there is scarcely any rise in surface temperature.

RESULTS:

1. A subjective feeling of warmth in the affected leg. This is permanent if the treatment is adequate.
2. Improved nail growth, reappearance of lanugo on hairless legs and of sweating.
3. Improvement in walking which is a good index of the success of the treatment.

Contraindications to this method of treatment are cardiac and renal failure especially if associated with oedema. If the myocardium is weak, the weaker solutions may be used first.

In the preparation of the solution double distillation is desirable. Faulty sterilisation may cause chills, fever, nausea and headache.

Thrombosis of injected veins may follow the 5% Saline injections. If that happens the 2 or 3% solutions should be used. If the peripheral veins are impossible to inject or are thrombosed the external Jugular vein must be the last resort. The injection must be slow, else dizziness and a sense of heat in the body follows. Thirst is a common sequel of the injection but any reactions following the injections imply inefficient sterilisation.

The amount to be injected varies, but 300ccs of the 5% solution twice a week is the average for an adult. The duration of the treatment is from 6 to 12 months, depending on the severity of the case and the degree of subjective improvement, but it must be continued for some months after apparent cure in order to build up a collateral reserve. When ulcers or gangrene are present tri-weekly injections are desirable.

Non-specific Protein Therapy is now being given up. There are certain dangers attached to this form of treatment, apart from the very transient effect that it has on the peripheral circulation. There is a very real danger of arterial thrombosis during the chill phase of the reaction following an intravenous injection of T. A. B. vaccine.

Tissue Extracts. Carnacton, a deinsulinised pancreatic extract given intramuscularly or intravenously, is very useful in relieving the pain of claudication. Its mode of action is unknown.

Operative Measures directed towards the Sympathetic System are likely to be of benefit only in those cases with marked vaso-spasm; but these are precisely the early cases which are likely to be profited by the simpler measures outlined above *viz.*, rest, cessation of smoking and intravenous saline, with or without the other accessory methods. The striking results due to this treatment definitely shows that the day when such a drastic operation

as Ganglionectomy undoubtedly is, will be extinct, is not far distant.

If however a Ganglionectomy is contemplated by a surgeon who is not convinced of the value of conservative therapy, it is necessary to estimate the degree of vaso motor release possible by ganglionectomy. The more permanent operative ablation of the sympathetic can be temporarily paralleled by the induction of artificial pyrexia, or in the case of the lower extremity by spinal anaesthesia. In the upper extremity it is possible to perform Ulnar block at the elbow and in both upper and lower limbs a paravertebral sympathetic block may be attempted. The latter is a difficult and a somewhat dangerous procedure.

For the induction of Pyrexia, Brown has recommended 50 million organisms of T. A. B. Vaccine intravenously but it is found that a dose of at least 250 million organisms is necessary to produce a pyrexia of about 102° F. Temperatures of the limb are taken before and after vaso-motor release, and what Brown has termed the *Vaso-motor Index* is estimated. This is $\frac{\text{Skin Rise} - \text{Mouth Rise}}{\text{Mouth Rise}}$. If the

index is 1.5 or more, good results may be expected from sympathectomy. In some cases of pure vaso-spasm as in Reynaud's disease, vaso-motor indices of 3 or more are quite common. Later operators have not been able to convince themselves of the value of the index as a guide to treatment, and they rely more on their clinical estimate of the increase of the blood-flow to the part, shown by an improved colour of the limb and the rise in surface temperature.

It has to be remembered that these are serious operations (Stellate and Lumbar Ganglionectomy) carrying a high mortality. Many of the patients afflicted with Thrombo-Angiitis Obliterans are sufferers from coronary disease, especially those between 40 and 55 years, and the presence of this complication contraindicates operation. If any good is to result from ganglionectomies, the operations must be done at an early stage of the disease

while the vaso-spastic element is predominant and the vaso-motor index is high.

The great value of ganglionectomies is supposed to be as a prophylactic against amputations, certainly the high amputations, that were once the fashion. Jefferson's statistics have already been quoted above.

If *Periarterial Sympathectomy* has not been given any importance at all it is because it has no place in the treatment of Thrombo-Angiitis Obliterans. The operation is theoretically unsound, as the sympathetic supply of the peripheral vessels travels via the peripheral nerves and such effects of vaso-dilatation as it has, is only temporary. It has been used empirically however for the relief of pain in Senile and Diabetic Gangrene. How the pain relief is brought about has not been adequately explained.

Results to be expected from Ganglionectomy.

1. The claudication does not disappear at once, but does so gradually, in a few cases this symptom persists. Sometimes a relapse of the superficial phlebitis may occur showing that the operation has no specific effect on the disease.
2. The single great purpose served by the operation is to act as a prophylactic against subsequent amputation. It affords a degree of protection to the limb against gangrene during the frequent relapses, from the presence of a high circulatory efficiency when an efficient circulation is most necessary.

Ganglionectomy is valueless in the relief of pain due to ulcers or gangrene.

It must not be concluded from the above account of the merits of ganglionectomy that I am convinced of its necessity in the early cases of Thrombo-Angiitis Obliterans with marked vaso-spasm and a high vaso-motor index.

In the early cases the milder conservative measures mentioned above have just as much effect on the disease as the more serious operations, and in the later cases

with occlusion, ganglionectomy is valueless. If a detailed account of the operative measures adopted in the disease has been given it is so that this article may not appear to be lop-sided or unduly biased.

TREATMENT OF GANGRENE AND ULCERATION.

These are largely preventable by adequate treatment.

Prophylactic: The avoidance of trauma, either accidental or operative is of supreme importance, the latter especially from a mistaken diagnosis of "Ingrowing Toe nail".

Careful attention of feet and hands is essential, to avoid and treat epidermophytosis and fissures. These affections are rare in India where most people go about bare-footed. More important with a bare-footed people is the protection of the feet with a foot wear.

Impending Gangrene: The most important aspect of treatment is resting the feet horizontally. Hot Sitz baths and postural exercises may be tried, but baking must be avoided for fear of precipitating gangrene.

Intensive intravenous Saline treatment must be kept up with bi-weekly injections. The important thing is patience, both on the part of the surgeon and the patient, and this attitude is rewarded in 4 or 5 weeks. The pain diminishes and the patient sleeps better. The surgeon must never be tempted to amputate.

Gangrene may supervene however despite all these precautions. The inception of gangrene is always associated with agonising pain. The general treatment still continues—rest, abstention from tobacco and intravenous saline.

Locally. The maintenance of asepsis is essential. If the infection is severe the case must be treated as an infected wound.

The old distinction between dry and moist gangrenes is factitious at least so far as local treatment is concerned.

The main point is whether infection is present or not.

In the presence of suppuration, either Carrel-Dakinisation of the involved area or immersion of the limb in a Eusol Foot-bath is useful. Alternatively, the part may be irrigated with a 0.5% solution of Chloramine once or twice a day. The main purpose is to clean the wound and wash away the irritating secretions. Later when infection is under control moist dressings of 4% Boric acid solution may be used. As these dressings sometimes cause pain by becoming dry and adherent, it is necessary to keep them moist.

For the severe pain which occurs before the delimitation of the gangrene and which so often lures the conservative surgeon to amputation, anaesthetic ointments, such as 1% Percaine ointment are often useful. They must be used liberally and the surgeon must not be tempted to perform a hasty Neurectomy or amputation. Opiates may be used sparingly. The pain only occurs during the acute spreading phase which lasts a few weeks, and if the surgeon bides his time and does not lose his head, the patient is safely tided over this distressing period. Peripheral Neurectomy is particularly a dangerous measure in cases of Thrombo-Angiitis Obliterans. The consequent anaesthesia may lead to unnoticed injuries to the feet with a circulation already grossly compromised, and thus be the starting point of a spreading gangrene.

As demarcation of gangrene occurs, there is a striking change in the general condition of the patient. He sleeps better and looks less emaciated.

During the healing stage one must resist the temptation to hasten healing by cutting away toes, tendons or sloughs. Amputation of toes is dangerous as the operative wound may not heal and the operation may determine spread of the gangrene. Rest is essential to the very end.

With the upper extremity, the results are much better with conservative treatment, from the presence of a richer blood supply, and therefore amputation should never be called for.

In cases of gross secondary infection of the gangrenous and ulcerated areas, a rare event, the usual conservative line of treatment must be followed. Copious moist dressings should be used locally. Abscesses are to be treated as they arise. One must studiously resist the temptation to amputate as the infection spreads very rapidly to the inguinal glands, and it is virtually impossible to head off the infection by an amputation however

high. Besides, an operation through infected lymphatics and tissues often hastens bacterial absorption and turns the scales against the patient.

CONCLUSION: I have attempted to make a case for the conservative Saline treatment of Thrombo-Angiitis Obliterans in both the pregangrenous and the gangrenous phases. It would seem that the drastic surgical procedure of ganglionectomy will, with increasing knowledge and experience, have fewer and fewer indications for its performance, the operation being reserved for those early cases with pronounced vaso-spasm that do not respond to Saline Therapy.

THE ROLE OF CALCIUM IN MIDWIFERY.

BY DR. S. PATRAO, BSC, M.D., M.S.,

Bombay.

The part played by Calcium in Midwifery has been recently stressed very much. In Calcium we have a valuable aid in the prevention and treatment of some of the major disturbances of pregnancy and of a good many of the minor discomforts which a pregnant woman is subject to. As a prelude to the study of the variations of calcium metabolism in pregnancy it is essential to have a cursory idea of calcium metabolism in a normal person.

Calcium is intimately associated with Phosphorous and Vitamin D. The principle sources of calcium are foodstuffs which are rich in it—namely Milk, Cheese, Eggs and Green Vegetables. It is absorbed mostly as CaCl_2 ; the absorption from the stomach and intestines being controlled and helped by Vitamin D. The latter is also principally responsible for its fixation and storage in the bones. The amount needed in the diet is 4 to 1 gramme daily for an adult. A portion of calcium ingested in the food is converted into insoluble carbonates by the digestive juices and excreted unabsorbed. Cal-

cium salts taken by mouth are absorbed with difficulty.

From the bone storage, calcium is drawn into the blood according to the necessity of the organism by the solvent action of the Parathyroid hormone and also to some extent by the Thyroid. Excess of these hormones causes a rise in the calcium-phosphorous content of the blood and greater excretion of these in the urine and ultimately to rarefaction and cystic degeneration of the bones.

The normal serum calcium is 9 to 11 mgm. per 100 c. c. The amount of ionised calcium in the blood varies with the P: H of the blood. Greater the alkalinity the less the active calcium in the blood. Hence, excess of alkalis given by mouth leads to a variety of Tetany.

Calcium is excreted by two routes. Unabsorbed calcium "Exogenous" from the diet is got rid off in the stools, 0.4 grammes daily. From the blood—"Endogenous" by the kidneys 0.5 gram-

mes daily. Excretion by urine varies directly with the quantity in the blood.

Some functions of Calcium: It takes, part in the:

- (1) Formation of bones and teeth.
- (2) In the coagulation of Blood.
- (3) It controls the irritability of the muscle and nerve cells. It is a tonic to these cells, diminishing their irritability.
- (4) It helps the cells of the liver and kidney in their detoxicating effects.
- (5) It protects the cells of the liver and kidney from the destructive action of these toxins.

Hypocalcemia leads to increased irritability of nerve cells and muscle—Spasmophilia. This may be accounted for by 3 factors.

- (1) Diminished intake of calcium in the food.
- (2) Defective absorption from the alimentary canal due to lack of Vitamin D.
- (3) By defective circulation of calcium, due to lack of Parathyroid Hormone—or due to the combination of all or any of the above three causes.

Metabolism in Pregnancy: The foetus requires large amounts of calcium for its growth of bones and draws it from the mother. There is a higher concentration of calcium in the foetal than in the maternal blood. The blood calcium is 9.8 m. grammes and is slightly lower at term. The most marked demand on the maternal calcium is during 4–7 weeks before delivery. Recovery soon takes place. The lactating mother shows a higher percentage in the blood 10–11.5 m. grammes, which if not adequately replenished from food is drawn from the bones; which become porous. The teeth have a tendency to become carious. To prevent this drain 1.6 gm. of

calcium is daily necessary. (A pint of Mother's Milk contains 1.3 gm. of calcium. mother loses this amount per day.)

Metabolism of Foetus: Mallanby finds that 25 gms. of calcium and 15 to 16 gms. of Phosphorous are retained by the foetus and drained from the mother between 28th and 40th week. The average new born infant contains 30 gms. of calcium and 19 gms. of Phosphorous. This shows the demand in the mother.

Clinical manifestations of Calcium deficiency in Pregnancy: A great variety of minor and major disturbances occur more or less due to direct disturbance of calcium metabolism. The disturbance varies with the foetal demand and maternal supply.

The manifestations are, carries of the teeth—the old saying "A tooth for every child is only too true"; brittle nails, badly nourished hair and skin affections like Pruritus and Urticaria. Repeated pregnancies cause rapid depletion of calcium, causing flabbiness of the abdominal and back muscles, uterine inertia and tendency to haemorrhages. One of the most troublesome train of symptoms is cramps in the muscles, especially of the thighs and back. These cramps were formerly ascribed to pressure of the foetal head on the pelvic nerves and to the weight of the enlarging abdomen, causing a mechanical strain on the muscles of the back. The backache and cramps are definitely due to loss of tone and can be effectively controlled by exhibition of calcium. Similarly, vague osteocopic and arthritic pains of a flying nature, mistaken formerly as rheumatic in origin, are really due to depletion of calcium from the bones. Osteomalacia now has been quite definitely put down for calcium deficiency and Avitaminosis. Irregular uterine contractions and violent foetal movements are also due to calcium deficiency. Calcium is one of the chief substances which is deficient in the diet of patients who develop toxemias. Lastly, there is a great tendency to premature births in women, who manifest calcium depletion. Considerable stress

has been laid on calcium in the treatment of toxemias. Theobald gives intramuscular injections at frequent intervals of 10 c.c. of calcium gluconate 10% for pernicious vomiting. The detoxicating power of the liver is reduced in pre-eclampsia and eclampsia. Considerable improvement may follow in the exhibition of calcium. The explanation is that calcium protects the cells of the liver and the kidney from the degenerative action of the toxins. At the same time by increasing the tone of the nerve cells of the brain prevent the onset of convulsions.

The natural sources of calcium are articles of diet such as milk, cream, cheese, eggs and fresh green vegetables.

In the absence of these, calcium can be supplemented by certain commercial proprietary preparations. A popular one is calcium gluconate 10 to 20 grs. T. D. S. by mouth. It is easily soluble but large doses are required, as the calcium element forms only 9% of it. Parke Davis' Dical Phos is also soluble and causes no gastric irritations and has in addition the Phosphorous element in it. One of the best combination is Condossan Bikha, which contains Calcium-Phosphorous and Vitamin A & D in very happy combination. Three tablets T. D. S. forms an adequate dose. When calcium is to be given by injection, Calcium Gluconate (Sandoz) or Wasserman calcium serve the purpose well.

SCORPION STING.

By DR. A. LAKSHMINARASAYYA L.M.P.

Medical Officer, Municipal Dispensary, Proddatur.

Scorpions belong to the order of the Scorpionida. They are very common in hot countries. The scorpion has a body which is broad and segmented. It has a long and flexible tail, which is also segmented. The segments become smaller and smaller as the tail end is reached. It has a strong spine with a swollen base in which are situated a pair of poisonous glands, with ducts opening terminally. It has a pair of claw like legs used more as feelers at its front. It has 4 pairs of legs useful for its crawling. It has a very small mouth situated deeply between the claws or Pedilaps. The abdomen is composed of 2 parts, the anterior consisting of 7 segments bearing the breathing slits. The posterior portion consists of five segments. They are viviparous and nocturnal in habits.

The scorpions are grouped in seven families and each family is again subdivided into a number of species. The most common variety found in the black cotton soil area as in Proddatur

Cuddapah District, is the black variety, which undoubtedly is very poisonous.

The scorpion naturally lives in dark and dirty corners of the houses. It selects holes in the floor or in the walls, of the houses. During day time they remain in the holes and come out in the evening or in night. This is especially the case in summer, when the whole earth is heated during the day and its surface cools more rapidly than the interior, in the early part of the night. Then it comes out of its abode to cool and airiate itself. Certain Districts where the soil is red or sandy, instances of scorpion stings are known only in summer nights; but in the black cotton soil and saline soil where the earth is more easily and quickly heated and has more numerous cracks, instances of scorpion stings occur both during day and night. Even on chill and rainy days, I am having cases of scorpion stings in Proddatur.

From the death register of the Proddatur Municipality, it could be gathered

that the scorpion stings are sometimes fatal and that scorpions are active throughout the year.

They also abound in fields both in towns and villages. There are certain plants, whose roots are natural abodes of the scorpion. They are frequently found on the creepers of the Kasari plant, which bears very bitter fruits. They are also found at the roots of the Touch-me-not plant. The scorpions found in fields are more poisonous and bigger in size than those found in residential quarters. Almost all the domestic animals are affected by the scorpion sting except the cat. The hen is its deadly enemy. It pricks it with its beak. The lizard eats the scorpion. Certain centipedes such as Thati Jarri or Kalla Jarri eat the scorpion. I have one day killed a centipede which was holding a scorpion in its mouth. It seems the snake is terribly afraid of the scorpion. One pensioned head constable, who is aged 80 told me that he actually saw a big snake being chased by a scorpion and after all the scorpion overtook and stung the snake which met with instantaneous death. Every one of us must have witnessed at one time or other a dog suffering from scorpion sting.

A certain position is necessary for the scorpion to sting. The part of the body must be slightly in front and above its sting. It must have space to withdraw a little and strike its sting. Sudden and firm pressure from above on a scorpion will not enable it to deliver its sting. It will be crushed undefended. A scorpion may fall on a body of a person and crawl all over but still may not sting for want of appropriate position. There are several people, who catch the sting from behind and play with it, holding it in that position. A scorpion crawls more quickly after stinging. There is a common notion that it loses its dullness due to the excretion of the poison.

The nature of the scorpion poison is said to be similar to that of a snake. The poison gets absorbed from the part of the body stung and is arrested in mild cases in lymphatic glands draining that area.

I think the poison gets absorbed through the lymphatics only. Thus a sting anywhere in the lower extremity is arrested in the femoral glands in the upper extremity in the axillary glands, in face and scalp in cervical glands and so on. It is only in severe cases that the poison gets generalized and they show toxic symptoms.

SIGNS AND SYMPTOMS: Generally scorpion sting is received unaware. Immediately the man feels as though he has tread on some fire or burning piece of iron, he jumps and looks behind.

If, fortunately there is light, he sees a scorpion which will be running very quickly. The burning sensation slowly radiates towards lymphatic glands which drain the area. He feels a sensation as if the limb is slit and the pain vibrates throughout the limb from the point stung to the nearest group of lymphatic glands. Locally there may not be seen anything. In some cases some sweating may be seen there. In others who are fair, a black or red point may be seen. The patient himself will not be able to localize the sting. After some time the pain is localized about the area of the sting and catching pain may be felt at the lymphatic area. These will continue for 24 hours. In mild cases, these are all the symptoms. Of course, the severity of pain varies with the size and nature of scorpion and the resistance and endurance of the patient.

SEVERE TYPES: In severe types, the poison instead of stopping with the nearest group of lymphatic glands become generalized. The patient feels tingling sensation all over the body. The head gets heavy and dull. The tingling is more marked in the tongue. There may be vomiting of glairy mucus sometimes even blood. Vomiting relieves the general symptoms but the pain persists as in the mild variety.

BAD CASES: The symptoms come in the above order, and there is vomiting and sweating all over the body. The patient complains of pain in the cardiac region. The sweating is so profuse

that it not only drenches the garments but runs out in a stream if he is on the ground or dribbles like raindrops if he is on a cot. The patient is very dull. The pulse is very weak. In these severe cases local symptoms such as pain at the site of the sting and above the limb are completely absent. Slowly respiratory embarrassment sets in. The lungs show signs of oedema. The face gets cyanosed and in spite of the best attempts to save the patient he succumbs.

In some cases the patient comes round but within an hour the sweating stops and he continues in that weak state for 24 hours. In others the sweating goes on intermittently. First he gets pain which gets generalized. He sweats profusely. Tingling and numbness of the whole body especially the tongue are felt and then he becomes unconscious. He recovers consciousness by the administration of stimulants and again complains of the local pain and is free from the general symptoms for about half an hour. The pain starts again as if he had a fresh sting. It extends up the limb and gets generalized and again the tingling, sweating, unconsciousness return. Again recovers with treatment. In this way I have seen patients suffering for 72 hours.

There is one peculiarity with these stings. On account of the sweating the patient naturally feels thirsty but if water is given the symptoms such as tingling and sweating will be increased and the respiratory and circulatory embarrassment may set in. In mild cases also if water is given within half an hour after the sting all the symptoms may return and repeat.

There are some cases where the pain instead of stopping at the lymphatic area gets into the pelvic region if the sting were on the leg. The pain radiates round the pelvis. There is a tendency to pass urine; but actually the urine does not flow. There may be at times haematuria. The pain increases and he feels as if he were suffering from Chordee. He screams with agony and

tosses in the bed. These symptoms subside within 12 hours. Some years ago I had to treat a boy aged six, son of one a Police Officer who lived near my house. The boy had been stung at about 7 p.m. I was called in about 15 minutes after the sting. I found the boy tossing in the bed with his back arched, his penis stiff, and he himself holding it with his two hands and crying out. When I enquired he told me that he wanted to pass urine; but could not. I tried an injection of cocaine 5% locally with no effect. I put him in a tub of hot water with the hope of relieving the spasm but with disappointment. As a last resource I injected 1/6 grain of morphine tartarate and 1/300 gr. of atrophine solution. The boy got quieter but all the same the penis continued stiff and he passed small quantities of urine after some hours.

In some cases of severe type there will be local oedema which is painful and persists for 3 or 4 days after all other symptoms have subsided.

TREATMENT: The indications for treatment in scorpion sting, like any other poisonous stings or bites are.—

(1) To ligature the limb tightly just proximal to the affected part.

(2) To encourage bleeding by incision at the site of the sting.

(3) To rub into the wound some oxidising agent like potassium permanganate which will counteract the poison. This treatment, though simple has many drawbacks, *viz.*,

(a) The site of the sting is not always a convenient spot to allow ligature. It may be on the face or trunk where the ligature is out of question.

(b) Even in cases where the part could be ligatured, the patient has rarely the presence of mind to tie a ligature tight enough, immediately.

(4) As the poison is absorbed through lymphatics, a uniform pressure seems to be necessary which the patient may not be able to apply.

(5) In majority of cases the physician is helpless because, the patient comes to him 15 to 20 minutes after the sting without having made any attempt at ligaturing.

For the above reasons this treatment is not always practicable though ideal. The next best is to apply reflex stimulation or irritation.

In this method an irritant is applied into the ear or the eye of the opposite side of the sting. It brings down the pain from the lymphatic area to the site of the sting. After I read somewhere the advice of Mahatma Gandhi of pouring a saturated solution of common salt into opposite ear, I did it in several of my cases and found it useful in 60 to 70% of mild cases. A clean saturated solution may also be dropped into the opposite eye. It gives more speedy relief. This sort of counter-irritation relieves the pain in the lymphatics and brings it to the site of the bite.

For some years past I have been using Linimentum Camphor Ammoniata for inhalation. The pain is usually relieved in mild cases. Even in severe cases where the poison gets generalized and the patient develops, tingling of the tongue and dullness of the head, this inhalation has some good effect. But in nervous people and in those who do not inhale properly it may fail. It is an ideal medicine for general use in all varieties of scorpion stings, where the poison has not been arrested locally. Because it stimulates the circulation and respiration and improves pulse, removes drowsiness and brings down the pain to the site of the sting.

After the pain has come down by one of the above measures, I usually inject a few drops of cocaine 2% solution at the site of the sting. This relieves the pain like magic but the relief is not long lasting. The pain returns 15 or 30 minutes in several cases and the patient again worries for a second injection, which is not as effective as the first. It increases the tendency for sweating on account of its toxic action upon the heart. Old people bear it badly. Further it is

useless unless it is given exactly at the site of the sting, which is not practicable in children, who cannot point out the place. In strong and robust persons where there is no tendency for bad symptoms this is a very effective remedy for the time being at least. In case of children who cannot point out to the site, I used to apply Tr. Opii. on the site. It acts as a local anodyne and is quite safe. It, at times, gives relief. I used for some time the spray of Ethyl Chloride, but it is not effective as cocaine and it is costly enough; but it has no bad action upon the heart.

Some years ago, I read an article in Bharathi a Telugu monthly journal on scorpion stings. The author describes three treatments:

1. To kill the scorpion and rub it at the site of the sting.
2. To preserve the dead scorpion in kerosene oil and rub that oil on the site of the sting.
3. To make a compound of black Dathura and a scorpion and rub over the site of sting.

I have not tried the third. The first I have tried in a few cases and I cannot say it is useless. The second I have tried in number of cases, and the results are not more encouraging than other treatments. Moreover the solution emits a very bad odour and it is very difficult to withstand it.

Lastly the most popular remedy of applying the crushed onions has its own advocates.

In severe cases none of the above treatments are useful. The poison gets generalized and the patient gets sweating, dullness etc. There are only two indications at this stage. (1) to neutralize the poison and (2) to treat the symptoms as they rise.

To neutralize the poison in these cases, the most useful remedy is anti-scorpion

serum. In all cases where I used the serum there was no death. But all the same the severity of the symptoms continued. Further it is very costly for routine use. Each tube costs about Rs. 3 nett.

The prominent symptom is sweating. I have injected 1/100 gr. of atropin sulph, 1/16 gr. of strychnin, 1/100 of digitalin hypodermically. This never fails to relieve the symptoms for some time. I have also used camphor in oil with good results. Where the blood-pressure is low and the patient is cynosed, and is shivering, I used to inject adrenalin 1/1000 solution about $\frac{1}{2}$ to 1 c.c. with benefit. The patient is put on stimulant mixture with Tr. Digitalis 10 minutes a dose every 2 hours till the sweating subsides.

When the patient complains lot of pain in pelvic region, and there is not much sweating, and pulse good, I inject Morphine and Atropin, which will relieve him promptly.

DIET: I usually restrict the diet of patient to nothing, for three hours in mild cases. In severe cases I never allow anything by mouth for 24 hours except stimulant mixture. Then if the symptoms subside, and the pulse improves, I allow him to have a cup of strong coffee with very little milk. If the symptoms do not recur, I allow him everything. A hot bath at this stage is comfortable. As already pointed out the regulation of diet, is very useful in severe cases, to avoid the repetition of symptoms.

For the inflammatory swelling at the site of the sting which may persist, Pigmentum Bellodonna for a day will completely relieve. In severe cases where there is sweating, it should not be allowed to dry on the patient as it takes away the latent heat from the body. It should be wiped with a towel and the patient covered, and hot-water bottle applied. The popular method of applying powdered horsegram mixed with camphor may also do some good.

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The XIVth All-India Medical Conference.

MADRAS, DEC. 26.

The Fourteenth All-India Medical Conference commenced its sittings to-day at a special pandal erected in the Medical College grounds with Dr. Bidhan Chandra Roy of Calcutta, in the chair. A large number of medical men from different parts of India were present. The Hon. Mr. Nausher Ali, Minister of Public Health, Bengal, was among the distinguished guests seated on the dais. The Hon. Dr. T. S. S. Rajan declared the Conference open, after a prayer.

DR. RAJAN'S SPEECH.

I consider it a privilege conferred on me by the All-India Medical Conference in having asked me to take part in their sitting which is held to day in this City. This is perhaps the first time that an All-India Conference of medical men is being held here. There have been in the past a number of Conferences of medical men, but they have all been under different denominations, restricted in their scope. I believe the All-India Medical Association keeps an open door and every one of the qualified allopathic medical practitioners is entitled to be a member of the Association. In that way it may be considered to be a truly representative Conference of the whole profession.

Although it is fourteen years since the inception of this Association, its activities have not been brought before the public eye except during the last four or five years. Personally speaking, my attention was particularly drawn to the existence of this Association and also to the imperative necessity of all Indians taking a due share in the activities of this body by the late lamented Col. Bolanath. I might say that he spent the last two years of his life as an ambassador of this Association, travelling to every nook and corner of the Province, trying to canvas as many medical men as possible to become members of the Association. It is a great tragedy

that such a valuable service as the one he rendered was denied to us by his passing away suddenly from our midst. He was a seasoned soldier, having had an unblemished record of service to the State and to the country during his long association as a doctor and as an administrator. I am sure that those of you assembled here will be one with me in recording the great services he has rendered for the Association.

PROVINCIAL MINISTRY'S AIM.

I am glad you are meeting here at the headquarters of a province which is now under the Congress Ministry under the new scheme of Provincial Autonomy inaugurated by the Government of India Act, 1935. Of all the Provinces in India, it has been given to us in this Province to show the great strength of public opinion on behalf of the Indian National Congress and to-day we possess a clear majority in both the Houses of the Legislature of this Province. The Medical administration has naturally passed into the hands of this Ministry; and it is needless for me to tell you at this stage that responsibilities which the Ministry has undertaken is no small task. I shall not recount to you here the inherent incompleteness of the organisation of medical services which are placed at the disposal of the Ministry here to-day. But whatever may be the limits of the Government of India Act, we have made our minds clear with regard to the utilization of all available sources of power that are at our disposal for the service of the public of the province, particularly to those that stand in need of help and service. It is in that spirit we have taken ourselves to this task and time alone shall decide as to how far we have been able to discharge this self-imposed duty. But I may say this, that there has been a universal welcome from the medical profession in this province for the Ministry, and this fact has made us more than ever conscious of those things that are expected of us. I hope and trust that we would have deserved well of the profession when we lay down our office.

It is true that the association of a medical man in the Cabinet in charge of the Public Health portfolio is an innovation that was started first in our province. Whether the association of a medical man in the Cabinet is an unmixed blessing is debatable. There are those that hold the view that medical men have certain convictions of their own and some petty aversions which they are likely to perpetuate from their seats of power; whereas a lay man, who is free from preconceived convictions and opinions is perhaps in a position to deal justly and fairly with facts presented before him. Well, this charge against medical men may, to a certain extent, be held, but I am sure you would agree with me when I say that the medical man in charge of this portfolio is certainly in a better informed position with regard to the administration and is certainly more advantageously placed with regard to medical and sanitary schemes that may come up for consideration before the Government, not only on his behalf but also as an adviser to the Cabinet of which he is a member. It is therefore the reason that the public in general and particularly so the medical men have welcomed this association of a medical man with the Cabinet.

It is my earnest desire, as the late Col. Bolanath has put it so very often, that this Association should be a representative body of all medical men in this country. It must secure a place and position equal to that of the British Medical Association in the United Kingdom. I am afraid that the membership of the Association is still not proportionate to the large body of the medical men in this country. To make it a really representative body must be the endeavour of the Association and to enrol all possible qualified medical men in its register. Time and money spent in that direction will certainly be a very good investment. I would suggest that a full time officer be appointed for each province so that in the course of the next year it might be possible to rope in almost all available medical men into the register of this Association and when we meet next year, it may be said that "you are really the

the Indian Medical Association." While saying this, I am not unaware of the fact that there are a number of medical organisations, each having its own independent existence. There is the All-India Medical Licentiates Association which is indeed a very powerful body and of greater antiquity than this Association and which has been rendering yeoman service for that particular class of medical men. There is the Provincial Medical Association which consists mostly of University Graduates, both in service and outside. There are then again branches of the British Medical Association in India comprising of men of Indian qualifications as well as of Britishers who are doing work in India in various capacities.

LICENTIATES.

With regard to the Licentiates Medical Association as far as this province is concerned, the Government have decided on the abolition of the L. M. P. Course and when it becomes a *fait accompli* as I expect it will soon be, you will find that this Association may not increase in numbers; on the contrary, their membership will come to a standstill and in the course of time will gradually dwindle. That the Association has got an obligation to all its constituent members cannot be denied. They seem to feel an inherent inferiority complex in all their acts, and it is but just that this Association should make special endeavours to make them feel equal as comrades and that there shall be no differentiation in the membership of the All-India Medical Association on the score of qualifications. I am also aware of the fact that this Association has made no such distinction, particularly in view of the fact that they did not hesitate to meet under the presidency of a Licentiate in the person of the Hon'ble Dr. U. Rama Rao while it held its session at Nagpur last year.

It is very regrettable that the United Provinces Medical Licentiates Association should have felt constrained to carry on a campaign against this Association. Whatever may be the justice or otherwise of

the charges laid by them against this body, I cannot certainly congratulate them on the destructive separatist activity which they have advocated.

With regard to the Provincial Medical Association, which comprises mostly of service men who are University Graduates, I would like them to merge themselves in the All-India body while they are at liberty to maintain their separate provincial existence. The British Medical Association, whatever may be its tradition and its services to the profession both in the United Kingdom and in India during the past, must now give room to the Indian Medical Association and should add strength to us by ceasing separatist activities in this country. I would like every Britisher, while he is in this country, to consider himself an Indian and feel and act as one who is a native of this land. It is only in that way that they could continue to be faithful comrades and workers in the cause of human service rendered through the medical profession. I would like to see the Indian Medical Association to be as powerful, influential and strong as the British Medical Association is to-day in the United Kingdom. It should become the premier body which will have a deciding voice in the medical administration and the diffusion of medical knowledge in the country. It should be in a position to speak on behalf of the entire country in its international relationship, and this claim is certainly not beyond the scope of the possibilities of an Association of this sort.

TASK BEFORE THE MEDICAL ASSOCIATION.

Besides being a protector of the claims of Indians both in and outside the Services, this body should, like the British Medical Association, develop a robust existence by its contribution to the science of medicine. In this world of to-day, no country or civilisation could ever hope to exist unless it has a part to play in contributing to the general knowledge and general welfare of humanity. India is a peculiar country, peculiar in its traditions and peculiar in its wealth, peculiar in its climate, and

peculiar also in the way in which she has solved problems in the past. That we have made some contribution in the past is not an asset on which we could continue to draw for long. We have got to contribute to the knowledge of the world from the peculiar conditions and circumstances in which we have lived and evolved all these years. We should make living contributions in the field of practical medicine, a subject which will be entirely our own and to which we should contribute to an extent which other nations may not be able to do. I presume that the activities of this Association shall be so co-ordinated and made fruitful not only for us in this country but also to others outside ours so that it shall be given to us to give to others to the same extent that they are giving to us. We shall not be beggars for all time with our bowl extended beyond our territories so that other nations might drop what they desire. It must be open to us also to give them and share with them what we have got to give. It is only then we should have deserved well of our existence and also be worthy recipients of a great heritage.

PREVENTION OF DISEASE.

You are all medical men of great learning and reputation. I shall not digress into those fields of academic knowledge which many of you possess in a much greater degree than I claim to know and I shall not venture to tell you as to what you should or should not do. But I would just like to remind you of one fact which all of you know—that disease is really the outcome of deviations, ignorant or wilful, from laws of nature and when we could restore our life to natural conditions, probably there will be no need for us to exist. But it is an impossible Utopia with which we are not concerned at present. Disease has come into our midst, partly through our ignorance and partly through our neglect and partly through conditions over which we have no control. We have developed medical men not so much to prolong life which we cannot do, but only to give relief from pain. The function of medicine, pure and simple, does not extend beyond the relief of pain and

suffering. But the prevention of disease is a nobler aim, and service rendered in that direction is certainly more lasting than the spasmodic or organised efforts at relief of pain. Therefore, curative and preventive medicine have got to work hand in hand, and the two may not be bifurcated to an extent where one ceases to be operative on the other. Modern tendency has been to isolate the practitioner or the healer of diseases into a groove as if his function terminates with curing ailments. I hold the view that the medical man is pre-eminently a worker in the preventive field, and his medical service will be worthy of public recognition only to the extent that he is able to battle with the preventable epidemics which afflict our population. It is my belief that sanitation and medical relief should ordinarily go hand in hand and should become part and parcel of the whole system of medical service in this country. A medical man tackling disease, should also see and render help in preventing large epidemics by working as a sanitary officer. We have to-day in our province a large army of subsidised rural medical practitioners, over 500 in number, who are carrying help to all out-of-the-way villages. If these could be made also sanitary officers in the particular locality and their service utilised for dealing with epidemics and also for looking after water-supply, village sanitation, vaccination, inoculation, etc., they would indeed be a useful army of men to the ultimate advantage of the village population.

INDIAN SYSTEMS OF MEDICINE.

We have in our country to-day various systems of medical treatment. The allopathic practitioner has indeed established his sway in the field of anatomy, surgery and midwifery. With regard to pathology, symptomatology and diagnosis of diseases, the Ayurvedic system still claims a different outlook and its therapeutics also differs from the one which we are used to. In our Government Indian Medical School, we have recognised this conflict, but we have in a way attempted to arrive at the fair synthesis of the two

systems. How far this synthesis will be an advantage and whether it could become a national evolution of a medical system peculiar to our country is very difficult to envisage, but signs are not wanting that such a possibility may evolve as a result of a sympathetic understanding and willing co-operation. Besides the Ayurvedic system, there is the Unani and the Siddha systems of therapeutics which, like many castes in our country, claim a right to exist and often through conflict they manage to have a rather attenuated development. Personally, I hold the view that it is certainly possible to evolve a synthesis of these systems, having a basic test; and that, in the end is the amount of relief and comfort that is given; that perhaps is the only test by which each system and the synthesis of all may be found to be advantageous. Whatever may be the system of treatment or method adopted by practitioners, it is high time that we sought measures to protect the public against the vagaries of the quack and the untrained man. Penal provisions against such people will only be possible when the existing systems are properly standardised and all practitioners are brought into a register in which a successful practitioner, apart from his qualifications may find a place. This was the origin of medical registration in other countries and so we have to-day in this province an Ayurvedic Practitioners' Register, wherein we are trying to bring in all practitioners of all systems who have been doing professional work for some years. When all possible people can be so registered, we would have a complete list of men who are authorised either by diploma, or heredity to practise the profession and who have in a way established their credentials and then perhaps it will be possible to make laws preventing quacks from practising medicine.

FAVOURABLE AUSPICES FOR CONFERENCE.

I am glad you are meeting at a time of the year when perhaps Madras climate is at its best. You are having in the Chairman of our Reception Committee, Lt.-Col. Pandalai, an esteemed member of the

profession who is an ornament to our province particularly in the field of surgery. You are certainly lucky in getting this illustrious patriot of eminent position in the person of your President-elect of the Conference, Dr. B. C. Roy. I am also happy to see that the Surgeon General of our Province, Major-General Wilson, who is a very keen and sympathetic officer and who is trying to do his best for the profession has also been associated with one of the functions of your Conference. Under such auspices and under such able leadership, I am sure your Conference will not only discuss scientific matters which will be of great advantage to the profession, but will also resolve upon finding out the ways and means to develop the strength of the Association so that it might take its rightful place in our country to-day. I am sure you shall also frame such resolutions by the adoption of which it will enable popular Governments to function in a proper spirit of useful service to the people.

I am thankful to you for having asked me to open this Conference, which I do so with very great pleasure. Perhaps this is also the first time that a Minister of the Government has been called upon to perform this pleasant task. It is a sign of the times that there should be a complete identification of the Government with the people in all walks of life and perhaps more so in the field in which it has been given to you and to me to share and shoulder the great burden of fighting disease to which human flesh is heir to. I have very great pleasure in declaring this Fourteenth All-India Medical Conference open.

LT.-COL. PANDALAI'S WELCOME ADDRESS.

Lt.-Col. K. G. Pandalai I. M. S., Chairman of the Reception Committee then delivered his welcome address. He said:

On behalf of the Reception Committee of the XIV All-India Medical Conference I have great pleasure in welcoming you to this ancient city. The Medical public may be aware that this is the first time

that this Conference is held in Madras and many may wonder why we did not extend an invitation to the Conference to our city earlier. It is not the case that neither ourselves in Madras nor the authorities of the Indian Medical Association had thought of holding the Conference in the Southern Presidency: but on account of the circumstances prevailing at the time chiefly our diffidence and doubts about its success if the Conference was invited here in view of the existence of a number of sectional organisations with divergent view points, we hesitated to suggest such an idea before. We feared that the official section of the profession might not be with us as the Indian Medical Association was known to hold views which were critical of the ways of Government, and the independent medical profession did not feel strong enough to command the allegiance of a majority in their own ranks. A reaction was already beginning to be noticeable when about three years ago, the late Colonel Bholanath of the I.M.S., in his advanced age and at his own expense, came on a tour to South India to deliver the message of the Indian Medical Association to the medical men of these parts. Many of us who heard his eloquent speeches were convinced at once of the pressing need for a common organisation which would bring together the diverse elements in the profession in this Presidency. Very soon and directly as a result of his mission, branches of the Indian Medical Association were opened in this city as well as in the districts, but the roll of its membership remained small and its influence and usefulness were not in proportion to its position as an All-India Organisation. It was at this juncture that my esteemed friend and a former President of the Indian Medical Association, Dr. U. Rama Rao, made bold to invite the Conference to this city. His courage and foresight were great, for he saw that an Indian Medical Association in which the Southern Presidency did not have its due share could never exercise its full influence in the affairs of the country as a whole. We have thus to thank Dr. U. Rama Rao for the good fortune of holding this meeting in Madras.

CHANGE IN POLITICAL ATMOSPHERE.

This first meeting of the Conference in Madras takes place under peculiarly happy circumstances. It is the first Conference held in India after the Congress has assumed charge of Government in a majority of the Provinces. It is common knowledge that for many years, Indian Medical Conferences have been passing resolutions on various grievances of the profession without result; for, what the medical men of India have been asking for, have been generally the very things which Government did not wish to give. It was obvious to all, therefore, that our medical grievances could not be redressed without a change in our political conditions. This change has, to a certain extent, occurred, at any rate, the general atmosphere has greatly changed on account of the acceptance of power by those who have the people's interests at heart. The independent medical profession now feel that the new Government is their own Government and if the reforms they ask for do not materialise immediately, they understand that it will not be for want of sympathy on the part of the authorities. It behoves us, therefore, in this Conference, to express ourselves freely on all the current medical and public health problems of the day and place before the authorities concrete proposals which would form our immediate and minimum demands.

Medical men of Madras have a special reason for gratification in that this Conference is being opened by the Hon. Dr. Rajan in whose charge the destinies of the medical profession in the Province are now placed. In his hands, the country's rights are secure and the medical profession expects much from him.

CLOSURE OF MEDICAL SCHOOLS.

The City has already an old Medical College which celebrated its centenary last year. A second Medical College in the city is in process of formation. Thanks to the foresight and courage of the Hon'ble Dr. Rajan, the large Medical School at Royapuram which, for

years has prepared several hundreds of Licentiates, is to cease producing Licentiates and is to be converted into a Medical College from April next. It may be remembered that about 15 years ago, we had as many as six Medical Schools in this Province, all of them producing licentiates. Gradually, as a result of agitation by the licentiates themselves who laboured under the stigma of an inferior diploma, these schools have been closed one by one, and the credit of closing the last one goes to Dr. Rajan. When this school ceases to exist, the system by which a separate and inferior grade of medical men was produced to meet the growing demand for increased medical relief, will disappear in this province, and we shall have only one grade of Medical men—the University graduates. It has at last been realised that adequate medical relief can only be administered by men of high standards and that mere increase in the numbers of the profession will not meet the country's demand for efficient doctors. I wonder if other provinces in India have such a number of medical institutions as here, for, in addition to the two Medical Colleges above mentioned in the city, we have one at Vizagapatam and yet another in Mysore under a separate University. Also, it is not unlikely that the newer Universities of Annamalai and Travancore would, in time, have their own Medical Colleges with hospitals attached. The Vizagapatam Medical College is still in a state of development and having survived the recent financial depression, is now having a difficult time in the matter of official recognition of its degrees by the Indian Medical Council. It is known that the teachers of the Vizagapatam Medical College are holders of approved Indian or foreign qualifications and are considered competent enough to be examiners of the Madras University whose degrees are recognised, but the strange position is that the Vizagapatam students trained by such instructors are not fit for the approved practice of medicine in the eyes of the Indian Medical Council. The Vizagapatam Medical College, a creation of the Madras Ministry of some ten years ago, was never too popular with the later

Governments of the Province and was consequently left in a state of semi-starvation. But when the time came to account for these omissions, the new Congress Government happens to be in power, and has to answer for the sins of its predecessors. With the best of wills, the new Government must have time to carry out essential reforms, and we hope that in the meanwhile the students of the college would not be penalised for the shortcomings of a former Government.

It has been the feeling in these parts among all grades of medical men, that the large class of medical men now labelled as Licentiates should cease to exist, and we are glad to say that the first step in this direction has already been taken by our Minister Dr. Rajan. They will not be produced any longer in this Province and this is indeed a very great achievement. I, however, feel that this problem has only been partially solved, as even though all provinces may immediately stop producing Licentiates, large numbers of those produced already during the past years, who are now in practice in different parts of India, would continue to keep alive the objectionable class distinctions for many more years until the last of them ceases to exist. Meanwhile, in the interests of the public whom they serve, something should be done to improve their standards and position. The Universities will be chary of doing much for them as they are conservative in their out look and would not care to offend the Indian Medical Council which is not over-indulgent to these Licentiates. But the Governments of Provinces are free to take any steps they like and to offer facilities in the Colleges and Hospitals for the post-graduate education, of these men and after examination to grant them Diplomas which would entitle them to positions corresponding to those of graduates, as is the case with holders of Diplomas of the Colleges of Surgeons and Physicians in England.

INDIGENOUS SYSTEMS

Another problem in medical education in India, no less important than the removal of class distinctions in the Profes-

sion by abolishing the Licentiates' Course, is the equally difficult one of approximating the large amount of clinical and therapeutic knowledge available in the indigenous systems of Medicine to the more modern systems which we call scientific and rational. We cannot afford to ignore the great benefits rendered by the ancient systems to the poorer people of the country-side. The question for the future will be whether it is possible to incorporate into the national Medical Service of India, all the advantages claimed by the different systems, now in vogue, and not to allow any medical practitioner to remain in ignorance of the practice of any system of the healing art, whatever its origin. I do not think it is impracticable to let our students of medicine acquire a general knowledge of the various systems now prevailing in the country, as this is easily ensured by the provision of adequate teachers in existing Medical Colleges. As matters stand, the student of Ancient Indian Medicine is taught a great deal about modern medicine, including the basic sciences, while the student of western medicine grows up in ignorance of the system which is extensively favoured by millions of his country-men and which is most probably favoured by his own parents. The modern student should also be told about Ancient Medicine; otherwise, he will develop into a man without a national background.

MEDICAL RELIEF.

One hears everywhere complaints of the inadequacy of medical relief both in the cities and in the country-side. The position here is not so bad as in certain other provinces, but even here in large cities, we often come across cases where the existing provision for rational medical relief is not taken advantage of through ignorance or prejudice of patients or relatives. A great deal of public education is necessary before people learn to use the facilities provided for them. It is, therefore, of the greatest importance for the future well-being of the nation that due attention be paid to the proper education of the future citizen in the school going

age in matters relating to health and prevention of disease and particularly to seek relief at the proper quarter before health is seriously under-mined. This process should go on alongside the provision of medical officers for treating the sick of rural parts and the expenditure of large funds for erection of buildings and provision of equipment should follow the demand of the public for increased medical benefits.

NURSING

As in the case of the Medical Profession, a new orientation in the outlook of nursing in India is immediately necessary. In the earlier days, we began by producing nurses with the same outlook and standards as the nursing profession of the West. We find now that at that rate the supply will be slow, expensive and inadequate and we look everywhere for a type more in keeping with the lives of the Indian people. There is a large demand everywhere for the Indian nurse, but the right type of Indian girl is too shy to take to nursing. But in Madras, at any rate, there are signs of improvement in the situation and the rate of production by Training Institutions of Indian nurses, of whom great numbers are required by the community, would be greatly advanced if only suitable arrangements could be made in Hostels or private residences for their accommodation while training.

SERVICES.

By far, the greatest problem of the Profession in India is the special position of the Indian Medical Service. All the best appointments in Hospitals are reserved for European members of these Services, necessitating a constant supply of junior men to fill up gaps arising through casualties. As Indians with high qualifications and experience are now available for all such positions in the Medical Department, the absurdity of having to import young inexperienced recruits of a particular community, in preference to tried men available on the spot, is apparent and I need only say that both our

self-interest and self-respect demand that this state of affairs be brought to an end as early as possible. Until this is done, the position of popular Governments in the Provinces will be anomalous and the prospects of the other members of the Medical Profession throughout the country will continue to remain as deplorable as ever. We have no objection to special arrangements being made for the treatment of British officials by doctors of their own race, if they wish it, but not at the public expense. Reservation of the best appointments in the Civil Medical Departments of Provinces for the sake of a handful of European officials cannot be reconciled with the Autonomy which has been granted to the Provinces.

THE FUTURE.

One of the urgent needs of the moment is the raising of the standard of Medical Education all round. We have abundant clinical material in the country, and it only requires teams of select men to make use of it and turn it to our advantage. Encouragement should be given by Government to men of initiative and force to work in Government hospitals which should cease to rely on a monopoly of men from the Services to man such institutions. The Government of Madras is reported to have already some schemes on hand in this direction, and let us hope that, when these schemes take shape, rules will be so framed that subordinate officers who have no sympathy with these changes are unable to frustrate the intentions of Government by executive orders. Raising of standards of teaching and treatment in our medical institutions is a most important step for another reason, as, without it, those of our people who are anxious to prosecute advanced studies are obliged to go abroad in pursuit of knowledge and thus scatter India's meagre wealth in foreign countries.

Not less important is the need for Indianisation of medical supplies. Apart from the desirability of this proposal on general grounds, it is a matter of urgent necessity in view of the present world situation. A serious war may

begin at any moment in the West and our supplies of medical and surgical requisites now imported from the West, may be suddenly stopped or seriously curtailed especially for the civil population. Towards such a contingency, let us prepare and by a process of active help to medical industries, small or big, the Government should be able, in a few years, to place the country on a secure basis industrially and make it independent of foreign supplies. We must not forget also that in the event of war in the West, the Indian market would be more than ever at the mercy of the Japanese manufacturer and we shall find it well nigh impossible to shake off their supremacy unless we begin early to emulate their ideals of combining cheapness with efficiency.

In conclusion, I wish to tender the grateful thanks of the Reception Committee to the Hon'ble Dr. Rajan for the willing help rendered by him towards holding this Conference but for which our work would not have been so easy, and for his readily consenting to open this Conference. Our thanks are also due to the Surgeon-General with the Government of Madras, who has kindly agreed to open the Exhibition. The Principal and Staff of the Medical College as well as officers of the Public and other Departments have all willingly rendered us help without which this meeting could not have been held to-day. Wherever we went, men and women have come out to help us and large numbers of doctors, all over the presidency, including Government servants, have joined us both as delegates and members of the Association. To them all, I wish to express our heartfelt thanks for their willing assistance in making this Conference a success.

I must not omit to mention that the Exhibition, which has by now become a normal accompaniment to this Conference and which will be opened this morning by the Surgeon-General with the Government of Madras, is a comprehensive one illustrating the conditions prevailing in India as regards medical and surgical requisites. This exhibition amply indicates the steady advance in the standards

of medical supplies as obtainable in India and I feel sure that as we go on, future Exhibitions will be utilised by the Indian manufacturers and Exhibitors in greater numbers than at present.

SURGEON-GENERAL OPENS EXHIBITION

Major-General N. M. Wilson, Surgeon-General with the Government of Madras, then formally opened the Exhibition of surgical appliances and medicinal preparations attached to the Conference.

Exhibitions of the kind, Major General Wilson said, played a very important part in the success of medical conferences throughout the world. In India, perhaps, such exhibitions were more necessary and certainly more appreciated than in other countries. For, owing to the scattered location of manufacturers and their agencies, and the long distances to be covered in travel, it was not easy in India for the profession to get into direct contact with the manufacturers. This difficulty was not experienced in the West, where travel was quicker and easier and agencies existed in all big cities for almost every known drug or appliance. It was through such exhibitions that the profession at large was able to get into touch with the latest medicinal preparations, surgical instruments and hospital equipment, which changed from day to day. Such exhibitions were means of bettering the knowledge of members of the profession with a view to better treatment of disease.

It was most gratifying, the speaker continued, to see Indian firms so well represented in the Exhibition. The Bengal Chemical and Pharmaceutical Company were the pioneers in India in drug manufacture. (Cheers.) The firm was started in 1892 by Sir P. C. Ray and now had reached a high standard of efficiency and reliability and was much respected by the whole profession in India. He was sure that younger Indian firms would rapidly follow the fine lead of the Company. The well known firms of Burroughs, Parke-Davis and

others were also represented in the Exhibition. India was a country which was "rather backward" in the manufacture of surgical instruments at present. This industry should be encouraged in India by all of them. There were in this country many first class mechanics and he, therefore, could see no reason why India should not hold its own in future in the manufacture of surgical instruments. They should strive to maintain the very highest standard of efficiency, whether in medicines, vaccines or instruments. Such exhibitions, he felt sure, would help them to keep up a high standard.

Major-General Wilson then declared the Exhibition open.

Dr. Vyas proposed Dr. B. C. Roy to the chair and Lt.-Col. Cruickshank seconded the proposition.

Dr. B. C. Roy then took the chair amidst cheers and delivered his address.

DR. B. C. ROY'S ADDRESS.

Dr. Roy in the course of his address said:

"Since we met last year, great changes have taken place in this country of ours, a bloodless revolution has come about; the Congress, the predominant political party has withdrawn its opposition and taken up the reins of Government in seven out of the eleven provinces: and who can say, that the ideal to which Congress is wedded and for which its members are pledged to work, is not silently but effectively influencing the activities of the remaining four provinces?—And what is that ideal? The ideal is service to the dumb, down-trodden, oppressed, afflicted masses. And what should be the attitude of the medical profession to this ideal? Can the members of a noble profession, whose lives are dedicated to the service of suffering humanity, and whose governing ideal has been and continues to be "going about doing good," remain passive during this revolution? If the Congress Ministries are to justify their existence, they have to devise a scheme for the medical relief of the masses, they have to plan out an intensive campaign to dispel ignorance

and superstition and to develop an intensive health consciousness of the people, which alone can effectively check the inroads of epidemic diseases and the immense mortality rate due to them; they have to break down the barriers of entrenched service interests, and bring the profession in direct touch with the masses and their needs. I do not forget that medical practitioners also have to exist and cannot live on charity and also deal out charity. But I do plead that even in our own interests, it is essential that, as early as possible, the masses should be protected from the ravages of the preventable diseases, so that the economic position of the country as a whole is bettered. It is a well-known truism that ignorance leads to poverty, poverty brings on disease and that these three factors act and react on one another, and thereby ruin millions. After all, people do not live their lives in water-tight compartments. All the defects and disabilities of the people are to be handled together; and all communities and classes should join in the struggle. Whatever I shall have to say to-day will be from this point of view.

INDIAN MEDICAL COUNCIL.

"The Indian Medical Council has no power to influence the ethical standards of the 500 graduates who pass out of the Colleges each year, because it possesses no Register and has no power to admit or erase any names from the Provincial Registers. The scope of usefulness of the All-India Council has, therefore, been narrowed down. There are some fundamental propositions, however, regarding medical education, which must be accepted by every medical institution whether it be a school or college. A candidate for admission must possess a sufficiently high standard of preliminary training in order that he may profit by the instruction given to him. A minimum period must be spent in the study of the fundamental sciences, like Anatomy, Physiology and Pharmacology and then, a minimum period of clinical work is essential for obtaining insight into the nature of disease and mode of treatment. In the schools, it may not be necessary, perhaps, to lay much stress on

special subjects or departments as is done in the colleges, but a minimum period of instruction must be provided for the study of Fundamental Sciences and for clinical work. In my view, this period cannot be less than five years. A college or a school may make their own arrangements for selecting particular types of candidates for admission, having regard to their preliminary training and to their intellectual capacity. Once it is conceded that every medical student must possess a suitable type of preliminary training and undergo a minimum period of study in a medical institution, there is no reason why the Indian Medical Council should not be put in charge of both types of institution and there is no reason why the Indian Medical Council should not possess an All-India Register. I am glad to find that the Bill Drafting Sub-Committee of the 13th All-India Medical Conference, appointed at Karachi, have suggested an amendment of the Act to include Licentiates. To my mind it should be made clear that these licentiates will in future obtain a 5 years' training after receiving a sound preliminary scientific training. I suggest also that the Act should be amended so as to include the creation of an All-India Register.

"So much for efficiency at home. What about honour abroad? The Medical Act says, "The Indian Medical Council may enter into negotiations with the authority in any State, outside British India, which is entrusted by the law of the State with the maintenance of a Register of medical practitioners, etc." In all cases of such approach by the Indian Medical Council, these countries must have found it curious that the Indian Medical Council maintains no register and wondered how was it possible for the States possessing a register to have a scheme of reciprocity with the Indian Medical Council "without" a register. And the enquiries by the Indian Medical Council showed that most countries refused to deal directly with the Indian Medical Council, as they were satisfied with dealing with the General Medical Council in England, which is all that matters to them. And, why should any country bother about the

Medical Council of a country which does not possess the status of an independent State? The Indian Medical Council has not even the elementary power of protecting the interests of the Indian Medical profession by prohibiting or disallowing non-nationals from practising in this country.

MEDICAL EDUCATION.

"The next important subject that we have from time to time discussed in these Conferences is the question of medical education. I have incidentally referred to it in my discourse on Indian Medical Council. We have stressed the necessity of having a suitably arranged pre-medical course in Biology, Chemistry, Physics, so that students after admission into a medical institution are able to take full advantage of the training they receive. All the world over, educationists have felt that with the growth of medical science, the type of instruction hitherto given to students should materially change. Everywhere it is agreed that of the five year course, two should be devoted to Fundamental Sciences, three to clinical work, that subjects like Hygiene and Medical Jurisprudence, however important they be, should not be given any extra attention in the education of an average medical student, as they should form special subjects for experts, that Applied Anatomy and Physiology, Pathology and Pharmacology should be continuously studied during the clinical period, that, in effect, all subjects of medical education should be organically linked together and not grouped in such water-tight compartments as to make the student feel that, as he progresses on in his studies, he should forget what he has learnt in one year before he goes on to the next.

"But I urge that even after he has satisfied the examiners in the final test, the graduate, under a recognised teacher should have at least six months' course of post-graduate studies, during which period he will be given the option to choose any special subject he is interested in. It may be urged that there is not enough room for giving such post-graduate training to all who have passed the final test. Such argument, however, cannot be allowed to

prevail in view of the necessity and desirability of giving post-graduate instruction to all persons on whom the responsibility for human lives would rest. Provision for such instruction, therefore, must be made.

MEDICAL TEACHERS

"But any scheme, however perfect, will fail in producing effective results unless teachers are appointed who can really teach. It is a tragedy that teaching appointments, should be reserved for members of a Service which admittedly exists for two main purposes—namely, to serve as a War Reserve and secondly, to secure for Europeans in Government Services medical help from members of their race. For a man in the service, continuity of work in a particular department or post cannot be ensured, and in the absence of such continuity, teaching, research, and even efficient treatment are bound to be defective.

INDIAN MEDICAL SERVICE

"On numerous occasions, in public and in the press, in Conferences and Committees, members of this Association have commented on the mode of recruitment to this Service, on the differential racial treatment meted out to the members of the Service particularly regarding salary and allowances, on the way in which they are allowed to usurp important teaching and research appointments; in fact, the Association have often declared that this Service need not exist at all.

"We have in India to-day according to the latest report available, 220 members of the Indian Medical Service transferred to the Civil Side. Out of the 220 posts, 166 are reserved for Europeans, because they are required to look after the European members of the Services in India. A large numbers of specialists' research and teaching posts are reserved for Europeans "in order that specialists' attendance shall be available for European Government servants and families." On a rough calculation, the number of Europeans in the Services in India and their families, would not exceed 20,000 and for them we have 160 European I. M. S. officers with facilities for specialists' posts and

overseas allowances and travelling allowances. It is clear that the system of appointing a few men on high salaries and allowances, avowedly to satisfy the sentimental needs of a particular community cannot, in the interest of the suffering millions, be continued in India as she is not capable of affording the luxury of such highly paid services.

HOSPITAL AND DISPENSARY SERVICE

"There are over 6,000 hospitals and dispensaries either maintained by the State and statutory bodies or aided by them; a few are maintained by private agencies. Two hundred members of the Indian Medical Service, a few belonging to women's medical service, 1,750 belonging to the Assistant Surgeon's service and about 6,000 licentiates, work in these Hospitals. The smaller hospitals and dispensaries are generally maintained by district or local boards and they constitute more than 3/5th of the total number. It is calculated that, on the average, a small dispensary in a rural area is expected to serve 50,000 to 60,000 persons living in scattered villages. The remaining 2,000 odd hospitals, mostly situated in urban areas, have 72,000 beds in all and treat on the average, according to the officials report, one million people annually. But we are unable to find any scheme behind this hospital system. In Britain to-day, hospitals work under a definite scheme which provides for general and special services to the community, prevents overlapping and affords opportunities for intensive research work. The hospitals in India though mainly maintained out of public funds are yet the close preserve of the services. The patient, a member of the public, puts more faith—and rightly so—in the service men, because they have the unique opportunity of gaining experience and practice in the healing art in these hospitals with the immense materials available therein. The private practitioners thus find it hard to compete with them. In order that these private practitioners can give efficient service to the people at large, it is essential that they should keep themselves up to date and for that purpose they should have opportuni-

ties of getting experience such as are only available in a hospital. Therefore, while the hospitals have to be maintained to give free service to the poor, the opportunity to work in them should be open to all, both in the interest of the suffering public and the practitioners themselves.

"What then should be the hospital system in India? Many of these institutions owe their inception to the generous instinct of private donors in whom the agony of suffering humanity has evoked a ready response. But the bulk of the money spent on these hospitals still comes from the funds of the State or of statutory bodies. These hospitals should be placed under the control of local committees consisting of representatives of the people, of the Government and of the Statutory Bodies who are and might be contributing towards their upkeep. They should no longer be under the complete control of the department of the Government as heretofore.

"It is safe to premise that power coupled with responsibility always evokes responsive activity on the part of those on whom the responsibility is placed. The institutions should be classified as General and Special. The General Hospitals should be properly equipped with nurses and efficient staff and should have a fairly large number of paying beds, so that these hospitals will ultimately be maintained more by contributions from the people, made directly to the Hospital, than indirectly through the State. The Special Hospitals, on the other hand, should be provided with facilities for teaching students, for research and for treatment on special lines. No effort should be spared to make them efficient; and these institutions should also be the training ground for post-graduate work.

RESEARCH WORK.

"At present we have no arrangement for post-graduate training anywhere in India. The Research Department as I have stated above, is kept a close preserve for the benefit of the few; Teaching and Specialists' posts are likewise preserved. Naturally, those Indian students who desire to pursue higher studies in Medicine and to improve

their status and prospects in life have to go to foreign countries. There, again, difficulties have arisen. In England, where the students might naturally expect sympathy and aid, they get none. The India Office does not give any help except to members of the Services, particularly those belonging to the I. M. S., officials of the Indian House and the High Commissioner also give no effective aid, because they have no real power, although they display pomp and show. In numerous instances, to my knowledge, they could not give to the students even such help which any one of us individually could give by influencing and interesting the authorities of the Institution with which we were at one time associated. This fact was brought home to me very forcibly during my recent visit to Europe. Many students complained to me of the difficulty of joining any institution in England because of the indifference or unsympathetic attitude of the authorities of those institutions. Even in the institutions under the control of the London County Council, which is dominated at present by the Labour Party in England, the Indians fare no better. No one can marvel at the attitude of the authorities of such institutions, much as we may deplore it. I found that there are in England, to-day, a large number of Indian practitioners settled in the country and carrying on a fairly lucrative practice. The success of the Indian practitioners, even when they possess ordinary qualifications, naturally reacts on the minds of Englishmen. If the Indians were to take higher degrees and then settle to work in England, their success would be more marked. Naturally, such success cannot be viewed with equanimity by those whose interests are affected. Incidentally, I may mention that the success of the Indian practitioners in England is a fit reply to the argument of those who always raise the side issue in India, namely, that Europeans always desire to be treated by persons of their own race. Our boys, in their anxiety to get post-graduate training, resort to other countries of Europe or go to America. In

Paris, Rome, Berlin, Munich and in Vienna, we see a large number of Indian students taking post-graduate training. In Vienna, perhaps, we have a larger number of Indian students than in other places. Austrians, as a rule, have a warmer heart than the people of other countries and Vienna has numerous institutions where ample materials and efficient staff exist. We welcome the presence here, amongst us, to-day, of Professor Rudolf Demel, Professor of Surgery in Vienna and a well-known surgeon in that city.

PUBLIC HEALTH SERVICE.

"It is admitted that elementary ideas of sanitation are lacking among the ignorant poor in this country and the development of national health services is still in its infancy. Illiteracy, want of proper educational facilities, lead to ignorance. Ignorance makes people cling to encrusted habits. Age-long customs, however insanitary and unscientific they be, become irremovable; superstition and blind faith in them serve to petrify them. And further, a bad habit which in a village is innocuous may become positively harmful if persisted in, when the villager migrates to a town. During the last two decades, due to causes we need not enter into now, thousands of villagers are migrating to towns carrying with them insanitary habits and unhygienic customs. This adds to the difficulty of effective health service in India. If 6·8 millions of people die every year in India, it is safe to assume that 10 times that number actually suffer from diseases requiring treatment."

Citing figures relating to rate of mortality due to various diseases, Dr. Roy said: "It seems to me that the best way to solve the problem is to organise the public health service in the following manner: The service should be divided into Rural and Urban. There should be a rural health centre in charge of an official of the Health Department. Each such centre should be in charge of an area of not more than 100 sq. miles on the average. In Bengal, at present, each such centre coincides with a thana area. It is a wrong method to mix up

administrative units with health units. Each rural centre should be responsible for the following:—(1) Vaccination; (2) registration of births and deaths; (3) conducting educational propaganda; (4) holding school clinics and giving health instructions in schools; (5) generally looking after sanitation of the area, particularly in cases of fairs and festivals; (6) protection of sources of water supply, (7) enquiring into the plague spots within that area, whence epidemic diseases start every year and providing facilities for observation and investigation in all cases of epidemics. Peripatetic dispensaries may also aid the work of the village health centres.

"Urban health centres besides performing duties similar to the rural centres should be particularly concerned with the health problems of factory labour and workers in mines, shipping, railway and aerial transport, with supervision of food and drugs, poisonous or otherwise, and with health in jails.

CONTROL OF EPIDEMICS.

"Besides these rural and urban centres there should be, to my mind, a special staff trained to work for the control of epidemics. Epidemics means mass infection. On a reference to mortality tables it will be seen that preventable diseases like Malarial Fever, Plague, Smallpox, Cholera, Dysentery, Tuberculosis, Ankylostomiasis, Rabies, Leprosy, Kala Azar constitute 66 per cent of the total deaths in the year. If we can adopt early and effective measures, as soon as the first case appears in an area, we may prevent the disease spreading and the need for providing treatment in a large number of such cases will not arise. Hence my suggestion is to have an epidemic staff as a part of health service, trained to treat particular diseases who will be stationed at different convenient centres.

"If we are able to stop the spread of epidemic diseases, which cause the largest number of morbidity and mortality in India, we are left with a comparatively smaller problem, namely, that of provision of treatment of about 10 to 15 millions of people for the whole of India, suffering from diseases other than those dealt with

by the epidemic staff as mentioned above. A small proportion of this number would be treated in the existing hospitals and dispensaries. I say, the creation of a new type of village practitioners by giving them a three years' training would not meet the situation."

Discussing different alternate schemes for providing medical relief to areas not served by hospitals and dispensaries, the President said the problem was a vast one.

HEALTH INSURANCE.

"It is not easy" he said, "to devise a scheme for giving efficient medical relief to millions of patients living in villages isolated from one another, with means of communication between them difficult and in certain periods of the year absent. The marshy deltaic districts of Bengal, the dry parched areas in the North, the unfavourable weather conditions in India, the polluted sources of drinking water, are physical factors which enhance our difficulties. There are 500,000 villages in India, of which 425,000 have population of less than a thousand. Therefore, poor as they are, the villagers cannot afford to maintain a doctor in village or even in a group of villages and any form of concerted action amongst them to establish a "voluntary" system of insurance against sickness and unemployment is out of the question. On the other hand, with the increasing poverty in the land, the starving poor are becoming more and more victims of diseases which are and have been found to be preventable in other countries and lands. And yet the poor by themselves cannot arrange for proper treatment in case of illness. The tragedy lies in the fact that while poverty in this country is increasing, medical practice is getting more and more expensive. The more people long for medical aid, the less can they afford to have it. Remembering the difficulties of the medical practitioners in getting a decent sum for their living, as also the fact that the large bulk of people in all countries cannot afford to pay for medical services in these days, the League of Nations at Geneva adopted a Draft Convention in 1927, recommending to the Governments of all the different

nations, a system of health or sickness insurance. This system, the Conference of the League urged, should be operated by self-governing societies under the administrative and financial supervision of competent public authorities and in consultation with medical experts. They should not be carried on for profit. In case no such society existed, the Governments were urged to provide a State system."

"While every country in Europe and America has adopted," he continued, "some form of compulsory sickness insurance to protect the poor people against disease and unemployment, India lags behind. No one at this stage, without further information, can lay down any scheme which is suitable for India, nor can one assert that any particular system would be suitable for all parts of India. But I desire to emphasise that some step must be taken immediately to prevent this great waste in men and money. Therefore, I suggest that the Central Government should take early steps to appoint a Committee to inquire into the whole problem. They must not stand on ceremonies and consider their own experts as infallible guides in such matters. Failing the Central Government, the Provincial Governments should take necessary steps as early as possible. The question remains as to what part the medical profession in India is going to take in this matter. In England, the British Medical Association has given constructive suggestions at every stage of the introduction of health insurance scheme in that country and I see no reason why the members of this Association, individually and collectively, should not give all possible help towards the solution of this great problem. I do not conceal the fact that there are difficulties in the way of introducing any form of health insurance in India. The solution of the problem is beset with difficulties but with the determination and perseverance it would not be difficult to find a solution. Friends, let us band together and help to make this dear country of ours a land of health and affluence and to rehabilitate it in its pristine glory." (Cheers)

Resolutions passed by the Medical Conference.

MADRAS, December, 28.

1. This conference puts on record its appreciation of the steps taken by the Hon. Dr. T. S. S. Rajan, Minister for Public Health on having decided to abolish the medical schools and the L. M. P. course and on having one uniform minimum degree of M. B. B. S. for the Madras Presidency.
 2. The conference requested the Governments in other Provinces of India to take early steps to abolish medical schools giving L. M. P. or equivalent courses of instruction; and thus to unify medical education with M. B. B. S. as the minimum qualification throughout India (as in Madras).
 3. The Indian Medical Association was requested to arrange, through the authorities of medical institutions in different provinces, for regular refresher courses for practitioners possessing registerable qualifications and also to provide post-graduate courses to enable socialisation in various courses.
 4. This conference protests against the action of the Indian Medical Council in withholding recognition to the degree granted by Andhra University; this conference thanks the Madras Government for its assurance of doing all that is necessary to have the Andhra University degree recognised, and hopes that they will effect the necessary improvements in the Vizagapatam Medical College at the earliest possible moment so as to expedite the said recognition.
 5. This conference reiterates the resolutions of the last conference and desires that provincial branches of the Association should take up these questions immediately.
- Regretting the action of the Punjab Government in not withdrawing the ban on medical officers in Government service joining the Indian Medical Association, and requesting the Punjab branch to arrange a deputation to bring the facts to the notice of the Punjab Government;
- Resolving that Provincial Governments be requested by the Indian Medical Association to amend local Medical Acts on the lines suggested recently in the communique issued by Madras Government;
- Requesting the Government of India to amend the Indian Medical Degrees Act of 1916 to make it unlawful for unqualified persons to write letters or words with their names, which may denote in a direct or indirect way the resemblance of these letters or words to be genuine or *bona fide* medical degrees, (b) to declare it an unlawful practice for such unqualified persons to place or write the designation of "doctor" before their names.
6. This conference resolves that the local Government of different Provinces be requested to take effective steps to control and regulate the

manufacture, public advertisement, sale and import of patent and proprietary medicines. This conference holds the opinion that in addition to the name of the patent medicines and manufacturer's name, their composition should be mentioned on the labels, but no description of their properties should be allowed to be advertised except in the medical press, and as far as possible the medical profession should stick to pharmaceutical and extra pharmaceutical drugs.

7. This conference condemns the Government of India's scheme of reorganisation of the I. M. S. as announced in the resolution dated Mar. 25, which instead of abolishing the civil side of the I. M. S. as recommended by the services sub-committee of the first Round Table Conference, has thought fit to perpetuate the civil side and "thus has hampered the legitimate growth of the medical services of India as envisaged in full provincial autonomy."

Further, this conference lodges its emphatic protest against this retrograde scheme as it maintains gross racial discrimination, perpetuates the doctrines introduced in the Lee Commission, almost doubles the personnel of British officers in proportion to Indians, whose number has been correspondingly reduced, and perpetuates unfair and distinctive system of recruitment to the I. M. S. by nomination and selection. This conference also reiterates the oft-repeated demand for the complete abolition of the civil side of the I. M. S. and the administrative post of Inspector-General of Civil Hospital or Surgeon-General and requests local Governments to dissociate I. M. S. officers from district hospitals.

8. That the Central Council of the Indian Medical Association be requested to approach the various Provincial Governments to appoint, wherever available, as honorary surgeons, physicians and such other specialists, only those persons who practise as specialists in that particular subject exclusively.

9. This conference recommends to the Government that free medical advice to Government officers by Government medical officers should be discontinued.

10. This conference requests the Central and Provincial Governments to take immediate steps to impart training to medical men and the public, regarding the treatment and prevention of gas poisoning from air raids.

11. This conference requests the Indian Medical Association to form a committee, to prepare, in consultation with competent economists, a national health insurance scheme for the whole of India.

12. As the existence of a nation depends mainly upon the physical fitness of its people, this conference urges Provincial Governments to take, amongst others, the following steps immediately for the physical regeneration of our people of India.

Open Physical Culture Centres under trained instructors in all Municipalities and District

Ministers' Conference Conclusions.

MADRAS, DEC. 30.

The Conference, attended by the Health Ministers of Bengal, Bombay, Bihar, Assam and Sind and presided over by the Hon. Dr. T. S. S. Rajan at 11 a.m. on December 29, passed resolutions recommending suitable action by Provincial Governments in regard to the following subjects:

(1) the appointment in larger numbers, wherever practicable, of independent medical practitioners as honorary teachers and professors in the teaching institutions and as honorary surgeons and physicians in the hospitals owned and managed by the State; (2) the adoption of a uniform standard of medical education throughout India consistent with the special circumstances prevailing in each Province and without lowering the standard of University education; (3) the prevention of persons who have not attained the prescribed standard of medical education from setting up medical practice; (4) the institution of refresher courses to be made obligatory on all medical employees of State and local bodies, including the subsidised rural practitioners; (5) the establishment of laboratories for the free examination of clinical material in all suspected cases of infectious diseases sent by registered medical practitioners; (6) the extension of rural medical relief to all villages; (7) the institution of post-graduate courses of study in theory and practice of Public Health for rural medical officers so as to enable them to discharge efficiently their duties as sanitary officers; (8) the supply of pure drinking water to all villages; (9) the investigation of the health conditions of the people by means of health surveys as conducted in the Province of Madras under the Poonamalle Health Unit Scheme; and (10) the encouragement in all possible ways of the manufacture in India of drugs, biological products and hospital equipment and the testing and certification as to the quality of such drugs, products and equipment by authorities constituted by Provincial Governments before they are put on the market.

Boards, and make Physical Culture a compulsory part of the Educational System of the country.

Open Scientific Cooking Demonstration Centres in all Municipalities and District Boards.

Open Women Welfare Centres under proper medical supervision in all Municipalities and District Boards; formation of health volunteer corps in each local area to educate the masses and do propaganda in matters of sanitation, preventive medicine and proper curative treatment with the co-operation of the rural medical officers in the area concerned.

A resolution was moved placing on record the thanks of the Conference to the Madras Government, the Surgeon-General and the Principal of the Medical College for placing the Medical College grounds at the disposal of the Conference, the Hon. Dr. T. S. S. Rajan for opening the Conference and for his encouraging words about the aims and objects of the association, the Surgeon-General for opening the exhibition, the authorities and the Warden of the Medical Students' Hostel and Members of the Madras Ambulance Corps for all their efforts in making the Conference a success.

Dr. Mehta moved a resolution thanking all for the successful organisation of the Conference which was given a fillip by the presence of the Hon. Dr. T. S. S. Rajan. The President associated himself with the resolution and said that Madras with the zeal of a new convert had done more than what they expected.

Dr. D. V. Venkappa moved a resolution placing on record the grateful thanks of the Conference to Dr. B. C. Roy for having presided. The President expressed his thanks to all who helped him to run the proceeding successfully.

The President announced that an Indian Surgical Association would be started and the inaugural meeting would be held at a central place, probably at Bombay and that the Conference would meet at Meerut in 1938.

NOTICE.

A large number of subscribers have been repeatedly requesting us to increase the reading pages of The Medical Practitioner. We were originally printing only 24 pages which were increased to 32 pages a few years ago. We now intend printing 36 to 40 pages as the scope of the Journal has been materially increasing. The current issue contains 40 pages. We are therefore forced to increase the subscription to Rs. 3 from January '38 and request our readers not to grudge us additional help and patronage. Such of the junior practitioners who cannot afford to pay at the enhanced rate, are kindly requested to intimate to the undersigned before the end of February 1938 after which date it will be taken for granted that the subscribers have agreed to pay the enhanced rate of subscription that is Rs. 3, a year.

V. RAMA KAMATH,
Managing Editor.

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THE ALL-INDIA MEDICAL CONFERENCE.

We owe an apology to the readers of The Medical Practitioner for devoting the columns of the Journal usually reserved for publishing matters of scientific interest. The readers who are aware of the aims and policy of the journal will, we trust, not grudge this indulgence. As has been repeatedly mentioned in these columns, the scientific medical profession in India is suffering for want of organisation to find work for its members though it is said that India has not at present one practitioner belonging to Scientific system to a population of 20,000. So we have been striving hard not to lose sight of any opportunity which is likely to meet our purpose—that is—to have a contented though not as prosperous a scientific medical profession in India. The Indian Medical Association has rightly assumed the role of Ma-Bap of the Indian Medical profession. The fact that the Conference met in Madras under the immediate patronage of the Public Health Minister of the Madras Government is most momentous. The Hon'ble Dr. Rajan occupies an unique position of responsibility in the Madras Government. The Premier said on 29-12-'37 while opening the Conference of Public Health Ministers, "I have found in Dr. Rajan, a colleague who is, in my opinion quite competent to look after the work in every respect and who leaves nothing to me to worry about." On the same occasion, the Premier declared, ".....So far as the physical aspect of life goes such departments as Education and Law and Order for instance, may even be neglected for the time being; but if the Department of Public Health is neglected, it will be very difficult to claim that we are carrying on a civilized administration." This is the ideal of good Government which The

Medical Practitioner has been preaching and this is the ideal which The Medical Practitioner placed before the medical profession on the eve of the election to the present Legislative Assemblies and Councils least anticipating that medical practitioners would be the Public Health Ministers of two major provinces in Madras and Bombay and in two minor provinces—Central Provinces and Sind. Soon after the National Congress formed Ministries in the six provinces where the strength of the Congress was in majority, we suggested in these columns that a conference of Public Health Ministers might be convened and a definite uniform policy of Medical Relief and Medical Administration be decided upon throughout India. That such a conference was convened and that in Madras by its Public Health Minister at a time when the All-India Medical Conference met and when the Public Health Minister Hon'ble Dr. Rajan not only opened the conference but associated himself whole heartedly, is yet another circumstance which compelled us to publish the proceedings of the conference in detail so that such of our readers who could not read the Madras Dailies either in this Presidency or more so in other provinces may note the justification of our comments in regard to the proceedings of the Conference.

All these years we were able to get official reports of the Conference from the General Secretary of the Conference where they were held but this year we have to be satisfied with the news paper report of the proceedings. We wish those in high command over the affairs of the Indian Medical Association realise that the Medical Press is not neglected in their enthusiasm to reach the public through lay press.

The gathering at the Conference must have been a grand spectacular sight. For the first time in Madras perhaps next only to the social gathering of the Pan-Schismatic Dinner organised last April by the Madras Medical Profession, it was made possible to have a gathering of a heterogeneous mass of the members of the medical profession officials and non-officials, of a variety of qualifications academic as well as social not to mention of the subdivisions even in social status, mixing with each other and attempting to demonstrate unity in heterogeneity. The Hon'ble Dr. Rajan a Medical Licentiate who later became a member of Royal College of Surgeons, London and a Licentiate of the Royal College of Physicians, England was heard in wrapt attention by the Conference when he addressed the gathering in his capacity as a most important unit of the Madras Government in charge of Medical Portfolio and who was honoured with a request to open the Conference. Dr. Rajan kept his audience spellbound when he pointed out the necessity of organising the Indian Medical Association making it a real power to represent the scientific medical profession as is the British Medical Association in Great Britain. In his zeal he forgot for the time being his pronouncement published on the eve of the conference regarding the appointment of Honoraries in Government hospitals, the Licentiates being given the position only of House-Physicians and House-Surgeons. The popular Minister must have known from his personal experience that the inferiority complex of the Licentiates was not a delusion or an illusion. The Medical Profession in this country has been depending upon the Government for its prestige and status and even for its existence unlike in other civilized countries. So Dr. Rajan could conceive what it is for the members of the Medical Profession to be under the good estimation of the Government. An association which enrolls members on footing of equality should also get for its members recognition on equal terms. When the Hon'ble Dr. Rajan denies the Licentiates this status as qualified practitioners, his advice to maintain solidarity in the pro-

fession falls to the ground. The gesture of Dr. Rama Rao being made the President of the Association or a few more licentiates as Vice Presidents cannot bring additional status to the Licentiates as medical men to exercise the profession. The past achievements of the Indian Medical Association to ameliorate the condition of the rank and file of the profession—leaving alone the Harijan class of Licentiates—has not been encouraging. The I. M. S. looms large in the minds of those at the top ladder of the medical profession who are holding the strings of the Indian Medical Association. Instead of knocking their heads on impossibilities if they organised the medical profession and found materials to enlarge the fields of independent private practice keeping in view the sufferings and the inability of the indigent poor to get scientific medical aid, the I. M. S. grievance would have solved itself without much ado. We do not wish to be understood that we brook the I. M. S. supremacy. Our aim is independence for the medical profession and this is only possible if the masses in the profession are made to feel that the Indian Medical Association is keen to protect the interests of the rank and file in the profession. The most important item which the Indian Medical Association ought to have thrashed to find a solution must have been medical relief in rural areas. If this problem is solved and if the village practitioners were made to show their capacity to serve the village folk, the other major problems of the profession could be very easily tackled. What is wanted in the medical profession is the spirit of charity to be cultivated and not preached. Indians belong to a race who did not pay medical men in coins but all the same they revered their vaidyans and paid them always in kind. The vaidyans as well as priests are the first to be remembered on ceremonial occasions and rewards were set apart to them even before they were distributed to the kith and kin. The members of the medical profession should be made to adjust themselves to the habits and customs of the masses especially in villages.

The Western methods of approaching the patients for remuneration has created a feeling of suspicion in the medical attendants. It must be common knowledge to a large section of medical men of their being suspected by their patients for prolonging illness to make more money. So unless a few leaders make up their minds to settle in villages and show by their association with the rural practitioners how to lead a life congenial to village welfare not minding personal comforts, no amount of preaching of ideals and that by those who have been enjoying the plums in the profession or did so in the past, will have any effect and the profession will continue to be as heterogeneous and as discontented as it is to-day. Medical men of high qualifications and enjoying full benefits of science and lucre both in official and non-official capacity have not been able to contribute anything worth mentioning to the field of practical medicine and as the present tendency seems to be not even a living wage to the members of the profession, we are afraid if dictated ideals will evolve a race of medical scientists amongst Indians who have to depend upon entirely on the Government for their evolution. It is our conviction that as in politics so also in medicine, villages are the best training grounds.

It is indeed regrettable that though the Conference met under "favourable auspices" as described by the Hon'ble Dr. Rajan, it did not take advantage of these auspices and neither those who led the Conference nor others who were being led grasped the deep underlying causes which have been preventing the scientific medical profession in India to have an united existence to be in a position to evolve itself to the needs of the Country. The existence of the Medical Licentiates and the Indigenous Systems of Medicine in India are the real stumbling blocks. The abolition of the L.M.P. in course in the Madras Presidency even if followed in other provinces cannot do away with the castes in the profession in the immediate future when it is known that there are over 20,000 Medical Licen-

tiates in India. Affording facilities to the Licentiates to get M. B. B. S. degree or even the latest suggestion of the universities granting a practitioners' M.B. B.S. degree will not solve this problem. On the other hand there is every danger of an inter-caste amongst the Licentiates themselves even if the "conservative" universities throughout India are disposed favourably towards the Licentiates. The suggestion made by Lt. Col. Pandalai, Chairman, Reception Committee, seems to us to be commendable both in the interests of the Licentiates as well as the profession. The L. M. & S. Diploma which was once granted by the universities all over India may be revived by the provincial Governments and a Licensing Board be brought into existence temporarily for a period of ten years at least, the members constituting the Board being selected by a Faculty to be brought into existence by the Government. The members of the Faculty should be exclusively the Medical Licentiates of not less than 20 years standing who should pay a fee of Rs. 500 to the Government treasury to enrol themselves as such. Such a faculty should be empowered to select examiners for the L. M. & S. Diplomas examinations. All Medical Licentiates over 5 years standing should be entitled to sit for only one final examination and in case of Licentiates who have undergone 5 years course it must be made possible for them to get the L. M. & S. Diploma instead of L. M. P. The members constituting the Faculty should get the L. M. & S. Diploma automatically without examination but there should be a suffix (Hon) behind the L. M. & S. to indicate that it is an Honorary Diploma. The qualifications of the examiners should be fixed by the Provincial Medical Council. The holders of L.M. & S. diploma should enjoy all the privileges of the medical graduates. There cannot be any objection or difficulty even financially to work such a scheme to bring the Harijans in the fold of the profession to enjoy equal rights and privileges.

It is most unfortunate that the Congress Ministries are fighting shy to evolve

a scheme of medical education incorporating the Indigenous Systems. Separate medical schools, separate medical registers for those practising these systems far from encouraging the growth of these systems, are showing signs of ruining them. As has been repeatedly pointed by us those who have passed out of the Madras Government School of Indian Medicine, are practising Allopathy and employing Western methods in diagnosing and treating of the diseases. Financially also it is a bad policy for the Government to run Hospitals and Schools of Western and Eastern systems side by side. We fail to see why the Congress Ministries feel nervous to incorporate all the Medical Systems into one when the members of the Scientific Western System do not raise any objection to such a course. We should say that the Congress Governments are to a certain extent encouraging quackery by their policy of hesitancy and drift which is incompatible with the Congress creed. India cannot be independent if she cannot have an independent medical profession to suit her conditions.

Dr. B. C. Roy, the President of the Conference who is also a member of the Indian Medical Council condemns the existence of the Indian Medical Council in unequivocal terms and says that this Council has failed to establish "efficiency at home" or "honour abroad". This Council is a sky without the Sun or the Moon. Should it exist at all costing the Central Government over a lac of rupees every year? Neither Dr. Roy a patriot of shining merit and as brilliant a figure in the medical profession nor others like him who have been attending the all-India Medical Conferences in the past, have thought it fit to show effective ways and methods either to mend this Council or end it. Even the leaders among the Medical Licentiates who are hard hit by this Council, are being soporified at these annual gatherings, being given the honour of moving resolutions in which task they get absorbed before they could think of themselves and their class whose level of inferiority is being steepened year after year. At times even the

mandates of their association to move resolutions regarding this grievance of their class, are forgotten by their representatives who were sent specially to attend these yearly gatherings. The primary object of medical councils is to establish a Register to enable the public to know who is qualified and who is not. The fixing of standard of medical education is quite secondary. We refer our readers and also those in high command over the affairs of Indian Medical Association to read the preamble of the British Medical Act when the Bill was first introduced in the House of Parliament in 1858. Under the circumstances we wish to point out to the President, Indian Medical Association to agitate so that the Licentiates are included in the All-India Register contemplated by him and are brought within the purview of the Indian Medical Act and in case the Medical Council is adamant, to find out ways and methods by which all Indian Members of the Council resign and the Congress Provincial Governments, at least, refuse to send their official representatives to this council. Whether these tactics will have the desired effect or not, a move must be made in this direction. Then only the Licentiates would feel that it is beneficial to join the All-India Medical Association and the Medical Licentiates in U. P. and elsewhere will have no cause for dissatisfaction against the Indian Medical Association.

The glaring injustice meted out to Vizagapatam Medical College has been treated very lightly by the Conference. Neither the authorities of the Andhra University nor the Madras Government in the past and even under the present Congress regime did attempt to go deep and find out the real causes at work which made the Indian Medical Council to refuse the recognition of the M.B.B.S. degree of the Andhra University. We have dealt with this subject in one of the recent issues of The Medical Practitioner. Early in the month of December last the Vice-Chancellor of the Patna University visited the Andhra Medical College and hospital attached to it and gave his impressions to a press repre-

sentative that the equipment of both the institutions were on a higher level than those of the Patna Medical College and the hospital attached to it and he gave his opinion to the effect that non-recognition of the Andhra Medical College was not reasonable. We wonder if Dr. B. C. Roy and leaders who attended the Conference knew about the visit of the Vice-Chancellor of the Patna University to the Andhra University at the time the Conference passed a resolution on this subject and that Patna Medical College has been recognised by the Indian Medical Council.

Col. Pandalai did well in bringing to the notice of the Conference the desirability of raising the standard of Medical Education all round, so that the members of the profession will not find any need to go abroad for higher studies or post-graduate training and unnecessarily spend large amounts of money. He also suggests that "*men of initiative and force to work*" should be given encouragement by Government to work in Govt. Hospitals. This is as it should be and quite consistent with the changes wrought about by the present "Political Atmosphere". But we fail to apprehend any danger from "*subordinate officers*" which Col. Pandalai fore-shadows in his address, who, the Colonel suggests, are likely "*to frustrate the intentions of the Government*" towards the employment of the type whom he now sees amongst the members of the independent medical profession. The President of the Conference goes a step further and advocates the necessity of giving at least six months post-graduate training to all that pass out from schools and colleges. This salutary reform The Medical Practitioner has been repeatedly pointing out in these columns and the late Dr. M. S. Krishnamurthi Aiyar, the then senior Editor of the Journal moved a resolution in the Madras Medical Council a few years ago at the very first and the last meeting he attended as the representative of the Madras Graduates, that one year's post graduate training should be made a necessary condition for registration of practitioners newly passing out of medical schools and

colleges. The resolution was shelved out by the Council on the plea that the existing hospital accommodation was insufficient. Last year Dr. V. Rama Kamath moved a resolution more or less to the same effect. The council would not pass the resolution some of the members holding the view that unlike the members of the legal profession the newly passed out medical men did not need apprentice-course. As a compromise Dr. Kamath agreed to pass a resolution requesting the Government to afford House-appointments on a large scale to the newly passed medical men in all Government Hospitals. Now that the Indian Medical Association has been requested by the Conference "to arrange through the authorities of medical institutions for regular refresher courses" for practitioners possessing registrable qualifications, we trust something will be done in this direction to raise the efficiency of Medical Relief in this country.

The President of the Conference has by statistics proved that about 200 members of the Indian Medical Service, 1,750 belonging to provincial service and 6,000 licentiates of the subordinate Medical Service are certainly too inadequate a number to look after medical relief in India and that some sort of Health Insurance scheme should be launched immediately by the Congress Governments to justify the concern shown by Congress for the welfare of the masses. Dr. Rajan's scheme of Honorary Service will be a great drawback towards affording Medical relief to the masses, unless the public hospitals and dispensaries are prevented from admitting anybody else excepting the really indigent patients. Even paying wards or payment system at the out-patient dispensaries will lead to corrupt practices so long it is human agency that has to do the assessing work. It must be the concern of the State to keep the practitioners above want. Even at the living wage of the humble sum of Rs. 20 a month, the Government will not be able to pay as many medical men as are needed for medical relief.

The ideal put forth by the Madras Minister that prevention of diseases is a co-relative duty of curative medicine and that both these functions should be carried by one individual, will we hope be given effect to departmentally. Then only general practitioners' work in this direction will be appreciated by the public. We are glad that the Madras Minister depends upon Rural Practitioners for carrying out his ideals in rural areas and trust he would afford necessary facilities to them to carry out welfare work of the type the popular Minister has at his heart.

The President has certified that "*Madras with the zeal of a new convert had done more than what was expected*". We in our turn trust that Dr. B. C. Roy who occupies the *Gadi* of the President of the Indian Medical Association for a second time, will give a right lead to the Indian Medical Association and bring it to a level of efficiency of the British Medical Association and work out ways and methods by which the medical profession is able to maintain itself honorably depending upon its own activities and not on the bounty of the Government, not forgetting their responsibilities to the public with regard to medical relief including for those that cannot afford to pay for it.

OTHER IMPORTANT EVENTS.

In India the Xmas season has been most eventful. Advantage is taken of the holidays and time is spent in holding gatherings for serious thoughts. Politics, religion, education, and various other subjects concerning the welfare and prosperity of the people form the themes of discussion at these gatherings. Almost every province in India has its own conference or conferences for variety of purposes. Madras has two such conferences which are likely to affect the welfare of the public and the prosperity of the

Medical Profession. The one, the All-India Medical Conference we have dealt with in the current issue of the journal. The conference of the Public Health Ministers was held in camera though the decisions arrived at were published and find a place in the current issue. The other important events are the publication of New Schemes of Re-organisation of the Madras Medical Department and Medical Relief of which the sole author is the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister of Madras. He has taken the role of a benevolent Dictator and how far his benevolence will be conducive to those to whom it is meant will be discussed in these columns next month.

SUBSIDIZED RURAL MEDICAL RELIEF.

The Hon'ble Dr. Rajan, the Public Health Minister was pleased to meet the members of the Interim Committee of Management of the Provincial Subsidized Rural Medical Practitioners' Association at the Secretariat on 25.1.38. The Surgeon-General, the Director of Public Health, and Dr. V. Rama Kamath, the President of the Subsidized Rural Medical Practitioners Association were also present at the Conference. The minister discussed with the members of the Interim Committee the various items of the terms of the Agreement wherein alterations were suggested by the Association at the Conference which met in Madras on 10.7.37. The majority of suggestions made by the Association were agreed to by the Hon'ble Minister, the most important of these being the deletion of two clauses which were recently introduced in the Agreement prohibiting the Subsidized Practitioners taking part in Civics and Politics. A detailed account of the discussions that took place at the Conference will be published in the next issue.

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A Monthly Medical Journal

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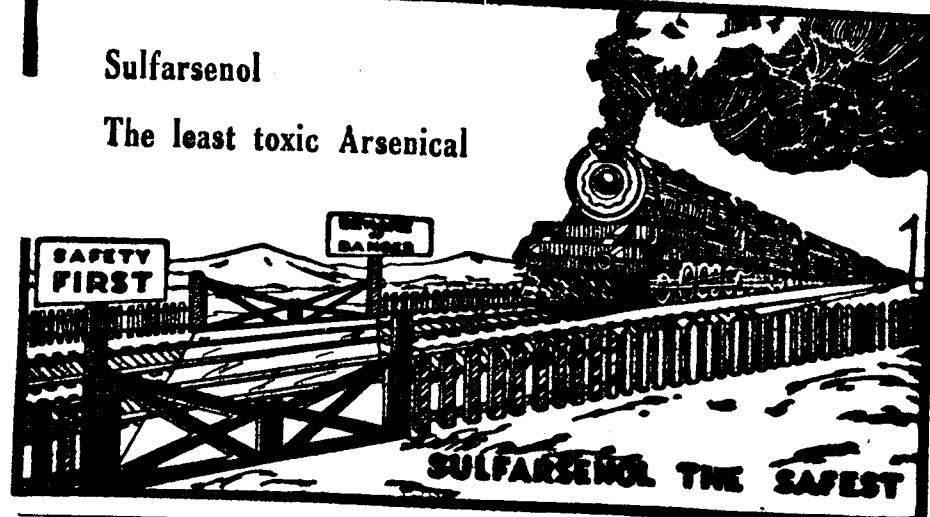
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Vol. IX]

FEBRUARY, 1938

[No. 5

Original Articles.

DIAGNOSIS OF CONGENITAL HEART LESIONS.

By

DR. S. D. AMBEGAONKER, M.B., M.R.C.P. (LOND.)

Bombay.

This article is essentially meant to facilitate a distinction between the various congenital anomalies of the heart occasionally met with in general practice. An attempt has been made to confine to the clinical findings in each condition so far as possible, with only occasional references to Radiography and to Electrocardiography as neither of them may be accessible to the patient and sometimes even to the practitioner. Minute embryological and obscure technical conditions have been avoided with a view to remove part of the mystery which I have sometimes found shrouding around the congenital lesions of the Heart.

of distinguishing this condition is not being exaggerated when I remember that one of the Heart Specialists of to-day had been taken from one doctor to the other in his boyhood, to find out what really was "wrong" with the boy's heart? Even when present, neither does it indicate any impairment of the heart-functions nor does it add to the gravity of another concomitant condition if any. It would be worse than useless therefore, to lay down restrictions in exercise to the former type of case and make the boy's life invalid at that age.

Congenital Heart diseases can be grouped as (1) Cynotic and (2) A-Cynotic.

(1) CYNOTIC GROUP:

In this are included,

- (a) Fallot's Tetralogy.
- (b) Pulmonary Stenosis.
- (c) Septal defects.

I must start with a warning that Sinus Arrhythmia is a very common condition in the young, and for every irregularity of the pulse accidentally detected by the relatives of the patient or the doctor himself, it should be excluded first, bearing in mind its relation to respiration and disappearance on exertion. The importance

ould be well to remember here that cyanosis to occur early in infancy (tricus Coeruleus) the normal shunt from left to right must be reversed and this is obviously favoured by a septal defect associated with Pulmonary Stenosis causing a hypertrophy of Right Ventricle.

(2) THE A-CYNOTIC GROUP INCLUDES.

(a) Co-arctation of the Aorta.

(b) Patent ductus Arteriosus.

(c) Aortic Stenosis.

(1) CYNOTIC GROUP.

Fallot's Tetralogy

This condition consists of:—

(i) Pulmonary Stenosis at the conus,

(ii) Rt. Ventricular hypertrophy,

(iii) Defect in Inter-Ventricular Septum,

(iv) Dextro-Aorta.

It is characterized by cyanosis, dyspnoea, clubbing of the fingers and polycythemia: with exertions the cyanosis deepens and the dyspnoea increases.

The clinical findings are a systolic murmur heard best at the 2nd or 3rd left interspace conducted to the left clavicle, but the murmur is not so harsh and the thrill not so constant as in Pulmonary Stenosis.

No Pulmonary Stenosis and a dilated Pulmonary artery form Eisenmenger complex.

The average age of death is regarded 12 years, death being due to infective Endocarditis, Pulmonary Tuberculosis or crossed Embolism, but patients do sometimes reach an adult age. Dr. Evans Bedford had given an interesting demonstration of a case of Fallot's Tetralogy at the National Heart Hospital, London, in October 1936, the patient was a female about 30 years old.

The X-ray findings are,

(a) Right sided Aortic Arch,

(b) Concavity in the place of Pulmonary shadow.

(c) Right Ventricular hypertrophy, pushing the apex away from the diaphragm. (Coeuren, Sabot)

Pulmonary Stenosis.

Pulmonary Stenosis usually coexists with some other congenital heart anomaly or a septal defect with a closed septum. The cyanosis is late to appear, but if associated with some lesion involving more strain on right ventricle, the normal shunt is reversed and cyanosis sets in.

The physical signs are a harsh systolic murmur best heard at the pulmonary area always accompanied by a thrill and conducted towards the left clavicle with evidence of right ventricular hypertrophy.

The X-Ray findings of this condition depend upon the patency or closure of foramen ovale, the shadow of conus being prominent in the former and that of the superior vena cava in the latter which is rarer of the two.

Septal defects.

The commonest septal defect is a patent foramen ovale, the incidence of which is 30% even in the normal hearts and to which no significance need be attached. A widely patent foramen ovale again, seldom occurs alone being usually associated with a Pulmonary Stenosis or a patent Ductus Arteriosus or some other congenital lesion of the heart. The patient may not be cyanosed, the cyanosis being terminal and may seek advice for pallor, thin build or delayed puberty all being explicable in view of the less blood flowing through a hypoplastic aorta.

A systolic or presystolic murmur at the 3rd left interspace of a varying intensity with no definite conduction and thrill may be the only physical signs.

Defects at the lower part of the septum may be complicated by involvement of the mitral valve causing mitral incompetence or occasionally an acquired stenosis may be superimposed on the congenital defect. In the former auricular fibrillation is common, a point of great diagnostic significance, since fibrillation is seldom found in any other congenital lesion, if at all.

In the A-Cynotic group of lesions, I believe, coarctation of the Aorta is the chief.

Coarctation of the Aorta.

Most of these patients come under observation as cases of "Hypertension". Dyspnoea on exertions may or may not be present. Dr. Sheldon demonstrated two cases of coarctation of the Aorta consecutively at the King's College Hospital, London in March 1937, both the patients were boys, aged about 12 years; and he uttered a very useful warning, "Before you diagnose 'Hypertension' in a boy, always put your fingers on his Femorals."

The physical signs are characteristic and they are.

Unequal Radial pulses, weak and delayed Femorals, dilated tortuous and pulsatile arteries in the interscapular and supra-scapular regions, and in front of the chest, systolic murmurs heard over these and signs of an enlarged left ventricle. Blood pressure in the arms is high, that in the legs is low, though the blood flow to the legs is normal.

Radiographic Examination only clinches the diagnosis and may not be found essential in typical cases. The findings are a dilated ascending Aorta, absence of aortic knuckle and notching of the lower borders of the ribs due to pressure from collateral vessels.

The average age of death is 35 years but longer spans of life have been recorded. Coarctation of the Aorta may be an antecedent of rupture of the Aorta and cerebral haemorrhage may blow out life's little candle.

Patent Ductus Arteriosus.

This is usually associated with coarctation of the Aorta, Pulmonary Stenosis and if alone it may give rise to Pulmonary Atelectasis (nonexpansion of air cells).

The patient comes under observation for pallor, dyspnoea on exertions (there is no cyanosis) and occasional paroxysmal tachycardia.

In the physical signs, a see-saw murmur in the 2nd left interspace, accompanied by a thrill conducted upwards towards the left clavicle are the more important. This is the only congenital lesion which may cause aphonia due to pressure of the ductus, on the left recurrent laryngeal nerve.

Aortic Stenosis.

Under this heading, I include the adult type of stenosis, neither the stenosis at the orifice nor above the ductus arteriosus.

The usual complaint may be a pallor or dyspnoea following exertions or both.

Physical signs are, a characteristic pulse with a slow rise and a slow fall which is always present. A harsh systolic murmur in the Aortic area conducted upwards towards the right clavicle into the great vessels of the neck, accompanied almost always by an aortic systolic thrill is diagnostic. It must be borne in mind however, that contrary to the common belief, an absence of this thrill does not negate the diagnosis of Aortic Stenosis. This Systolic thrill has been sometimes found in anæmia where no stenosis was detected post mortem. On the other hand, an absence of the characteristic pulse should lead the observer to revise the diagnosis after a careful examination of the pulse, in view of the fact that this pulse is due to a low systolic pressure which must co-exist with an Aortic Stenosis.

I do not feel this brief survey of the diagnosis complete without a reference to Dextro-Cardia.

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As the word signifies, it means a right-sided heart more commonly as a 'Mirror image' with the arterial ventricle forming the apex but pointing to the right. The heart is usually normal and seems to partake of the transposition of other viscera like the stomach and the liver. Dr. Frederick W. Price had demonstrated a case of Dextro-Cardia at the National Heart Hospital, London, in October 1936: the patient was a female, age about 40 years and had in addition, thyrotoxicosis. Although not a common condition it would be, I believe, a good rule to try for

the apex beat on the right side, if it is not palpable on the left in any case, for one reason or the other.

Out of all the conditions mentioned so far this is perhaps the only one that gives a typical Electrocardiogram. It shows an inverted lead I, in which all deflections point downwards. The tracing shown on the next page shows inverted P, R and T in the normal cycle. The T wave is upright in the extra Systole; there is coupling of beats. This patient also had an acquired Mitral Stenosis.

RADIUM VERSUS OPERATIONS IN THE TREATMENT OF MALIGNANT DISEASE.

By

DR. N. S. NARASIMHAM, F.R.C.S.

I. *Introduction.*—In opening this discussion my object is to bring before the profession (a) the prevalence of certain common forms of malignant disease in this province, (b) the practical results of the use of radium in malignant disease and, (c) the conclusion that radium cannot abolish surgery and that good results can be obtained only by a combination of surgery with radium and by deep X-ray therapy. Radium workers should be very conscientious surgeons, and the co-operation of a group of conscientious radiologists is essential; the surgeon and the radiologist should work together and assist each other to ensure the safety and comfort of the patient and to achieve better end results.

II. *Incidence of Malignant Diseases as estimated by the cases treated in the Madras General Hospital:* No discussion on a subject like this can be complete unless the incidence of malignant disease is surveyed. The following brief survey is based on the records of the General Hospital, Madras.

During the period dating from 10-4-'35 to 17-12-'37, 860 patients were treated at the Government General Hospital,

Madras, of whom 745 were males and 115 were females. Out of these 623 cases, i.e., 72 per cent were oral Carcinomata; 553 being males and 70 females. The rest 28 per cent were cases of Sarcoma, Fibroma, Rodent Ulcer and other tumours of different types including malignant tumours of unknown origin. It may be observed that attendance of cases of malignant disease at the General Hospital, Madras, has not increased during the past nine years when the patients had the benefit of radium treatment. The comparatively low number of female patients who have been treated for malignant disease in the above list is probably due to the following facts:—1. There are two separate hospitals for women where alone cases of the carcinoma of the cervix are looked after. 2. The number of beds available for women in the Government General Hospital is less than a third of the total number of beds. 3. The attendance of women at out-patients is less than half that of men. 4. The average in-patient attendance of women is one-third the attendance of men.

III. *Some General Considerations for Radium Therapy and for Surgery in*

the Treatment of Malignant Growths.—This is the only province in India where radium is available for the poor in three centres. The Government has 1.5 grammes at present in Madras. And as Radon is now being used here and will also be available in the moffusil centres in future one may review the cases for future guidance.

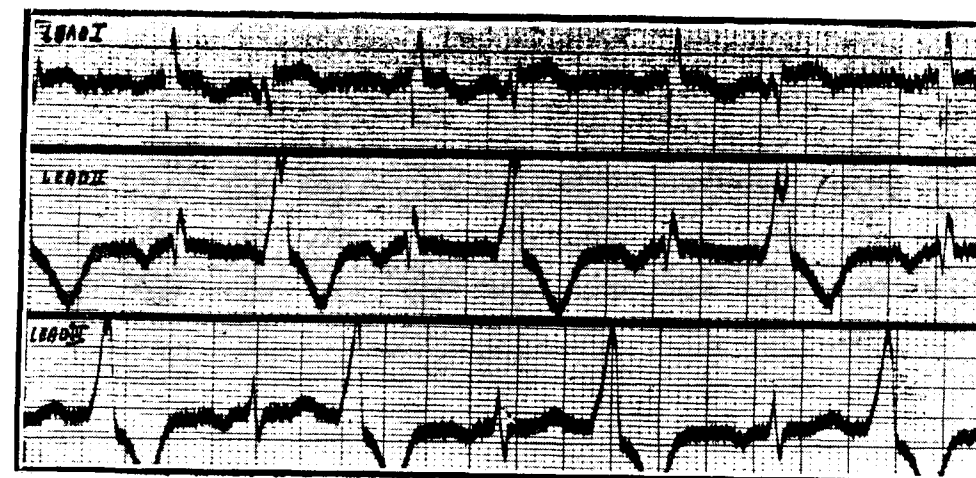
Even the poor and the ignorant know about the value of radium as a remedy, and its availability in Madras brings to the city hospitals a large number of advanced cases for which nothing can be

2. Growths of kidney, ureter, and
3. Some cases of growths of bladder.

Coagulation diathermy is the treatment useful for Growths of bladder.

Radium treatment:—(a) It is effective for primary conditions of

1. Carcinoma of the lip. 2. Epithelioma of the anus. 3. Tongue, and cheek.
4. Carcinoma of the cervix uteri. 5. Rodent ulcer, if it has not involved the cartilage or the mucous membrane.



abilities are exaggerated, its pitfalls are underestimated and the medical literature as well as the lay press offer constant examples of unreasonable claims and unjustifiable statements. It is however as cruel and misleading to deprecate as to exaggerate the usefulness of this very delicate weapon, which in careful hands, controlled by minds unbiassed or unprejudiced cures a "selected" few, relieves a great many and robs us of one of the benefits of excisional surgery".

Pure surgery is the only treatment for

1. Carcinoma of the stomach, caecum colon and rectum,

IV. *Radium and Surgery in the treatment of Malignant Growths of the various regions of the body:—*

A. *Carcinoma and other malignant growths in the region of the mouth.*—The incidence of oral carcinoma has already been referred to. When it is realised that these 623 cases involve the cheek, the tongue, the lips etc.—parts which are looked at so frequently either by oneself in the mirror, or by the other members of the household or by the friends, parts which even in the earlier stages of the disease interfere

with the ordinary cleansing of the mouth, with drinking and eating—it is very surprising that they do not come for treatment in the early stages.

1. *Malignant growths of the tongue and cheek*: Operative treatment has been entirely abandoned for the primary lesions of lips, cheeks and the anterior part of the tongue, and floor of the mouth. Interstitial radiation under an anaesthetic with the preliminary removal of septic teeth two weeks before radiation are practised. Surface application, by moulds over the tongue and cheek, can be tried effectively in cases where the patient is not suitable for an anaesthetic, provided, (a) the patient can open his mouth well, and (b) the radium is available for a fortnight.

There is some difficulty in diagnosing the cases of the posterior third of the tongue; they come with dysphagia and an examination under an anaesthetic and the co-operation of a throat surgeon are very helpful. They react well to radium but a mould is not suitable; the growth should be made accessible for radium implantation by splitting the cheek; I did not find retrograde needling from the neck effective. Cases of carcinoma of cheek, which have invaded the gums, the jaw, angle of mouth and lip and floor of mouth do not react so well and the prognosis is definitely poor, when the floor of the mouth is involved.

When the growth degenerates and forms a number of fistulous communications with the exterior and when the masseter muscles get infiltrated, there is difficulty in opening the mouth. To this is added, the sepsis, resulting from neglect of oral hygiene. These classes of sufferers are not obviously suitable for any radium treatment or surgery.

Cases treated with radium must be examined in three to four weeks' time and suitable treatment of the lymphatic areas of the neck must be given. A radium pad for the lymphatic area when there are no palpable glands and a block dissection when glands are palpable must be done.

There is no doubt that cases whose lymphatic areas have been dealt with live much longer than the cases whose lymphatic areas have not been dealt with by operation or by radiation with deep X-ray or radium. It is here that the conscientious surgeon and the radium worker and the practitioner should co-operate. The practitioner knows that careful palpation without hurry, by relaxing the structures, is essential to detect lymphatic gland enlargement. Patients are often correct when they complain of a pulling sensation or a cord like feel under the lower jaw and in the neck. It is the metastasis and not the primary disease that usually cause the death of the patient. It is here that I want to sound the warning note, that the indiscriminate use of Radon may not after all be useful or enhance the end-result. Surgical diathermy is useful if the jaw is affected and the resulting necrosed bone may subsequently be removed. Excision of the lower jaw, has become a very uncommon operation now-a-days, but in suitable cases the end result will be better. There is still an indication in some of these cases to excise the lower jaw.

The tongue cases require careful watching. Primarily, radium for the tongue and a radium collar for the neck is given. We must take out the glands before they are infected. If the glands are clinically invaded, there is no use taking them out. Theoretically a double block dissection is required. I have noticed that in two of my block dissection cases, two years afterwards, the patients came back, with enlarged glands in the opposite side of the neck.

Gland dissection by itself is a first class operation and there is no use in half-hearted operations. The operative mortality in this hospital, after this operation is very low. Primary growths disappear and a mobile tongue results. Recurrences are common after a year. A second dose of radium should not be given earlier than three months; it is important to be able to diagnose a radium reaction from a recurrence.

2. *Epithelioma of the palate* is treated by radium mould or by burning them with diathermy cautery; the cervical glands (upper deep cervical region) must be treated with radium collar. These cases are unsatisfactory and they depend upon the type of malignancy. There is a case of an elderly man of seventy with adamantinoma of the upper jaw, alive for eight years. These are obviously rare. Majority of the palate cases do badly and no excision of the jaw is practised at present in this hospital.

3. *Epithelioma of the lip*: Some of these cases are seen early but some in a very advanced stage. They are of low grade malignancy and even the advanced cases react well to radium. The lymph glands must be removed by a block dissection and in most cases, a bilateral removal of at least sub-mental group and sub-maxillary group is essential.

Bloodgood says "my experience of radium in early cancer of the tongue is the same as with cancer of the lip; it cannot compete with good surgery. Many early operable cases are made inoperable by the use of radium. There can be no question, concerning the value of the use of radium in the treatment of malignancy of the tongue, under certain conditions, but clearly operable cases should not be treated with radium."

4. *Epithelioma of the floor of the mouth*: It may appear primarily on the floor of the mouth or secondary to epithelioma of the tongue. Prognosis is bad and these cases do not react to radium. Pure surgery has been followed by high mortality and is not practised here at present.

5. *Uvula*.—If the growth is confined to uvula it is better excised; and double Block dissection is required. Prognosis is not good. Radium in early stages is good, but in late cases it is definitely bad. It is difficult to retain radium by interstitial method here.

6. *Upper jaw*.—Excision of the superior maxilla was a routine operation with

40% mortality, ten years ago. Radiation by interstitial method with or without a surgical exposure, embedding radon seed in the growth and or deep X-ray are practised. Cases come only in the advanced stage. Most hospital cases die in a year and there was one case where after radium treatment, the patient lived for two years. It is wise to operate after radium treatment, if the disease is confined to the bone, followed by a block dissection. If the disease has spread beyond the limits of the bone into the cheek, or backwards into the sphenomaxillary fissure, complete excision is not possible and should not be attempted. In a case, recently, in a young man, after radium the growth of the jaw disappeared, the glands in the neck faded away, only to be followed by a metastasis in several parts of the body. Radium needles are dangerous weapons, if used with insufficient skill; there is no doubt that it stimulates a malignant growth of a certain type; there is no doubt in the statement that metastasis appears as a result of radium treatment, in far away parts of the body.

7. Tonsils:

(a) Sarcoma of the tonsils melt with radium.

(b) In carcinoma of the tonsils, a block dissection with pre-operative radiation with X-rays is always to be done. The effect of radium is most disappointing in carcinoma.

8. *Sub-maxillary growths*: These are rare. A case treated by excision with post-operative radiation is alive after 8 years; he has had two further radiations, for local recurrence 5 and 3 years ago. He is rapidly declining in health.

B. *Malignant Disease of the Pharynx*.—Malignant disease of the pharynx is fairly common. They all come in a very advanced stage and the utmost that has been possible to do is to apply a radium pad externally. It has not been possible to get early cases for operation. A carefully planned operation in suitable early cases, will give good results.

C. *Extensive carcinoma of the larynx* is very commonly seen, in advanced stages here. The number shown in the list, at the General Hospital, Madras is no guide to its true prevalence. Many advanced cases could not be admitted. It is not possible to do anything for them when they come so late. It is well to realise, that if operation is carried out, when the growth is confined to the vocal cord, the prospect of ultimate cure is better than that for carcinoma in other parts of the body. Obviously early detection is of great importance.

D. *Malignant Tumours of the nose*.—Radium and deep X-rays are almost always used now.

E. *Parotid growths* must be treated by removal as they are all potentially malignant. A malignant growth is treated by radium first and can be excised six weeks later. Operation itself has been followed by a large percentage of recurrences.

F. *Carcinoma of the oesophagus* is a baffling problem. Excision has not been attempted so far here. In view of the misery and suffering, which is witnessed, I am convinced that gastrostomy must be done as early as possible; this will give them a comfortable life for 18 to 24 months; their lives are made miserable by local sepsis, and extension into peri-oesophageal tissues, involvement of pleura-bronchi and mediastinum. This can be minimised or postponed by early gastrostomy. Gastrostomy in the hospital type of advanced cases has 40% mortality and is hence unpopular with the surgeon and the staff. Deep X-ray therapy and intra-cavitary radium are the usual routine.

G. *Carcinoma of the rectum*—While radium is the most effective method of treatment for carcinoma of the anal region, radium is not of any value in rectal growths. Intracavitary methods, interstitial method of application in the post-rectal space, intra-peritoneal interstitial methods have been used and they are of no value in my experience. Radium must not be used without a colostomy; the plight of such

a patient who has had radium without colostomy is very miserable; colostomy followed by a standard operation is the ideal method. Colostomy alone, will give a lease of life for three years and it is well managed. The profession must dispel the idea that a colostomy is inconsistent with an active life.

H. *Breast*.—Before discussing the treatment of Breast carcinoma, one may as well remind oneself, that ten years of radium treatment in this province i.e., treatment by non-removal of breast, has not in any way brought early cases to the doctor. The early cases are those that come with mastitic breasts and one has to make up his mind in the treatment of these cases. Sir Anthony Bowlby used to point out that the natural period of existence without any treatment is three years for these cases. One has to consider how much more can be gained by the operation or radium or both combined, in the lease of life.

The *clinical course* of the breast carcinoma can roughly be divided into four periods:—

(a) the first period of 7 to 9 months, when nothing is palpable except only a lump with no superficial or deep attachments and no glands.

(b) the second period of 9 months with deep or superficial attachments; but there is no extension outside and there is no ulceration.

(c) the third period of nine months with enlarged glands, and later ulceration and fungation is present.

(d) the fourth period, when skeletal metastasis is seen.

Treatment.—With the best operative technique by the best surgeon, only less than half the patients will be free from any signs of the disease at the end of 5 years, even when the growth is in its earliest stages, apparently confined to the breast itself and when no evidence of invasion of glands can be detected, on the most careful microscopical examination.

Mr. Keynes of St. Bartholomew Hospital, London, advocates radium alone, as the method of treatment reserving local excision for any remnants of tumours or for local excision of breast. Mr. Keynes has produced figures in support of this opinion. I have seen his cases demonstrated and they are really good results. I consider that his cases are really very early ones as compared with our cases here. Not only his cases but all the cases that I have seen in various London hospitals are really early cases compared with ours.

Mr. Keynes' colleagues, all still practise the Halstead operation in the same hospital and it is difficult to understand why they are not convinced of his views. It is true that there is a definite operative mortality and risk in this country nearing 5 to 10% in the Halstead operation. 10 cases were operated in 1935 and 16 in 1936 while 36 had radium treatment. Two cases who have been under prolonged observation are cases who have been operated (Halstead's method) and who have had post-operative radiation by surface application, of radium or deep X-ray therapy repeatedly. The treatment of choice for early cases is by operation (Halstead). In other cases Radium treatment is good. Radium treatment may be followed by local excision of the tumour mass or breast. Radium treatment does not prevent metastasis in the glands or distant metastasis or into the opposite axilla and breast. One has noticed large number of nodules on skin after interstitial treatment and this cannot be a coincidence. In what type of cases exactly this will occur it is impossible to say. Cases of duct papilloma, duct carcinoma all must be operated.

If the neuro-vascular bundle in the axilla is affected it is not worth while operating and you should not treat the axilla in these cases with radium. Deep X-ray is useful to get rid of skin nodules. The technique of Radium therapy is that advocated by Mr. Keynes. Do not push the needles into the tumour. You may disseminate.

In atrophic schirrhous of breast, radium and operation are not to be advocated. They live 5 to 10 years without operation. If you interfere, you will get widespread dissemination. Deep X-ray may be used.

The following are contra-indications for operation. 1. Widespread extension of the growth. 2. Presence of secondary skin nodules. 3. Wide ulceration or oedema of skin. 4. Enlargement of supra-clavicular glands. 5. Presence of distant metastasis. 6. Involvement of both breasts. and 7. Enlarged fixed glands in the axilla.

Method of dealing with doubtful lumps.—There are occasionally difficult cases; a case of tuberculous adenitis, of the pectoral group, was met with in an elderly lady; a growth was mistaken for an abscess in a young woman; local excision and aspiration with a needle on the operation table are not to be despised in doubtful cases.

The above remarks on carcinoma of the female breast, apply also to the cases of carcinoma of the male breast. These also come in advanced stages.

I. *Epithelioma of the Genitalia*:

Penis.—When surgeons in western countries advocate radium for these cases they probably see the case, with less than a shilling-size ulcer. Here, we see huge cauliflower like growths, ulcerative types, which definitely have invaded the body of the penis. Experience in three cases with radium does not encourage me to advocate this treatment at all. Extirpation of the penis with removal of lymph glands easily gives a freedom from trouble for 7 to 15 years and operation has to be advocated as a routine.

2. *Prostate*.—The prostates removed must be examined microscopically and if found histologically malignant, they must be treated with deep X-rays.

The type of prostate, which is clinically diagnosed malignant, runs its own course without being affected by deep X-ray. In

one case of a young man, interstitial radiation did not mitigate the agony of the disease which pursued a rapid course.

3. *Vulval and vaginal growths* are better operated. Limited experience of two cases showed extensive infiltration after radium.

J. *Growths of the Urinary Tract.*

1. Growths of the kidney and ureter are dealt with successfully by operation. May I stress, that every case of hæmaturia, must be sent to the surgeon for a thorough investigation at once.

2. Growths of the bladder do not respond to radium. Surgical diathermy was useful in one case for 2 years. In spite of the dysuria, most Indian patients have arrived in this hospital at a late stage.

K. *Malignant Growths of the skin.*

1. *Rodent ulcer.*—There is no doubt that unscreened radium or interstitial radium acts well on a large percentage of these cases; it leaves a supple area and the cosmetic result is good. Although it occurs in other situations, the common situation being face, it is no doubt desirable to get a good cosmetic result.

Here again a radium worker who may not have the opportunity to see the bad cases, or the Surgeon who does not see his recurrent cases may draw fallacious conclusions regarding the efficacy of treating these cases, with radium alone.

I have a case who first saw me in 1930, who is in a terrible plight now; he has had three radium treatments. There is a lady, who has been under treatment for 8 years. Half her nose is destroyed, and the disease is not arrested.

In Guy's hospital, London, the results of operation alone, in a large number of cases, for the past ten years, has been quite superior to Radium alone.

The following rules of practice may be laid down. Size of two anna silver-bit

can be cured by anything as CO₂, Radium, X-ray, diathermy excision, surgical diathermy.

Up to the size of half a rupee wide excision if possible must be done.

If mucous surface is involved, radium is of no use; the ulcer will go on spreading. It requires wide excision, flat diathermy application is best; there will be necrosis of bone which will separate later. The scar is supple and the ulcer heals rapidly.

In the case of Ear, in one case the *Pinna* had to be excised. In spite of the deformity, this is better done, as the bone or the dura or both may become involved and the ulcer may spread into the meatus.

Radium burns may occur in small or large cases. The majority of radium burns become epithelioma. Rodent ulcer and epithelioma round about the eye treated by any method except excision has led to conjunctivitis and even panophthalmitis; an operation would have been better. Excision and skin grafting have to be done. This cannot be done without excising the eye. If the rodent ulcer involves the muco-cutaneous junction, it is difficult to eradicate it.

(2) *Skin Epithelioma* is better treated by wide excision and skin grafting. When the bone is invaded amputation is the treatment of choice. Dissection of glands must be done after 2 weeks.

(3) *Melanomata* are better treated by wide excision: the other methods of treatment by caustics, CO₂, diathermy, ligatures and partial excisions are to be condemned.

Conclusions.

(1) Oral cancer predominates in this hospital where patients come from all parts of the province.

(2) A central organisation for each province to educate the profession on the

early diagnosis of malignant disease is essential.

(4) All surgical measures must be adopted for the treatment of the lymphatic area.

(3) Radium is no panacea for malignant disease; it has to be used intelligently and conscientiously as regards (a) the application (b) correct spacing, (c) uniform linear intensity and (d) the correct period of application.

I thank Lt.-Col. Cruickshank the Superintendent of the Government General Hospital for the permission to publish this paper.

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Abstracts.

CHOLECYSTITIS

By

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The subject of gall-bladder infection has been discussed in recent years at many times and in many places, especially by hospital physicians and surgeons. It is a good choice for discussion at an Annual Meeting of the British Medical Association, because its great frequency and clinical importance may then be emphasized to the general practitioner, who, after all, has the main opportunity and responsibility of recognizing inflammation of the biliary tract in its earliest and most important stages.

The combined results of many observations, by physicians, surgeons, and pathologists, seem to show without any doubt that disease of the gall-bladder is now the commonest of all organic troubles of the digestive tract. This has been repeatedly stated by Sir Arthur Hurst, and he will no doubt speak on this point to-day. Statistics in different countries and in different clinics must vary, but Piersol (1936) has recently published an analysis of the admissions to the gastro-intestinal clinic of the University of Pennsylvania Hospital, Philadelphia, and shown that 16.3 per cent. of all the patients were diagnosed as suffering from gall-bladder disease. Duodenal ulcer, cancer of the stomach, gastric ulcer, and chronic appendicitis followed, in this clinic, in order of frequency, but these are merely the results in one American hospital. I am unable to present the statistics of any large series of gastro-intestinal cases in Britain, but it may safely be accepted that cholecystitis is now established here as one of the most common and important intra-abdominal diseases.

It is obviously my duty in opening this discussion to give a general survey of the problem before us and not to spend undue time on matters which will be dealt with in greater detail by subsequent speakers.

AGE, SEX, AND TYPE OF PATIENT

It must nowadays be realized that the female who is "fat, fair, forty, and fecund" is by no means the only type subject to biliary disorders and to their common sequel of gall-stones. It is true that cholecystitis is more common in females than in males, for reasons which have many times been discussed and which need not detain us now. Gall-bladder troubles are, however, quite common in men, and it may be emphasized that cholecystitis occurs in young men and young women, and even in children. These facts are, I think, not yet sufficiently and universally realized. With the increasing of outdoor games and exercise in young people this disease may diminish; but there are many, mostly living in cities, who have sedentary occupations in offices and factories and are prone to dyspepsia and biliary disease. In acholuric jaundice, a disease generally recognized in youth, there is a special tendency to disorders of the biliary tract—both pigment stones and cholecystitis.

AETIOLOGY.

I have already referred to sedentary occupations as increasing the risk of cholecystitis, and indeed the factor of biliary stasis is the only important predisposing cause on which almost everyone will agree. It would not be justifiable here to discuss disturbances in the physiology of the biliary tract as a cause of biliary symptoms, since so little is known with absolute certainty. Problems concerning the sphincter of Oddi, contraction of the gall-bladder, and spasm of the main bile ducts are all involved here; and frankly, in my view, the time has not yet come to bring questions of disturbances in the physiology of the biliary tract into the realms of ordinary practical medicine. We have enough to deal with at present in gall-bladder pathology, due

to microbic infection of the gall-bladder and biliary tract, the essential cause of the subject we are discussing—namely, cholecystitis. Here, too, we are faced with the difficulty of reconciling the divergent views of physicians and surgeons for the ultimate benefit of our patients. This matter will no doubt be examined fully by Sir Arthur Hurst and Sir David Wilkie, and I need only place the general position before you.

The points of importance are:

1. What are the common microbes which infect the gall-bladder, and what is their relative frequency?

2. By what route is the gall-bladder infected—by passage along the ducts from the intestine or by the blood stream? Do the microbes in fact exist mostly or partly free in the bile, or is the infection essentially deep-seated in the wall of the gall-bladder?

The importance of focal sepsis in teeth, tonsils, appendix, or elsewhere in the aetiology of cholecystitis is an essential part of the problem, which I only mention to give a lead to other speakers.

VARIETIES.

Cholecystitis with Gall-stones.—It is obvious that in the past the diagnosis of cholecystitis was seldom made before the common sequel of gall-stones had occurred and given rise to obvious signs or symptoms. Even now-a-days the frequent accidental discovery of gall-stones of inflammatory origin at post-mortem examinations shows either that a diagnosis was missed or that the symptoms were insufficient to make the patient seek treatment for biliary disease. It must be remembered that in patients who have already developed gall-stones recurrent attacks of cholecystitis are common and often severe.

Acute Infective Cholecystitis.—This is a surgical emergency and needs no discussion.

Catarrhal Cholecystitis.—This is the variety I wish to bring into the forefront

of discussion to-day. It is due to infection with organisms of obviously low-grade virulence, and often smoulders on without giving rise to serious or acute symptoms for a long period of time. It is difficult to diagnose, but if untreated is likely to be followed by gall-stones and many other complications.

SYMPTOMS AND DIAGNOSIS

Moynihan, in the days of the rapid development of gall-bladder surgery, described the "inaugural symptoms of gall-stones." These we know now, were the symptoms of the preceding cholecystitis, but at a later stage than we must now identify them. At that time it is fair to say that the early stages, except of the acute and fulminating variety constituting a surgical emergency, were seldom if ever sought for or recognized. It is the diagnostic problem involved in the common catarrhal cholecystitis that I wish to emphasize, and a correct diagnosis will often be missed and treatment too long delayed if the doctor fails to investigate further all cases of dyspepsia which do not respond to simple treatment. He may, and generally does, consider the possibility of gastric or duodenal ulcer, and is disappointed when the X-ray examination by barium meal which he advises yields a negative result. He may think of chronic appendicitis; but up to the present he too seldom thinks of the great frequency of gall-bladder disease as a cause of dyspepsia. The association of flatulence with the dyspepsia is suggestive, but by no means conclusive.

It is best at the very outset, when considering how the diagnosis of gall-bladder infection may be proved, to admit the difficulties involved. The diagnosis by simple clinical methods is easiest when gall-stones are present. Biliary colic occurs in roughly 40 per cent. of such cases, while recurrent acute attacks of cholecystitis lead to obvious signs in the right upper quadrant. Further, it is in these cases that cholecystography is of such great diagnostic value. Even when gall-stones are absent the local signs of tenderness or pain or both below the right costal margin may, along with the pre-

sence of flatulent dyspepsia, strongly suggest the diagnosis. The real difficulty arises in the cases—and they are many—in which a catarrhal cholecystitis is associated with dyspepsia only, without local pain or tenderness over the gall-bladder at all. These are the early cases in which medical treatment may be of avail. How are such cases to be completely and positively diagnosed so that proper treatment may be carried out? Ordinary simple clinical methods fail us here—what help can we obtain by other methods?

I must first refer to cholecystography, but omit any lengthy discussion, since Dr. Hardman is to deal with this aspect of the subject. I will only say that in my experience, which is now considerable the use of the dye followed by X-rays generally does not yield information of positive diagnostic importance in the early cases of catarrhal cholecystitis in which physicians are so interested. I am too often confronted with an X-ray diagnosis of "pathological gall-bladder," or poor filling," or "faintness of shadow," which are taken to indicate disease, when I know full well the differences in technique and the differences in absorption of the dye, even on different days in the same person. On the whole I am still very chary of accepting a diagnosis of early cholecystitis on X-ray evidence, whatever improvements in technique may later make possible.

We now come to the method of duodenal intubation, and here I feel on quite different and much more secure ground. I would go so far as to say that in early cholecystitis it is at present the only diagnostic method on which we can positively rely. It is far too little used in Britain, but is a routine method in America and elsewhere. I have indicated in a recent paper some of the reasons why it has not yet obtained its proper place in diagnosis with us; and I feel this defect must be remedied. Perhaps, as in many tests of this kind, too much was at first claimed for the method; but of its diagnostic value in experienced hands I have no doubts at all.

DIFFERENTIAL DIAGNOSIS.

This is at times easy, but is often difficult unless the technique of duodenal drainage is employed. This section might easily detain me too long, for the differential diagnosis from chronic gastritis, pylorospasm, peptic ulcer, carcinoma, and peripyloric adhesions would require consideration. Moreover, peptic ulcer and chronic cholecystitis may coexist: I have seen a number of examples of this combination. The clinical differentiation between cholecystitis and chronic appendicitis is not easy; and here again the duodenal tube may be the only real help. Diseases of the liver itself, especially early cirrhosis, are frequently confused with gall-bladder infections. I have made this mistake too often and have seen the cirrhotic liver exposed by the surgeon when my confident diagnosis was chronic cholecystitis. I deliberately omit more than a reference to important diseases situated outside of the abdomen—such as coronary thrombosis—which have frequently been mistaken for cholecystitis, since Dr. Miller will be speaking on this point.

TREATMENT.

This will be discussed in detail by subsequent speakers, and I need only deal with some general principles. I have already alluded to the difficult problem of deciding on the site of the microbic infection and the important bearings the solution of this problem must have on treatment by drugs excreted in the bile. Next I must refer especially to the form of treatment now commonly known as "non-surgical drainage of the biliary tract." This treatment began with the use of the duodenal tube, repeated emptying or rather partial emptying of the gall-bladder being induced by the direct injection through the tube into the duodenum of either a concentrated solution of magnesium sulphate or olive oil. Later it was found in practice that the passage of the duodenal tube was unnecessary, the same drainage of the biliary tract being obtained by giving the patient a small dose of concentrated magnesium sulphate solution on an empty stomach. I am

convinced of the great value of this form of treatment when persisted in daily for months.

As regards diet in the treatment of early cholecystitis and the prevention of gall-stones, I am far less strict (except when obesity forms part of the problem) than are many physicians. I do not see the need for restriction in cholesterol-containing foods, since the body can obtain a supply from so many foods. The only essential restriction is cooked fat, and especially "fried foods," which aggravate the common flatulent dyspepsia. I do not exclude butter or milk in moderate amount, and olive oil (a food) has great value in preventing flatulent dyspepsia and in emptying the biliary tract, although it does *not* dissolve gall-stones.

It must be remembered that in cholecystitis the liver itself is damaged or deranged in function, and a sojourn for treatment at a spa which specializes in hepatic diseases and in the other frequent accompaniments of cholecystitis, such as obesity, may be of great value. Disordered function of the liver, so commonly associated with cholecystitis, is claimed by some to be concerned in the aetiology of migraine, but I must state that I have never seen migraine in direct association with hepatic disease.

CONCLUSION.

In conclusion, my plea is for the more general recognition by doctors in Britain of the great frequency of cholecystitis, of the difficulties that must be faced in making a correct diagnosis, of the methods that are of real practical use in diagnosis and treatment, and of the great diagnostic value of the duodenal tube. Further, I would express my belief that catarrhal cholecystitis can be cured in its earlier stages by medical treatment, and that in this way we may hope to diminish the incidence of gall-stones with their frequent dangers and complications.

(B. M. J.—Oct. 16, '37).

Notes on Therapeutics, Diagnosis and other Medical Subjects.

TREATMENT OF RHEUMATISM.

E. SCHLIEPHAKE (*Zbl. inn. Med.*, July 10, 1937, p. 577) is of the opinion that all sources of focal infection must be removed before any other treatment of rheumatic conditions is instituted. The teeth, tonsils, gall-bladder, and the urogenital system may require attention, after which short-wave therapy may be started. The author does not advocate temperatures higher than 38° C.: more treatments are required than when higher temperatures are used, but improvement is more lasting. The condition may temporarily become worse and improvement only begin at the end of the course. The author had good results in 80 per cent. of cases, usually of chronic conditions in patients who had previously received various treatments without result. His criterion of improvement is restoration of function and relief of pain. Anatomical changes could not be influenced. About one-third of his patients were treated with short-wave therapy alone, but the author believes that if medical measures are added treatment is less drastic and is shorter, and for this purpose he uses gold preparations, salicylates, and atophan. A diet poor in carbohydrates is also given for five days after the temperature has become normal.

H. SEEL (*Fortschr. Therap.*, July, 1937, p. 391) points out that in spite of the advances in the study of rheumatism and in the increase of therapeutic adjuvants the place of the salicylates is still recognized. They are of value (1) because of their bactericidal, antiseptic, and desensitizing properties, (2) because of their central analgesic action and their ability to inhibit inflammation, (3) because they increase metabolism and lower temperature, and (4) because they can be absorbed locally and stored in the tissues. When applied locally they induce hyperaemia by enlarging the lumen of the capillaries,

by their absorption and storage in the diseased tissue, by their local analgesic action, and by changing the reaction of diseased tissue. The pharmacological action of salicylates on the rheumatic organism is not yet clear, however. In a febrile local conditions the inunction of salicylate derivatives is of value. In febrile affections, especially of the joints, oral and cutaneous therapy is indicated. Local inunction is contraindicated when heat in the form of fomentations or diathermy is applied, because physical hyperthermia in combination with chemical hyperthermia often results in local burns. In certain severe cases such a reaction may be made use of in order to increase the effect of salicylates.

QUININE IN OPHTHALMOLOGY.

J. W. ROBINSON (*New Orleans Med. Surg. J.*, July, 1937, p. 30) states that quinine may be used with success in ophthalmology on account of its astringent, bactericidal, and anaesthetic properties, and because it inhibits scar-tissue formation. It may be used either in the form of a 2 to 4 per cent. quinine bisulphate ointment or in a 2 per cent. solution. The bisulphate is fairly soluble in water and is less acid and less irritating to the eye than are other salts. Robinson has used it with success in cases of interstitial keratitis, trachoma, old and recent corneal opacities, vernal catarrh, and phlyctenular conjunctivitis. He also recommends a 1/2 to 2 per cent. solution of optochin (ethyl-hydroxycupreine), which is one of a number of alkaloids formed from the replacement of one of the two chemical rings composing quinine by an alkyl group, and which resembles quinine but is less active. It is a weaker protoplasmic poison, but is bactericidal in the presence of protein, and is antiseptic and anaesthetic. It is especially toxic to all types of pneumococci, streptococci, and staphylococci, and is of value in the treatment of conditions due to the Koch-Weeks and the Pfeiffer bacillus, and in some virus infections causing catarrhal conjunctivitis. Both quinine and optochin can be used in conjunction with mercury and the iodides.

HYPEREMESIS GRAVIDARUM.

J. VORON and H. PIGEAUD (*Gynec. et Obstet.*, June, 1937, p. 401) classify admissions to hospital for this condition into three groups: (1) a majority of patients whose vomiting was not originally serious, and who at once respond to hospitalization; (2) grave cases of hyperemesis which are sent sufficiently early by the medical attendant for treatment at a time when the patients still possess adequate protein, fat, and carbohydrate reserves; and (3) advanced, serious cases with little or no metabolic reserves. In both the second and third groups the initial treatment is absolute isolation, psychotherapy in which the personalities of the physician and nurses are of great importance, absolute starvation for twenty-four hours, exhibition of salines subcutaneously and rectally, and the free addition of chloral hydrate to the rectal infusion. In the second group neurovegetative imbalance, a rapidly progressing condition of dehydration, and bilious vomiting are conditions which call for special therapeutic measures. Neurovegetative disturbances demand detailed consideration and are not susceptible to a routine treatment. Sympathicotonia, with tachycardia, epigastric pain, facial vasomotor reactions, brilliant eyes, and a negative oculocardiac reflex, require eserine. Vagotonics, with slow pulse, sialorrhoea, and a positive oculo-cardiac reflex, should be given belladonna. Amphotonics are given eserine and belladonna, also ergotamine, tartrate; and in cases in which the blood pressure is below 100 mm. (systolic) adrenaline injections are added to other treatments. For dehydration hypertonic saline-serum injections are given intravenously. Abundant bilious vomiting calls for the daily introduction of a duodenal tube, through which 33 per cent. magnesium sulphate solution as well as foodstuffs may be introduced. Even in the third class of patients it is exceptional to see one in whom abortion should at once be induced, but there are rare cases in which medical treatment is ineffective. Signs tending to justify induction are a high increasing Maillard coefficient and a declining alkali reserve.

(*B. M. J. Sept. 25, '37.*)

ADDING SODIUM ACID PHOSPHATE TO TABLE SALT TO CORRECT PHOSPHORUS DEFICIENCY

With reference to the addition of acid sodium phosphate to table salt for the purpose of correcting a dietary deficiency of phosphorus, Dr. W. H. Sebrell, of the United States Public Health Service, doubts the efficacy of such a measure in which it is required that all salt used for food purposes shall contain 4 per cent of acid sodium phosphate. The following is an excerpt from a memorandum on the subject recently prepared by Dr. Sebrell:

Sollman states that the phosphate ion is poorly absorbed. The absorption depends, partly at least, upon the amount of calcium and vitamin D present. However, disregarding such important considerations as the utilization of phosphorus furnished in this manner, and the advisability of increasing dietary phosphorus without increasing dietary calcium proportionately, the practical futility of attempting to make a diet adequate in phosphorus by adding sodium acid phosphate to table salt can be shown by a little simple arithmetic.

The average daily consumption of sodium chloride by adults has been variously estimated at from 10 to 20 grams per day. The average daily requirement is estimated at about 2 grams per day. From the available estimates of the amount of sodium acid phosphate proposed to be imported into Chile annually, it would appear that the Chilean consumption of sodium chloride is well within this range and possibly near the lower figure. However, we may base our calculations on the highly improbable maximum average daily intake of 20 grams of sodium chloride: 1 gram NaH_2PO_4 (sodium acid phosphate) contains 0.224 gram of phosphorus. If a 4 per cent mixture is made with sodium chloride, every gram of the sodium chloride-sodium acid phosphate mixture contains 0.00896 gram of phosphorus. On the basis of an average daily intake of 20 grams of the sodium chloride mixture, the average daily intake of phosphorus would be only 0.1792 gram.

Since an adult needs 0.88 gram of phosphorus daily for maintenance (Sher-

man), and the recommended intake per day per adult is 1.32 grams, and the fact that the requirement for children and pregnant and lactating women is even higher than this, it is obvious that the addition of a variable amount of phosphorus, which in all probability will not equal 0.1792 gram per adult per day and will more than likely be in the neighbourhood of half of this figure and even less for children will not be sufficient to correct any material deficiency in phosphorus existing in the population—*U. S. Public Health Service.*

APPENDICITIS FOLLOWING TONSILLITIS AND RESPIRATORY INFECTIONS. CAPTAIN GEORGE R. DAWSON, JR. MED. RES. U. S. ARMY.

The Military Surgeon 80: 447 (June) 1937.

Appendicitis as a sequela of tonsillitis and infections of the upper respiratory tract has been little stressed by American writers. It is admitted that the surgical treatment of appendicitis has attained a high degree of excellence, nevertheless the etiology of the infection is still a matter of divergent explanations. Numerous case histories are reviewed. Three of four patients in the camp infirmary suffering from upper respiratory infections developed acute appendicitis within a period of twelve hours. Nine consecutive cases of appendicitis seen by the author in the CCC were suffering from acute tonsillitis or respiratory disease immediately preceding the attack of appendicitis.

SEPTICEMIA FOLLOWING ACUTE SINUSITIS TREATED WITH SULFONAMIDE COMPOUNDS. J. COLEMAN SCAL.

New York S. J. M. 37: 1147 (June 15) 1937.

According to the author the action of these compounds is derived from their ability to inhibit the growth of hemolytic streptococci by their apparent bactericidal effects on the blood. This is accomplished by stimulating phagocytoses to such an extent that they easily inhibit or destroy the streptococcus. A case report is cited. And in conclusion: "While this chemotherapeutic agent is being tried and exploited it should be borne in mind that it is

not a specific for streptococcus infection. Sulfonamide compounds do not act directly on the organism but in some way influence the action of the body so that it produces a phagocytosis of streptococci in a few hours after administration and the blood assumes a strong bactericidal power.

The dosage of Prontosil in a five c.c. ampoule can be injected intramuscularly three times daily. In extreme cases and in obese patients ten c.c. can be used with impunity. Prontylin tablets can be given at the same time to supplement the Prontosil. One or two tablets given every four hours are sufficient. The dosage should be reduced and the interval lengthened as the patient improves.

These compounds are quite safe in administration to humans as the toxicity is very slight, the dye appears in the urine in about ten or fifteen minutes and stains it red. The only ill effects that have been reported are some renal irritation in the form of albumin and some epithelized red blood cells as well as nausea and faintness. Saline laxatives should not be given during the administration of the dye. Overdosage and long continued administration may result in mild jaundice.

TREATMENT OF DENDRITIC KERATITIS WITH QUININE BISULPHATE ELIAS SELINGER.

Arch. Ophthal. 17 : 1035 (June), 1937.

Dendritic keratitis seems to be a much more uncommon disease in the Middle West than in the New England States. Gunderson reported on the treatment of two hundred and twenty-one patients with dendritic keratitis seen within forty-two months. He found the incidence to be highest before the tenth year of life and reported good results from cauterization of the cornea with strong solution of iodine.

In the past two years eleven adults with simple dendritic keratitis—no children with this disease were seen—were treated with quinine bisulphate in addition to the usual treatment with hot compresses, atropine and bandages. An ophthalmic ointment containing 2 per cent quinine bisulphate was applied to the unanesthetized conjunctival sac twice a day by the patient. No massage was used. In none of the cases was there any extension of the process

as evidenced by the fluorescein stain. The subjective symptoms improved from the beginning—possibly as a result of the anesthetic action of quinine on mucous membranes—and in most of the cases the corneal lesions healed within from a week to ten days. In practically all the cases the eyeball was pale within one or two weeks. In no case did the disease last more than three weeks. In all the cases the condition was moderately severe and in some there was considerable iritic irritation. It is possible that in instances in which the condition was unusually severe the course of the disease might have been more prolonged. No complication in the form of hypopyon keratitis were observed, and up to the present recurrences have not been seen. Most of the patients had an accompanying or preceding infection of the upper respiratory tract. In one case the onset followed removal of a foreign body from the cornea. None of the patients had malaria.

The good results obtained with local quinine therapy suggest a destructive action on the virus producing the disease. The same treatment was also tried in a case of a related virus disease, namely herpes zoster with corneal involvement. The result was good, the corneal lesion going on to healing within three weeks, but as herpes zoster corneae is uncommon, no occasion to check the results has presented itself and no conclusions can be drawn from the results in a single case.

In dendritic keratitis this therapy compares favourably with any other form of treatment previously suggested and because of its simplicity and the lack of discomfort accompanying it is preferable to more strenuous therapeutic measures. The burning sensation which follows the application of the quinine bisulphate ointment is comparatively slight the drug having been used successfully in children from 2 to 5 years of age for other conditions, as was previously reported in other communications.

This report is submitted in order to stimulate the investigation of the action of the quinine in the treatment of dendritic keratitis in regions where this disease is more prevalent.

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REORGANISATION OF MEDICAL SERVICES.

PART I.

On the 25th December 1937 the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister of Madras released his scheme of Reorganisation of Medical Services in the Madras Presidency about which he had been talking without giving details till that day whenever and wherever he had opportunities to do so. Whether the 25th December will be remembered as a memorable and as happy a day by the Medical Profession as do the people in Christendom or the reverse of it, only future history can judge. But as it is, there seems to be pessimism prevailing more than optimism. Excepting the underlying spirit of the scheme no section of the Medical Profession has taken the announcement well as it is. All the same the Hon'ble the Public Health Minister seems to be enthusiastic regarding his scheme which in his opinion is as benevolent to the Medical Profession as it is useful to the lay public and as economic to the Government.

We are glad that we deferred the consideration of this scheme last month. We have now before us the written speech of the author of the Scheme delivered on 3rd February 1938 at the Stanley Medical School when the Minister took advantage of a gathering of medical men summoned by the Superintendent of that School to

celebrate the School Day. The first charge against the Scheme was that Medical Associations were not consulted before the new scheme was announced. Dr. Rajan is always frank. He gives out what he feels for the time being irrespective of the effects on those who hear him. There was no need for him to be dilatory explaining why he did not consult the existing Medical Associations. Knowing the activities of the Medical Associations and of some of the leaders amongst them who profess leadership without a following, we should say as frankly without meaning any disrespect either to the Associations or to those who are holding their strings, if Dr. Rajan began the consultations, the Reorganisation Scheme would not have seen the light of day till perhaps Dr. Rajan lay down his office due to age. So far two Associations in the Madras City and one from the mofussil, seem to have submitted their memoranda to the Government. The South Indian Medical Union is a cosmopolitan organisation for admitting members to the Association. It admits all registered practitioners excepting those in Government service. But the Memorandum submitted by the Medical Union is conspicuously silent about the grievance of the Medical Licentiates though there are a good number of Licentiates in the Union, its managing committee and even in the Editorial Board of their official Journal. The Minister may know as do the rest of the members of the Medical Profession that there are at least a few common members in the Executive Committee of the

management of the South Indian Medical Union and that of the Madras Branch of the All-India Medical Licentiates' Association who were responsible in the drafting of the respective memorandum submitted to the Government. The fact that the Madras Branch of the All-India Medical Licentiates' Association which permits its members to be members of the South Indian Medical Union, did not protest against the latter body in being silent for the non-recognition of the Licentiates for honorary posts excepting that of House-Surgeon and House-Physician, should convince or at least deduce a supposition that the Medical Licentiates cannot claim sympathy from the South Indian Medical Union for "the invidiousness of the segregation of the Licentiates to one particular cadre of honorary service". This is not all, at the very psychological juncture when the memorandum of the Licentiates' Association protested against "the invidious segregation," the self same members who were responsible in the drafting of the memorandum to the Government, thought it fit to interview one of the solitary members of the faculty of the Madras University and pleaded before him to help them to remove the inferiority complex by lessening the severity of conditions for the admission of Licentiates to M. B. B. S. degree. Is this attitude of the Madras leaders of the Licentiates tenable when they complain about the remarks of the Public Health Minister that, "No Government order can ever make a licentiate equivalent to an M. B. B. S. and create opportunities equal to all of them", as untenable. If this Deputation that waited on a member of the Faculty of the Madras University did not precede the protest, the sense of the resolution passed at the urgent meeting of the Madras Branch of All India Medical Licentiates' Association on 4-2-'38 would have been more graceful. The resolution runs as follows:

Resolved to inform the Minister that the position taken up by his Government that "no Government order can ever make a licentiate equivalent to an M. B. B. S. and create opportunities equal to all of them" is untenable inasmuch as the licentiates are statutorily registered

as legally qualified practitioners; and that since they possess the minimum standard of medical qualification as prescribed by the Madras Medical Council, the Local Government is not justified in prescribing particular academical qualifications for the appointment of even ordinary posts as Honorary Assistant Medical Officers.

We should say that the Licentiate leaders have been a bit fussy though their intentions may be good. They have done more harm than good to the status of their class. There is no need for the Licentiate practitioners to be M. B. B. S. for practising the profession though it may help those in Service. The Hon'ble Dr. Rajan is himself a licentiate who later became a M. R. C. P., L. R. C. S. He acknowledged that it was possible for him to earn Rs. 2,000 a month while practising at Trichinopoly. This amount he could earn because he was recognised as a good surgeon and as good a physician. Yet he has denied in his Reorganisation Scheme the right of a Licentiate to be even an Asst. Honorary Medical Officer. A M.B.B.S. a M.R.C.S., L.R.C.P. and members of the Medical Profession possessing equivalent qualifications cannot be anything more than an Asst. Medical Officer in the Honorary Service. Even the wording of the qualification clauses, is so vague that it is not clear if practitioners holding qualifications equivalent to the Madras M.B.B.S. can be eligible to the posts of Asst. Medical Officers. The Reorganisation Scheme would have been quite consistent with the Congress ideals of democracy if the Government were tactful and did not restrict appointments to particular qualifications but gave administrative direction to the appointing authority to choose practitioners of the highest qualifications available at the time for the post advertised, mention being made in the advertisement that those possessing particular qualifications will be preferred. The times are such that the candidate that applies for the post can easily know whether he is likely to be selected for the post advertised for. No registered practitioner would have complained against the Government if the best available candidate was chosen. A casual perusal of the advertisements for

the medical posts, honorary or paid as published in foreign journals should convince the Minister that no member of the profession has cause for complaint in such advertisements. It is one thing to say that a practitioner possessing a particular qualification is required and quite another to mention that a practitioner of a particular qualification is not eligible for such a post.

It is true there is a clause in the order that the Government reserve the right to employ honorary house-surgeons or house-physicians as honorary assistant medical officers if they show extraordinary merit. Such an assurance cannot be thought much of during the days of democratic Government even under Congress regime. The successor of the present Minister may not know the intention of the original author of the scheme. We trust that the Hon'ble Dr. Rajan has not forgotten that soon after he assumed charge of his office, a deputation of Medical Licentiates working in the City Hospitals as Honorary Clinical Assistants represented to him that they were denied the designation of Hon. Asst. Surgeon or Hon. Asst. Physician though at the time they entered the Honorary Service, the then existing G. O. contemplated their promotion if they were found fit. The profession in service or in private practice did not protest against such promotion of Licentiates; yet somebody somewhere in authority suggested to the Government then in power and a new name was invented, Hon. Licentiate Medical Officer 1st, 2nd, and 3rd, grade. Such a nomenclature would have been hooted in any other civilized country which maintains a Medical Register. Yet the Surgeon-General recommended such a name. So any thing is conceivable in a country like India and at any time.

Too much is made about an unguarded statement of Dr. Rajan at the Stanley Medical School that the All-India Medical Conference which was held in Madras a day after the announcement of the Reorganisation Scheme, "fully welcomed the principles of the Scheme". Though perhaps Dr. Rajan cannot be said to be legally correct, nobody can deny that he was

morally correct for all practical purposes. The Reception Committee of the All-India Conference entertained the Delegates at a dinner and it was reported in the News papers that there were as many as 400 members of the medical profession present at the Dinner. Such a dinner is a part of the proceedings of the Conference and at this Dinner Dr. Rajan was one of the Chief guests. Dr. Jivraj N. Mehta of Bombay while proposing the toast in honour of Dr. Rajan eulogised his services as a Congress Minister and congratulated him for the lead given by him to other provinces in regard to honorary medical relief scheme. Dr. Mehta objected only to the low honorarium of Rs. 20. Licentiates who took prominent part in the proceedings of the Conference and who had had exceptional opportunities of bringing any subject concerning the medical profession before the Conference but who did not do so, are the persons who taunt Dr. Rajan whom they call as their own. It is most surprising that neither the prominent members of South Indian Medical Union nor the members of the Madras Branch of All-India Medical Licentiates' Association did not open discussion on this important subject at the right place and at the right moment though many of them took active part in organising the Conference. The Hon'ble Minister was justified to a certain extent to think that the All-India Conference approved his scheme on the assumption that silence is half consent.

The Government was perfectly right in fixing the term of an honorary ordinarily for five years. The practitioners who are now in honorary service should know that in this province there are over 5,000 registered practitioners out of whom about 1,200 or very near this figure, will be in service under the Government and Local Bodies, about 165 are in honorary service. All the medical institutions where the Minister thinks of appointing honorary medical officers belong to the State maintained by public revenue. So every practitioner, a domiciled resident in the Province has a claim to demand honorary service on conditions offered by the Government

especially when it is the intention of the Government to give adequate training to the members of the medical profession. The members of the public outside hospitals require as efficient treatment as those inside the hospitals. Though it is a fact in the case of many that honorary appointments give opportunities "to chalk out careers" for individuals but unfortunately it is this very danger that the Government should guard against. The honoraries need not have much anxiety just at present to take to teaching except in the hospital wards. For some time at least there cannot be a dearth for teachers from amongst the full-time officers of the Government. Dr. Rajan did rightly say at the Stanley Medical School on 3rd ultimo that "the main purpose of the new scheme is, not to reserve berths for private medical practitioners who may not be able to get much from private practice but to reduce the expenditure to the Government and at the same time to give ample opportunities to private medical practitioners to do public work." Dr. Rajan would have done well if he added after the word "work" "in regard to medical relief by gaining up-to-date scientific knowledge in Government hospitals". The selection of honorary physicians and surgeons is not an easy problem as a few honoraries now working in the Government institutions are inclined to think. For a few years during the stage of transition the Government will be well advised to find their way to employ as part time professors from amongst the experienced members of Provincial Service who have retired or are about to retire. There may be at least a few amongst them who may even take up this work without any allowance. If the Hon'ble Dr. Rajan released his new Scheme at least by bits as occasions demanded before the Scheme took the shape of a G. O., the profession as a whole, would have had chances of expressing constructive criticisms. The next best thing to do would have been to publish the Scheme in the form of a proposal and to invite criticisms before publishing the Government order as is usually done with Legislative measures.

Even now, from what we can judge from the speech of the Premier at the Conference of all India Ministers which met in Madras four days after the publication of the G. O. on Reorganisation of Medical Services and from the latest utterance of the Public Health Minister on this subject, we may say that the Government are prepared to modify their order, and the sooner they do it the better it will be in the interests of all concerned. The Government know much more than we do that there is unanimity in the criticisms regarding honoraria. The criticism have even assumed the form of a protest from a prominent member of the medical profession hailing from Bombay, Dr. Jivraj N. Mehta. We should say that the opinion of such a person cannot be discarded knowing as the Government does that Dr. Mehta is the Dean of King Edward Memorial Hospital and Seth Gordandas Sunderdas Medical College, Bombay, both these institutions being run by honoraries and quite creditably too. Dr. Mehta is a staunch Congress man to boot.

The post of House-Surgeon and House-Physician should be deleted from the nomenclature of honorary service. These posts should be made available to as many newly passed medicoes as could be accommodated in the City hospitals and mofussil hospitals having 100 or more beds. These posts only should be paid for, the period of appointment not being more than a year. The pay may be Rs. 50 in the City and Rs. 30 in the mofussil hospitals. The House-Surgeon and House-Physician should not be allowed private practice. There cannot be objections for appointing medical Licentiates as House-Surgeons and House-Physicians in non-teaching hospitals. To give such a training to newly passed medical men will be in the interests of the suffering public. As in the past the Honorary Service should begin with Clinical Assistant who should be promoted later as Assistant Physician or Asst. Surgeon and from amongst the latter a choice should be made for appointing Honorary Surgeons and Physicians. None of these posts should receive any

allowance except when they do teaching work in addition. This need not be above Rs. 50 for Assistants and Rs. 100 to Physician and Surgeons to be paid as conveyance allowance and not as an honorarium. It looks as if the Government has not given much thought regarding the selection of honoraries, the method to be adopted in promoting them and much less about the disciplinary control over them. We shall deal about this subject in the next issue and attempt to point out to the Government that Honorary Service can be not only honorable but the only ideal medical service for India.

PART II.

MADRAS MEDICAL SERVICE.

The revised rules published by the Government for the Madras Medical Service have not effected any material changes either in the existing cadres, their number, methods of recruitment excepting the denomination and the increase in the number of classes under which the denominations are shown in particular categories. The classes are grouped under 3 Sections, A—Men's Section, B—Women's Section, C—I. M. D. Section. Under Men's Section there are IX classes and Class I shows 15 categories in which are grouped the Civil Surgeons and Civil Asst. Surgeons depending upon the duties performed by them. In the Class II to IX there are a few non-medical officers such as Director of Bernard Institute, Government Analyst etc. In the B—Women's Section, there are only 5 categories consisting of one Superintendent, Victoria Caste & Gosha Hospital and clinical and non-clinical lecturers and their assistants and tutors all belonging to the old Asst. Surgeon cadre. In the C—I. M. D. Section there are two categories Civil Surgeons, 2, and thirteen Asst. Surgeons. We refer our readers to the Fort St. George Gazette dated 21.12.37 pages 2111 to 2118 both inclusive for fuller details. The total strength of this service is not reduced including leave reserve. It looks as if it was not possible for the Hon'ble Public Health Minister to effect suitable changes consistent with the expectations of the

profession both in service and in independent practice. Nowhere in the rules could be seen the intention of the Government for the reduction of numbers in the existing cadres. On the other hand provision for leave reserve of 24 officers in all the 3 Sections is likely to upset at least a few that even Congress Government could not grasp what a bureaucratic Civilian in the position of a Finance Member pointed out a few years ago that the leave reserve was a wasteful expenditure of public funds as such a reserve of officers is not provided in any other Department of the Government. We did also point out in these columns more than once that leave reserve was unnecessary especially when the Government was inaugurating Honorary Service on a large scale. We also expressed that the Government could follow the procedure adopted in the Judicial Department in filling the temporary vacancies of Dt. Munsiffs from amongst those selected for these posts. They are not absorbed in permanent service but made to work temporarily and are reverted to the vakil profession when the temporary vacancy ceases. It is also a pity that the Government did not conceive the idea of creating two separate cadres one for teaching the other non-teaching appointments. Want of such different cadres in the past has caused lot of resentment in service due to unjustifiable supersession of seniors, as a large number of very junior Asst. Surgeons were promoted as Civil Surgeons. Later when vacancies arose in teaching appointments originally held by Civil Surgeons, the Government thought that their old policy of transforming junior Asst. Surgeons into Civil Surgeons for the purpose of teaching in Medical Colleges was wrong and at the Vizagapatam Medical College, Asst. Surgeons possessing high foreign qualifications, do teaching work without being promoted as Civil Surgeons as was done in the past. There are a few posts including one of the Chemical Examiner which are at present held by junior Asst. Surgeons. The foreign qualifications possessed by these persons must have been the consideration which weighed with the Government to select them for

these posts. Almost all those juniors who superseded their seniors as Civil Surgeons went to England at public cost while in service. If the Government notified to all the Asst. Surgeons and selected the senior most amongst those who were willing to go to England for qualifying themselves to occupy the post which was originally held by an I. M. S. or a Civil Surgeon there would not have been discontent in the profession. If the Hon'ble Minister goes through the history of the service of at least of a few amongst the lucky in the service, he could find that it was possible for even a temporary Asst. Surgeon to be a Civil Surgeon and that at least one temporary Asst. Surgeon who did not even have a year's temporary service to his credit, could go to a foreign country on study leave at Government expense. It was expected that the Hon'ble Minister would note all the past omissions and commissions and evolve a contented and disciplined service under him. At present the teaching appointments held by the officers of the Madras Medical Service do not depend upon a healthy evolution but mere accidents depending upon luck in a very few and favouritism in many. The poison of such unhealthy evolution has taken deep roots and the resulting inefficiency and indiscipline have become unfathomable. It would have added to the credit of Congress Government if the Public Health Minister took some time to go patiently into the depth of the mysteries in service. We wonder if the Public Health Minister knows that as a result of such mysteries apart from juniors superseding seniors, it was made possible by the Government for a junior Asst. Surgeon working in the Department of Chemistry to be transformed into a Physician and a Surgeon and put in charge of stations as Civil Surgeon claiming superiority and merit in medicine, over those who have been all through in service doing work in the three branches of Medical Science. Would any Government in a civilised country have dared to let loose a chemist to treat human ailments and that in the capacity of a District Officer? There are a few more such legacies of the

past Government bequeathed for the treatment of human ills.

It has been pointed out in the new rules that promotion from the grade of a Asst. Surgeon to Civil Surgeon post did not depend on seniority alone but on approved service of more than ordinary merit. Apart from the usual dangers of favouritism and of the assessing of merit of Asst. Surgeons by different superiors over them under varying conditions there is another handicap which the Government ought to have noted. Of late the Asst. Surgeons employed in the City hospitals (majority of them being teaching institutions), have escaped transfers on the ostensible plea that in teaching institutions such transfers are not conducive in the interests of teaching. Such Asst. Surgeons were not born in the profession as teachers majority of them might have been born only lucky in their stars. They began their service for the first time in the teaching institutions only as raw Asst. Surgeons. Within a few years of their temporary service they had opportunities for qualifying themselves for M. D. or M. S. degrees (the latter very few). So the chances of more than extraordinary merit will be more for such lucky juniors than the many unlucky seniors in service. Before these juniors take deeper roots in the City, the Government will be well advised to give chances to the more senior amongst the Junior Asst. Surgeons to earn merit by qualifying themselves to higher degrees than the M. B. B. S. So considering the past history of Madras Medical Service no time should have been lost to create two distinct cadres one for appointments in teaching and other non-teaching Government institutions. Having done this the Government ought to have fixed a minimum period of service—say—20 for the promotion of Asst. Surgeons to Civil Surgeon grade. From amongst such seniors a selection would be more just.

It is rather strange that when the National Congress is fighting against foreign rule, the Congress Government in Madras, value the foreign qualification more than those obtainable in Madras.

We do not wish to be misunderstood that our appreciation of foreign qualifications is less than that entertained by the Government. Members of the Medical Profession in Government service possessing the M. B. C. M. and M. B. B. S. qualifications and those possessing qualifications like M.R.C.S., L.R.C.P., and L.R.C.P.& S., (even in I.M.S. service) were not found wanting to discharge the duties expected of the offices held by them. Even in Great Britain and other foreign countries qualifications alone did not count to the extent experience and merit did. We could mention the name of one of the most eminent surgeons in Great Britain the late Dr. S. Robert Jones, M.R.C.S., L. R. C. P., who till his death had no need to sit for examinations to procure higher qualifications. Yet, he was so much honoured in the profession that almost all the examining bodies in Great Britain and America conferred on him honorary distinctions. The Government seem to have been guided by the qualifications possessed by the officers now in service in fixing qualifications for their successors in future. This was perhaps an easier process to follow. Even in this process we are at a loss to understand why the Government has fixed F.R.C.S. Diploma in Ophthalmology for the post of Clinical Professor of Ophthalmology. This Diploma is granted only by the Royal College of Surgeons, Edinburgh. If the rumours that racial feelings are predominant in Great Britain and more in Edinburgh Eye institution under the present Surgeon in charge of it are true, it will be really a hard task to aspire to the post of Clinical Professor of Ophthalmology in Madras. We are afraid if the Public Health Minister was given this information by those who suggested to him this novel and perhaps an impossible test. The past history of the Madras Medical College and the Government Ophthalmic Hospital would show that till to the present day all the professors of Clinical Ophthalmology in Madras did not even possess ordinary qualifications to indicate speciality in Eye Surgery. Yet, Elliot, Kirkpatrick and Wright have

been considered as Ophthalmic Surgeons of international reputation. The first officer who possesses special qualification, D.O.M.S. is now the Acting Professor of Ophthalmology. We are glad we are in possession of authoritative information that the present acting incumbent will have the right to be the future Professor of Ophthalmology when his turn comes. Excepting the general reduction in salaries which would accrue in after years due to the reduction of salaries all round, the new rules will not bring any saving to the Government. The only features that are new in the changed rules are restriction of private practice to the speciality for which a particular medical officer holds the appointment, the prohibition of private practice to officers holding non-clinical appointments and the preferential selection of spinsters and widows from amongst women candidates applying for service in women section. How far the restriction of private practice to specialities will be adhered to and what are the means which will enable the Government to take notice of delinquents, seems to be problematic. As it is, it does not seem to be possible for the Government to take notice of complaints which they know are true but say cannot be proved. There are instances of medical officers practising though practice is totally prohibited to them. Specialities will have too many loop holes. It is really not a good policy to encourage service for married women. An ideal wife will scarcely find time to attend to anybody else excepting her husband and children and if the spacing of pregnancy is less than 2 years there will be material loss to public finance also as women in service are entitled to special leave before, during, and after puerperium. Unless married women who enjoy conjugal happiness are totally debarred from public service, the present rule is not likely to yield expected results. For, a woman may be a spinster or a widow at the time of application for service but may make up her mind or will be forced to make up her mind to marry after entering service. We trust these rules are not final and will be modified as and when necessary.

SUBSIDIZED RURAL MEDICAL SERVICE.

There cannot be two opinions that the ideal honorary Medical Service is that offered by the Subsidized Rural Practitioners in villages. But unfortunately the authorities running the Scheme and majority of the practitioners who have undertaken medical service in villages have not grasped the usefulness of the Scheme and its possibilities. The authorities seem to mistake the subsidy as regular pay and the practitioners are at times treated worse than the regularly paid menial subordinates. They forget that the persons who have undertaken to render service are independent practitioners and that they should be treated with dignity and respect that is due to the noble profession to which they belong. The rural practitioner is the real adviser of a village unit on public health questions as the District Medical Officer is the adviser to the Government for District Health Administration. The orientation of the new policy regarding the responsibilities of the rural practitioners envisaged by the Hon'ble Public Health Minister and approved by the conference of All-India Public Health Ministers that met in Madras during last Xmas, is in keeping with our views. If those who control the Rural Medical Relief Scheme dealt with the practitioners, feeling at every moment that they are as independent as the elected members constituting the Local Bodies, the Subsidized Scheme of Medical Relief, would have yielded much better results. As it is, though the Subsidized Rural Medical Practitioners are considered independent, they are made to feel the reverse of it being under the yoke of three masters, the President District Board, the District Medical Officer and the Government who cannot get out of the subconscious feeling that the Rural Practitioners receive remuneration for service rendered. The amount of the subsidy being a humble one, the treatment accorded to them depends upon the humble amount but not on the magnitude of free service rendered. The practitioners taking up this honorary service are young with little or no knowledge of worldly affairs and the feeling that they are really independent practitioners

overpowers them when they are dealt with scant courtesy. The result of all this has been a discontented Rural Medical Service.

That the practitioners doing subsidized service in villages are not devoid of the ideals of service and are also not wanting in imagination as to how they should acquit themselves, was demonstrated at the Conference organised by them at Madras on 10-7-'37 when the Indian National Congress was contemplating to run the provincial Governments in India. They are keen in reorganising their Association consistent with the Congress ideals of service in villages and the responsibility of drafting the memorandum of the Association has been entrusted to the Interim Committee of Management with Dr. V. Rama Kamath as the President. It is expected that the draft of the memorandum of the Association will be submitted to the general body which would meet in a convenient village in Trichinopoly in the near future. In the meanwhile the Interim Committee met the Hon'ble Public Health Minister, on 25-1-38 in company with the Government Secretary, the Surgeon General, the Director of Public Health and the Parliamentary Secretary and discussed the draft of the Agreement form submitted by the Interim Committee to the Government through the Surgeon-General on 7-9-37. This new draft based on the resolutions passed at the Madras Conference. There was a heart to heart discussion on majority of points raised at the Conference and it is hoped that many of them are likely to meet the approval of the Government. The details of the discussion have been published in the Correspondence Columns. As it is not desirable to publish the actual decisions arrived at till they are published by the Government in the form of an Order, the President of the Association has only mentioned the details of discussion.

We wish that the authorities who run the Scheme and the practitioners realise that the Subsidized Rural Medical Relief Scheme is a Mission and the practitioners belong to a special order of service. The spirit of Rural Medical Service is certainly of a higher order than the Honorary Medical Service. The practi-

tioner in the Subsidized Rural Service goes to a village with little or no ambition giving up the amenities of urban life having tasted the same to a large extent during his student life in the City. It is indeed a nobler trait to restrain taste after enjoyment than not to have enjoyment of a taste which one has not enjoyed at all. The rural practitioner has actually to educate the village folk to make them realise the benefits of scientific system of medicine and this he has to do amongst credulous masses who are easily led away by the persuasive tongue of the village quack and charlatan. Whereas the honorary has the benefits of an urban life and instead of educating his patients gets himself educated in the up-to-date knowledge of diseases and their treatment, gets publicity and has a large and as lucrative field for private practice. Year after year his status is on the increase and with it his income. The honorary has moreover fixed hours of service whereas the subsidized practitioner has to be in his village night and day as the village folk have nobody else to depend upon. Amongst the subsidized practitioners one or two here and there, in some districts may be well off but these are exceptions. On the whole the lot of the majority of subsidized practitioners is only a hand to mouth living. To command and secure service from practitioners of this lot by means of an indenture is against the spirit of missionary service and as only such missionary service that is required for lifting the villages from their present deplorable conditions, it behoves the Government to formulate a contract consistent with the spirit of service expected of them. The origin founder of Subsidized Rural Medical Relief Scheme, the late Raja of Panagal was a politician more than a philanthropist. For himself there was no need to take advantage of this scheme for political purposes but his disciples in politics and their successors belonging to his faith or other faiths did take advantage of the Scheme for political purposes and some amongst them found it to be useful for finding employment to the relations of their political adherents. Later, after the entry of the Congress into politics, the subsidized practitioners were deprived of political freedom which was done by the then

Government on the suggestion of a strong political partisan in Andhra Desa. The then Government would not have yielded to the suggestion of a politician but for the fact that any Government has to depend upon politicians for its stability. Though the present Minister in charge of Public Health has indicated repeatedly that the Subsidized Practitioners are independent practitioners there are signs here and there of attempts of victimising these practitioners who showed anti-Congress tendencies during the last elections. We take advantage of this opportunity and request the Government not to take a serious view of what had happened and be magnanimous by demonstrating that the Congress Government is above party politics in regard to the welfare of the people.

It is therefore necessary that the Subsidized Scheme of Medical Service should be above the tides of political currents. This is possible only if Government keeps the scheme under their direct control without the intervention of local bodies. The Government is at present spending much larger sums for this Scheme than the Local Bodies do and there cannot be any difficulty for the transfer of entire control of the scheme under the Government. It is contemplated in the Honorary Medical Relief Scheme to have Honorary Physicians and Surgeons in the mofussil hospitals; therefore the D. M. O. will be relieved of a good portion of professional work and it is the legitimate duty of the District Officers to supervise the work of Subsidized Practitioners in the villages. There is also felt a need to combine the preventive and curative medicine under one department. Sooner it is done the better it will be for the medical profession and the public.

The Government must have begun the work of re-drafting the Agreement form and we request the Government on behalf of the village folk more than the Subsidized Practitioners to consider our suggestions and reorganise Subsidized Rural Medical Service embodying in it noble spirit of missionary service and not high-sounding legal terms of indentured service. If this is not possible now during Congress regime, it cannot be for ever.

News and Comments.

Health Ministers' Conference: In the last issue we published the ten items of programme discussed at the All-India Ministers' Conference and about which there was an unanimous understanding. The first was about the employment of honorary service on an extensive scale. Second was regarding the necessity of having an uniform standard of medical education throughout India. The third item concerned about the prohibition of medical practice by those who did not come to the standard of medical education recognised by the Government. The fourth decision was that provision should be made for giving refresher courses to all medical officers employed under Government and Local Bodies including subsidized practitioners. The fifth required the Governments to establish Clinical Laboratories where facilities to be given to the private practitioners for diagnosing epidemic diseases. The sixth decision recommended the inauguration and extension of rural medical relief. The seventh item laid stress on giving special public health training to rural practitioners. The eighth recommendation was about the inauguration of health survey scheme of the type now conducted by the Public Health Department of Madras in a group of villages in Poonamallee and the last pressed the need of encouraging indigenous drug industries and establishment of Laboratories for testing chemical and biological products manufactured in India. It is most gratifying that the non-Congress ministers from Bengal, Assam and Sind co-operated with the two Congress Ministers of Bombay and Madras. Though the Hon'ble Dr. Rajan took the initiation or is it because a Congress Minister was responsible in summoning the Conference as many as the remaining five Congress Ministers did not make it convenient to attend the Congress hoping to follow their comrades. All the same this event has brought credit to Indians by demonstrating that in spite of serious differences of opinion in politics it is possible for the varying elements in India to unite and show their deep concern about the welfare of the people. The

Budget forecasts in Bengal, and Bombay indicate that the Government of these two provinces are giving effect to at least some of the recommendations of Ministers' Conference. All the decisions arrived at by the Conference are commendable excepting the 4th and 9th. Till the provincial Governments turn out to be Soviet Unions, if the Provincial Governments are sincere about the welfare of the suffering public it should be the duty of the Governments to see that the independent practitioners are given equal facilities for refresher courses along with the state-paid practitioners as the public now depend upon the private practitioners more than on the Government Medical Officers (whose number is undoubtedly insufficient) for the needs of medical relief in this country. The Poonamallee Health Unit Scheme now costs 8 annas a head of population of the unit according to the calculation of the Madras Minister and at this rate 2 crores of rupees are needed to educate the entire population of Madras Province. After all what is done at Poonamallee are experiments on well established health laws. Is there a need for wasting money to find out the effects of well established health principles? We have said in these columns more than once that the money spent at Poonamallee about Rs. 30,000 every year may be more profitably utilised in extending medical relief preventive and curative by increasing Subsidized Rural Dispensaries so that there may be a qualified medical man for a population less than 24,000 which is the present ratio more or less.

Synthesis of Indigenous Medicine:

Ever since the Medical Portfolio came under the charge of the popular Ministers in Indian Provinces there has been persistent agitation for the encouragement of different systems of indigenous medicine such as the Ayurvedic, the Unani, and Siddha, etc. After the inauguration of Provincial Autonomy the agitation has been more acute especially in the provinces under Congress Government. In three provinces out of seven under Congress rule the Public Health Departments are run by medical men. These are Madras, Bombay and Central Provinces

in the last of which the Public Health Minister is also the Premier. The intensity of enthusiasm displayed by the Congress Ministers in the three provinces seems to us in the order the provinces appearing above. Synthesis of Indigenous Systems of Medicine with the existing Scientific System (popularly known as Allopathic) is always on the tongue of the Madras Minister; the Bombay Minister has a plan of his own for encouraging the indigenous systems but he has not talked so far regarding synthesis, the Minister of Central Provinces has set on foot an enquiry to find out the therapeutic importance of indigenous drugs. Our view on the subject is known to the readers of The Medical Practitioner. The Chairman of the Reception Committee of All-India Medical Conference Lt. Col. Pandalai, F. R. C. S. holds our view as could be seen from his address. Recently another F. R. C. S. in the position of a District Medical Officer, Salem expressed the same view at a gathering of medical men who entertained the Madras Minister at Salem. The following is the opinion of eminent medical men deputed by the League of Nations (Health Organisation) to visit Far Eastern Countries to get first-hand information of health problems who after an extensive tour submitted a report to the League.

"European medical science is everywhere invading Asia, where it encounters what has remained of the old medical lore of Hindu medicine, the Arabian school, and the old Chinese institutions, all of them based upon traditional empiricism. The importance of all these should not be underestimated, and official medical science, overconfident of its own infallibility and of the inferiority of this ancient popular medicine, has made the mistake of scorning it. Yet many an old precept can be found which accords with our own views, even though put in a somewhat different form. Thus, frequently we strongly oppose the use of the medicinal herbs and other substances of popular Eastern medicines, forgetting that our own pharmaceutical industry has produced in addition to sound and valuable medicines, much that it would have been better

never to administer to any sufferer. The study of these ancient medical cultures and of their remaining vestiges would be of value. They should have a place in the training, so that the young doctor may have at least an elementary knowledge of these questions when he begins practising. Such knowledge is essential if he is to adapt himself to his social environment. Lastly, it would be desirable honestly to consider how far these old medical traditions can be reconciled with our own principles, instead of rejecting them in a body as useless and obsolete."

So, the consensus of opinion amongst the members of the Scientific System of Medicine, is for unification of all existing systems of medicine in India under one Scientific System. We have been saying that even financially this is a more economical proposition than the running of Government medical schools and hospitals of Indian Medicine for teaching as well as for treating. This is one of the most important subjects for the consideration of the Provincial Governments. But was not found in the agenda of the proceedings of the Conference of ministers which met in Madras last December. We trust that in the interests of medical science as well as sound economy this subject will receive the attention of all the provincial ministers in the near future.

Homoeopathy : Homoeopaths throughout India are agitating as much if not more than the practitioners of indigenous systems of medicine in India and have been trying to get them recognition in State medical service. The popularity of Congress Ministers is taken advantage of and in the Punjab, a Minister suggested to the Homoeopaths to place before him substantial propositions for giving Homoeopathic treatment in rural areas. A lecture, introductory to a course arranged by the London Homoeopathic Hospital was delivered by Dr. Charles E. Wheeler in the Hastings Hall of the British Medical Association House on October 8. Dr. Wheeler's discourse was entitled, "One Hundred Years of a 'Heresy' ". This lecture has been published in the Correspondence Columns of this Issue for the benefit of the readers

post-graduate or refresher courses. We trust this at least will not be denied to them.

An Opportune Test: The non-recognition of the L. M. P. Diploma for honorary posts of a higher status than that of house appointments, has given rise to discontent and disappointment in the largest section of the practitioners in the Madras Medical Register. The Hon'ble the Public Health Minister assured the Medical Licentiates on 3-2-38 at the Stanley Medical School that the Licentiates would not have cause to complain against the Government Order as there was a rule in the order that Licentiates of extraordinary merit would be promoted to honorary appointments. The Surgeon-General with the Government of Madras assured the Licentiates at Madura on 18-2-38 that "the Minister and himself were keen on helping the L.M.Ps". We are told that there is now at least one application before the Government from a Medical Licentiate working for nearly five years as a Clinical Assistant in the Ophthalmic Department of a moffusil Head Quarters Hospital. He possesses the special L. O. Diploma granted by the Government. Eye treatment has been his speciality ever since he began practice about 15 years ago. More than two District Medical Officers who were the Superintendents of the Head Quarters Hospital where this L. M. P. has been working as a Clinical Assistant did appreciate his work and recommended him to the post of Hon. Asst. Surgeon in the Eye Clinic of the same hospital. According to the G. O. of the revised scheme of Honorary Service which was in vogue during the regime of Major-General Sir C. A. Sprawson with Rao Bahadur P. K. Warriar as his Personal Assistant, a Licentiate possessing the L. O. Diploma was promoted as Hon. Asst. Surgeon in an Eye Clinic attached to one of the City Hospitals. But during the regime of Major-General Sir F. P. Connor with Rao Bahadur Dr. S. K. Pillai as Personal Assistant, when two Licentiates were recommended for the post of Hon. Asst. Surgeon, they were asked to apply after a year or so. In the meanwhile a special G. O. was

promulgated in which the Licentiates were assigned a name indicating their qualification. The candidate who has now approached the Government for the consideration of his claim for the post of Hon. Asst. Medical Officer is one of the two victims of the intermediary G. O. Apart from his special qualification of L. O. he has been recommended by at least two D.M.Os to be fit for promotion. The Hon'ble the Public Health Minister and the Surgeon General have now a splendid opportunity of testifying their sympathies to deserving Licentiates

Surgeon-General's Announcement: Major-General N. M. Wilson took advantage of the opportunity of his meeting a large number of medical practitioners of the Madura District when he presided over the tenth annual gathering of the Madura District Medical Association on 18-2-38 and made the following announcement:

"The Government proposed, to train a number of doctors in the treatment of tuberculosis, in the Medical College and award them a Diploma (T.D.D.), and to open a number of clinics in District Headquarters. They also proposed to open a number of sanatoria, at least one for every six districts."

It looks as if the Madras Government woke up to the need of educating medical men in the treatment of a most common disease only after Lady Linlithgow started a fund to combat Tuberculosis though it was said a few years ago by a Madras Government specialist in Tuberculosis that nearly 75 per cent of the population in this province had in them Tubercular infection. If the Surgeon-General opines that the general practitioners passed out of Medical Schools and Colleges cannot diagnose and treat Tuberculosis, the best thing to do is to find out if the lecturers and professors have been doing their work satisfactorily and see that in future at least medical students are given proper training in the diagnosis and treatment of such common social diseases such as Tuberculosis. Specialists are necessary but not of the type proposed by the Madras Government for the treatment of Tuberculosis. To combat any social disease and that of the magnitude like

that of Tuberculosis, the persons whose help is needed should be mostly the general practitioners who alone can be relied upon for the contact of the home of the people. The next person is the nurse but this is a rare commodity in Indian houses just at present. It is most unfortunate that the members of the medical profession in India have to depend upon the Government for the estimation of their capacity to treat human ills. It has been possible at least in Madras Province for a Professor of Hygiene to be a specialist in the treatment of Tuberculosis though till the date of his appointment as such, he had not treated even a single patient suffering from any disease in any Government institution. Yet soon after he was made the Superintendent of the Government Tuberculosis hospital and the Director of Tuberculosis Institute connected with this hospital, not only the patients who resorted to these institutions depended upon him for treatment but also the entire public. After the inauguration of these two institutions in Madras if a general practitioner warned his patients suffering from signs and symptoms of pretubercular toxemia such as dyspepsia, emaciation with low fever and other concomitant signs and symptoms the next day he would lose this patient. The effect of speciality in Government service is not peculiar to Tuberculosis only. Till about the year 1920 the general practitioners in Madras had plenty of work in general surgery. About this time the idea of surgical units were talked about in the City teaching institutions which afterwards took a definite shape. Simultaneously or perhaps a few years later, surgeons employed in General Hospital ran special surgical clinics. Ever since, a general practitioner cannot get even minor cases for operation. Even experts have to treat patients and not diseases only. The most common manifestation of Tubercular infection is consumption and the success of treatment of consumption depends entirely on early diagnosis when the disease has chances of being nipped in the bud. It is at this stage the disease has to be detected and this can be done without the gene-

ral practitioner passing the new test T.D.D. proposed by the Government. It is the detection of early stages of consumption that should be aimed at for a successful campaign against Tuberculosis. If medical students are trained in the art of observation, palpation, percussion and auscultation thoroughly they will be expert practitioners to treat tuberculosis or any other disease. The above art cannot be learnt within a few months though the principle may be taught in a few days in the wards of the hospitals. Laboratory methods of diagnosis and special treatments such as artificial pneumothorax, phrenic evulsion, and thoracoplasty have to be resorted to in advanced cases when a patient is an economic drain to a household as well as to the State. The special diploma contemplated by the Government, may only get a practitioner a knowledge of the technique of special treatments which cannot usually be adopted in a household and a practitioner who may be well up in laboratory methods of diagnosis and the technique of special treatments cannot be called as an expert in the treatment of Tuberculosis unless he has to his credit general practice of at least 10 or 15 years. Great Britain is the only country where multiplicity of general and special qualifications is in abundance. We do not wish to discuss the psychology which led Great Britain to such a course not adopted in other foreign countries. But we might say that even in Great Britain the special qualifications were of recent origin. Perhaps the very senior members of the profession who became specialists not by passing any special examination but by their special talent in the art of diagnosing and treating special diseases, thought it was necessary to give a hall mark to their disciples. But they might not have dreamt at the time that a practitioner could abuse the special qualifications by sitting for special tests soon after passing the general test. Dangers of specialities are more in India than the place of their birth for the simple reason that the Government values the foreign qualifications more than the experience and skill of the members of the profession and almost all the Government specialists were junior Asst. Surgeons at the time of

their appointments as such. So we warn the Government that though they may get juniors in the profession for the T. D. D. course who command little or no practice and consequently less contact of patients in their houses, the efficiency and result of anti-tuberculosis campaign, are likely to be much less than the Government contemplates. On the other hand if the Government provide facilities

for laboratory methods of diagnosis and for special treatments without the hall mark of a Diploma, a large number of experienced general practitioners who would not care for the T. D. D. Diploma, are likely to co-operate with the scheme of Her Excellency Lady Linlithgow and this benevolent Lady will have the satisfaction that her efforts in combating Tuberculosis are not in vain.

Correspondence, Reports, Etc.

Provincial Subsidized Rural Medical Practitioners' Association, Madras.

The members of the Interim Committee of Management and the President of the P. S. R. M. P. Association met the Hon'ble the Public Health Minister on Deputation on 25-1-38 at the Secretariat. The Government Secretary in charge of Public Health, the Surgeon-General, the Director of Public Health and the Parliamentary Secretary were also present.

Soon after the President introduced the members of the Interim Committee of Management to the Minister, one of the members of the Interim Managing Committee Dr. K. Govindan of Audithorai read the memorandum on behalf of the Committee and said:

"The Provincial Subsidized Rural Medical Practitioners' Association is highly grateful to you for your kind and prompt response to the request made to you by its President to meet us, the members of the Interim Committee of Management and have a heart to heart talk about the affairs of the Subsidized Rural Medical Relief Scheme....."

Though you have announced what the future policy will be regarding the Medical Department and Medical Relief and the role of the members of the independent medical profession, you have not so far made public the reorganisation of the Subsidized Rural Medical Relief Scheme. We know you and the Govern-

ment you represent have the welfare of the villages most dear to your hearts and this is why we felt bold to approach you this day and know from you what you want us to do.....

Sir, We hope you must be now in possession of the July 1937 Issue of The Medical Practitioner which is the official organ of our Association. We submitted a copy of the journal and also a draft of the Agreement form, embodying some changes to be effected immediately in the working of the scheme, to the then Surgeon-Major General Sir Frank P. Connor on 7-9-'37.....

We respectfully reiterate what we said and what the Conference decided regarding the scheme. All these decisions and the views of the Association have been expressed by us on a similar occasion on 7-9-'37 before the then Surgeon-General and in addition we put before you a few more suggestions basing on the utterances made by you on the Public platforms and the experience gained by us these few months and they are:

(1) The urgent and immediate necessity of entrusting the control of the scheme to a body to be appointed by the Government in each district consisting of those who are interested in the village uplift work and not to local bodies who primarily concern themselves with politics.

(2) The Subsidized Practitioner should not be interfered with his professional work in which each practitioner should

have free initiation as to the professional work in village up-lift and he should be the appointing authority of the staff including the mid-wife who are to work directly under him.

(3) Even in Public Health Work which is contemplated to be entrusted in future to the practitioners, the official control of the Department should be one of guidance and not dictation of mere official authority.

(4) The Government should be pleased to have a complete survey of the whole Province for the purpose of locating Subsidized Dispensaries which may be in future styled as Village Health Units, so that these may be uniformly and proportionately distributed depending upon the distance, area of population or both.

(5) Under no condition a Subsidized Rural Dispensary should be converted into a pucca L. F. as such conversion is against the very spirit of the scheme and in case of a growing village in which the Subsidized Practitioner had a major share, the Subsidized Dispensary should be well-equipped with staff and drugs and appliances as are needed to meet the demands of medical relief and the Subsidized Practitioner if able to maintain himself without the help of the subsidy the subsidy may be stopped. But these changes in the working of the subsidized dispensary should be affected only with the consent of the existing subsidized practitioner.

(6) In the Honorary System of medical relief announced recently by the Government, the Subsidized Practitioner should be given preferential claim when vacancies occur in the District where he is working.

(7) The Association while expressing its gratitude to the Hon'ble the Minister for permitting the Subsidized Practitioners to take part in Politics and Civics feels it desirable in the interests of Public Health in villages that the Subsidized Practitioner is recognised as the advisory head in matters of Public Health and to keep the practitioner above party

politics it is desirable that provision be made in the existing Local Acts and in the future Acts that may be enacted that the Subsidized Practitioner is to be nominated to the Panchayat Board of the locality where he practises.

(8) As it is contemplated by the Government to give the Subsidized Practitioners, Refresher courses and special training in Public Health and even otherwise to meet the exigencies of illness etc., a leave reserve be maintained to fill temporary vacancies and for this propose a panel of Registered Practitioners should be brought into existence preferably by the Association who should supply temporary hands to fill up such vacancies.

(9) The excise rules in relation to the stocking of excisable drugs supplied to the subsidized practitioners, should be operated as in the case of Government and L. F. Medical Institutions.

(10) As inordinate delays and consequent hardships are noticed, in regard to appeals of the Subsidized Medical Practitioners to the Government especially concerning the termination of their services, it is desirable that the services of the practitioners should not be terminated, unless and until the Government disposes the appeals and for this purpose it must be made compulsory that the aggrieved practitioner should appeal to the Government within a month from the receipt of the adverse order.

Discussion.

The Minister said at the very outset that he would consider that day only about the draft of the Agreement form, submitted to the Government by the then Surgeon-General whom the Deputationists met on 7-9-'37 and discussed with him about the necessary changes in detail in regard to the Agreement form :

(1) The discussion on the period of service to be fixed in the Agreement was keen on both sides, the Government view was that the words "for not less than one year" was comprehensive and less definite while the view of the Deputationists was that the practitioner would be at the mercy of the District Board and his service might be terminated a day after one year as per the Agreement and they even pointed out about a recent case when an innocent practitioner was

a victim due to this clause and pressed that the period should be not less than five years. The Minister assured the Deputationists that special instructions would be issued to the Local Bodies not to vitiate the spirit of Subsidized Rural Service and the discussion was dropped without arriving at any definite conclusion. All the same the Deputationists felt that instructions to the Local Bodies would have the desired effect.

(2) The idea of increasing the subsidy uniformly to Rs. 600 a year was not favoured by the Minister.

(3) The hours of attendance have to be the same as before.

(4) The Minister opined that it was reasonable to grant leave for 30 days in a year but the period of leave at one stretch should not exceed more than 15 days. As there is already a condition in the existing agreement that a practitioner may avail himself of leave without previous sanction for special reasons, it was not found necessary to mention in the agreement a clause to enable the practitioner to leave the station without waiting for previous sanction on emergencies.

(5) There was no difficulty for the Deputationists to plead for the deletion of clauses 8 and 9 in the existing agreement which prohibit practitioners from taking part in politics and civics as the Minister seemed to have made up his mind about their deletion long ago.

(6) About Public Health work it was agreed that those who were deputed for this work at present need not do the actual vaccination operation. And those who do not do Public Health work will be paid for their special services as per conditions of old Agreement. The Minister said that he would consider the desirability of increasing subsidy for Public Health work more than Rs. 15 after the passing of the Public Health Act and after the subsidized practitioners got the necessary training in Public Health work.

(7) About the termination of services of the Subsidized Practitioner on any ground, the Minister favoured the suggestion of the Deputationists that it should be done only after the previous sanction of the Government.

(8) The Minister did not favour the idea of removing the control of Local Bodies over the Subsidized Practitioners. The Deputationists did not wish to press a few more minor items regarding the maintenance of unnecessary registers, etc., as it was felt that they took a pretty long time (more than two hours) in discussing the major items. They expect that the Government would not increase the clerical work required for maintaining too many registers at the cost of professional work.

(9) Any subsidized dispensary which showed a daily average attendance of more than 50 for two

years is likely to get an attendant and it is expected that the District Boards would be advised to pay Rs. 3 a month for stationery expenses.

(10) When the deputationists brought to the notice of the Minister that they should have the help of a cooly while doing Public Health work, the Minister suggested that instructions would be issued by the Government to the Revenue authorities so that the village munsiff rendered all help to the practitioner while doing Public Health work and it is also likely a clause will be added in the Public Health Bill to this effect.

(11) The Minister seems to hold the view that the Subsidized Practitioner should be put in charge of a L.F. Dispensary in a station where the practitioner has been a subsidized practitioner. It was said that communal G.O. regarding this appointment had been cancelled and the question of not restricting age was under the consideration of the Government and was likely to be favoured. The Deputationists put forth a suggestion that in stations where medical relief needed a pucca dispensary the Government might direct the Local Bodies to equip the Rural Dispensary to the standard of Pucca Dispensary and put the Subsidized Practitioner in charge of it as an honorary medical officer consistent with the principles of both the Honorary and Subsidized Rural Medical Relief Scheme. The Minister did not object this suggestion.

(12) The suggestion of leave reserve to fill in temporary vacancies in the Subsidized Service was accepted.

(13) About Excise rules the Minister pointed out that the Subsidized Practitioners being in the Medical Register, they were entitled to stock a specific quantity of excisable drugs without License and therefore there was no need for any special arrangement.

It is expected that all the above decisions agreed to at the Secretariat Conference will be embodied in the Agreement and the Government will be pleased to pass an order on the subject at an early date.

NOTICE.

The Subsidized Rural Medical Practitioners are requested to consult the President on any controversy between them and the authorities governing the Subsidized Rural Medical Relief Scheme before they commit themselves to any statement. The President regrets that trivial matters which might have found easy and amicable settlement, have in some instances complicated matters beyond solution.

V. RAMA KAMATH.

ONE HUNDRED YEARS OF HOMŒOPATHY.

LECTURE BY
DR. C. E. WHEELER.

A lecture, introductory to a course arranged by the London Homoeopathic Hospital, was delivered by Dr. CHARLES E. WHEELER in the Hastings Hall of the British Medical Association House on October 8. Dr. Wheeler, whose discourse was entitled "One Hundred Years of a 'Heresy,'" said that it was a little more than a century ago that the practice of homoeopathy, following the teaching of Hahnemann, became known in this country. For the benefit of those who were unfamiliar with the subject, he explained that homoeopathy taught that in any given case of disease the remedy most likely to prove curative, or at least helpful, was the one most similar to the disease itself—that is to say, a remedy which, given in poisonous doses to the healthy, would produce a symptom picture most closely resembling that given by the disease. Most homoeopaths used infinitesimal doses, but the principle of homoeopathy was applicable with any range of dosage; indeed, Hahnemann used doses not far removed from those of ordinary practice.

Homoeopathy, Dr. Wheeler continued, was not concerned with diagnosis, with surgery, or with any form of treatment except medicinal. There was no quarrel between the "heretics" and the orthodox save over the remedy which was most likely to help the sick man. Homoeopathy was a simple rule of practice applied to a particular sphere of medicine—the treatment of the sick by drugs. Few opponents of the system had troubled to understand its aim, much less experiment with it. Its followers until quite recently had been shut off from all professional intercourse, often deprived of help in emergencies, and rejected from societies. There had never been in this country more than a few hundred practitioners of homoeopathy, so that it had not been easy to collect a volume of statistics of results to compare with those of the dominant

school. For a hundred years this "heresy" had had to find its supporters from among men trained by their teachers to consider it folly or worse, and who, when accident or curiosity had brought them to think there might be something in it, knew full well that to proclaim that belief meant ostracism and all kinds of professional disabilities, and an end to professional advancement.

SCIENTIFIC BASIS OF A "HERESY"

The homoeopathist before selecting his remedy looked for the closest similarity, not only in gross pathology but in every kind of minute personal detail which might be significant of the nature and constitution of the patient. He did not want a drug for a disease, but far more—a drug for the person whom a certain disease had attacked. It was a commonplace that no individual was exactly like another. The charge sometimes made that the homoeopathist treated only symptoms and not causes was based on the fact that he took note of every slight (to others negligible) symptom, and gave it weight in choosing a remedy. But the value of each symptom depended upon its contribution to the whole, like each brush stroke in a painting. The homoeopathist was not concerned to relieve this or that symptom in itself; he thought in terms less of the attack of disease than of body resistance, and he regarded symptoms as indications of the kind of help the patient needed. When the most similar remedy was chosen it was given as a reinforcement to the natural defences, not as a substitute for them. Dr. Wheeler discussed the parallel of vaccine therapy. To the homoeopathist any drug was thought of as his orthodox colleagues thought of a vaccine, as a stimulant to natural resistance. Therefore he tried to follow the rule of minimal doses and repetition, not at regular intervals, but as the symptoms called for them. The belief in infinitesimals was not a fad or a mere tribute to a theory, but the result of experiment much more rigorous than that applied to most new claims.

In conclusion Dr. Wheeler discussed some later developments of Hahnemann's

teaching with regard to chronic disease. His teaching foreshadowed the conception that certain deep poisons (tuberculosis and venereal disease were obvious examples) could so affect the system that they coloured all superficial manifestations of ill-health, and no final release from these manifestations was possible without an attack on the deeper enemy. This opened up the further question: the nature of the greater or less susceptibility to these profound poisons. It was coming to be realized that not only the seed—that is, the micro-organism—but the soil on which it was sown was vitally important. Hahnemann and his followers had always thought first of the soil, believing that by influencing this it became possible to control the growth or inhibition of the seed.

"Our 'heresy' at the end of a weary century of opposition looks like becoming almost respectable—presently it may even be incorporated in the general body of imedical learning. But the gain, if ever it comes, will be incomplete unless somehow we can all overcome the tendency to turn lazily away from coming challenges and meet each one with full and dispassionate investigation, extracting from it what is good, and rejecting only what is unproven and unsound."

(B. M. J., Oct. '38).

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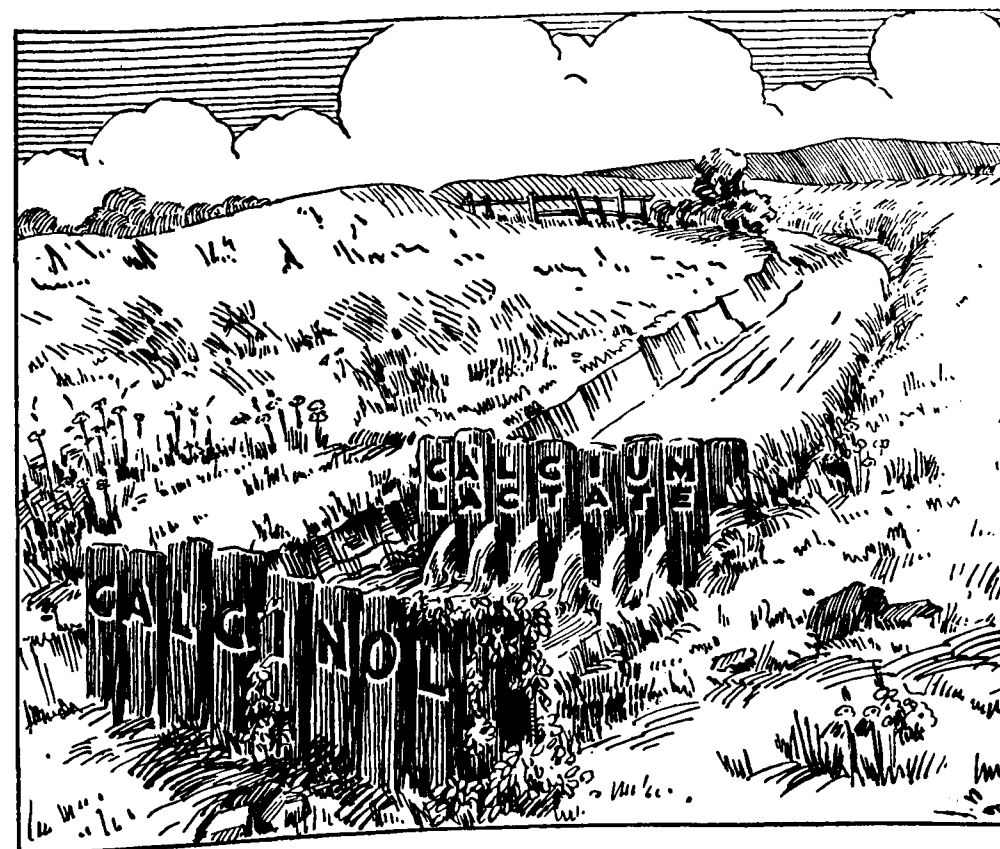
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A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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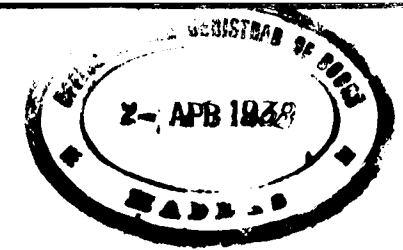
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THE Medical Practitioner

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Original Articles.

"CONGENITAL TALIPES EQUINO-VARUS"

By

DR. N. S. NARASIMHAN, F.R.C.S.,

Orthopaedic Department, General Hospital, Madras.

DEFINITION: By the term Talipes is understood a permanent deformity of such a nature that the foot is inclined to an angle to the leg, so that the sole no longer rests upon the ground in the normal position, when the patient bears his weight upon it.

the foot can still be replaced in its proper position with a little effort, the alternation in the bones not having yet reached such an extent as to offer any great impediment to its performance.

The cases of Talipes Equino-Varus fall into 3 distinct groups :

(1) Those in which the deformity can be completely rectified by manipulation alone ; these are the cases in which there are no shortened structures to impede materially the reposition of the foot and where the deformity of the bones is only slight.

(2) Cases in which the condition has lasted for a longer time, and which are marked by shortening of the tendons and ligaments, resulting from the long continued faulty position of the limb ; when these contracted structures are divided,

(3) The third group consists of those cases in which the deformity has lasted for a very considerable time, and where the obstacles to reduction are not merely the presence of tight tendons, ligaments and fasciae, but are caused by alterations in the bones themselves (more especially in the direction and extent of the articular surfaces which have reached such an extent that re-position by mechanical means is impossible). These alterations in the bones consist, partly in the changes in their shape and direction, and partly in alterations in the articular cartilages.

Even when the bones are placed in proper position, the opposed surfaces are no longer covered with articular cartilage.

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Besides this, alterations in the shape of the bone beneath may also develop. This is generally in the direction of over-growth, so that it is no longer possible to bring the two joint surfaces into proper relation with each other, and before this can be done, some alteration in their shape must be made mechanically.

In T. E. V. there are 5 composite deformities:

- (1) adduction of fore-foot,
- (2) inversion of whole foot,
- (3) equinus,
- (4) plantar flexion and
- (5) inward rotation of tibia.

All the deformities take place below the talus; the bony changes are secondary arising from the constriction of ligaments on the inner side of the foot. Head of the talus remains in normal position. It is a congenital dislocation of the astragaloscapoid joint. Adduction deformity occurs at the midtarsal joint; inversion deformity occurs at the sub-astragaloid joint; plantar flexion is due to shortening of structures on the inner side and sole of the foot, and this is an important deformity. Equinus is due to shortening of Tendo Achillis.

The Deltoid Ligament of the ankle joint and plantar fascia are important obstacles to reduction. Posterior fasciculus of the deltoid ligament does not participate in the deformity; middle fasciculus produces inversion of the os calcis; anterior portion of the ligament blends with internal and inferior calcaneoscapoid ligament forming a strong band between the internal malleolus, sustentaculum tali and tubercle of the scaphoid. This is called "astroscaphoid capsule."

Look at the sole; one may find,

- (1) kidney shaped foot,
- (2) concave inner sole or
- (3) convex outer sole.

All these are due to adduction of midtarsal joint.

Rotation of tibia is made out by feeling the external malleolus on the same level as the inner malleolus.

Feeling the talus on the dorsum is due to the contraction of the tissues on inner side—as the inferior calcaneo-navicular ligament. Heel slopes inwards instead of sloping outwards.

Function is poor in the club foot. Even at birth only a small range of passive movement is possible and time reduces this still further. The fixity is not due to muscular defect but to the foot being "cast in a faulty mould".

ANATOMICAL OBSTACLES TO CORRECTION OF TALIPES EQUINO-VARUS

(1) Tight shortened capsules of joints on inner side of the foot.

(2) The very resistant Tendo-Achillis and ligaments at the back and inner side of the heel, which hold the os calcis twisted with its inner surface meeting the internal malleolus and the heel pulled up behind the ankle. With age the deformity is accentuated and the tarsus undergoes bony consolidation. Slight compensation is afforded by the outward rotation of the femora.

No other deformity as T.E.V. presents such a record of failures and incomplete cures. A long hard struggle is involved; the best results naturally follow when the treatment is begun soon after birth. The structures are tender and yielding and there is no osseous tissue to remodel. Patience and tenacity on the part of the surgeon are demanded to an unusual degree.

The mother must clearly be told at the outset that active treatment for 12 to 18 months entailing regular and frequent visits will be required and a further period of remedial exercises and supervision for two or three years.

THE METHODS NORMALLY ADOPTED FOR THE CORRECTION OF ANY DEFORMITY ARE:

- (1) Gradual correction of the deformity
- (2) Forcible correction of the deformity
- (3) Surgical exposure with division of tight structures and
- (4) Operation on bones.

Gradual correction of deformity is a method which was successfully employed before many of the operations at present practised, were surgically safe, and we can assess the value of modern operative methods only if we have experienced the possibilities of correction of deformity by gradual splintage. Nature resents tension and allows relaxation of structures to which correction is constantly applied. It is generally agreed that division or elongation of muscles reduce their power, so that, methods of gradual correction of deformity have a definite advantage. Gradual correction is the method of choice for the early treatment of congenital club-foot.

Forcible correction is mainly utilised in cases of club-foot in which treatment has been delayed.

If the patient is seen in the first two months, without any anaesthetic, manipulate every day, apply strapping and massage.

MANIPULATION OF THE FOOT—SAY RIGHT FOOT.

Left hand grasps the lower part of tibia to prevent epiphyseal strain while the knee is flexed or held by an assistant to avoid strain. The ball of the surgeon's left thumb will rest to the outer side of the foot and the forward part of os calcis and should act as a lever for the correction of adduction at midtarsal joint, the right hand grasping the forefoot. When this has been effectively done the epiphysis should still be held

by the hand while the sole of the foot, is flattened and everted and the Tendo-Achillis stretched by the right hand. Correct the varus position of os calcis, the bone being tilted, so that its outer surface approaches the external malleolus.

If much force is incorrectly applied in manipulation under anaesthesia, there may occur in infants an incomplete fracture of the anterior part of the tibia just above the ankle or a separation of lower epiphysis of the tibia.

CORRECT ONE BY ONE THE DEFORMITY IN CERTAIN DEFINITE ORDER:

- (a) Tackle mid-tarsal deformity first.
- (b) Then the sub-astragaloid joint-eversion of the whole foot.
- (c) For correcting equinus—Do not push the forefoot upward. It will give a false correction judged by the convexity on the lateral side of the sole; later on, they will get a painful callosity.

The correction is deceptive, for although vigorous upward pressure on the sole might still seem to produce dorsiflexion it would do so, not by drawing the heel down, but by tearing the plantar ligaments in the mid-foot, and so angulating the foot at the mid-tarsal joint. A V-shaped foot would result. If there is unusual resistance in a late case, open tenotomy seems preferable and the posterior ligament of ankle joint may need division.

To correct adduction, the outer portion of the dorsum of the foot is placed upon a covered wedge block or hard roller bandage. An assistant grips the front and back of the foot. With both hands the surgeon obliterates the adduction angle and flattens the sole. This should thoroughly be done. Secure a certain degree of adduction at the mid-tarsal joint. The persistent adduction deformity is fatal to success.

To correct inversion: With a twisting movement, the foot is twisted into ever-

sion. Particular care is taken to overcome the inversion of os calcis.

Adhesive plaster strapping: Retain the foot in an over-corrected position by adhesive plaster 1 to 1½ inches wide. This is applied round the fore-part of the foot beginning on the outer border of the tread taken across the dorsum round the sole and fixed to the starting place, but not torn off. The foot is then held in extreme eversion and slight dorsiflexion, while the strapping is drawn very tightly, parallel with the leg and applied to and around the back of it from below the knee joint.

Type of foot in infants easy to correct: Very marked inversion deformity,—fairly long heel,—very little adduction at the mid-tarsal joint.

Type of foot which is difficult to correct.—Short heel with adduction deformity, though there may not be any marked inversion of the foot.

The classical methods of splinting ignore function. Function is more important in any disability than structure. To correct function, muscle balance and mental impression of how it should be used, and movement must be allowed in the corrected position. Dennis Browne's Splint is used commonly now and most people agree that it is an useful splint.

DIFFICULTIES THAT MAY BE MET WITH DURING THE MANIPULATION TREATMENT.

1. The skin of the foot and leg must be cleaned with spirit and powdered and a day's rest is given every week; if the skin is bad, give two or three days off; eczema of the leg and foot and inflammatory complications are seen in the poor class children.

2. *Dangers of manipulations under anaesthetic:*

(a) Slipping of the lower tibial epiphysis.

(b) Fracture of the anterior part of tibia just above the ankle joint.

(c) Injury to knee joint. You have to steady the knee joint and protect the tibia.

(d) Knock knee; correct the deformity with the knee flexed; otherwise there is a strain on the internal ligament of the knee joint.

3. These children will be late in walking; when they walk they tend to walk with flat foot; look from behind to see if the condition is well corrected; the foot should be in the valgus position.

4. The most troublesome feature of congenital club-foot is a small drawn-up heel. This will descend with the use of a Dennis Browne Splint. The child probably by pushing against the splint, gradually stretches the tendo achillis.

5. Danger of over-correction leads to Pes-Planus.

TREATMENT OF A CASE WHEN SEEN AT TWO MONTHS AND UPTO TWO YEARS.

Continuous Rectification is applied. You have to use a retentive splint; three or four manipulations under anaesthetic will be required. The Splint does not correct; it will only hold the foot in the corrected position;

The following are the types of splint:

(a) Outside aluminium splint.

(b) Strapping only.

(c) Plaster—(good).

(d) Dennis Browne Splint—It is easy to apply; strap the foot piece to foot and then correct; one foot holds the other; the baby can kick up; there is no wasting of muscles; put feet under the mid-tarsal region.

(e) Other retentive apparatus as Scarpa's shoe, Boots with median iron.

The disadvantages of retention apparatus: The calf muscle is not developed; it gets a funnel shaped deformity; you can always spot that had a retentive apparatus.

Technique of strapping is already given.

Technique of plaster application: In order to keep inversion after correction on plaster of paris, it is necessary to get some fixed point from which the foot can be twisted; this is only possible, if the knee is flexed and included in the plaster. A plaster case which only reaches as far as the calf, can rotate upon the leg and allow the foot to invert. Although Dennis Browne does not like the method as he thinks that muscles get wasted, there is absolutely no doubt that this is the correct procedure, if plaster application is used. Never cease the splinting because of pressure sores or skin irritation. If a half-corrected foot is set free, it will become far more obstinate than if it had never been touched. Upto two years manipulations by hand alone is good. The soft parts are becoming strong at the 2nd year. There are two schools of thought regarding methods of treatment at this period.

(a) *Wrenching:* The treatment is done in the outpatients; the mother is cautioned about undue compression by the bandage. The toes should be inspected next day; the baby is returned in two weeks. The night previous to the visit, the mother takes off the plaster bathes the leg and some oil can be applied over the skin.

Every two weeks the foot is wrenched and the plaster removed, until at about four months, the unsupported foot remains in the valgus position. Two or three wrinkles in the skin anterior to the external malleolus afford confirmation that the underlying astragalus has receded to the inner aspect of the foot. Mild

eversion of the Os calcis is a welcome sign.

So far no attention has been paid to the equinus. It is when the Os calcis is in its normal position below the astragalus, that this can be more advantageously treated.

A very important point to remember in the treatment of all cases of T. E. V. is that the patient must not be regarded as cured as soon as the foot can be got into its proper position or even after it has been maintained in its new position for some weeks. As a matter of fact, if the treatment be let off too soon, a relapse takes place almost at once and the subsequent condition may become almost as bad as or even worse than if no treatment at all has been employed. Hence in all cases of club-foot, it must be impressed on the parents that the treatment must be continued for a long time, even after apparent complete recovery; some years at least must be devoted to it.

If ultimate function is to be obtained, the continuous after-treatment of operated cases is important.

The mere obtaining of over-correction and maintaining it for a few weeks is of no value, unless it is followed up by the other two elements of successful treatment. These are measures (1) to enable the over-stretched anterior and outer muscles to function and (2) the deflection of body weight in such a way that it will become corrective. Unless adequate over-correction of the foot is secured at the time of operation, failure is inevitable.

The ability to use the overstretched and weakened anterior and external muscles must be restored by muscular re-education in children, old enough to obey orders. Of all the measures connected with the after-treatment of club-foot, this is the most often neglected, and it may be again insisted, that unless this measure is carried out the foot is mechanically little better than are those feet where after poliomyelitis, the anterior

and external muscles remain paralysed or weakened. The second measure which is of equal importance is the deflection of body weight in such a way that the centre of gravity falls inside the centre of support. In weight bearing, the foot must be so balanced that it tends to roll into its inner instead of its outer border.

The foot is maintained in over correction by strapping combined with a light wooden sole-plate. If strapping alone is used (Whitman) its upward pull is confined to the instep, instead of spreading over the whole sole. This would further induce the cavus deformity already noted as inherent in club-foot. It is manipulated into extreme over-correction at daily exercises. Then assess the effect of treatment as to whether there is an excessive adduction of the foot and pes-planus, or, what is more frequent, a tendency to relapse.

Either of these extremes are controlled at this stage. After about 12 months, the foot is measured for special night shoes and day overshoes. The child attempts to walk now and the exercises are continued. During the second year, boots are fitted; regular supervision is necessary. An intensive course of remedial exercises make good any deficient power. Intoeing when the child begins to walk, is corrected by exercises and thickening of the outer margin of the shoe. No part of the foot escapes the varus deformity and the metatarsus and hallux varus must be corrected by the continuation of the plaster to the end of the inner margin of the big toe. Intoeing and traces of Equino Varus are the most frequent residues of the deformity.

In children, who are able to get their weight on their feet, the shoes should be raised from $1/4$ to $1/2$ inch on the outer side to throw the weight on to the inner border. In some cases a better balance will be obtained if only the front of the foot is raised and the heel left square. This induces a twist in the medio-tarsal joint which is of itself corrective.

RETENTIVE APPARATUS.

Some form of night retention shoe is desirable for a while, if during the night the feet at first tend to fall back into a position of deformity. The simple form of apparatus is a splint holding the foot at right angles, and somewhat everted, consisting of a sole plate and two up-rights.

CRITERIA OF CURE.

Completely correct all the deformities; if the deformities are corrected, you will find (a) nice-everted valgus position of the foot; (b) sole of the foot not kidney shaped; (c) heel coming down with slope outward; and (d) outer border of the foot is concave. No case is cured till the muscles are properly balanced again *i.e.*, the child must actively keep it in the correct position; otherwise, recurrences are common. Get the child to actively evert the foot; it may take six months; if the muscles do not get lengthened, recurrence is common. There is congenital shortening of muscle fibres although it has good muscular fibres. These are associated with arthrogryphosis congenitals.

Length of muscle fibres depend on the range of movement of the joint upon which they work. Club foot being a fixed foot, muscle fibres are short. Peronei are lengthened but their muscle fibres are short. To get them function, you must train the muscles; muscle training is required to produce active eversion. The child must be able to evert and also dorsiflex the foot well above the right angle. Even if these criteria are present, it cannot be claimed that the deformity will not relapse. When a deformity does relapse, Brockman thinks that the correction which had been obtained before, must have been a spurious one, and that the deformity had in fact been hidden by a false correction of the fore part of the foot.

FAILED CASES.

Reasons for failure or of recurrence: The important cause is the failure of the

surgeon to obtain adequate over-correction.

(1) Failure to produce correction at the proper place; correction must be done at the ankle for equinus. Otherwise, the anterior articular surface of os calcis will be directed downwards with dorsiflexion of fore foot.

(2) Correct the four deformities of joint and the inward rotation of tibia; correct them in the reverse order starting from in front; finish one joint first before you begin the correction of the other joint. The equinus must be corrected last. The reason for this is that in equinus, the bone is locked and you are able to correct the deformities. A club-foot is fixed; it is a stiff joint in the fixed extreme position.

(3) Correction of equinus has to be done with great care; you must do it in front of Os calcis. All the apparatus and splints produce only a correction of fore-foot and not at the Os calcis. Dennis Browne splint too, does not correct at the proper place.

(4) A failed case has a wasted calf muscle; the muscle may be on a higher level than the fellow of the opposite side if a tenotomy of the tendo-achillis had been done. A high calf and a thin leg means a tenotomised tendon.

(5) Inability of the overstretched anterior and external muscles to function sufficiently, to pull the foot actively into an over-corrected position.

(6) The erroneous deflection of body weight, in walking so that super incumbent weight does not act as a corrective force but emphasises the deformity.

(7) Discarding of apparatus too early.

(8) Artho-gryphosis congenita; there were two such cases last year in the General Hospital wards.

(9) Myotonia.

Paralysis of muscles as in Anterio-polio-myelitis: even though treatment was commenced at the end of first week these cases have not improved.

TREATMENT OF FAILED CASES.

They require some form of open or bone operation.

The worst type of foot to be corrected is one that has relapsed after the removal of bone, and therefore the surgeon is under the grave responsibility to make the operation an effective one or leave it alone.

The co-operation of the nurses, child welfare centres, maternity hospitals and the profession is required in getting satisfactory results.

Open operations on soft structures are required after the age of 2 or 3; treatment becomes difficult after the age of 5. In these cases operations on bones are required. They are not discussed here.

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ANAEMIA.

BY DR. S. S. RAU, M.D.

Anaemia is poverty of the blood. The blood may be reduced as a whole or the reduction may be in the corpuscles or haemoglobin.

To understand the subject properly it is necessary to remember the physiology of the formation of the red blood corpuscles. From the time the baby is born the R. B. C. are formed in the bone marrow from the endothelial cells lining the walls of intersinusoidal capillaries. The primitive cell is called the erythron and from its division the megaloblast is formed. Its cytoplasm is basophile and the nucleus reticular. The substance which is necessary for this transformation is not known. Megaloblast divides and forms the normoblast which contains more haemoglobin in its cytoplasm and has got a well stained pyknotic nucleus. For this development to take place a substance called the haematinic principle should be present in the blood. This principle also known as the Pernicious Anaemia (P. A.) factor is a combination of the intrinsic factor of Castle which is an enzyme secreted by Brunner's glands at the pyloric end of the stomach and adjacent part of the duodenum and an intrinsic factor which is found in all well balanced diets and plentifully in marmite (autolysed yeast). The haematinic principle thus formed is stored principally in the liver and slightly in the kidney and nervous system. If it is not found the megaloblasts fail to develop into normoblasts and megaloblastic anaemia develops.

The nucleus of the normoblast is extruded and the normocyte or the normal R. B. C. is formed. For this change to occur iron with traces of copper, vitamin C and thyroxin are necessary. Lack of any of these interferes with the development of the normocytes resulting in microcytic anaemia.

Blood consists of Plasma, R. B. C., W. B. C. and blood platelets. In the

average adult the blood volume is 6000 cc. and the R. B. C. for purposes of calculation is 5 millions per c. mm. The average diameter of the R. B. C. is 7.2μ and 14.5 gm. of haemoglobin are contained in 100 cc. of blood. This amount of haemoglobin is taken to be 100% for calculation purposes.

The most important sign in anaemia is pallor; this may not be marked in anaemias whose colour index is more than unity, because in them the haemoglobin is not reduced in the same proportion as the number of R. B. C. It is best seen in the conjunctiva of the lower eyelid, the mucous membrane of the lips and tongue and the finger nails.

The patient complains of great weakness, inability to do physical or mental work, giddiness, dyspnoea, palpitation, praecordial pain and want of appetite.

On examination in addition to the pallor and puffiness of the face and oedema of the ankles is found in well marked cases. The pulse is soft and slightly collapsing. Auscultation over the praecordium shows murmurs, best marked at the base over the pulmonary area. Bruit de diable is heard over the jugulars.

The diagnosis of anaemia is not complete unless the cause is found out.

If the patient is very restless, with cold clammy sweats, air hunger and very great dyspnoea, the anaemia is due to sudden and great loss of blood due to trauma and rupture of an organ or blood vessel, rupture of an aneurysm, severe haemoptysis or haematemesis. The bleeding should be arrested and 500 cc. of blood should be transfused. If it is not possible 500 cc. 6% gum acacia should be given intravenously. An alternative procedure is to give 50 cc. of 50% glucose intravenously followed by 500 to 1000 cc. of 5% glucose saline. A careful history should be taken and

physical examination done to find out the cause which should be treated.

Haemorrhage may occur in small quantities at frequent intervals. The most common causes are bleeding piles, fistula, fissure, polypi in children, cancer of the rectum in old persons, cancer of the stomach, intestines, ankylostomiasis, epistaxis, haemoptysis due to tubercle or bronchiectasis, haematuria due to stone in the kidney or bladder or pyelitis, cystitis, tubercle of the kidney, tumours of the kidney or bladder whether simple or malignant, menorrhagia or metrorrhagia in women, purpura and haemophilia.

History and careful examination will reveal the cause. In doubtful cases special aids like microscopical examination for hook worm ova, X ray and laboratory examination e.g., for occult blood and urine culture should be undertaken.

The treatment consists of curing the cause. Iron in the form of Ferri et Ammonia citras 30 gr. 3 times a day should then be given.

If the patient has got jaundice in addition to the anaemia one should think of the haemolytic anaemias. The jaundice varies according to the number of R.B.C. that are broken down at a time. If a large number is haemolysed, there is intense jaundice and haemoglobinuria; if the number is small there is only slight jaundice. The following are the common varieties of haemolytic anaemia.

(1) *Protozoal*.—Malarial fever. Here there is fever or history of intermittent fever, enlargement of the spleen, and the blood smear shows the malarial parasite.

(2) *Bacterial*.—The following bacteria are the causative agents.

(a) *Streptococcus haemolyticus* e.g., septicæmia, ulcerative endocarditis and rheumatic fever.

(b) *Diphtheria bacillus* causing Diphtheria.

(c) *Typhoid bacillus* causing Typhoid fever.

(3) *Spirochaetal*.—*Treponemapallida* causing paroxysmal haemoglobinuria. The attacks occur after a chill and the Wassermann reaction is positive.

(4) *Chemical Poisons*.—(a) Arsenical preparations: Arsenobenzol and Trinitro toluol. Here there is a history of the patient having taken arsenical preparations or working in factories where arsenic is used. (b) Lead poisoning: In cases of lead poisoning, the R. B. C. show basophilic stippling. Blue line on the gums and intestinal colic are the characteristic sign and symptom respectively.

(5) *Organic Poisons*.—(a) Snake venom from viperidae. (b) Incompatibility in blood transfusions.

(6) *Congenital abnormality*.—(b) Acholuric jaundice: In this condition the patient does not appear ill and goes on with his usual activities though there is jaundice and anaemia. The jaundice varies in intensity from time to time, but the urine is not coloured. The disease is due to abnormal fragility of the R. B. C. due to an inherited condition. The R. B. C. are biconvex instead of biconcave and are fragile in 6 per cent sodium chloride solution. The fragility ends in 42 per cent saline, the point at which normal fragility begins.

(7) *Unknown causes*.—Familial icterus gravis neonatorum. Here the child which is apparently normal develops within a few hours intense jaundice and passes into a drowsy condition. This is thought to be due to a morbid exaggeration of the normal physiological destruction of the R. B. C. which occurs soon after birth.

The treatment for haemolytic anaemia is the removal of the cause and exhibition of iron. The best way of giving iron is as ferrous sulphas, 3 gr. three times a day. In acholuric jaundice removal of the spleen and in familial icterus gravis, injection of 5 to 10cc of mother's or father's blood is very beneficial.

If physical examination by itself does not reveal the cause, a careful examination of the blood should be made. A general examination of the blood film under the microscope will show whether the R.B.C. are smaller in size, equal or bigger than the normal. This is of great importance from the standpoint of treatment as megalocytic anaemia responds to liver treatment, and normo and microcytic anaemias to iron therapy. The following examination is useful to classify the anaemias.

- (1) The total number of R.B.C.
- (2) The percentage of haemoglobin.
- (3) The colour index.
- (4) Abnormalities in the shape and size of the Red Blood Corpuscles.
- (5) Abnormal cells, megaloblasts, normoblasts, myelocytes, etc.

If the total number of R.B.C. and the percentage of haemoglobin are diminished, the colour index less than one and there is poikilocytosis, anisocytosis, the size of the R.B.C. being less than normal and no nucleated R. B. C. the anaemia is a deficiency anaemia due to lack of iron (with traces of copper) vitamin C or thyroxin.

A brief description of the common forms of these anaemias will not be out of place here.

(a) Children who are fed only on milk even after the ninth month are apt to develop this kind of anaemia; milk contains very little iron. This deficiency is made good by the storage of iron in the liver of the infant acquired during foetal growth from the maternal blood.

This store is exhausted by the ninth month and if the baby's food does not contain iron, anaemia develops. Iron in the form Ferri et ammonia citras (9 gr. per day) in divided doses should be given to the child, either mixed with the bottle milk or given in solution after the breast feed.

(b) Middle aged women who have got complete lack of hydrochloric acid in the gastric juice develop this anaemia because hydrochloric acid in the stomach helps the absorption of iron in the intestines. In addition to the usual symptoms these women complain of flatulence and dyspepsia, the tongue is inflamed, the finger nails are thin and spoonshaped (koilonychia) and in extreme cases there is difficulty in swallowing also (Plummer Vinson Syndrome). A fractional test meal reveals complete achlorhydria. In these cases dilute hydrochloric acid $\frac{1}{2}$ dr. three times a day mixed in a tumbler of water flavoured with orange juice and sucked through a glass tube and Ferrous sulphate 3 grs. thrice a day after food will cure the condition and restore the blood picture.

(c) Chlorosis or green sickness is rare now-a-days on account of the active open air life which is led by the modern women. It is found among women at puberty who lead a sedentary life indoors. Generally they are unmarried and suffer from constipation. Iron, outdoor life, marriage and relief of constipation act as specific. Bland's pill in 30 grs. doses with Ext. cascara sagrada, 4 grs. the time-old remedy still holds the field.

(d) During pregnancy on account of the growing demand of iron by the developing foetus, iron deficient anaemia is apt to develop unless iron is given to the mother.

(e) Coeliac disease: This disease is found in children. They have got fatty diarrhoea, protuberant abdomen and signs of deficiency of calcium *i.e.*, rickets, tetany etc. It is due to obstruction to the lacteals. Hence not only iron, but calcium, vitamin D and haematinic principle, are not absorbed. The cure consists in giving all these substances parenterally.

(f) Scurvy: This disease due to lack of vitamin C is rare now-a-days in the classical form on account of plenty of fresh vegetables containing the vitamin being available. In children fed on patent milk foods however, anaemia due

to this deficiency develops unless fresh orange juice or lemon juice is given.

(g) Myxoedema: Anaemia is found in this disease due to lack of thyroxin. Even in people in whom thyroxin is deficient but not completely absent anaemia is present. In such conditions, if the patient is a child having a thick slightly protruding tongue, dribbling saliva, dry skin, scanty hair and the usual healthy activities of the infant such as turning on the belly, lifting up the head, crawling on all fours are not in evidence. In an adult, a thick skin, mental deficiency, slow pulse, subnormal temperature and a low B. M. R. may be noticed. Treatment consists in giving thyroid extract beginning with gr. $\frac{1}{2}$ and gradually increasing to grs. 5 provided there are no untoward symptoms.

If the blood examination proves anaemia to be megalocytic with colour index more than unity the deficiency is due to the haematinic principle.

The anemias which come under the above category may be due to:—

(a) Deficiency of extrinsic factor: This factor is plentiful in all well balanced diets and hence is found in poor people who lack it. If pregnancy occurs in women of this class the condition is aggravated. It can be distinguished from Addisonian anaemia by the fact that there is no achlorhydria, and from sprue by the fact that there is no diarrhoea and the characteristic tongue. Half an ounce of marmite 3 times a day cures the condition. Maintenance dose is 1 dr. twice a day.

(b) Want of intrinsic factor: This causes the true pernicious anaemia, now called Addisonian anaemia. The glands secreting the intrinsic factor may be absent or wanting on account of certain operations involving the glandular area. The tongue is found to be glazed and there is complete achlorhydria. The patient is not at all emaciated and the colour of the skin is lemon yellow.

(c) Want of absorption of the principle as in:

(1) *Sprue* when there is atrophy of the mucous membrane of the intestines. The mouth becomes sore and there is early morning diarrhoea with frothy fatty stools.

(2) *Coeliac disease*: A megalocytic anaemia is also found in it due to obstruction of the lacteals.

(3) *Gastro-colic fistula*: This generally occurs in cancer of the bowels.

In all the above cases liver extract should be given parenterally on account of the uncertainty of absorption when given by the mouth. In serious cases 5 c.c. of a patent liver extract like Hepatex (P.A.F.) should be given intravenously very slowly followed by 5 c.c. of Campolon intramuscularly every day until reticulocytes are increased to about 10 per cent (normal 1 to 1 per cent) or when such facilities are not available until there is a sensation of well being in the patient after which 5 cc. of Campolon can be given every week until the blood picture is restored to normal and there are no symptoms. Addisonian anaemia is a deficiency disease like diabetes; hence a maintenance dose of haematinic principle is necessary. Generally 5 cc. of Campolon once a fortnight or a month is sufficient. Where facilities for examination of blood are available, the dose and interval of the maintenance dose should be such as to keep the blood picture normal.

(d) Failure of Storage.—This occurs in extensive diseases of the liver *e.g.*, cirrhosis. The signs and symptoms are very much as in (c), the differentiation can only be established by a *laevulose tolerance test* when the liver is found to be defective.

Liver extract by injection is the treatment but the response is not good.

(e) Failure of utilisation.—In this condition also known as *echrestic* (failure to utilise) anaemia the haematinic principle

is formed, absorbed and stored properly in the liver but the body fails to utilise it. Signs and symptoms of this condition resemble those of the previous two varieties and the marrow obtained by sternal puncture is megaloblastic, but treatment by injection of liver extract is found to be useless. The final diagnosis can only be established post mortem when the liver extract obtained from the cadaver of such a person is useful in curing cases of pernicious anaemia, thereby conclusively proving that the haematinic principle though present, has for some reason or other not been utilised.

If the blood picture shows diminution of the number of R.B.C. the size remaining more or less normal, the colour index about one, and the leucocytes either diminished or greatly increased with the appearance of myelocytes one may conclude that the anaemia is due to abnormality of the bone marrow. The chief of these are:

(a) Aplastic anaemia: This resembles Addisonian anaemia but the blood picture shows no megaloblasts or megalocytes and the colour index is about unity. There is no glossitis and no achlorhydria, but there are necrotic ulcerations and hæmorrhages. The condition is due to an atrophy of the blood forming elements of the bone marrow caused either by X-rays, radium, benzol and its derivatives, the heavy metals like mercury, silver and gold, acute infections like diphtheria, typhoid fever and measles or from unknown causes. The prognosis is grave and the patient dies within a year except in some of the cases where the cause is known and removable e.g. X ray or radium treatment. The treatment consists in removing the cause if any and frequent blood transfusions of 2,000 to 3,000 cc.

(2) Lukæmia: In this affection of the bone marrow there is hyperplasia of the leucopoietic tissues. The anaemia is due to disturbance in the maturation of the erythropoietic tissue caused by this hyperplasia. The anaemia is not very profound but is characterised by the varieties of the white and red blood cor-

puscles which appear in the peripheral blood and the large number of W. B. C. which may come to 1,000,000 per c. mm. There are two varieties, the spleno-medullary lukæmia where the liver and the spleen are enormously enlarged and the predominating cell in the blood picture is the megalocyte and the lymphatic lukæmia where the spleen and the lymphatic glands throughout the body are enlarged and the predominant cell in the blood is the lymphocyte.

The prognosis is bad. Exposure of the bones to X-ray controlled by blood examination and Liquor arsenicalis by mouth prolong the life of the patient suffering from this fell disease.

(3) Carcinosis of the bone: Here the secondary growths which occur in the bone interfere with the development of the erythropoietic tissue. The primary growth may be in the thyroid, testes, breast, stomach or lungs. The metastasis may be seen with the aid of X-rays.

Lastly we come to anaemias whose causation is not exactly known. These are:

(1) Anaemia due to chronic septic foci like Pyorrhoea alveolaris. The Pyorrhoea should be treated; in extreme cases, the teeth should be extracted.

(2) Anaemia of Nephritis: Iron should be given after the nephritis has been treated.

(3) Splenic anaemia: The spleen is enormously enlarged and hæmorrhages like hæmatemesis occur. Removal of the spleen is the only hope.

(4) Von Jaksch's anaemia: It is found in children. The spleen is enlarged; the abdomen is protuberant, there is irregular fever and hæmorrhages. Some of these children have rickets, tuberculosis or congenital syphilis. This condition is to be treated with iron and liver extract.

The above article is not exhaustive. Uncommon varieties of anaemia like Lederer's anaemia and that due to *dibothriocephalus latus* are omitted. Investigations which are extremely necessary are described. With the aid of the microscope, most of the anaemias which

cannot be diagnosed by simple physical examination, can be identified and treated. Liver extract is only useful in the megalocytic anaemias and iron in microcytic anaemias, and anaemias due to hæmorrhage.

Abstracts.

DEPTH OF ANAESTHESIA FOR VARIOUS OPERATIONS.

BY

C. LANGTON HEWER, M.B., B.S., D.A.

It is frequently stated that the least possible quantity of the least toxic drug or combination of drugs should be administered to produce just sufficient depth of anaesthesia for any given operation. Like most generalizations this is only a half-truth. At first sight it appears most laudable to produce the lightest degree of narcosis which will enable the surgeon to perform his task, as it is evident that the less a patient inhales of a toxic drug the less there is to eliminate, and consequently metabolic changes will be minimized.

may scarcely change. As examples of the protection afforded by nerve-blocking, a disarticulation through the hip-joint or a hind-quarter amputation may be cited. The immediate effect on a patient's condition may be almost unnoticeable under spinal analgesia. As a rule it is not possible for the general practitioner to perform combined methods of general and local anaesthesia, so that in this article it will be assumed that he only has the simpler forms of general anaesthesia at his disposal.

OPERATIVE SHOCK.

In practice, however, a formidable difficulty arises. One of the causes of operative shock is the effect of traumatic stimuli on the central nervous system. This "reflex" type of shock was at one time thought to be due to exhaustion of the vasomotor centre from excessive stimulation. The modern view, however, is that there is a definite inhibition of the centre by certain afferent stimuli. Whatever the actual mechanism may be, this type of shock can be greatly diminished by deep general anaesthesia and practically abolished by suitable local analgesia which prevents the stimuli from reaching the central nervous system. A good example of the first method is afforded by the operation of osteoclasis for rickets. If the child is lightly anaesthetized he may show signs of severe shock immediately after fracture of the bones, but if he is deeply etherized the pulse rate and blood pressure

ABOLITION OF REFLEXES.

The question of reflexes must next be considered. It is obvious that the normal response to stimuli must be abolished, but what of the protective cough reflex? If there is any possibility of liquid or solid material reaching the air passages during the performance of the operation either the anaesthesia must be kept sufficiently light to preserve the protective cough reflex, or adequate provision must be made to prevent aspiration, such as by endotracheal anaesthesia, with packing, suction, etc. It is possible for the operation to induce inconvenient reflexes unless anaesthesia is extremely deep. For example, if an inflamed bladder is distended with fluid before cystoscopy straining will occur unless the narcosis is carried to a very deep plane.

In certain cases a light anaesthesia may be more dangerous than a deep one. For instance, if chloroform or a mixture con-

taining it is being used there is an increased risk of primary cardiac failure if the patient is incompletely anaesthetized, the most dangerous period being at the end of the second stage. In most prolonged operations there are times when the anaesthesia can be appreciably lightened without detriment to the surgeon's work, and a careful anaesthetist who takes advantage of these periods may save his patient much unpleasantness afterwards by a quicker recovery and freedom from after-effects.

Lastly, we have to remember that deep anaesthesia is not always accompanied by complete muscular relaxation. Straining may actually occur during overdosage if the airway is partially obstructed. Conversely, the anaesthetist who is always careful to maintain a perfectly clear airway will find that he can obtain adequate relaxation at a surprisingly light level of narcosis.

Passing next from the general to the particular, we have to consider the depth of anaesthesia necessary for certain common operations.

MINOR OPERATIONS.

Small surgical proceedings, such as circumcision, myringotomy, the incision of whitlows, the removal of superficial tumours, etc., do not give rise to an appreciable amount of shock and can consequently be performed under the lightest anaesthesia which will prevent reflex movements. The only proviso is that no chloroform or mixture containing it may be employed.

DENTAL EXTRACTIONS.

The removal of teeth does not require muscular relaxation provided that a prop or gag has been inserted in the mouth before anaesthesia. In children the single-dose ethyl-chloride or di-vinyl ether technique is usually adequate. It sometimes happens that the depth of anaesthesia is such that the cough reflex is abolished. It is always wise, therefore, to insert a sponge or pack to obviate any chance of

the inspiration of fragments of teeth. For short extractions in adults gas or nasal gas and air is the usual method. Although the cough reflex is generally unimpaired it is prudent to employ packing as an additional safeguard.

If a long dental operation is proposed the patient should, if possible, be removed to a hospital or nursing home and anaesthesia be conducted by the nasal endotracheal route, with packing. This is the only safe method of securing a smooth anaesthesia for an indefinite period. A plane of light third-stage narcosis will suffice for this type of operation. The actual techniques are discussed in another article.

REMOVAL OF TONSILS AND ADENOIDS.

The rapid guillotine method of tonsillectomy in children is as a rule performed under the single dose ethyl-chloride or di-vinyl ether technique, preceded where possible by oral nembutal or rectal paraldehyde. Unfortunately the majority of such operations are performed upon out-patients and adequate premedication is impossible. A rather deeper anaesthesia is needed than for dental extractions, as the pharyngeal reflex should be abolished. Immediately after the removal of the second tonsil the child should be turned on to his side and allowed to come round until the cough reflex returns before the adenoids are scraped. If any solid matter should then slip off the curette and be inhaled it will be immediately coughed up.

If the tonsils are to be dissected continuous anaesthesia is necessary. The simplest method is the pharyngeal insufflation of ether vapour through the tube on the tongue-depressor of a Davis gag. Anaesthesia must be sufficiently deep to enable the surgeon to exert traction on the tonsils without causing retching. With this plane of anaesthesia the cough reflex may be absent, so that blood must be prevented from reaching the larynx. This can be accomplished by suction and by the position of the patient. The latter varies with the individual surgeon, but is usually the "thyroid" position with extend-

ed head, or the lateral "Butlin" position with the head low. The only certain method of protecting the air passages from blood and debris is the nasal endotracheal technique with a gauze pack. Neither the tube nor the packing must be removed at the end of the operation until the cough reflex has returned.

NASAL SURGERY.

Short procedures such as antral puncture and turbinectomy can be done under a "single dose" anaesthetic technique.

In longer intranasal operations, such as sinus drainage or submucous resection of the septum, continuous anaesthesia is needed. Pharyngeal insufflation with a postnasal pack or Shipway's ballooned airway is only safe if the cough reflex is preserved, since it is impossible to be certain that no blood will leak past the pack. Oral endotracheal anaesthesia with gauze packing or a ballooned tube is undoubtedly the method of choice, and an even level of narcosis can then be maintained with perfect safety.

ABDOMINAL SURGERY.

Comparatively minor procedures such as operations for hernia and varicocele require little relaxation and can be performed under light third-stage narcosis. Extensive intra-abdominal operations, on the other hand, demand good relaxation. The nearer the incision is to the diaphragm the greater will be the respiratory excursion and consequently the greater the need for shallow respiration. The suturing of hollow viscera is both tedious and difficult if the suture line is moving over an extensive range. Furthermore, traction on the diaphragmatic attachments tends to cause reflex laryngeal spasm with consequent laboured breathing and poor relaxation. For these reasons an ordinary inhalation anaesthesia may not prove satisfactory for such operations as gastro-enterostomy, partial gastrectomy, and cholecystectomy. A thorough cocaineization of the glottis may help to obviate laryngeal spasm, but the only certain preventive is the passage of an endotracheal

tube. In many cases it is possible to use this technique without additional apparatus by means of "blind" nasal intubation, the administration being continued as before with a mask. A "gas" mixture is naturally preferable if an apparatus is available.

Pelvic and lower abdominal operations, such as appendicectomy and hysterectomy can generally be performed satisfactorily with a straightforward inhalation anaesthesia carried well into the third stage. Prostatectomy, if done under general anaesthesia, necessitates the absolute minimum of ether, as the patient is practically always a poor risk with damaged kidneys, and often suffers in addition from chronic bronchitis.

There are three stages in an intra-abdominal operation when a deep plane of narcosis is necessary. They are (1) on opening the peritoneal cavity, (2) during traction on peritoneal attachments, and (3) on closing the peritoneum. The "sewing-up" must be anticipated by some minutes as it is impossible to deepen the anaesthesia suddenly, and straining at this stage is particularly trying. Similarly, a surgeon who without warning suddenly explores the gall bladder having finished an appendicectomy, may upset a lightly anaesthetized patient very badly. Renal operations performed through a lateral incision do not require such deep anaesthesia, as the peritoneum is not opened.

THORACIC SURGERY.

Minor operations upon the thoracic wall, such as the excision of breast tumours and the application of radium needles, can be carried out satisfactorily under quite light anaesthesia. A good technique is fairly heavy premedication followed by gas and oxygen.

Thoracoplasty can be performed by the same method if sputum is not excessive, but owing to the fact that the patients have a poor vital capacity and are lying on their sound sides an excess of oxygen should be used. This will necessitate the addition of small quantities of di-vinyl ether or, failing this, of chloroform. If

cyclopropane is available and the diathermic cautery is not employed, an even better anaesthesia will ensure. The same remarks apply to the drainage of acute empyema if this is to be carried out under general anaesthesia.

Should a patient be coughing up an excessive amount of sputum (as in bronchiectasis) and an extensive thoracic operation be contemplated, the cough reflex must either be retained (as in high spinal or other local technique), or the fluid must be confined to the affected lung (as in intrabronchial anaesthesia) or evacuated by tracheal or bronchial suction combined with endotracheal anaesthesia. These procedures are mostly outside the scope of the general practitioner and will not be considered further.

THYROID SURGERY.

Operations for the relief of toxic goitre have recently become so frequent that

some reference must be made to them. Since tracheitis is one of the most frequent sequelae the anaesthetic chosen must not aggravate it. Consequently the use of ether and the passage of tracheal tubes should be avoided unless respiratory obstruction is present. Since relaxation is not necessary a light level of narcosis is adequate, and the avoidance of toxic drugs such as ether and chloroform may just turn the scale in favour of an extremely ill patient. A good technique is heavy premedication or basal narcosis with avertin, followed by pure nitrous oxide and oxygen. The surgeon may prefer an additional infiltration with novocain and adrenaline or adrenaline solution alone (1 in 500,000) in order to separate tissue planes and minimize capillary oozing, but this is not essential. In total thyroidectomy for congestive heart failure cyclopropane is indicated, but for ordinary cases its employment causes excessive bleeding.

(B. M. J., August 14, 1937.)

MENESTRIN CAPSULES

How do Menestrin Capsules prevent pregnancy?

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

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

RHINOLARYNGOLOGICAL CLINICS

ROBERT F. RIDPATH, M.D., Sc.D., F.A.C.S.
Sphenoidal Sinusitis.

GENTLEMEN:

We have today two cases of sphenoidal sinusitis to operate upon, but because of the difficulty of your seeing the operation, as it is performed through the nasal opening, we will operate in my small operating room after the clinic hour. I wish the first ten men to stay after this talk and be present at the operation. I shall ask a report be prepared and presented by them at our next meeting.

A few thoughts in relation to this sinus with the symptoms of empyema seem to be apropos at this time. First the anatomy—up until the third year the sphenoidal sinus is nasal in position, rather than sphenoidal, and it is after this period that the rudimentary sinus is surrounded by bone, rather than the ostium, enlarging into a sinus through reabsorption of the sphenoidal body, which takes place much later.

The adult sphenoid sinus is a cavity directly in the body of the bone and occupies almost a central position in the skull varying in size according to its development. Should the reabsorption and the pneumatization continue very large sinuses with walls of extreme thinness may result and we can readily understand the orbital and cranial complications, the result of empyema, occurring from these cavities.

Of the six walls, the most important, rhinologically, is the anterior. This is so on account of having the ostium and the means by which we may enter the sinus for drainage purposes. The ostium is situated in the upper third of this wall.

Closely associated with the superior wall we have the right and left optic nerves and the optic chiasm. Above or slightly posterior, the coronary sinuses and pituitary body in the sella turcica.

The external wall helps to form a portion of the middle cerebral fossa and is, therefore, in direct communication with the cavernous sinus and the internal

carotid artery. Unfortunately as the development of the sinus increases in size, this, the external wall, becomes thinner and thinner, sometimes disappearing entirely, leaving only the periosteum or a dehiscence in place. Numerous perforations or openings are formed for the passage of small venous capillaries which anastomose or empty directly into the cavernous sinus. So we are able to see that situated as it is, the sphenoid sinus occupies a position which, when diseased, may and does give rise to a complexity of symptoms.

The symptoms of this as in the other accessory sinuses are spoken of as subjective, objective, and ocular. Under the subjective we have pain, inability to concentrate, forgetfulness, aversion to mental or physical work, cough, lassitude or malaise, anorexia, lack of interest, vertigo, etc. Under the objective we put discharge, cacosmia, crust or pus on the pharyngeal wall with probably a more or less proctosis of the eye. The ocular symptoms might be an enlargement of the blind spot, scotoma, either of the scintillating, spot or hair or feather varieties.

Taking up the symptoms of sphenoidal infection, let us first consider those associated with our first division. **Pain**—this phenomena may be divided into various forms of headache due to pressure, and reflex or toxic manifestations. It mainly depends upon the pathological condition present within the sinus. Pressure, whether the result of congested and swollen membrane impinging on its fellow membrane, or through a tenacious, mucilaginous pus filling the cavity and occluding the ostium, is likely to give symptoms of a similar nature.

The headache is mainly situated in the occipital region, radiating in fan-shaped formation upwards toward the vertex. Reflex pain of toxemia or other origin may extend over the mastoid region, simulating in character and severity acute mastoiditis. This pain accompanied frequently with considerable muscular stiffness in the neck muscles may extend downward toward the clavicular region or even as far as the humerus-scapular-clavicular articulation.

Pain back of the eye of a dull character giving a feeling of pressure exerted from

behind forward, which is not increased by pressure made over the eyeball or lids is almost pathognomonic of sphenoidal infection.

Vertigo. This is present either in a continuous or interrupted nature and is manifested whether the patient is in a recumbent or upright position, and may be so pronounced and distressing in character as to cause a fall.

Sleeplessness. In spite of the general and sometimes profound toxemia present the majority of sufferers are unable to sleep with any degree of comfort.

Cough. This most persistent symptom and annoyance is always present; is spasmodic and of a throaty character.

Malaise. Malaise and forgetfulness with inability to concentrate or take interest in one's surroundings or work or play are symptoms usually elicited.

The objective symptoms are few and mainly consist of congested post ethmoidal mucous membrane and swollen tissue in the sphenoid-ethmoidal fissure with possibly a discharge discernible in the olfactory fissure and on the pharyngeal wall, or we may see the discharge coming from the sphenoid ostium either with or without the pharyngoscope. A temperature of $99\frac{1}{2}^{\circ}$ or 101° is usual in this infection. Should the secretion be present on the pharyngeal wall its color quickly changes from that seen in the post nasal space to a dark yellow or greenish nature. It becomes very tenacious and scab formation results with the typical casomeric odor.

Ocular Symptoms. Besides the symptom of pressure pain back of the eye, sudden or gradual unilateral or bilateral blindness may occur due to compression of the optic nerve in the optic foramen or by peri neuritis or toxemia.

Olfactory Disturbances. Due to the mucous membrane in the olfactory fissure and that covering the septal side of the middle turbinate and septum being congested and covered with pus olfaction is diminished or lost entirely.

There are many, many other symptoms I should like to bring before you but as our time is up and the patients are waiting I shall have to close today. Next week we will have our report of what we did for

these cases and I hope to bring them before you greatly improved or perhaps well. Thank you.

—*The Eye, Ear, Nose and Throat Monthly*, Nov. '37.

VITAMIN C AND CATARACT.

Sir Stewart Duke Elder calls attention to an interesting series of experiments recently performed in Russia on the etiology of cataract by N. Moniukova and M. Fradkin (*Sovet vestnik. oftal.* 1934, v. 97), associating this condition with a deficiency of vitamin C. They came to the following conclusions: (1) Tillman's reaction demonstrates in the normal anterior chamber of the rabbit a high concentration of vitamin C; (2) the aqueous of a cataractous eye has no ascorbic acid; (3) the reducing property of vitamin C plays an important role in the oxidation processes of the lens; (4) the high concentration of vitamin C in a normal anterior chamber can be explained by one-way diffusion of ascorbic acid from the blood into the eye; (5) opacity of the lens is observed only in severe, advanced cases of scurvy; (6) the emptying of the anterior chamber of the scorbutic animal leads to opacification of the lens; (7) a disappearance of vitamin C from the anterior chamber is an etiological feature in opacification of the clear lens; (8) in the light of this experiment, senile cataract is a result of disturbance of the permeability of the eye on a background of general insufficiency of vitamin C.

KERATITIS BULLOSA.

This is an intractable disease which results either in marked impairment of vision or destruction of the involved eye. "The characteristic symptoms are recurrent attacks of severe pain, irritation, and photophobia, together with the formation of one or more large blebs which recur at intervals over an indefinite period. These blebs rupture, leaving an abraded area. Constant repetition of the blebs with the attendant inflammation causes scarring of the cornea and impairment or loss of the vision, or destruction of the eye." Bullous keratitis may be said to be either primary or secondary. The latter is commonly associated with trauma, glaucoma and iridocyclitis. Under this classification a dystrophic type also has been described. The treatment consists in relieving the

symptoms, removal of the bleb, and prevention of its recurrence and complications. Various drugs have been tried. The pain is often so severe that no drugs relieve it. Enucleation then becomes essential since it may also prevent a sympathetic-like similar condition in the other eye. The prognosis either as to vision or saving the eye is poor. In view of these discouraging results the use of X-rays has been suggested. While this treatment has produced a cure in one case, its possibilities cannot be accurately judged from this. Experience in a series of cases being required.

—*The Eye, Ear, Nose and Throat Monthly*, Nov. '37.

OTITIS EXTERNA. L. GRAHAM BROWN.

British M. J. (Oct. 9), 1937.

In the treatment of skin infections the three principal measures are: (1) cleansing of the affected part as thoroughly as possible; (2) the application of some form of non irritating germicide; and (3) protection from further irritation and infection. In treating a relatively inaccessible region such as the meatus we are necessarily limited in our choice of methods and medicaments. In cleansing the many ointments suggested preference should be given to those containing a zinc basis. Cream of zinc and Lassar's paste I personally have found most useful. These act probably more by reason of their protective nature rather than their germicidal qualities. Sulphur and mercury ointments more often than not appear to be too irritating. When a stimulating ointment is required it will be found convenient to add liquor carbonis detergens (or its successor, liquor picis carbonis) to the zinc preparation. When desquamation is present, salicylic acid, 10 grains to the ounce, is essential.

Local treatment will also include that of a coexistent lesion of the auricle and surrounding parts, especially an infected meatus I still prefer, in spite of many opinions to the contrary, the old-fashioned method of syringing. The simplest and most suitable lotion I have found for this purpose is a warm boric acid solution. The softening and hence adverse effect of

water upon skin infection, especially those of an eczematous nature, can be easily overcome by the subsequent installation of a few drops of 60 to 70 per cent alcohol, used as a dehydrating agent. The latter also acts as a germicide and readily penetrates right down to fundus of the canal, where ointments obviously cannot be conveniently applied. Ointments, however, can be used for the outer portion of the meatus, and here the cotton wound-applicator is of most service. Protection can be afforded to the meatus very simply either by a pledget of cotton-wool in the region of the concha or by narrow ribbon gauze inserted into the meatus itself. The latter, if kept moist with drops, may also serve as a means of applying a continuous antiseptic to the walls of the canal.

The choice of a suitable non-irritating germicide presents the most difficult problem in the treatment of all types of otitis externa. There is also the personal factor to be considered, a certain germicide being found efficacious in one type of patient but not in another. Hence in any individual case we may have to find out by actual practical experience what sort of germicide will produce the best results. Of the scalp, or incision of furuncle or a diffuse suppurative meatitis, or possibly a retro-auricular abscess.

As regards general treatment many different methods have been tried, but as yet their true value has not been determined. They include vaccine and serum therapy (intra-dermal or subcutaneous); injections of colossal manganese, stannoxyl, etc.; various diets (especially in the eczematous affections); treatment of the seborrhoeic patient; light therapy; and X-rays. Upon their value I can offer no useful opinion beyond the statement that each in turn has proved successful in certain cases, but none is really specific in all.

—*The Eye, Ear, Nose, and Throat Monthly*, January, 1938.

CONVALESCENCE AFTER TONSILLECTOMY.

Tonsillectomy is today one of the most frequent of operative procedure. It is performed by the surgeon, the laryngologist and the general practitioner. Children comprise the largest majority of

subjects, but adults, too, in good numbers find it necessary to undergo operations for the structures when they are diseased.

Children usually recover rapidly with a period of convalescence ranging from three to five or six days. Not so with adults. If statistics were available they would show that the average time of complete recovery for adults ranged from seven to fourteen days. Why such a protracted convalescence in numerous instances?

The answer is not an easy one as the reasons are not always the same. In some cases the throat remains sore, making only a liquid diet possible. This reduces the bodily resistance and slows up the healing process. In other instances, the resistance of the individual at the time of operation is such as to enable the prediction of a slow convalescence. Coexisting conditions—arthritis, for example, likewise play a role, with the result that the patient develops an indifferent mental attitude not conducive to a prompt end result.

Physicians have adopted a rather arbitrary position, usually that of waiting for the throat to heal. They accept the delay in certain cases as a matter of course, knowing that finally the result will be satisfactory. It is neither scientific nor proper to adopt such a stand. Patients should be made comfortable during the convalescent period. Anodynes should be prescribed which will afford sufficient comfort to enable an adequate food intake. Dehydration should not be permitted to occur and can be avoided by suitable prophylactic measures.

Rest is an important consideration. Too many tonsillectomized adults are permitted to return to their duties prematurely. Rest, comfort with analgesics, food and fluids sufficient for adequate sustenance are essentials which in the majority of cases will reduce a protracted convalescence to one of normal length. Closer attention to after-care will often avoid the unpleasantness which tonsillectomized individuals experience.

—*The Eye, Ear, Nose and Throat Monthly, Dec., '37.*

HYPOGLYCEMIA WITH PARADOXICAL SUGAR TOLERANCE CURVE SIMULATING PEPTIC ULCER.

A, Robert Peskin, New York (*Journal A. M. A.*, May 8, 1937), points out that disorders of metabolism produce symptom complexes as variable as individuals in their constitutional make up. Human beings are particularly sensitive to humoral changes. Such changes as excessive intake or loss of water will produce abnormal reactions. Changes in the mineral or colloidal constituents of the body, such as loss of salts or plasma proteins, will produce varied clinical pictures. An excess of sugar, as well as a lack of sugar, is reflected in a particular symptom complex. The degree of variance that will bring forth an abnormal response differs among individuals. A drop in the sugar level of the blood plasma of one human being may not play as important a part in the clinical picture as a similar drop in another. The critical level of change in the constituents of the body humors is characteristically individual. To illustrate this point, three cases of hypoglycemia with an abnormal response to sugar tolerance tests are cited in which there was a similarity of symptoms produced by this condition with the symptoms of peptic ulcer. The criteria which distinguish this condition from peptic ulcer are: 1. While the pains are relieved by frequent feedings, the diet may contain highly spiced and seasoned foods which are anathema to the true ulcer. 2. Periodic frequency and seasonal recurrence of pains are associated with the true ulcer; they are not characteristic of this condition. 3. These patients bear their pain continuously, while it is infrequent for a true ulcer, except in the chronic, calloused, penetrating type, to cause unremitting pain throughout the year. 4. A more distinguishing characteristic of this group is the recurrence of pain four or five times a night, from which relief is to be had only after the ingestion of food. 5. While hyperacidity is a frequent accompaniment of peptic ulcer, these patients show a decided tendency to diminution in acidity even to the point of achlorhydria.

—*The Journal of Medicine, Nov., '37.*

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HONORARY SERVICE.

MINOR DETAILS.

The readers might remember that when we discussed the Re-organisation scheme of Honorary Medical Service in the Madras Province, in these columns last month, we reserved criticisms of some details of the scheme for the current issue. These details are in regard to selection of honoraries, method of promotion, disciplinary control, etc. All this work has been assigned in the G. O. to the Superintendents of the State Hospitals and the Surgeon-General. In fact, the Honorary Medical Officers Scheme has been literally made another branch under the Surgeon-General with conditions of service harder and humiliating the only difference between stipendiary service and honorary service being that the former are paid full time salaries and the latter to be paid Rs. 20 to Rs. 100 which is considered as their living wage. Even under these conditions the Government expects and rightly so that there will be rush of applicants to the Honorary posts. What is the psychology of this situation? Why is hospital service more attractive than private practice? Is it the love of free service or is it want of work outside hospitals that attracts private practitioners to hospital practice? Are honorary appointments taken up to learn work and gain experience? If so, why do honoraries say that tenure of office should not be fixed but should continue one's life time? Answers to these questions may be better imagined than expressed. That the patients who consult a Honorary Medical

Officer outside hospital should not be admitted in the wards of that particular honorary medical officer is one of the rules laid down in the G.O. about the Re-organisation Scheme. This rule anticipates the answer for at least a few of the above questions. There is a similar G.O. published in the Civil Medical Code. It has not been possible and will not be possible for the medical officers (at times even the most conscious amongst them) to obey the G. O. The practice of admission of patients after private consultations is so common that it was a surprise even to those in the Surgeon-General's office from where the G.O. must have been first promulgated years ago when the G. O. was published and was commented in *The Medical Practitioner* a few months ago. The prevailing idea now seems to be that it is financially cheaper if hospitals are misused by honorary medical officers instead of by salaried officers. Any number of G. Os. will be of little or no consequence to those who are corrupt whether they be paid or honorary medical officers. It is the callousness on the part of the authorities to weed out the obnoxious elements in the hospitals though they know as a matter of fact who they are that has been the cause of the unpopularity of State Hospitals. The popularity of a hospital cannot be judged by the bulk of admissions. Hospitals are usually meant for the poor and the indigent and so long such people choose to be in their huts or even by the roadside during their illness, the popularity of hospitals as reckoned by their overcrowding cannot be considered to be real

excepting from a business point of view. The net result of all this has been a competitive spirit which has resulted in indiscipline and which seriously affects the welfare of the patients in the hospital. When hospitals are hot beds of competitive strifes or even otherwise it was not fair for the Government to entrust to the paid Superintendents the allocation of duties to the honoraries, disciplinary control over them and even their selection in the mofussal hospitals.

There is consensus of opinion all round that House-appointments cannot be included in the nomenclature of honorary service and the designation of an honorary should depend upon the nature of work performed by him and that there cannot be cadres in honorary service as in paid service. The designation Asst. 'Medical Officer' is a misnomer and we trust the Government will style the Asst. Medical Officer as Hon. Asst. Surgeon or Asst. Physician depending upon the work he does. The Hon. Asst. Surgeon and Asst. Physician should be chosen from those who can afford to have only consultation practice and not from those who run dispensaries as general practitioners. They should stick to the practice of those branches of medicine for which they hold the honorary appointments. The Asst. Surgeon or Asst. Physician should be selected by a Board consisting of the paid and honorary medical officers of the hospital where his services are required. The candidate should be made to give extempore lecture on any disease that may be selected by a sub-committee of the Board. The tenure should be ordinarily for five years subject to renewal either immediately after the expiry of the first term or later when his services are required. When the Asst. Honorary is discharged from hospital he should continue to be a consultant and in case he takes to general practice he should be debarred from holding honorary appointments in the hospital. The selection of Honorary Surgeon and Physician should be done from amongst those who have served as the Honorary Asst. Surgeons and Honorary Asst. Physicians of not less than 15 years standing. The Government

should appoint a committee once in three years consisting of representatives of all registered medical Associations two from each association to be selected by these Associations and as many nominated members of the Government all of whom should be medical practitioners of over 25 years service. The chairman of the committee should be the President of the Madras Medical Council for the City of Madras and in the Mofussal the District Medical Officer. In stations where registered Medical Associations do not exist the Government should nominate a Committee consisting of 5 members including the Chairman who should be the D. M. O. and the four members should be in active private practice for at least 25 years. Such selection committees of representatives of existing medical associations will be able to choose right sort of honoraries in whom the profession has confidence.

The Disciplinary control over the Honoraries should be exercised by the hospital committee consisting of honoraries and paid medical officers who should select a small standing sub-committee of three members in hospitals where the hospital staff of senior honoraries and paid officers is over 5 in number. The recommendation of this committee should be submitted to the Government whose decision should be final. In case of infamous conduct the committee should report the conduct of the officer to the Medical Council for necessary action.

The term of office for Hon. Physicians and Surgeons should be for a period of 5 years, subject to renewal by the vote of the selection committee of each hospital. There is no need for age restriction. The State should provide facilities for the deserving practitioners at all times to enter Honorary Service. If those who entered service are to continue till their life time the Honorary Service will be a close preserve for only a few. If the tenure of office is fixed for five years subject to renewal by the vote of the selection committee deserving Honoraries may continue their service, non-deserving

may be sent out and substituted by a fresh batch of practitioners. The medical profession as well as the Government should realise that if hospital practice is made available to as many practitioners as come forward for Honorary Service efficiency of medical relief will be levelled up and the suffering public will be materially benefitted.

As mentioned above the G. O. that medical officers should not admit their private cases in the State hospital wards under them, has not been observed at all and cannot perhaps be observed. The fate of the rule in the G. O. regarding the honoraries will just be the same. The only effective method of stopping corrupt practices in State Hospital is the appointment of Almoners for making admission into the hospitals. Charges for special wards in the hospitals should be as much as in private nursing homes and fees should be also charged for attendance by medical officers. In case of full time medical officers the fees so collected should go to the Government treasury but in case of Honoraries the total fees for attendance should be paid to the Honoraries. Treatment of patients in the Special Wards of the hospitals should not be restricted to the staff of the hospitals. The patients should be permitted to engage private practitioners of their choice. Such a procedure has the approval of British Medical Association in Great Britain. In case the special wards in the State hospitals are cheaper than those charged in private nursing homes, the public will necessarily prefer to go into the Government hospitals and there will not be an incentive for private enterprise.

A NEW CASTE IN BOMBAY.

There is a strong feeling in Bombay that the Government do not recognise the higher University qualifications of M. S., and M. D., to the extent they do in regard to British qualifications. This grievance has taken a definite shape and the Doctors of Medicine and Masters of Surgery of the University of Bombay

have formed themselves into a separate Association and have been agitating for their recognition in par with similar higher qualifications obtainable in Great Britain. It is said that the representatives of the Association met the Minister in charge of Medical Portfolio on deputation once in 1928 and a second time in 1935 and were assured that their grievance would receive the consideration of the Government though nothing was done tangibly. The Congress regime with a medical man in charge of Medical Portfolio has necessarily created real hopes in the hearts of M. Ds and M. Ss of Bombay whose representatives met the Hon'ble Dr. Gilder on 15.9.37 and presented a memorandum. The memorandum avers amongst other things that the Government has been depriving the nationals of the Bombay University of their legitimate claims especially in honorary appointments preference being given to those possessing British qualifications. It is said in the memorandum that majority of persons holding foreign qualifications do not possess practical experience to the extent the M. Ds and M. Ss do, who after graduating spend many years in House-appointments in the hospitals before appearing for the higher degrees. The Deputationists who waited on the Hon'ble Dr. Gilder pointed out that in foreign countries indigenous talent is encouraged by preferential treatment to local qualifications and gave examples that in England English qualifications are preferred, in Scotland the Scottish and in Ireland the Irish and they expected that during Congress Regime Indian qualifications should be preferred to the Foreign. The Deputationists were not blind to the fact that medical men have much to gain by visiting foreign centres of learning but pleaded that this learning could not be gained by the mere possessing of academic qualifications alone. They deprecated the glamour for things foreign and desired that the Congress Government should as a matter of course not belittle Swadeshi medical qualifications to the detriment of the growth of Medical Science in India.

It is rather surprising that in Bombay

where we see a large number of England returned medical men in eminence including the Hon'ble the Public Health Minister clad in Khader and possessing very idealistic instincts of national honour, are found wanting in imagination to conceive how detrimental it is to the growth of national medical institutions if a high premium is offered to foreign qualifications. It looks as if the ideals of nationalism are different in regard to evolution of medical science in India. We learn that the report of the commission appointed some time ago by the Bombay University to go through the University medical education is far from satisfactory. The University Medical Education is now entirely under the control of those possessing foreign qualifications. We do not for a moment suggest that the state of affairs of University Education would have been better if it was controlled by those possessing Indian qualifications. There is no doubt that in India the affairs of Medical Education and Medical Profession are far from being satisfactory. It may be said that this is due to I. M. S., supremacy. This may be true to a certain extent but we are afraid things will be much worse during the declining period of I. M. S., as is seen these few months in almost every province where things threaten towards a decline of the evolution of Scientific System of Medicine. The members belonging to Scientific System of Medicine have been rightly expecting lot of reforms in matters medical especially in provinces where the Medical Portfolio is in the hands of medical men. Bombay is one such province. We trust the M. Ds. and M. Ss. and all the rest of the members of the medical profession in Bombay who are proud that one amongst them is on the saddle of the Government, will not have cause for

disappointment and despair in the matter of national evolution of medical science and medical education. Such an evolution is only possible if the National Degrees and Diplomas are not ridiculed. Every attempt should be made to bring the National Medical Degrees and Diplomas to a very high level and this is possible if talent is honoured and appreciated more than academic qualifications. Nobody can deny the claims of those who have returned from foreign countries with high qualifications. We will not be far wrong when we say that in Bombay amongst the younger generation there may be more possessing high British qualifications than those possessing the M. D. and M. S. qualifications. We had occasion recently to see a few amongst the both classes. It was difficult for us to judge who is superior to whom. We were very glad to note that all of them had very high ideals regarding medical education and what was more every one of them had as high ideals of nationalism. It is a pity that advantage is not taken of this healthy atmosphere by the authorities and instead a cleavage is encouraged with the result that an additional separate caste of M. Ds. and M. Ss. of Bombay University is established in an otherwise cosmopolitan City of Bombay. We wish the Hon'ble Minister of Bombay will soon find out ways and methods of recognising talent in the medical profession while making appointments in the State Hospitals and make the M. Ds. and M. Ss. feel that they are not dubbed with an inferiority complex. We learn that there are likely to be selections for the posts of Honorary Asst. Surgeons and Physicians in the Government Hospitals in Bombay and trust that the M. Ds. and M. Ss. will not have cause for despair.

NOTICE.

Subscribers of The Medical Practitioner are requested to note their registered numbers appearing on the postal wrapper of the Journal while corresponding with the Managing Editor.

News and Comments.

Danger Ahead: It looks as if the scientific system of medicine is in real danger. When the National Congress consented to take up the Government of majority of provinces, the medical profession felt glad that there would be no more obstacles of vested interests for the healthy growth of scientific medicine at least in the Congress provinces. The hopes were heightened when it was announced that two Public Health Ministers in two major Provinces of Bombay and Madras were medical men and another medical man in the minor Province (C. P.) is the Premier. But recent events in the Congress Provinces are likely to make the members of the Scientific System of Medicine ponder, 'Where are we drifting'? Nobody can deny the efficacy of the therapeutics of the drugs and preparations of the indigenous systems of medicine, be it Ayurvedic, Siddha or Unani or anything else. We published in these columns last month the favourable opinion of eminent members of the medical profession belonging to the League of Nations regarding the indigenous systems of medicine which opinion they formulated after visiting all the important cities in the Eastern Hemisphere. Efforts ought to have been made by the Government of all the provinces in India to find out ways and means for the synthesis of all existing systems and evolve one all-pervading scientific system. Unlike the state of affairs of the medical profession in other countries where the control of these affairs are vested entirely in the profession itself, medical education and medical relief are being run as a part of Government machinery in India and are bound to be affected by political currents. Excepting the fact that the Government of Central Provinces have appointed a Committee to find out the therapeutic value of indigenous drugs, nothing more is heard from that province which is likely to startle medical profession as in Bombay and Madras.

conference held last October in Kolhapur recently waited on the Hon'ble Dr. M. D. D. Gilder, Public Health Minister, Bombay, and pleaded amongst other things the necessity of establishing Research Clinics and Diploma in indigenous systems of medicine. It is reported that the Minister ridiculed this idea and said that during his visits in the existing institutions of indigenous systems in the Bombay Presidency, he found the practitioners adopting 'Allopathic lines' of treatment and 'Western methods of diagnosis'. Yet the Hon'ble Dr. Gilder is keen in imparting 'elements of Anatomy, Surgery and Midwifery' to such practitioners of indigenous system and this he does to give medical aid to the villages. To the scientifically minded people this looks as an eye-wash in political medicine and highly detrimental to the welfare of the villagers who are as good human beings as their more fortunate brethren living in urban areas. The Scientific System of Medicine will be in death grip soon after this Hon'ble Minister gives these practitioners a legal status by bringing into existence a Medical Register separately for them to get them recognized by the public. In Madras the old Justice Government has taken the credit of being the saviour of the indigenous system by establishing a hybrid school where every known system including the Allopathic is taught and yet the school runs under the name of Government School of Indian Medicine. The practitioners passing out of this school are practising in the way expressed by the Bombay Public Health Minister on 'Allopathic lines' adopting 'Western methods of diagnosis'. The Madras Minister has not so far expressed his view about this practice as his brother Minister of Bombay did. The latest in Madras is that the Minister proposes to send the women students of the Government Medical School of Indian Medicine to the Victoria Caste and Gosha Hospital now a teaching institution for the women students undergoing training for L.M.P. diploma.

Both the Hon'ble Ministers of Bombay and Madras are practitioners belonging to Scientific System of Medi-

A deputation of the representatives of the Maharashtra and Karnatak medical

cine and being Congress men have a reputation for the courage of conviction. The description of the practice of the indigenous systems of medicine given by the Bombay Minister depending upon his personal knowledge amounts to rank quackery. It is not different in Madras. The Madras Minister has abolished the L.M.P. course as dictated by his conviction that there should be only one standard of medical education. To us it looks that his conviction is inconsistent with the low standard of medical education imparted at the Government school of Indian Medicine which is recognized by the Government of Madras.

Elements of the Western systems of medicine being taught in this hybrid school, the credulous amongst the public are led to believe that the practitioners passing out from this school are better qualified than those trained in the recognized medical schools and colleges where only one system of medicine is being taught. Both the Ministers are really capable of evolving only one system of Scientific Medicine by incorporating all that is effective in the indigenous systems of medicine. They have demonstrated their courage of conviction in other directions, why not in the synthesis of all systems? Both of them can afford to resist the political currents. We wish they do so in the interest of the Scientific System of Medicine.

A Belated Memorandum: As pointed out by us in these columns last month, the Hon'ble the Public Health Minister, Madras, would have done satisfactory service to the Honorary Medical Relief Scheme in case he published his views before they assumed the shape of a Government Order. The fact that he freely gave expression about the launching of a liberal scheme of honorary service before 25th January when the scheme was actually announced, naturally evoked high expectations from all quarters. Unfortunately, soon after this scheme was released in the shape of a G. O., the profession felt very much disappointed though the underlying principles of the scheme of employing a large number of

the members of the medical profession in honorary service with a hope of substituting the stipendiaries by the honoraries, was approved by all shades of opinion.

We have received a copy of the memorandum submitted to the Public Health Minister by the Madras Branch of the Indian Medical Association. It is a pity that this Association lost a splendid opportunity of placing before the Madras Government the considered opinion of the Indian Medical Association by placing the G. O. on the re-organization scheme before the All-India Medical Conference held in Madras under the auspices of the Indian Medical Association. If the Conference discussed the subject and nothing else and submitted the decision arrived at by the Conference to the Madras Minister who also took active part in the Conference, the Indian Medical Association might have taken the credit of having achieved something real and substantial, not only to the members of this Association in this province, but also in other provinces in India. The Conference might also have suggested to the Madras Minister who summoned a conference of All-India Public Health Ministers to place the recommendations of the Conference about the scheme before the conference of the Ministers and might have thus demonstrated the All-India medical opinion about the scheme of honorary service and facilitated uniformity in honorary medical relief scheme throughout India. The memorandum though belated touches all points mentioned in the G. O. No. 360 Public Health dated 23-12-37.

We are disappointed that the medical licentiates have been left alone in the memorandum and while pointing out the designations and the qualifications of the honoraries, no mention has been made about them and their fitness to serve as honoraries. As has already been mentioned by us last month, there should not be any difficulty to appoint them as honorary assistant medical officers in non-teaching institutions, whether in the city or outside. This glaring omission about a class of practitioners who are

admitted as members of the Indian Medical Association is inconsistent with the very name of the Association. All the same we agree with the views expressed in the memorandum that the designation of the honoraries should indicate not their qualifications, but the nature of work performed by them professionally.

The Madras Branch of the Indian Medical Association seems to have lost sight of the fact that all the hospitals in this province and elsewhere are run by the Government with the help of the public funds unlike in Great Britain and other civilized countries where hospitals are run either by associations or by voluntary funds. There can be little or no comparison about the conditions prevailing in Great Britain and in Madras regarding honorary service. There are two purposes served by honorary service. One is the gaining of experience and status by those who work in State hospitals and the other, the economy of the running expenditure of these institutions. The Government cannot therefore refuse to entertain as many as apply for honorary posts. For this purpose the tenure of office has to be fixed. After all, the number of patients treated in the hospital is many times smaller than the number treated by private practitioners outside the hospitals. So, in the interest of the profession and the public, the Government should give equal opportunities of service as honoraries to all those who apply for such service. We have briefly mentioned in the Editorial columns of the current issue how this could be achieved with satisfaction to all concerned.

We agree with the views expressed in the memorandum regarding the principles in the selection of the honorary medical officers, but as pointed out in the Editorial on the subject in the current issue, a bigger committee consisting of representatives of existing Registered medical associations, would be more conducive than the small committee of practitioners suggested in the memorandum. We also agree with the other details regarding the allocation of duties etc., which should

not be entrusted to the Superintendent of the hospital or even to the Surgeon-General but should be vested in the Hospital Committee consisting of both honoraries and paid medical officers of the staff of the hospital. The principle should be the same with regard to the control of discipline amongst the honoraries. In fact, the aim of all concerned should be that the control of matters medical, should no longer be one man's show whether it be a Superintendent of a hospital, the Surgeon-General or even the Public Health Minister. As the Government have decided that bulk of the staff in the State hospitals should be honoraries, it is consistent with this policy that the Honorary Service should be controlled by non-official agency under the direct authority of the Government.

Bombay Minister and Medical Problems: The representatives of the Maharashtra and the Karnatak Medical Conference which met in Kolhapur last October have done some service to the profession, by waiting on the Hon'ble Dr. Gilder and submitting to him the resolutions passed by the Conference on some of the important problems of the medical profession which they did on 17th December. Down below we have published the subjects of the resolutions, the Bombay Minister's views and our comments.

RESEARCH CLINICS AND DIPLOMAS FOR THE INDIGENOUS SYSTEMS OF MEDICINE: The Minister opined that no good purpose would be served by the experiment and gave his reason that even the practitioners of the Indigenous system have been employing Western lines of treatment in their practice. We have commented on this subject elsewhere.

RESEARCH OF INDIAN DIETS: The Minister was in favour of this resolution but pleaded financial stringency to do anything in this direction.

EXCISABLE DRUGS: The Minister expressed his views that the Registered practitioners are permitted to possess without licence preparations of Opium whose alkaloidal content amounts to

120 grains of Morphia and in case of Cocaine the practitioner could easily procure solutions for their use from recognized Chemists. We have no idea how the Deputationists expressed their troubles with the Excise Department before the Minister. It is true that the Registered Medical Practitioners could possess without licence a certain quantity of the preparations of Opium and Cocaine. The Excise Department objects that these two preparations should not be charged for by the practitioners when they use it in the exercise of their profession. The general practitioner has to supply medicine to his patients in the exercise of the profession. Technically the amount received by the practitioner for the advice and supply of medicine has to be treated as fees received by him. The Excise Department has no idea what all includes in the exercise of the profession by a medical practitioner; so this Department holds the view that in case preparations of Opium and Cocaine are supplied to the patients and money received for the same, it amounts to the sale of medicine. This will certainly be the case if a practitioner dispenses medicines and sells them on the prescriptions of other doctors. Or if the practitioners sell the preparations of Opium and Cocaine as such, such sales might violate the excise rules. The troubles from the Excise Department are just the same everywhere in India and quite recently a practitioner brought to our notice his troubles with the Excise Department. We referred this to the Hon'ble Minister in charge of Excise Department and have not as yet got a reply from him. In the meanwhile till the technical difficulties are solved once for all in favour of registered practitioners, we have advised the members of the Medical Profession to inform the excise officers that the preparations of opium and cocaine used by them in the prescriptions are not charged for and put a notice to that effect in their dispensaries as sales alone of excisable drugs without licence can violate the Excise rules, but not free supply of these preparations. For example, a person can buy any amount of intoxicating liquors and treat his friends

free without violating the excise rules. The rules framed by the Geneva Convention are meant specially for preventing illicit sale of intoxicating drugs. A registered practitioner cannot be treated along with lay people; he is one who is expected to be under the control of Medical Councils. If a registered practitioner misuses his privilege as a doctor in the matter of prescribing excisable drugs, his name is liable to be removed from the Register, certainly a more effective punishment than the fine or even imprisonment in a Criminal Court. So it is certainly derogatory to the prestige of Registered Practitioners to be controlled by Excise Department.

CONTROL OF PATENT MEDICINES: The Minister announced that the Bombay Government was contemplating legislation on the subject.

PROHIBITING PRIVATE PRACTICE TO WHOLE-TIME OFFICERS OF THE GOVERNMENT: The representatives of the Conference mentioned to the Minister that medical officers in State Hospitals had a distinct advantage in private practice over the independent practitioners as they could supply medicines free from the hospital to their patients and pressed that the medical officers should be debarred from private practice. The Minister would not agree to the proposal of stopping private practice as he was of opinion that one of the conditions of full-time medical service included the privilege of private practice. He added that the State-paid medical officers could not supply free medicines from their hospitals to the private patients and in case they violated this rule and if the same was brought to the notice of the Minister he would take disciplinary action against them. As far as we know full-time medical officers were originally permitted private practice not as a matter of right, but to afford facilities to the public to take advantage of scientific system of medicine as in days gone by when the Western system of medicine was introduced in this country by the British Government there were no private practitioners to supply the needs of the public.

Even otherwise it is mentioned in the Government service conduct rules (for the members of the medical profession) that they cannot claim private practice as a matter of right but will be permitted to do so if it did not interfere with the ordinary official duties. So the discretion for allowing private practice to full time medical officers of the Government rests entirely with the Government. If the Government has a will, they can certainly find a way; it must be so especially with the Congress Government. In no other civilized country full-time medical officers are permitted even consultation practice. Unwholesome and unequal competition between paid practitioners and private practitioner has been hampering the growth of medical profession in India.

FACILITIES FOR PRIVATE PRACTITIONERS FOR X-RAY AND LABORATORY SERVICE: The Minister said that X-ray service would be made available (of course on payment of fees) if private patients were taken to the hospitals at a time to be fixed by the Officer-in-charge of the hospital. Regarding Laboratory service the Minister deprecated the idea as, in his opinion most of the subordinate officers to whom the Civil Surgeons entrusted the work were quite unfit to do the work expected of them. If this is the Minister's personal impression not basing on the reports submitted by the Civil Surgeons to the Government, the Minister was not justified to condemn the medical subordinates. But if the Minister spoke on the strength of the reports received by him he ought to see that 'most unfit' staff is not entertained in State Hospitals to do Laboratory work.

COUNTERSIGNATURES: The reply of the Minister on the subject of the countersigning the medical certificates of the private practitioners by the Government Medical Officers was as unsatisfactory as it was unconvincing. He is reported to have said that there was plenty of room for malpractice. When it was said by the Deputationists that Government Medical Officers were not free from such malpractices, the Minister expressed that he had a control over the

Government Servants and the Disciplinary control of Medical Council over the private practitioners was not satisfactory. The Madras Medical Council condemned this procedure as unethical some years ago and the Madras Government is now following a procedure of obtaining second opinion in cases where the veracity of a certificate is questioned and the practitioner who gave the original certificate is given the option of being present when the second opinion is recorded. It is the Surgeon-General who sits in judgment over the malpractices of Government Servants. Whereas if the malpractices are reported to the Medical Council the practitioner who commits them, is tried by a judicial tribunal consisting of elected and Government nominated members presided over by Surgeon-General. Yet the Hon'ble Dr. Gilder seems to have more faith in the judgment of one person and not in a tribunal. If the Minister finds that the Medical Society is so bad, he should as one of the members of the popular Government find out methods for raising the standard of morality in any society or else democracy will be a dangerous mockery. If the medical council, a statutory body cannot be trusted to function in regard to Disciplinary control over registered practitioners, the council may as well be deprived of this responsibility and the Minister may assume the same if necessary by special legislation and save the honour of the medical profession of which the minister is a member.

MEDICAL COUNCIL: Deputationists pressed for an elected President, an elected majority and a larger representation for the Medical Licentiates in the Bombay Medical Council. The Minister said that to have an elected President was more a sentiment and that the General Medical Council, Great Britain, had only six elected members and that a large number came from teaching institutions. Did he forget that unlike in this unfortunate country all the teaching institutions in Great Britain are neither owned nor controlled by the Government and all the representatives of the teaching institutions in the G. M. C. are private practi-

tioners and that when the G. M. C. came into existence, the British Government did not feel the necessity of a nominated President even for a short time as a trial? Though on democratic principles the Licentiate should have a larger representation, the Deputationists would have done better if they pressed for the grouping of all Registered practitioners together as in the British Medical Register and for a sufficient number of elected seats to have a non-official majority. The theory propagated by the Minister that because the Licentiate were an inferior lot and should be put up with a smaller representation in the Medical Council, is likely to wound the feelings of this class of practitioners.

DOCTOR TITLE AND QUACKS: Persons in the position of the Hon'ble Dr. Gilder cannot perhaps conceive the danger of unqualified people styling themselves as 'Doctor' amongst the credulous public especially in rural areas. There is a feeling throughout India that the courtesy title, 'Doctor' should be assumed only by qualified practitioners but the Bombay Minister opines otherwise on the excuse that it is not easy to handle this question. He has indicated more faith in his proposed Bill as a means to combat quackery. But we fore-shadow more quackery in Bombay if the practitioners of Indigenous systems of medicine are to be given elementary knowledge in Anatomy, Physiology, Surgery and Midwifery with the Government stamp of Registration on their backs.

REFRESHER COURSES: The Minister has promised help to the Medical Colleges in case they start these courses.

The answers of the Minister must convince the members of the profession how futile it is to depend upon any Government even the Congress Government for the evolution of Scientific Profession on healthy lines. The Bombay Minister made it appear that principles of democracy should be different in different planes. The English who rule India have taught Indians what democracy is and the Congress has demonstrated how to fight for it.

The Congress has just stepped into the shoes of Englishmen for ruling India. The little freedom the Indians are enjoying was not got for mere asking. The members of the medical profession have now to fight with their own countrymen and tell them that the medical profession should control its affairs and not one Minister though he may happen to be a medical man.

A Gloomy Function: The annual prize distribution of the Lady Willingdon Medical School for Women, Madras, took place at the School premises on 14.3.'38. The Hon'ble Dr. Rajan, the Public Health Minister, presided and due to the unavoidable absence of Lady Marjorie Erskine who was expected to give away the prizes, Dr. Rajan acted for her.

It is now a note-worthy feature that advantage is taken of public functions for giving expression to the grievances especially when a member of the Government or the Head of a Government Department associates himself with such functions. The latter does not lag behind in giving expression to the policy of the Government. Dr. (Miss) Lazarus the Superintendent of the school must be aware of the closure of medical schools in Madras though perhaps she did not expect that the school for women would be closed by the end of April 1938 as there were women students from the 2nd to 5th year of the L. M. P. course who entered the Lady Willingdon School least dreaming that they would one day be sent out of the women School to undergo training along with men students of the Stanley Medical School.

The annual prize distribution function would have been more pleasant and less gloomy if the Minister deferred the announcement of the sudden closure of the Lady Willingdon Medical School to a future date. The conspicuous absence at the function of Her Excellency and of the Surgeon General with the Government of Madras must have added to the gloom materially.

Dr. Lazarus while presenting the report of the School for 1936-37 academic

year welcomed the idea which she had been favouring in the past, in having one standard of Medical Education, but pointed out the necessity of having one Medical College exclusively for women when the Government could afford it. She said:

".....that chivalry might urge men to give way to women students but the desire for knowledge could not always be set aside for chivalry. The atmosphere in which women would fearlessly take their place as leaders and organisers was denied to women in mixed institutions. Qualities of leaderships should be developed during student days and women should not be relegated to the background where they were not free from a feeling of self-consciousness."

"I request I may be forgiven for mentioning the needs of women Medical students. But having studied in a mixed college myself, I am keenly aware of the deficiencies in medical co-education. Medical women all hope that some day soon a separate college for women will be an accomplished fact".

Dr. Rajan in the course of his speech said:

"I hold that the right place for women is by the side of man now and for ever. There is no use cloistering women in separate cells either for the purpose of education or for social enjoyments."

Opinions differ and quite reasonably regarding co-education of boys and girls. Those for and against see things in their own vision. Dr. Lazarus is a product of the Madras Medical College where co-education has been continuing ever since the college came into existence and Dr. Rajan belonged to Stanley Medical School, known during his days as the Royapuram Medical School when boys and girls were taught together. We wonder whether the Hon'ble Dr. Rajan found it necessary to go through the history of the Royapuram School which prompted the old Government to remove the girls from Royapuram Medical School

and provide for them a separate school at Egmore. This happened in 1923 when Dr. Lazarus was not likely to be the Superintendent of the Victoria Caste and Gosha Hospital. It cannot be said that the then Government was against co-education in principle or else they would have removed the girls from the Medical College also and furnished them a separate College. It must be possible for the Minister to find out from records how many girls passed out from the Royapuram Medical School and how many girls qualified themselves as L.M.Ps. from the Lady Willingdon Medical School. If we remember right Dr. Rajan was the prosector of his class when he was at the Royapuram School and we wonder if he could remember even of one lady student having been as his class mate. As a matter of fact co-education is against Indian sentiment and the parents of the girls would always like their girls to be away from boys whether it be in a School or even at social functions. Under the circumstances Dr. Rajan would have justified the existence of a popular Government if he consulted the parents of the girls now undergoing training in the Lady Willingdon Medical School before he decided to send the girls to the Stanley Medical School. There is a moral if not a legal obligation on the part of the Government not to disturb the Students at the Willingdon Medical School till they finished their course of studies from that very school. Sending the girls to Vellore Medical School may be less objectionable but the Government should know that such of the girls who sought admission into Lady Willingdon Medical School, did so knowing at the time that there was a school for Women at Vellore. Cost alone is not the only consideration with the parents who send their children outside their homes for education. The best and the most honest and as conscientious findings of a single individual may look tyrannical at times and those in power have to take things as they may appear to the people in general. The views and personal experiences of Dr. Lazarus and Dr. Rajan regarding co-education though they may appear to be divergent are reconcilable and Dr. Rajan

who appreciated the action of a neighbouring foreign Government in making a Lady Doctor as the Surgeon-General, has a splendid opportunity of giving women a place of rank and equality with men in the Madras Medical Department. Two of the lecturers of the Lady Willingdon Medical School have been promoted to the rank of Civil Surgeons. Both of them possess qualifications of no mean order to be professors of a Medical College. Their past experience as successful teachers of Medicine and Surgery will be an asset to the Stanley Medical College if their services are utilised. Financially also it will be a sound proposition.

An Appreciation: Dr. (Miss) H. M. Lazarus, B.A., M.B., F.R.C.S., W.M.S.I., Superintendent, Lady Willingdon Medical School for nearly 10 years has been relieved of her duties on the 15th March 1938 on account of the closure of the School. In spite of several handicaps in regard to insufficiency of staff, equipment etc. Dr. Lazarus has been able to maintain a good record of work in the school in regard to the examination results, discipline and other details. The examination results of the Lady Willingdon Medical School compared more than favourably with those of the Stanley Medical School throughout her regime as the Superintendent of the School. Even in the inter-school competitions the girl students competed successfully with the boys and many a time fared much better. This indicates the efficient and hard work which Dr. Lazarus was able to command from the teaching staff working under her, with the spirit of love and comradeship and not one of authority. Whatever may be the advantages of co-education as expressed by the Hon'ble the Public Health Minister of Madras, such of the women students who may be sent to the Stanley Medical School are likely to feel their separation not only from the surroundings to which they were accustomed but also from their old Superintendent who loved the students as her own children. Dr. Lazarus has a knack to command discipline and popularity a rare combination of gifts seen only amongst

people of religious temperament. She is as stern in her discipline as she is kind to the wants and the sufferings, and she is therefore able to create an atmosphere which is conducive to the well being of those who are under her care be it in a School or a Hospital. She loves work wherever she is and not the glamour of the office which at times brings more money also. It is said that she was offered the Principalship of the Lady Hardinge Medical College, Delhi, more than once and she would not take it up; perhaps she loved to do humanitarian work in her own native province where she and the family to which she belongs are loved and admired not only by those belonging to her religion but belonging to all religions. This is not the time for us to say anything about the excellent work she has been doing in the Victoria Caste and Gosha Hospital, Madras as she continues to be the Superintendent of that institution.

Women Civil Surgeons: We congratulate Dr. (Miss) E. Maduram, M.B., F.R.C.S., (Edin.), M.C.O.G., (Lond.), and Dr. (Miss) A. B. Hardy, M.B.M.R.C.P., (Edin.), M.R.C.S., L.R.C.P., D.T.M. & H. (Lond.), on their being promoted to the rank of Civil Surgeons. The former is the lecturer in Surgery, Lady Willingdon Medical School and Surgeon, Victoria Caste and Gosha Hospital, Madras, the latter, Lecturer in Medicine, Lady Willingdon Medical School and Physician, Victoria Caste and Gosha Hospital, Madras. This is the first time in the annals of the history of the Medical Department in Madras and perhaps in India that the services of ladies were recognised to be promoted to the highest post a member of the provincial medical service can aspire. We learn that the women Assistant Surgeons in the Madras Medical Service submitted a memorandum to the Government a few years ago pressing their claims to the Civil Surgeon cadre. It is certainly to the credit of the Congress Government in having recognised merit in women. This news coming soon after the notification that a Lady in Travancore has been raised to the highest position in Travancore

core Medical Service as the Surgeon-General will be welcomed by those of the fair sex in the medical profession. If these appointments were made a year earlier, these two ladies would have earned more than the pay they are now getting as Assistant Surgeons. As it is, the higher status brings them less pay *i. e.*, Rs. 380/- whereas both of them have been drawing more than Rs. 400/- as actual pay. The recent G. O. of cuts has been responsible to give these ladies higher status and less pay. This is rather an unfortunate circumstance. Unless the two women officers are absorbed in the staff of the new Stanley Medical College, the other scope of service for these two women Civil Surgeons will be to serve as District Medical Officers. The former course may be more conducive.

Political Fasting: A few weeks ago the Honourable Dr. T. S. S. Rajan, Madras Public Health Minister, presided over a function in a High School at Madanapalle. One amongst the staff of the School delivered a lecture on 'fasting.' The Minister while winding up the proceedings laid special stress on 'Political Fasting' and referred to the 'hunger-strike' of the political prisoners and their effect even on His Excellency the Viceroy. A few days later a medical man belonging to the Subsidized Service who felt desperate on a recent order of the Government wrote to the Public Health Minister that if his grievance was not redressed he would offer Satyagraha and starve himself. It is difficult to say except by the sequence of events whether the subsidized practitioner took the hint from the Newspaper reports or was prompted by the general atmosphere of 'Hunger-strike' now prevailing all round. Whatever it be, such strikes will have demoralising effect on Government Administration if not on society. Satyagraha involves non-violence and hunger strike is certainly inconsistent with the spirit of non-violence. Depriving a body of its daily food is a violence though the body subject to starvation belongs to the person who offers Satyagraha. This is a crime against the laws of God who

created the body on which a man has no right to force starvation. Hunger-strike Satyagraha is therefore the worst violence that could be imagined.

The action of the Government which made the Subsidized Practitioner lose his head and become desperate is mentioned elsewhere in these columns. The Subsidized Practitioner on the advice of the President, Subsidized Rural Medical Practitioners' Association has since made an unconditional apology and obeyed the order of the Government though it has to be said that the order which was his grievance was not just. We trust the Public Health Minister who is himself a Medical man will make allowance to all the circumstances including the mental condition of the individual and take a light view. We recommend to the Government this unfortunate practitioner for mercy and justice.

Subsidized Medical Relief and Government Responsibility: The Congress Government are determined to make the villages the foundation of reform and progress. No work on reconstruction can be complete or even satisfactory unless the welfare of the villagers forms the important item of programme in the work of reconstruction. The Government has recognised the value and usefulness of honorary service in medical relief and even here the unit of real honorary service is the subsidized rural practitioner. It therefore behoves the Government to make the subsidized rural medical relief scheme not being affected by the political currents. The delay, drift and procrastination which have become a permanent feature of this useful scheme due to causes at times beyond the control of even the Government and want of a book of reference (similar to that of the Civil Medical Code) for easily finding out different Government Orders based on different and individual grievances of the Subsidized Practitioners, have made matters worse. At times there may be instances where the Government action would appear to be unreasonable and even illegal. The fact that many a time the Government Orders as communicated to

the aggrieved practitioner do not contain more than a sentence or two and are not made to appear in the form of a judicial order, misleads the aggrieved practitioner and the effect of such orders instead of bringing about reformation either in the working of the scheme or of the particular aggrieved practitioner, will lead to desperation.

The most important and salient conditions mentioned in the Agreement that is to be executed by the Subsidized Practitioner with the Government and the District Board and which contemplate the termination of the service of a practitioner are:

- (1) Breach of any of the conditions in the agreement,
- (2) Infamous conduct,
- (3) Unsatisfactory working of subsidized Dispensary due to whatever cause and
- (4) Financial Stringency of the local bodies which prevents these bodies to run the Dispensary.

In all the above cases before any action is taken by the District Board, the District Medical Officer should concur with the action contemplated by the District Board. There have been appeals before the Government quite recently in one of which at least the procedure laid down in the Agreement to the effect that in case of breach of any condition of the Agreement the Practitioner should be given an opportunity of explaining his conduct was not heeded to by the District Board and a Subsidized Practitioner's services were terminated quite abruptly. The circumstances of this case were such that the District Board President provided another subsidized dispensary to this Practitioner after he appealed to the Government, in the meanwhile his appeal was delayed at the District Board Office and finally the aggrieved Practitioner gets an order from the Government nearly 9 months after the date of his appeal which runs thus:

"The petitioner is informed that the Government see no reason to interfere with the order already passed by the President, District Board

—in regard to the handing over charge of the Rural Dispensary at —as he has already been appointed as a Medical Practitioner in the Rural Dispensary at —."

If the action taken by the authorities is defective it is the duty of the Government to point out such defects before a petition is decided upon. Excepting for the subsidy he receives which is an honorarium and not a pay, the Subsidized Practitioner is as good an independent and honourable a person as anybody else and has to be treated with due courtesy not taking into consideration the humble sum he receives as a subsidy. If he is kept surville and treated as such by all concerned, he is likely to lose his soul as one belonging to a noble profession.

It is reported that the Government has at present a few cases more where it is alleged that there are serious defects amounting to illegality in regard to the procedure adopted by the District Board Presidents on their own authority not even seeking the formal sanction of the District Board for their action and also of the District Medical Officers as contemplated in the conditions of Agreement. If the Government connives at these defects or at least not make the aggrieved practitioner understand that the Government have taken notice of such irregularities in the procedure, there is every cause for the scheme to be unpopular.

Transfers of Subsidized Practitioners are not at all contemplated in the Agreement as they are against the principle and spirit of the Scheme; yet practitioners are transferred. There exists an order passed by the old Justice Government recommending to the Local Bodies that in case a Subsidized Dispensary is to be converted as a L. F. Dispensary, the practitioner of the particular Subsidized Dispensary should be made the medical officer of the newly converted L. F. Dispensary. But the communal rotation G. O. and age restriction came in the way and the G. O. was not workable. The Congress Government have rightly repealed the communal G. O. and have perhaps by this time removed the age restriction also. The Subsidized Practitioners were pleased to

know a few weeks ago about the Government intentions. But recently a G. O. was communicated to a rural practitioner that he should proceed to another village where till then there existed a L. F. Dispensary and start there a rural dispensary, his dispensary being converted as a L. F. Dispensary. The reason for the conversion of the Subsidized Dispensary into a L. F. one was that the attendance at the L. F. Dispensary which is now converted into Subsidized Dispensary was poor and the attendance of the Subsidized Dispensary where the transferred Subsidized Practitioner was working showed a higher attendance. The transfer as well as the omission of the claims of the Subsidized Practitioner cannot be said to be just and even legal and when the Government who framed the Agreement did not mind their previous orders, a humble individual in the person of a rural practitioner was naturally led to desperation. His notice to the Minister that he contemplated a hunger-strike indicates his helplessness and can never be treated as a threat. The remedy for all these ills is to have a machinery directly under the Government instead of entrusting the same to three different authorities in different places who cannot usually afford time to go into the details of the Scheme having plenty of routine work of their own. This is why perhaps the authorities are forgetting the conditions of the Agreement and several orders passed by the Government at different stages of the working of the Scheme while dealing with the grievances of the practitioners.

A Happy Closure: The readers of The Medical Practitioner might remember that last December an item of News appeared in these columns under the caption "A Fit of Pique in Bombay". This was in regard to the defying of the orders of the Dean of the Seth Gordhandas Sunderdas Medical College by some of its students who arranged a social function outside the College premises and gave valedictory addresses to certain members of the honorary staff of the College. As anticipated, the subject-matter of the controversy was made a subject of discussion by the Bombay Corporation as the College as

well as the K. E. M. Hospital attached to the College belonged to this body and on 2-12-'37, the Corporation passed a resolution requesting the Commissioner to make a report on all the relevant facts pertaining to the holding of the function in honour of some of the retired members of the honorary staff particularly on the circumstances that led to the refusal of the use of the College premises for holding the function. It was alleged by some speakers at the function that the Dean behaved like an autocrat. The Commissioner submitted the report to the Corporation on 12-1-'38 and the report was placed before the Corporation at one of its recent meetings. It is seen from the report that the Dean acted most reasonably and constitutionally too and consulted the Commissioner who is the Executive Head of the Bombay Corporation at every stage of the controversy. The Commissioner while commending the action taken by the Dean says:

"In my opinion, the attitude of the Dean throughout this affair was entirely correct. The Dean in particular would, in my opinion, have failed in his duty had he suffered such conduct to pass unnoticed or omitted to inform all the parties concerned of the true facts".

The report of the Commissioner was recorded without any discussion though a member tried to rake up the matter again by proposing a committee to go into this unhappy matter again. The proposal was thrown out and the original resolution of recording the report was carried. We congratulate the Bombay Corporation on the good sense displayed by its members. This will encourage the Dean to carry on the administration of the Seth Gordhandas Sunderdas Medical College and the K. E. M. Hospital, maintaining prestige and discipline.

The Tinnevely District Medical Association: We have received the 9th Annual Report of the above Association which is a good record of useful work turned out by the Association under the guidance of its President Lt. Col. T. S. Shastri, I.M.S., the District Medical Officer, Tinnevely. The Association has been made a Branch of the Indian Medi-

cal Association and has 105 members on its roll. The Association has regular meetings every month, five of which are at the Head Quarters the rest seven outside the Head Quarters. It meets in three important temples of the District, Nangneri, Shankarnainarkoil and Srivaikuntam. Two meetings are held at two water-falls, Papanasam and Courtallum and the Association meets once at a sea-side station, Tiruchendur. The industrial centre of the District, Koipatti has one meeting a year. Music, Picnic, Dinner are the usual adjuncts to serve as relaxation after serious discussions on scientific subjects. Preventive medicine has its share in the programme of meetings and Health Exhibitions are held and the public are entertained. The annual gatherings are presided over usually by the Surgeon-General with the Government of Madras. This year Dr. T. S. Tirumurti, Professor of Pathology, Madras Medical College was invited to preside over the gathering. Dr. Tirumurti, is a person of varied activities and has exceptional opportunities of coming in contact with the gatherings of the nature over which he presided at Tinnevely on 22-1-'38 and we cannot do better than quote his impressions of the activities of the Tinnevely District Medical Association. Dr. Tirumurti said amongst other things:

"I congratulate your Association, which has been able to do such good work during the past year. The membership of the association has increased. I may say that this is the most prosperous District Medical Association in the Presidency, not only in the number of members on the rolls but also in the kind of activities which the Association has been able to do. I know Col. Shastry, wherever he goes, and in whatever district he works, tries to infuse new life into the moribund Medical Associations, by combining social with professional and scientific activities. The laymen and the elite of the town, who attend your social meetings, would be able to know the doctors, who are specialists, by the social contacts afforded thereat. I am sure Col. Shastry will bear in mind the financial position of the Association and of its members...."

We wish only to add that the Association has opportunities of coming in contact with the members of the profession outside Tinnevely District if reports of the scientific discussions are published in detail in the medical journals instead

of mentioning only the names of the subjects and of the doctors who talked about them. A few months ago we made a suggestion in general to all the existing Associations who send us reports of the clinical meetings with no details. We even published, to serve as a model, the proceedings of the clinical meeting arranged by a Branch of the British Medical Association. So far we had no response. We take this opportunity of suggesting to the President of the Association that his activities will be appreciated by a large section of the medical profession not only in this province but also throughout India if he sends us the reports edited in a form as appearing in foreign journals which the President must have been reading more than we do.

The Tinnevely Independent Practitioners: While we were perusing the annual report of the Tinnevely District Medical Association last week, the post-man put on our table a long cover containing the annual report of another Association in Tinnevely which is styled as "The Independent Medical Practitioners' Association, Tinnevely". The President of this Association is Dr. R. Sundaram, M.D., retired Civil Surgeon and the Vice-President is Dr. T. N. Govinda Aiyar, M.B.C.M., one of the oldest practitioners in the Tinnevely Town. He is also the Vice-President of the Tinnevely District Medical Association. The Association is a year old and has 24 members on its roll. It is said in the report that "the rules of the Association have been so framed that even those in service can join the same as associate members and derive the benefits of the Association". We mused for a while but could not reasonably argue within ourselves the need for an independent activity and that with a common Vice-President. Both the President and Vice-President of the Independent Association are elderly members of the profession commanding respect and unless there were strong reasons for the starting of an Independent Association, we presume that this independent activity would not have been thought of. All the same we are glad to note that the feelings between two

Associations are most cordial. We refrain from commenting on the suggestion of Dr. Tirumurti who in the course of his speech while he presided over the annual gathering of the Tinnevely District Medical Association, said that the Independent Medical Practitioners' Association

might as well be absorbed with the District Association. Health rivalry may be perhaps conducive for better progress especially when the destinies of both Associations are controlled by eminent medical men one, amongst whom, being a common Vice-President of both.

Correspondence, Reports, Etc.

Kistna District Subsidized Rural Medical Practitioners' Association.

The following resolutions were passed at a meeting of the Kistna District Subsidized Rural Medical Practitioners' Association held at Masulipatam in D.M.O.'s Office premises on Saturday 19-2-'38 at 3 p.m.

I. Resolved to request the Managing Editor, 'The Medical Practitioner, Madras', to keep the subscription rate of the journal at Rs. 2-8-0 per year for all the Rural Practitioners as per the resolutions Nos. 8 and 9 passed at the Provincial Conference on 10-7-'37.

II. This Association strongly protests against the action taken by the Kistna District Board in dispensing with the services of the Rural Medical Practitioner, Pallevada who has been in charge of the dispensary ever since the beginning of the Rural scheme on the simple ground that the District Medical Officer, Kistna, has recommended the Practitioner for a refresher course of 3 months and requests the President, District Board, Kistna to rescind his orders which are not consistent with the terms of the agreement and to reinstate the Practitioner immediately.

III. This Association while expressing its gratitude to the Government for the G. O. No. 3066 P. H. dated 15-11-'37 has reasons to apprehend that the local bodies may utilise the same for removing some practitioners from their stations on political reasons and therefore requests the Government to add a sub-clause to the above G. O. that the considerations of the District Boards to shift the existing dispensaries should also include the opinion of the practitioners concerned besides those of the District Medical Officers regarding the population of the village, the work of the dispensary and other facilities which may justify retention.

IV. As there are rumours that the Government intend to enforce Vaccination and Public Health Work on the Rural Practitioners for villages within a radius of 5 miles with a paltry honorarium of Rs. 15 per month, the Association requests the Government to drop such a proposal and give the practitioners supervising work only

on the preventive side with a Vaccinator as an assistant and an honorarium of Rs. 30 per month in accordance with the resolution passed at the recent Provincial R.M.P. Conference held on 10-7-'37.

V. This Association requests the Government to enforce the local bodies for supplying raw Indian Drugs to all the Rural Practitioners of Indian Medicine working under them thus enabling the practitioners to manufacture genuine medicines themselves as the medicines now supplied are found mostly not genuine.

Editorial Comments.

The resolutions referred to in the proceedings of the Kistna District Subsidized Practitioners' Association and passed at the Conference held in Madras on 10-7-37 run thus:—

Resolution No. 8:—Resolved to request the Managing Editor, The Medical Practitioner, to permit the Provincial Subsidized Rural Medical Practitioners' Association to use the Medical Practitioner as its official organ.

Resolution No. 9:—Resolved to increase the yearly subscription for membership from Rs. 2 to Rs. 2-8 out of which Rs. 8 being earmarked to be paid towards the funds of The Medical Practitioner.

It is evident that the membership fees mentioned in Resolution No. 9 was in regard to the membership of the Association and the subscription for membership was raised to Rs. 2-8 out of which annas eight has to be paid to The Medical Practitioner as a subsidy. Those who wish to be subscribers of The Medical Practitioner have therefore to pay the subscription of Rs. 2 annually. The subscription for The Medical Practitioner has been increased to Rs. 3 per year from January 1938 but the Subsidized Rural Medical Practitioners will be charged subscription at the old rate that is—Rs. 2 only.

Regarding the vaccination work we refer the Kistna District Subsidized Rural Medical Practitioners' Association to the understanding arrived at when the members of Interim Committee of Management waited on the Public Health

Minister at the Government Secretariat on 25-1-38 when the Hon'ble the Minister favoured the idea that the Subsidized Practitioners doing Public Health work need not do actual vaccination operation.

Ramnad District Medical Association.

February, 1938.

In addition to the discussion on clinical subjects the following resolutions were passed:—

1. Resolved to appoint the President of the Association as their representative to the I.M.A.

2. Resolved to appoint Dr. N. C. Appayya as the representative of the Association in the District Leprosy Council.

3. Resolved that this Association requests the Government that they may be pleased to provincialise the services of the Medical Officers under Local Boards and Municipalities as in the case of other officers connected with Local Bodies.

4. Resolved that this Association welcomes wholeheartedly the scheme of the Government in the matter of Honorary Medical Services and is of opinion that no allowances need be paid to the Honorary Medical Officers other than a conveyance allowance ranging from Rs. 20 to 50,

this allowance being paid at the discretion of the Government and only when applied for.

5. Resolved that every Honorary Medical Officer appointed to a post shall be entitled to promotion to the higher cadre only on his merits irrespective of the academic qualifications.

6. Resolved that this Association favours the formation of the Provincial Branch of the Indian Medical Association at Madras.

7. Resolved that the annual gathering may be arranged to take place about the end of March or beginning of April, 1938 and the Secretary in consultation with the President to do the needful.

The West Godavary District Medical Association.

Managing Committee of the above association met on 27-2-'38 and decided to have the anniversary of the association on 30th April 1938 and to request the Surgeon-General to preside on the occasion. They also proposed to have the Andhra Medical Conference at Ellore on 1st May 1938, the West Godavary District Medical Association being the Reception Committee for the Conference. A panel consisting of the Hon'ble Dr. T. S. S. Rajan, Dr. A. Lakshmanaswami Mudaliar, and Dr. Muller, was suggested, from whom the President of the Conference is to be selected.

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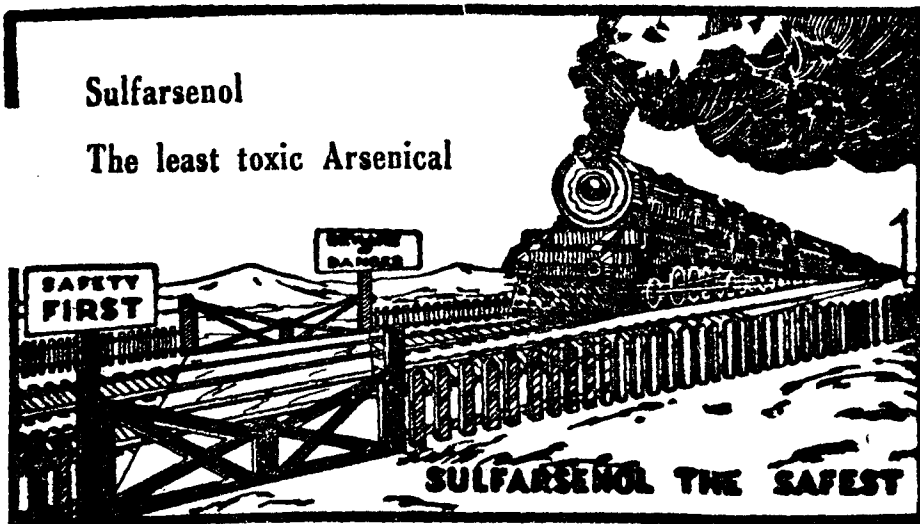
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