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The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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Member, Madras Medical Council.

SCIENTIFIC SECTION.



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Original Articles.

INFLUENZA.

By V. R. K.

It is not my intention to discuss in this article about the causative factors that bring about Influenza, or to determine the causes which make the disease a pandemic spreading all over the world within a brief period of a year as it did in 1918. Text books give all these details and it has not been possible for the members of the medical profession in India to write books on diseases as the history of Western System of Medicine is only as old as the advent of the British in India and the entire profession being under the patronage of the Government ever since, our knowledge of diseases cannot go very far from what was taught to us in Schools and Colleges by Government Medical Officers and what the members of the profession experienced in the exercise of the profession themselves. It is my desire to make this article one of professional interest as apart from academic interest. So I shall attempt to make observations from a clinical point of view so as to enable the readers to discuss within themselves or through the columns of The Medical Practitioner, the indications and rationale of treatment

of a very grave disease whose sequelae and complications are more dreadful than the original disease itself.

History : Text books say that Influenza was known as an acute infectious disease from the middle ages and that no country on the face of the earth was free from it. It is enough for the purpose of this article if I were to draw the attention of the readers to the Influenza pandemic which did havoc in India for about a year in 1918. Ever since India has been never free from this infection though it has to be said that the disease did not assume the virulence and the fatality which were the prominent features of Influenza in 1918. Since 1918 it has been very difficult to draw a border line between benign catarrh and the catarrh which is usually the forerunner of Influenza, until a neglected catarrh brought the patient to bed with complications of a mild or severe variety of Influenza ending at times in death. It must be within the knowledge of at least some practitioners that they themselves were the victims of a neglected

cold. It is also possible for the practitioners to conceive that Influenza has increased the incidence of Tuberculosis of the lungs and that in some patients who died suddenly of heart failure a history of an attack or attacks of Influenza could be elucidated.

Taking into consideration the course of Influenza, the practitioners know it is a very contagious disease spreading with remarkable rapidity, either in a house or from house to house, street to street throughout a parish, a town or a city. The outbreak does not depend upon a particular season though it may be said that epidemics are more in evidence during the period when one season passes on to another. One attack never protects an individual from another; on the other hand one attack makes a patient liable to get another. It is within my experience that some persons do not catch the disease at all.

As mentioned at the very outset it is not the object of this article to discuss what the exact causating factor is in Influenza whether it is Pfeiffer's bacillus or a virus; future will decide the exact cause but it has to be said that most serious cases which end fatally assume 'lethal character' due to 'virulent Streptococci.'

Whatever may be the actual cause which brings on an attack of the disease it must be borne in mind that defective drainage, over-crowding, impure air, deficient clothing and insufficient or unsuitable food, powerfully conduce to its prevalence. All the same we do know that the rich living in healthy sanitary surroundings are not immune to this disease which has been baffling the scientific world.

Symptoms: Influenza manifests itself in such a variety of ways attacking almost all the organs and their tissues. So the symptoms depend upon the seat where the disease has taken a strong hold. Though certain types are described in books depending upon the organ or the system which is attacked there are cases

of Influenza where several organs and systems are attacked simultaneously that it is difficult to say where the infection primarily manifested itself. It is said in almost all books that the onset of the disease is sudden and abrupt, but if one goes carefully into the history of the case it will be noticed that the disease is not as abrupt as described in books. There will be a history of exposure either to cold or heat or slight running from the nose, pain in the throat, at times the patient would say that he was sneezing rather unusually. Muscular pain in the neck, or back or a lumbago is at times the starting point in some. While a few will give a history of indigestion attendant with nausea or actual vomiting, others will give a history of diarrhoea or mucoid motions a few days before the onset of severe manifestation of the disease. Dull or severe headache will be the only prominent symptom in another class of patients. Ear ache will be another preliminary manifestation of which the patient did not take much notice. It has been invariably my experience that when Influenza is not a pandemic, the onset of the symptoms has not been abrupt though the patient would say that he got fever quite suddenly.

Usually in straight-forward typical cases of Influenza, the symptoms start with coryza attendant with rheumatic pains either in the limbs back or neck or a general rheumatic pain all over the body attendant or not attendant with headache. Fever may be slight to begin with or not noticeable by the patient. Generally symptoms of cold and rheumatism come on with high temperature preceded by a chill. At first there is dryness of nostrils with or without scratching sensation. Soreness of throat is also present with a dry hacking cough. The expectoration is scanty at first and consists of glairy scanty mucus. Later there is more copious discharge of opaque mucus. Even careful examination of lungs may not show any adventitious sounds to indicate involvement of lungs. The rheumatic pains abate after a few days and if symptoms of coryza persist with the running of thick glairy fluid from the

nostrils there is little or no cough and the lung from the trachea downwards escapes infection at least to the extent of making the patient not suffer. If the coryza symptoms abate along with fever, it is well and good. But if running from the nose stops suddenly but the fever persists especially with a sensation of chill, it should be taken as a grave warning. Either hyperpyrexia attendant with toxemia will set in or there is likely to be a severe infection of the lungs. A temperature ranging from 100° to 101° with a dry hacking troublesome cough with no signs or symptoms in lungs is the usual course in an uncomplicated case of Influenza. Whether a case is complicated or not, nervous prostration disproportionate to any other existing symptoms is a characteristic phenomenon in all cases of Influenza. Whether this prostration is due to cardiac weakness brought about by toxemia or the feeling is due to action of the toxin on the nervous system is difficult to say for certain. But it looks to me that Influenza attacks almost all the vital systems in the body that it is difficult to pitch out a particular system as the starting point for a particular manifestation in the vicious circle produced by the toxins.

Febrile Type: The prominent manifestation in these cases is high fever ranging from 101° to 104° or even hyperpyrexia. As mentioned above the high temperature may come on after the sudden disappearance of the symptoms of coryza or fever may be the only symptom attendant with acute or dull headache as in typhoid fever. There may not be any trace of catarrhal symptoms at all. Constipation or diarrhoea may be present and there are cases where tympanitis manifests itself as in a case of typhoid fever. Even pulse may be diocratic. In fact the symptoms may simulate a picture of typhoid fever and the patient may develop typhoid state with delirium and other cogent symptoms. If there is a preliminary history of catarrhal symptoms or if the patient sneezes in the course of high fever, one may be almost certain that the case is one of Influenza. But at times either the history will be

defective or the attending physician was not careful to go through a detailed history. In such cases the diagnosis is very difficult. But I have invariably noticed that the characteristic typhoid tongue with dirty fur at the back and red edges is not seen in Influenzal cases. On the other hand we see a tongue dirty if mouth cleanliness is not attended to or a thick sore tongue with a tendency to bleed. The gums are also sore and in some cases the gums give an appearance of mercurial poisoning.

At times after the high fever persists for a few days catarrhal symptoms appear, the nasal catarrh being very slight or nothing at all, the catarrh being located to pharynx travelling as far as trachea and not further. In these cases as soon as patient begins coughing there is a fall in the temperature. There have been cases where the fever is the only symptom and the fever goes up to 106° or 107° and keeps on in spite of hydrotherapy and the patient collapses within two or three days developing oedema of lungs attendant with severe type of toxemia. Such cases of hyperpyrexia are common in children under 10 years of age. Uncontrollable convulsions are a concomitant feature in these cases. I have come across a few cases of this type even in adults. Instead of oft repeated convulsions as in the case of children, the adults, manifest profound brain symptoms, severe delirium or as marked stupor. They too develop oedema of lungs as in children and succumb within a week or even within 48 hours. Such cases are described as Malignant types of Influenza by some authors.

The respiratory type: The air passages and the lungs are the most common seats of infection in Influenza. After the onset of the preliminary catarrhal symptoms, the initial fever slowly rises and the catarrhal process is growing in intensity involving first the upper air passages and insidiously or rapidly the infection travels down first to the bronchioles and then into the substance of the lungs. The respiratory complications manifest themselves in a variety of ways either in a

portion of one lung or in the entire lung or both lungs. Almost all the manifestations of lung diseases from a localised dry pleurisy, bronchitis—capillary or of bronchioles, a small patch of pneumonia in a particular area to lobar pneumonia involving one or all the lobes of one or both lungs may be made out in one and the same patient. It is a peculiar characteristic in Influenza that the constitutional and toxic symptoms in lung involvement do not at all depend upon the area of the lung attacked as could be judged by physical examination. In some cases though it is not possible to observe anything more than harsh breathing with a few crepitations here and there, the patient is in great distress, with marked cyanosis, temperature ranging from 102° to 105° with rapid pulse but having little or no cough. In contrast to this condition one might see a small area of one lung or both lungs affected, at times nothing could be made out anywhere in both lungs excepting perhaps harsh breathing and the patient is troubled with incessant paroxysmal cough (worse in the mornings) very much resembling whooping cough. These cases bring out little or no expectoration; at times the profuse expectoration brought out is disproportionate to the lung condition and may even be tinged with blood. There may be seen cases where a large patch of consolidation could be made out but the patient does not expectorate at all but greatly cyanosed having 30 to 50 respirations per minute and a pulse rate of 120° to 140°. These are dangerous cases, they usually end fatally with the best possible efforts. I have come across cases with marked consolidation at the base of one lung or lungs with little or no signs of distress. Temperature is very high for a few days in these cases but comes down markedly and reaches normal by lysis. Pulse rate does not go beyond 100 per minute. No marked toxic or any other constitutional symptom is noticeable excepting a feeling of constriction on the affected area. In straightforward cases signs and symptoms are evident proportionate to the area involved and the intensity of the involvement. There is a tendency in protracted lung

cases especially in children and in elderly patients for the development of empyema which usually goes unnoticed for a long time.

The gastro-intestinal type: This is another variety of Influenza mentioned in books where the main attack of infection is manifested in the organs of digestion. Even in this variety a history may be obtained that the patient had an initial attack of nasal catarrh and all at once the patient gets high fever with or without a chill and has all the symptoms of acute gastritis attendant with a severe attack of diarrhoea which continues as such or assumes into dysentery. There may not be vomiting and the only trouble may be diarrhoea or dysentery. The symptoms may appear like those of cholera or ptomaine poisoning.

In sporadic cases one may come across patients having signs and symptoms very much resembling acute abdomen with paresis of the intestines. Usually this complication is observed in the course of other types of Influenza especially in the febrile type and an enthusiastic surgeon might even operate on these cases with disastrous results.

Jaundice with or without gastric symptoms may at times be the only manifestation. Generally jaundice does not persist as it does in non-influenzal cases. It might even pass away manifesting only an icteric tinge in the conjunctivae and the skin.

Hiccough generally appears in all types when the patient is toxemic, but the practitioners must have come across cases where hiccough is the only symptom in Influenza with little or no fever.

All the above varieties in the gastro-intestinal type are usually mixed with other types of Influenza which rarely present themselves as a separate entity. In such cases there will not be any difficulty in arriving at diagnosis. But when the gastro-intestinal symptoms appear themselves, it will indeed be a very hard task

to arrive at any definite conclusion. History of the patient having nasal catarrh at the time or within a week before the onset of gastro-intestinal symptoms will be the only guide to arrive at diagnosis.

The nervous type: Some authors describe a type of Influenza under this heading. It looks to me that it would have been more appropriate to have a separate heading as '*The mixed type*'. Nervous symptoms of different grades appear in almost all types of Influenza depending upon toxemia. These symptoms appear both during and after acute infection. It will not be possible to describe a type separately under a separate heading. On the other hand we see lot of cases of Influenza where a particular patient manifests prominent symptoms of all types so far described and in all of which the nervous symptoms appear in a variety of ways.

Complications and Sequelae: Whatever might be the views regarding the actual infective agent that causes Influenza, it cannot be questioned that its nidus is in the naso-pharyngeal region. This is why perhaps the naso-pharynx and its adjacent regions are the fields for majority of complications and sequelae. Naso-pharynx being the gate way to the respiratory system the power of resisting the infection depends naturally upon the healthiness or otherwise of this portal. If this fact is kept in mind the seats of infection or their complications, their nature and severity may be comprehended and ways and methods adopted to prevent the complications and resulting sequelae.

The ear, nose and throat get the brunt of infection along with the lungs. Sinusitis, middle ear disease are common complications usually met with. Pulmonary tuberculosis is the real danger to be dreaded after severe attack of Influenza involving the lungs. If it is conceded that Influenza is primarily a disease of the upper air passages all the various manifestations in respiratory, digestive, circulatory and nervous system may be the complications and sequelae and

avoided or at least treated more successfully. It is the neglect of the initial catarrhal symptoms that has been the cause to increase the mortality in Influenza. The complications and sequelae in the circulatory system have to be dreaded more than the complications of the other systems including the respiratory. Deaths in Influenza are due to heart complication and the sequelae of the degenerative processes starting with an attack of Influenza are causes of sudden deaths in after-life. Heart complications during an acute attack of influenza are more deceptive and more dangerous than those seen during the course of acute attack of rheumatism. The quality and the rate of pulse are considered to be a safe guide to a physician to judge the action of heart in all diseases but I have been not only baffled but deceived by the condition of pulse and many other physicians must have been likewise while treating serious cases of Influenza with or without lung complications. I have seen cases where after the onset of fever and catarrh in Influenza, patients suddenly developing dyspnoea with little or no cough, pulse full, regular and not above 100°. They look cyanosed and in death agony always keeping their mouths open due to air hunger. Death is almost certain in these cases. Though I had no opportunity of conducting autopsies in such cases the clinical picture was of heart failure without a shadow of doubt. Apart from myocardial degeneration the toxemia in Influenza produces vasomotor disturbances in the heart.

In addition to the nervous disturbances concomitant to high fever such as headache, insomnia, delirium, stupor etc., all patients suffering from Influenza whatever manifestations of the disease they exhibit, suffer from nervous depression of an extra-ordinary type which seems to be peculiar to this infection. Though restlessness attended with sleeplessness is very common, there are a few cases where the patients may be seen sleeping the whole day so much so that the patient's relatives suspect if the attending physician has administered powerful medicines to induce sleep. At times,

though rarely, patients exhibit brain symptoms very much resembling meningitis. Absence of Kernig's sign in these cases is characteristic, so also superficial abdominal reflexes and stiffness of the muscles of the neck. Such cases are common in children. It is mentioned in books that Influenza patients suffer from typical meningitis. Apart from active nervous disturbances during the course of illness neuritis, nervous headaches are quite common, persisting for months after an attack of Influenza. Neuralgia of the nerve ends in teeth is characteristic in this disease. I had a patient, a boy about 8 years old, who lost power of speech during the course of fever attendant with a bad type of delirium and it took two months for him to get back the lost function. There was another patient who would shriek holding his head with both hands as if his head will split and he would immediately get a fit resembling epilepsy but without frothing at mouth. This condition was later diagnosed to be a reflex phenomenon due to error of refraction. The boy had hypermetropic astigmatism of a high degree. On the very day his pupils were dilated with Atropine, the fits disappeared like magic. It is worthwhile if physicians remember that persistent headaches after an attack of Influenza (as in other diseases) may be due to refraction error.

Very few authors have mentioned in their books that Influenzal complications could be traced to the urinary system also. It is usual to see traces of albumin in urine of patients suffering from infective fevers, but in Influenza I have come across cases of nephritis and I am led to believe that some cases of heart distress in Influenza may be due to Influenzal Nephritis. Infection of hilum of the kidney and of the bladder may also be mentioned among the complications relating to the urinary system.

Diagnosis: In the febrile and gastro-intestinal types the diagnosis will be at times a difficult problem especially at a time when Influenza is not an epidemic. Ever since 1918 either Madras or other provinces in India have not been free

from the infection and Influenza has been prevailing epidemically or sporadically. In doubtful cases the practitioners should not forget to demand a history if the patient suffered from nasal catarrh, pharyngitis or had sneezing in the course of the illness or immediately preceding his illness. This will be the only and the most reliable guide. In febrile cases blood examination, blood culture and Widal's test have to be depended upon. It is worth while knowing that in almost all cases of Influenza as in other infected fevers there is enlargement of spleen and at times Influenza simulates a typical case of Malaria regarding the daily onset of fever at a fixed hour preceded by shivering as in malaria and followed by profuse sweating. So it is always a wise plan to examine blood as a matter of routine. The difficulty of diagnosis is all the more in gastro-intestinal cases, especially in cases of Influenza resembling Ptomaine poisoning. In respiratory cases the diagnosis may be arrived at with little or no difficulty. All the same the practitioner should keep in mind that in an Influenza season cases of lobular or lobar pneumonia may occur without influenzal infection. Whether it be a mere catarrh, bronchitis or pneumonia in respiratory cases; slight nausea, vomiting attendant or not with intestinal symptoms in gastro-intestinal type; the severe prostration and depression characteristic of this disease should enable the practitioners to distinguish the manifestations of Influenza when it attacks a system or group of systems. In fine the watch-word in diagnosis should be a keen observation of the patient and the attendant symptoms.

Prevention: During these days of pleasure hunting and pleasure loving civilization, when the child, the adult and the aged revolt against any interference of self-determination, the task of advising patients against any illness is most tedious and at times looks not worth attempting. The difficulty is all the more when so many nostrums are being advertised by the money making firms both in the medical and lay press. The preparations of quinine and ammonia

are very much abused in this respect. The fact that it has not been possible so far to find out the real causating factor in Influenza has made the task of prevention literally a hopeless one. Yet, though the task is uphill and even thankless it is expected of the members of the medical profession to lose no opportunity of enjoining upon their patients in season and out of season that the only reliable prophylaxis is to keep one 'fit' by not disobeying the laws of nature and impress upon them that if nature is disobeyed the punishment meted out will make life not worth living. The physicians will do yeoman service to the humanity if they hang posters in the place of their business with an inscription '*Do not neglect a cold however mild and trivial*'. Side by side another poster may be hung mentioning the diseases from which people may suffer in case they neglect 'cold'. Though it may not be practicable to prevent 'cold', the practitioners can surely prevent the complications of 'cold'; for Influenza is a malignant catarrh and the practitioners have to treat the complications of malignant catarrh, so if they prevent the malignancy of a catarrh they would prevent complications or combat

them with much greater success. Rest on bed soon after one gets catarrh of the air passages till he or she is free from such catarrh is the safest and most sure prophylaxis that practitioners may advise and the patients may follow. Teachers of medicine in schools and colleges would do well to give a course of lectures on the efficacy of rest and the methods and mode how to secure the rest for the entire human system when it is needed.

At present the tendency seems to be to depend more on therapeutic agents than on nature either for preventing or curing human ailments. The fallacy of such faith has been fully established by Influenza.

Regarding the role of vaccine or serum therapy in Influenza I shall only quote what appears in a text book of medicine (edited by F. W. Price). "The available vaccines for protective inoculation perhaps aim as much at raising resistance against the secondary infections which are frequently so harmful as against the primary invader. Regarded in this light they are rational; but it is still too soon to give a proper judgment upon the question of their therapeutic efficacy".

N.B.—The treatment of Influenza will be discussed in the next issue.

SENILE CATARACT OPERATION.

AS DONE IN A MUFFOSSAL HOSPITAL.

BY

DR. G. V. HANUMANTHA RAO, L.O., L.M.P., (Mad.), L.C.P.S., (Bom.).

Senile Cataract is a most common eye disease in the Madras Presidency and the Government and the private practitioners are consequently keen in establishing Eye clinics wherever there is a necessity for the same. Being in charge of such an Eye clinic at the Government Head Quarters Hospital, Guntur for some years, I have chosen to speak on this important operation when the District Medical Association celebrates its third Anniversary under the distinguished presidentship of the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister.

As the time allotted to me does not permit me to be as elaborate as I would have been otherwise on a subject of such an importance, I shall as briefly as possible narrate what I do while operating on cases of Senile Cataract. For the purpose of describing my way of operating, I take it for granted that the case is a ripe cataract with normal tension with a free lachrymal passage and the general condition of the patient healthy. I usually take a week to prepare the patient for operation. These days I apply the yellow ointment of mercury (4grs. of Hydrargyri oxidi flavi to

an ounce of white vaseline) and instill Zinc Sulphate drops. The patient is given internally Calcium Lactate and a Bromide mixture. I insist on this preliminary step as I find by this means the conjunctival sac is made perfectly sterile and the patient's nerves get settled. I have not so far lost any case as a result of sepsis. I am glad to tell you with a certain amount of pride (for which I may be pardoned) that I manage to perform the whole operation from start to finish single-handed. That does not mean that there is nobody to assist me but I have practised my work all these years singly with great success. After attending to minor details the previous day, as the cutting of eye lashes and opening of the bowels, the patient is brought to the operation room. The eye is cocainised and adrenalin drops put in after applying atropine ointment. In 15 minutes the pupil is dilated. I submit that the atropine ointment is better than drops because the ointment obviates the need of any atropine application to the eye immediately after the operation and consequently facilitates the speedy closing of the operated eye with bandage. I have entirely given up the Hydrargyri perchloride lotion wash for cataract cases. You may ask why? My simple answer gained by experience is that preliminary treatment with plasma for one week is decidedly more effective than the wash with the lotion. If it is done I consider it is a waste of time and the manipulations on the conjunctiva and lids cause some irritation. We want a clean aseptic eye and it is achieved by plasma itself. Certainly you will all agree with me that one week's repeated application of zinc drops and plasma is much better than once washing with lotion to ensure asepsis and also the curing of the chronic conjunctivitis common in old people with cataracts.

Coming to anesthesia, I always have recourse to $\frac{1}{2}$ to 1 c c. Novocaine solution facial block over the neck of the mandible in front of the ear. That will paralyse the orbicularis muscle and as a result the patient as you are aware cannot squeeze the eye. I do not give ciliary block because I consider it not an absolutely necessary

step for the operation and there is some risk of bleeding into the orbit causing proptosis of the eye, necessitating postponement of the operation. To bring about a deep anesthesia of the cornea instead of ciliary block I actually put into the eye at the limbus in its upper portion pure powder of cocaine about one to one and a half grs. and close the eye for 3 minutes. The anesthesia is so good and so appreciable that the patient gives the least trouble during operation.

Afterwards the eye and fornices are cleaned with swabs and also washed with pure sterile warm water, for one or two minutes.

The patient is now on the operation table, of course the covering of the patient with aseptic towels and so on are understood as being done. The operation is performed by me generally, without the help of a torch light and I depend on the good sun light only, except in exceptional circumstances as when the sun is not bright or there is a complication during the operation but the electric torch is always kept ready at hand.

For the operation I use exactly eight instruments only. (1) Speculum without tight spring. (2) Cataract knife with good point and sharp blade (3) Bowman's needle with sharp point (4) one double tooth fixation forceps (5) one fine iris forceps (6) one curved iris scissors (7) one iris repositor and (8) one cataract spoon. I do always extra capsular operation. I mention only a few important points of the process of the operation having in view how I manage single-handed. Till I finish capsulotomy the patient as a rule has to look at the ceiling of the room. Then as I proceed with the section of cornea from limbus to limbus beginning from half of it and working the knife upwards the patient is directed in a coaxing manner to look down towards his own feet and the section is completed, generally ending in a short conjunctival flap. Now I have done once for all with the knife and the fixation forceps. With light strokes with cataract spoon over the cornea below and iris repositor at the upper margin of the

scleral lip, the lens is brought out easily. For delivery of the lens the patient need not be worried as to the movements of his eye because such movements do not trouble me to bring out the lens. To proceed with iridectomy the patient is asked to look down and iridectomy is finished and anterior chamber washed with pure sterile distilled water only. Setting the iris pillars and conjunctival flap in position, the eye is closed along with the other and a full bandage is applied in spirals, and the patient is carried to his bed in a stretcher and instructed not to get up from bed for any purpose for 48 hours. If I do not insist on 48 hours the poor ignorant patients will get up and walk about even within 6 hours. In spite of all advice they do not keep in the bed more than 24 hours.

On the 3rd day only I relieve the other eye and the operated eye on the fifth day, bandage changed and Argyrol and Atropine drops. The patient leaves the hospital in two instilled weeks with a green eye shade and given for use at home Z. B. drops and plasma to apply to the operated eye for some days.

As to complications during the operation, escape of vitreous is one which is mostly due to the excessive squeezing of eye lids in unruly patients. In such a case the eye is closed at once and bandaged to save as much vitreous as possible and the patient is kept on the back for four days without being allowed to get up. By that time in my experience the lost vitreous is made up to a great extent and the form of the eye looks more or less normal with a closed section with some useful vision. There are some other complications which require mentioning but the time given to me is already over and I do not want to stand in the way of other speakers.

My idea in reading this paper is to impress the practitioners that in private practice it is essential during these hard days to curtail initial and recurring expenses to the lowest minimum possible and also to be self-dependent. With about Rs. 25 one can get the eight above-mentioned instruments and other necessary things and start a cataract clinic provided one has got real earnestness in the work, of course, with a good training to one's credit in that speciality.

MADRAS MEDICAL COUNCIL.

REVIEW OF THE PROCEEDINGS OF THE COUNCIL, SEPTEMBER 1937 SESSION

By DR. V. RAMA KAMATH

MEMBER, MADRAS MEDICAL COUNCIL.

Readers of The Medical Practitioner are aware that the Review of the Proceedings of the Madras Medical Council has been a special feature of the Journal ever since its birth and this work is undertaken by me. The proceedings of the September 1937 could not be reviewed earlier as they were confirmed only on 4.4.38.

At the very outset before the proceedings of the meeting commenced, the President (Major General Sir Frank P. Connor) made a reference to the sudden demise of Mr. J. P. Pinto, late Registrar of the Council and the high level of the efficiency of his work. A resolution of condolence proposed by

Dr. R. J. Dyson and seconded by Dr. T. S. Tirumurti was passed by the Council all the members standing.

REGISTRATION.

Three practitioners, Dr. C. W. Richardson, Dr. (Mrs) Richardson holding American Medical Degree of M. D. and another Dr. (Mrs) Anna Hardt possessing M. D. (Hamburg) degree applied for registration. Till about 1933 the Madras Medical Council was indiscriminately registering all those possessing foreign qualifications as almost all of them were medical missionaries. After the influx of German doctors to India, the Madras

Council seems to have realised the need of refusing registration of practitioners hailing from foreign countries and colonies and is now refusing registration of all foreign degrees under Sect. 20 of the Madras Medical Act wherein it is provided "that no Medical degree, Diploma or Certificate granted in any British Colony or foreign country which does not recognize the Medical degrees, Diplomas or Certificates of a British Indian Government or University shall be included in the Schedule....." It may be noted that the Council has always a good backing from the European section in this respect. So all the three applications were rejected by the Council. All the same the Council is alive to the interests of the Indians who obtained Medical qualifications abroad. There was an application from one Dr. T. D. Nair, who possessed a Diploma of the type granted to Military Asst. Surgeons in India and in addition was an L. M. (Dublin) and D. T. M. (London). The Council made an exception in the case of this person and recommended him to the local Government for Registration.

DISCIPLINARY CASES.

The Council decided 6 cases at this Session :

1. Information was received by the Registrar that severe strictures were made by the District Judge of Anji Kaimal in Cochin State in a judgment in a case in which one Dr. S. Survothama Rao was the Plaintiff, alleging that the Plaintiff who was a registered practitioner gave and circulated testimonials relating to preparations sold by himself to puff up a concern by name, the Navaratna Pharmacy. The practitioner in his explanation mentioned that at the time he gave the testimonials in 1926 the concern was run by his father who is an Ayurvedic physician of 45 years standing and that ever since the proprietorship came to him he did not issue any testimonials. The three members of the Disciplinary Committee gave separate but almost concurring opinions regarding the offence but differed with regard to the

mode of action. The Council passed the following judgment.

"That in view of the explanation offered by Dr. S. Sarvothama Rao and in view of the fact that the events occurred as far back as 1926, the case be dropped with a warning in writing to be communicated by the President."

2. The readers may remember that when I reviewed the Proceedings of the Council of the April 1937 Session, mention was made about a complaint against one Dr. R. Kondal Rau by one Dr. K. Satyanarayana Rau alleging that the former distributed leaflets relating to his professional skill. Dr. Kondal Rau denied all knowledge about the leaflets and contended that one of his grateful patients was responsible for the printing and publishing of the leaflets. The three members of the Disciplinary Committee opined individually that there was no case and that the practitioner may be summoned and warned to be vigilant that such acts were not repeated by his patients. This was done accordingly.

3. Information was received by the Registrar, Medical Council that one Dr. T. Lakshminarayana, M.B., B.S., published hand bills relating to a preparation, "Thymo Pills" prepared and offered, by him for sale. The practitioner pleaded ignorance of the Code of Medical Ethics which prohibited registered practitioners from taking part either in the sale or manufacture of secret remedies. He pleaded also about his youth, inexperience and domestic troubles. The Disciplinary Committee to whom the case was referred to decided to accept his explanation. The Committee also opined that the President may be requested to send to the practitioner a warning in writing. This was accordingly done and further proceedings dropped.

4. Information was received by the Registrar that one Dr. K. N. Krishnamurthi in Guntur had published a hand bill about his place of business called "Medical and Optical Emporium". The practitioner when asked for explanation said that he distributed the hand bills about three years ago and pleaded

ignorance of the Code of Medical Ethics. As in the previous case the Disciplinary Committee accepted his explanation and the President sent a warning in writing for the future guidance of the practitioner.

5. A complaint was received against Drs. C. Sripathi Chetti and P. Sudarshanam from the Superintendent of Post Offices, Nellore, alleging that the two practitioners issued false certificates to one of the clerks belonging to Postal Department. The former practitioner certified on 16th June 1936 that the clerk's illness was piles and recommended him leave for one month. On the expiry of the leave, the clerk was recommended leave for another month by the latter practitioner, till 16th July 1936. On the 21st July the clerk was directed to appear before the then D. M. O., Bellary who declared that the clerk was fit for duty. The D. M. O. wrote in his report in addition, "There is no sign of there ever having been piles. He can never have suffered from piles. Action should be taken against this or the practitioner who gave certificate or both." The complaint against these two practitioners was entirely based on the report of the D.M.O. Dr. C. Sripathi Chetti said in his explanation to the Registrar amongst other things :

"The letter from the District Medical Officer, Bellary, to the Superintendent of Post Offices, Nellore Division, is dated 28th July 1936, one month and 12 days after I gave my certificate. It is not known from the extracts supplied by you to me what the requisition letter dated 21st July 1936 addressed by the Superintendent of Post Offices, Nellore Division, to the District Medical Officer, Bellary, contained really. So at this stage, I do not wish to pass any remarks on the opinion said to have been given by the District Medical Officer in his reply to the Superintendent of Post Offices, Nellore, regarding my certificate. But I cannot but say even at this stage that they are unjustifiable, and provocative, if not defamatory, as I am at a loss to understand under what existing privilege either in the Madras Medical Registration Act or the common law of the country, a person in

the position of a District Medical Officer can pass remarks against me.

I am not a subordinate of the District Medical Officer, Bellary. From the perusal of the Madras Medical Registration Act and the rules framed thereunder, I cannot find anywhere anything to indicate that the statement of a District Medical Officer would itself be sufficient to establish a charge against me as expressed in your letter dated 5th January 1937 which charge runs thus: 'From the statement of the D.M.O. it is very clear that you have intentionally furnished a medical certificate which is untrue.' In the absence of any specific provision in the Madras Medical Registration Act, I should say that this charge at this stage of enquiry is unjustifiable and uncalled for and is likely to prejudice my interests. Even in criminal law, the principle is that a person is to be considered innocent, till the charge or charges against him are legally proved. In this case, you not only make a charge against me but establish guilt, which, to say the least, is most uncharitable.

From the records you have placed before me charging me for infamous conduct in a professional respect, I cannot at this stage offer any other explanation than requesting you to convey to the President that I did not contravene the provisions in the Warning Notice referred to in your charge, as I expressed my opinion in the certificate to the best of my knowledge and ability."

The Disciplinary Committee did not approve the action of the D.M.O. The Council decided that no case had been made against the two practitioners.

6. One Mr. B. Bulli Subbanna made a complaint against Dr. N. Rama of Tanuku alleging that the latter issued a false certificate to an Insurance Company relating to the death of one, I. V. Somaraju. The practitioner in his explanation deduced evidence depending upon which the members of Disciplinary Committee individually opined that there was no case against the practitioner and that further proceedings be stopped. The Council agreed and the case was dropped.

The 3rd and 4th case show that though it is nearly 24 years since the Madras Medical Registration Act was passed there are registered practitioners who confess their ignorance about the existence of a Code of Medical Ethics. The Medical Practitioners are bound to receive a copy of the Medical Register soon after they are registered; but till about the year 1932 the affairs of the Council especially those of the office of the Registrar were known to be most unsatisfactory and the Registers not being published in time required by the Act many of the practitioners who registered themselves before 1932 might not have been supplied with the copies of the Register. From about the year 1929 persistent attempts were made by me to set right matters and it took nearly 4 years to bring the affairs of the Registrar's office to order. It was during the Regime of Major General Sir. Frank P. Connor that the Madras Medical Register was published in time for the first time in the annals of the history of the Madras Medical Council. Practitioners who got into the Medical Register before 31st December 1933 cannot possibly complain of their ignorance of the "Warning Notice" the whole of it as appearing in the British Medical Register was approved by the Madras Medical Council soon after the Medical Act was passed. From the year 1934 the practitioners cannot have any difficulty in obtaining copies of the Medical Register free and the Register contains the "Warning Notice" printed in bold types. In future the plea of ignorance cannot be condoned by the Council. The following proposal made by the President was approved by the Council:

"The attention of the Principals of Medical Colleges and Superintendents of Medical Schools be drawn to the desirability of drawing the attention of Final Year Medical Students to the Warning Notice. A brief address might be given to students before they appear for their final examination explaining these warnings".

The source of information in some of the cases is anonymous. It is question-

able whether judicial notice could be taken on anonymous information even taking it for granted the information is true. It is a matter to be seriously considered by the Council if the practitioner should not be informed at the time a preliminary explanation is demanded of him about the nature and source of information. Such and similar serious questions of law cannot be lightly passed over. The Medical Council is seriously handicapped for want of a legal assessor while constituting itself as a tribunal in trying cases of infamous conduct in a professional respect. The General Medical Council, Great Britain has a legal Assessor. The rules framed under the Act contemplate the obtaining of legal advice in disciplinary cases but such advice has not been so far obtained.

The fifth case against two doctors should interest the readers and should serve as a guide to the Medical Officers in Government Service. They will do well to realise that the Medical Act has to treat all registered practitioners alike and opinions expressed by registered practitioners should be treated by the Medical Council for what they are worth irrespective of the official position occupied by those who express them. The D. M. O., Bellary, would have done his duty quite satisfactorily if he gave his professional opinion without making aspersions against the practitioners in the way he did.

There is an impression especially amongst some high officials in medical profession that a few at least in the rank and file in private practice are reckless in issuing medical certificates. There is a corresponding impression that some of the highly paid medical officers are as reckless if not more than their humble brethren in private practice. These officers have an additional advantage on account of their official position and they feel more secure in spite of the reckless certificates. If the monopoly of safety enjoyed by Government Medical Officer is removed and if the good and honest in the official and non-official section in the profession join together

for a common purpose and weed the profession of all those who bring the profession to contempt, they will enhance the prestige and status of the noble profession. If the Medical Councils are made to wield power and authority in the right direction, the profession may enjoy better days and rise itself in public estimation.

MISCELLANEOUS ITEMS.

1. As Major General Sir Frank P. Connor was to retire the Council passed with acclamation the following resolution:

"The Madras Medical Council has great pleasure to place on record the very devoted and valuable services rendered to the medical profession through the Council by Major General Sir Frank P. Connor as the President of the Council by showing uniform courtesy to the members of the Council and conducting the proceedings in a democratic manner. The Council wish him long life of health and happiness during his retirement."

Sir Frank P. Connor made a suitable reply.

2. The Council passed a resolution that a sum equivalent to three months' pay be given to the wife of the late Mr. J. P. Pinto in recognition of the meritorious work rendered by him to the Council as its Registrar.

3. At the April 1937 Session of the Council while recording the order of the Government on the resolution of the Madras Medical Council that inoculations during epidemics should not be done by the non-medical staff of the Health Department, the Council requested the Government to reconsider the order. The Government have declined to do so. If the profession takes up the agitation which the Council had initiated there may be a hope of the Government re-considering their order during these days of popular Government.

4. There was a reference to the Council if Registered Medical Practitioners may serve on the Directorate of Insur-

ance Companies. The Council opined there could not be any objection.

5. As reported by me in The Medical Practitioner last June while reviewing the proceedings of the Council, I moved the following resolution at the April 1937 Session:

"The Council feels that it is highly desirable in the interest of the medical profession and the public, that post-graduate training is necessary for all who pass out of the Medical Schools and Colleges and to consider if such training is possible under the existing conditions, the Council appoints a committee for this purpose, with a request to the committee so appointed to send its report at the next meeting of the Council".

Accordingly the Committee recommended to the Council that the Government be requested to afford more opportunities for house appointments in the existing Government institutions and to publish the names of the hospitals where such facilities are available. The recommendation was approved unanimously.

6. The Local Government sent a memorandum to the Medical Council relating to a letter from the Government of India on the subject of amending the Indian Medical Degrees Act. The above memorandum with a Draft Bill prepared by the Surgeon-General's Office was considered by the Council on the 27th October 1936 and a committee consisting of Dr. V. Rama Kamath, Dr. M. R. Guruswami Mudaliar and Dr. T. S. Tirumurti (convenor) was appointed by the Council to draft the amendments. The committee submitted its report to the Council and it was accepted by the Council. The amendments proposed by the committee appear in the Correspondence columns of the current issue of The Medical Practitioner.

The other miscellaneous items discussed by the Council concerned with matters not affecting the profession and therefore have not been included in the review.

RESOLUTIONS BY THE MEMBERS,

Dr. V. Rama Kamath moved :

1. "The Council requests the Local Government to amend section 13 (a) of the Madras Medical Registration Act by deleting clause (a) in section 13 and inserting in its place the following clause: 'is possessed of any of the qualifications granted in Great Britain and which are recognized by the General Medical Council, Great Britain' and requests the Government of India to amend the second schedules B and C mentioned under section 12 of the Indian Medical Council Act, in such a way as to exclude recognition of the medical qualifications granted by Licensing bodies in the British possessions or by the Licensing bodies in foreign countries and which British possessions and foreign countries do not recognise all the medical qualifications registrable in the Provincial Medical Registers in India".

The resolution was lost with the following result on the poll demanded by Dr. V. Rama Kamath: *For*: Dr. V. Rama Kamath and Dr. Y. Suryanarayana Rao. *Against*: Dr. R. J. Dyson, Dr. (Miss) Ida S. Scudder, Dr. (Mrs.) O. M. Monahan and Dr. N. Venkataswami Chetti. *Neutral*: Dr. M. R. Guruswami Mudaliar, Dr. T. S. Tirumuthi and Dr. U. Krishna Rao.

My object in moving the resolution was to raise the question of reciprocity of recognition of L.M.P. qualification by the British Colonies especially Ceylon. In this colony the Medical Licentiates are not recognised whereas the Madras Medical Council are under compulsion to recognise the medical qualifications granted in Ceylon.

Section 13 of the Madras Medical Registration Act reads thus:

"Subject to the provisions of Section 14, every person who—

(a) is for the time being registered under the British Medical Act, or

(b) is possessed of any of the qualifications described in the Schedule shall be entitled to be registered on furnishing to the Registrar proof of such registration or qualification, whether or not such person practises or intends to practise the Allopathic or any other system of Medicine....."

The Ceylon L. M. & S. is recognised by the B. M. C. and if an L. M. & S. of

Ceylon gets into the British Medical Register, the Madras Medical Council should automatically register the practitioner possessing the L. M. & S. degree. The Indian Medical Council has recognised the L. M. & S. Ceylon for the same reason. I thought a resolution of the nature proposed by me if passed by the Madras Medical Council would serve as a protest. It was expected that at least the Indian Members of the Council would vote for the resolution.

I believe in the dictum that 'if at first you do not succeed, try, try and try again.' So later when the Medical Council had to discuss about the amending of the Madras Medical Registration Act (on my resolution) I pressed for the same amendment and gained my object with the surprising yet happy result that the entire Council voted with me for the amendment which in substance means the same resolution which the Council did not approve.

2. Dr. V. Rama Kamath moved :

"The Council is of opinion that the Madras Medical Registration Act has to be amended to suit the times and appoints a committee consisting of all the members of the Council residing in Madras with a request to the committee so appointed to send its report to the Council at its next meeting and let the quorum of this Committee be five".

The motion was seconded by Dr. T. S. Tirumurti and carried unanimously. It was further resolved by the Council that the President of the Council should be the Convener of the Committee.

3. Dr. V. Rama Kamath moved :

The Council is of opinion that permitting Nurses and Compounders to administer Anaesthetics or give injections to the patients in hospital or in private practice comes under the clause described in the Code of Medical Ethics under the heading 'Unqualified Assistants and Covering' and as such cannot be permitted. The Council further resolves to give publicity to this resolution."

Dr. Y. Suryanarayana Rao seconded the motion. The resolution was lost, three voting for and seven against it. A poll

was demanded by Dr. V. Rama Kamath and taken with the following result :

For: Dr. V. Rama Kamath, Dr. Y. Suryanarayana Rao and Dr. U. Krishna Rao. *Against*: Dr. (Mrs.) O. M. Monahan, Dr. (Miss) Ida S. Scudder, Dr. R. J. Dyson, Dr. T. S. Tirumurti, Dr. M. R. Guruswami Mudaliar, Dr. N. Venkataswami Chetti and Lt. Col. C. A. F. Hingston.

4. Dr. V. Rama Kamath moved :

"The Council resolves to have the meetings of the Council from 2 to 7 p.m. day to day till the agenda of a particular meeting is finished."

The motion was seconded by Dr. Y. Suryanarayana Rao. Dr. U. Krishna Rao moved an amendment to substitute the words "12 to 5 p.m." for the words "2 to 7 p.m.". The amendment was seconded by Lt. Col. C. A. F. Hingston and accepted by the mover of the resolution. The motion, as amended, viz., "the Council resolves to have the meetings of the Council from 12 to 5 p.m. day to day till the agenda of a particular meeting is finished." was put to vote and lost.

5. Dr. V. Rama Kamath moved.

"The Council authorises the Registrar to compile the next Medical Register avoiding a person being given two registration numbers and two

persons being given the same registration number, as shown on page 219 of the Medical Register for 1936, such mistakes having occurred in the year 1932."

The motion was seconded by Dr. T. S. Tirumurti. As the President assured the Council that he would take the necessary steps in this direction, the motion was by leave withdrawn by the mover.

6. Dr. Y. Suryanarayana Rao moved.

"This Council respectfully requests the Government to include also the Membership of the Madras Medical Council among the qualifications prescribed for the votership of the Madras Legislative Council, as this is not in any way inferior to those mentioned in part II 2 G. III, VI and VII of the schedule of the qualifications."

This was seconded by Dr. V. Rama Kamath and was carried unanimously.

As the Local Government has undertaken to amend the Madras Registration Act, a special meeting of the Committee appointed by the Council to discuss resolution 2 (above) was held on 30th October 1937 and an extraordinary meeting of the Council was convened on 18th November 1937 to consider the Committee's report. The proceedings of the Committee and the Council are published in the Correspondence Columns of the current issue of The Medical Practitioner.

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Abstracts.

POST-OPERATIVE TREATMENT AFTER ANAESTHESIA.

BY DR. MACHRAY, M.B.

A variety of conditions needing treatment arise after an operation. Some of these result more or less normally from the disturbance produced by the operation and the anaesthetic, while others are due to error in technique or to idiosyncrasy on the part of the patient. An important factor that is often overlooked is the necessity for gentle handling of an anaesthetized patient while he is being returned to bed. A profound change may follow the sudden alteration in position of a shocked patient, as may be demonstrated if after an operation in the Trendelenburg position the table is suddenly restored to the horizontal. Sufficient assistance should therefore be available for all necessary movements to be carried out as gently as possible.

PULMONARY COMPLICATIONS.

When in bed the patient's head and shoulders should be raised on pillows, if there is no contraindication to this, as soon as he is sufficiently conscious. He should be encouraged to move himself as much as possible and to expand his lungs fully at frequent intervals. If unconsciousness is prolonged this latter manoeuvre can be brought about by the administration at half-hourly intervals of carbon dioxide in quantities just sufficient visibly to stimulate respiration without it being at all laboured. These measures will do much to combat the incidence of pulmonary complications. Should any such complications supervene—bronchitis, broncho-pneumonia, pulmonary collapse—then suitable treatment must be given. In cases of pulmonary collapse from blocking of a bronchiole, carbon dioxide inhalation is probably harmful, as it causes the plug to be sucked further in. A stimulant mixture should be used in the hope that the plug may be dislodged by coughing. Bronchoscopic suction may be successful in some cases. In bronchitis and broncho-pneumonia expectoration is often interfered with by pain in the wound. Here small doses of morphine repeated four-hourly may, paradoxically, render the coughing easier by making it less painful. The administration of iodides and stramonium will help to loosen the secretion. Ammonium carbonate, 4 grains in milk, is of value, but as it is a powerful stimulant of secretion it should not be given when this is profuse, as in acute ether bronchitis. Hot inhalations may prove soothing and beneficial, especially when there is a tenacious plug of mucus in the trachea that moves up and down with respiration. If there is any dyspnoea or cyanosis, oxygen should be given through a nasal catheter or, better still, the patient should be placed in an oxygen tent.

These conditions, however, are best avoided by prophylaxis, which should take into account the three groups into which the causative factors fall. First, the patient's resistance should be at the maximum and sources of focal sepsis removed. Secondly, the position of the patient during the operation should interfere as little as possible with respiration, the operation should be conducted gently and speedily, body temperature should be maintained, and tight bandaging around the chest be avoided. Thirdly, the anaesthetic, including pre- and post-operative sedatives, should be carefully selected and controlled, and all risk of gross aspiration of blood and vomit prevented during and after the operation.

PAIN.

Post-operative pain varies widely, not only with different operations but with the same operation in different patients, and it is therefore impossible to lay down any routine treatment. Two principles must be kept in mind; first, the dosage must be adequate to provide relief; and, secondly, overdosage must be avoided as

leading to respiratory depression and hindering recovery from shock. Occasionally these two principles will prove incompatible, but in such cases it should be suspected that the drug employed is not the most suitable, and trial should be made with other drugs or different preparations of the same drug. Sometimes lack of success with full doses of a potent narcotic will be followed by complete relief or pain with what is, generally speaking, a much milder drug. Alternatively, tincture of opium may prove more successful than injections of morphine.

It is a good plan to prolong the analgesic effect of the anaesthetic by giving rectally 30 to 60 grains of potassium bromide in saline as soon as the patient returns to bed. This is especially valuable where recovery would otherwise be very quick, and greatly reduces the amount of restlessness, which is often so troublesome. Aspirin, 15 to 25 grains, is frequently given with the bromide, but there is evidence that it is not absorbed through the rectal mucous membrane. It is better to withhold morphine until there are definite signs that it will be needed rather than to order its routine administration while the patient is still fairly deeply anaesthetized. But after a varying length of time the necessity for some more potent drug is evident. When these signs appear—restlessness and pain—morphine should be given promptly, so that it will have its effect before full consciousness is attained. The dose needed varies with the patient and the degree of pain, but usually 1/6 grain for adults is sufficient, and this dose may be repeated four-hourly. When this is necessary for any length of time the possibility of starting an addiction must be guarded against, and the morphine withheld unless there is very real need for it and some other drug substituted. Heroin is sometimes given instead of morphine, but its analgesic action does not appear to be superior, while the amount of respiratory depression is occasionally considerable. Its use is therefore better avoided except in difficult cases where morphine produces little relief. In such cases heroin may be more effective. In many operations the pain can frequently

be removed by less potent drugs. The pain after orthopaedic operations, for instance, often yields to aspirin 10 to 20 grains, phenacetin 2½ to 5 grains. This can, of course, only be used in cases where it is likely to be retained.

Local treatment should not be overlooked. For example, the application of heat or cold and the immobilization of a limb in a comfortable position may produce more relief than the administration of an analgesic drug.

VOMITING.

When vomiting occurs it varies in amount from a little retching to copious and persistent vomiting lasting several days and possibly ending fatally. It may follow any anaesthetic in susceptible patients—for example, those who have made up their minds that they are going to be sick and those especially liable to sea-sickness and other such forms. Some patients never vomit whatever anaesthetic is given. Apart from these extremes the incidence and amount of vomiting vary with different anaesthetics, being infrequent and slight with nitrous oxide, more frequent and greater in amount with chloroform, and most with ether. In some instances the preliminary injection of morphine may be responsible, and inquiry should be previously made as to any such susceptibility.

In its milder degrees the vomiting results from the nausea associated with the elimination of the anaesthetic. In the severer and the more persistent cases the toxic effects of the anaesthetic on the liver are responsible, though it is probable that these changes occur in a less degree in the milder cases as well. It must be remembered that causes other than the anaesthetic may be responsible—for example, manipulation of the abdominal viscera, the swallowing of blood after throat and similar operations, and occasionally the use of radium. The possibility of intestinal obstruction and uraemia must always be kept in mind. In most cases no treatment is required, as the condition clears up spontaneously in a short time. Treatment should be directed locally to the stomach, to hastening the elimination of the anaesthetic, and in

severe cases to correcting the metabolic changes, both those producing the vomiting and those produced by it. A large drink of warm water with sodium bicarbonate should be the first thing tried, and is often all that is necessary. It acts by loosening and dissolving the ether-impregnated mucus and producing one copious vomit which clears out the stomach. When sodium bicarbonate is not retained long enough to act properly, a stomach tube should be passed and the stomach washed out with the solution. Tincture of iodine in 1-minim doses hourly should be tried, while half-normal saline is sometimes retained where all else fails. Less vomiting will follow a deep ether anaesthetic if as little ether as possible is left in the patient at the end of the operation. This can be achieved by the administration of carbon dioxide towards the end of the operation, as soon as the peritoneum is closed.

The metabolic changes associated with vomiting are in the direction of acidosis, and result from the toxic action of anaesthetics on a damaged liver, or sometimes on an apparently normal liver if the poisoning is sufficiently intense. Where the liver is known to be damaged, therefore, care should be taken to avoid the use of chloroform, to a less extent of ether, and of more than small doses of barbiturates, using spinal or local anaesthesia if it is thought that general anaesthesia without these drugs would be unsatisfactory. Even when the liver is apparently healthy it must be remembered that lipid-soluble anaesthetics, chloroform especially, can produce structural and functional changes when administered over long periods. This type of vomiting, known by its old name of delayed chloroform poisoning, may start after an interval of a day or two during which there has been little or no vomiting. These disturbances are less likely to arise in a liver well stocked with glycogen, and attention should be directed to this before the operation. Diabetic patients are much more sensitive to these influences, and, quite apart from the question of vomiting, their metabolic equilibrium may be upset by a relatively innocuous anaesthetic. They must be well controlled before

operation, and a close watch be kept on them afterwards, by blood-sugar estimations if necessary, insulin and glucose being given as indicated. In addition, while acidosis induces vomiting, the vomiting if severe will increase the acidosis.

The indications are to make good the fluids and chlorides lost and to supply glucose, and if necessary insulin, for the control of the acidosis, although insulin has probably little influence on acidosis not pancreatic in origin, at any rate in part. The glucose is given as a 5 per cent solution in normal saline per rectum.

SHOCK.

This usually becomes evident while the patient is still in the theatre, and the main lines for its treatment are laid down there. Warmth must be supplied, preferably by an electric cradle, but overheating (indicated by sweating) avoided; and the foot of the bed should be raised on blocks to assist the cerebral circulation. Saline should be given freely, intravenously if urgently needed, followed by a continuous rectal drip. If the urgency is not so great a pint of saline should be run into the rectum and after an interval the continuous drip started. Absorption is slower by this method, but the results are more lasting, and there is less tendency to waterlogging of the tissues and oedema of the lungs. Careful watch must be kept for these. If a suitable donor is available in time a transfusion of 400 to 800 c. cm. of blood, followed by the rectal drip, is best.

OTHER ABDOMINAL COMPLICATIONS

Abdominal distension is often troublesome, and is usually the result of the handling and exposure of the viscera. The anaesthetic may be partly responsible, for chloroform and ether diminish intestinal movement, while in spinal anaesthesia a reactionary period of quiescence may follow the wearing off of the anaesthetic. It is relieved in most cases by the passage of flatus tube or a large rubber catheter through the internal sphincter, or, if this is unsuccessful, by a soap enema with half an ounce of turpentine to the pint. The aperient will make

the patient feel much more comfortable. He should assist by changing his position frequently and contracting and massaging his abdominal muscles if this is not too painful. The distension may be a sign of peritonitis or intestinal obstruction, and diagnosis in these circumstances is difficult.

Acute dilatation of the stomach is a rare but very serious complication. Here the stomach is completely atonic, with frequent and copious vomiting and the patient in a very shocked state. Keeping the stomach empty by aspiration through a stomach tube, and treatment on the lines of toxic vomiting, should be tried, but the condition is usually fatal.

Hiccup may be troublesome, but it usually yields to the administration of carbon dioxide sufficient to produce deep respiration for several minutes. It may return, but it can be treated any number of times in this way. It is extremely wearing and, where all else fails, needs treating by morphine or by crushing of the phrenic nerve.

Retention of urine may follow any

(B.M.J., Oct. 16, 1937.)

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

TEN DOCTORS AND A HEADACHE.

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This is an unusual title for a scientific paper; and yet there is more in this title than is apparent at first glance. Considering that the term "headache" generically means nothing more than a pain somewhere in the head, it is no wonder that it is a baffling symptom which cannot be eliminated by a routine guess of its cause or any old combination of analgesics. The underlying causes in many instances are baffling or complex and even the most thorough preliminary investigation will leave the patient as badly off as ever.

My title was suggested by a recent article in one of the weekly magazines in which a moronic individual was interviewed and was examined by ten different doctors because he had repeated headaches which he couldn't cure by home remedies, even those so widely advertised over the radio. Our simpleton friend saw a doctor's sign in a window and therefore took it for granted that any doctor with a sign could cure a headache. But the three dollars he paid this first doctor didn't relieve his pain nor did the expenditure of other fees to nine other doctors cure it, with the result that he informs millions of people suffering from headaches that no doctor is worth a tinker's dam, when it comes to curing a headache. The only doctor he had any confidence in was the young man who frankly stated, after a pains taking examination, that he had no idea of the cause of his ailment. I haven't the least doubt in the world that anyone would have his pains aggravated after being pawed over by ten doctors, laying out fifty dollars or so for advice that did no good and buying an endless array of medicine which proved to be worthless.

Perhaps someone will say that a topic of this kind should not be discussed in a

specialty journal. I think otherwise because in the majority of cases the patient with a headache is referred to the eye specialist or the otolaryngologist for a thorough examination which may include X-ray pictures of the sinuses or a pains-taking survey of the eye muscles.

Such specialists should not be satisfied with a local examination nor should they jump at conclusions that a local condition is causing all the trouble. If the specialist is up to date, he will inquire into the emotional or nervous instability of the patient. He will note certain physical habits which lower vitality. He will insist upon urine and blood examinations, basal metabolism tests, etc. And surely he will note whether there is any gastrointestinal toxemia which may be partly or wholly causing the trouble.

In our practice, hardly a day goes by without one or more patients presenting themselves with a complaint of headache. They have been referred for a thorough nose, throat and ear examination. In many cases we can positively say that there is not enough local pathology to cause the trouble. But should we stop there? By no means. Let me give two interesting illustrations in children.

A few months ago a physician referred a little girl of nine to us who had severe pain over her right eye at irregular intervals. He thought that the X-ray pictures showed some pathology in her right antrum. Examination of the nose and sinuses was negative. The X-ray pictures were carefully viewed. One could suspect some trouble with the antrum but not enough to cause her symptoms. It was observed that the clinoid processes almost entirely closed the pituitary gland. The child was stripped and examined carefully. One saw an overgrowth of hair in the axillae and in the pubic region. No doubt the headaches were due to a pituitary disturbance.

A citation of the next case is even more important. A few years ago a young boy of fourteen was examined. He complained of excruciating, sharp, lancinating

headaches over the eyes which came on at fairly regular intervals, particularly in the morning. A sinus condition was suspected. But no sinus trouble was found. I insisted on the boy coming down to see me alone so that we could have a quiet talk in the office. The parents were amazed that almost immediately after that talk, his headaches disappeared. The answer? This boy was becoming a chronic masturbator and had to have some interested doctor steer him in the right direction. Do not think that this is a unique experience. Dozens of boys have headaches because they masturbate and once they are taught how to stop the habit, they are cured. One boy had one of the worst suppurative sinus conditions I have ever seen and no amount of local treatment helped until he was told how to stop masturbating.

Every eye, ear, nose and throat specialist should realize that the patient who wishes to be cured of a headache is complaining of a symptom and nothing else which may have a thousand and one causes. If he will keep this in mind, he will try to put two and two together and aim to discover the cause which may be indirectly connected with a local pathology.

In certain writings in the past I have spoken of pseudo-sinus conditions, usually associated with severe headaches. The pain was there; the suspicion was there that one was dealing with a sinus condition. Many of the symptoms were caused by a gastro-intestinal toxemia. I could cite a number of examples but one will do.

A patient who had a great deal of discharge of mucus from the nose, began, to have excruciating, generalized headaches which finally became so severe that no medicines could relieve her. Finally she became unconscious and a tentative diagnosis of a meningeal condition was made. A spinal tap was negative. The blood count was normal. There was only a moderate temperature. One could not be convinced that the sinuses were causing the symptoms so inquiry was made about conditions in the gastro-intestinal tract.

It was discovered that she was habitually constipated and much more so during this recent illness. She was given a high soapuds enema with little results. Three grains of calomel with fifteen grains of sodium bicarbonate, followed six hours later by salts, started the bowels moving. She regained consciousness and for the following week she was given high colonic irrigations daily. Of course proper attention was given to her general and local symptoms. She eventually got well.

It is surprising how few patients realize that their headaches may be due to emotional upsets, their general routine of life, the unsanitary conditions under which they work, poor lighting at work and at home, a formation of bad habits such as excessive cigarette smoking, etc. Such patients will go to ten doctors, perhaps more than ten, with their symptoms and never be cured until they place themselves in a different mood or a different environment.

I am sufficiently versed in psychology to appreciate that emotional disturbances are accountable for a thousand and one physical ailments. Nothing lowers physical resistance more than emotional instability. I venture to say that the moron who wrote the article in that weekly magazine did not have any investigation made of his emotional life. Was he happily married? What were his sex habits? It might be possible that an investigation along these lines might have turned up some trouble which was accountable for his headaches. Recently a young girl who had been suffering from a severe sinus condition which was practically cured, developed symptoms of acute appendicitis with such excruciating pains in the abdomen that she had to be given injections of morphine. A competent gastroenterologist could find no indication of an acute appendix inflammation and so she was requested to have her sinuses examined again. They were found to be normal. Inquiry revealed that the basic causes of her abdominal pain were a misunderstanding with her mother and a severe scolding from her teacher. When she was told how to handle these problems, her symptoms disappeared.

So if a patient consults ten doctors for a headache, he should not speak of the whole medical profession derisively because he still has his headaches. He, like every other human being, is a complex organism which cannot be taken apart and put together again. His symptom may be a freakish one which will baffle the most acute and intelligent physician.

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

SOME EXPERIENCES WITH POSTERIOR PITUITARY SOLUTION IN HERPES ZOSTER.

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The severe pain in herpes zoster is perhaps the most pressing symptom which causes the patient to seek relief. Here the usual methods of therapy including morphine are not as effective as pituitrin in most of the cases.

In 1923 S. N. Vandell was the first to report the results of injections of pituitrin in herpes zoster. He stated that the pain disappeared within a few minutes after one injection and that the eruption involuted in several days.

In 1930 D. M. Sidlick reported a series of fifty-four cases of herpes zoster treated with pituitrin. The duration of eruption varied from twenty-four hours to five weeks. He was impressed by the immediate and marked relief from pain often occurring in even the most severe cases after only one or two injections but he did not state the effect on the lesions nor how many patients, if any, failed to obtain relief.

In 1932 N. D. Niles reported sixteen cases treated with pituitrin and stated that the most brilliant results were obtained in the very early cases. The value of the pituitrin varying inversely with the duration of the disease. He also noted the shortening of the course of the disease.

In 1934 F. H. Gillett stated that pituitrin here is by no means infallible. However, it appears to act more effectively when the pain is most intense.

The commercial preparations of either surgical or obstetrical pituitrin (posterior pituitary lobe extract) are used. Although the former is considered to be stronger than the latter, no difference in the results obtained was noticed. The dosage used was one cubic centimeter and the number of injections and frequency with which they were repeated were governed by the intensity of the pain from which the patients suffered. The injections were followed on infrequent occasions by increased intestinal peristalsis and rarely by trembling of the extremities, etc.

The physiology of the pituitary gland is complex and one can discuss it only abstractly, therefore I do not consider it within the scope of this paper to enter into a discussion of it at large.

The following were the cases observed:

Case 1. Mr. J. F., age 62, came in March 2, 1935, complaining of pain over the right forehead extending toward the back of the right ear and over the entire right side of the head. Right simple mastoidectomy had been performed twenty-five years ago. In view of otherwise negative findings, a diagnosis of neuritis was made and symptomatic treatment given.

Two days later, on March 4, 1935, the patient returned with a typical supraorbital herpes zoster eruption with a few vesicles over the right mastoid area and swelling of the right upper eyelid accompanied by intense pain. For the next two days the treatment consisted of aluminium acetate compresses, infra red heat, sodium iodide by mouth and morphine for pain. Since the above measures were insufficient in controlling the pain, pituitrin was given in addition. On March 6, 1935, 1 c.c. of the surgical pituitrin was given hypodermically. Immediately following the injection the pain began to subside and a few minutes later it was entirely gone. The patient became nauseated and vomited. His blood pressure which was 140/80 before the injection did not change. The next day the injection had to be given twice, at 11:00 a. m. and 8:00 p. m. On the following two days one injection a day of 1 c.c. was sufficient to control the pain.

This time no reactions were observed except the immediate cessation of pain. Thenafter the patient was left with a parasthesia which gradually disappeared with the abatement of the disease in the next three weeks.

Case 2. Mrs. N. B., age 55, came in May 18, 1937, complaining of a burning and shooting pain of the right side of her head particularly over the right temple, in the right ear and jaw of two days' duration. The usual ear, nose, throat and dental examinations were undertaken.

Meanwhile, the next day, the patient developed the typical supraorbital herpetic eruption with involvement of the upper eyelid and complained of severe pains. In addition to the palliative measures, the pituitary therapy was given with the same results as in the first case. The pain subsiding immediately after each injection. Five hypodermics, each given once a day for five successive days were administered until May 23, 1937. The patient's blood pressure did not change; however, after each injection the patient had to have a bowel movement. The disease lasted four weeks abating in the usually gradual manner.

Conclusion.—Although the pituitary therapy (posterior pituitary lobe extract) is not infallible according to many observers, it certainly is dramatically effective in controlling the pain in herpes zoster in many cases and therefore is a valuable asset to the physician in his attempt to relieve pain in this disease.

—*The Journal of Medicine, Feb., 1938.*

GASTRIC ACIDITY IN HEALTH AND DISEASE IN INDIA.

Napier, Chaudhuri and Chaudhuri tabulated the results of all the gastric analyses that had been done in the Tropical Diseases Hospital during the last 18 months; some of these patients were suffering from anæmia, others from gastrointestinal disturbances, and yet others were persons undergoing a routine examination for symptoms unconnected with the gastro-intestinal tract. The alcohol test meal was used in this series of cases.

One hundred c.cm. of a 7 per cent. alcohol solution in distilled water were used as the 'meal.' After the fasting contents have been withdrawn, the meal was injected and subsequently samples of the contents, about 10 c.cm. were obtained every fifteen minutes up to a maximum of 10 specimens. The biochemical investigations were carried out in the usual manner by titrating a measured volume of each specimen in turn against a decinormal caustic soda solution, using Topfer's reagent as the indicator.

They summarise as follows:—The current belief that the gastric acidity in Indians living in the tropical and sub-tropical parts of India is lower than that of Europeans living in temperate climates has been shown, by recent investigations on normal Indians at the Calcutta School of Tropical Medicine and elsewhere, to be incorrect. Fractional gastric analysis with alcohol as the test meal, was done in 209 hospital patients suffering from a number of different diseases. The series was a mixed one as regards race and sex. The standards which we adopted arbitrarily for applying the terms hyper and hypochlorhydria in individual cases are slightly higher than those used by British Physicians. Amongst their hospital patients, Europeans show the highest mean acidity and the highest incidence of hyperchlorhydria. Bengalis come next and the lowest acidity is seen in 'other Indians' most of whom were Punjabis; the latter group showed by far the highest incidence of achlorhydria. The significance of this is not clear. The Bengali group included by far the largest percentage of vegetarians who were all rice eaters.

It is known that in S. India rice eaters are notoriously liable to peptic ulceration and that the wheat-eating Punjabi is much less so, but this does not explain the high incidence in the meat-eating European; most of these were well-to-do and possibly the high incidence of hyperchlorhydria in this class was a sequel to alcoholic and dietary indiscretions and the accompanying gastritis.

Achlorhydria is not common in non-anæmic persons in India; the incidence is

apparently, as far as can be judged from the literature, about the same or a little lower than that in Europe and America.

Hyperchlorhydria occurred in 16.3 per cent of men against 6.4 per cent of women, and achlorhydria in 10.2 per cent. of men against 17.7 per cent. of women; the difference is not statistically significant in either case.

Hyper-acidity is more common in the higher age groups. The highest incidence of achlorhydria occurred amongst patients diagnosed as anæmia; this is the universal experience but only one case of true pernicious anæmia was included in the series.

When the cases were analysed according to the symptoms there were noticeable associations between epigastric pain and high acidity, and diarrhoea and low acidity respectively. The 'acid peak' occurred early, about three-quarters of an hour after the 'meal,' in all groups; this can probably be accounted for by the more rapid action of alcohol, as compared with gruel, in stimulating acid secretion.

In only a few instances was there initial fall in the acid curve in the European group, in the other groups this initial fall was more frequent. The amount of 'fasting' gastric secretion was higher in men than in women, the mean being 35.7 c.cm. in the former and 29.0 c.cm. in the latter. The amount of 'fasting' gastric secretion was 'significantly' higher in the hyperchlorhydric cases; this is the usual finding.

(*Indian Medical Gazette*, Feb. 1938)

INFLUENCES OF TONSILLECTOMY ON RHEUMATIC INFECTION.

Tonsillectomy is widely recommended for the prevention and treatment of rheumatic infection, though not all clinical observers have been impressed with the value of tonsillectomy, Ash has analysed 522 cases of children, treated at the Children Hospital between 1922 and 1936. She finds that tonsillectomy did not prevent recurrences of rheumatic manifestations. Neither the presence nor the absence of tonsil at the time of the initial infection nor the removal of tonsil subse-

quent to the onset had any demonstrable influence on the incidence of cardiac involvement or the death rate, due consideration being paid to the associated variable statistical factors. A high incidence of rheumatic exacerbations followed immediately on tonsillectomy performed early in the course of the disease. Tonsillectomy for the rheumatic child seems to be indicated only when there is definitely evidence of disease in the tonsils and not as a routine procedure. The operation should be performed only during an inactive phase of the infection. Associated with the absence of other symptoms, the combination of a normal temperature curve and a normal sedimentation rate of the erythrocytes may be taken as indications of an inactive phase.

(*American Jn. of Diseases of Children*, Jan. 1938.)

CATARRHAL CONJUNCTIVITIS

A solution or ointment of 2 per cent quinine sulphate has been found useful in this condition. The conjunctival infection decreases by one-half within a couple of days, on the average. Exudates from the eye so treated are found to be sterile after one week. The solution is somewhat slower in action than the ointment.

ACUTE PURULENT SINUSITIS

One of the important factors in the treatment of this disease in infants and young children is to eliminate allergic factors. Locally: toilet of the nose, by suction or irrigation followed by vasoconstrictors and mild antiseptics, is of value, together with general pediatric treatment, rest in bed, diet and proper hygiene.

OTITIS EXTERNA

The treatment of this condition involves three factors, namely, (a) cleansing of the affected part as thoroughly as possible, (b) the application of some form of non-irritating germicide, and (c) protection from further irritation and infection. Vaccines, light therapy, and X rays are to be considered as valuable aids.

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MADRAS MEDICAL BUDGET.

ASSEMBLY MEMBERS' CRITICISMS.

Now that the Indian provinces are under popular Ministers elected by the people the criticisms coming from the people's representatives may be fairly taken as the opinion of the people. The Budget session of the house or houses of Legislature is the time when the peoples' representatives have opportunities of criticising the Government for their policies. Advantage is also taken during the Budget debate for ventilating the grievances of the people. For several reasons chief of which was the overwhelming majority of the Congress members in the Madras Legislative Assembly, the Budget session in Madras was much tamer than was the case in the past. If a member fortifies himself with facts and figures and has sincerity and tenacity of purpose whatever might be the strength of a party in power he would be able to make himself felt. The sins of omission and commission relating to people's demands have been accumulating in the past and an organised party which made a capital of the woes of the people has come to power. On account of solid strength in numbers there comes a subconscious feeling in those who are in power that what they have in mind is the best for the people whom they sway. Some amongst them are likely to exhibit impatience and intolerance to the views that are against those cherished by them and instead of winning those with whom they differ by persuasive arguments, make the position of those who do not agree with them

uncomfortable by the heat of the power. We were very much relieved to read the speech of the Hon'ble Dr. T. S. S. Rajan, in reply to the criticisms levelled against the Government by the members representing a variety of interests not excluding the communal. The Minister could not be provoked even when a member opposite thought it fit to make a personal remark that Dr. Rajan was 'exacting' in his 'professional capacity'. Though the popular Ministers of Madras have notified that they are easily accessible to the people, it will be a wise thing to see and address them in meetings and conferences if the purpose of meeting them is a public one or of public importance. Naturally the popular Ministers are so much engrossed with a desire to do the maximum good to the people that private talks on public matters are likely to be misunderstood. We wish the members of the scientific medical profession either here or else, where realise this aspect of public life and meet the Public Health Ministers in as many conferences and meetings as they can possibly convene and before doing so prepare themselves how they should address the Ministers in public and professional matters. The Public Health Minister of Madras is being requested to attend gatherings of medical men and we would like that those who are responsible for such gatherings have useful programme for redressing the grievances of the profession. The debate and its psychology on the floor of the Madras Assembly should be studied by the members of the profession so as to be able to earn maximum good during the regime of a

medical man as the Public Health Minister, not forgetting that popular Government has and must depend upon popular opinions.

The Honorary System of Medical Relief as recently re-organised and extended by the Government came in for criticisms in a large measure and majority of members who took part in the discussion of Medical Budget made some remark or other. The member who talked first disfavoured the idea of the Government in encouraging caste system even in Honorary Service by allocating only one grade of honorary service to one particular class of practitioners. Some expressed doubts if the Scheme would be a success especially when the Honoraries were offered a very small honorarium and went even to the extent of suggesting that there would be more room for corruption. Very sensible remarks were made by a member belonging to the medical profession. He said:

"Sufficient opportunity was not given to the public to consider the honorary medical service scheme. He was of the opinion that the work of purifying some of the medical institutions ought to have been undertaken before the introduction of the scheme. The Government had made a 'great mistake' in introducing the system hastily. 'The unwholesome and unequal competition' that had been going on between the State-paid practitioner and the private practitioner had been hampering the growth of a healthy independent medical profession. As long as the independent profession was not above want, the introduction of the honorary system was 'fraught with danger'. The actual working plan of the present honorary system was less progressive than that of the system introduced some years ago. The honoraria were too low and would surely lower the profession in the eyes of the public. The selection and the allocation of duties to these honoraries had been assigned to the District Medical Officers, and this was an 'unnatural' procedure."

It was also suggested by this member and one more that the selection of Honoraries should be entrusted to senior members amongst the private practitioners, suitable committees being appointed by the Government for this purpose.

A few members said that the policy of the Government should be more liberal in recognising and extending the scope

of Indigenous systems of medicine and a suggestion was made that the Government should convert the Stanley Medical School into an Ayurvedic College instead of another College to teach Western System of Medicine. The claims of Homoeopathy were claimed by another member. A lady member pleaded for the training of more nurses and midwives while a Muslim member wished that the Government should have more Mohammadan doctors in service. The closing down of the Lady Wellington Medical School was severely criticised by a Muslim Member who desired that girls should have an institution for themselves so as to encourage them to take to medical profession in larger numbers.

Principalship of the Madras Medical College was also a subject of comments by one member who accused the Government for reverting to 'the old policy of placating the Indian Medical Service'. He contended that nothing could prevent the Government from appointing an Indian to the post of Surgeon-General.

One of the members representing labour complained that the medical staff employed in hospitals was not adequately paid.

Subsidized Rural Medical Service did not escape the notice of the members and the medical member's criticisms were as cogent as they were real.

"Referring to the conditions of the Subsidized Rural Medical Practitioners who had an important part to play in rural reconstruction he said it was an ideal system of honorary service for which every encouragement should be given. But they were now under triple control. They ought to be made to serve only one master. The policy of asking such practitioners to hand over the dispensaries to the local fund authorities justifiable and was against the spirit of the scheme."

The Minister's reply was more accommodating than convincing. Yet it has to be said that he displayed a keen desire to meet the criticisms levelled against his policy. The significant fact that none of the criticisms raised by a medical member of the Assembly were touched by the

Minister is likely to disappoint the members of the medical profession. The Honorary service which the Minister has in contemplation with a low honorarium is one of a very high order and which doctors of as high and religiously charitable temperament can undertake to do and unless the environment of the Government charitable institutions is substantially changed to suit the ideals of honorary service, the infection of corruption complained of by the public in State hospitals is likely to spread and bring the noble profession to disrepute more than what one sees at present. The Minister's plea that corruption in hospitals which had been an abuse for a long time could not be put an end to by the Government is not only most disappointing but is likely to increase corruption in hospitals and his assurance that the Government could spare no effort in seeing that poor people in the hospitals were treated well, would not have practical effects as the poor would not be able to stand the demands from the ward boys, leave alone the rest who demand money for service in the hospitals. If the unwholesome and unequal competition between State-paid practitioners and private practitioners referred to by the medical member of the Assembly, was not checked, the private practitioners who wish to take up honorary service and who have to depend upon only on private practice outside hospital, will certainly find it difficult to keep their body and soul alive and a tendency will be forced on their souls either to leave the body or the bodies will refuse to listen to the dictates of the souls. The Minister has been a practitioner himself and it will not be difficult for him to realise how difficult it is for practitioners these days to get their legitimate dues from the patients and the position of the majority of practitioners is such that they cannot exact. So, side by side with the extension of Honorary Service, the Minister should devise means to stop corrupt practices in hospitals. This can only be done by having recourse to Almoner System. The eventuality referred to by the Minister in his reply that he would stop the Honorary system if found unsatisfactory in its working will not arise if the Govern-

ment take up the suggestion made by the medical member of the Assembly.

Regarding the Indian System of Medicine the Minister pointed out that there could not be any conflict between these systems and the Western system with the only difference that the latter had made rapid strides scientifically while the former did not. This view of the Minister can be translated into action by him by finding ways and means of amalgamating all systems into one Scientific system. This is certainly possible for the popular Government now on the saddle with the Hon'ble Dr. Rajan as one of its important units.

In regard to recognition of Homoeopathy by the Government the Minister rightly asked its votaries first to establish Homoeopathic Colleges on Scientific lines and then demand its recognition. The Government of Madras have recognised this system by permitting Local bodies to run Homoeopathic village dispensaries. The next step would be to start a College or School. This depends upon its votaries. If the Assembly has a majority of such votaries, the Government cannot say 'No' to their demand. Homoeopaths have been agitating persistently for their recognition by the Government not only in this province but all through India. In other countries the aim of votaries of medical systems is the recognition of their systems by the people. In India it is the Government that is asked to recognise them. Either now or in the future, will it be possible for any Government in India to recognise all the existing Systems and run hospitals and colleges at the cost of public funds however accommodating the party running the Government may be to satisfy their political opponents. There can be only two courses open to the Government—the one is to continue their present policy of the entire control of medical education and medical practice of all systems under their control or allow the votaries of particular systems to control these systems themselves, the Government taking care that only qualified practitioners of particular systems

practise these systems. We have been advocating the latter policy in the interest of the variety of systems existing in this country and more on financial grounds. The present policy of the Government relating to the encouragement of indigenous systems, imparting to the students of indigenous systems a smattering knowledge in Medicine, Surgery and Midwifery on Western lines is certainly against the healthy growth of the scientific as well as Indigenous systems of medicine. The Minister repeated on the floor of the Legislative assembly his favourite idea of 'synthesis of all the systems—Ayurvedic Allopathic and Unani' but either here or elsewhere, he had not as yet explained how this synthesis could be brought about. If by synthesis the Minister means starting of teaching and treating institutions for all the existing systems by the Government, it will be a political synthesis and not a scientific synthesis. Politics is a science of good Government and exists for the welfare of the people and the welfare of the people depends entirely on the good health of the people and the latter cannot exist without Scientific medicine. So the aim of the Government should be the evolution of Scientific medicine and the members of the medical profession of whatever system cannot help such an evolution of Scientific medicine because the Government has been running the show of all the systems themselves.

BOMBAY MEDICAL PRACTITIONERS' ACT.

The Hon'ble Dr. M. D. Gilder, Minister of Public Health introduced a Bill in the Bombay Legislative Assembly on 29-3-38 to regulate the qualifications and providing for the registration of practitioners of Indian Systems of Medicine. The statement of objects and reasons runs thus:

"For some time past there has been an insistent demand from the Public in this Presidency for the recognition by Government of the Ayurvedic and Unani systems of medicine, and repeated representations have been made to Government for the adoption of legislative measures to remove the disabilities from which the practitioners of these systems of medicine

are suffering at present. The object of the Bill is to provide for the registration of such of the indigenous medical practitioners as have had a full scientific training in the Ayurvedic and Unani systems of medicine and to protect the public from the activities of uneducated and half educated quacks of all systems".

The Bill consists of three parts. They are: Title and extent, Indian Systems of Medicine; and medical practitioners in general. The items of the Bill relating to the constitution of the Board of the Indian Systems of Medicine are more or less the same as those appearing in the existing Provincial Medical Acts including the rights and privileges conferred on the practitioners by virtue of registration. In fact there will be no distinction between the Registered practitioners already existing and the practitioners to be registered under the new Act.

The question naturally arises whether there was any need to bring into existence another Act for registering the practitioners of Indigenous Systems of medicine if the Hon'ble Public Health Minister of Bombay considered that the existing practitioners of Indian Systems and those that would pass the tests to be prescribed by the new Board of Indian Systems of medicine could come to the standard of the practitioners now in the provincial register of Bombay. The best thing for the Minister to do would have been to amend the Bombay Medical Registration Act giving adequate representation to the practitioners of the Indigenous systems and maintain one omnibus register. Such a policy would have been more consistent with the Congress principles of economy and would have satisfied the political purpose of the Government recognising the Indigenous systems of medicine. It is indeed a sad irony that a highly qualified medical practitioner in the person of the Hon'ble Dr. Gilder should have thought it fit to bring into existence a rival medical register in Bombay when he was himself one of the parties to agree at the Conference of Public Health Ministers held in Madras last December that there should be one uniform standard of medical

education. The irony looks to us quite strange when we recollect the opinion expressed recently by the Hon'ble the Public Health Minister of Bombay to the representatives of Maharashtra and Karnataka Medical Conference. He told them that he found the practitioners of Indigenous Systems of medicine adopting 'Allopathic lines' of treatment and 'Western methods of diagnosis'. The effects of this hasty enactment would be in practice detrimental to the very objects mentioned in the preamble of the Bill. The Bombay Presidency will have more quacks recognised by Law. For, what else will the practitioners of Indigenous Systems be if they resort to Western System?

The majority of the laymen of the Bombay Legislative Assembly are not likely to apprehend the danger of this Bill. All the same we are glad to note that the leader of the opposition though he congratulated the Minister in bringing forward a measure to prevent quackery, pointed out to the Minister that the Act to be enacted would not succeed in ridding the province of the activities of the quack. On the other hand he said that the provision to give recognition to persons who have been in practice for ten years prior to April 1938 would give a status of protection to those against whom the Bill was directed. He wanted the Government not to halt half way but root out the evil of quackery of every kind. If the leader of the opposition knew what the Hon'ble Dr. Gilder said to the representatives of the Medical Conference referred to above he would have certainly hesitated to approve the very preamble of the Bill.

The Bill would have been less objectionable and in conformity with the action taken by the provincial Governments of Madras, Bengal, and United Provinces in regard to encouragement of Indian systems of medicine if Part III was not added to it. The clauses in Part III gives the practitioners equal rights and privileges with the practitioners of scientific system of medicine. One of the members of the Assembly did move for the deletion of the

whole Part III of the Bill. There was at least one member in the Bombay Assembly, a qualified doctor practising in Bombay City who expressed the feelings of the profession "that it was an irony of fate that the Bill should have been introduced by a doctor who possessed eminent foreign degrees. If until now any doctor whose name was on the register maintained under the Medical Act of 1912 encouraged anything outside the system of Allopathy, under medical ethics he was considered to be guilty of infamous conduct. Now, the Minister had taken a really bold step. Times had changed and one had to change with the times." The aim of the Government whether in Bombay or elsewhere should be to develop Indigenous system of medicine on Scientific lines. This could have been done by the Bombay Government and may be done by other Governments if the time, energy and money they spend for creating Boards of Indian Systems of Medicine and in starting rival teaching and treating institutions of various systems of medicine, are utilised for creating special chairs to teach indigenous medicine in the existing medical schools and colleges of Western System. Quackery might have been safely controlled and the existing practitioners of Indian systems might be allowed to practise if the Bombay Government brought into existence a Licensing Board consisting of representatives of all the systems not excluding those belonging to the Western System. This Board might have been empowered to grant licenses to such of those who wish to practise any system of medicine and to have disciplinary control over them. We are told such Licensing Boards exist in Siam and Portuguese India.

We have no doubt that the Bill would neither stop quackery nor encourage the development and growth of Indigenous System of medicine on Scientific lines. The Bill may perhaps sop a few guileless and well-meaning members of the Assembly by the false idea of safety from quacks and as false a suggestion that the Indigenous Systems are likely to be encouraged. We warn all such persons that they are likely to be disappointed.

The immediate effect of this measure will be the bolstering of the practitioners of the Indigenous Systems either by themselves or by others who will with authority deceive the public more than they do now by saying that they know not only Indigenous medicines but also Allopathy. This is what we see in Madras and Hon'ble Dr. Gilder needs no evidence for he himself was a eye witness to what was happening in Bombay in regard to the practitioners of Indigenous Systems even before the introduction of the Bill.

The scientific medical profession will suffer materially on account of unhealthy and dishonest competition. The specialists among them are not likely to feel the competition until the Board of Indian System of medicine institutes specialist courses also. The members of the Scientific Systems of medicine in Bombay feel perhaps helpless even to suggest constructive criticisms as the originator of the Bill is one amongst them. They may also feel they will be misunderstood by the public if they oppose the Bill. The Indian Medical Association should come to the rescue of the Scientific profession. Is it too much for us to suggest that the Bombay Branch of the Indian Medical Association may request Dr. B. C. Roy the President of the Indian Medical Association to save the profession and the public from the effects of this Bill? It is a fortunate circumstance that Dr. B. C. Roy is a staunch Congressman and his words are likely to have effect on the Bombay Government. It may also be said that he favours encouragement of Indian Systems of Medicine. All the members of the scientific system of medicine cannot for a moment say anything adverse against these systems but they question the ways and methods of the Government either in Bombay or elsewhere to encourage these systems on non-scientific lines.

2nd ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS, BOMBAY.

The Bombay Obstetric and Gynaecological Society organised the second All-India Congress in Bombay under the

leadership of Sir. Mangaldas V. Mehta, Principal Medical Officer of the Nowrosjee Wadia Maternity Hospital, who was the Chairman of the Reception Committee. Dr. B. D. Mukherjee, Professor of Midwifery Carmichael Medical College, Bombay, presided over the Congress and the Hon'ble Mr. B. G. Kher, the Premier of Bombay opened the Congress.

The Chairman, Reception Committee after welcoming the distinguished visitors mentioned some of the activities of the Bombay Society which was started in 1933 and then traced the origin and growth of Maternity work in Bombay which Sir Mangaldas Mehta said was not given much attention till about 30 years ago. According to the statistics collected by Sir. Mangaldas Mehta, there are at present 14 public and free institutions with 468 beds. The number of semi-charitable institutions is 8 and these have 155 beds while the paying nursing homes are 61 in number with an accommodation for 677 beds. Thus the total number of all maternity institutions is 83 with 1,308 beds. The total number of births registered during the year 1937 was 37,795 out of these 27,758 were delivered in the maternity institutions showing a percentage of 73.4. He also said that the maternal and infant death had been going down steadily, the former being 4.4 per 1,000 and the latter 245 per 1,000 in 1937. Reference was made to the comprehensive health and nutrition enquiry undertaken by the Infant Welfare Society of Bombay which Sir Mangaldas Mehta said was nearing completion and the report would be available in the near future. Mention was made of the researches conducted in Bombay by 4 members of the Society (1) Dr. S. B. Anklesaria on the subject of Rabbit Ovulation Test, (2) Dr. De Sa in the causation of foetal and maternal Dystochia, (3) Dr. Purandare on the location of anterior shoulder and its importance in the diagnosis and management of labourer and (4) Dr. Miss Jhirad on investigation of Maternal Mortality. Sir Mangaldas Mehta wound up his address by pointing out to his audience the three most important causes of maternal morta-

lity—Puerperal Sepsis, Toxemia of Pregnancy and Anæmia and appealing to those present to make diligent and proper use of their knowledge and skill in relieving human suffering.

The President first invoked the blessings of Almighty on the Congress. Dr. Mukherjee expressed his gratitude and that of the profession to the Madras Obstetric and Gynaecological Society for having conceived the idea of organising the first Congress in Madras two years ago and eulogised the activities of the Bombay Society who invited the second Congress to that City. He said that the purpose of such gatherings could not be served by sporadic activities of a few individuals, the action must be a concerted one and the purpose should be to understand 'one of the most fundamental aspects of Nature viz., the Procreation and Preservation of Species'. He quoted a verse from the Bhagavath Geeta and said:

"The whole Universe is Brahma Jagna and we, the created, are as it were, the servants of Brahma, the Creator sent here to carry out His Will in our respective spheres of life."

He said that the goal of the Congress should be the 'ensuring the future greatness of India by laying the foundations of millions of happy homes throughout the length and breadth of this vast land'. He then reviewed the existing poverty of masses, the dangers of the 'indigenous Dhai' and pressed the necessity of the general practitioners knowing the up-to-date knowledge in obstetrics so as to enable them to discharge their responsibilities effectively. Dr. Mukherjee referred to the over-crowding of specialists in Cities and pointed out the necessity of the Government throwing upon the State-hospitals to specialists in the mufussil area so as to enable them to get up-to-date knowledge. In the task ahead Dr. Mukherjee enumerated several items of activities such as training and registration of midwives, rural maternity centres in addition to maternity centres in district and sub-divisional towns. He also pressed the need for re-organisation of State-managed and private-managed hospitals so as to provide facilities for the specialists to

work and conduct research. He pleaded that the specialists should be paid subsidies for the work they do in State Hospitals. He advised the senior specialists to be more liberal in the allocation of duties to their juniors so as to make them self-reliant. He pointed the present tendency in big Cities of the over-crowding of the maternity hospitals due to the public realising the benefit of efficient scientific relief in maternity work and this he said could be avoided if the State equips the mufussil maternity institutions with specialist staff and other conveniences provided in City hospitals. He was against the present policy of the Government of entrusting the control of maternity and child welfare work to the Public Health Department. In fine, the gist of the Presidential address was that without State help nothing appreciable could be achieved in Obstetric and Gynaecological work. Dr. Mukherjee concluded his address by appealing to the Delegates about the necessity of starting immediately an Indian Journal of Obstetrics and Gynaecology. He also wished that propaganda should be conducted in educating the women-folk by means of pamphlets in popular languages and that domestic midwifery should be taught to girls in Schools and Colleges.

The Hon'ble Mr. B. G. Kher, the Premier before declaring the Conference open recapitulated what all was said by Sir Mangal Das Mehta about the growth of maternity institutions in Bombay and said that the City of Bombay was enjoying an unique privilege of having one bed for 300 confinements, compared with the ratio of one bed for every 1,102 confinements in the whole province. The Premier said that the public in recent years had been cultivating the hospital habit and there were complaints that some of the private institutions were not kept up to the required standard and that the Government wished to introduce a system of inspection and supervision of maternity homes. In conclusion he appealed to the doctors present that they should place at the disposal of their motherland their skill, knowledge and

service. The Premier concluded by saying:

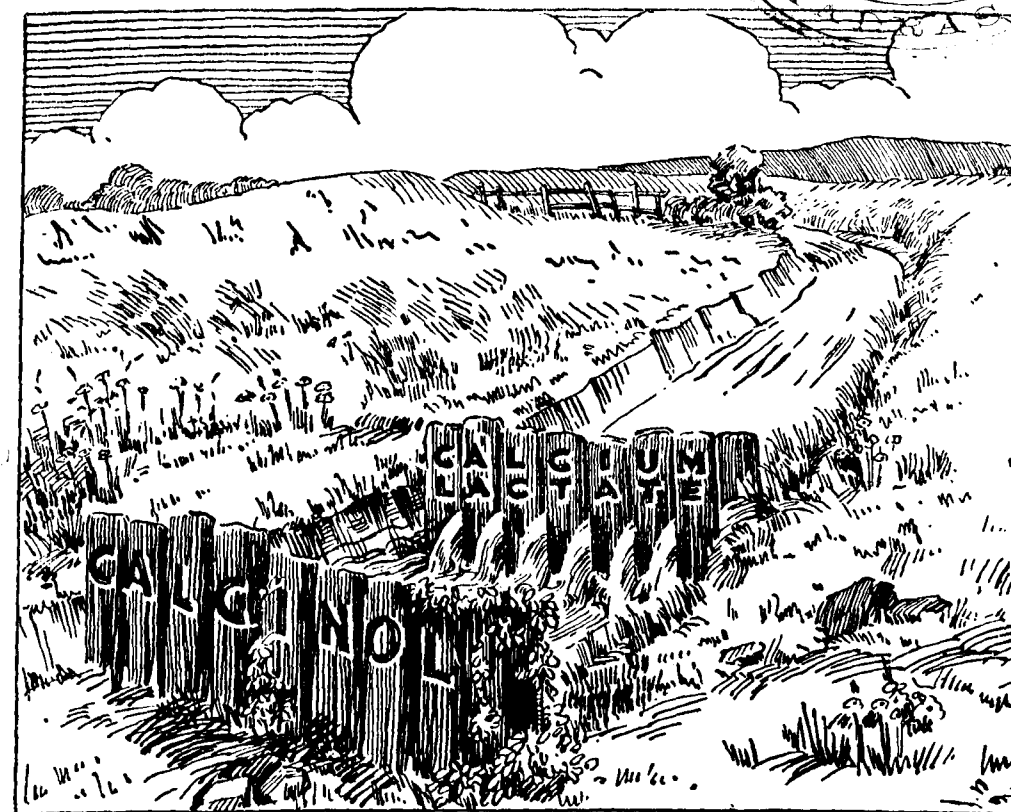
"In a country where nearly 50 millions are badly nourished and almost starving, you can well understand its plight. I appeal to you to place at the disposal of your motherland your skill, knowledge, and service. It is the spirit of service, not the love of wealth, that should dominate a noble profession."

Some at least among the Obstetricians and Gynaecologists that met in Bombay must be aware of a heated controversy going in Great Britain between the specialists and the general practitioners about their knowledge and skill in the practice of this special branch. Many general practitioners hold that what was taught and learnt by them in the medical schools and colleges was enough to enable them to handle all sorts of cases in midwifery practice and if the specialists thought that the general practitioner was found defective, the fault must be laid at the doors of the teaching institutions. Nobody can deny the skill of persons who do nothing else than that in which they display their skill. To get such skill special hospitals are the only places. There is now a tendency to believe that operative skill alone is a speciality in a particular branch of medical science. No practitioner in whichever special branch of medicine can claim speciality unless he has a thorough knowledge of medicine. Ante-natal, post-natal or any work connected with 'Procreation and Preservation of Species', cannot be conducted with success by a practitioner unless he is an experienced physician. So the cleavage in the profession caused by specialists is artificial and should be guarded against especially in a poor country like India where a medical practitioner should know all about all specialities so as to be able to select his cases at least to be sent to ideal specialists in time. We are glad to learn that the Obstetric and Gynaecological Society of Bombay do not make any difference between a specialist and a general practitioner in the matter of membership of the Society.

The President of the Congress who laid much stress on the responsibilities

of the State to develop maternity service to satisfy the needs of the people would have, we hope, realised after he heard the Hon'ble Mr. B. G. Kher that the Profession would do well to depend up on itself more than anybody else to render as much service as they can to the suffering humanity. The need is for the profession to organise itself as efficiently as it is possible and demand from the Government to hand over the charitable institutions to the profession. The next best alternative would be for the Government to socialise the Government as well as the medical profession. As it is there is enough chaos in the medical profession and this chaos would be much worse after the passing of the pet Bill of the Hon'ble Dr. M. D. Gilder to regulate the qualifications of the practitioners of the Indigenous Systems of Medicine.

An Apology: As The Medical Practitioner is keen on guarding the interests of the members of the scientific medical profession uniformly in all the provinces in India, the territory of its activities, we do not miss any opportunity coming to our notice which we feel should be made an item of discussion. This is why we have been publishing the proceedings of the Madras Medical Council in detail to enable the readers to compare and contrast the activities of the Medical Councils in all the provinces. The fact that the Madras Government has taken up the work of amending the existing Medical Act and the members of the profession in other provinces are interested in the reform of the provincial Medical Councils, persuaded us to publish the proceedings of the Madras Medical Council in detail. The Indian Medical Degrees Act has been defective to prevent the quacks assuming recognised medical qualifications and the recommendations of the Madras Council to the Local Government have also been published in the Correspondence Columns to serve as a model to other provinces. The Scope of The Medical Practitioner is such that we have to limit only fixed number of pages for each edition. We therefore regret we had to omit Comments on News made available to us to which we shall do justice in the next issue.



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Madras Medical Registration Act

(TO BE AMENDED).

Minutes of the Extraordinary Meeting of the Madras Medical Council dated 18th November 1937 to consider the amendments :

The Council resolved to consider serially: the proceedings of the Special Committee of the Madras Medical Council held on 30th October 1937, regarding amendments to the Madras Medical Registration, Act :

1. That the President be nominated by Government for the first four years after which period the President be elected by Council. Carried, Dr. V. Rama Kamath dissenting.

2. That the Madras and the Andhra Universities continue to elect the representatives, one for each University, as they do at present. Carried.

3. That clause (c) to section 5 of the Act be deleted. Carried.

4. That each Medical College in the Presidency elect and return one member to the Council.

The amendment of Lt.-Col. C. A. F. Hingston to substitute the words "each Medical College Council" for the words "each Medical College" was lost.

Dr. T. Satakopan's amendment to substitute the words "each Medical College and the hospital teaching staff" for the words "each Medical College" was also lost.

After some discussion, the following was put to vote from the chair :—

"That the teaching staff of each of the Medical Colleges in the Presidency elect and return one member to the Council." The motion was carried.

5. That two members, one from men and one from the women medical school, be elected to the Council,

Dr. V. Rama Kamath proposed that in place of the above, the following may be substituted :—

"That two members, one from men and one from the women medical schools, be elected by the teaching staff of the respective medical schools and returned to the Council". Carried.

6. That the existing parts of the Medical Register be combined into one and the names of the Registered Medical Practitioners be arranged in alphabetical order. Carried.

7. That seven members be elected by the total electorate of Registered Medical Practitioners.

The amendment proposed by Dr. U. Krishna Rao and seconded by Dr. V. Rama Kamath that the word "ten" may be substituted for the word "seven" was lost. The original resolution of the Special Committee was, therefore, carried.

8. That the system of transferable votes be introduced in the above election. Carried.

9. That the number of seats for nomination by Government be restricted to three. Carried.

The amendment proposed by Dr. V. Rama Kamath and seconded by Dr. U. Krishna Rao that there should be no nomination was lost.

10. That clause 3 to section 8 of the Act be deleted. (This relates to the vacation of seat by a member if he is absent out of India for six consecutive months.)

11. That clause (a) of section 13 of the Act be deleted and all the qualifications registered under the British

Medical Act be mentioned in the schedule at the end. (This relates to the automatic registration of all those found in British Register Vide Dr. V. Rama Kamath's resolution No. 1, referred to in the review of the Proceedings of the Madras Medical Council, September 1937 Session.)

12. That section 17 (1) of the Act be deleted and the following be substituted :—

17. (1) An inquiry under section 13 or section 16 may in the first instance be held by the Preliminary Committee or Disciplinary Committee consisting of three members, annually elected by the Council who shall consider the matter and submit a confidential report to the President as to whether further proceedings should be continued under section 13 or section 16 of the Act or not.

(2) If the Preliminary Committee or Disciplinary Committee be unanimously of opinion that all further proceedings be dropped, and the President agrees with their opinion, he may direct that further proceedings be dropped. This decision shall be deemed to be the decision of the Council. In all other cases further inquiry shall be started by the Council.

(3) The Council or the preliminary or Disciplinary Committee, as the case may be, may, at its discretion, hold such inquiry in camera.

Re-number the existing section 17 (2) as section 17 (4). Carried.

13. That the words "before the Council" be deleted and the words "before the Committee" be substituted in the last line of first paragraph of rule 4 (1) on page 28 of the Medical Registration Manual.

That the second part of rule 4 (1), viz., (a), (b) and (c) be deleted and the following be substituted as rule 4 (2) :—

"The preliminary Committee or disciplinary Committee elected under

section 17 may then inquire into the matter and submit a report to the President who shall decide in conformity with section 17 (2) as to whether further proceedings should be instituted under section 13 or section 16 of the Act or not. If the case is one in which further inquiry under section 13 or section 16 of the Act ought to be held the President shall order further inquiry and direct the Registrar to take steps for the institution of the same and for having the case determined by the Council."

That the third part of rule 4 (1) be retained.

That the existing rule 4 (2) be deleted.

14. That the declaration and the voting paper be printed in separate sheets of paper (referred to in page 26 of the Manual), and consequential changes be made in the instructions issued with the voting paper, so that the declaration paper be kept outside the voting envelope in the addressed envelope. Carried.

15. That section 11 of the Madras Medical Registration Act, 1914, be renumbered as section 11, sub-section (1) and that the following be added as section 11, sub-section (2) :—

To enable the Registrar to fulfil the duties imposed upon him by sub-section (1) above, he may send through the post an unregistered letter to any registered practitioner addressed to him according to his registered address, to inquire whether he has ceased to practise or whether his residence has been changed; and if no answer to any such letter is received within a period of three months, from its despatch, the Registrar shall send a registered letter and after the expiry of a further period of three months, erase the name of such registered medical practitioner from the Register, and report such erasure to the Council at its next general meeting for record. Provided that any name erased under this sub-section may be re-entered in the Register under the direction of the Council, upon payment of a fee of rupees five. Carried.

16. That the Government be requested to suitably word the Act and the rules thereunder in the light of the above resolutions for amending the Act. Carried.

Dr. V. Rama Kamath's dissenting minute to the Report of the Special Committee was taken up by the Council for consideration. Dr. V. Rama Kamath's dissenting minute:

With due regard to the conclusions arrived at by the majority I feel I shall be failing in my duty if I do not write this minute dissenting from the report of the majority.

My purpose in moving the resolution at the last Session of the Council was to bring it to a level of the General Medical Council, consistent with the local conditions.

The position of the medical profession in Madras Presidency is quite different from that obtaining in British Isles. All the medical teaching institutions in Great Britain are under non-official control whereas here they are entirely under Government control and the interests of the official and non-official elements in the profession differ materially. Consequently it has not been possible for the members of the profession doing private practice to enjoy the rights and privileges conferred by the Medical Registration Act to the same extent as those in Government service do. It is therefore necessary to amend the Medical Act so to ensure equality of the rights and privileges conferred on the Registered Practitioners. Medical certificates granted by the Registered practitioners should not only be valid but also recognised without being sent for countersignature or second opinion.

The constitution of the Medical Council suggested in the majority report cannot be democratic as the constitution of the Council proposed therein consists of ten Government members as against seven non-official members. The two universities, the two medical colleges and the two medical schools have to elect officials only. To this number is to be added four more Government members—the Surgeon-General and three nominated members.

There is no need for the Surgeon-General to be the nominated President of the Council even for four years. If Provinces could have autonomy why not the Provincial Medical Council? The Medical Council has nothing to do with the Medical Administration of which the Surgeon-General is the head.

I suggest that the Medical Council should consist of 15 members of which five should be nominated by the Government, one from each teaching institution, and ten elected members

who should be elected by all Registered Medical Practitioners. One seat should be reserved for an European, three for medical graduates and six for medical licentiates. Out of three medical graduates one should be from the fair sex and so also one lady from amongst the six licentiates. The President of the Council should be an elected one. Government nomination will ensure better representation of the teaching profession in the Council than the election by the Government Staff.

I agree with the rest of the suggestions of the majority Committee and wish that the rules regarding elections to be amended so that the Returning Officer is a person independent of the Medical Council and the election court should not be the Medical Council itself as it is now. Provision should be made so that the election disputes are tried by a judicial officer not below the status of the Chief Judge of the Court of Small Causes.

V. RAMA KAMATH,
4th November 1937.

Dr. V. Rama Kamath proposed that the Returning Officer should not be the Registrar of the Council. The motion was lost.

Dr. V. Rama Kamath then proposed that provision should be made so that the election disputes are tried by a judicial officer not below the status of the Chief Judge of the Court of Small Causes. Carried.

Amendment of the Indian Medical Degrees Act.

At the meeting of the Council held on 27th October 1936 the Medical Council appointed a committee consisting of Drs. V. Rama Kamath, M. R. Guruswami Mudaliyar and T. S. Tirumurti (with the last mentioned as the Convener), to enquire into the question of amendment of the Indian Medical Degrees Act.

After going through the file of papers submitted to the Committee by the Registrar, Medical Council, and going through the concerned correspondence, etc., the Committee suggested the following amendments:—

(1) Section 2 of the existing Act to be amended as hereunder.

In this Act "Medical Science" means the Art and Science of Medicine, Surgery and Obstetrics, recognised by the Governments in India and elsewhere in the world by the respective Governments, or by bodies, recognised by the said Governments.

(2) In section 3, *delete* the word "Western" appearing in line 3.

Section 3 runs thus: "The right of conferring, granting, or issuing in British India Degrees, Diplomas, Licences, Certificates or other documents stating or implying that the holder, grantee or recipient thereof is qualified to practise Western Medical Science, shall be exercisable only by the authorities specified in the Schedule, and by such other authority as the Governor-General in Council may, by notification in the *Gazette of India*, and subject to such conditions and restrictions as he thinks fit to impose, authorize in this behalf."

(3) In section 4, *delete* the word "Western" appearing in line 7.

Section 4 runs thus: "Save as provided by Section 3, no person in British India shall confer, grant, or issue, or hold himself out as entitled to confer, grant, or issue any degree, diploma, licence, certificate or other document stating or implying that the holder, grantee or recipient is qualified to practise Western Medical Science."

(4) In section 6, *delete* all the words between "section 3," in line 6, and "shall be" in line 9, and *substitute* "or assumes any title, either before or after his name, which in the opinion of the Madras Medical Council is likely to convey an idea to the public, that he is qualified to practise scientific medicine."

Section 6 runs thus: "Whoever voluntarily and falsely assumes, or uses any title or description or any addition to his name implying that he holds a degree, diploma, licence or certificate conferred, granted or issued by any authority referred to in Section 3, or recognised by the General Council of Medical Education of the United Kingdom, or that he is qualified to practise Western medical science, shall be punishable with fine which may extend to two hundred and fifty rupees, or if he subsequently commits, and

is convicted of an offence punishable under this section, with fine which may extend to five hundred rupees."

"Provided that nothing in this section shall apply to the use by any person of any title, description, or addition which, prior to the commencement of this Act, he used in virtue of any degree, diploma, licence or certificate conferred upon, or granted or issued to him."

(5) *Delete* the sub-paragraph of section 6.

(6) In section 7, *delete* all the words after *Local Government* in line 4 and *add* at the end "in consultation with the President, Madras Medical Council" and *read* the section as section 7 (a).

Section 7 runs thus: "No Court shall take cognizance of an offence punishable under this Act, except upon complaint made by order of the Local Government, or upon complaint made, with the previous sanction of the Local Government, by a Council of Medical Registration established by any enactment for the time being in force in the province."

(7) *Add* the following as section 7 (b):—

"The Local Government shall undertake the prosecutions contemplated in the Act."

(8) *Add* as No. 12 in the Schedule mentioned in section 3, "All other medical degrees and qualifications recognised by the Governments in India or foreign countries or by bodies recognised by the said Governments." (The Schedule contains all the qualifications recognised by all the Provincial Councils in India).

N. B.—The Indian Medical Degrees Act was enacted by the Government of India. According to the new Government of India Act this subject comes under the purview of Provincial Legislature. So the amendments to this Act must be done by Provincial Councils.

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.

Review.

The Nowrojee Wadia Maternity Hospital

Fifteenth Annual Report for 1937.

The report is an interesting document of the good work turned out in this hospital in the year 1937. The total number of admissions in the Hospital was 6,866 as against 6,369 the previous year of which the number of confinements was 5,070 as against 4,728 in 1936. The average number of beds occupied in 1937 was 136.5 against 117.6 in 1936.

The origin founder of this institution is Sir. M. V. Mehta who started it in 1921 as a small maternity home of six beds in Parel, the mill area of Bombay. With the generous help of Sir Ness Wadia, the mill-magnate of Bombay the home was accommodated in a bigger building and the number of beds were increased to 35 and by the end of 1926 Sir M. V. Mehta's indefatigable energy and zeal enabled him to develop a humble maternity home into an ideal well equipped maternity hospital having accommodation for 150 beds which was done with the co-operation of the Government, the Bombay Municipality and the Wadia Brothers.

The hospital is turning out excellent scientific work and is a teaching centre for two medical colleges. It trains also nurses and midwives. The report is well arranged and affords interesting reading to scientists and statisticians interested in Maternity and Child Welfare work. There are as many as 27 tables in the report and each table indicates a special feature of work turned out in the hospital. Table No. 1 gives particulars of comparative statements for 15 years about the number of patients admitted and nature

of relief given to them. Table No. 2 mentions the communities who sought admission in the hospital. Table No. 3 gives particulars of the stages of condition of patients at the time of admission. Table No. 4 gives the various presentations. The next table confines itself to infant mortality. Tables No. 7 to 21 both inclusive give particulars of operative interference. Tables No. 22 to 25 both inclusive give an idea of ante-natal work. Two separate tables are set apart for Eclampsia and they give detailed information of the history of the cases, diet and treatment. Nos. 26 and 27 tables give description of maternal mortality. In addition to these tables the Principal Medical Officer has given short notes on maternal deaths of booked cases.

Sir M. V. Mehta has been devotedly working as the Chief Medical Officer of this popular institution ever since he started it and it is noteworthy that it was possible for this busy practitioner to turn out highly scientific work in an honorary capacity. It has been possible also for Sir M. V. Mehta to have as devoted a staff of hono- raries in the persons of Dr. N. A. Purandare and Dr. H. D. Sa, the eminent Obstetricians and Gynaecologists of Bombay. The nearness of another ideal institution the K. E. M. Hospital, enabled this Maternity Hospital to avail itself of the benefits of Honorary Service from the Physicians, Surgeons of repute, working in that institution. Both these institutions in combination have been showing a team work in teaching as well as in treating and have brought credit to the Indian members of the medical profession. We congratulate Sir. N. V. Mehta on his selfless work of usefulness which we hope will serve as an example to the younger generation of medical practitioners not only in Bombay but in other provinces in India also.

TREATMENT OF ECZEMA.

The Oriental Research Laboratory announced that they would keep at the disposal of the Members of the Medical Profession a special preparation for **Clinical Trial** at a nominal price of annas eight only, the selling price of this preparation being annas 12. We are having lot of enquiries from the medical practitioners who wish to know the ingredients of the Preparation and as we find it difficult to answer each query individually, we are giving a short account of the preparation which is known as **ZAMA**.

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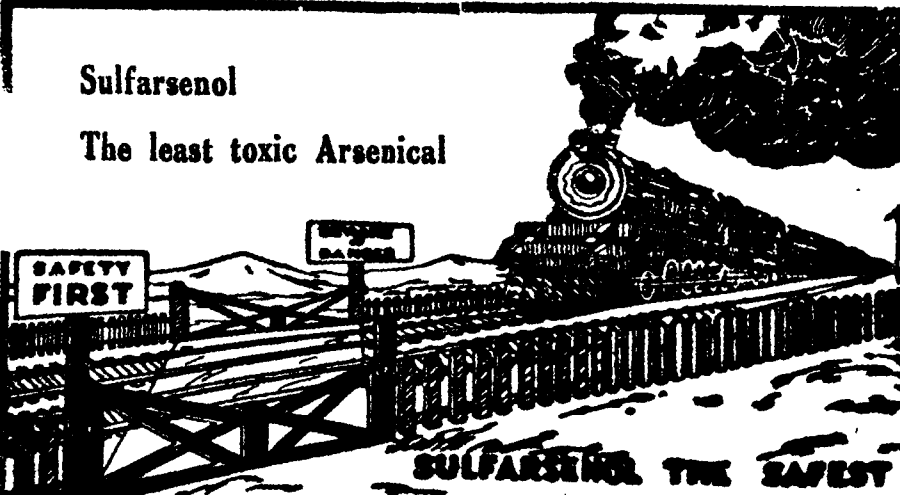
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Original Articles.

INFLUENZA.

By V. R. K.

(Continued from last issue).

TREATMENT.

HYGIENIC: The most important indication for treatment is to combat toxemia. Fever and the rest of the symptoms in the air passages, lungs, gastro-intestinal system, nervous system or urinary system are all due to toxins liberated from the virus germs and which cause Influenza or complicate its course. No drugs or chemicals have so far been found out to act directly on the virus or the organisms which either cause or complicate Influenza and consequently the physicians have to depend upon their knowledge relating to the resources of nature. Influenza patients require absolute rest in all possible ways physical as well as mental. They need more air as fresh and as pure as can be possibly made available. A quiet surrounding is also very conducive to their well being. If the patients cannot afford the above necessities, the best thing to do is to transfer them to the homes or hospitals where they can have the above conveniences. The other cheap and yet most effective source for combating toxemia is

to dilute the toxins with a liberal supply of water which the patients should be made to drink, hot drinks being preferable to cold ones. Water is a good diaphoretic as well as a diuretic and large quantities of toxins will be sent out of the system by two routes, the skin and the kidneys with no strain on the system.

The imperative necessity of keeping the mouth and air passages clean and aseptic must be stressed in this disease more than in any other on account of the fact that the home of the factor that causes Influenza is the upper air passages. Nurse should be given instructions that each time the patient is given any diet the mouth and throat should be gargled with a very weak solution of potassium permanganate (just a light rose tint). Strong antiseptic solutions must be avoided as they destroy the delicate lining membranes and lessen in their resisting capacity. After gargling, the gums, lips and tongue should be smeared with glycerine boracic. In case of



children and unconscious adult patients who cannot gargle their mouths, the nurse should clean them with lint or clean rags soaked in weak potassium permanganate lotion. The skin also should be kept clean by sponging with warm water as a routine measure.

Diet must be liquid in form. Well strained and decanted coffee with plenty of milk once or twice a day, milk diluted with rice water, barley water sweetened to taste, patent dry milk foods at nights when fresh milk is not available, fruit juice are all that are necessary for feeding the patient. Some patients show an idiosyncrasy for acid fruit juice as is evidenced by irritation of throat and recrudescence of catarrhal symptoms. Sweet butter milk is also an ideal diet especially in intestinal cases.

MEDICINAL.

In a typical case: In straight-forward cases of Influenza with moderate fever, coryza with or without pharyngitis and rheumatic pains, the following mixture answers all the indications.

(Doses used in this and other prescriptions appearing in this article are for adults):

R/
Soda Bicarb grs. 15.
Soda Salicylas grs. 10 to 15.
Tinct. Camphor Co. mms. 20 to 30.
Spt. Ammon Aromaticus mms. 20.
Aqua Chloroformi ad. oz. 1.

One ounce 3 or 4 times a day depending upon the severity of symptoms. 10 to 15 grs. dose of Pot. Bromide may be added to the above mixture if there is headache or ear-ache.

If pharyngitis is present the throat may be gently swabbed with the following solution:

R/
Glycerini Acidi Carbolici drs. 1½.
Glycerini Aluminis oz. ½.
(total drs. 5½.)

Stuffing of the nose is relieved with frequent inhalation of Tinct. Benzoin Co.

It is not desirable to attempt checking the secretion from air passages. The ideal should be to relieve discomfort by the use of solutions whose aroma acts as a mild antiseptic. Sedatives such as solution of Cocaine relieve discomfort no doubt for the time being but later produce hyperæmia of the mucous surfaces.

If the catarrh is severe it travels to the middle ear through the Eustachian tube giving rise to inflammation attendant with severe pain worse at nights. Dry fomentation to the ear every 4 hours and instillation of ear drops containing equal quantity of Glycerini Acidi Carbolici and Glycerine is all that is necessary at this stage. Pain may be relieved with 5 grs. dose of Asperin if the Salicylate mixture with Bromide does not relieve the ear-ache.

In the majority of cases the above treatment and rest will bring round the patient. In case the fever persists the following effervescing mixture does good:

Acid Mixture.

R/
Quinine Sulph. grs. 2½.
Acid Citric grs. 15.
Pot. Bromide grs. 10 to 15.

(if there be headache)

Syrup drs. 4 to 8.
Aqua Chloroformi ad oz. ½.

Alkaline Mixture.

R/
Pot. Bicarb. grs. 20.
Ammon. carb. grs. 5.
Soda Salicylas grs. 10 to 15

(if Rheumatic Symptoms persist)

Tinct. Camphor Co. mms. 20 to 30
(if there be irritating cough)
Vin Antimony mms. 20
(if there be tendency for bronchitis)
Syrup simplex drs. 4
Aqua chloroformi oz. 1

One dose of acid mixture to be mixed with one dose of alkaline and taken while effervescing every 3 or 4 hours depending upon severity of fever.

After the fever subsides irritative cough is a persistent troublesome symptom with no appreciable lung involvement. At times even the throat does not look inflamed. Perhaps the cough may be due to tracheitis. Alkaline sedative mixture is indicated in these cases containing ingredients like Syrup Codein. At times nothing relieves the irritative cough except time. In a few cases the following mixture did relieve the cough marvelously.

R/
Pot. Iodide grs. 5
Mag. Sulph. dr. 1
Liq. Morphia Hydro. mms. 10 to 15
Syrup Zingiberis drs. 2
Aqua Chloroform oz. 1

One ounce every 5 to 6 hours after food and one dose at bed time. Mag. Sulph. is added to counteract the constipating effect of Liq. Morphia.

The febrile cases: After the catarrhal stage of varying degree and at times even without catarrhal symptoms high temperature is the only manifestation with which a physician has to concern himself. The high temperature usually abates after the toxemia settles either in the lungs, the gastro-intestinal system or the nervous system. In all these cases the ideal should be to control fever by hydrotherapy and watch symptoms in all systems prone to catch the infection. Antipyretics which bring on profuse perspiration are contraindicated in Influenza. The action of these drugs while exposing the skin to the risk of atmospheric changes tend to give room to the congestion of internal organs. There is a danger to the heart action which these drugs usually depress. Ice to the head and cold sponging or wet pack in cases of hyperpyrexia is the rational treatment in these cases. In case wet packs do not bring the temperature down and on the other hand the fever rises even while the patient is in the pack, it may be safely concluded that these are malignant cases of Influenza which will end in death within 48 to 72 hours.

Serious Lung Complications: In a few cases the only trouble is dry pleurisy at times it is located to the diaphragmatic area and the signs are masked. Nothing relieves the pain excepting an opiate mixture:

R/
Pot. Citrs. grs. 15
Urotropine grs. 10
Pulvis Doveri grs. 5
Soda Sulph. dr. 1
Liq. Ammon. Acet. drs. 2
Spt. Aether Nitrosi mms. 20
Syrup Zingiberis drs. 2
Aqua Chloroform ad. oz. 1

One dose every 4 to 6 hours. (Soda Sulph. is added to counteract constipation due to Pulvis Doveri. Chemists should be advised to add Pulvis Doveri to the mixture last after straining the mixture as it does not dissolve. Mixture should be well shaken before administered). If temperature is over 102° and if there be rheumatic pains, 10 to 15 grs. of Soda Salicylas may be added to the above mixture.

Other Serious Lung complications: As referred to above while mentioning symptoms all conceivable pathological changes may exist and do usually exist in one or both lungs of a particular patient in mild or severe variety. The symptoms are disproportionate to the area of lung or lungs involved and many a time the constitutional symptoms are in the inverse ratio. So the indications of treatment should depend on the actual sufferings of the patient, aim being to relieve suffering and not the pathological conditions which in Influenza take care of themselves so long as the patient's strength is maintained. For Bronchitis a diaphoretic with Soda Salicylate and non-stimulating expectorant such as Vin Ipecac or Vin Antimony and later adding to the mixture stimulating expectorants (one or two) will meet the requirements. In conditions where there is dyspnoea, cyanosis with or without consolidation (at times not detected being deep) the safe thing to do is to treat the case as one of pneumonia (there is not much

difference between capillary bronchitis and pneumonia). In all such cases there will be marked toxemia. It will be always safe to prevent palmony or cardiac failure and for this purpose I have recourse to hypodermic injection of mms. 5 of Liq. Strychnine and $\frac{1}{2}$ c.c. Adrenaline of reliable make. These two preparations maintain both heart and lungs and Adrenaline is a sheet anchor in combating toxemia in addition. The following mixture will answer all the indications in grave lung complication :

R/		
Pot. Citrs.	drs. 1 $\frac{1}{2}$	
Urotropine	dr. 1	
Ammon. Carb.	dr. $\frac{1}{2}$	
Tint. Cinchona Co.	drs. 3	
Spt. Aether Nit.	drs. 2	
Tint. Digitalis	dr. $\frac{1}{2}$	
Spt. Vin Gallici	oz. 1 to 2	
Syrup Tolu or Simplex	oz. 1 $\frac{1}{2}$	
Aqua Chloroform	ozs. 6	

1/6 part every 4 hours.

In alcoholics brandy may be given in addition with food to make up for the daily quantity the patient has been using. I have great faith in Cal. Lact. and Soda Salicylate in Influenzal Pneumonia. Apart from supplying Calcium to make up for Calcium deficiency it is supposed to help resolution of the exudates. Salicylates controls fever in Influenzal Pneumonia. If after 3 or 4 days use of the Salicylate, the temperature does not show signs of remission this drug may be stopped. As Urotropine does not go well with Salicylate it is advisable to give Urotropine separately when Salicylate is added to the Pneumonia mixture. It should be remembered that patients after 40th year do not tolerate Urotropine as do children. It seems to irritate the bladder. So the dose of Urotropine may be reduced or suspended now and again to prevent cumulation in case of adult patients. I am fond of prescribing Urotropine as a routine in Influenza as my experience of this drug has invariably been satisfactory. It is a safe harmless bactericide. My patients have this drug even at the early catarrhal stage. At times fluid in pleural cavity undergoes

suppuration. When temperature persists unduly for a long time in cases of Influenza complicated with pneumonia, this fact should be kept in view and if necessary the area of consolidation should be explored to decide surgical interference without delay.

The gastro-intestinal cases : Usually this type of cases are not seen as such separately. Constipation should not be relieved by drastic purgative as there is always a tendency in Influenza for diarrhoea or dysentery. Apart from this consideration too much depletion of the system by purging will debilitate the patient and materially lessen his resisting capacity to the infection. One satisfactory daily evacuation is all that should be aimed at. In children divided doses of Calomel will act. Liq. Paraffin may be given a trial. In serious cases Glycerin Enema is the safest measure to relieve constipation. When active symptoms have subsided the bowels may be made to act with a daily dose or two of Cascara Saggrada, a good old remedy for relieving constipation.

R/		
Ext. Cas. Sag. Liq.	dr. $\frac{1}{2}$ to 1	
Tint. Nux. Vomica	mms. 5 to 10	
Tint. Bellodona	mms. 5	
Spt. Menth Pip.	mms. 5	
Glycerine	dr. 2	
Aqua add	oz. 1	

The dose to be taken every day at 6 p.m. to be repeated the following morning if necessary. (The dose of cascara should be steadily and gradually reduced.)

Vomiting may be present at any stage and may be the only manifestation. All diet should be stopped immediately and the patient given sips of hot water. I deprecate the use of ice which is too much abused. If the patient is able to retain fruit juice it may be given in teaspoon doses frequently and later whey and sweetened congies without milk. When nausea is completely absent milk may be given with Soda Citra. It will be a safe plan to examine the patient's urine every day as due to starvation or even otherwise there is a tendency for Ketosis

in infectious diseases. This may be relieved by judicious doses of Insuline hypodermically and administering glucose by mouth and if this is not possible by the intravenous route. Gastric sedatives such as Bismuth, Hydrocyanic Acid have little or no action in cases of vomiting of toxic origin. So all attempts should be made in eliminating the toxins rather than tending their retention by administering gastric sedatives. In these cases till the patient is able to retain his diet one pint of saline enemata twice or thrice a daily is not only indicated, but necessary. The following prescription may be tried :

R/		
Rect. Tinct. Iodine	mms. 2	
Tinct. Aconite	mms. 2	
Sol. Adrenaline	mms. 2	
Tinct. Card Co.,	mms. 10	
Glycerine	mms. 30	
Spt. Chloroformi	mms. 5	
Aqua add	oz. $\frac{1}{2}$	

one dose every 2 hours.

If vomiting is not controlled after the administration of 8 doses of this mixture it should not be continued.

Sinapism at the pit of stomach is worthy of trial soon after vomiting starts.

Diarrhoea and dysentery are common more in cases of children and invariably such children suffer in addition from Bronchitis or Pneumonia. This may perhaps be due to the fact that children usually swallow the expectoration. Adults do suffer from the intestinal symptoms, but not to the extent children do. It is possible that at times adults also swallow their own sputum. I mention this fact for what it is worth. I do not mean to say that diarrhoea is caused only by the patients swallowing their expectoration. As in vomiting so also in diarrhoea and dysentery the plan of treatment must be one of helping the patient to throw out toxins by the intestinal route. If Bismuth and such astringents or sedatives which checking peristalsis movements are prescribed especially in cases of acute diarrhoea or dysentery even if there were

to be a temporary relief, the fever is bound to shoot up and later the intestinal symptoms grow worse and with it the toxic symptoms due to absorption of toxins. For diarrhoea a simple prescription as the following may satisfy all the indications :

R/		
Calomel	gr. $\frac{1}{4}$ to $\frac{1}{2}$	
Soda bicarb.	grs. 5 to 10	
Salol	grs. 5	
Pulvis creta Aromat	grs. 5 to 15	
Ft. pulv. no 1		

One in honey every 4 hours.

The above recipe with strict observation of diet will be ample in all cases of diarrhoea. The patients should be put on farinaceous diet without milk or meat soup etc. Thin arrowroot gruel sweetened to taste is the ideal diet in diarrhoea or dysentery till acute symptoms are subdued. If the motions are dysenteric, the following prescription does good.

R/		
Gum acacia	dr. 1	
Ol. ricini	drs. 2	
Salol	grs. 5	
Spt. cinnmomim	mms. 5	
Aqua chloroformi	oz. 1	

One dose every 4 hours. After a day or two the dose of castor oil may be reduced to dr. 1 and gum acacia proportionately less. If after the acute symptoms subside and the fever comes down comparatively low and toxemia is very much less, the diarrhoea or dysentery persists, 5 grs. dose of Pulvis Doveri may be added to the powder prescribed above for diarrhoea and also to the castor oil emulsion. Bismuth subgallate and such harmless astringents may also be added in small quantities and calomel omitted.

Meteorism may be present during the course of diarrhoea or dysentery or may itself be a manifestation without diarrhoea or dysentery. In the former case Turpentine stipes every 4 hours relieves ; but if meteorism manifests itself without diarrhoea or dysentery, the patient has

stubborn constipation amounting to paresis of the intestines. If this condition is not relieved the whole trouble looks like 'acute abdomen', the patient having vomiting also later. In such cases milk and protein food should be stopped and the patient put on sips of hot water and later on thin arrowroot gruel. In addition to turpentine stupes, the patient may be given internally:

R/
 Gum acacia grs. 20
 Ol. terebinthene mms. 10 to 15
 Spt. menth. pip. mms. 5
 Aqua chloroformi oz. 1
 One dose every 4 hours.

There are some cases where the bowels do not move even after having recourse to enemas. In these cases I have succeeded in re-starting the normal peristalsis by administering 5 cc. dose of Pituitrin hypodermically and giving Turpentine or Glycerine enema soon after.

Nervous cases: The more troublesome symptom is sleeplessness. If the patients are attended to in hygienic surroundings, the chances of the patient having restful nights are more than otherwise. Yet there are some cases where sleeplessness is the only complication, all other symptoms though present being under satisfactory control. Bromides with or without Chloral Hydras acts well in cases of children and nervous women, but has not the same effect in adult males as a rule. In these cases paraldehyde in 1 or 2 drs. doses works very satisfactorily. The only objection to this otherwise sovereign remedy is its nauseating smell. So it is desirable to prescribe it with some flavouring ingredients. Trional, veronal and this group are said to be not safe drugs in cases of Influenza and other infective diseases perhaps due to their cumulative effect on the kidneys.

Heart failure: The danger of heart failure is confined generally to pulmonary complications and cases of hyperpyrexia. In both these cases alcohol should be given. The indication for pushing

alcohol is that after its use the temperature should show a tendency to remit, a dry tongue should appear moist, so also the skin, patient should be more restful and pulse should be soft but full and not bounding and delirium if present, should show a tendency to decline. If on the other hand, the above symptoms are worse after administering alcohol, the indication is to stop alcohol or give it in smaller doses. In patients who are not addicted to alcohol there is no need to give more than 2 drs. for a dose every 4 hours. Patients who habitually drink should have their day's supply and perhaps a little more.

Prevention being always better than cure, it may be a good plan to keep up the heart and nerves by a daily dose of Strychnine and Adrenaline as referred to above. I had no need to think of anything else except these two drugs to combat asthenia and toxemia.

Administration of Glucose needs no mention as its use and benefits are so widely known these days. There is a tendency for using glucose in larger doses than necessary. I had a few cases where patients were given glucose more than 4 ounces a day and who kept on a high temperature which came down after glucose was reduced, eliminating it from the diet completely for a couple of days. It was likely that the rise of temperature may be due to extra combustion due to a large quantity of glucose in the system. My explanation is only a clinical guess which I have thrown out for verification by the readers. Glucose is a costly item of expenditure. I remember to have read in one of the issues of B.M.J., a practitioner making a suggestion that cane sugar is as good a substitute for glucose and all my poor patients depend on cane sugar.

The after-care of patients who survived grave crisis should receive the attention of the practitioners. There is no other disease which undermines the health of the patients so much as does Influenza. A mild attack should receive as much attention or perhaps more than a severe one. The patients, even the educated

amongst them, have little or no conception of the danger in neglecting a cold, but once the complications set in, they are alive to the situation and expect medical men to work wonders.

I have attempted to give out a few prescriptions and my purpose in doing so is to impress on the profession especially the juniors that it is possible to treat gravest disease with a few time honoured

B. P. drugs. The need for this suggestion cannot be exaggerated in this age when there is a tendency to forget what is taught scientifically. The manufacturers of patents are thriving more than those who prescribe these patents which is much to the detriment of the profession and more of the patients as patent medicines are several times more costly than the most useful and effective B. P. drugs.

DYSENTERIES.

BY DR. K. NARAYANAMURTI, M.D.

The object of writing this article is not to follow the text book description of dysenteries under various headings but to serve as a compendium of the views and opinions gathered from available literature from all sources and their applicability to the conditions found in India so as to enable the general practitioner to treat cases of dysenteries on rational lines as indicated by the symptoms. The term dysentery is itself a symptom complex which does not indicate any particular disease. So in the past dysentery was described as a febrile disease accompanied by considerable nervous prostration and characterised by inflammation of the mucous membrane of the large intestine, sometimes ending in resolution but frequently terminating in ulceration, occasionally in sloughing or in gangrene; always in acute stage accompanied by griping pains in the lower bowels and tenesmus, the latter being more marked when the disease is situated in the rectum or lower end of sigmoid flexure; stools at first are more or less faeculent, later on very much less faeculent or not faeculent at all containing in addition, mucus and blood and gelatinoid exudation or as in the cases of sloughing and gangrenous forms, the stools look like washings of meat having a putrid gangrenous odour and contain ash coloured gangrenous or pus infiltrated sloughs. With the advance in the knowledge of bacteriology, as in other diseases organisms were discovered by different workers in different fields

of work throughout the scientific world and dysentery was found to be caused by several parasites. Accordingly dysenteries are now classified according to the causating parasite or parasites which primarily start the dysenteric symptoms and no other. Malaria, Kala-azar, Influenza, Typhoid, Tuberculosis and a few more diseases give rise to dysenteric symptoms in the course of those diseases and such dysenteries do not come under the scope of this article. These are called pseudo dysenteries. It should also be remembered that one type of dysentery might superimpose another type or be a complication in other diseases.

There are three types of specific dysenteries. They are classified as:

1. Bacterial or Bacillary
 - (a) Shiga
 - (b) Flexner and Sonne
2. Protozoal
 - (a) Entamoeba histolytica
 - (b) Balantidium coli
3. Helminthic
 - (a) Bilharzia mansoni; B. japonicum; B. haematobium
 - (b) Oesophagostomum apiostomum

DEFINITION AND HISTORY: The three groups will be considered each separately.

In the Bacillary type the causating organisms are those mentioned under this heading. The general definition of dysentery given in the introduction holds good for all types of dysenteries but each type has its own characteristics. In Bacillary dysentery presence of mucus in the stools and tenesmus are to be specially noted more than the presence of blood. In this type toxic symptoms depending upon damage done to the mucous and submucous tissues of the large intestine are more marked than is the case in other varieties, the most severe toxemia being present in the Shiga variety.

The morbidity and mortality due to dysenteries in India are not very well-known to the medical profession as we have no statistics of this disease among the civil population. In order to arrive at some approximate idea, the annual reports of the Public Health Commissioner has to be relied upon. Judging from the report of the Public Health Commissioner, it is seen that dysentery is as important a cause of death as Kala-azar or other fevers. In the returns for the civil population it is impossible to sort out cases of diarrhoea from those of dysenteries. So far as the mortality rate of India is concerned Malaria clearly comes first and foremost. Respiratory diseases including Pulmonary Tuberculosis come second whilst Kala-azar and Dysenteries are almost equally placed for the third and fourth places and both have a much more mortality-rate than Plague. Even this statement does not represent the true state of affairs for, dysentery is many a time a terminal and fatal infection as in persons suffering from chronic Malarial cachexia, Kala-azar, Pulmonary Tuberculosis or other devitalising diseases. It is probably not an exaggeration to say that as many as 300,000 to 350,000 persons die every year in India from dysentery. It is unfortunate that this disease has never been investigated in India by an organised commission of enquiry and research work carried out on these dysenteries has always been by individual workers. Investigations on Kala-azar have been taken up; Malaria is engaging the attention all over India and at present

anti-Tuberculosis campaign has been started and ere long it may be expected at least that the subject of dysentery will be investigated on proper lines. Perhaps to-day the treatment of dysentery is more random and less satisfactory a problem which constantly faces the medical practitioners in India and whose solution cannot be said to be entirely satisfactory. I shall detail as briefly as possible, the chief aspects of this type of dysentery including its pathology so as to enable the practitioners to have a grasp of the available and limited knowledge of dysenteries to help them to arrive at rational conclusions in treating this disease.

The Indian population suffers a great deal from dysentery while the European population is affected much less. This is due to the hygienic and sanitary conditions of life which the Europeans could afford better than the Indians. From Kaulalumpur Institute for Medical Research, Fletcher and Jepps published a very instructive article dealing with the relationship of poverty amongst the immigrant Tamil and the Chinese people who suffer more severely while the indigenous Malay is comparatively free from dysentery. They concluded that poverty, privation, exposure are the chief factors which are accountable for the high death rates amongst the immigrant population in Malay States. The same conditions are responsible for the high mortality among the Indian population in India.

SEASONAL INCIDENCE: Bacillary dysentery is prevalent all over India in rural as well as urban areas. But it is not prevalent in hill stations though another sort of diarrhoea known as Hill Diarrhoea is pretty common in the hill stations. It is well known that during the rainy season incidence of dysentery is much greater. Pillai and Murti published a paper in the *Antiseptic*, May 1935, on dysenteries analysing 1,265 cases during a period of four years in the civil population of Madras, admitted and treated in the General Hospital, Madras. They drew a graph by which they showed 2 peaks one in month of January and the other in month of July when there is little or no rain in

Madras. There is a period of quiescence during the rest of the months in the year. They accounted the great incidence of dysentery during January due to influx of a large floating population from the moffusil visiting the City of Madras to witness Park Fair and other amusements during the Xmas. The temporary increase in the population made the existing tenements more congested. There must have been more passive carriers during this season in Madras. Their presence added to unhygienic surroundings, irregular and unwholesome dietary, must have made up for the other concomitant factors for the increase in incidence of dysentery during the month of January. A comparative scarcity of water more than its abundance with the resulting uncleanness and low vitality during the hot weather might be attributed to the high incidence in July. So, though the observations of eminent workers like Ronald Rogers have to be admitted regarding high incidence of dysentery in the rainy season, the existence of other factors such as those accounted for by Pillai and Murti have also to be considered relating to incidence of dysenteries.

RELATIVE FREQUENCIES OF VARIOUS FORMS OF BACILLARY DYSENTERIES: As early as 1916 dysentery in India was thought to be of Amoebic origin. With the onset of the Great War, dysentery became a most important problem when epidemics of dysentery broke out in Egypt Mesopotamia and other Mediterranean theatres of war among the British and Indian troops. Wenyon and O'Connor did splendid work on this subject and they came to the conclusion that Bacillary dysentery is the most common form of infection occurring in the troops. Dobell and Harvey in London and Cunningham working in the jails of Eastern Bengal and Mopallah prisoners at Bellary also came to the conclusion that 86 per cent. of the dysentery among prisoners was Bacillary in origin. Fletcher and Jepps on analysis of 983 patients at Kaulalumpur District Hospital found 87 per cent. of them were suffering from Bacillary dysentery. So far Madras is concerned, out of an analysis of 1,265 cases, the relative incidence of

Bacillary dysentery was found to be 5 times as common among the civil population of Madras as the Amoebic dysentery (Pillai and Murthi). Wats, Loganandan and Conquest (1928) working among the British and Indian troops in the Secunderabad command accounted 69.3 per cent. of the admissions were of Bacillary dysentery and these authors remark that medical officers who use Emetine or allied drugs without laboratory diagnosis, would be wrong in nearly nine cases out of ten. The military station at Poona is notorious for the great prevalence of diarrhoea during the rains—a condition locally referred to as "Poon-itis"—Manifold and De Monte have shown that Poon-itis is due to Flexner infection.

We cannot definitely establish any seasonal variation in the types of dysentery met with in India, but there appears a definite difference in the geographical distribution of the two infections. Amoebic dysentery is frequent in the wind-swept dry regions where the infective cysts are blown on to food stuffs by hot winds, whilst Bacillary dysentery is relatively more common under communal and insanitary habits of the people where more primitive conditions of life lend themselves to the spread of the disease. In Europe Bacillary dysentery is to day mainly an institutional disease occurring not infrequently as out-breaks amongst prison camps, lunatic asylums and military stations. Bacillary dysentery has always been a war disease. It was found to be an important factor in the Napoleon wars, in the Franco-Prussian war and in the South African war. Large epidemics occurred in the belligerents during the Great War and as a cause of invalidity was hardly second to that of any other disease.

MODE OF INFECTION: Direct contagion by faeces can occur among people in which the ordinary sanitary regulations are either unknown or disregarded. Its occurrence and spread in the lunatic asylum and the Indian Bazaar are attributed to personal habits which lend themselves to the spread of the infection. Indirect contagion can take place through

the house fly. It is able to spread the infection in two ways either by its habit or regurgitation preparatory to feeding or by its faeces. Buxton has found human faeces in the majority of house flies caught in Iraq.

Water was found also to act as a medium of infection especially in the Malaya States (Fletcher and Jepps). It has been shown by them that the *Bacillus* can survive in drinking water for over three days but dies quicker if exposed to the sun or if the water is contaminated with putrefactive micro-organisms. Susceptibility of the individual is another factor responsible for the occurrence of this infection. New arrivals in the tropics and small children are susceptible. Patients whose health is undermined by such diseases as Malarial, Pellagra and Tuberculosis are apt to contract dysentery as a terminal and fatal symptom. The problem of carriers has also to be taken into account in the spreading of the infection. This carrier question in Bacillary dysentery cannot be compared with other infections such as Typhoid or Cholera. Bacillary dysentery has a short incubation period and is essentially a localised disease in the body. The bacilli remain confined to the large intestine and the mesenteric glands. We are still without accurate statistics to prove the frequency of the carrier state but we are sure that carriers are responsible for starting of an epidemic. The majority of recognised carriers are convalescent carriers—a term which implies, that the victims have incompletely recovered from the disease but are still passing blood and mucus containing dysentery bacilli in the stools. A healthy carrier in a Bacillary dysentery is a rare phenomenon. There is no evidence to show that Gall-bladder acts as a reservoir of infection as in Typhoid. Therefore the infection by the carrier does not persist for any great length of time in Bacillary dysentery. The organisms might persist in the retention cysts in the intestinal mucus, in collections of pus from beneath the scars of ulcers. Usually the carrier state lasts only for 4 to 6 months after the onset of the disease and at the end of the year most of the victims cease to be carriers.

The maximum period in carrier state can last three years. The infection by the carriers of the Flexner bacillus is much more frequent than the Shiga bacillus carriers. Generally the average Flexner carrier is in good health while the Shiga carrier is an invalid. There is a condition in patients in which ulceration is localised in the lower part of the rectum. These patients often pass viscid blood and mucus though otherwise in good condition. The bacillus may be isolated from these cases after lapse of three years after the initial attack.

ETIOLOGY: The causal relationship of the bacillus to disease is practically established. *Bacillus dysenteriae* was discovered by Shiga a Japanese in 1898 and confirmed two years later by Kruse in Germany. Therefore it is also known as the Shiga-Kruse *Bacillus*. Cultures of Shiga's bacillus are extremely toxic to laboratory animals especially the rat. But in these animals characteristic lesions of dysentery are not produced while the filtered toxins if injected intravenously cause necrosis of the large intestine. In two experiments in man—one intentional and the other accidental ingestion of pure cultures was followed by well marked symptoms of dysentery within a short time. Flexner bacillus is morphologically similar to Shiga's. The bacillus was isolated by Flexner from cases of dysentery in Manila islands in 1900. Since that date a very large number of organisms belonging to this group have been described. A sub-grouping of these bacilli on the serological basis was made by Murray, Andrews and Immann. From their work it appears that five definite strains of the bacillus can be identified which are termed respectively as V W X Y Z and for their recognition five specially prepared homologous serums are necessary. For laboratory purposes of recognising the bacilli a pooled preparation of these five components is obtainable. Sonne's *Bacillus* belongs to this group and it is responsible for outbreaks of enterocolitis and may also produce symptoms of food poisoning. As a general rule the dysentery bacilli can be isolated only from the intestinal canal or

from the mesenteric glands. Very rarely the bacilli are obtained from the blood, gall-bladder and from effusions in the joints. The Shiga bacillus is responsible for the most severe clinical forms of the disease while Flexner causes a mild diarrhoea. The incidence of Shiga infection is only 12 per cent while that of Flexner accounts for the next of 88 per cent.

PATHOLOGY: In mild cases the earliest lesions in Bacillary dysentery are found in the solitary lymphoid follicles of the large intestines which become hyperaemic and swollen and ulcerated. From this origin snail-like ulcerations are produced which spread across the bowel wall. Along with this there is a generalised catarrhal inflammation of the whole mucous membrane and hyper-secretion of ropy mucus. In less acute cases the signs of generalised toxemia are slighter. The mucosa of the colon is of a rosy plum colour due to innumerable sub-mucous haemorrhages. In very acute cases the process consists of intense hyperaemia of the large intestine which eventually culminates in gangrene of the mucosa of the entire colon. If the patient survives for a week or longer the stage of acute haemorrhagic infiltration of the gut wall passes into a state of colliquative necrosis of the mucosa. The large gut especially the sigmoid flexure and rectum are narrowed down into a contracted rigid tube, olive green in colour. Its colour is thought to be due to the staining of the necrotic tissue by the bile pigments. Should the patient survive such a state of affairs which he rarely does, the necrosed mucous membrane is exfoliated in much the same manner as a diphtheritic membrane exposing a raw granulating bleeding surface underneath. In such cases death may occur in the third or fourth week of the disease. Plastic peritonitis may lead to the matting together of the coils of the large and small intestines and omentum. The ulceration in Bacillary dysentery usually does not extend deeper than the sub-mucous coat, but very occasionally it may involve the muscular and even peritoneum. In scattered portions in the lower part of the large bowels polypi might form. In some

chronic cases the mucous membrane may be entirely destroyed rendering recovery impossible. In those cases the gut resembles a piece of chamois leather. Mucous retention cysts due to the formation of pseudo adenomata from the bases of Lieberkuhn's follicles may sometimes be found as a sequela of bacillary ulceration. Dysentery bacilli may be isolated from these cysts. Many cases of chronic Bacillary dysentery acquired in the Great War showed no ulceration but only a granular condition of the mucous membrane of the bowel as a result of which stenosis of the large intestines either localised or general may take place. Mixed infection of Amoebic and Bacillary dysentery may also be met with.

SYMPTOMS: The disease after a short incubation period from 1 to 7 days begins in a variety of ways suddenly or insiduously in all grades of severity from a mild diarrhoea to a fulminating choleraic attack with fatal results within 2 or 3 days of onset. The main clinical symptoms are those of inflammation of the large intestine *viz.*, griping, tenesmus, the frequent passage of loose scanty muco-sanguinous stools often with dysuria. The onset in all cases, with the exception of the choleraic type is always with fever; the fever is of intermittent character and accompanied by drowsiness and headache. Early in the disease the recti muscles are rigid but later especially in fatal cases, the abdomen becomes quite lax and the pain appears to be no longer felt as the patient is overwhelmed by toxemia. The sigmoid flexure is generally very tender on palpation and if contracted by a spasm can be rolled like an elastic chord under the examining finger. The transverse colon and the caecum are rarely affected. As a general rule if the lesion is nearer to the rectum the more troublesome is tenesmus and nearer to the caecum the more is the griping pain. The general constitutional symptoms are due to the absorption of toxins and may be very marked. Vomiting may occur on the onset or be absent altogether.

CHARACTER OF THE STOOLS: The number of the stools passed during the

first twenty four hours varies enormously according to the severity of the disease and generally we can take their number and character as a guide to prognosis and treatment. They may number 3 or 4 per day and there may be up to 100 stools a day, or the passing of stools may be so incessant that the patient is almost continuously on the bed pan. In those cases which run a favourable course after an initial diarrhoea the stools consist of gelatinous blood-stained mucus which has been compared to red currant "Jelli" or "frogs spawn" and which are generally odourless, or may have a faint smell of spermin. After 3 or 4 days the stools become more purulent, contain less blood and are of yellowish colour. Finally the bile pigments make their appearance together with grey faecal matter. The appearance of pasty yellow stools indicates that convalescence has begun. In many cases of Flexner infections the stools are diarrhoeic and offensive, contain mucus but little or no blood. In the most acute and fulminating forms the stools contain dark blood and resemble meat washings. When necrosis of the mucosa has become finally established, the stools become very offensive, grey in colour and contain much altered blood but no mucus. In hyperacute cases the stools may consist only of pure blood or of serous exudate. The blood changes are not characteristic in Bacillary dysentery. In few cases there may be moderate leukocytosis. The urine in severe cases is high coloured concentrated specific gravity about 1030 and contains large quantities of urates. Generally the tongue is clean but in acute cases it may be coated with thick yellow fur. On clinical grounds the Bacillary dysentery may be classified under the following headings:

1. *Mild or Catarrhal forms*:—The patient to begin with was supposed to have had an attack of diarrhoea. By degrees the stools become less copious and more frequent, less faeculent and more mucoid. The passage being attended always by a certain amount of straining and griping. The whole attack may be over in a week and the stools may not be more than 12 in 24 hours. There may not be one accom-

panying fever. The majority of those cases are due to Flexner's or due to Sonne's bacillus.

2. *Acute Bacillary dysentery*:—In this the onset is very abrupt. It goes to a full swing within a few hours of its commencement. The stools first faeculent, soon contain blood-stained mucus. There is a desire to pass the stool, more frequently with griping and tenesmus. The tenesmus may be accompanied by the most distressing dysuria. The fever might start with rigour and the temperature shoots up. The face is pinched; slight delirium and mental confusion may be present. Thirst is considerable with anorexia. Within a week all these urgent symptoms may diminish and pass off into a sub-acute or chronic condition or it may end as abruptly as it began.

3. *Fulminating Bacillary dysentery*:—This begins suddenly with vomiting, headache rigours, with a rapid rise of temperature. After the rigour, purging begins and the stools rapidly assume dysenteric characters. In two or three days up to a week collapse sets in with sub-normal temperature and the patient may die during this time. Sometimes the toxemia is so virulent that death may take place before the stools have the typical appearance of dysentery. The abdomen is sunken and acutely tender. Towards the end there may be no blood or mucus in the stools, yet they may be innumerable. A choleraic form is sometimes met with. The onset is acute with vomiting. The stools are watery and the collapse may set in very early. The temperature is usually subnormal and the patient dies within three days.

4. *Relapsing Bacillary dysentery*:—Though in a great majority of cases, the urgency of the symptoms may subside, the patient does not completely recover. The stools may become faeculent yet they continue to be passed too frequently attended by griping and tenesmus. Bacillary cases of this type may be either due to fresh infection or to lighting up or recrudescence of an old focus.

5. *Chronic Bacillary dysentery*:—In a large proportion of cases the stools do not become normal and on the slightest indiscretion in diet attacks of diarrhoea might set in, for months and even years. There is a tendency for constipation alternating with diarrhoea. The clinical appearances of these cases were formerly known in India as the *Morbus bengalensis*. The patient loses much weight in these cases. Considerable anaemia may develop with cardiac failure and dropsy.

BACILLARY DYSENTERY IN CHILDREN: Dysentery in childhood is almost invariably of Bacillary origin. And this point is especially to be noted in connection with the infectivity of the condition. A mother who is nursing a child suffering from Bacillary infection may certainly carry the infection to other members. Amoebic dysentery in young children is an extremely rare condition and one is not justified in treating dysentery in children by the administration of Emetine. In young infants enterocolitis is frequently due to the *Bacillus proteus* in which infection the stools are extremely offensive. At a later age the infant suffers from diarrhoea which is usually due to the morgan's bacillus or sometimes an infection with the *Bacillus pyocyaneus* is associated with diarrhoea and the passage of green slimy stools containing much pus. If a child is attacked by *Bacillus Shiga* it may die in convulsions before the intestinal symptoms have had time to develop.

POST DYSENTERIC ASCITIS: According to Megaw ascitis is said to be common in hospitals in India as a sequela to Bacillary dysentery. This condition is supposed to develop in untreated and not properly treated cases wherein toxins of dysentery pass through the intestinal wall and set up an irritative peritonitis resulting in accumulation of fluid in the peritoneal cavity. Cirrhosis of liver is not found in these cases.

PREDISPOSING CAUSES: Patients with enfeebled state of health due to starva-

tion, unsuitable diet, physical exhaustion, exposure, or whose health is undermined by chronic diseases such as malaria, tuberculosis, etc., are prone to catch the infection. Pregnant women, young children and the aged are liable to get the disease in a severe form.

COMPLICATION: Dysenteric arthritis or dysenteric rheumatism are amongst the complications well known to the Indian practitioners. Effusion into the knee and ankle joints may take place either during the acute stage of the disease or during convalescence. It is common in some epidemics and in others it is entirely absent. High temperature usually accompanies the joint effusion. The effusion may clear up without leaving any deformity or a permanent disability may result. The fluid from the joint is sterile and will generally agglutinate the dysentery bacillus. This condition has to be distinguished from serum arthritis which often occurs after the injection of anti-dysenteric serum. Eye complications such as acute conjunctivitis and iritis occur in a small percentage of cases. Parotitis, intersusception of the large or small intestine may be found to occur in children and in them it is often a terminal event.

SEQUELAE: Stenosis of the large intestine, abdominal adhesions causing pain and discomfort or an idiopathic dilatation of the colon are some of the common sequelae. Some patients suffer from peripheral neuritis, post dysenteric tachycardia. The latter condition may probably due to a toxic myocarditis may persist long after the dysenteric symptoms disappear. *Bacillus coli* nephritis is yet another sequela in chronic Bacillary dysentery which is sometimes found in the tropical country.

The differential diagnosis, prognosis and treatment will be dealt with in the next issue.

(To be continued.)

Abstracts.

RISKS OF ANAESTHESIA

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Difficulties of one sort or another are to be expected with certain types of patient or operative procedure. If the anaesthetist is on the look-out for them he should by intelligent anticipation be able to prevent their occurrence, or else by a suitable anaesthetic technique counteract their effects. During anaesthesia many situations arise which will develop into emergencies unless the anaesthetist recognizes the early signs of trouble and immediately takes the necessary steps to regain control. Sometimes an accident occurs with no warning at all, and a successful outcome may well depend on the right thing being done promptly and without hesitation. The difficulties encountered during anaesthesia, though small in number, crop up again and again in slightly different forms. Only the chief risks can be outlined here with the general principles of treatment; these principles, however, can be modified to apply to other emergencies which have in fact originated from similar faults.

OXYGEN WANT.

The respiratory and circulatory systems are closely linked together, so that oxygen want in the tissues (anoxia) arising from failure or partial failure of one system will quickly embarrass the other. Anoxia being the underlying factor in so many anaesthetic troubles it will be well to emphasize some of its physical signs. These are: (1) increase or decrease in the rate of the pulse, which is slow, bounding, and often irregular in acute oxygen want; (2) rise or fall in systolic blood pressure; (3) altered breathing—depressed, quick and shallow, or periodic respirations, or yawning; (4) nausea and vomiting; (5) muscular twitchings; (6) restlessness;

(7) cyanosis. Cyanosis always indicate suboxygenation, but a high proportion of patients suffering from oxygen want show no cyanosis.

Anoxia is responsible for many of the troubles encountered during spinal anaesthesia, and is not infrequently present during or after general anaesthesia. Pyrexia, fear, pain, and hyperthyroidism all increase the patient's oxygen requirements.

ABUSE OF CARBON DIOXIDE.

Nowadays carbon dioxide is commonly regarded as the "cure" for practically all anaesthetic difficulties. Actually its injudicious use has cost many patients their lives. It should be remembered that morphine and the basal hypnotics depress the breathing by decreasing the sensitivity of the respiratory centre to carbon dioxide, with the result that the alveolar content of carbon dioxide banks up to a higher level than usual. The patient's physiological processes are deranged by this excess, and will consequently not benefit from any addition to this burden. For the majority of patients who happen to be in this depressed state the lesser of two evils is probably the use of sufficient carbon dioxide or rebreathing during induction to secure normal pulmonary ventilation. Creating a higher concentration of carbon dioxide with the objects of producing an exaggerated hyperpnoea and rapidly inducing anaesthesia with intolerable concentrations of ether, or any piling up of carbon dioxide in an acidotic patient, is not to his advantage. Individual susceptibility to carbon dioxide is very variable, and if the normal immediate response to a low concentration—namely, an increased depth of respiration and a rise in

blood pressure—does not appear overdose for that particular patient is a probable contingency, and the use of carbon dioxide must be immediately discontinued.

The signs of toxicity due to carbon dioxide are: a fall in blood pressure, depressed or gasping breathing, and muscular twitchings, which may pass on to generalized convulsions and death. Waters and his associates, who are responsible for most of the experimental work on carbon dioxide, have shown that the improvement in cases of circulatory depression and shock commonly attributed to carbon-dioxide-oxygen mixtures is in fact due to the good effects of the high oxygen concentration outweighing the ill effects of the carbon dioxide. The continued inhalation of a concentration of carbon dioxide above 10 per cent will produce unconsciousness in normal unanaesthetized subjects. In this connexion it is of significance that asphyxiated patients and newborn babies recover more certainly and more quickly when pulmonary ventilation is carried out with 100 per cent. oxygen.

For success with the carbon-dioxide-absorption technique efficiency of the absorbent material and of the canister design and reduction of the dead-space to the minimum are essential. Towards the close of the operation the contents of the rebreathing bag must be repeatedly changed in order to wean the patient slowly from the warm, moist—and possibly high oxygen-containing—atmosphere which he has been breathing, and to restore him to normal atmospheric conditions.

It has been shown that carbon dioxide, oxygen, and all anaesthetic gases are rapidly and completely absorbed from the pulmonary alveoli. After operation the patient should be encouraged to take deep breaths. If he cannot or will not comply a gentle flow of pure carbon dioxide—a watch being kept for any signs of toxicity—may be blown at his face. This will make him fill his lungs with air, the presence of the *unabsorbed* nitrogen decreasing the risk of pulmonary collapse. The use of carbon-dioxide-oxygen mixtures, in contrast to this, may be followed by patchy areas of atelectasis or even complete collapse of lung.

Oxygen want and carbon dioxide overdose, singly or combined, are liable to crop up on many occasions during anaesthesia, and are the underlying factors in many anaesthetic states which are difficult to explain on any other basis—at least I myself can call to mind situations which at the time I never attributed to carbon dioxide overdose, but in which I am now convinced excess carbon dioxide played an important part.

OVERDOSE OF SEDATIVE DRUGS

Among the effects of overdose with sedatives are those of low alveolar oxygen and high alveolar carbon-dioxide concentrations. If it relieves the anoxia resulting from the low blood pressure and the depressed breathing an atmosphere enriched with oxygen will improve the respirations. The administration of carbon dioxide and oxygen may break the vicious circle, but on the other hand this additional carbon dioxide may be beyond the patient's tolerance and still further depress the breathing and the blood pressure. Artificial respiration with a high percentage of oxygen and other treatments for shock are indicated in serious cases.

Picrotoxin is the specific antidote for barbiturate poisoning, but if injected too quickly or in excessive dosage it will produce convulsions, the treatment of which is an intravenous dose of a barbiturate. An unimpaired liver function is essential for the normal detoxication of a barbiturate. Apomorphine, 1/40 to 1/60 grain, aborts scopolamine reactions; coramine may be a useful temporary stimulant in cases of *avertin* depression. It is much safer, however, to place no reliance in analeptics and to be more careful in assessing the sedative dose for each individual patient.

Another serious risk which should be mentioned here is the existence of a partially obstructed airway. This can kill a patient from anoxia just as surely as can complete respiratory obstruction, and since it is so commonly overlooked it may be even more dangerous. When the breathing is depressed any further reduction of the alveolar exchange—such as occurs in the presence of an obstructed airway—imme-

diately produces respiratory failure without any intervening period of respiratory stimulation.

OVERDOSE OF THE ANAESTHETIC AGENT

When the breathing is shallow or has stopped there is a high alveolar content of carbon dioxide as a result of insufficient pulmonary ventilation. The respiratory centre is, however, so depressed by the anaesthetic agent that its threshold has been raised above the point at which this high concentration of carbon dioxide can, so to speak, ring the bell. At the same time the insufficient respiratory exchange is failing to supply the body's requirements of oxygen, and anoxia itself will cause respiratory failure.

No more anaesthetic must be given until the situation is relieved, an atmosphere rich in oxygen being substituted after the patency of the airway has been verified. If respiratory movements are inadequate or absent a two-gallon bag should be filled with pure oxygen, an accurately fitting mask applied to the face, and the lungs rhythmically inflated by manual squeezing of the bag. A rapid recovery usually results. If this procedure has to be at all prolonged, the bag must be emptied to remove the accumulation of exhaled anaesthetic and carbon dioxide, and then refilled with pure oxygen. When it appears that the circulation has also been brought to a standstill by the high concentration of the anaesthetic agent, treatment for primary cardiac failure must be instituted unless there is a prompt response to artificial respiration.

If pre-anaesthetic sedatives have been given, the failure is due to the combined depressant action of these and the inhalation agent. Recovery will naturally be more prompt when the major part of the depression has been evoked by the inhalation agent, since a volatile anaesthetic can—provided the circulation is reasonably efficient—be removed as rapidly as it has been introduced. When, however the failure has been produced entirely with non-inhalation agents, such as intravenous pentothal or evipan, all that artificial respiration can do is to maintain life until such time as the body

itself has detoxicated the drug. This unwelcome state is apt to arise when the operative stimulation has ceased, and again emphasizes the importance of not using these powerful drugs in a haphazard fashion. In these circumstances, as there is no inhalation anaesthetic to be eliminated, only carbon dioxide accumulates in the bag of oxygen; if a canister of soda-lime is in position between the mask and the rebreathing bag, there will be no necessity to empty its contents during the period of artificial respiration. When oxygen has been administered freely throughout an operation its use must be discontinued gradually, otherwise respiratory failure may occur before the patient has had time to readjust himself to atmospheric condition.

Sometimes in cerebral cases and other poor operative risks patients cease to breathe as soon as they lose consciousness. Their general condition will be kept nearer normal if anaesthesia is induced and maintained by a manually produced respiratory exchange rather than if carbon dioxide is continually added with the idea of making these patients breathe.

A patient with chronic laryngeal obstruction has become accustomed to a high alveolar content of carbon dioxide, and his respiratory centre has adjusted its threshold accordingly. After the obstruction has been relieved the alveolar content of carbon dioxide at once returns to normal, and the patient may die of oxygen want before his respiratory centre is stimulated. The administration and gradual "tapering off" of carbon dioxide as his respiratory centre readjusts itself to the normal threshold will prevent such a tragedy. It is all a question of the difference between threshold and stimulus; a similar state of affairs may be seen following over-ventilation due to nervousness during induction (apnoea) or after the stopping of an anaesthetic in which carbon dioxide has been allowed to accumulate by rebreathing. The depressed and possibly irregular breathing of respiratory failure must be distinguished from the shallow or hesitant breathing of too light an anaesthesia.

(B. M. J., Oct. 23, 1937.)

Notes on Therapeutics, Diagnosis and other Medical Subjects.

THE SCORPION STING.

BY DR. N. RAMA RAO,

Subsidiary Rural Practitioner, Collapalli.

Having gone through the article on the above subject by Dr. Lakshminarasayya of Proddatur in the January issue, I feel called upon to give a few of my experiences in the subject since scorpions are abundant in other Andhra Districts also.

I do not agree with the writer when he says that the venom of the scorpion is similar to that of the snake because the signs and symptoms vary in both the cases. The former is generally arrested at the lymphatic glands and in rare instances is generalised. But that is not the case with the latter which enters the general circulation quite early without manifesting any of the local phenomena like pain, burning etc. Undoubtedly the snake venom is the more powerful and more rapid in action. The action of the scorpion venom is more a vaso-motor phenomenon whereas the snake venom directly affects and depresses the respiratory and cardiac centres.

There are a few varieties of these scorpions namely the black the red scorpion, the big or the giant type of the black variety and a white scorpion also. Of these the last is found only in forests. The quality of the poison in the red and white varieties differs from those of the others in that it is more potent; while the giant type at each sting is capable of injecting a larger dose than any of the rest.

The effects of the scorpion sting vary a good deal according as when the scorpion is pregnant or not and the patient when stung is on a full or empty stomach. They say, the poison is more deadly when the scorpion is pregnant and also when the patient happens to be with a full stomach at the time of the bite. My findings also coincide with the above

statement. Mere fright of a touch not even a bite by a scorpion makes some people display severe mental symptoms. The signs and symptoms vary in different individuals. I had a woman patient who was brought to me four times with a history of Scorpion bite. Each time I saw her unconscious for 2 or 3 days frothing at the mouth now and again. Slight touch on the area of the sting brought her to partial consciousness. A boy aged about 14 got fits of coughing immediately after he was bitten by a scorpion. Adrenaline relieved his cough but hiccup started which was also relieved by Adrenaline and Ephedrine. There were two cases in women whose only symptom was shivering relieved also by Adrenaline.

It is said that a scorpion becomes more venomous if its abode is near by a cobra or if it crawls over a cobra. There are a set of charmers in villages who cure scorpion or snake bite poisoning by manthrams. Though this phenomenon cannot be explained scientifically I have personally seen the good effects of these manthrams. I got curious to know this manthram and an old resident in my village initiated me and I am led to believe in its efficacy especially in snake bites. I am not in a position to explain scientifically the effects of these manthrams. Once it so happened that a patient said to have been bitten by a scorpion and who appeared to be almost dead, was not relieved by the charmer. The charmer then questioned the people who brought the patient whether they were sure it was a scorpion bite and the people affirmed it was so. The charmer then chanted some other manthram and like magic I saw the patient slowly recovering and in a few minutes was all right. The charmer told us that this was a bite from a scorpion which must have crawled over a cobra or had its abode very near the cobra. He added that he had to make use of manthrams meant for cobra bite in that case.

Treatment of scorpion stings may be classified as medicinal and psychic. The latter treatment has marvellous effect if the person is really the proper man

possessing psychic powers. This treatment may otherwise be styled as suggestive treatment. Medicinal treatment may be divided into (1) External (2) Internal.

EXTERNAL.

(a) Application of a strong solution of Potassium permanganate over which dripping of tartaric acid is a time-honoured remedy at times successful. Indiscriminate use of this may bring on blisters.

(b) Rubbing of anodynes like—Tincture opii or the Liniment opii and Liniment Camphor ammoniata.

(c) Counter irritation by saturated solution of common salt in the eyes or ears.

(d) Application of a paste of soap-nut and after the paste dries fuming the spot with smoke of burnt cloth is usually advocated by grandmothers in the villages.

(e) Application of heat or cold.

(f) Cocaine or Novocaine injection on the bitten spot. It should be noted that some persons have an idiosyncrasy for cocaine.

(g) Application of Ethyl Chloride Spray has marvellous effects in my hands.

(h) Mild electric current.

INTERNAL REMEDIES.

These are for relieving pain, to combat heart failure and counteract the poisoning. The remedies usually indicated for these have to be had recourse to. In many cases the scorpion bite seems to be an Allergic phenomena. This is why Adrenaline and Ephedrine have good effects in neutralizing the poisonous effects.

CONSERVATIVE TREATMENT OF FRACTURES.

K. MERMINGAS (*Zbl. Chir.*, November 27, 1937, p. 2722) considers repeated radiographic examinations of a broken bone unnecessary, and at times even disturbing for the patient and relatives. The

old criteria of healed fracture—namely, strong callus, restitution of the extremity in all directions, mobility of the joints, and good condition of the muscles—still hold good. The repeated radiographic controls of the fracture showing possibly some overlap of the fragments or lack of alignment only disturb the peace of mind of the physician, and of the patient and his relatives. This sometimes leads to a superfluous or even harmful attempt at reposition of the fracture, or even to unnecessary operative interference. The author therefore omits all radiographic control after the fracture has been diagnosed and properly reduced. He avoids all manipulation during the first ten to twelve days following the fracture, during which time the callus is being formed. He illustrates his point of view by a number of radiographs taken immediately after the fracture and some months or years afterwards. The advantages of his mode of treatment, in his view, are: (1) avoidance of surgical shock and of respiratory and cardiac complications; (2) shortening of the duration of the extension; (3) prevention of the danger of pseudarthrosis.

—B. M. J. March 19, 1938.

SPINAL ANAESTHESIA.

L. MASSION (*Scalpel*, Liege, December 18, 1937, p. 1738) describes in detail Sebrechts's method, which he claims is undoubtedly the best for all operations below the diaphragm. For patients over 15 he uses Howard Jones's percaïne solution, and he admits only two contraindications—namely, cerebrospinal disease and sepsis at the site of injection. Sedol is injected one hour before, and in cases of hypertension, particularly in the aged, or in severe hypotension, an intramuscular injection of ephedrine is given immediately before the anaesthetic. The puncture is made sitting, or lying with the affected side uppermost; the site should not be higher than the third or fourth lumbar space; 5 c.cm. of percaïne are injected and the needle is left in place, with its stylet reinserted. For unilateral operations the patient remains lying on the sound side, for bilateral he is cauti-

ously turned face down. For upper abdominal operations, which require skin anaesthesia up to the nipples, the table is kept level; for lower abdominal operations, in which analgesia should reach the epigastrium, it is tilted slightly head down. At five-minute intervals skin sensibility is tested, and a further 5 c.cm. of solution are injected until adequate anaesthesia is obtained. The operation may be begun thirty-five minutes after the first puncture. The amount of percaïne employed varies from 5 to 110 c.cm. and averages 15 c.cm. for lower and 20 to 30 c.cm. for upper abdominal operations. It should be greatly reduced in pregnant women, who are usually sensitive to it, and also in all toxic cases. During anaesthesia the pulse, respiration, and mental condition must be closely watched. Minor degrees of syncope occurring early are remedied by deep breathing, sponging the face, and reassuring the patient. In more serious difficulties ephedrine should be given intravenously and intramuscularly. Severe collapse must be treated promptly with intravenous or intracardiac adrenaline, artificial respiration with oxygen, cardiazol, and lobeline. If the anaesthesia is not quite adequate, a slow and careful intravenous injection of sedol will calm and comfort the patient. If the failure is more complete a small dose of evipan or eunarcon will ensure a good result. The patient is kept horizontal for the first twenty-four hours, and after high abdominal operations the foot of the bed is raised for the first few hours. Sequelae, including headache, are now very rare. The latter may be treated with aspirin or belladonna, or 20 to 40 c.cm. of distilled water or 10 per cent. saline injected intravenously.

—B. M. J. March 19, 1938.

THE NEW INSULINS.

THIRD LETTSOMIAN LECTURE.

The third and concluding Lettsomian Lecture was delivered by Dr. George Graham before the Medical Society of London on March 7, the subject of the lecture being the new insulins. The first

two lectures were reported in the *Journal* of March 5, (p. 529) and March 12, (p. 579).

The new insulins, said Dr. Graham, had been available only for a short time, one of them for two years and the other for one year, and he himself had certainly not had enough experience to be dogmatic as to their value. His conclusions were for the moment tentative. Insulin when first introduced in 1922—3 was a very crude product, with certain impurities which had no value for the treatment of diabetes. Later the ordinary insulin became far purer. Nevertheless, the number of patients whom it seemed difficult to control had become greater. It had been suggested that this was due to a change in the insulin, the older insulin having a slower action than the newer.

The problem of looking after these difficult cases had been dealt with in various ways. The late Dr. Otto Leyton gave a mixed oil and insulin, which, however, was somewhat painful; others had tried a mixture of insulin and adrenaline, and others, again, a mixture of insulin and pituitrin. Then came the modification devised by Hagedorn of protamine insulin, an insulin being produced which was insoluble and had a much slower action than the ordinary product. Scott in Toronto, who had already found that zinc was always present in the pancreas, added zinc to protamine insulin, so that now there were three insulins on the market: first, the ordinary insulin; secondly, the protamine insulin of Hagedorn, known as "insulin retard"; and, thirdly, the insulin introduced by Scott and Fisher in the form of zinc-protamine-insulin. Hagedorn's insulin had been in use for two years, zinc-protamine-insulin for only one. The former had to be given, as a rule, in two doses; zinc-protamine-insulin could very often be given in one, which was a great advantage as many patients disliked the two injections.

OVERDOSE.

Dr. Graham devoted most of his remaining time to showing a series of case charts and discussing them. In most of

these cases he had started with two doses of ordinary insulin a day, and then introduced a certain number of units of one of the newer insulins. Most often he used a mixture of ordinary soluble insulin and zinc-protamine-insulin. In a certain number of cases he had been able to do away altogether with the ordinary insulin and to use only the zinc preparation. He dealt at some length with the question of overdose. When protamine insulin was introduced it was said that patients would notice the signs of overdose very much better, because the blood sugar would go down more slowly, and they would have time to recognize that something was the matter and to take sugar. But he found that some of his patients who did not recognize their signs of overdose were no better off with zinc-protamine-insulin. He had heard of some who when put on zinc-protamine-insulin suffered very severe overdosing, although in fact that had not happened among his own patients. But he did not think the new insulins were any better in this respect than the old.

The great advantage was the ability to give the day's injection in one dose. Hagedorn originally introduced his insulin for difficult cases, and in a number of such patients, whose case sheets he exhibited, Dr. Graham has found the product of value. A mixture of ordinary and "retard" had proved very useful indeed. He showed three cases of failure of control, the patients having their overdose soon after breakfast and feeling very miserable, but by a judicious working in of the new preparation with the old it had been possible to restore them to a happier condition. Among child patients especially the "retard" made them much better, easier to look after and less irritable.

At first he thought the slow-acting insulin never acted in quite the same way two days running. But since then he had looked up a number of patients who had had only ordinary insulin and had found the same fluctuations if the patient had his diabetes well under control. Therefore he had come round to the view that it was not the failure to absorb the

insoluble product which gave rise to the erratic sugar curve, but that the fault lay with the severity or type of diabetes. Some patients raised objections to the new insulin, saying that with ordinary insulin they knew when to expect their overdose; others refused to change because it would disarrange their habit of life, and others again were disinclined to try anything new. Nevertheless, he thought the new insulins were of great value for the mild cases especially, and he hoped that by a blend of insulins, using the slow-acting and the quick-acting together, control of the difficult cases might be obtained.

The fifteen years' experience of treatment of diabetes which had been the general subject of his lectures had been a most interesting period in which to work, and he felt increasingly what a debt of gratitude was due to Banting and Best.

—B. M. J. March 19th, 1938.

WHAT ARE THE IMPORTANT METHODS OF LOCALIZATION OF FOREIGN BODIES IN THE EYE?

In a recent article dealing with eye injuries from foreign bodies by W. J. Smith [Southwestern Med. 21:384 (Nov.) 1937] it is stated: "With advances in localization, diagnosis is usually relatively simple. The history of the case is suggestive, as patients often tell of being struck in the eyes by objects. The path of the foreign body is the first thing that should be noted. In the larger foreign bodies, where there has been a considerable tear, this is self-evident. In the smaller ones, it is possible to overlook the point of entrance, and magnification, with the aid of the slit-lamp may be necessary to bring out a small opening in the cornea, iris or lens, as well as to detect early inflammation. The slit-lamp is also valuable for detecting such light weight objects as wood, stone, glass and even cilia, which do not penetrate deeply into the eye.

"Often foreign bodies in the vitreous without hemorrhage may be seen with the ophthalmoscope.

"X-ray still remains the foundation of diagnostic work for determining the presence and later for localizing foreign bodies. One point to impress is: in every case where there is the remotest possibility of something entering the eye, although physical findings do not bear this out, it is best to take a picture and rule out or prove the presence of an intra-ocular foreign body. Many intra-ocular foreign bodies have been overlooked by not doing this. From a legal standpoint, as well as therapeutic, this is most important. As a rule, a so-called 'searcher' picture is taken first to establish the presence or absence of a foreign body. If one is present, then a localization is carried out. With the aid of Dr. Sweet's localizer the roentgenologist can give the exact size in mms. of the foreign body, its distance posterior to the surface of the cornea, whether nasal or temporal ward in the vertical plane, and above or below in the horizontal plane. Unfortunately, all objects do not produce satisfactory shadows but for the most part results are accurate.

"I report a case to show the efficiency of X-ray diagnosis. While chopping wood the axe struck a bolt and the man felt something strike his right eye with great force. X-ray report by Sweet's localizer showed a foreign body 3x4x1 mm. embedded in the sclera 24 mms. back of the centre of the cornea. The eye could not be saved; it was enucleated and the piece of steel was found embedded in the sclera as described.

"In the event that a Sweet localizer is not available or a roentgenologist familiar with its use, a method has been devised by H. Gifford in which 2 small pieces of fine silver wire, 2 mms. long are placed beneath the conjunctiva. Lateral and anterior-posterior views are taken and the position of the foreign body noted in relationship to the 2 pieces of silver wire.

"Another valuable aid in detecting the presence or absence of a foreign body is the magnet. Levine tabulated the composition of common forms of steel from a table obtained from the U. S. Steel Corporation, and found that in 14 kinds of

steel, only 2 contained a fair percentage of any other metal than iron. These 2 contained about 14 percent manganese, and are used for street railway track work. He felt that foreign bodies from this source were extremely rare, but were more apt to come from hammers or chisels, made of highly magnetic steel. If the foreign body magnetic, the patient will complain of a pull when a magnet is placed over the eye and the current is made. A resulting bulging of the iris may be seen—caused by the pressure of the foreign body on it from below. With copper the magnet will not aid. However, the fact that the body in question is not magnetic, and is dense, would cause us to suspect copper, in case the clinical history bears this out."

—The Eye, Ear, Nose and Throat Monthly, March 1938.

SULPHUR DIOXIDE IN EPIDEMIC COLDS.

A. G. Rawlins (Arch. Otolaryng., Chicago, February, 1937, p. 119), with the majority of observers, accepts the following data on the causation of the common cold: (1) No definite organism has been proved responsible. (2) Visible bacteria are probably secondary invaders. (3) There is considerable evidence that colds are due to an invisible, unculturable, filterable agent of some kind. The period of incubation is from one to three days, and the period of immunity from three to four months. Many so-called colds are flare-ups of chronic posterior sinusitis. Such conditions did not come into the scope of the author's investigation, neither did epidemic streptococcal infections of the throat. The author's brother, a professor of plant pathology, working on filterable viruses which attack plants, found that these viruses do not behave towards ordinary antiseptics as do visible bacteria; 70 per cent alcohol and 1 in 1,000 solution of mercury bichloride had little effect in destroying these viruses. However, low concentrations of sulphur dioxide 0.6 to 1.5 percent readily destroyed these plant viruses, and also the virus of foot-and-mouth disease. Rawlins conceived the idea that sulphur dioxide

might likewise destroy the filterable virus of the common cold if this antiseptic could be applied to the infected area in the early stage of the disease. This can be done easily by inhaling a concentrated solution of sulphurous acid, as this liquid gives off sulphur dioxide in large quantities. In a recent winter epidemic treatment with sulphur dioxide was tried on eighty patients who were in the first stage of what appeared to be an epidemic cold. Of these fourteen received no relief, 65 stated that they were completely cured on the first or the second day after treatment. On the third and fourth days of a cold the results were practically negative. The patient is given a three-ounce bottle half filled with a saturated solution of sulphur dioxide. He inhales the gas from the bottle for ten minutes three times during the first day. Inhalations need not be deep, only sufficient to fill the nose and mouth cavity is necessary. By closing the mouth the gas is forced into the nasopharynx. Sulphur dioxide is a harmless gas as has been shown in chemical factories where workmen are exposed to these fumes.

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

STERNAL PUNCTURE.

S. GREIF (*Med. Welt*, June 19, 1937, p. 847) advises sternal puncture by means of a special needle passed through the anaesthetized skin into the sternum at the level of the second or third rib: 0.1 c.cm. of marrow if then withdrawn by a syringe and placed in a watch-glass for examination. Sternal puncture is safe and painless provided anaesthesia is complete, and the special needle prevents a passage through the posterior cortex into the mediastinum. The external table of the sternum is rarely too thick, and there are hardly

ever osteosclerotic processes to prevent the marrow from being extracted. The author advocates the use of the first and smallest possible drop of marrow for quantitative estimation. He found that from 45 to 150,000 cells are found in normal marrow, the difference in cell content in marrow taken from the same place at different times is slight, but is great when obtained from different levels in the sternum. In pernicious anaemia megalocytes, megaloblasts, and preme-galoblasts are round in the sternal marrow and in secondary anaemia there is a proliferation of normoblasts. In achylic chloranaemia the marrow is rich in cells, and there is hyperplasia of the erythropoietic system and especially an increase of erythroblasts and macroblasts. In haemolytic icterus normoblasts are increased. In leukaemias all leucocytes are increased; in aleukaemic myelosis the myelocytes are increased; in agranulocytosis leucocytes and myelocytes are absent, but lymphocytes and reticulocytes are increased in fatal cases; in milder cases myelocytes and reticulocytes are increased; in cases with rapid remissions the myelocytic elements are increased; the segmented elements are decreased; in mononucleosis there is no change in the bone marrow. When myeloma is suspected sternal puncture is the diagnostic method of choice. In cases of secondary bone tumours puncture at the site of maximum pain is useful. A large-cell type occurs in adenocarcinoma and a small-cell type in simple carcinoma. Aleukaemic conditions and myelomata can be diagnosed by sternal puncture alone. This method is an important adjunct to the prognosis of cases of agranulocytosis, secondary anaemia, Addisonian anaemia.

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BOMBAY MEDICAL ETHICS.

The Bombay Medical Council intend to revise the existing Code of Medical Ethics to suit the present conditions of medical practice in Bombay Presidency and have invited the suggestions from registered practitioners and medical associations on the proposals submitted to the Council by the Executive Committee of the Council. We wonder if the Committee were aware of the intention of the Public Health Minister, Bombay of moving a Bill to register the practitioners of the indigenous systems of medicine, at the time they drafted their proposals. We would suggest to the Bombay Medical Council that the rules for 'covering', etc., will have to be modified basing upon the new Act for the regulation of indigenous systems of medicine and providing registration of the practitioners of these systems.

Coming to the recommendations of the Executive Committee we wish to point out that the Code of Ethics should be formulated in a manner that while it protects the prestige and status of the profession gives no room for vague interpretations which will make the registered practitioners at times victims of technicalities or personal prejudices. Deriving pecuniary profit from the sale of any secret remedy is certainly objectionable but taking any part in the manufacture or sale of a proprietary medicine or food whose ingredients are not held secret cannot be an offence. If it were so, registered practitioners who are Editors or Proprietors of medical journals which publish advertisements in their journals will offend this

particular item of the Code. This will also affect eminent members of the profession who take part in the manufacture of proprietary medicines whose ingredients are not kept secret. Such a clause cannot find a place under Obligatory rules of Medical Ethics.

Under General Rules for Medical Practice and Consultations, the very first clause making it incumbent on a practitioner to have 5 years' experience in a public or private hospital before he styles himself as a consultant, is highly unreasonable and as objectionable and will be a hardship to practitioners who after extensive practice as general practitioners take to consultation practice. The responsibilities of treating patients in their own houses cannot certainly be of a lower order than the responsibilities of treatment in public or private hospitals. Apart from skill, experience or qualifications the candidate applying for posts honorary or paid in public or private hospitals has to depend upon the commodity of favouritism which all cannot command. The fact that M. Ds and M.Ss of Bombay find it very hard to compete for posts in hospitals depending upon merit and experience should also be noted by the Medical Council. Five years experience is certainly too short a period for a practitioner to style himself as a consultant. We would put the period at 10 years as the minimum whether the experience gained is in houses or hospitals. The rule that a consultant should not give advice to a patient unless a general practitioner introduces such a patient by means of a letter or in person is not practicable to follow.

are patients who do not wish to have anything to do with general practitioners who have been treating them but desire to consult a specialist direct. The consultant must not refuse to give such patients necessary advice and in case such patients are in need of injections or any other form of treatment including an operation, the consultant has to do it in the interests of the patients who go to him for relief. If this rule is forced upon the consultants it will predispose the violation of another rule which condemns fee splitting.

We have no idea of the purpose of the very first rule under the heading 'Hospitals and Dispensaries' which prohibits registered practitioners in accepting 'honorary appointments in such hospitals and institutions which treat both poor and well-to-do patients free'. Even supposing this rule is workable that it should be made applicable to practitioners wishing to work as honoraries and not to the registered practitioners in Government service is beyond our comprehension. Registered practitioners cannot be held responsible for the rules and conditions for admitting patients either in State or private hospitals. This rule if given effect to will undermine honorary medical service. The meaning of the words 'medical significance' appearing in the rule prohibiting a practitioner from styling a medical institution after his own name or with a medical significance, do not convey clearly what the framers of the Ethics have in mind. A registered medical practitioner exists for the public and the public should know the institutions where they can get medical relief and unless these institutions are made known by sign boards, it will not be possible for the members of the public to find out these institutions easily. So this rule should be modified so as to permit the practitioners to name their private institutions in a language not objectionable ethically.

The first rule under the heading 'Miscellaneous' describes the process of exhibiting a sign board and the practitioners are warned not to make use of 'an unduly large sign board.' It is not known who is to judge the size. This cannot be left to the discretion of anybody much

less of a trying tribunal. The Council should fix the size taking into consideration that Bombay is a city having very high storied buildings. As in this rule and in many others the language and wording are not definite and far from being legal. Non-compliance of the rules of Ethics being an offence to be tried by the Medical Council as a Tribunal it is highly desirable that the rules should be worded in a proper way to avoid any legal flaws.

THE CONGRESS PREMIERS' CONFERENCE.

A DISAPPOINTMENT.

The Congress Premiers' Conference sat in Bombay for full five days commencing from the 11th May. Excepting for a short reference of Medical Services specially concerning the I.M.S., nothing was mentioned in the agenda of the proceedings regarding the medical administration policy of the Congress. Summary of proceedings about a lot of political subjects could be seen in the Newspaper columns while the public are kept in the dark even about the reference about Medical Services. The Medical Profession should realise how futile it is to depend upon the politically-minded public whether they be Congress men or Congress Ministers for the development of medical relief to the masses. A few prominent members of the medical profession who are in touch with the innermost circle of the Congress have been using their influence only to displace 227 (or very near this number) members of I.M.S. by Indian Medical men not belonging to this service as if this is the only concern in which the Medical Profession is to be interested. The Medical Profession did entertain high hopes that the two Hon'ble Ministers in charge of Medical Portfolios in two major provinces of Bombay and Madras would organise medical administration in these two provinces in a way most conducive for the healthy growth of the Scientific Medical Profession whose members if encouraged to organise themselves would have been able to tackle medical relief in

urban and rural areas more effectively than through the agency of officials. Unfortunately the activities of these two ministers forbode a definite de line in the high expectations. The Madras Minister has been telling those who approached him with addresses, that the Government have no funds either to construct additional hospitals or to enlarge the existing hospitals in urban areas and it can be easily conceived that for the self-same reasons, the Government cannot be depended upon either now or in future to afford even first aids in diseases to the rural population, though village uplift is one of the main items in the Congress programme.

The affairs of the Medical Profession in Bombay or in any other province cannot be otherwise than what it is in Madras. It is conceded by all that no Government anywhere on the face of earth can afford to give free medical relief to the total population under its rule. As politics is a science of good Government and as no Government can be said to be good unless the Government concentrates itself on problems of the welfare of the people, the Congress Government should tackle the question of medical relief satisfactorily. As the urban areas are not so helpless in regard to medical relief as the villages, the Congress ought to concentrate its attention as to how best to solve this question on a large scale in villages instead of doing spoon feeding in places of political importance. There is no other alternative for the Congress Government than depending upon the high ideals of service in the members of the medical profession and persuade them to co-operate with the Government to make villages healthy abodes for the poor people to live. We therefore expected that the Premiers' Conference would include in the Agenda the subject of medical relief to the masses and are very much disappointed that nothing was done relating to this most important subject. The Congress ought to decide whether it is possible for the State to establish teaching institutions and hospitals for all the existing systems of Medicine and whether the present tendency of the

adoption of eye-wash measures to satisfy reasonable or unreasonable demands of the public, is conducive to the welfare of the people and whether such eye-wash methods are financially sound even for political purposes? We still stick to the view which we have been expressing repeatedly in these columns that the State should be in charge of Preventive Medicine otherwise known as Public Health and the Curative Medicine should be handed over to the votaries of particular systems, the Government taking care that those that practise any system of medicine possess the qualification demanded by the faculties of such systems. The present policy of Congress Ministers to establish Hybrid Systems of medicine by imparting elementary knowledge in Anatomy, Physiology, Surgery and Midwifery is not scientifically sound.

Our disappointment at the callousness of the members of the medical profession in Bombay was all the more when we found no signs of the Bombay Medical Profession taking advantage of the Premiers' Conference for expressing the views of the profession relating to the ill-conceived Bill of the Hon'ble Dr. Gilder. The proposed Bombay Medical Practitioners' Bill is likely to do more harm than good either to prevent quackery or encourage the growth of indigenous systems of medicine. We suggested in these columns last month that the Bombay Branch of the Indian Medical Association would do well to consult Dr. B. C. Roy, the President of the Association and discuss with him about Dr. Gilder's Bill. We wonder if our proposal had any effect. We could say that in the Premiers' Conference the reference of medical services especially relating to I. M. S. must be a suggestion from Bombay. The Medical man or men who were responsible for such a reference would have done much better service to the profession if Dr. Gilder's Bill was made a subject of discussion at the Premiers' Conference. There is yet time for the Bombay Medical Profession to give their thought about Dr. Gilder's Bill. The silence of the members of the medical profession in Bombay will be

construed as their half consent to this measure. What is happening in Bombay might be repeated in other provinces as the affairs of the medical profession are entirely under the control of Government everywhere. We suggest to the members of the Scientific Profession throughout India not to lose time but consider seriously about the dangers of the Hon'ble Dr. Gilder's Bill not only to the profession but to the general public not to mention to the coffers of the Government.

Before closing, we warn the medical practitioners practising in the urban and rural areas alike that they cannot afford to be lethargic about the affairs of the medical profession. They should realise that without the help of the members of the medical profession the Government cannot solve the most complicated and as costly a problem of medical relief to the masses. The practitioners should feel that the Government is theirs and the Government policy should be one dictated by the people. Nobody can mould and formulate the Government policy relating to Public Health in all its branches excepting the members of the medical profession. The fact of medical men being in charge of medical department should be considered not to be a permanent arrangement in the Government of any province. The interests of the profession cannot always be safe in the hands of medical ministers. There is a danger of the popular assemblies being misled by the medical ministers more than by lay ministers in matters medical. It is therefore necessary that the members of the medical profession should be more alert in the two provinces of Bombay and Madras than in any other. The medical practitioners even those on the lowest rung of the ladder of the profession have more opportunities of enjoying the effects of mass contact and make the masses enjoy their contact. Let the members of the profession love Service and not money and good service will not fail to bring them what they want.

News and Comments

Research on Infantile Biliary Cirrhosis: The Indian Research Fund Association have appointed Dr. K. Narayanamurthi, M.D., private medical practitioner, Mylapore, Madras, and collaborator in medical subjects, to the Editorial Staff of The Medical Practitioner to conduct research on Infantile Biliary Cirrhosis. Dr. Narayanamurti is equipped with an office and Laboratory adjacent to the Pathologic Institute of the Madras Medical College. Dr. T. S. Tirumurti, Professor of Pathology of the Madras Medical College has been requested by the Indian Research Fund Association to supervise the work for Dr. Narayanamurti. It is not likely that there will be any reliable statistics relating to the incidence of this disease in children which is reported to be common in Madras Presidency and in Bengal more in the former. We wonder if true cases of Infantile Biliary Cirrhosis are really so common as they are supposed to be. Even in normal health, children usually have a liver which may be palpable a finger width below the costal arch. Apart from Malaria and Kala-azar any infective fever has a tendency to make the liver and spleen enlarged. In ricketty children one could always palpate these two organs. Children who have a tendency for voracious appetite have usually an enlarged liver. In all conditions mentioned above, the liver could be felt, easily and if the spleen could be felt, it is proportionally smaller except in Malaria and Kala-azar.

The existence of a large number of quacks who profess to be specialists in curing this disease and their enchanting advertisements in the scientific medical journals have made even the members of the scientific medical profession the victims of faith and all enlargements of liver from whatever causes are erroneously considered to be Cirrhosis of Liver. This error has given rise to a false and exaggerated idea of the incidence of the disease. There is a tendency amongst the members of the profession to be less cautious and more careless and we are surprised to note that medical officers in charge of Child-

ren's Wards recommending their patients to be taken to these quacks. The presence of a protuberant abdomen is the only guiding factor with these quacks for diagnosing this disease and commencing treatment. We have come across about a dozen patients of true Cirrhosis of liver in the course of 25 years in the city of Madras, three of whom, were from the household of three members of the medical profession. All these patients were treated by one of the famous Vaidyans in the city of Madras and all of them succumbed to the disease. The parents of all these children cursed themselves for having yielded to the advice of qualified medical men who recommended the treatment of the famous Vaidyan. We could say from our experience that death is more certain after a correct diagnosis of Infantile Biliary Cirrhosis than cure by the medicines so far advertised. The members of the medical profession have a splendid opportunity of knowing something more definite of this disease if they take advantage of the research conducted at the Madras Medical College. The practitioners in the City and outside may avail themselves of all Laboratory tests for the diagnosis of their cases and may even attempt to try all known drugs in the treatment of this disease in a scientific way. We do not think the Research Medical Officer will have any objection to observe patients under the care of Vaidyans so long as the preparations used are handed over to him for chemical examination. The Madras Corporation will do well to co-operate with the Indian Research Fund Association and conduct a survey to find out the correct incidence of this children's disease in the city. We are told that Col. H. E. Shortt the officiating Surgeon-General with the Government of Madras was mainly responsible to recommend to the Indian Research Fund Association about the necessity and desirability for conducting research on this disease whose aetiology is as unknown as its treatment.

Dt. Medical Associations and the Hon'ble Dr. Rajan: The fact of the Public Health Minister being a medical man is taken advantage of by the District Medical Associations in the Madras Presidency

and the Hon'ble Dr. Rajan is being invited to address these Associations either during his official visits to the District Head Quarters or on the occasions of the annual gatherings of the Associations. The very first District to do this honour to the Medical Minister was Trichinopoly which was the sphere of the activities of Dr. Rajan as a general practitioner. Ever since, the Hon'ble Dr. Rajan had opportunities of meeting the members of the medical profession in perhaps 17 Districts out of 23 and he had also opportunities of meeting the members of the medical profession in Madras several times. Naturally he is heard with wrapt attention and what comes out of his lips is noted and remembered. Till the 25th December last, the members of the profession belonging to all grades in service and outside entertained very high hopes that radical and progressive reforms would be the special features during the regime of the Hon'ble Dr. Rajan, as the minister made no secret of his policy and declared wherever he met medical men that he had lot of schemes in his sleeves. He released his first scheme, the Reorganisation of Medical Services on the 25th December. Ever since the utterances of the Minister are viewed with mixed feelings and many a time with grave disappointment both by urban as well as rural practitioners. A portion of the speech delivered by the Hon'ble Dr. Rajan at Coimbatore on 25.4.38 when he was entertained by the District Medical Association, encourages us to review his 3 speeches, one delivered at Coimbatore and the other two at Guntur and Mangalore. The Minister said at Coimbatore amongst other things:

"He was aware of his shortcomings and his consciousness of it became more when he knew he was a medical man and was entrusted with the Medical Department. But he claimed to have one virtue. He was always ready to retrace his steps, if they were wrong and own his mistakes. In his desire to enhance the reputation of the profession to make it more useful and also to add dignity, through the service he was expected to render, he sought the co-operation of the smallest as well as the highest in the profession. It was in the hope that he might have the chance of doing something useful that he had accepted this office. Whether he had been doing well or ill, it was for the country to decide."

The question next arises who should bell the cat to announce what the Minister did was wrong. Courage may not be wanting and also the tact but what is hidden in between the sentences uttered by the Minister just before he confessed about his short-comings was likely to upset those who must have criticised the policy of the Government relating to the Public Health Department. As per the Newspaper reports the gist of what Dr. Rajan said just before he confessed his shortcomings is:

"Dr. Rajan then referred to his own career and the struggle that had often been waged in him between loyalty to the profession and loyalty to the country. Therefore, when he occupied this ministerial office, it had not been possible for him to wipe off entirely the past that had made him what he was."

The experience gained by at least a few who had the honour to interview the Minister on public matters before 2-5-38 should undergo a change. We wish the Minister hears his interviewers as patiently as he hears those who address him on public platforms. Then only it will be possible for those who interview him with best of interests to point out the short-comings in the Government policy. Then only 'the smallest' as well as 'the highest' in the profession will feel bold to co-operate with the Government forgetting the short-comings if there be any. Philosophy should be one of the items of treatment and not part of a speech only. That the Hon'ble Dr. Rajan means well even his enemies cannot deny. But the profession expects Dr. Rajan to do what he means. At Guntur, when the Hon'ble Dr. Rajan addressed the District Medical Association on 9-4-38, he said that the Department of Public Health was one of social service and to the army of medical men was entrusted the care and happiness of humanity. He added that it was his desire to have one medical man for at least a population of 10,000 and that this could be achieved only by voluntary and patriotic service. He declared:

"I refuse to consider medical service in terms of barter and could not think of it in terms of rupees, annas and pies. We can only conceive it in terms of national prosperity and prolongation of human life".

The Minister considered that the budget grant of a crore of rupees was too inadequate to run his department in view of the pressing need of rural population. The gist of his speech was that the Government is unable to meet the demands of medical relief and that patriotic medical men should come forward and offer voluntary service.

The Hon. Dr. Rajan forgot at Guntur that before he was made the Minister he was a general practitioner and he did barter his services for money. Yet he concluded his address at Guntur:

"Every sick or old man has to be paid for by the society and so if all medical men realise this and attend to prevention and cure of diseases without expecting anything in return, the society of which he is a part, will be less taxed. Therefore, I appeal to you not to reduce the consideration of medical service in terms of cash or kind but as national prosperity and happiness."

The ideals thrown out by Dr. Rajan could be followed by persons like himself who have enough and more to depend upon and can afford to be charitable and patriotic. The major portion of the members of the profession cannot afford to do what Dr. Rajan expects them to do.

At Mangalore when he addressed the South Kanara District Medical Association the theme of his address was National Dietary and the need for eating hand pounded rice and the use of butter milk, both of which he exhorted his audience were ideal dietary. He deprecated the request of the public for more hospitals, and he said,

"Given good water and good food and better hygienic conditions, most of the medical men would have to walk out very soon. He looked forward to the day when State hospitals would be deserted and vacated, very few people seeking admission."

He opined that Honorary Medical Service would bring the Government a saving of 14 lakhs. He declared that the future policy of Government was to substitute officials by nonofficials keeping a

bare minimum for administrative and technical purposes.

Judging by the events the members of the profession are hesitating to conceive if the hopes held out to them be realised at all even if it were possible for them to volunteer indiscriminate free medical service of the type which the Hon. Dr. Rajan expects of them without bartering their service for money. Recently there was a vacancy caused by the retirement of Dr. Guruswami Mudaliyar. There were amongst the private practitioners persons who possessed high qualifications not inferior to those possessed by the Assistant Surgeon appointed for the vacancy. The private practitioners are disappointed that Hon. Dr. Rajan did not give effect to the policy he gave expression to at Mangalore and elsewhere.

Regarding Subsidized Rural Medical Service, the practitioners are made to feel the insecurity of the conditions agreed to in the form of an indenture between the Government, the Local Bodies and the practitioners apart from the other hopes held out to them by orders of the Government. Political exigencies more than the interests of the Subsidized Service seems to have an upper hand in guiding the destinies of this service. The latest news that the Government have ordered the conversion of an Allopathic dispensary into an Ayurvedic one in Tanjore District, an act against the fundamental principles of subsidized service and against the very agreement to which the Government is a party, will shock the subsidized practitioners. Even under prevailing conditions the Government will have as many honoraries if not more and applications will not be wanting from practitioners for Subsidized Rural Service on worse conditions than now exist. The Government should feel more humiliated than the profession itself for the helpless position to which the profession is drifted to by the Government. Can the Hon'ble Dr. Rajan expect a healthy growth of the medical profession if the Government were to pursue a policy of permitting a small official minority in the profession to enjoy adequate salaries and privileges of private practice and expecting the large

majority of private practitioners in the profession to serve in State hospitals under the style of honoraries, being given a starting 'pay' of Rs. 20/- rising to Rs. 50/- the maximum being Rs. 100/-. It cannot be a surprise to him if under such conditions '*honorary men stealing away cases from the hospitals or getting their patients admitted into the hospitals for obtaining consultation free*' to use the Hon. Rajan's words picked out from his speech delivered by him at Mangalore. Can he not conceive that petty thefts by starving honoraries are nothing compared to the State robberies by the State-paid practitioners which are time-honoured by the Government even before the honoraries entered the State hospitals. In addition to such robberies there are burglaries committed in the day light on persons who are entitled for free service relating medical certificates, etc. Yet high values are assessed to such certificates by the Government.

It is not our province to speak about other professions under Government Service but the profession cannot treat lightly the views expressed by a member of the Government, who says that the morale of the medical profession is at a low ebb forgetting entirely that this is due to the indifference of the Government in not checking malpractices amounting to grave crimes in institutions run by the Government under the control of highly paid officials. During the discussion of the Medical Budget Estimate last March, the Minister openly confessed that corruption in State hospitals had assumed such proportions that it was not possible for the Government to check it. If Hon. Dr. Rajan did nothing else except making State Medical Institutions free from corruption during his regime of office, he would do excellent service both to the profession as well as to the public. The medical profession can and may do free service in State hospitals and in institutions run by themselves without the help of the State, depending upon their own resources if the Government ensures purity in Medical Administration putting a stop to the unwholesome competition between the State-paid practitioners and private practitioners,

The honoraries did not demand any honorarium why pay them in a niggardly way, call it a living age and discredit the profession. The Hon'ble Minister can remain loyal to the profession and expect the profession to do its best to co-operate with the Government to render free medical service to the indigent whether it be in rural parts or in towns and cities if he concentrates his attention in purifying the Administration under him.

C. P. Premier and the Profession: It is difficult to say whether it was tactfulness or modesty which made Dr. Khare, the Premier of Central Provinces not to take up the portfolio of Public Health though he is a medical man. The Nagpur Branch of the All India Medical Licentiate's Association gave the Hon'ble Dr. Khare a splendid opportunity to let know the profession what his individual views about the duties of the medical profession to the public are when he inaugurated the fifth Provincial Conference of the All-India Medical Licentiate's Association on 27.4.38. The Hon'ble Dr. Khare said in the course of his address:

"After completing your education, go to the villages and settle down there. You will thrive well. Though you may not have all urban amenities in the countryside, you will certainly have the satisfaction of doing something for our Motherland".

India was a poor country, continued Dr. Khare, and whatever the Government be, it could not afford to pay for all the services. Dr. Khare earnestly placed before them the ideal of selfless honorary social service and stressed the imperative need of rendering help to people in rural areas, where conditions of appalling misery and disease were yet unchecked. The Premier added that he was expressing his personal views and not that of the Government. Though he was the Premier, the Medical Department was not in his charge. It would have been, therefore, better, had they persuaded the Minister of Health, the Hon. Mr. D. P. Mishra, to attend their Conference. There was a very noble profession and perhaps the noblest of all. It had certain rights and duties and their ideal now should not be mere acquisition and possession of knowledge for personal gain. He wanted them to render some service to the Motherland.

"Spurn personal reward," he continued, "and do social service in a noble spirit of selfless service to the rural population. It is a noble cause, deserving the support of the medical profession." The Premier advised the Licentiate's

to emulate the example of the British doctor who, during the reign of the Emperor Jehangir obtained trade concessions from the Mughal Emperor for his country (England) and made no personal gain for himself, in return for restoring the Emperor's daughter to normal health. Alluding to the demand for improvement of the status of the Licentiate's who claimed fair, reasonable treatment, in respect of recruitment to the medical services, the Premier opined that their grievances were legitimate. The present distinctions and differential treatment were the result of the policy of Imperialist rulers, who created various classes in the Medical Services to carry out their orders. The Premier believed that it was in India's interests to have one set standard of qualification, eliminating the present divisions. In fact, he held the view, as in England that their hospitals should be under the management and control of non-official medical men who, he felt, could render valuable honorary service if they were given the opportunity. He advised them to ignore the false glamour attached to British and foreign degrees and do away with this feeling of inferiority complex.

The Premier, proceeding, welcomed the proposal for the early establishment of a Provincial Medical Council in the Province and agreed that they (the Licentiate's) should have adequate representations in the body, when it was constituted. He also endorsed the demand for a medical college.

The Hon'ble Dr. Khare did not mince matters. He agrees with the views expressed repeatedly in these columns that the Government of this country was solely responsible to create castes in the medical profession for the purpose of creating assistants to serve the medical officers of the Government. He does not hold hopes of Government subsidies to practitioners to render help to the public either in urban or rural areas. He exhorted the profession that social service is a part of the duties of the medical profession which he said was the noblest. The medical licentiate's proved themselves quite equal to the occasion and the General Secretary Dr. K. T. Sonak informed the Prime-Minister that the Association was now seriously engaged in examining a scheme to utilise the services of private doctors to give free medical aid to some villages in Nagpur District and open nursing centres in selected areas. We wish Medical Associations in other parts of India follow the noble example of the Nagpur Association. Such Associations will be able to dictate terms to the Government

instead of Government humiliating the noble profession by dictating terms and that for voluntary service. The Government is bound to give grants to the Associations for such work instead of paying subsidies to individuals and force upon them indentured service as in Madras Province. The Madras Provincial Subsidized Rural Medical Practitioners Association will do well to get their Association registered and take up the work of rural medical relief through their Association asking Madras Government to give grants to the Association instead of subsidies to individuals. Then only the ideals of service in the medical profession can be made tangibly visible without being tarnished or eclipsed by politics.

Constructive Criticisms:—About two months ago we received two letters from two of our esteemed readers, one from an Indian practitioner practising in F. M. S. and another from a retired Civil Surgeon of Madras. Both of them are published in the Correspondence Columns and worth reading for the constructive unbiased opinions expressed by them. The practitioner evidently had no full information about the subsidized service in urban hospitals contemplated in the Hon'ble Dr. Rajan's scheme. He perhaps is under the impression that all those who pass out from schools and colleges will have equal opportunities of serving in the State Hospital being given a subsidy. The ideal which this practitioner has in view in the interests of the profession and the public is that all newly passed medical men should have equal opportunities of service in State hospitals. This is possible and can be safely put into action without extra financial commitment if the Madras Public Health Minister pays Rs. 50 in the city and Rs. 30 in the mofussil to all the newly passed medical men and employs them as House Surgeons and House Physicians for one year. At the most the number of medical men so employed will not exceed 200 a year. The total expenditure on this account will be about Rs. 8,000. For this purpose the Government may abolish the post of two paid officers every year which they can do with no suffering to the existing staff as

it is very likely that two medical officers under the Government will retire every year. Private practice should be prohibited to those holding house appointments. Honorary Asst. Surgeons and Asst. Physicians should be recruited from amongst those who held house appointment and none of these should have dispensary practice or be attached to any of the Chemists shops. It is only those who possess high ideals of service and who can afford to render the same depending upon their own resources that have to be depended upon for honorary service in the medical profession.

The second correspondent, a retired official of the Government is of opinion that full time medical officers cannot claim privileges of private practice as a matter of right. They were allowed private practice in the interests of the public as at the time the British Government started hospitals for the civil population there were no private practitioners of the Scientific system to satisfy the needs of medical relief to the public. The correspondent quotes the example of State Medical Service in the Federated Malay States where medical officers are only permitted consultation practice and Asst. Medical Officers cannot have private practice at all and in emergent cases, in case a patient cannot get the services of a private practitioner the Asst. Medical Officers should obtain the permission of the authorities for rendering service outside hospitals. The retired Civil-Surgeon disfavours the argument of the Hon'ble Dr. Rajan that the public should not be deprived of the benefit of experience of doctors working in State Hospitals and presses the need of the Government shutting the doors of the hospitals to the rich and giving them cheap service. Such reforms can be profitably worked out with benefit to the profession, the public and the Government.

We have discussed in these columns several times and pointed out to the Government the desirability of designating medical men honorary or stipendiary depending upon the nature of work entrusted to them.

Two Madras Doctors Honoured:— We congratulate Rao Bahadur Dr. T. S. Tirumurti, Professor of Pathology, Madras Medical College, on his election as the President of the Medical and Veterinary Research Section by the Indian Science Congress Association an all-India organisation whose chief object is the advancement of Science in India by holding annually Congresses in the important cities in India. The Association interests itself in Mathematics and Physics, Chemistry, Geology and Geography, Botany, Zoology, Anthropology, Agriculture, Medical and Veterinary, Research, Physiology and Psychology. In fact these sections concern chiefly all the sciences necessary for the economic and social uplift of a nation. The Science Congress Association came into existence in 1914 and celebrated its Silver Jubilee with great pomp in Calcutta last year and the Congress was opened by His Excellency the Viceroy, the Patron of the Association. Every branch of Science which the Association deals has its own section. A president is elected each year by the Central Council of the Association and Dr. T. S. Tirumurti who was the Recorder for Medical and Veterinary Research Section for the past two years has been honoured in appreciation of his past services to the Association of which Dr. Tirumurti is a member. The fact, that in the past, persons of eminence in Scientific Research such as Dr. Sir, U. N. Brahmachari, and Col. H. E. Shortt, the present officiating Surgeon-General with the Government of Madras were elected as the Presidents for this section, will give an idea to our readers of the responsibilities of the honour of the post. We have been observing the activities of veterinarians exceedingly more than those of medical men in the proceedings of the annual Science Congress and we trust Dr. Tirumurti who has had exceptional opportunities of coming in contact with all the Universities in India and a large number of eminent medical men in the field of Research, in the course of his many-sided activities of cosmopolitan nature, will be able to give a better record of medical research in India during the tenure of his office as the

President of Medical and Veterinary Research section of the Indian Science Congress.

News has also reached us that Dr. P. Rama Rau, the Director of the Radiological Institute and Cancer Hospital in Madras has been chosen by the All India Radiological Association as the President for the current year. Dr. Rama Rau is one amongst the private practitioners in Madras who has brought credit to the medical profession specially to the Licentiate section of it. He has proved that given sufficient opportunities the Medical Licentiates are second to none in their capacity to work as specialists in any branch of medical science. In the case of Dr. Rama Rau the credit is all the more when it is known that he depended upon himself for the opportunities. A few months ago when the Madras Minister for Public Health opened the Cancer ward in Dr. Rama Rau Institute the Minister certified that Dr. Rama Rau's Institute compared favourably with that of the Bernard Radiological Institute, a Government institution attached to the Madras General Hospital. Dr. Rama Rau has been keeping his Institute up-to-date by visiting important Radiological Institute in the continent. He was one of the representatives from India at the International Congress of Radiology held recently in Chicago. The profession in the Madras Presidency will not only be glad but proud that one of them has been honoured by the All India Radiological Association.

Civic Activities of the Profession: From Newspaper reports we learn that members of the medical profession in the Madras Presidency are evincing more interest in Civics than they used to do in the past. This is as it should be. Though everybody including the Ministers preach that Municipal and Local bodies should be run on non-political lines, it will not be possible to achieve this impossibility. What those who are themselves politicians preach cannot be fathomed by us. Yet we may say that it is possible for medical men to work out civic administration for the welfare of the public eschewing

politics. It is no sin to take advantage of a popular party and enter the fields of civic or political activities. But it is expected of the members of the medical profession to avoid compromising civic conscience for political purposes after they have entered these fields for common welfare. Congress principles are not only good but sublime but some of the leaders take crooked paths and bring discredit to this National Organisation. We hope that the members of the profession who are clever diagnosticians will know which path is safe. We congratulate all the practitioners on their election success. Some of them are the readers of The Medical Practitioner, the oldest among them being Dr. P. S. Srinivasan, M. L. A., Conjeevaram, who has been a staunch Congressman. His activities towards the Congress made him enjoy the jail life more than once. Our joy is all the more when we learnt that Dr. Srinivasan has been unanimously elected as the Chairman of the Conjeevaram Municipality.

Ramnad District Medical Association: A report of the proceedings of the eighth annual gathering of the Ramnad District Medical Association is published in the Correspondence Columns. The annual report presented by the Secretary, Dr. K. S. Srinivasan seems to be one of progress. Capt. B. Dayananda Rao, the District Medical Officer of Ramnad, has been able to infuse enthusiasm in the Association and the official and non-official medical men in Ramnad District have been moving with each other in a spirit of comradeship and have been taking keen interest in matters affecting the profession in addition to the promotion of scientific development of the profession. The geographical situation of the District has made it possible for the members of this Association to come in contact with their brethren in Madura, Tinnevely and Trichinopoly Districts and the medical men of the neighbouring Indian State Pudukottah.

The fact of the affiliation of the Association to the Indian Medical Association as a regular branch has increased its activities and matters of general interests to the profession now find a place more frequently than it was in the past and it is

a good sign that the President who is an official does not disfavour such discussions consistent with the changed times. We trust the activities of the Association under the guidance of Capt. Rao with his energetic Lieutenant Dr. K. S. Srinivasan will make it more attractive and in course of time the strength of the Association will be cent percent of the existing members of the profession in the District changing the present percentage of 33.

Director-General, Indian Medical Service: We congratulate Major-General N. M. Wilson, Surgeon-General with the Government of Madras on his being appointed to act as Director-General, Indian Medical Service in the temporary vacancy caused on account of Major-General Sir. E. W. C. Bradfield going home on leave for four months. Madras has to be proud that for a continuous period of nearly fifteen years, five of the Madras members of the I. M. S. have been occupying the highest position in that service, the last one being Major-General Wilson. The first Surgeon-General with the Government of Madras to be appointed as Director-General, Indian Medical Service was Major-General Sir. T. H. Symons. He was succeeded by Major-General Sir. J. W. D. Megaw. The third Surgeon-General with the Government of Madras who occupied this position was Major-General Sir. C. A. Sprawson, the fourth being Major-General Sir. E. W. C. Bradfield. Though the last officer was not the Surgeon-General of Madras Province at the time of his appointment, Major-General Sir E. W. C. Bradfield spent the major portion of his service in the Madras Medical Department. It was an official accident that he was to be the Surgeon-General with the Government of Bombay instead of Madras. Col. H. E. Shortt, Director of the King Institute is acting as the Surgeon-General with the Government of Madras. This is the second occasion when a Research worker of eminence is made to occupy the position as the Head of Medical Department in Madras, the late Col. Bannerman being the first one. We send our greetings to Col. H. E. Shortt through these columns and hope he will have opportunities of studying the Medical Department and finding out if there are opportunities for Research to make the Medical Department more useful.

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the newly passed out medical men will be opposed to my views. Perhaps they may all welcome the new proposal of the Hon'ble Minister for Public Health, for there is no compulsion in it, but only an opportunity is given to those that are newly passed out to strengthen their professional knowledge before they start their regular battle of life independently. In fact, if some take advantage of this proposal and then start their independent work they are bound to succeed much better than those that did not take advantage of the privilege. They will prove by their self-confidence and ability that the post-graduate training had been of such great advantage to them as well as to their patients that a general adoption of the plan would eventually become a necessity. This period can be spent in one, or two, or more departments according to the nature of work the individual wishes to take up later in his life.

K. V. Krishna, M.B., B.S.,
Kuching, SARAWAK.

Sir,

The more one thinks of the Honorary Medical Relief Scheme, the more he will be convinced that the Hon'ble Dr. Rajan in his anxiety to satisfy the independent Medical profession, was rather hasty in re-organising the Scheme. He has neither socialised medical relief and medical services for the purpose of extending medical relief nor put the scheme on a basis to be attractive to the profession. There was no need at all to fix honoraria much less to justify that the humble amount of Rs. 20 was enough for a practitioner as a living wage. Such a justification coming from the lips of one occupying the responsible position of a Minister of a Province has a most degrading effect on the independent medical profession. His idea seems to be that any private practitioner can easily earn his livelihood by private practice, judging perhaps from his own experience as a private practitioner. According to service rules recent or old, Government Medical Officers cannot claim private practice as a matter of right. If private practice is prohibited by the Government to all full time officers of the Government in

stations where there are qualified practitioners as is the case in Straits Settlements, under the British Rule and anywhere else except India, there would have been less unequal unwholesome competition between private practitioners and Government Medical Officers and eventually Government Service would have grown less attractive and private practice more paying. The result would have been that the necessitous poor would have had the benefit of hospital treatment more than the rich. Consequently the rich, the higher middle class and the middle class public would have thought about the necessity of starting private hospitals and nursing homes with the help of the members of independent medical profession. As it is, when the rich find the hospital treatment cheaper than in their own houses there is no incentive either to the members of the public or the members of the medical profession to start hospitals or nursing homes. The argument usually put forward by interested people that if service men were deprived of private practice the public will be deprived of the benefit of their knowledge cannot be sound reasoning. That Dr. Rajan has been adducing the same argument is indeed a matter for surprise and for disappointment. Let me mention an instance—in the Judicial service of the Government eminent practising lawyers are recruited as Judges of the Court. A lawyer is made a judge because of his proficiency in law. By the elevation of such able lawyers the public will be deprived of the benefit of their advice. Yet the Government have not as yet felt the necessity of permitting private practice to the judges.

It will be more appropriate to style the paid Asst. Surgeon as Asst. Medical Officer consistent with the designation, District Medical Officer. There is no meaning in calling a Medical Officer in the mofussil in independent charge of a station as Asst. Surgeon or Sub. Asst. Surgeon when he does the Surgeon's work himself. So the title Medical Officer is incongruous for Honorary Medical Service. Nobody has raised this objection as yet though other points mentioned in my letter have received the attention of the profession.

A Retired Civil Surgeon.

Ramnad District Medical Association.

The Eighth Anniversary of the Ramnad District Medical Association was held on Saturday the 9th April, 1938 at the S. M. S. High School, Karaikudi. There was a large gathering of medical men. Lt. Col. N. K. Bal, I.M.S., presided.

The functions started with a tea party and a group photo. At the business meeting presided over by Captain B. Dayananda Rao, the Annual Report approved by the Executive Committee and presented by the Secretary was adopted. The following suggestions were made by some members of the General Body:—

- i. The amount of Rs. 58 spent on Taxi and bus:—It was suggested that such expenses should be minimised.
- ii. Professional subjects should as far as possible be read and discussed every month.

The following resolutions were carried:—

1. This Association having become a Branch of the Indian Medical Association, the Association's official year be changed from 1st April to 31st March to the 1st October to the 30th September every year. The subscription of Rs. 3/8 and Rs. 2 for the extra half year of the 1st April to the 30th September, 1938 for every regular member and associate respectively of the Association be also collected and the accounts for this extra half year be included in the accounts for the year 1938-39 i.e., from the 1st October 1938 to the 30th September 1939.

2. A Special Committee be formed to amend the existing bye-laws so as to be in conformity with the rules of the Indian Medical Association and that the Committee do consist of Drs. Ratnaswami, Rajaram Bharathi, R. Bheem Singh, the President, the Treasurer and the Secretary of the Association for the new year with powers to co-opt and the Secretary to be the convener.

3. The following were elected as Office-bearers for the next year:—

President: Captain B. Dayananda Rao,
Vice President: Dr. F. Ysander,
Secretary: Dr. K. S. Srinivasan,
Joint Secretary: Dr. R. Bheem Singh,
Treasurer: Dr. S. Subramanian,
Committee: Drs. K. R. Ratnaswami, E. Ivatts, S. Rajaram Bharathi, C. Sambamurthi
Auditors: Dr. A. Jabbar and Dr. T. V. Appaswami

4. The President of the Association Captain B. Dayananda Rao, District Medical Officer, Ramnad, was elected to be the representative of this Branch on the Central Council of the Indian Medical Association.

It was suggested that any function in the name of the Association should be done after consultation with the Committee.

The Annual meeting commenced with a welcome address by the President of the Association, Captain B. D. Rao.

The Secretary read messages of greetings from the District Medical Associations of Tinnevely, Tanjore and the 'Independent Medical Practitioners' Association of Tinnevely, Professor Tirumurti, Col. T. S. Shastri, Drs. U. Krishna Rao and V. Rama Kamath. Dr. O. R. Balu of Trichinopoly District Medical Association, Dr. M. V. Natesan of Madura Association and V. Ramachandran of Pudukottah Medical Association also greeted the gathering on behalf of the respective Associations.

Dr. K. Vasudeva Rao, Director of Tuberculosis Institute, Madras, delivered an interesting and impressive lecture on the value of Temperature Charts in the Diagnosis and Prognosis of Pulmonary Tuberculosis. Dr. R. Sambasivan, M.B. & B.S. of Trichinopoly read a paper on 'Food' illustrated with charts. Discussions followed in which the President took keen interest and wound up the proceedings. The Secretary proposed a hearty note of thanks to Col. V. K. Bal, the lecturers and the guests. After music and dinner the gathering dispersed.

Review.

A PRACTICAL GUIDE IN THE TREATMENT OF EYE DISEASES.

BY DR. V. KRISHNAMURTI,
*Ophthalmic Surgeon, L. N. Hospital, Chodavaram,
 Vizagapatam District, South India.*
 Demi octave 86 pages. Price Rs. 2/-

The author after specialising in Eye Surgery at the Minto Ophthalmic Hospital, Bangalore, in 1931 is running a private Eye Hospital in Chodavaram, Vizagapatam District, Madras Presidency. The book is a compendium for easy reference for junior practitioners who wish to undertake Eye work in general practice and this is a necessity for practitioners settling in small urban towns or villages where a general practitioner should have a comprehensive knowledge in all branches of medicine and surgery. This little book is likely to serve also as an encouragement to practitioners to do eye work in the moribund in addition to its serving as a book for reference. We congratulate the author on his spirit of enterprise in the theory and practice of Eye Surgery as a speciality.

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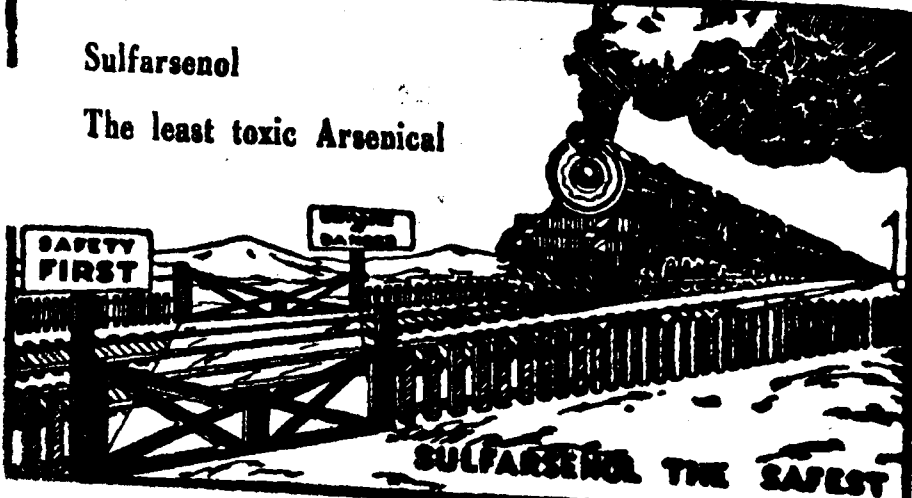
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A Monthly Medical Journal

EDITED BY

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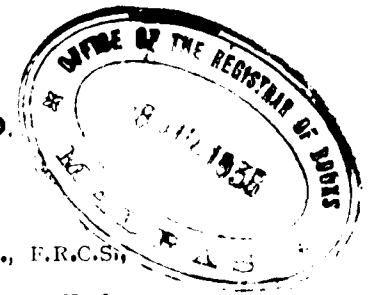
Original Articles.

INFECTIONS OF THE HAND.

BY

DR. B. M. SUNDARAVADANAM, B.A., M.B., F.R.C.S.,

Honorary Surgeon, Government General Hospital, Madras.



Infections of the hand form one of the commonest conditions met with in general practice. For a correct diagnosis and treatment of this condition, a thorough knowledge of the anatomy of the part is essential. To Kanavel belongs the credit for having clarified the whole subject of suppurative in the palm.

Infections of the hand can be considered under three groups :

1. Infections of the Fascial Spaces of the Hand.
2. Infections of the Tendon Sheaths.
3. Paronychia.

In any case of hand infection it is important to diagnose between Tenosynovitis, fascial space infection, and lymphangitis. The second condition is generally the result of an extension of the first and takes about 48 hours for its onset. It is important to diagnose between Tenosynovitis and primary lymphangitis as in the former condition, the treatment is immediate operation while

in the latter, conservative treatment should be adopted.

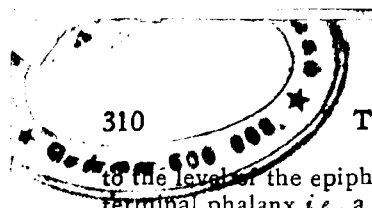
INFECTIONS OF THE FASCIAL SPACES.

There are seven well defined fascial spaces where pus can accumulate. Kanavel describes six but to these the pulp space at the tip of the finger can also be added.

These are :—

- (1) the pulp space,
- (2) the thinar space,
- (3) the middle palmar space,
- (4) the hypothenar space,
- (5) the lumbrical spaces,
- (6) the dorsal subcutaneous space
- (7) The dorsal subaponeurotic space.

1. THE PULP SPACE: This compartment extends from the tip of the finger



to the level of the epiphyseal line of the terminal phalanx *i.e.*, a quarter of an inch distal to the last interphalangeal crease. Infection generally occurs by a punctured wound especially when made by infected safety pins and surgical needles. The finger becomes red and very tender and the constitutional symptoms may be very severe. If left untreated, necrosis of the terminal phalanx and infection of the joint or the flexor tendon sheath may follow.

TREATMENT: When the tenderness is most marked over the pulp of the finger, hot saline baths and fomentations are given. As soon as induration is felt over the pulp, an incision is made and the pus is let out. A tourniquet is placed around the base of the finger. The best incision is a curved incision passing through the middle of the pulp of the finger from one side to the other. Fomentations are applied for the first 48 hours and then the wound is irrigated daily with eusol. When treatment is delayed the terminal phalanx becomes necrosed and may come away on incising the pulp. The patient is left with a good functional digit although it is shortened and there is an ugly curved nail at its tip.

2. THE THENAR SPACE: This space lies between the superficial muscles of the thumb and the adductors of that digit. Medially a strong fascial septum which is attached to the middle metacarpal bone, separates it from the middle palmar space.

Infection of this space is generally due to the bursting of the tendon sheath of the index finger and rarely of the middle finger and thumb. There is "*balloning of the thenar eminence*"—this appearance is characteristic of infection of this space. Flexion of the distal phalanx of the thumb occurs but there is no resistance to extension, unlike as in tenosynovitis of the flexor longus pollicis.

Drainage should be instituted at the earliest possible moment. The incision is made on the dorsum, parallel to and a third of an inch on the radial side of the

metacarpal bone of the index finger, extending to about the distal two-thirds of the bone. A sinus forceps is introduced and it passes across the palmar aspect of the bone, to enter the thenar space. The tip of the forceps should not be allowed to go beyond the radial side of the middle metacarpal, lest the middle palmar space be infected. No drainage tube is necessary.

3. THE MIDDLE PALMAR SPACE: This lies deep to the flexor tendons and the lumbrical muscle and is limited on the radial side by the fascial septum already described as being attached to the middle metacarpal bone. Deep to it are the intrinsics muscles.

The middle palmar space may become infected from rupture of the tendon sheath of the middle, ring, or little finger rarely from penetrating wounds of the palm, and sometimes from osteomyelitis of the middle and ring metacarpal bones.

There is enormous swelling of the whole hand and the concavity of the palm is obliterated and is replaced by a slight convexity. Drainage of the middle palmar space is effected through lumbrical canal. The web between the ring and middle fingers as a rule or that between the ring and little fingers, is opened up by an incision beginning on the dorsum of the web and passing on to its palmar aspect, ending a little distal to the distal flexion crease of the palm. Pressure is applied over the middle palmar space and if pus exudes through the web incision, a director is passed along the lumbrical canal and the incision is extended, dividing the web almost to the distal flexion crease. Often the accompanying tenosynovitis of the middle or ring fingers must be treated at the same time.

4. THE HYPOTHENAR SPACE is strictly localised and has no connection with any other space or tendon sheath and is of little importance.

5. THE LUMBRICAL SPACES of which there are four, lead from the palm round the radial sides of the fingers to

the dorsum. They form a channel through which pus may track from the palm to the dorsum of the hand. Fluctuation can be elicited just above the web on the dorsal aspect. The lumbrical spaces are drained by splitting the interdigital web.

6. THE DORSAL SUBCUTANEOUS SPACE: Infection of this space is rare; often the dorsum of the hand becomes swollen from oedema when the infection is in the palm. There is pitting on pressure if it is only oedema but in cases of infection of the dorsum, there is induration and the looseness of the connective tissue allows pus to travel all over the hand.

7. THE DORSAL SUBAPONEUROTIC SPACE: As in the preceding the infection of this space is also rare. Dorsal incisions are made in the intermetacarpal spaces, usually two being enough. Often more than one space may become simultaneously infected in which case all the infected spaces should be drained.

INFECTIONS OF THE TENDON SHEATHS

Suppurative Tenosynovitis is generally due to infection from punctured wounds, or by extension of the suppuration in one of the other varieties of whitlow. The whole finger becomes extremely painful and tender. The finger is kept semi flexed and attempts at extension cause severe pain. The whole finger and often the hand is red and swollen, the swelling being most marked on the dorsum of the finger and hand.

In the palm of the hand, surrounding the tendons of the flexor sublimus and flexor profundus digitorum, is the great palmar bursa. This sheath extends downwards to the middle of palm and passes under the anterior annular ligament up the forearm from $1\frac{1}{2}$ inches. The tendon sheaths of the index, middle and ring fingers end blindly over the heads of the respective metacarpal bones. The tendon sheath of the little finger is a direct prolongation downwards of the great palmar bursa. The sheath of the

flexor longus pollicis extends from the base of the terminal phalanx of the thumb to $1\frac{1}{2}$ inches up the forearm above the annular ligament. In about half the number of cases, this sheath communicates with the great palmar bursa.

Tenosynovitis of the little finger and thumb readily extends into the palm and under the annular ligament to the forearm. As a result of suppuration in the synovial sheaths sloughing of the tendons is common, the interphalangeal and metacarpophalangeal joints are frequently infected and the condition may be so advanced as to necessitate amputation of the finger or rarely, even the whole hand.

TREATMENT: Consists in free and early incisions and drainage of affected part. A general anaesthetic is necessary, preferably gas and oxygen anaesthesia. A tourniquet should be applied above the wrist. The incision is made to one side of the tendon sheath so as to avoid prolapse of the tendon. Two incisions are made as a rule, one over the proximal and the other over the distal phalanx. If there is much swelling, the incisions can be joined together. If the tendon has sloughed away, the proximal end of the tendon is anchored to the periosteum by a catgut suture and the rest of it is excised. If the lumbrical canal is infected, at the same time, then the web should be split as far as the distal palmar flexion crease. The procedure is the same in the case of the index, middle and ring fingers.

THE LITTLE FINGER AND THE PALMAR BURSA: There is much oedema of the back of the hand; and there is also swelling in the forearm, above the anterior annular ligament. The point of maximal tenderness is situated between the two distal flexion creases of the palm in a line with the interdigital cleft between the ring and little fingers.

TREATMENT: An incision is made over the proximal two phalanges on the ulnar side of the sheath. If after this incision is made, pus exudes from the proximal portion of the wound, on exerting pressure over the ulnar part of the palm, then

it is a sign that the palmar bursa has become infected. This is opened up by an incision from the distal flexion crease along the centre of the hypothenar eminence towards the base of the palm. If there is pus in the forearm, then an incision is made on the ulnar side of the forearm, commencing about $1\frac{1}{2}$ inches above the tip of the styloid process of the ulna.

THE THUMB: The terminal phalanx of the thumb is kept flexed with marked tenderness over the sheath. There is swelling in the forearm also just above the anterior annular ligament. In cases of tenosynovitis of the flexor longis pollicis careful examination should be made to determine if there is any spread of the infection to the palmar bursa as there is a communication between the flexor pollicis tendon and the palmar bursa in a fair percentage of cases.

TREATMENT: An incision is made on the proximal phalanx of the thumb, a little to the radial side. The tendon is followed through the thenar eminence to within an inch of the anterior annular ligament. The sheath is laid open and drainage is provided for. An incision is made on the radial aspect of the front of the forearm for about two inches, commencing an inch above the anterior annular ligament. If there has been severe infection and delay in adopting drainage, then the removal of the flexor longus pollicis tendon should be considered. If it is not likely to recover, then it should be removed after the proximal end has been anchored in the forearm.

AFTER TREATMENT OF HAND INFECTIONS: A good number of elderly patients come up with infection of the hand, who are suffering from Diabetes and this should be borne in mind. In case of tendon sheath infections, the hand should be put up in splint in the dorsiflexed position.

Hot saline baths for two hours at a time are given twice a day during the first two or three days and afterwards, sterile paraffin or vaseline dressings applied. If there is much slough, eusol baths are better. Morphia can be given to relieve the patient of the pain on the first day.

PARONYCHIA

Paronychia is due to infection of semi-lunar fold at the base of the nail. It is not a serious condition. If neglected, necrosis of terminal phalanx may occur.

TREATMENT: Consists in making two lateral incisions, one on either side, the incision starting in each case at the edge of the base of the nail and passing proximally for above half an inch. In very early cases, one lateral incision may be sufficient. Hot moist magnesium sulphate dressings are applied to the whole finger for 48 hours. If there is much pus under the nail, the base of the nail will have to be removed, to provide efficient drainage. Only the proximal portion of the nail is removed the distal portion is left on to protect the sensitive part.

DYSENTERIES.

By

DR. K. NARAYANAMURTHI, M.D.

(Continued from the last issue.)

The readers will note that in this issue as in the previous, only Bacillary dysentery is dealt with. Other varieties of dysentery will be taken up separately in the future issues of The Medical Practitioner.

DIAGNOSIS: Though the diagnosis of milder forms of dysentery is a difficult problem, one can be certain of diagnosis in all severe forms. The Laboratory diagnosis of dysenteries has its own value but for all practical purposes, the clinical naked eye appearance of the stools as described by Cunningham has been of great value in controlling epidemic and endemic dysentery in such institutions as schools where it has been possible not only to segregate the patients but also to follow a definite line of treatment. A typical stool of bacillary dysentery is inoffensive containing almost entirely of bright red blood and mucus with little or no faecal matter during the first few days. In amoebic dysentery the character of the stool may be very varied indeed. It may be a simple diarrhoea or the stool may be semi-formed with or without blood and mucus and its colour may vary from deep brown to green. It is often a small stool with cellular exudate. As a rule the blood and mucus tend to mingle more freely with the faecal matter than in the case of a bacillary stool. There is a simple test which gives very useful information. The stool of Bacillary dysentery when tested with litmus paper is strongly alkaline with a pH. of about 8.0 while that of Amoebic dysentery is often markedly acid with a pH. of about 6.1 to 6.6. This phenomenon is due to the fact that in the Bacillary stool the red blood

corpuscles and hæmoglobin are unaltered. In the acid stool of Amoebic dysentery the red blood corpuscles are affected and their hæmoglobin is changed into acid hæmatin.

It must be borne in mind that very often there are cases of mixed infection of Bacillary and Amoebic dysentery. Fletcher and Jepps noticed in a series of 198 cases, 27 cases i.e., 14 per cent were of mixed infection. According to Pillai and Murthi (1935) out of a total of 319 cases, 22 cases i.e., 6.4, per cent were found to be of mixed type. It is much more common for acute Bacillary dysentery to supervene in the intestine which has chronic Amoebic ulceration. The Bacillary dysentery is frequently contracted in a hospital by a patient who has come there for the treatment of Amoebic dysentery. Amoebic ulceration superimposed on a Bacillary infection is a rare condition. Keeping a four hourly temperature chart, will often help, in the diagnosis of the two dysenteries, the Bacillary dysentery is always associated with rise of temperature while in Amoebic there is rarely a rise in temperature. Ballantidial dysentery is so rare in India that we need not consider it here. The other Flagellate Protozoa, Chilomastix and Trichomonas and Giardia may be present in considerable numbers in Bacillary dysentery especially during the convalescent stage. This Protozoa are secondary invaders and they are not pathogenic. The differential diagnosis between Bacillary and Amoebic dysentery is given in every text book, but a few points which are of great interest to a practitioner are mentioned in a tabular form.

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BACILLARY DYSENTERY.

An acute disease with a tendency to spread as an epidemic—"Lying down dysentery".

Incubation period—a short one, 7 days or less.

Onset—acute.

Pyrexia—common.

Course—days or weeks.

COMPLICATIONS—Polyarthritides; eye complications.

DEATH DUE TO:

(a) Exhaustion.

(b) Toxaemia.

SIGNS: General tenderness over whole abdomen, more marked over sigmoid flexure.

Tenesmus very severe.

PATHOLOGY: Acute diffuse necrosis of mucous membrane of large intestine due to toxins of the dysentery bacillus.

ULCERS: When present are on free edge of transverse folds of mucous membrane and distributed transversely to the long axis of the gut.

Serpiginous in outline, with ragged undermined edges, often communicating with neighbouring ulcers; bases consist of granulation tissue.

Intervening mucous membrane, hyperaemic, rarely perforate, no compensatory thickening of bowel-wall.

STOOLS: Scanty, many in number, bright blood-red, gelatinous; viscid mucous, odourless resembling red-currant jelly.

REACTION: Alkaline.

MICROSCOPIC PICTURE: Numerous, red cells, polymorphs numerous with clear cut ring nuclei. Macrophage cells may be numerous. Few visible micro-organisms.

BLOOD EXAMINATION: No leucocytosis.

The sigmoidoscope examination is positively harmful in both chronic and acute stages of the disease for, the trauma caused by instrumentation is positively harmful and dangerous. Therefore its

AMOEBIC DYSENTERY.

A chronic epidemic disease—"Walking dysentery".

Incubation period a long one, at least 20—90 days, it may be more.

Onset—insidious.

Pyrexia—rare, unless complicated.

Course—usually prolonged.

COMPLICATIONS: Hepatitis, abscess of liver; abscesses more rarely in other situations.

DEATH DUE TO:

(a) Exhaustion.

(b) Perforation.

(c) Haemorrhage.

(d) Liver abscess.

SIGNS: Local tenderness and thickening, mostly over sigmoid flexure, transverse colon and caecum.

Tenesmus not so severe.

PATHOLOGY: Local lesions confined solely to the large intestine due to the characteristic ulcers.

ULCERS: Commence as abscesses of sub-mucosa distributed in long axes of gut. "Flask-shaped ulcer".

Oval in shape, regular in outline flask shape in section involving all coats; bases consist of necrotic black tenacious sloughs.

Not uncommonly perforate; compensatory thickening of bowel-wall, intervening mucous membrane not affected.

STOOLS: Intermingled with blood and mucus, resembling anchovy sauce (sago-grain stool), very offensive, smelling of decomposing blood, generally copious.

REACTION: Acid.

MICROSCOPIC PICTURE: Red cells, numerous and in clumps, polymorphs much damaged, often extruded nuclei, Macrophage cells scarce, large number of motile bacilli. Entamoeba histolytica, generally with ingested red cells, Charcot Leyden crystals common.

BLOOD EXAMINATION: Usually a moderate leucocytosis.

value is very much limited to cases of chronic and sub-acute types wherein probably the ulcerations are seldom seen. It is possible to get fresh material for microscopic examination and culture by

passing a sterile rubber catheter into the rectum rather than make an attempt to get the material by passing a sigmoidoscope.

Serological diagnosis is of little aid in the early stages of the disease or in the very acute or rapidly fatal cases. But it is of considerable assistance in the chronic Bacillary dysentery where high-titer agglutinations are obtained.

PROGNOSIS: This depends upon the susceptibility and the physical conditions of the patient. The mortality rate among the debilitated poverty-stricken and malaria infected Indians attacked by this disease is very great.

TREATMENT: The treatment of an acute or sub-acute attack of dysentery essentially consists in an accurate diagnosis. It is usually possible to decide the plan of treatment by a clinical examination of the stools if necessary supplemented by cultural examination. It is quite rational to commence treatment for any dysentery with castor-oil emulsion with an idea to gain time for doing Laboratory tests. In a case where a patient has slight temperature passing inoffensive stools containing blood and mucus, one is perfectly justified to start the treatment for Bacillary dysentery as the percentage proportion between Bacillary dysentery and Amoebic infection is 81 to 19 per cent as in Madras (Pillai and Murthi). However, we have to recognise that there are two main types of acute Bacillary dysentery. In one, the Shiga type, pyrexia is usually marked with collapse. The stools are very frequent 20 or more or none at all as in gangrenous variety. The Shiga bacillus produces an intra cellular and extracellular toxin in addition to the production of poisonous pressor bases from animal proteins. Acton, Chopra and Boyd have shown that pressor bases which are extremely toxic and are not destroyed by heat, are formed from the amino acids of the protein molecules in the gut and can be isolated in the argenin fraction. They are therefore not identical with

histamine. Pressor bases cause dysentery with collapse. They have a marked selective action on the uterus and this accounts for the frequency of miscarriage in pregnant women. In Flexner dysentery the symptoms are usually milder and collapse is less frequent. Flexner bacillus produces an intracellular, but no extracellular toxin. It is of interest to note that both Shiga and Flexner group of organisms are facultative and anaerobes and hence infect the large intestines. Both groups can exist at a wide pH range varying from 5.4 to 9.1 and so the administration of alkalis is of little or no value in Bacillary dysentery. The growth of Shiga bacillus is inhibited by sugars such as glucose. Armed with this knowledge the first and the most important principle in the treatment is to restrict patient to bed. The patient should have absolute rest, must be made to use the bed pan and should be warned that any neglect to carry out details, would be disastrous. In cases where there is a tendency for collapse, patient should be kept warm using hot water bottles if necessary. Solid food in any form should be withheld. In Shiga's infection all animal proteins should be eliminated from the diet; by so doing it will help reducing the toxemia. The diet should consist solely of carbohydrates such as arrowroot, sago, barley water or rice congee sweetened with glucose but with no milk. In Flexner infection on the other hand, carbohydrates should be eliminated from the diet and such articles as meat extracts, citrated milk, butter milk, jellies, weak chicken broth, and later eggs may be allowed. During convalescence fish and meat may be gradually added to the diet but carbohydrates should be added last of all. Cold drinks are not permitted as they are apt to increase intestinal peristalsis. Dysentery patients should not be rushed through convalescence as the ulcers in the bowel take time to heal and any indiscretion in diet is very often followed by a relapse. The patient and the attendants should be told that the stools are highly infectious and warned that special care to be taken about disinfection.

SPECIFIC TREATMENT: Opinion is nearly unanimous that the administration of Polyvalent Anti-serum is of very great value in Shiga infection. The action of the serum is to be regarded as purely anti-toxic rather than antimicrobial. It should therefore be remembered that the serum has no value in Flexner infection, as the toxin of the Flexner bacillus is an intra-cellular one. The idea underlying the administration of the serum is that of neutralizing the toxæmia and also of preventing cellular necrosis of the mucosa. When necrosis has occurred it is doubtful whether the serum has any effect whatsoever. Therefore it is always desirable to administer the serum within the first 48 hours of the disease, if it is to be of any value and it is practically useless after 48 hours from the onset of the symptoms. It is to be noted that every case of Bacillary dysentery does not require antiserum treatment. The indications for the use of the serum should be based upon:

- (1) the patient's general condition,
- (2) the pulse,
- (3) the number of stools,
- (4) acute abdominal pain and
- (5) temperature.

A prompt serum treatment should be given if the case is running high temperature with the passing of more than 12 to 20 stools with mucus and blood within 24 hours. Fletcher and Jepps recorded very disappointing results with anti-dysentery serum as they have used it indiscriminately on cases due to both types of bacilli. They record that out of 246 consecutive cases (*B. dysenteriae* Shiga 20; *B. dysenteriae* Flexner 226) with 74 deaths the case mortality being 30.1 per cent. In the control group of 329 patients (*B. dysentery* Shiga 11; *B. dysentery* Flexner 318); where no serum was given 100 died, the case mortality working to 30.4 per cent. They discovered that the serum even if administered at the beginning of an attack of Flexner was almost always useless and so its administration did not affect a real reduction though they used

the Leicester institute serum supplied in cold storage. The Lister serum showed a full agglutination titer against Flexner bacillus but rapidly lost its agglutinating properties against Shiga's bacillus. It is obvious therefore the necessity of using always fresh serum which could be possible only if it is manufactured in India.

There are various routes by which the serum may be administered. In fulminating cases it is best given intravenously 60 to 80 c.c. diluted with a pint of normal saline. The fluid should be injected slowly. If a deposit is present it is better to strain it through a sterilized filtered paper. If there is any reason to suspect that the patient had received any injection of serum against tetanus or diphtheria, it is advisable to desensitize the patient by giving $\frac{1}{2}$ to 2 c.c. of the serum subcutaneously and wait for 12 hours before the administration of the larger intravenous dose. The other route by which the serum could be given is the intramuscular in which case also one has to be cautious of the possibility of hyper-sensitivity to horse serum. In all cases it is advisable to give a small quantity of the serum subcutaneously and watch for the development of the symptoms of Anaphylaxis. A convenient site for the injection is the adductor muscles of the thigh. The serum can be given also subcutaneously but it causes not only great discomfort and pain but also the time taken for its absorption is well nigh over 48 hours as against 8 hours when given by intramuscular route. Whichever route chosen if the toxic symptoms do not abate, a second injection may be given after 48 hours of the first injection. In children who are very susceptible to toxins of dysentery the serum may be given by the intraperitoneal route. About 10 to 20 c.c. of the serum should be diluted with 100 c.c. of 5 per cent glucose in normal saline. It is essential to see that the serum is not deteriorated before use. In the tropics it is very essential that all curative sera should be stored in 'frigid air' or in the ice chest. After a week of the injection the patient may develop serum sickness *viz.*, urticaria, rash, pyrexia, stiffness of joints, and palpi-

tation of the heart, etc. To anticipate and further prevent the advent of such symptoms calcium lactate 30 grs. a day may be given by mouth on the day of the injection and in a lesser dosage to be continued for 2 or 3 subsequent days. One has to give straight away an injection of Adrenalin $\frac{1}{2}$ c.c. subcutaneously soon after the symptoms of serum sickness are observed.

Serum treatment is no good, in the chronic form of the disease or in debilitated individuals.

BACTERIOPHAGE: It is possible that a natural recovery from an acute attack of Bacillary dysentery lies in the development of a bacteriophage in the intestines to combat the infection. A potent anti-Shiga phage has been prepared by Prof. d'Herelle, Marison and others. The reports of recovery after the administration of the phage vary. But it is worthwhile trying it in children who are debilitated as the administration of the phage is simple. The dose is usually 1 to 2 c.c. to be given once or twice daily by mouth. No drugs should be given during the treatment by phage. The phage can also be given by rectum as retention enema. It is difficult to obtain accurate statistics as to the failure or otherwise of the treatment of the phage. Fletcher records disappointing results of the use of the phage in Flexner infection. He found the bacteriophage was more active against Shiga bacillus. The observations made by Tylor and Cresval (1930) show that the results obtained by the use of the bacteriophage were inconclusive.

TREATMENT WITH DRUGS: If the patient is seen during the earlier phase of the disease, whatever might be its severity, castor oil emulsion may be given. This has the effect of cleaning out the small intestines, which may be loaded with proteins and carbo-hydrates—the result of pancreatic digestion. The routine treatment with saline aperients has received universal support. The aperient sulphates act mechanically by flushing the gut of the toxins altering the pH. of

its contents to a more alkaline condition and thereby check the production and absorption of toxins. The sodium salt is less irritant than the magnesium salt. In adults the sodium sulphate is given in drachm doses every two hours for the first day and afterwards every four hours till the stools become faeculent. The routine treatment of dysentery with opium is to be deprecated. If, however, the patient is exhausted with constant tenesmus and pain and cannot obtain sleep, $\frac{1}{4}$ gr. of morphia may be given subcutaneously at bed time. The resulting rest and sleep will materially help in the fight against the disease.

Of other drugs the use of bismuth is very valuable in severe cases. The carbonate is better than the subnitrate as the latter is apt to contain some impurities. Salicylate is used if there is high temperature; Kaolin can also be used. Kaolin prevents the absorption of the dysentery toxins in the intestinal canal by providing probably a protective coat to the inflamed mucus membrane. A mixture of animal charcoal and Kaolin has been utilised in Germany and in Austria. Lacto-Kaolin and similar preparations are available in the market.

The intestinal antiseptics are of no avail during the acute stage of the disease though they might have a place later. It is almost impossible to kill the dysentery bacilli *in situ* by antiseptics. Yatren given in pill form by mouth or injected by rectum has its advocates in Germany. The manufacturers advise very big doses of this compound, but anything more than 15 grains a day is distinctly irritant to the gut. Rivanol an intestinal disinfectant has been used in epidemics as a mass treatment for Bacillary dysentery. The dose for an adult is 1 gram (*i.e.*) 15 grains tablet three times daily. This drug is not only cheap but has no untoward effects.

Irrigation of the colon is of distinct value in very severe cases as it mitigates strain and incessant desire for defecation. The simpler the irrigating fluid the better. Warm saline or boric lotion drachm to

a pint is perhaps the best. The anal parts should be thoroughly cleaned particularly in children. Linoline, hazelin or mere vaseline may be applied.

TREATMENT OF URGENT SYMPTOMS: Collapse is easier to guard against than to overcome, when it is once established. It is due to physical exhaustion inherent to the disease, made worse by excessive straining and loss of fluid. Stimulants such as brandy and glucose are very helpful. Intravenous saline should be administered, 1 to 2 pints with 20 c.c. of antidyenteric serum in case of Shiga infection. In choleric cases Roger's hypertonic saline treatment is useful. The solution consists of 120 grs. of potassium chloride to sterilized water one pint, 35 grains of glucose may be added to this solution. Vomiting and hiccough are serious symptoms. A small dose of adrenalin may be tried by the mouth. This sometimes allays severe hiccough but it should be noted that these symptoms are due to severe toxæmia and are of serious import.

Pain due to griping and tenesmus is relieved by hot bath or hot fomentations or turpentine stupes. Tenesmus, dysuria are best relieved by morphia given hypodermically; or by an enema of thin starch (4 ounces) containing 40—60 drops of laudanum or by suppositories of morphia and cocaine. Manson-Bahr gives the following mixture in severe colic.

R/

Tr. Belladonna	mms. 7.
Pot. Bromide	grs. 10.
Tr. Chloroform et. morphia	co
	mms. 10.
Syr. Auranti	dr. 1.
Aqua menth pip add	oz. $\frac{1}{2}$.
Fiat Mist. $\frac{1}{2}$ ounce T. D. S.	

AFTER TREATMENT: The majority of cases of Bacillary dysentery get well as a rule with judicious dieting and the use of aperient saline for 3 or 4 days. As soon as the stools become faecal the salt should be stopped and Bismuth salicylate

gr. 10 with Pulv. ipecac Co. Grs. 5 be given at 4 or 6 hourly intervals. The chief trouble during convalescence is constipation. The best aperient for such patients is liquid paraffin or plain Pétrogar or a tea-spoonful of castor oil at bed time. Bael fruit sherbet is a useful adjunct to the dietary as it acts as a demulcent and also as an astringent. Another good demulcent is ispaghula seeds, soaked over night and taken early morning. The mucilage from the seeds is not acted upon by the enzymes but forms a smooth coating over the inflamed mucosa. The treatment of chronic Bacillary dysentery cannot be said to be satisfactory; for the healing of a chronically scarred and ulcerated bowel is effected slowly and with difficulty. The diet should be carefully regulated and no pungent things should enter the dietary for months. Gentle abdominal massage over the course of the large intestine is helpful in promoting normal peristalsis, in relieving the pain and discomfort and in promoting the nutrition of the intestines.

TREATMENT OF COMPLICATIONS: Little need be said by way of treatment of the complications of acute Bacillary dysentery as they are so uncommon in India. Arthritis is best treated by application of Scott's dressing, by radiant heat or by hot sand baths. The fluid collected in the joint is usually not sufficient in amount to call for aspiration. Iritis is treated by atropine and the use of an eye-shade.

SURGICAL TREATMENT: In chronic cases, when the patients' health deteriorates, drastic methods like right inguinal colostomy or appendicostomy has to be adopted to save life. The caecum and colon can be washed as frequently as desired. In cases with a polypoid condition of the mucous membrane and incessant blood stained diarrhoea, caecostomy should be certainly given a trial. The results have been successful in cases which were recorded to be incurable by medicinal treatment.

PROPHYLAXIS: Consists in the supply of pure water and in avoiding unwholesome

and contaminated food. Patients suffering from mild symptoms particularly in jails and asylums should be isolated. First the carrier is found out, as he is potentially infectious. He is isolated and treated with vaccines. Kolmer treats such cases by giving an initial dose of 1 million bacilli subcutaneously, increasing it to 5-10 million organisms.

Research workers in Japan and later Gibson in England introduced an inoculation by which the toxic effects are neutralized by the addition of a potent anti-Shiga serum, which is known as sero-vaccine. The vaccine and serum are put in a phial with two arms, the bacillary emulsion being in one arm and the serum in the other. Both are mixed before use. The initial dose is 0.25 c.c. containing 500 million Shiga organisms

mixed with 0.1 c.c. of serum; the second dose given 10 days later contains 1,000 million organisms with 0.2 c.c. of serum.

This line of prophylaxis according to the available statistics, is distinctly good. A similar method has been applied in Austria and Germany. Beserdka prepared an anti-dysenteric bili vaccine made out of killed dysentery bacilli with the addition of bile. It is administered on three successive days, before breakfast a dose of bile followed by a pill containing the dessiccated vaccine. No food is allowed for 2 hours after the dose. The results of Beserdka's treatment are not definitely encouraging.

The Calcutta School of Tropical Medicine reports favourable results with vaccine therapy.

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Abstracts.

ANAESTHESIA APPARATUS AND EQUIPMENT

By J. K. HASLER, M. B., B. S.

The amount of anaesthetic apparatus required in general practice depends very largely on the practitioner himself and the type of practice in which he works. In a country practice, where major operations are infrequent and anaesthetics must often be given under difficult conditions, it would require an exceptionally keen man to carry round a McKesson apparatus with a closed circuit for carbon dioxide absorption. On the other hand, a practitioner who works in a town with a well-equipped hospital near by, where he may have to give anaesthetics for every type of operation, will hardly be satisfied with open ether as a routine. Every practitioner must have some ideas of his own on the subject, according to, first, the methods taught at his medical school and, secondly, the opportunities and inclination for keeping himself up to date while engaged in practice. It is therefore difficult to lay down hard and fast rules as to how much apparatus is necessary and what types are best, and I propose simply to discuss on general lines the more important aspects of the subject.

OPEN ANAESTHESIA.

The simplest way to give a general anaesthetic is by open inhalation. All that is required is a metal mask which can be covered with gauze or lint, and a bottle from which the anaesthetic is dropped on to the mask. The Bellamy-Gardner mask is a convenient one to use, and it should be covered with four or five layers of gauze folded into a square. If open ether is being given the overhanging gauze at the sides of the mask should be tucked inside, but this need not be done when chloroform or a mixture of chloroform and ether is being used. Some anaesthetists prefer to place a layer of gamgee tissue between the patient's face and the mask. Care must then be taken to prevent any movement of the gamgee, which might separate the eyelids and rub the cornea. When chloroform is being given even the

mask may be dispensed with and a piece of lint or the corner of a towel be employed instead. With open anaesthesia the amount of apparatus is reduced to a minimum, and when ether is used the method is nearly foolproof. The Bellamy-Gardner pattern of dropper is the one most commonly employed for administering ether, and most chloroform bottles have an outlet in the stopper through which the liquid can be delivered. A simple dropper can be improvised by inserting a small wick of gauze between the neck of the anaesthetic bottle and the cork or stopper. This allows the liquid to drip out when the bottle is tilted. A chloroform drop-bottle is convenient for giving open ether to children.

Where operations are to be performed on the mouth or nose it is impossible to maintain anaesthesia by means of a mask, as this would obstruct the surgeon. After induction the anaesthetic must be delivered to the patient in the form of a vapour through a piece of tubing. Two simple pieces of apparatus which have proved useful for this purpose are the Junker inhaler for chloroform and the Shipway apparatus for ether or chloroform or both. The Junker inhaler consists of a bottle containing chloroform through which air or oxygen is bubbled, thus carrying the anaesthetic through the outlet tube in the form of a vapour. The Shipway apparatus contains in addition a rather larger bottle for holding ether, and the air or oxygen can be passed through either or both bottles. A vacuum flask attached to the apparatus enables the anaesthetic vapours to be warmed by passing them through hot water before they reach the patient. Both these pieces of apparatus should be tested before use to see that they are working properly. If air or oxygen is delivered at the exit instead of the inlet tube the anaesthetic will be blown over in liquid form, and the consequences may be unfortunate. Where electrical apparatus is being employed in the mouth or throat,

it is preferable to drive the anaesthetic over by means of air from a bellows rather than by means of oxygen from a cylinder owing to the possible risk of an explosion. In this connexion it should be mentioned that explosions have been caused not only by the cautery and diathermy electrode but also by the tiny electric-light bulbs on such instruments as oesophagoscopes or bronchoscopes when these bulbs have become loose or the insulation has been faulty.

CLOSED ANAESTHESIA.

Although open anaesthesia is easy to administer and requires the minimum of apparatus it is a wasteful method, for much of the anaesthetic is lost by evaporation into the surrounding air. With a closed apparatus more accurate control is obtained and the amount of anaesthetic necessary is reduced. The simplest form of closed anaesthesia is by means of gas and air. Apart from the cylinders of gas all that is required is a rubber bag, a face-piece, and some form of stopcock containing valves whereby an occasional breath of air may be given. This is, however, only suitable for minor operations; when longer anaesthesia is required with the addition of ether some other form of apparatus is needed.

A very simple yet efficient form of closed apparatus is Clover's inhaler or the modified pattern known as Hewitt's wide-bore inhaler. This consists of a closed container in which the ether is placed and through the centre of which is a passage-way for respiration. By turning a lever part or all of the patient's breathing can be passed over the ether in to and fro respiration. A face-piece at one end and a rubber bag at the other complete the apparatus. As little as three to four ounces of ether an hour is required to maintain anaesthesia, and with a small stream of oxygen delivered under the face-piece patients keep a good colour and often stand an anaesthetic given in this way remarkably well.

Rather more elaborate are the various forms of apparatus for giving gas and oxygen with or without ether. The simplest of these are the continuous-flow machines, which in principle are rather like a Shipway apparatus with a flowmeter at one end and a rebreathing bag and a

face piece at the other. The flowmeters, by which the proportions of gases delivered may be regulated, are of two main types. The older pattern consists of metal tubes which dip into a bottle of water and into which the gases flow. A row of holes down the side of each tube allow the gas to escape. The greater the flow of gas the greater will be the number of holes from which the gas bubbles. In the more modern pattern the gases pass through upright glass tubes each containing a tiny bobbin, and as the flow of gas is increased so the bobbin rises and floats at a higher level in the tube. The older type of flowmeter has the disadvantage that with the continuous flow of gas through the water a certain amount of water vapour is carried over, and this may tend to block the inlet tube in the ether bottle by turning to ice owing to the evaporation of the ether. A jacket of warmed water placed round the ether bottle will avoid this. The simplest and most popular gas-and-oxygen machine is the Boyle's pattern, and it is either used in a portable form or is incorporated with the anaesthetic trolley. Models devised by Magill and Ivor Lewis have, in addition to the bottles for chloroform and ether, a hot-water chamber for warming the ether, a manometer, and an attachment to hold a sparklet bulb containing carbon dioxide, the whole being neat and compact. In the intermittent-flow machines the gases flow from the cylinders when the patient takes a breath, and therefore the greater the degree of rebreathing the slower is the rate of flow of the gases. Three models in common use in this country are the Walten, the Magill, and the McKesson, the last-named being the most elaborate and efficient machine. Any gas-and-oxygen apparatus can easily be filled with a closed circuit for carbon dioxide absorption if so desired.

EQUIPMENT.

Some practical points with regard to equipment may be of value to the practitioner who has to give anaesthetics.

Cylinders.—One of the drawbacks to any form of gas anaesthesia is the weight of apparatus that must be carried, most of it made up by the cylinders. It is now possible to get steel cylinders which, though they are still some what expensive, are considerably lighter than those in

common use. Reducing valves must only be employed on cylinders containing the gas for which they are intended. Thus valves meant for cylinders of nitrous oxide must not be used on oxygen cylinders, and they should be tested from time to time by the manufacturer. Both cylinders and valves must be kept free from any sort of oil or grease.

Face-pieces and Bags.—All face-pieces are constructed with rubber pads to fit the face. These are either pneumatic or of some form of sorbo rubber. While the latter are more durable they are not so soft and yielding as the pneumatic pads, and when a really good fit is required, as in closed-circuit anaesthesia or when using a positive pressure, the pneumatic variety are more satisfactory. A helpful piece of apparatus for holding the face-piece in position is the Clausen's harness. This consists of a triangular sheet of rubber with each angle prolonged in the form of a strap containing a row of perforations. It is placed at the back of the patient's head and the straps are brought forward and hooked on to a metal ring situated over the face-piece. When properly adjusted it holds the face-piece firmly in position and leaves the anaesthetist's hands free for other duties, such as changing gas cylinders or taking the blood pressure. Rubber gas-bags and rebreathing bags which have become stiff and perished through age and lack of use can temporarily be rendered more pliable by holding them in front of a fire for a few minutes or dripping them into hot water.

Anaesthetic Agents.—Unless a practitioner administers anaesthetics frequently a large supply of ether or chloroform should not be stored as these drugs are apt to deteriorate particularly if not kept in the dark. The bubbling of air or oxygen through ether also tends to cause decomposition, but the presence of metallic copper will help to prevent this. Many of the ether bottles in anaesthetic apparatus have their internal fittings made of copper, and one firm of chemists even nails a small piece of copper foil on the under surface of the cork in the ether bottle. Ether through air or oxygen has been bubbled should not be kept in the bottle until such time as it is required again unless the interval is short. Stale ether need not be

wasted, as it is an excellent cleaning material; it will, for example, remove paint or grease from the hands with ease. The standard of purity of ether and chloroform as supplied by the various manufacturing firms is extremely high, and all brands appear to be equally efficient in producing anaesthesia. While the same is true of ethyl chloride each brand appears to have a characteristic odour masked to some extent by the eau-de-cologne or lavender water that is often added. With this addition some brands are more fragrant than others, though they seem to be equally efficient as anaesthetics. It should be remembered that ethyl chloride as well as ether is a highly inflammable liquid.

ACCESSORIES.

Every anaesthetist should carry an airway, a simple piece of apparatus which frequently transforms an indifferent anaesthetic into a good one. The Phillip's airway is as satisfactory as any, and it should be fitted with a medium-size rubber tube rather than a large one. For hospital work it is an advantage to keep half a dozen on the anaesthetic trolley. Each patient can then return to bed after operation with the airway still in position, and the anaesthetist can get on with the next case without having to worry whether the last patient is likely to have his respiration obstructed before he reaches the bed. A home-made airway can easily be contrived by cutting a suitable length of a piece of rubber tubing and inserting a safety-pin through one end to prevent it being swallowed. It is of advantage to carry a mouth gag in the anaesthetic bag, but opinions differ as to the desirability of using tongue forceps.

For endotracheal anaesthesia it is necessary to have some form of laryngoscope; Magill's pattern which contains a dry electric cell in the handle, is a popular choice. The Magill endotracheal catheters which are slightly curved are better for general purposes than the straight gum-elastic ones as they can be used for blind intubation through the nose without the need for a curved stylet. Some lubricant such as liquid paraffin or K. Y. jelly should be applied to the catheter before it is inserted.

Every anaesthetist should have a supply of drugs at hand, though these need not be excessive. For purposes of premedication morphine and atropine are still widely used, and have recent years nembital capsules have become popular. For nervous subjects, particularly children, suppositories of nembital have been recommended. Coramine has been found useful in the treatment of those states of emergency which sometimes occur with even the best of anaesthetists. It has also been injected at the close of an operation to diminish the action of any barbiturate which the patient may have taken as preliminary medication. For quick action it should be given intravenously. Where spinal anaesthesia is being used it is advisable to have at hand a supply of ephedrine. This, too, should be injected intravenously if a rapid action is desired. An extra cylinder is not necessary in order to have a supply of carbon dioxide available. A more convenient method is to carry it in the form of sparklet bulbs which can be fitted into a special metal container like a miniature cylinder and placed in the anaesthetic bag. In an emergency a small supply of carbon dioxide can be obtained by turning an ordinary soda-water siphon

upside down and pressing the trigger. Syringes of various sizes are necessary for hypodermic injections, spinal anaesthetics, and basal narcotics such as evipan and pentothal sodium. It is useful to have a vacuum flask when giving avertin, for the solution can then be prepared at home and taken to the patient's house or the nursing home warm and ready for use. A sphygmomanometer can be usefully employed for the double purpose of taking the blood pressure and compressing the arm before giving an intravenous injection. It is of advantage to have at hand a stomach tube when administering an anaesthetic in a case of intestinal obstruction, and some anaesthetists always carry a tracheotomy set for use in an emergency.

The foregoing list, though necessarily incomplete, contains an outline of the more important items which the occasional anaesthetist may find useful in the course of his work. In conclusion it is suggested that every anaesthetist should possess a watch with a second hand. A serviceable alternative is a theatre clock which has a large second hand or which gives a tick at every half-minute.

(B. M. J. Nov. 6, 1937.)

TREATMENT OF ECZEMA.

The Oriental Research Laboratory announced that they would keep at the disposal of the Members of the Medical Profession a special preparation for **Clinical Trial** at a nominal price of annas eight only, the selling price of this preparation being annas 12. We are having lot of enquiries from the medical practitioners who wish to know the ingredients of the Preparation and as we find it difficult to answer each query individually, we are giving a short account of the preparation which is known as **ZAMA**.

It is an elegant Coal-Tar preparation with which is combined Hydrargyri Ammoniatum, Lead Acetate and a few more ingredients to answer all the rational indications in the Treatment of Eczema.

That Eczema is a manifestation of Allergy Phenomenon, the medical profession knows very well. So this factor should be kept in view while treating cases of Eczema and the Diet and Regimen of the patients should be controlled depending upon individual idiosyncracies.

The value of Calcium and Cod Liver Oil to make up for deficiencies should also be remembered and above all the state of bowels.

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

TREATMENT OF GLAUCOMA.

By DR. G. V. HANUMANTHA RAO,

L.O., L.M.P. (Mad.) L.C.P.S. (Bomb.)

In my practice as an Eye Specialist both in the Government Headquarters Hospital, Guntur and outside, it is the acute Glaucoma that I come across more often than a chronic one. It is on account of the unbearable pain of the eye radiating into the head with deep redness of the conjunctiva and watering of the eye, the patient approaches me with a dejected look of anxiety. In almost all these cases the patients were having full mature cataracts and their age ranging between 45 and 65 years with all general signs and symptoms of senility proportionately to their age.

The affected eye is so tender that any manipulation by me other than dressing is resented by the patient for fear of increasing the pain. On careful examination the eye generally looks bigger than its fellow, and the pupil comparatively more dilated and not much reacting to light, showing in its open space the mature white opaque lens touching the whole of pupillary border. The eye when felt is stone hard. The case is diagnosed as acute glaucoma supervening cataract. In these cases the history of the acute trouble is about one week. I proceed to know if the perception and projection of light are normal or absent, with the aid of a torch light. If the light is recognised in all directions at least to some extent, the case is for medical and surgical treatment of glaucoma or if light perception is absent totally, excision of the eye is advised because any other treatment for glaucoma under the circumstances is a waste, for the eye, as such is a dead organ and no known treatment can restore sight to it. Excision will surely relieve all trouble at once. When excision is refused, I remove 1 c.c. of Vitreous fluid having recourse to Posterior sclerotomy at the site of the

equator of the eye on the temple side. To remove the fluid I ask the patient to look down towards his nose fully and I take 1 c.c. hypodermic syringe with strong sharp point needle and push it into the Vitreous about $\frac{1}{4}$ to $\frac{1}{3}$ c.m. in length and draw out into the syringe $\frac{1}{2}$ to 1 c.c. fluid, when the collapse of the eye ball is noticed by the receding of the cornea. This operation is performed under cocaine anaesthesia with all other aseptic precautions. The next step is to inject into the posterior pole of the orbit about 2 c.c. of Novocaine sol. 2% with pure carbolic acid 3 or 4 drops. This is done with a 5 c.c. of hypodermic syringe with a long needle which is pushed into the orbit at the outer canthus from below the lower lid. So I withdraw about 1 c.c. of Vitreous fluid and injected about 2 c.c. of Novocaine sol. with carbolic acid into the orbit posteriorly so as to reach ciliary ganglion. The eye is bandaged with a warm boric pad instilling into the eye Argyrol drops. Purgative is given and the patient is put on soda salicylas and bromide mixture. The effect of this treatment is merely wonderful. The patient feels as if the pain is removed literally by the hand of the doctor. For one week the patient is put to bed with the same internal treatment and hot pads and Argyrol drops to the eye. So far as my experience goes, the eye has never suffered once again from rise of high tension and, on the other hand, it gets into a state of slow shrinking. Cases which are absolutely blind to all intents and purposes are few in number. Majority of them with full cataracts and acute glaucoma supervening do possess some perception of light, unless otherwise proved by the history of the case, that cataract has supervened the glaucoma in which cases the eye is absolutely blind in all respects. In these cases the cause for rise of tension is probably due to swelling of the lens which impedes the angle of filtration by encroaching upon the periphery of the iris and thus the out-flow of the aqueous is reduced, giving rise to increase of tension of the eye.

Coming to the treatment of glaucoma with cataract, where the eye has got evidence on examination that it is not completely blind and that some sight can

be retained by treatment, the first thing that I have been doing is to put the patient on Eserine (2 gr. to 1 oz.) application to the eye—daily 6 times morning and evening at intervals of 5 to 10 minutes, after which Argyrol drops are put in and warm pad is applied. Daily one application of eserine is given to the other eye just as a control treatment. A brisk purge is given and the patient is put to bed and the diet also is changed to milk and bread only. Internally Pot-bromide and Soda Salicylate mixture is given daily 3 times. If the pain is still severe, Aspirin in 5 grs. doses is given. In about two days the whole trouble is much alleviated and the patient feels much better and puts on a look of confidence. Tension is much reduced though not exactly normal and redness of the eye is much lessened and pain is not much complained of. The same treatment is continued until all the signs and symptoms of the acute condition have subsided. In the ordinary course an Iridectomy is done in about a week. But if there is a suspicion that rise of tension will occur again, immediately a complete Iridectomy is performed under local cocaine anaesthesia. The patient is discharged in about ten days, completely relieved of all the trouble with an advice to return in about 2 months for cataract operation. The patient is given home Eserine drops (1 gr. to 1 oz.) to be used daily for a long time.

I wish to point out that the above mentioned treatment has been very successful in my hands and I have often noticed, on careful examination, the contraction of the swollen lens in the affected eye to some extent, so that the filtration angle is freed, thus aiding free drainage of the aqueous. I rarely resort to other lines of treatment as Adrenalin packs, Amin Glauosan, and so on, because I am quite satisfied with the Eserine treatment with warm packs, combined with other general treatment.

As for the treatment of other kinds of glaucoma, I shall write in the next issue. I thank the Superintendent of the Government Headquarters Hospital, Guntur, Captain W. Happer, I.M.S. for

having permitted me to make use of my knowledge gained in the hospital in writing this article.

BOILS AND CARBUNCLES.

By DR. P. R. SUBBIE, I. M. & S.,

Retd. Surgeon, Travancore State.

Boils are caused by staphylococcal infection of the Sebaceous glands and hair follicles of the skin while carbuncles are caused by infection by the same organism of the corium and connective tissues of the skin. Usually there is a history of Diabetes, Malaria, Nephritis, convalescence from infectious fevers, and pain, swelling, redness and enlargement of the lymphatic glands are the cardinal symptoms.

Boils.—Treatment: Never incise a boil or squeeze it because by incising you open up the venous sinuses around hair follicles which are devoid of muscular tissue and hence unable to contract when incised and this will cause sapraemia and septicaemia. The ideal treatment is application of heat and this can be done by means of linseed poultice, bread poultice and hot boric poultice. Glycerine and Mag. Sulph paste may also be applied. The ideal treatment is the application of Antiphlogistine quarter inch thick applied directly over the boil which has been previously cleaned with alcohol and padding with two layers of sterile cotton wool.

General treatment.—Old remedies are sulphur in the form of Sulphur precipitate one teaspoonful every morning and yeast. Modern modifications of the above are Calcium sulphide tablets and Nuclein tablets. Tin and Manganese in the form of Stannoxyl and Manganese Butyrate or Collosol Manganese are the latest forms of treatment. A course of polyvalent Staphylococcal stock vaccine injections starting from 100 millions to 500 millions also does good and stock vaccines are superior to auto-vaccines in my experience.

Carbuncles.—These are due to staphylococcal infection of the corium and subcuta-

neous tissues of the skin. Its most common sites are places where there is friction and pressure like the nape of the neck inter-scapular spaces etc. Carbuncles of the face are very serious because of their proximity to the cavernous sinus. Signs and symptoms are the same as for boils but in more severe form.

Treatment.—Conservative and operative. Conservative treatment is to be preferred to operative *vide* "The Lancet," 25th December 1930. Apply heat till suppuration is well established and afterwards, dress it with hypertonic saline one ounce of salt to a pint of water. The disadvantage in this is that it takes a long time. Application of Urea and Glycerine-magnsulph paste also do good in some cases. Bier's cupping for carbuncles of the trunk and application of Antiphlogistine for carbuncles of the face are very effective.

Operative treatment.—Crucial incisions with edges stitched back to the healthy skin. All haemorrhage should be arrested. Acriflavine dressing 1 in 1000 dissolved in liquid paraffin for the first two days and then crude cod liver oil dressings are the best.

General treatment.—Treat underlying cause like diabetes and nephritis; a course of polyvalent staphylococcal stock vaccine should also be given. Bacteriophage and Prontosil are of no use in my experience. Boils and carbuncles can be aborted by the injection of 10 c.c. of the patients blood around the periphery of the boil or carbuncle quarter of an inch from the centre.

N. B.—The above article is a summary of a lecture delivered by the author at a meeting of the Independent Medical Practitioners' Association, Tinnevely on 16-5-'38.

CAUSES AND TREATMENT OF FLATULENCE

At a meeting of the Medical Society of London on February 28, with Mr. J. E. H. ROBERTS in the chair, a discussion was held on the causes and treatment of flatulence.

Professor HENRY COHEN said that flatulence was one of the commonest of dyspeptic conditions, yet its mechanism was very little understood. Flatulence was a term often used by a patient in order to shield his own inability to describe his symptoms. Such symptoms as palpitation, nausea, constipation, headache, and cardiac pain were hidden in the usual complaint of flatulence. But "flatus" meant wind, and thus the essential symptoms must include wind or gas as an integral feature. There were five symptoms which might be complained of by a patient whose true complaint was flatulence. The first was belching or eructations; the second, the passage of flatus per rectum in excessive amounts; the third, a feeling of distension; the fourth, gurgling or borborygmus; and the fifth, pain or discomfort.

Flatulence could be defined as gas in the stomach or bowels, giving rise to discomforts which were relieved when the gas was expelled. The sources of gas in the alimentary tract were threefold: (1) swallowed air; (2) gas arising as a result of certain chemical changes; and (3)—a possibility but not yet with certainty proved—the direct excretion of gases into the stomach and intestine from the blood stream. Four factors tended to modify the absorption of gas from the intestine. The first was the nature of the gas itself. Carbon dioxide was absorbed very rapidly, oxygen much more slowly, and nitrogen hardly at all. The first factor which tended to modify absorption therefore, was the diffusion constant of the gas, and second, the tendency of gas to combine with haemoglobin. The third factor was the diffusion of certain gases in the tissues themselves, and the fourth, the mucus membrane of the intestinal wall. If gases such as carbon dioxide and oxygen were absorbed into the blood stream, it was clear that any interference with the circulation in the gut would result in the accumulation of gases therein. This could be produced by any condition which caused venous stasis. Under normal conditions the amount of gas in the gut which was not absorbed was relatively small; its average composition was

10 per cent. carbon dioxide, 30 per cent. methane, and 60 per cent. nitrogen.

THE CLINICAL ASPECT

From the clinical standpoint flatulence might be divided into gastric and intestinal. Gastric flatulence was very largely the result of air-swallowing or aerophagy. Its most common symptom was a feeling of distension which was relieved by belching. Intestinal flatulence was much less commonly the result of aerophagy and much more commonly the result of fermentative processes. The division into gastric and intestinal flatulence was largely artificial, and it was far better to classify flatulence according to the mechanisms just described, although, of course, more than one mechanism might exist in any particular case. But the mechanisms described should enable certain types of flatulence to be recognized, and Professor Cohen considered each of five groups in turn.

The first of these was excessive air swallowing or aerophagy. More air than usual might be swallowed because meals were hurried or mastication inadequate, or because there was excessive salivation which last was responsible for the aerophagy in many post-operative conditions. Certain foods, such as omelettes and rusks, might, if taken quickly, carry more air into the stomach, and this was true of aerated water. But perhaps the commonest cause of aerophagy was a different one. Any epigastric or substernal discomfort would almost certainly result in aerophagy as an attempted mechanism of relief. The trouble was that, like every habit spasm, it tended to go on after the cause had disappeared, and thus what was at first a purposive act became a tic. Having decided as to the mechanism, what was the obvious treatment? In the first place, the cause must be investigated with the greatest care. There were obvious causes like gastric ulcer or cancer, cancer of the oesophagus, and so on, but there were much less obvious causes, such as the early phase of angina pectoris, or some of the earlier manifestations of cirrhosis of the liver. To correct the deficiency, meals should be taken more leisurely, by relatively dry, salivation

might be checked in certain cases by administering belladonna, and the rather sensitive nervous system treated by small doses of sedatives. What should not be done in aerophagy was to administer carminatives.

So much for aerophagy. Of the second group—delays and obstructions in the stomach and bowel—responsible for flatulence, these were very largely surgical conditions such as cicatricial stenosis in the stomach, giving rise to pyloric stenosis. A diverticulitis affecting the ascending colon was not an infrequent cause. Delay in the passage of food down the alimentary tract might be associated with spasm, and spastic colon was a cause of intestinal flatulence. It could also be associated with atony of the gut, and atonic constipation was again a not infrequent cause. The treatment of delays and obstructions must in the first place be directed towards the underlying lesion. The third group, consisting of fermentative activities in the gut, was a rather difficult field because so little was known of the subject. Two main types had been differentiated, one that of intestinal carbohydrate dyspepsia, and the other the cases occurring in intestinal affections in which there was excessive protein putrefaction. In the case of intestinal carbohydrate dyspepsia cereals should be avoided, also root vegetables, and in the protein forms of flatulence a lacto-vegetarian diet should be imposed. The fourth factor was a disturbance of the circulation in the intestinal wall. This was a factor not yet adequately assessed. The fifth factor was damage to the intestinal mucosa, not from toxins which arose in such diseases as typhoid and dysentery, but rather from poisons which one took optimistically and called purgatives and which undoubtedly irritated the mucous membrane of the stomach and intestine and promoted considerable inter-change of gases and toxins which would not otherwise be allowed to pass through.

The treatment of any condition had not only to overcome the causes but to deal with symptoms. There were three main ways of dealing with symptoms:

(1) the administration of carminatives; (2) the administration of absorbents such as charcoal and kaolin, neither of them a very effective remedy; and (3) particularly in post-operative flatulence, the passage of tube for the removal of the gas.

SURGICAL CONSIDERATIONS

Mr. C. W. GORDON BRYAN thought there was a danger of being unduly impressed by the nervous or functional element in these cases and overlooking the organic causes of partial obstruction which could be removed by surgery. This applied especially to early or partial obstruction of the ascending or transverse colon where flatulence was commonly a permanent symptom. One problem in great need of solution was how best to treat cases of so called visceroptosis of various types. In many of these cases the element of mechanical obstruction seemed to be important, the result of the congenital bands and membranes that were so common about the ascending colon and right half of the transverse colon. A large measure of relief could be given by freeing the colon as the result of a thorough removal of these bands, but he would not advocate wholesale operations on the neurasthenic, tired, thin young woman, usually suffering from an anxiety neurosis, who had a dependent caecum and complained of a dragging or spasmodic pain when fatigued.

Passing to the difficult subject of Post-operative flatulence and the more serious difficulties of mechanical and paralytic ileus, Mr. Bryan said that the causes of these dangerous conditions were of importance because the surgeon should be able to do so much to avoid them. In the great majority there was an element of mechanical obstruction, and true paralytic ileus was very rare. He briefly mentioned the measures which seemed important to him in the treatment of post-operative paralytic ileus. These were: (1) rest and avoidance of stimulants; (2) continuous siphonage of duodenum by a tube passed through nose or mouth; (3) repeated administration of anti-gas-gangrene serum; (4) continuous

application of heat to the abdomen; (5) administration of a spinal anaesthetic; (6) the giving of large quantities of fluid. Continuous intravenous method were sometimes the best, but often the giving of large quantities of normal saline subcutaneously was the simplest and most practical means. The simplicity and value of this method and the large quantity of fluid that could easily be given were perhaps not generally realized. On the question whether morphine should or should not be used he had an open mind. He preferred to avoid it, because he thought it caused vomiting. Although it might not increase distension, it did tend to prolong it.

GENERAL DISCUSSION

Sir. ARTHUR HURST was surprised that Professor Cohen had not referred to the gall-bladder as one of the most common causes of so-called gastric flatulence. The individual with cholecystitis had an uncomfortable feeling in his epigastrium which he misinterpreted as due to the presence of gas. As there was no wind to bring it away he made futile efforts which manifested themselves in swallowing air. With regard to adhesions, he believed that these very rarely accounted for the chronic uncomfortable abdomen and flatulent dyspepsia. He had seen many patients who had had operations for adhesions and had never been the better for them. Only twice had he found it necessary to advise operation for diverticulitis. Even in severe cases where obstruction was present it was nearly always possible to overcome it by medical means and to keep a patient well afterwards. He did not agree with Professor Cohen's depreciatory remark about charcoal.

Dr. A. H. DOUTHWAITE spoke of the post-operative flatulence which was so troublesome to those who had undergone an abdominal operation. He believed that a good deal of it was due to the Post-operative treatment. It was worse years ago when it was customary to purge these patients and starve them for twenty-four hours before operation. In certain cases patients, either owing to the advice

of their surgeons or owing to their own obstinacy, refused to follow the usual practice of living on a fluid diet for a day or a two after an abdominal operation, and took some solid food. These patients never stopped from having flatulence.

MR. ZACHARY COPE said that one subject which had not been dealt with was the class of case in which extreme distension accompanied renal disease. This was not due to any of the causes Professor Cohen had outlined. He held that it was in some way a reflex phenomenon. The same was true of gall-bladder trouble. He had seen the most extreme distension with biliary pain without much peritonitis. He had sometimes been tempted to open the abdomen, thinking the large bowel was obstructed, and in one or two cases he had actually done so, but had found nothing except the gall-bladder disease, and perhaps some local inflammation, but no general inflammation. He thought it possible that here they were dealing with a reflex phenomenon of the large bowel.

Dr. MAURICE SHAW was rather disappointed that Professor Cohen, while stating that carminatives were useful in intestinal flatulence, did not attach much value to them in gastric flatulence. His own experience suggested to him that, for some reason which he could not explain they were of use in that condition. He did not agree with Sir Arthur Hurst's praise of charcoal for the relief of flatulence. Dr. T. JENNER HOSKIN pointed out the importance of flatulence in heart trouble. One could say that it was like the trigger in angina pectoris. He had seen many cases in which flatulence had

been the cause of acute pulmonary oedema and paroxysmal tachycardia. In fact, he always felt that in the management of heart cases the treatment of flatulence was almost the main consideration. He also stressed the importance of a strict diet. The PRESIDENT spoke of the importance of giving patients who had undergone an abdominal operation a light, easily digested diet. He alluded to one cause of painful flatulence—namely, a troublesome spastic colon.

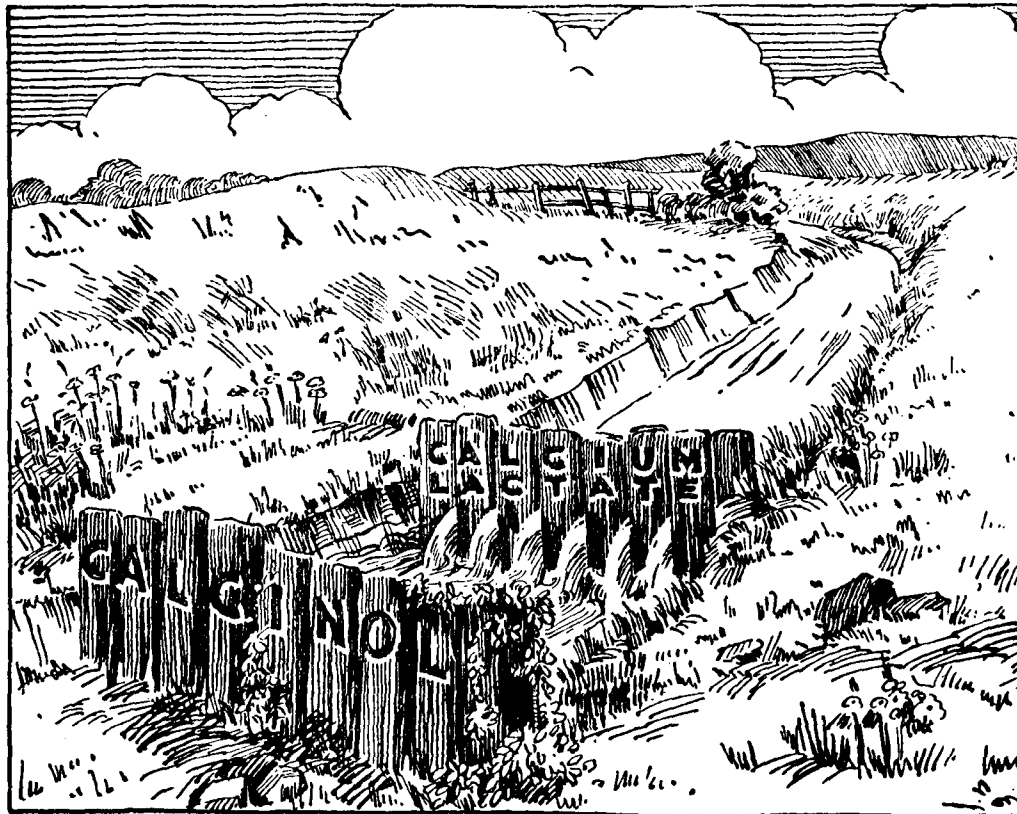
Professor COHEN, in reply, said that he would not like to claim that prostigmin or acetylcholine, of which he had little experience, or pituitrin, of which he had some experience, was of no value in paralytic ileus, but they must be used with some consideration, and regard must be paid to treatment by fluids and also the administration of chlorides. There was great loss of chlorides in many of these cases of paralytic ileus and they required replacement of rather more than the normal amount of chloride in normal saline. With regard to flatulence accompanying cholecystitis, he thought there were three factors which played a part, if not the whole part, in the flatulence of gall-bladder disease. The first was aerophagy, the second was the muscle tension which accompanied the gas content of the stomach, and the third—a factor commonly overlooked—was an associated chronic hepatitis. He hoped he had not said that gastric carminatives were of no value whatever. What he had said was that they should not be used in simple cases of aerophagy. He thought they had a certain value in some cases of gastric flatulence.

—B. M. J. 12th March, 1938.



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[No. 9

RE-ORGANISATION OF GOVERNMENT GENERAL HOSPITAL, MADRAS.

The Government of Madras published an order dated 16.5.38 advocating some changes in the staff, their working and the working of the hospital generally. In regard to the Out-patient Department at the very outset of the order it has been mentioned that the Skin-Department should be opened at 7 a.m. This gives an impression as if this department was not opened at 7 a.m. in the past or the other special departments may be opened later. It is not mentioned anywhere under this head that the Chief Officers in charge of the special departments should also attend the Out-patient department in the way their colleagues the Chief Surgeons and the Chief Physicians have been ordered to attend the Out-patient Department. It is not also clear if the Chief Surgeons and Physicians and other Chief Medical Officers in charge of special departments in the Out-patient Department have to attend the hospital in future at 7 a.m. the time when the Out-patient Department is opened to the public. At present we learn that medical officers belonging to the five special departments cannot be seen at 7 a.m. in the Out-patient department and with the exception of one or two of these specialist officers, all the rest are seen in the hospital invariably after 9 a.m. when the Out-patient Department is closed. In days gone by when the entire superior staff of the General Hospital consisted

of members of the Indian Medical Service, all the medical officers including the medical students were inside the gates of the General Hospital at 7 a.m. Now all officers except the Superintendent enter the hospital gates between 9.30 and 10 a.m. It was expected that the strict military discipline that prevailed in the General Hospital and which was demanded of the officers in the interests of the patients in a tropical climate would be re-introduced by a Government belonging to a party disciplined to look after the welfare of the public. The Minister in charge of the Medical Port-folio being a medical man himself we trust he will agree with us that in a hot country like India it is conducive to the well-being of the patients to undergo operations in the early part of the morning instead of midday as is the case now.

With a view to expedite the out-patient work, the Government desire to increase the number of unpaid House appointments. The Government also wish that the dressing in the Out-patient Department should be actually done by the House-Surgeons instead of by the junior students and the nursing orderlies. It is strange if not surprising that the Government anticipate that the Graduate House-Surgeons are not likely to take up the dressing work and next in order the L.M.P. House-Surgeons and make a suggestion that the paid Sub-Assistant Surgeons may be posted for this work if both the Graduate and L.M.P. House Surgeons refuse the work. Those who hold House appointments are expected to do whatever work assigned to them during

the period they hold the appointments consistent with the nature of work expected of them as professional men. Dressing the patients even after minor operations is the legitimate work of any doctor. Newly passed medical men who are entertained as House-Surgeons should do dressing work even in the Out-patient Department. Without training as dressers they cannot be expected to be efficient general practitioners or even surgeons. A Graduate or L.M.P. House-Surgeon who is to be entertained as such should do any professional work and doing work in the Out-patient Department is part of their training. Any order of the Government should not indicate or imply hesitancy which takes away the life of an order. In addition to this defect the order relating to the out-patient dressing work is likely to remind those already suffering from inferiority complex that this complex still looms in the Government Secretariat in spite of the fact that the Hon'ble Dr. Rajan has been advising those suffering from it to shake it off.

Why the Congress Government which is expected to put a stop to the order of inequalities, invidiousness and other distinctions of the past rule in the medical department should have overlooked to have one class of House-appointments either paid or unpaid is beyond our comprehension especially when the Hon'ble Minister in charge of this department is a medical man who has had experience of the working knowledge of these appointments at least in Great Britain, the country of our rulers from where designation of the House-appointments has been copied. All House-appointments are paid in Great Britain uniformly depending upon the institutions where these medical men have to work. The Government would do well to pay all House-appointments in all hospitals uniformly to the extent they can. The Honoraries need not be paid any allowance nor did they ask for it excepting those who are entrusted to do teaching work in the schools (till they exist) and the Colleges who may be given teaching allowance ranging from Rs. 50 to Rs. 150. As the Government do not intend to recruit paid service in

future they will do well to follow the example obtaining in Great Britain relating to House-appointments and honoraries. The Hon'ble Dr. Rajan should know that there was a time when there were two Resident Medical Officers in General Hospital who took duties by turn and the senior Assistant Surgeon in the General Hospital who till recently was from I.M.D. cadre did very little professional or office work as is expected from this officer now when this office is invariably held by a Civil Assistant Surgeon. We know till about a couple of years ago, the senior Assistant Surgeon was asked to do by the then Superintendent of the General Hospital major portion of the work of the Resident Medical Officer both administrative as well as professional. It will be a good reform in the interests of the hospital as well as Honorary System if an additional Resident Medical Officer's post is created to do professional work only. An experienced seniormost honorary Assistant-Surgeon may be selected to hold office for one year. He should be provided with quarters in the hospital and should not be allowed private practice. He may be paid Rs. 200 per month.

The privilege of admitting patients to their respective wards should also be given to the Honorary Chief Surgeons and Physicians as in the case of stipendiary officers.

Para 3 of the G. O. deals with Surgical and Medical Units. There will be in future six surgical and six medical Units three of each being in charge of stipendiary Chief Officers and three under Honorary Chief Officers. Each Unit is to consist of one Chief, one stipendiary Assistant, one honorary Assistant, one senior House-Surgeon or House-Physician and three junior House-Surgeons or House Physicians as the case may be. Junior House posts are meant for those who intend to prosecute higher studies as for M.D., or M.R.C.P. in medicine or M.S., F.R.C.S. in the case of surgery. It is also ordered that the Chief Officers in charge of Units should divide the beds equally between their assistants. It is

not clear in the order if the Honorary Chief Officers are to have two assistants one of them being from paid service.

Suggestion has been made in the G. O. that operative work should be entrusted to the assistants so that they be efficiently trained to do independent work in the mofussil. It looks as if it is the intention of the Government to transfer Assistant Medical Officers periodically giving chances to all in service to have the advantage of training in the General Hospital. Want of periodical transfers in the City Hospitals has been the cause for the insidious accumulation of corrupt practices. As there are now three medical teaching institutions of equal status there cannot be any excuse from any quarters for the transfer of not only assistants but also the stipendiary Chief Officers in all the hospitals in the City.

In para 4 of the G. O. it is mentioned that general wards should not be reserved for the Anglo-Indians, and that all nationalities should be treated alike in the wards excepting in the matter of supply of clothing. This reform if we may call it, is consistent with the Indian sentiments and while the Indians may feel satisfied, the Anglo-Indian community will resent it. To set right matters, the Government have suggested to open another C class paying wards in addition to A and B classes which now exist. The A class ward patient has to pay Rs. 15/- for a single bed room and the B class patient is charged Rs. 7/8/- in a four beds room. The C class patient may perhaps have to pay cheaper rates. Additional facilities for the admission of paying patients on a cheaper scale will certainly interfere with the income of private practitioners and proportionately increase the private income of doctors working in hospitals for obvious reasons and as the future policy of the Government is to depend upon private practitioners for honorary service in State Hospitals it must be made possible for private practitioners to treat their patients in the paying wards of State Hospitals so that there may exist a contented independent medical profession to take up

honorary work. We wish to tell the Hon'ble Dr. Rajan that the treatment of patients in hospitals by general practitioners has been made possible in Great Britain and in Bombay Presidency only in one hospital in Poona where practitioners belonging to the upper class only seem to enjoy this privilege. The Hon'ble Dr. Rajan will do well to study the ways and means by which private practitioners will have the facilities to treat their patients in the State Hospitals. At the same time the private practitioners will be failing in their responsibility to the public if they do not make up their minds to start institutions call them hospitals or nursing homes to cater to the needs of all class of people.

Para 5 of the Government order brings the control of the Barnard Institute of Radiology attached to the General Hospital, directly under the control of the Superintendent of the Hospital. This is a much needed reform and the medical profession feels very glad that Radiology which is an allied branch of the Medical Science has been rightly brought under the legitimate control of a medical man. The members of the medical profession even outside this province have been feeling the unethical conduct of the Madras Government in forcing qualified medical men to work under the direction of a non-medical man who is only an expert technician. All the same we do admit that it would not have been possible for Madras to boast of an up-to-date well equipped Institute of Radiology but for the efforts of Capt. Barnard to recognise which the old Government have called the Institute after his name. But the scientific medical profession feels that calling the Institute of Radiology as Barnard Institute has served to commemorate the unethical conduct of the Government. Capt. Barnard has been well paid and we will not be wrong if we say that nowhere on the face of earth a technician in the Radiological Department is to day earning an income which Capt. Barnard has been earning (pay and Commission for work done). Nobody is jealous of Capt. Barnard but the profession will

like the idea if the Madras Government changes the name of the Institute to a suitable one consistent with the change effected in its control. We wish to make another suggestion to the Government which will enable the Government to save some money also. We are told that Capt. Barnard is going on leave very shortly. The Superintendent, Government General Hospital will have an opportunity to know what has been going on at this Institute if during the absence of Capt. Barnard the Superintendent is requested to be in direct charge of the Institute in the way Surgeon-General is now requested to be in direct charge of the Public Health Department during the absence of Director of Public Health. If our suggestion is carried out the Superintendent, General Hospital will be able to study the rather complicated machinery of the Institute of Radiology by first hand information.

The 6th para in the Order relates to the appointment of an Almoner in the Government General Hospital. This is one of the most salutary reforms The Medical Practitioner has been advocating ever since it came into existence 9 years ago. The journal is justified in feeling proud that it was able to anticipate some of the reforms in the medical department which are dear at heart to the Congress Government. Almoner is an official distributor of alms. These are the officers in the royal household of Great Britain. Almost all hospitals in Great Britain have now in their staff an official bearing this name and the only function of this officer is to admit indigent patients into the hospitals and for this purpose the Almoner has to assess the income of those seeking admission into the charitable hospitals so that those who are not necessitous poor might not abuse the charity in the hospitals. The Government have designated functions to the Almoner not contemplated in the meaning of the word Almoner and other duties of preventing or detecting corrupt practices in the hospital which the Government order expects from the Almoner are beyond the scope of this office as is the case in the charitable hospitals in Great Britain where

Almoners are functioning. If the Almoner does his legitimate duty satisfactorily there cannot be room for many of the corrupt practices now rampant in the State hospitals. The Almoner should never be a medical man and should not control the professional work even in the out-patient department as is mentioned in the Government order. The Almoner should be one possessing some status and should be directly responsible to the Head of the Medical Department and not to the Superintendent of the Hospital as mentioned in the G. O. A person in the grade of a Sub-Assistant Surgeon even of extraordinary merit cannot be expected to carry out the responsibilities of the Almoner as enumerated in the Government order. If the Government persist to have the Almoner of the type and having the responsibilities explained in the G. O. the Government need not wait for the report of the Surgeon-General to declare that this office is a failure. Efficiency should be consistent with economy but efficiency cannot be sacrificed for economy. We suggest to the Government that efficiency and economy will be combined with benefit and the good intentions of the Government will be given effect to if the office of the Almoner and the Lay secretary are combined in one person. There cannot be any objection for a medical man to hold this combined office if he is debarred from doing professional work either in the hospital or outside. On the other hand a suitable medical man with these restrictions would be an acquisition to exercise the double functions. A retired medical officer of the status of Civil Surgeon and who he is declared physically fit will do very well to take up this office. But he should be one who had nothing to do with the General Hospital as such a person is likely to carry prejudices with him. The affairs of the General Hospital in the past were not dissimilar to the affairs of political parties in the Legislative bodies. They are getting a bit more medical and less political now and if, as has been repeatedly pointed by us transfers on 3 or 5 years basis are effected and if an Almoner of the type described by us is appointed, the

Congress Government may be proud of an ideal institution working in the City, the seat of the Government. We assure the Government the whole-hearted support of the medical profession and even of the public in all the legitimate attempts of the Government for reforming and reorganising the City Hospitals. If the City institutions are kept above reproach the mofussil hospitals will soon copy the city hospitals and the medical profession can expect a glorious future under the regime of a medical man as one of the units of the Government.

SUBSIDIZED RURAL MEDICAL PRACTICE.

The Madras Provincial Subsidized Rural Medical Practitioners met in Conference in Manachanalloor village in Trichinopoly District on 26.6.38 within a year after they met last in Madras.

The rejuvenated Association did get more nerve force when on 26.6.38 the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister performed the inauguration ceremony of the VIIIth Provincial Conference of the Subsidized Practitioners in a village belonging to Trichinopoly District, the field of past activities of Dr. Rajan as a practitioner. The zeal evinced by the Reception Committee and the presence of the Hon'ble Minister at the Conference made the proceedings a real success. The Rural Practitioners has had a splendid opportunity of knowing the policy of the Government at close quarters through the very Minister who is in charge of Medical Portfolio. The Minister made it known to those assembled that he was addressing them in his capacity as the Minister and not as Dr. Rajan, the medical man. The responsibilities of his office, he said, forced him to commit his address to writing instead of talking to them *extempore*. We have therefore published the written address in full in the Correspondence columns together with the address read by the Chairman, Reception Com.

mittee who is a subsidized practitioner. Both these addresses have been followed by the address of the President of the Association Dr. V. Rama Kamath. It is a strange yet very pleasant coincidence that the ideals of the Scheme of Rural Subsidized Practice enunciated in all the three addresses are identical. Strange because the atmosphere, the place and the position occupied by the three authors are quite different. Pleasant because with such common ideals held in high estimation by the responsible member of the Government, the members of the Subsidized Rural Medical Practitioners' Association and by the President of the Association, there is a real hope that the Subsidized Medical Relief Scheme will be a success in the long run. We are forced to say the run will be long as the Hon'ble Dr. Rajan's ideals of the Scheme cannot be reconciled to the actual working of it by the Government and if one reads his address carefully as the Hon'ble Dr. Rajan asked the Subsidized practitioners to do, it looks as if it is the intention of the Government to get even the indigent in the villages treated free by the rural practitioners after he was deprived of his subsidy which Dr. Rajan said was the intention of the Government when they see that the Practitioner can stand on his own legs. The Subsidized practitioners who have given a brief account of the village conditions through one of their own and whom they chose to be the Chairman of the Reception Committee, will in one voice say that the hope of the Minister cannot be possibly realised. The description of the village conditions as could be seen in the address of the Minister are not dissimilar to those as expressed by the Chairman, Reception Committee. While advising the practitioners to increase the scope of their activities the Minister said amongst other things:

"Therefore, I want you to extend the scope of your activities; for you have before you a rich field of unexplored territory populated with men and women who are more or less ignorant of the things of the world. Your experiences are quite different from that of a city practitioner. The peculiar mentality of the people, their faiths, their beliefs and the vagaries of quacks,

the good services of practitioners of other systems of medicines, all these give you a different type of experience. . ."

Mahatma Gandhi who advised the Congress to run the provincial Government said in the Harijan soon after the Congress assumed office, "*Attention should now be devoted more to the villages and the peasantry than to the cities*". Pandit Jawaharlal Nehru declared on, 28-6-38 before a London audience that "*India's real problem was the poverty of masses of peasants*". Later before the same audience the Pandit said :

"The poverty of the masses of peasants and workers was not a lawyer's problem, (meaning the India Act) or even constitutions. Because it was impossible to solve the problem under British or other Imperialism, that rule must go and Congress deriving strength from the hunger of Indian peasants must provide the Socialist solution."

The Leaders of the Congress party in all the seven provinces have been repeatedly expressing their sincere concern in the village folk. Even otherwise all Governments exist for the welfare of the people and Medical Relief and Education are the fundamental necessities for the growth of a healthy nation. As health ensures prosperity and as the hope of Mahatma Gandhi and his lieutenants like Pandit Nehru, in winning Swaraj or Independence is on the peasantry, the Congress Government will be answerable to culpable neglect if they do not spend from public revenue amounts proportionate to the collection of revenue from the rural area as against urban for the preservation of the health of those who pay the revenue. Out of an expenditure of nearly a crore of rupees for the Medical Department for curative purposes including medical education only about 6½ lacs are spent for 571 subsidised dispensaries, out of which about 420 belong to the Allopathic System of Medicine. Yet the Government grudges to make permanent arrangements to give free medical aid even to the indigent villagers whereas they spend money lavishly for medical relief in urban hospitals.

The higher ideals of service can be put into action only by disciplined workers.

The subsidized practitioners can be trusted for disciplined patriotism as much if not more than the members constituting District Boards. The public and the Government are aware of the existing state of affairs in the local bodies ; yet the Hon'ble Dr. Rajan on whose advice the Government recently took away the control over the subsidized midwives and transferred it to the District Medical Officers justifies the *triple control* over the subsidized practitioners, first by the District Boards, second by the District Medical Officers and the third by the District Health Officers. The ideals of independence held out by Dr. Rajan in the 1st para of his address appearing under the caption "Status of the Rural Medical Practitioners cannot be reconciled to the *triple control* adumbrated by him. He says :

"I have to remind you, even though the fact has been stated a number of times that you are *independent medical practitioners*. I want you to bear this in mind for more reasons than one. There is a tendency amongst the rural medical practitioners to consider themselves more or less as service men. This tendency has developed because of the difficulties and the environments under which they are asked to work. I am personally aware of the very many difficulties under which you have got to labour. But after having said that I do still believe that it is degrading to medical man's sense of freedom that he should try to rope himself under service protections or conditions."

The remedy to take off the complex of dependence of a most humiliating nature is with the Government and not with the humble practitioners who are groaning under the tyranny of the *triple control*. The Subsidized Practitioners are aghast that in spite of a medical Minister holding very high ideas of independence in medical practice they are persecuted and victimised to the knowledge of the very Public Health Minister.

This is why they groan and say "*Treat us at least as 'service men' though we are supposed to be independent.*" The actual meaning of 'Control' being 'to dominate', or 'to command' and as the control is followed by victimisation on account of the false notions of those who are made

to control the Subsidized Practitioners, there is a tendency in the practitioners to despair. If they are held in a state of perpetual intimidation, the Government cannot expect such persons to be resourceful either in the exercise of their profession or in the other activities expected of them by Dr. Rajan. All conceived methods of safeguards to protect the interests of Subsidized Practitioners so as to make them independent of the local bodies cannot be considered to be too many and the Minister's justification to be '*averse to providing more and more safeguards against interference of local bodies and the Government in matters relating to medical work and practice*' is an argument against the healthy growth of the Subsidized Scheme and against the hope of the Minister that the Subsidized Practitioners should develop themselves into a body of medical men doing service to villages independent of Government. The wielding of too much authority by those who have been provided control in the indenture to be executed by the practitioners, has deprived the status and prestige of the practitioners whom the Minister calls *independent* during public functions but not in the secretariat when the Government invariably allows these unfortunate village workers to be a prey to official victimisation. Termination of services is the last step taken by any Government in regard to their service men but in regard to Subsidized Practitioners it is the only punishment contemplated in the indenture.

We advise the Subsidized Practitioners to forget the past. A new leaf of ideals and safety has been placed before them by the very Minister who dealt with them before 26th of June 1938 when the Minister declared :

"Your grievances are many and at least some of them have been brought to the notice of the Government. Knowing the important position you hold in the medical economy of the country and the very important work you are asked to do, I can assure you on behalf of the Government that such grievances as you have suffered from or are suffering, shall certainly be looked into with the sympathy and care which the matter deserves."

Later on the same day the Minister observed :

"It is very difficult for the Government to dictate to you in the form of rules and regulations all those details of human conduct which should guide you in the peculiar circumstances in which you are placed. The Government have also got enough trust in the common sense of the Rural Medical Practitioners and are not afraid that you will allow yourself to be victimised."

For the very reasons found in the above statement by the Minister, indentured medical service is quite against the ideals of subsidized service which it is the intention of the Government to be self-reliant and work independently of Government in future. The past policy of the Government as experienced by the Subsidized Practitioners and given expression to by the President of the Association in his address at the Manachanalloor Conference are quite inconsistent with the lofty ideals placed before the Subsidized Practitioners by the Hon'ble Dr. Rajan. Breaches of the conditions of the indenture such as transfers of practitioners, conversion of Subsidized Dispensaries into L.F. dispensaries without appointing the Subsidized Practitioners as medical officers of the converted dispensaries, converting of an Allopathic subsidized dispensary into an Ayurvedic subsidized dispensary and thus driving away a subsidized practitioner from the village where he had been working for a number of years giving satisfaction both to the villagers as well as the District Medical Officers and terminating the services of practitioners on trivial grounds without even warning them once, are some of the unchallengeable examples of the past policy of the Government in running this most useful scheme of subsidized medical practice in the villages. The scheme is not only most useful but most beneficial to all concerned and as economical to the Government who, would have spent several times more money for medical relief in villages if the subsidized scheme did not exist. We repeat our advice to the Subsidized Practitioners to forget the past and at the same time we request the Government with all earnestness at our command to be magna-

nimous in their dealings with these practitioners not making them a prey to petty complaints.

We trust that the Subsidized Practitioners will not fail to note the sincere concern of the Hon'ble Dr. Rajan in the village medical practice. He said relating to the organisation of their Association:

"I am so glad to know that you have associated my very active and energetic friend Dr. Rama Kamath in your Association and I may assure you, you have not made a bad choice. Having said this, I must also remind you that your organisation is still weak and that mere cataloguing of grievances alone will not make you a coherent strong body for it is not every one of you that have got a grievance of a nature that could not be got rid of without the help of an organisation like this."

The aims and ideals of medical service in villages as put forth by the Government through the Public Health Minister and as expressed in the memorandum and the rules of the Provincial Subsidized Rural Medical Practitioners' Association being identically the same, the Government will not risk much if as suggested in the Presidential address the Government are pleased to transfer the entire control of the scheme to the Surgeon-General. This will not curtail the control of the local bodies as they can complain to the Surgeon-General against any erring practitioner and have him dealt with suitably. We suggest this course as a temporary measure till the Association gains status of a well organised responsible body when the Government can feel that the Association itself can be trusted with the entire administration of village medical service under the direct control of the Government, the individual subsidy being converted into wholesale grant to the Association.

MEDICAL PROFESSION AND RURAL PRACTICE.

It may be safely said that India has not one qualified practitioner to a population of 24,000. Yet it is a strange irony borne out by facts that majority of

qualified practitioners feel it difficult to make both ends meet. Our rulers are mainly responsible for the sad plight of the members of the profession. For it is the medical service that started the profession and still holds the sway. Want of efficient organisation of the profession is another cause which has been preventing the members of the profession to take up their legitimate place in the affairs of the profession. Though the provinces are enjoying autonomy the affairs of the medical profession are so complicated that the popular Governments have not been able to show a ray of hope for the solution of the problem. One thing is certain that is that the Government cannot provide jobs to the unemployed in the medical profession even on a small scale and the profession has to depend upon its own resources. Cities, towns are naturally overfull with practitioners either private or State paid. As is the case for other necessary commodities of life, the practitioners in urban areas especially in District Head Quarters have to depend upon village supply of patients for their prosperity and even for their maintenance. The Provincial Governments with their programme of prohibition and anxiety to make the people feel that their burden of taxation is relieved on account of the introduction of autonomy cannot hope to give medical relief even to the necessitous poor. The only hope for solving the huge problem of medical relief is the possibility for the members of the profession to socialise medical relief though indirectly with the help of the rich and well-to-do. The members of the profession should educate the masses on health questions and make them feel that spending money for preserving health and preventing diseases is a prime necessity of life as food is. The politicians who run the democratic Governments even in advanced countries have been incapable of educating the masses in this direction and the members of the medical profession have been callous not to mind their own responsibilities. So in advanced countries like America and Great Britain thoughtful leaders in the medical profession are appealing to their

brethren to organise a campaign for educating the masses to feel the responsibility of maintaining their welfare. The efforts of politicians to socialise medicine in America are being strongly opposed by the medical profession as many of the prominent members of the profession in that country dispassionately feel that socialised medicine will have adverse effect on the Scientific development of medicine as the incentive for research and enterprise will be very much less in paid social service. The medical profession in India are painfully conscious of the poverty of the masses and so in national interest as well as in individual interest the members of the medical profession should on their own accord divert their attention to the villages in their own interest and in the interest of the country. Team work in the spirit of brotherhood is less taxing and more remunerative. Charity can be made an honorable trade with the sole idea of converting trade into charity. This is only possible for the medical and the teaching professions which are the real foundations of nation building activities. Foreign missionaries have demonstrated the potential forces of medicine and education by depending upon charity and the inherent noble qualities of both these professions. The missionaries began their propaganda of service in the villages and this is known to all in India. Feeling as we do like the noble missionaries we have been helping the development of Rural Practice ever since The Medical Practitioner came into existence. This is why we have given prominence to the proceedings of a Provincial Conference of the Subsidized Practitioners which met in the village of Manachanallur in Trichinopoly District. We draw the attention of all lovers of medical profession to the addresses published in the Correspondence Columns: the authors of the addresses though in different positions in life are all medical men. The Chairman, Reception Committee is a subsidized rural practitioner working

in a village ever since the Scheme of Subsidized service was introduced in the Madras province. His experience of village practice can be relied upon. As was expected he did not ask for more money from the Government. He appealed for better facilities and more freedom in the exercise of his profession. The Hon'ble Dr. Rajan, the Public Health Minister kept before the practitioners lofty ideals of the medical profession. He made it plain that the village practitioners had eventually to depend upon themselves and that the Government also had to depend upon them for the treatment of even the indigent. The Minister repeated what he had been always saying that the subsidized practitioners should breathe and live on independence. The President of the Subsidized Rural Medical Practitioners' Association told the Government that the rural practitioners were very much discouraged by the past policy of the Government in condoning the breaches of contract between the Government, the District Boards and the rural practitioners and appealed to the Government to make the practitioners feel they are really independent.

Cities and towns are groups of developed villages and the affairs of the medical profession in these areas cannot be different from those in the villages. Therefore it is the duty of the urban practitioners to make common cause with their brethren in the villages. Mutual admiration and sympathy between the two classes of medical practitioners is the only solution for the medical profession to be contented and happy. Our ambition is that the medical practitioners should realise that they are the limb of the Government and instead of begging the Government for jobs honorary or stipendiary make the Government come to the profession for help. This is possible only if all the members of the profession feel one for all and all for one in the medical fraternity whether it be in the villages, cities or towns.

Correspondence, Reports, Etc.

THE VIITH MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' CONFERENCE.

MANACHANALLOOR.

26th JUNE, 1938.

Under the auspices of the Trichinopoly District Branch of the Madras Provincial Subsidized Rural Medical Practitioners' Association, the VIIth Provincial Conference of the Madras Provincial Subsidized Rural Medical Practitioners' Association met at Manachanalloor on the 26th June 1938. The proceedings began at 9 a.m. when there was an informal meeting of the members of the Association who formed a subjects committee and discussed and approved the Memorandum and Rules of the Association adopting a few amendments which are published along with the resolutions passed by the general body at the open session of the Conference. The Hon'ble Dr. T. S. S. Rajan, Minister for Public Health opened the Conference at 2.30 p.m. The open session of the Conference began at 4.30 p.m. after an At Home in honour of the chief guest, the Hon'ble Dr. T. S. S. Rajan.

WELCOME ADDRESS

BY

DR. S. SETHURAM RAO, L.M.P.
(Chairman, Reception Committee).

On behalf of the Reception Committee of the VIIth Provincial Subsidized Rural Medical Practitioners' Conference, I have great pleasure in welcoming you to this village of Manachanalloor. You may be aware that this is the first time that the Conference of Subsidized Practitioners is held in a village. We had met previously either in District towns or at the metropolis. Our last Conference was held at Madras on 10-7-1937, on the eve of the Congress agreeing to run the Government of this Province. Excepting the fact that the leader of the Congress party had been requested by His Excel-

lency, the Governor to form the Ministry, we did not know at the time that you, Sir, whom we respect and honour as one of our own, would be in charge of the Medical Portfolio. Or else, Sir, we would have availed ourselves of the opportunity of enjoying the honour of your company in our midst last year itself. It is a most pleasant coincidence that the very first Conference after you assumed the responsible office as the Minister in charge of Public Health, is to take place in Trichinopoly District, the field of your activities as a member of our profession and in a village the field of activities of a humble Subsidized Practitioner. Ever since the Congress came to power, there has been a change in the angle of vision of the Government and more attention is now paid towards the villages and rightly so as the rural population is nine times more than the urban population. A new spirit is pervading amongst the masses who are made to feel the Government as their own. It is to demonstrate to the villagers as well as the rest of the public the importance of the village life which is so dear to the present Government and to prove to you, Sir, that we, a humble band of village workers are interested in the village to the full extent the Government is pleased to entrust us with any responsibility, our Association made up its mind to choose Manachanalloor a village as our meeting place to-day so that all of us might remember the scope and purpose of the Subsidized Rural Medical Relief Scheme during the course of our deliberations. It is therefore, Sir, we decided to approach you to invoke your blessings on this humble gathering of village doctors so that your presence may serve as a fillip to work out the rural medical scheme to the entire satisfaction of all concerned. We are under a deep debt of gratitude to you, Sir, for having been so kind as to consent to open this Conference in spite of your multifarious duties.

We have lived and worked in villages these fourteen years, ever since the Subsidized Rural Medical Relief Scheme

was inaugurated by the late lamented Rajah of Panagal. Our problems are essentially those of a villager. Therefore it is in the fitness of things that we meet in a village. This is fairly a big commercial centre with nearly a dozen rice mills, outlying paddy fields and irrigation canals and practically on the out-skirts of the famous pilgrim centre, Sreerangam. But this is not a typical village where most of us have been working.

You will please bear with me if I give a short review of village life. The first thing that strikes a visitor to a village is the poverty of the peasantry. It is with difficulty that majority of them get one meal per day. When they have to economise in this way with regard to prime necessity of the body, you can easily imagine how they must be dealing with other wants which are not so essential to keep body and soul together. Thus ill-nourished, they offer poor resistance to the onslaught of disease. They live in small ill-ventilated and insanitary houses, clustered together in limited areas which constitute the nathams in the villages. The cattle so essential for their agricultural purposes are also accommodated in these dwellings. In many villages the water is brackish and unfit for drinking purposes. Even where good water is available, the only source will be one or two common wells without any arrangements to keep them from pollution. Water-borne diseases such as dysentery, cholera are consequently a scourge visiting the village population year after year especially after festivals and fairs with great destruction of human life. Tuberculosis and Leprosy are on the increase not to mention the age-long loss of life after child-birth. Equally staggering is the percentage of deaths of newborn before they attain one year. Recent researches into past history has brought to light that the old village life was well ordered, happier and healthy. It did not involve economic drain from the villages outside. It is outside my province to tell you the causes that worked against the peasant and landed him into this present day sorrowful plight. The need of the hour is how the villager could

once more be helped to develop the resources and take pride in his farm, his cattle, his family and his neighbours which he once did in days gone by.

The question of village uplift is at present claiming the anxious attention of the Government and the Public. In matters such as education, medical relief, communications and water supply which were hitherto considered as the only concern for urban population, the villagers were completely ignored. It is a sign of the times that the neglected villages are gradually coming into their own. The long neglect however has made the task of uplift very difficult.

Certain measures have of late been taken by the peoples' Government. It is said Prohibition has brought a life joy in most homes in the villages of Salem. The Debt Relief Act is in force. Fourteen lakhs of rupees have been provided to supply protected drinking water to the villagers. Reorganisation of Elementary Education on the modes of the Wardha Scheme has been introduced in selected centres. Over 200 midwives have been provided to Rural Dispensaries. A Public Health Act is on the anvil. Much more remains to be done. The proportion of Rural to Urban population is about 9 to 1 while the Medical Relief which they get stands almost in the reverse order. The private practitioners all flock to the towns as village life is not attractive. The result has been that the village population go without scientific medical treatment.

In this province there has been a Scheme of Subsidized Rural Medical Relief wherein private practitioners are paid a subsidy of Rs. 500/- per annum and local bodies supply free of charge medicines for Rs. 360/- a year and in turn the practitioner has to treat all the necessitous poor free. This experiment has been claimed by the Government and the public bodies as a success. Similar schemes were tried in other provinces in India without much success. Of late in the province of Sind a scheme with better subsidy than the one paid to us and equally with better equipment was inaugurated and had to be given up as there was little response from private medical men. So

this province has been lucky enough to get an army of nearly 450 rural medical practitioners to settle down in selected villages and work the scheme with some success. In spite of this, scientific medical relief works up to only one medical man for 36,000 of the population in the villages. The expansion of medical relief as to cover the whole province and to afford one medical man for every 10,000 population at least is well nigh impossible unless the Government and the public realise their responsibilities and encourage the medical profession to develop on healthy lines and take up the responsibility of medical relief.

The existing Rural Dispensaries are poorly equipped with inadequate supply of medicines and other equipments. The supply of medicines through Government owned store depot takes away over 30 to 40 per cent of the allotment of Rs. 360/- per year towards overhead charges. In very many centres there is no good accommodation to lodge the dispensary. Over and above these handicaps the practitioner has to work under too many authorities as per the indenture which he has to execute. It is needless now to recapitulate all the grievances and difficulties that the village practitioner had to contend so far. Therefore I am tempted to make a strong plea to the authorities concerned to devote more attention to the existing dispensaries by providing them with adequate accommodation, equipment, etc., and try to make them really useful.

From the facts enumerated by me about present day village conditions you will see that the problem is so vast and cannot be solved by one-sided activity of opening hospitals and dispensaries however efficient even if we can afford to do so. The people are steeped in ignorance and superstition. They attribute every trouble to Karma and blame some God or other and are in the clutches of the priest-craft, the religious-mendicants, mantravadins and hosts of others whose interest is to keep the villagers as credulous as they are ignorant. They have a prejudice against scientific medicine. Their ways of living are such that villages have become hot beds of certain preventable diseases as

Dysentery, Cholera, Tuberculosis and Leprosy to mention only a few. Last but not the least they are poor.

In the village uplift work neither the Government who have been considering this scheme nor the public bodies who have been working the scheme here and there seem to have realised the need of associating the village practitioners knowing as all of them do that the ultimate object of the village uplift is the welfare of the villagers. It is a fact and not a proud utterance when I say that there is no subject concerning the life of the people of which a medical practitioner does not know. He is taught and trained in the humblest work of scavenging so also in the difficult problem of diets and in the art of constructing dwellings to ensure the health of those entrusted to his care. The medical profession is most lucky in having a medical man as one of the units to run the Government in this province and the village practitioners naturally expect that they will be given their legitimate place in the rural uplift work.

I do not wish to mar the salubrious effects of a warm welcome to you all by repeating the story of our hardships and that in the presence of the Public Health Minister who is expected to know our pangs more than some of us do. He was in touch with us as a practitioner in this district and knows us and our lot. After he assumed office we have conveyed to him our wants and disabilities through the head of the Medical Department, the Surgeon-General with the Government of Madras, whom our representatives met on deputation led by our beloved President Dr. V. Rama Kamath in September last and he was personally reminded of all that our representatives conveyed to the Surgeon-General exactly six months ago on 25th January 1938 and though some of us did suffer even after the Hon'ble Minister was kind enough to assure our representatives on 25th January the deletion of some of the objectionable conditions now appearing in the indenture we are forced to execute, we have not lost faith in the Government. We know the complicated Government

machinery cannot be made to run as quickly as we would wish it did.

All the same we take this opportunity and request the Government through you, Sir, the popular Minister in charge of Medical Department to give effect without further delay to the decisions arrived at by you in consultation with the Surgeon-General, Director of Public Health and the representatives of our Association including our President. This will serve as an earnest of the good intentions of the Government towards the Subsidized Rural Medical Relief Scheme and encourage us to co-operate with the Government with heart and soul.

The treatment accorded to us by the concerned authorities in the past led us to a tendency of pessimism and majority of us in adverse circumstances naturally have been losing the zeal necessary to work out the scheme for the good of the village folk. Just at this juncture when the Congress sat on the saddle of the Government, Dr. V. Rama Kamath who till then was making use of his journal *The Medical Practitioner* to ventilate our grievances, came to our rescue and due to his indefatigable energy it has been possible for us to organise ourselves into an Association which within a year of its existence could enroll nearly 50 per cent of the strength of the existing Subsidized Practitioners in this province. I take this opportunity of thanking him on behalf of us all and also the members of the Interim Committee of Management for the selfless work rendered by them this one year on behalf of the Association. Dr. Kamath has been telling us in season and out of season personally and through his journal that the Subsidized Practitioners really belong to an order of service which is at a higher level than the one rendered by our brethren in the medical profession as honoraries in the urban areas. He says that the service rendered by us can be made to serve as an example to our more fortunate brethren living in towns and cities and a strong and well organised medical service may be built up which may eventually take up the responsibility of rendering service to the public in both

the curative and preventative medicine. The gleanings of his ideals and the practical ways by which the ideals can be realised may be conceived by those who have read the thought provoking address delivered by him at the Madras Conference last year.

I can say without fear of contradiction that till this day nobody either in this province or elsewhere has given his thought about village medical relief to the extent Dr. Kamath has done. He is full of hopes about our future. With the help of the members of the Interim Committee especially my colleague Dr. M. R. Bhat a Memorandum with rules for the future working of our Association has been very ably drafted by our President which will be placed before the General body to-day for final approval. Ideals enunciated by Dr. Kamath can, I hope, be worked if our Association is well organised. Our President and the members of the Interim Committee have done their part of the work with credit to themselves and the Association which entrusted this hard work to them. It is now for the Association to act their part gloriously.

Before closing I wish to give a bit of advice to my comrades. Though we are highly grateful to the Hon'ble Dr. Rajan for the deletion of the two clauses which prevented us from taking part in civics and politics, it is desirable in your own interest and the larger interests of the Subsidized Rural Medical Relief Scheme if we eschew local or provincial politics and concentrate our attention on problems concerning the welfare of those living in villages and for whose sake we have devoted our lives to village service. If we do not belong to any political party we will be able to command respect and regard from one and all. Our hobbies should be to educate those around us and infuse in them working knowledge of Physiology and Hygiene to make them understand the preventive methods in medicine. We should offer our services whenever possible and if there be opportunities to teach school children the same two subjects. It is true that the inherent defects in the working of the Subsidized

Medical Relief Scheme, have curbed in us the inherent noble ideals of the profession and we are not in a position to be useful to the extent we can be. The Government have recently taken away from the Local Bodies the control over the Subsidized Midwives working under us. This is a step in the right direction. I suggest to the Government most respectfully that most of our recurring troubles will disappear like a mist if for the same reasons mentioned in the G. O. in regard to midwives, the Government may be pleased to keep us all under the direct control of District Medical Officers for the time being till the Government are able to contrive an independent machinery of control to make the Subsidized Rural Medical Relief Scheme self-reliant.

Though I have not enumerated categorically our grievances, hardships and handicaps, the Hon'ble the Minister in our midst knows them well and I am almost certain that the Minister will not only mention what they are but would also tell us how best they could be solved. Our purpose in troubling the Hon'ble Minister to be in our midst is not a selfish one. Many of us sincerely believe that the huge problem of medical relief to the masses in the villages cannot be solved by any Government either here or anywhere else unless and until private medical practitioners co-operate with the Government and *vice-versa*. We, in the Trichinopoly District, had been noticing all round luck in all the undertakings of Dr. Rajan as a private practitioner and we are now full of hopes that the same luck will dawn on the Subsidized Rural Medical Relief Scheme if the Hon'ble Dr. Rajan makes up his mind to organise this scheme. If the Hon'ble Dr. Rajan guides us in the right direction which we are sure he will do, the Subsidized Rural Medical Relief Scheme of Madras will serve as a good example for other provinces to copy. His words of advice will encourage us and enable us to conduct the deliberations of the Conference worthy of his advice. May I now request you, Sir, to open the Conference and bless us all your younger brethren in the medical profession.

INAUGURAL ADDRESS.

BY

THE HON'BLE DR. T. S. S. RAJAN,
Minister for Public Health, Government of Madras.

For the first time in our country, our province has taken up this venture of rural medical relief by qualified medical men. Medical education costly and urban in its nature has instilled into our minds the idea of city life and it is impossible for most of us trained under such auspices to think of eking our livelihood in far off villages. The fear that the villagers are very poor and that the idea of paying for a medical man is more or less foreign to our people particularly in the villages, have frightened away qualified medical men from settling down in villages, with the result that there has been a certain amount of overcrowding in the cities. It is the idea of the Government to attract and encourage qualified practitioners to go and settle down in the villages to afford good medical relief for our people and with that view the subsidy was proposed and this contribution was meant to be only a sort of help and nothing more.

It was in the year 1924, the Government issued an order asking the local boards to take steps to give effect to the scheme of rural medical practice directing them to put this scheme into execution not later than 1st June 1925. The merit of inauguration of this scheme goes to the late Rajah Saheb of Panagal, the then Chief Minister and to Major General T. H. Symons, I. M. S., the then Surgeon-General with the Government of Madras. It was intended to bring medical relief within the easy reach of the rural population in the province. After a good deal of discussion, the present scheme was inaugurated. Some time later, after the introduction of the scheme, it was simplified by the inclusion of qualified practitioners of Indian Medicine and subsequently an additional provision of midwife has been made. The total number of rural subsidized dispensaries at the end of 1937 was 571. You will thus note that the scheme is developing rapidly

and has assumed proportions big enough to constitute by itself a separate department requiring control and direction.

STATUS OF THE RURAL MEDICAL PRACTITIONERS.

I have to remind you, even though the fact has been stated a number of times that you are independent medical practitioners. I want you to bear this in mind for more reasons than one. There is a tendency amongst the rural medical practitioners to consider themselves more or less as service men. This tendency has developed because of the difficulties and the environments under which they are asked to work. I am personally aware of the very many difficulties under which you have got to labour. But after having said that I do still believe that it is degrading to a medical man's sense of freedom that he should try to rope himself under service protections or conditions.

It is very difficult at this stage for me to assess the remuneration or the actual income of the Rural Medical Practitioners. I dare say some of you should have done very well; perhaps there are a host of others that are still trying to eke out a livelihood on the poor subsidy that they get. However, I find this cadre of Rural Medical Practitioners has come to stay and what is more that people with university qualifications have begun to apply for places in the villages under this rural medical scheme. That the subsidy is a great incentive for people to settle in the villages cannot be denied. I for one would not hesitate to continue the support from the Government till such time that it can be said with certainty that the help would be superfluous. The Government have already enlarged this rural medical development and propose to do so annually according to the nature of the finances at their disposal.

DUAL CONTROL.

As at present constituted, the local bodies are asked to contribute a moiety of the expenditure incurred on these

rural dispensaries. Moreover, the villages are so far apart and away from the headquarters, it is very difficult for any Governmental agency to control and supervise them effectively. Besides there is this fact that it is a professional service and lay people may not be able to judge exactly the very many difficulties of the professional men. Under such circumstances, a dual control has become necessary. While the District Board is asked to have its control to a certain extent, in the choice of the place and also in the choice of the doctor for a particular locality, the District Medical Officer in the case of allopathic dispensaries and the Principal, Government Indian Medical School, in the case of Indian systems of medicine, have been asked to control the professional side of the medical man's work. There is thus the control of the Government exercised through their medical officers and there is also the control of the presidents of the District Boards who are lay men and who are interested in providing efficient rural medical relief in the villages in their charge. Thus a dual control of what is apparently an independent medical profession has become necessary. The Government do not expect that this state of things would continue in perpetuity, for the moment a practitioner becomes self-reliant and could free himself from the restrictions of a subsidy and its attendant consequences, he is expected to do so, releasing the Government of its financial obligations so that the Government may divert the funds for provision of medical help in places that are not being served to-day. It is not as if the Government is going to consider this as a separate department which should be developed year after year without any regard even to financial exigencies but it is only in the nature of a little encouragement and initial help for medical men that the scheme has been devised. If you have followed what I have said carefully you would realise that this service should not be considered in terms of a perpetual permanent establishment and charge on the revenues of the Government but as that of mere subsidy for some time to come in the

case of those that have not had the encouragement to go and settle down in the villages. That is why I am rather averse to providing you more and more safeguards against the interference of local bodies and the Government in matters relating to your medical work and practice. The minimum of interference from the local bodies and the Government seems to be the only correct procedure in the terms of the interpretation I have given of the rural medical practice.

TRIPLE CONTROL.

There is another possibility in the future evolution of preventive medicine in this province in which Rural Medical Practitioners may be called upon to play a very great part. I believe that they perhaps will be the pioneers of knowledge with regard to rural sanitation and preventive medicine. They shall have to be good samaritans and preachers of scientific truths to the vast millions of men and women who from the population of the country living mostly in villages. Provision of protected water supply, correct and well-balanced diet, preventive methods of protection against epidemics, all these items will have to form the major portion of health work in our province. For this work I do not think a better fitted class of people could be conceived of than the Rural Medical Practitioners. There is no doubt that the Health Department is providing a number of trained Health Inspectors but they suffer from the handicap of not being medical men. It stands to reason, therefore, that with a certain amount of sanitary knowledge the Rural Medical Practitioner in a position of vantage not only with regard to medical work but also with regard to sanitation. It is fair that the rural medical man should to a large extent control and direct the activities of the sanitary staff under the direction of the District Health Officer. If this service is added on to the Rural Medical Practitioner, you will find there will be three masters to serve, the Health Department being a third master. The Government are now trying this experiment of employing Rural Medical Practitioners for sanitary work in selected

villages and after a little time we will be in a position to state how exactly the scheme has worked and on the results thereof a new sanitary policy shall be developed for working this system.

It does not matter whether a medical man is in Government service or an independent practitioner but the obligation on him to do work for preventing epidemics for the general well-being of our people and for imparting knowledge to them on health subject is a duty imposed on all by the very fact of our having had a medical education which is not accessible or available to the majority of our people. Viewed in that light, you will find the obligation lies more heavily on those who happen to get some sort of help from the Government. It is not so much the money that you can count as much as the principle underlying the whole scheme that we should bear in mind.

GRIEVANCES.

Your grievances are many and at least some of them have been brought to the notice of the Government. Knowing the important position you hold in the medical economy of the country and the very important work you are asked to do, I can assure you on behalf of the Government that such grievances as you have suffered from or are suffering shall certainly be looked into with the sympathy and care which the matter deserves. It will be easy for the Government to pass an order, as had been done, that you shall not take part in public activities, misnamed politics, but really questions on which every man and woman of this vast country has got a right to have their say and also avail themselves of the opportunities which are placed before us as a matter of fundamental right. It is not my desire to reduce the independent medical practitioner to the position of a Government servant whose time is entirely booked for carrying out the orders of the Government. You are not in that position. I feel you have every right to take part in the public administration of the country in whatever capacity it may be open to you to do. In

rural panchayats and the local board areas, your advice, your suggestions and your knowledge shall be of use to those bodies and the fear of party politics coming into the bargain should not shut you out from such benevolent activities. There is no doubt that some unpleasantness has been caused to the rural medical practitioners by party politics but if you are clever and if you have a sense of devotion to your duty and have a sense of patriotism above party factions, probably you may not get caught in the whirlpool. For whatever you may be you cannot become full timed politicians unless and until you give up medical work. In countries like Great Britain where party politics form the key stone of administrative machinery, the medical man has managed to trim his sails avoiding the storm. You need not feel small on the score of not being able to loom big in local politics but you may rest assured that your advice, your suggestions and your peculiar position in society will be sought after by all those who want to figure in public life and if you anchor yourself to a principle which will be above reproach and personal ambitions, you will find that your reputation as an entity in rural politics will be to your credit. But unfortunately all rural medical practitioners, I must confess, are not made of the same calibre. Some people in some places have been the victims of indiscretion, sometimes even of vindictive persecution and there are a great many others who have managed to get on cleverly and well according to the nature of the wind that blew and have come to retain their important position in villages. It is very difficult for the Government to dictate to you in the form of rules and regulations all those details of human conduct which should guide you in the peculiar circumstances in which you are placed. The Government have also got enough trust in the common sense of the Rural Medical practitioners and are not afraid that you will allow yourself to be victimised.

Some time ago a deputation of the Managing Committee of the Rural Medical Practitioners' Association submitted a memorandum to the Surgeon

General and later on led a deputation to the Government. A number of points for discussion were raised and tentative conclusions were reached. Amendments to the form of agreement prescribed for Rural Medical Practitioners have been found necessary in view of those discussions. A number of amendments to various sections have been proposed and these are now in the hands of the legal advisers of the Government. A new consolidated order regarding all these points shall be issued by the Government very early and I may once again assure you that the Government have done all that they could under the existing conditions to meet the reasonable demands made by your Association.

The Government are also aware that in your contentment and prosperity lies the progress of rural medical relief and therefore while they ask you to be efficient, sympathetic and humane in your dealings with the poor people, they shall also see that your difficulties are met and your work made as smooth as possible. But any amount of rules and regulations will not be able to level down individual temperaments and character. Therefore, it is up to you to so shape your work amongst the people in such a way as not to raise a wall of opposition to your endeavours. The best way at all times for people who are engaged in this type of social service work must be one of choosing a path of least resistance and it is that which I would advise you to follow and persevere.

YOUR ASSOCIATION.

I welcome the information of your organisation. After seven years of existence, I find that not all the Rural Medical Practitioners have yet joined the Association. I know personally the late Dr. Rama Subbu whose keen interest in the organisation of your group was so abundant that he even risked his professional work in his desire to give you a collective security. I am so glad to know that you have associated my very active and energetic friend Dr. Rama Kamath in your Association and I may assure you you have not made a bad choice. Having

said this, I must also remind you that your organisation is still weak and that mere cataloguing of grievances alone will not make you a coherent strong body for it is not every one of you that have got a grievance of a nature that could not be got rid of without the help of an organisation like this. Therefore, I want you to extend the scope of your activities; for you have before you a rich field of unexplored territory populated with men and women who are more or less ignorant of the things of the world. Your experiences are quite different from that of a city practitioner. The peculiar mentality of the people, their faiths, their beliefs and the vagaries of quacks, the good services of practitioners of other systems of medicines, all these give you a different type of experience and such knowledge should be collected and garnered and made available to the profession as a whole.

Secondly, you have an opportunity of developing your skill in facing difficulties of emergency practice in the villages. Resourcefulness is perhaps one of the great assets in a Rural Medical Practitioner. While a city man may rush to a specialist or to a big hospital or a nursing home for immediate relief or advice when he is in difficulties, you cannot in the very nature of the place in which you have got to work command the same facilities as are open to the rest. Therefore by your own ingenuity and resourcefulness you will have to evolve new suitable methods to give such help to the afflicted people in a way that other practitioners in the cities cannot do. That experience also should be recorded and made useful.

Thirdly, there is the question of employing cheap effective indigenous remedies that are in vogue in the villages. It may be that many of them are useless but there are certain things which certainly deserve your attention. Allopathic practitioners have got to wait for their indents and for their drugs from miles away from where they live. If you are interested and if you have got the leisure and the knowledge, it will be a useful task for each one of you to take up

for investigation the use of very many indigenous leaves and herbs that are in use by the village folk as well as by unqualified practitioners. A critical investigation of such an important matter will be a useful addition to the armamentaria of therapeutic medicine.

Fourthly, you have your duty as sanitarians. Your Association should develop this particular side of medical knowledge and it will be no mean contribution to the general knowledge with regard to diseases if you sit together and work it up. I learn that the "Practitioner" has been more or less made your official organ and that will be to your advantage. Such of you that take up this suggestion should find some time to record your findings in the Journal and also make them available for the city practitioners by your joining the District Medical Associations in large numbers and give them the benefit of your experience for their information. By this way you will find that you are really filling up a much needed gap in our ranks.

RADIO.

Now that the Government have developed a fully equipped Radio Station in Madras and another will be ready at Trichinopoly in the next few months, you would find that radio talks to the villagers on matter of scientific as well as medical interest will become part of the work of radio stations. The Government shall endeavour as far as possible to make these radio installations as effective and educative as possible. A small investment is necessary and it will be impossible for the Government to reach all the villages if Government alone is expected to share the responsibility. As influential men in the villages and as medical men it must also be part of your duty to give the benefit of this broadcast talk through the radio to the illiterate villagers. If you have got some money to spare or if your Association would contribute some money and help in getting Receiver sets in the villages, you would find your popularity as a medical man increases and at the same time serves

the people to become more intelligent and aware of world conditions and events. It will also be a very good propaganda for scientific information and of knowledge about epidemic diseases. This is a new addition which I suggest to your activities which while helping the general public and the villager will indirectly benefit you also.

PRESIDENTIAL ADDRESS

BY

DR. V. RAMA KAMATH.

It is eleven months and sixteen days to-day since we met last at Madras. Though at the time when a very few of you conceived the idea of summoning a Provincial Conference of Subsidized Rural Medical Practitioners last year everything was uncertain about the then Government in spite of the inauguration of the guarded Provincial Autonomy, such of you who attended the last Conference at Madras on 10-7-37 entertained very high hopes about the future development of the Subsidized Medical Relief Scheme when you learnt that the leader of the Congress Party had made up his mind to run the Government of this Province. A few days later your joy knew no bounds when you heard that Dr. T. S. S. Rajan was to be the Minister in charge of Medical Portfolio. And when the Hon'ble Dr. Rajan was entertained by Trichinopoly District Medical Association soon after the announcement of his office was made, references made by him about the Subsidized Rural Medical Practitioners in reply to an address made by one amongst you on the day of the entertainment, many of you were in a state of ecstasy. For you heard for the first time in the history of Subsidized Rural Medical Service a member of the Madras Government declaring that you were independent private practitioners for all purposes. Later the same day at the very entertainment when your comrades in the Trichinopoly District heard the Minister telling them that the two objectionable clauses prohibiting Subsidized Practitioner from taking part in civics and politics introduced in the

agreement for the first time in January 1937, should find no place in the indenture of your service, you thought that the dawn of independence envisaged by the Minister was not a mirage.

As decided by the General Body of your Association at the last Conference your representatives, the members of Interim Committee of Management saw the then Surgeon-General, Major-General Sir. F. P. Connor on deputation which was led by me on 7-9-'37.

"The Surgeon-General was very sympathetic and said that majority of the grievances were modest and real. He felt sorry that his term of office was to come to a close very soon and that he would not have time to write to the Government at length about them, but promised the deputationists that he would meet the Hon'ble Minister for Public Health and tell him in person what should be done in the immediate future in regard to the grievances of the Subsidized Rural Medical Practitioners.

As nothing was heard relating to the result of discussions which your representatives had with the Surgeon-General, the Interim Committee decided to interview the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister and a deputation of your representatives led by me waited on the Minister exactly six months ago and what transpired at the deputation is known to you all through the columns of your official journal. Just a while ago the Hon'ble Minister announced that the decisions arrived at during the interview with him on 25-1-'38 will be incorporated in the Agreement form and given effect to in a very short time.

Some recent events have naturally upset many of you and shattered the expectations you have been rightly entertaining about the working of the Subsidized Rural Medical Relief Scheme under the Congress Regime. There have been cases where the District Board Presidents set at naught the conditions of the agreement and on appeal the Government did not set right the wrong done to the Subsidized Practitioners. There are only three circumstances when the servi-

ces of a Subsidized Practitioner can be terminated by the District Board, viz.

1. If the Subsidized Dispensary does not work satisfactorily,
2. if the funds cannot be provided for the running of the dispensary and
3. if the Subsidized Practitioner is guilty of infamous conduct or violates any of the conditions in the agreement.

In all the above cases previous concurrence of the District Medical Officer must be obtained by the District Board before any action is taken by the District Board. And nowhere it is said that the District Board President can himself deal with the above cases. It is therefore to be understood that the District Board President should obtain previous sanction of the Board before he takes action on a Subsidized Practitioner.

In almost all the cases that came to my notice where the services of the Subsidized Practitioners were terminated, the President himself acted for the Board without even a formal sanction. When a practitioner commits breach of the conditions of agreement, it is said in the indenture that charges should be framed against him and explanation demanded before he is punished. I know at least one instance where a practitioner was actually threatened to hand over charge without assigning any cause on the plea that the District Medical Officer concurred with the District Board President about the termination of his services. Later it was known that those who got rid of the unfortunate Subsidized Practitioner appointed a fresh candidate who went to that District in search of employment.

There is a mandatory condition in the agreement that the Subsidized Practitioners should not be transferred from one village to another. Yet I know transfers were effected in more than one District Board.

All cases that were brought to my notice and where I found grave breaches of conditions of the agreement were committed by the District Board Presi-

dents have been brought to the notice of the Government.

Conversion of Subsidized Dispensaries into L. F. Dispensaries is fundamentally against the spirit and principle of Subsidized Rural Medical Relief Scheme. And it is certainly inequitable if not illegal to displace a Subsidized Practitioner by one in regular service and deprive the subsidized practitioner of the fruits of his labour. Yet this was done by the Government in the very District where we are meeting to-day. This seems to be a repetition of what was done by the Government in this District during the Justice Regime. It is no wonder that the victimised practitioner got desperate and thought of going on hunger-strike. When suicides have become very common these days amongst students who fail in examinations, we as medical men could conceive the mental condition of an unfortunate Subsidized Practitioner who in a helpless mood thought of having recourse to hunger-strike, a method adopted these days by persons of spiritual culture for much higher purposes than the one contemplated by this humble practitioner. No one having a mental balance would approve of the contemplated action of this Subsidized Practitioner and even he came to his proper senses and soon after the Premier advised this practitioner that hunger-strike was not justifiable in his case he made an unconditional apology to the Hon'ble Minister for Public Health.

In the September 1937 issue of The Medical Practitioner all of you must have read a statement published by me about the grievances of 12 subsidized Practitioners some of whom having preferred petitions to the Government for redress, others being advised by me to do the same. The 12th Practitioner in this list was from the Tanjore District. The President of the East Tanjore District Board served on this practitioner a notice dated 28.6.37 terminating his services on the plea that the Panchayat Board of the village where the Subsidized Dispensary was located wished to have

an Ayurvedic Dispensary. The Practitioner replied through the District Medical Officer that the notice served on him was invalid in law, obnoxious to the policy of the Government and without justification on the merits and requested the Board that the notice of discharge might be cancelled. The District Medical Officer stated that he could not agree to the notice of discharge as none of the conditions mentioned in para 12 of the agreement seemed to exist. The District Board was not baffled and contrived another device to drive away the practitioner and passed a resolution that the dispensary where the practitioner had been working for fourteen years was superfluous. So a fresh notice was served on the practitioner on this ground in January last. The District Medical Officer of Tanjore who did not agree with the District Board, East Tanjore on the previous occasion when the plea for terminating the services of this unfortunate practitioner was the conversion of the dispensary into one of Ayurvedic Medicine, was by this time transferred and the new District Medical Officer a member of the I. M. S. after inspecting the unwanted dispensary remarked on 8.3.38,

"I have inspected this dispensary this morning. The dispensary is in good order clean and well run. The doctor is conscientious and hard working and is popular with the local population. The registers are kept up to date. Very satisfactory. The dispensary should be retained in this place."

With all this the Government thought it fit to pass the following order on the appeal of the practitioner dated 21.4.38.

"The rural medical practitioner is informed that the President, District Board, East Tanjore has been instructed to allow him to run the rural dispensary until its closure is approved by the Government."

A few days later the Government seem to have advised the East Tanjore District Board that the best course to terminate the services of the practitioner would be to convert the rural dispensary of Allopathic Medicine into one of Ayurvedic medicine as resolved by the Board originally and give the practitioner three months' notice.

I have selected these two cases to serve as typical examples where the Government by their order did condone violation of the conditions of the Agreement. As mentioned by me a little while ago the termination of services of a Subsidized Practitioner is governed by only two clauses in the Agreement No. 10 & 12,

Clause 10 relates to the unsatisfactory working of the Dispensary; 12 relates to the conduct of the practitioner and financial stringency to run the Dispensary. Both these clauses are flouted by the Government and if my information is correct politics weighed more with the Government than justice and fair play. It is therefore natural that the subsidized practitioners have begun questioning, can there be a security of service in the Subsidized Rural Medical Relief Scheme?

It cannot be said that the Congress Government does not know or have not realised that it will not be possible for the Government to afford even the first aids in medical relief by paid service. The Government is now spending nearly one crore for the maintenance of curative side of the Medical Department including medical education and have not been able to provide one qualified practitioner to a population of 24,000. In advanced countries like Japan and America where so far the Governments have not introduced Socialised Medical Relief there is one doctor for a population of 1,600 in rural areas and one to 800 in urban areas. Excepting in the City of Madras where a ratio one to 800 or very near this figure has been reached, the distribution of doctors on population basis cannot come to that obtaining in America or Japan the two countries from where I could procure a rough statistics (as worked out by my late lamented revered colleague Dr. M. G. Krishnamurti Aiyer, retired Sanitary Commissioner, Travancore State). I remember the Hon'ble Dr. Rajan mentioned somewhere that his idea was to provide immediately one qualified medical man for a population of 10,000. Certainly a modest and reasonable ambition when it is

known that we have at present roughly one doctor for a population of 24,000 that too not uniformly distributed. For just now I told you that Madras City has one medical man for a population of 800. At this rate I wonder if rural areas could have one for 30,000 of population on an average as qualified doctors naturally prefer to settle in urban areas. To reach Dr. Rajan's figure of one doctor for 10,000 of population the Government may have to spend somewhere about 2 crores immediately. Such an expenditure for medical relief would not have been possible even during non-prohibition days and the Congress Government cannot afford it at all, at all times.

The concern of the Congress under the leadership of Mahatma Gandhi, for the welfare of the masses is quite genuine. The anxiety of the Congress to make the village folk as happy as their more fortunate brothers and sisters in urban area nobody can dispute. The policy of the Congress Government to get the maximum return for a minimum expenditure is a known fact. That the leaders in the Congress party have taken up the responsibility of running the Government in this country to render unalloyed disinterested service and not to enjoy power and glory cannot be disputed. This is why the Subsidized Practitioners entertained very high hopes along with the rest of the people living in villages that their lot would be improved and that many more would join their service and the Scheme of Subsidized Service would be not only popular amongst those who work it but will be made more useful to the masses in the villages than it was in the past.

It is common knowledge that one good act of a notoriously wicked man gets broadcasted as quickly as one bad act of a famous good man. The Subsidized Practitioner belong to a very noble profession if not the noblest. They have by virtue of their training a keener perception and the opinions they arrive at are generally more justifiable than those entertained by others who had not the benefit of their training. The error

of judgement displayed by the Government on some of the appeals submitted to them had shattered the hopes they have been entertaining under the Congress Regime.

If I am forced to criticise the acts of the Government of omission and commission I do so with the hope that without criticisms there cannot be progress and reform. I claim special liberty with the Hon'ble Dr. Rajan both of us being members of the same fraternity having been trained in the same medical school. Though age and other circumstances might affect changes in the human frame the bonds of fraternity are far stronger to pull us asunder.

As mentioned rightly by my friend Dr. Sethuram Rao in his Welcome Address there is no art which a medical man does not know. His profession is such that he should know the dirtiest art of scavenging as well as the complicated art of cooking, sound engineering in fact every art which is useful for the social, economical and materialistic well-being of a nation and as a nation building work should be in the villages, the rural practitioners can be reckoned as a power in the machinery of village uplift. It is quite possible for the Hon'ble Dr. Rajan to conceive that members of the medical profession can, if they will, render free service to the public more than the members of any other profession. He also knows that in ancient India medical men were paid in kind and not in coins and there was no need for a paid, honorary or subsidized service under the State control. All the same the medical men were held in great esteem. So the members of the medical profession in India have the double heritage of the country as well as of the profession to do public service independent of Government. Due to materialist civilisation in which we are made to live these days there have not been living ideals before the members of the profession to follow by example. Precepts without examples will have little or no effect. From my past experience and from personal contact in my capacity as an elected representative of the largest

section of registered practitioners in the Madras Medical Council, as a journalist and as the President of the Madras Provincial Subsidized Rural Medical Practitioner's Association, I can tell the Government through our brother the Hon'ble Dr. Rajan that there is sufficiently a large number amongst these humble practitioners who have vision of patriotism and zeal for service. If unity of action and organisation is perceptible in any branch of society in any part of the world, they were the result of adversity and never of prosperity though prosperity is the ultimate fruit of adversity. The adverse circumstances in which the Subsidized Practitioners are forced to live in, have naturally a tendency to bind them as soldiers of service. If the Subsidized Practitioners are properly guided, treated with the considerations due to them and given facilities to practise their profession, it will be possible for the Government to solve the huge problem of medical relief to the village folk very satisfactorily. A casual reader of the agreement which the Subsidized Practitioners have to execute, can easily understand that the intention of the framer or framers of this scheme was to create a very cheap, medical service in rural areas. The terms of agreement and the actual working of the Scheme have made the Practitioners most dependent not on one authority as is the case in other services, but on all the convivable authorities in Government and Local Board service all of whom treating the Subsidized Practitioner with the status of menials.

It may be possible for the Government to get medical practitioners to work the Subsidized Rural Medical Relief Scheme under the present conditions or even under much worse conditions than now exist. This is due to the fact that the destinies of the medical profession in India are entirely in the hands of the Government unlike in other civilized countries where the medical profession is in sole charge of the activities of the profession whether they be relating to medical relief or medical education. When the Government have realised that

it will never be possible for them to give medical relief to the masses by paid service, it should be the duty of the Government to help the medical profession to evolve into an independent entity and encourage the members of the profession to serve the masses when they serve themselves. I have said a little while ago that it is possible only for the members of the profession to be charitable. Coercion, threats and duplicity of action cannot have a place in the medical profession if they are expected to be true to the inherent ideals of the service which are inseparable in the exercise of the medical profession. In the Government medical institutions high salaried officials in the staff have not been able to demonstrate the noble instincts in the medical profession. It has been possible for the medical Missionaries only to demonstrate high ideals of service and I have been repeatedly pointing out to the members of the profession especially those working in villages to follow the examples of the Missionaries. If foreign Missionaries could run charitable institutions depending upon charity itself why not the natives of the country do likewise? The fortunate circumstance that a member of the medical profession is at the helm of the medical administration in this province encourages me to advise you not to lose heart. Your welfare as well as the welfare of the villages, the place of your activities could be effectively and efficiently controlled by you if you organise into an ideal service of brotherhood.

Ever since I came in contact with the lot of the Subsidized Practitioners I have been seriously considering about a plan for rendering cheap yet efficient medical relief to masses in the villages independent of outside control. The Subsidized Practitioners have been crying hoarse to rid them of the yoke of Local Bodies, and have been requesting the Government to bring them direct under the control of the Government. Though it is mentioned in the agreement that they can charge any body whose income is over Rs. 30 a month for the services rendered practically they are forced to earn from the poor as the few rich or upper middle

class people in the villages are the members of the District Board their relations or intimate friends who are useful to the members of the Board during elections. If a practitioner sends a bill for the supply of medicines or service rendered to such people, the very next day a mahajar is got ready against him making some allegation or other and he is doomed. But for the existence of a few conscientious District Medical Officers through whom the explanation of the practitioners has to reach the authorities there would have been more victimisation and the Scheme would have come to disrepute to a greater extent.

Quite recently the midwives working in Subsidized Dispensaries have been brought directly under the control of the District Medical Officers. I did suggest a similar reform in regard to the whole Subsidized Scheme once to the late Mr. Munuswamy Naidu the then Public Health Minister and recently to the Hon'ble Dr. Rajan when I had to lead deputations of the representatives of the Subsidized Practitioners, as the Government was paying the major portions of the expenditure of the Scheme, the Local Bodies paying only Rs. 360 a year towards supply of drugs. Both the Ministers argued that as the Local Bodies contribute towards the supply for medicines they should have a control over the practitioners. The result of such control has been free medical aid to the rich in the villages at the cost of the poor for whom the Subsidized Medical Relief Scheme is ostensibly intended.

It is true that there is an appeal against unjust orders of the District Board and the decision of the Government is final. But the procedures that have to be adopted for an appeal to reach the Government Secretariat are such that practitioners have lost faith in appeals on account of drift, delay and procrastination observed by them in the disposal of these appeals. The minimum period it takes for the files to reach the Government is perhaps three months and it is sometimes double or treble the number of months especially if the District Board President sits tight on

the file of an unwanted practitioner and there have been instances when Government had to send reminders to the Presidents, District Boards for the despatch of the appeals. The appeal should first go through the District Medical Officer to the District Board who should send it back to the District Medical Officer who in his turn should send it to the Surgeon-General and the Surgeon-General sends the appeal finally to the Government. Both the District Medical Officer or the Surgeon-General have to depend upon the subordinate staff to get in touch with the files concerning the Subsidized Practitioner and usually these officers have more urgent and useful work to attend than that of Subsidized Dispensaries. When the file reaches the Secretariat, interested District Board Presidents have interviews with the concerned Minister and even the most conscious member of the Government has at times to yield to political pressure as the democratic Government has to depend upon the solidarity of votes.

The Congress Government can afford to introduce drastic reforms. The Government did not mind opposition for drastic Legislative measures which they thought were for the good of the masses and got them passed. So it is possible for the Government to hand over the control of the Scheme to the Surgeon-General so long that office exists and give the Surgeon-General an additional assistant solely for the running of the scheme who should be directly under the Surgeon-General. A retired Civil Surgeon may be entertained for this purpose on an honorarium. In the meanwhile I would suggest to the practitioners to feel that they are a limb of the Government as the present Government is of the people and for the people and play their part as a noble band of workers for the uplift of the villages.

The village practitioners should make their Association a living active body with a secretariat of its own. The Association should be registered. Provision has been made in the Draft Memorandum and Rules for the

enlisting of eminent members of the medical profession as honorary members having power to actively concern themselves with the affairs of the Association with responsibility. When such an Association is put on strong foundation it is time for the Association to take up the responsibility of medical relief in villages independent of anybody. The Association can claim from the Government grants to the Association direct. Grants in aid system has been working relating to Educational institutions and even medical institutions run by missionaries. The Tirumani Leper Settlement, the Arogyavaram Tuberculosis Sanitarium at Madanapalle and many other Missionary institutions are helped by the Government. The Government can have no objection for helping a responsible organisation of medical men constituted to do village medical service.

Before closing I will be failing in my duty if I do not thank the Government on behalf of Subsidized Rural Medical Practitioners for the reforms introduced in the Subsidized Rural Medical Relief Scheme modifying some of the conditions of the conditions of the agreement which were working detrimentally to the healthy development of the Scheme.

It was also very kind on the part of the Government to have conceived the idea of giving refresher courses in professional subjects in the special hospitals in the city of Madras. There are many other minor details regarding the responsibilities of the Subsidized Practitioners for the exercise of the medical profession in the villages. I am told that the General Secretary has received many suggestions from the Subsidized Practitioners from all parts of the province and the subjects committee which met this morning has given these suggestions the form of resolutions which will be discussed presently. I wish to mention only one amongst them of some importance both to the public as well as to the profession. There are at present sub-police stations and out-posts in the villages and I am given to understand that the police do not send the injured relating to the cognizable offences to the Subsidized Practitioners for treatment and

instead cart these injured people to distant places to be attended to by medical men in regular service. Such an action on the part of the police especially when the injured person requires prompt attention and treatment will be detrimental to the well-being of the patient and I am told by one of the practitioners from Coimbatore District that once an injured person in an assault case who was profusely bleeding succumbed on his way to a distant medical institution though there was a Subsidized practitioner at the next door to the police station whose services could have been requisitioned in time. I am given to understand that on the recommendation of the Surgeon-General with the Government of Madras, the Government passed orders a few years ago that the services of the Subsidized Practitioners could be made available for the medico-legal work. It is for you to consider and tell the Government that you are prepared to do medico-legal work.

Brethren, you have heard the Hon'ble Dr. Rajan, our Minister. You heard me. The ideals you have in your minds as expressed by you through one amongst you, the Chairman, Reception Committee are identical to those expressed by your elders. March on brethren with heart within God overhead.

RESOLUTIONS

1. The General Body approves the action taken by the Interim Committee of management in accepting the resignation of Dr. K. Vittaldas Pai as Secretary, Treasurer and member of the Interim Committee.

Proposed by Dr. K. Srinivasa Rao and seconded by Dr. C. Kunjunni Nair.

2. Resolved to pass the balance sheet of the accounts of the Association as audited and passed by the Interim Committee for the year ending 25-6-38 and to adopt the annual report on the working of the Association placed before the General Body by the Interim Committee of Management.

Proposed by Dr. K. N. Hari Rao and seconded by Dr. Sheshadri.

3. The draft memorandum and rules of the Association were approved with the following amendments:—

(1) *Rule 5 (c)*:—After the words 'entrance fee' substitute 'Annas 4' in the place of 'Rupee 1'.

Rule 6:—In the place of 'Rupee 1' substitute 'Annas 4'.

Rule 13:—In the last para add 'If due to unforeseen circumstances any of the office-bearers resign or ceases to function the Working Committee shall fill in such vacancy and report the same to the Provincial Committee'.

Rule 14 (f):—After the word 'paid' in the first line delete all the words as far as and including 'District Branch' appearing in line 8 and substitute the following:—

'at the rate of Re. 1 for each member enrolled by the District Branch and Rs. 2 should be credited to the Provincial Funds'. Delete clause (g) in this rule.

Resolved that the Memorandum and Rules of the Association as amended be approved. Proposed by Dr. K. Srinivasa Rao and seconded by Dr. C. Kunjunni Nair. Passed unanimously.

4. Election of Office Bearers.

Resolved that the following medical men who are interested in the Subsidized Rural Medical Relief Scheme be admitted as honorary members of the Subsidized Rural Medical Practitioners' Association.

1. Dr. V. Rama Kamath.
2. Dr. C. Rama Kamath.
3. Rao Bahadur Dr. P. K. Warriar.

It was also resolved unanimously that Dr. V. Rama Kamath continue to be the President of the Association and if under any unforeseen circumstances Dr. V. Rama Kamath ceases to be a member, the Working Committee of the Association are empowered to selection from amongst the other two mentioned in the panel in the order their names appear in the panel mentioned in this resolution.

Proposed by Dr. K. Srinivasa Rao and seconded by Dr. Palani Nattar.

The following were elected as office bearers of the Association for the current year:

1. Dr. S. Sethuram Rao,
Vice-President.
2. Dr. M. R. Bhat,
General Secretary.
3. Dr. K. Srinivasa Rao,
Joint General Secretary,
Northern Circle.
4. Dr. C. Kunjunni Nair,
Joint General Secretary,
Southern Circle.
5. Dr. K. Govindan,
Treasurer.

As the members of the Association who attended the Conference from distant Districts expressed a desire that they had to leave Manachanalloor on the night of 26th itself all those present at the Conference desired at about 6 p.m. that the subject matter of the resolutions as passed by the Subjects Committee should be handed over to the President who was requested to put them in order taking into consideration the opinion and sense expressed by the members at the Subjects Committee meeting of the Conference. The General Secretary was requested to help the President in this work.

5. Resolved that as per the Memorandum and Rules of the Association it has not been possible to have district branches to elect members representing each district to constitute the Provincial Committee, the President is requested to organise District Branches as early as possible and soon after the District Branches are formed and the Provincial Committee is brought into existence the President shall select the members of the Working Committee and till such time the General Body empowers the President to choose members of the Working Committee in the way found suitable by the President.

6. The Conference expresses its heartfelt gratitude to Hon'ble Dr. T. S. S. Rajan for having announced at the Conference that the tentative conclusions arrived at during the interview with him by the representatives of the P. S. R. M.Ps' Association on 25-1-38 will be incorporated in the Agreement form to be executed by the Rural Medical Practitioners and a new consolidated order relating to all the points raised at the interview will be issued by the Government very early.

7. The Conference views with satisfaction the recent G. O. relating to the transfer of control of Subsidized Midwives entirely to the District Medical Officers and for the same reasons mentioned by the Government in the G. O. relating to the subject, suggests respectfully to the Government that the entire control of the 'Subsidized Rural Medical Relief Scheme be vested in the Surgeon-General with the Government of Madras as the Government is aware of the persecutions and victimisations of Subsidized Practitioners by the Local Bodies, and such a transfer of control will, in the opinion of the Conference, enable the Subsidized Rural Medical Practitioners to evolve into a self-reliant Scheme of Medical service as envisaged by the Hon'ble Dr. T. S. S. Rajan this day in his address to the Conference.

8. As rural uplift is one of the chief items of programme of the Government in the nation building work, the Conference requests the Government that expenditure to be incurred for medical relief in rural areas should be the first charge in the medical budget for medical relief.

9. The Conference reiterates its resolution No. 9 a, b, c and d and No. 10 passed at the fifth Conference and brings to the notice of the Government that many Subsidized Dispensaries have not been equipped with the most necessary surgical, dental and midwifery instruments in spite of the G. O. No. 761, P. H. dated 7th April, 1925 and requests the Government that a clause may be added in the Agreement to make it obli-

gatory on the part of the Local Bodies to equip the Subsidized Dispensaries consistent with the G. O. referred to in the resolution.

10. The Conference brings to the notice of the Government the inordinate delay at times even for a period of two months regarding the passing of the subsidy bills consequent to the delay of the District Boards not communicating the sanction of leave availed of by the Subsidized Practitioners which delay prevents the District Medical Officers from passing the Subsidy bills with the result that the practitioners are put to great hardship in not realising the subsidy earned by them in time. The Conference therefore requests the Government to vest the power in the District Medical Officer of granting permission to Subsidized Practitioners to avail of holidays whenever required by them.

11. The conference points out to the Government that District Boards have generally failed to give effect to the G. O. No. 9156 P. H. dated 7-8-'37 and amendments thereon which now form clause No. 12 of the Agreement executed by the Subsidized Practitioners in either not appointing Subsidized Practitioners to the vacancies in preference to others or not appointing the Subsidized Practitioners in charge of a Subsidized Dispensary which dispensary the Government sanctioned to be converted into a L. F. Dispensary consequent on increasing demand of medical relief in localities where the Subsidized Dispensary existed; the Conference therefore respectfully requests the Government to keep in view the G. O. referred to in the resolution when Local Bodies approach the Government to accord sanction to the appointment of medical officers in L. F. Dispensary or for the purpose of converting Subsidized Dispensary into L. F. Dispensary. The Conference further requests the Government that the District Boards should be advised to the effect that whenever the temporary or permanent vacancies in the cadre of Medical Officers in L. F. Dispensaries in a District arise the senior-most subsidized practitioner of approved

merit should be selected to fill in the vacancy.

12. As it has come to the notice of the Subsidized Rural Medical Practitioners' Association that G. O. No. 3036 P. H. dated 15th November 1937 relating to the selection of villages for locating subsidized dispensaries has been violated by some District Boards, the conference requests the President of the Provincial Subsidized Rural Medical Practitioners' Association to bring such violations to the notice of the Government to rectify the mistakes already committed by District Boards.

13. The Conference views with great concern a tendency in some of the District Boards for converting Subsidized Dispensaries of Allopathic Medicine into Subsidized Dispensary of Ayurvedic Medicine on some excuse or other even against the advice of the District Medical Officers who certify to the popularity and usefulness of Subsidized Dispensary of Allopathic system of Medicine and therefore requests the Government not to accord sanction to such conversion (especially against the advice of the District Medical Officers) as such conversions violate the principles and the spirit of Subsidized Rural Medical Relief Scheme and make the Scheme very unpopular. The Conference further wishes to bring to the kind notice of the Government that termination of the services of a Subsidized Practitioner for the purpose of converting an Allopathic Dispensary into an Ayurvedic Dispensary is not contemplated in the Agreement and therefore is *ultra vires* if not illegal.

14. As it is the experience of some of the Subsidized Practitioners that the District Boards delay in sending their indents to the Government Medical Stores the Conference requests the Government to advise the District Boards not to commit such delays and as it is not possible for the Government to know which District Boards commit these delays, the Subsidized Practitioners are requested to bring these delays to the notice of the General Secretary through the Joint Secretary of the respective territory.

15. The Conference requests the Government to advance loans to the Subsidized Practitioners for the construction of suitable buildings for their residence, the amount of loan to be returned in easy instalments to be deducted from the subsidy.

16. The Conference requests the Government that till the Subsidized Rural Medical Relief Scheme is made self-reliant so as to secure free medical relief to the necessitous poor in the rural areas the existing Subsidized Dispensaries should not be closed even if there were to be qualified practitioners in a village where a Subsidized Dispensary exists.

17. The Conference draws the attention of the Subsidized Rural Medical Practitioners to the sound advice contained in the Address of the Hon'ble Dr. T. S. S. Rajan, Public Health Minister that all the Subsidized Practitioners should join the Association and utilise The Medical Practitioner as a medium to express their views in matters concerning them and the profession.

18. The Conference feels that it is desirable in the individual interest as well as in the interests of the Association that the Subsidized Practitioners should obtain previous advice of the Working Committee of the Association before they take or intend to take action against any of their grievances.

19. The Conference resolves to accept the invitation of East Godavari District Branch of the Subsidized Rural Medical Practitioners' Association to have the venue of the next Conference in that District in a place to be fixed by the East Godavari District Branch of Subsidized Rural Medical Practitioners' Association.

20. The Conference thanks such of the District Medical Officers, other medical officers and private medical practitioners for encouraging the Association by sending messages of good-will this day.

21. The Conference expresses its gratitude to the Chairman and the members of the Reception Committee for successfully organising the Conference in spite

of short notice and thanks the Headmaster of the District Board Secondary School, Manachanalloor for permitting the use of the school for the Conference.

The Madras Provincial Subsidized Rural Medical Practitioners' Association.

NOTICE.

It was found during the audit of the accounts of the Association that 90 members had not paid the subscription in full and each such member is in arrears of annas eight. They are requested to remit the dues without delay.

As per the Memorandum and Rules of the Association, the Subscription will be Rs. 3 in future. The members are requested to remit the subscription for the current year to the Treasurer, P. S. R. M. Ps' Association, Vepery, Madras.

As the President has been requested to organise District Branches of the Association, the practitioners are requested to communicate with the President and fix dates for his visits to the Districts.

M. R. BHAT,
General Secretary.

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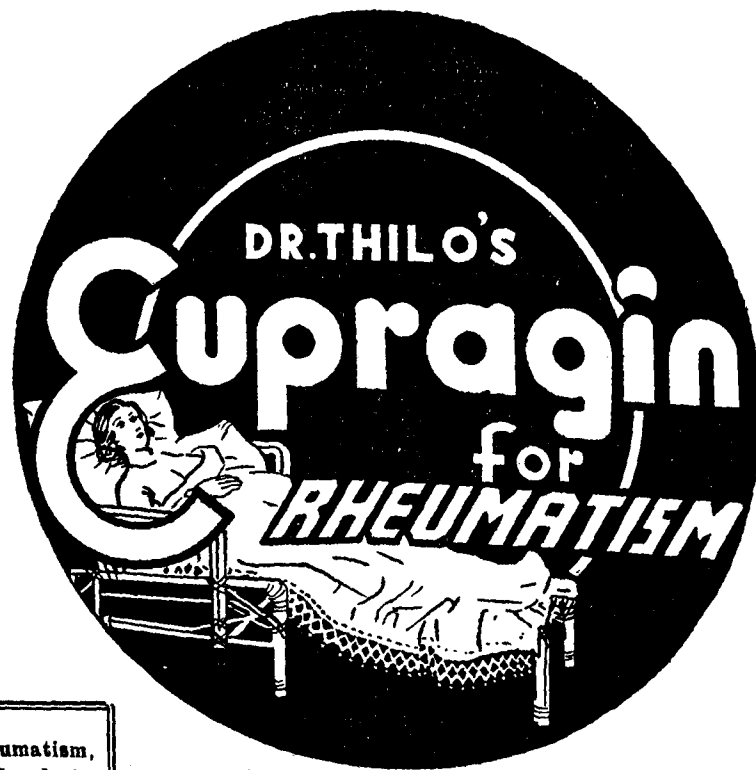
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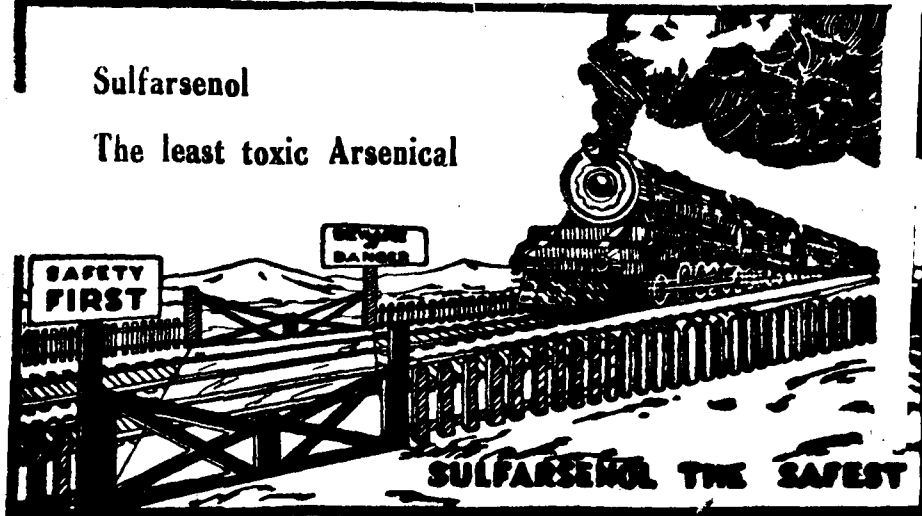
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