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THE Medical Practitioner

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Vol. X]

OCTOBER, 1938

[No. 1

Original Articles.

SIMPLE MANAGEMENT OF HYPERPIESIA.

By

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

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I have dealt with this subject in as practical a way as possible for educating the lay sufferer on the subject and to serve as an advice to a lay patient. That knowledge is wealth but little knowledge is dangerous is best illustrated by the self imposed misery of certain over inquisitive hypertensive subjects through reading bright and attractive advertisements on the subject and the so called "educational" columns of certain lay papers. On the other hand, the same persons may derive considerable benefit by simple instructions from their medical attendants if only the latter take the patients into confidence without in any way creating panic.

Frequent readings of the manometer are to be deprecated as the procedure is liable to induce an "Anxiety complex" either prior to the procedure, during or even after. Even if the pressure is raised above average normal limits (due allowance should be made for the personality, environment, mode of life, occupation etc. It should be clearly understood that the rise is a compensatory mechanism to ensure an adequate supply of blood to all

parts of the body against some resistance whose exact nature is still a matter of conjecture. No great hurry should therefore be exercised in reducing the blood pressure merely because the manometer registers a higher figure, in spite of the fact that the person is fit and well and is free from any other sign of cardiovascular disease. The commonly employed methods of reducing the degree of pressure by drastic purgatives, cutting down the scale of diet even below the basal requirements, depleting the blood volume by venesection, administering of toxic drugs either orally or through parenteral routes and inducing sweating to a weakening extent, cannot but upset the harmonious imbalance between the physiological working of the body and this moderate rise in blood pressure. Every medical man is aware of the grave consequences of such an interference. Anything from a simple cerebral attack such as a mild grade of unconsciousness twitching of a group of muscles, transient loss of memory etc. to a morbid catastrophe such as an attack of major epilepsy, (the word epilepsy is here used in the broadest sense in accordance with the

modern concepts on the subject rather than in the older way when the Haut-mal, Petit mal and the Jacksonian epilepsy were the only types mentioned in the nomenclature of diseases) coronary occlusion with or without the sequela—ventricular fibrillation leading to sudden death or even an apoplectic attack with a well marked hemiplegia—may be precipitated.

These remarks do not apply to a supernormal rise of pressure which is the main concern of the attending physician and not that of the patient. Sooner or later the patient himself begins to recognise this condition through one or other of the following symptoms especially when they have not existed before. They are:

1. Headache,
2. Giddiness or dizziness,
3. Sleepiness,
4. Tremulousness,
5. Agitation,
6. Throbbing in the head,
7. Sensation of warmth in the head.
8. Breathlessness on wonted exercise.

I shall briefly put down the regimen to be followed by the patient suffering from the milder grade of hyperpiesia.

The mental and physical activities should be keyed down to a lower pitch. Retirement from exacting occupations may be advised but a sudden and complete restraint of mental activities will induce an 'anxiety state' in the patient one main thing that has got to be avoided in the simple management of patients suffering from hyperpiesia. Night rest should be in the neighbourhood of nine hours—though some would have it at eight hours; much depends on the personality of the patient—a "human mollusc" or a "live wire." Past the middle age (or even nearing it) it is not possible to sleep right through this period. A state of complete relaxation is

therefore equally beneficial. A midday rest of one or two hours after the midday meal is essential. Every effort at work (mental or physical) should stop short of fatigue. Milder type of cases with no other cardiovascular changes may resort to such exercises as an evening walk on the flat. Climbing to the 1st floor of one's own residence is worse than hundred yard sprint. Heated rooms not to speak of heated arguments, civic dinners, crowded meetings etc., are to be severely eschewed from one's routine. Gardening is good (avoiding the sun and the spade) in the cool of the morning and evening. Late hours, even in the privacy of one's own house, is undesirable.

BOWELS: One satisfactory motion a day is desirable (the evacuation should be complete as evinced by the satiation experienced. Straining at stools is worse than the fatigue experienced by free purgative. Laxatives, should they be deemed necessary, need not be avoided. They should be taken over a larger period than one usually does. Far from inducing a habit, they assist the patient in deliverance from the drug by inducing a rhythm. The quantity of the drug adopted should be so regulated by the patient himself that the following results are achieved:—

- (a) One motion alone per day.
- (b) Not too fluid nor dry, nor hard.
- (c) No pain anywhere.
- (d) No sense of fatigue.
- (e) Should not affect organs such as the liver etc.

Keeping the above points in view the patient may be advised to use any of the proprietary medicines such as Eno's, Krushen's, Milk of Magnesia, etc. Liquid paraffin seems to be unsuited as it has a tendency to leave an undesirable coating over food absorbing area and the stuff is apt to be shot out when the person is almost unaware of its passage. A preparation of Cascara Sagrada with suitable additional ingredients to prevent griping will be an ideal laxative as it has an educative effect on the bowels. The

following prescription will answer the purpose very well.

R/
Ext. Cascara Sagrada Liq. $\frac{1}{2}$ to 1 dr.
Tint. Euonymin mms 10 to 15.
Tint. Nucis Vomica mms 5 to 10.
Tint. Belladonna mms 5.
Spt. Menth Pip mms 5.
Glycerin drs 2.
Aqua add. oz. 1.

The draught to be taken regularly at 6 p. m. to be repeated if necessary the following morning.

The dose of Cascara should be gradually reduced by a few minims every day after the bowels move regularly once a day. A glass of water hot or cold depending upon the liking of the patient early morning and at bed time assists in lessening autointoxication. Isphagool (seeds) which is easily available in Indian market is an excellent mechanical laxative. A teaspoon should be soaked in a tumbler of water for six to eight hours and taken at bed time.

SLEEP: Barbiturates such as luminol are both sedatives and hypnotics. But the combination of Coal Tar derivatives and barbiturates such as Veramon, Phanadorm etc., are safer. If a cardiac type of breathlessness or the asthmatic wheeze at nights is the cause of the disturbed sleep, opium derivatives may be of help. It is unwise to employ them at any early stage as the drug habit may be less bearable than the effects of the high blood pressure. Paraldehyde, when persisted has at times yielded very good results. Non-drug treatment of Insomnia should not be forgotten.

In case of intercurrent infections such as a cold in the head, definite and well-developed "flu", the patient should take to bed early and place himself under his medical attendant, ignoring the cold is undesirable. The "amateurish" treatment as laid down in the slogan, such as "feed the cold and fast fever" is best forgotten.

For those in whom the skin fails to act or such of those who are condemned to live in colder zones where the elimination work of the skin is relegated to the kidneys, an improvised Turkish-bath or a pucca one may be of some help. The former can be got up with a steam kettle attached to a hosepipe of convenient length and a water nozzle of the flower garden type and a country rope-cot with adequate number of woollen blankets. The duration of the baths should be brief and the intervals between the baths at least 4 days.

Massage of a milder grade is very useful, and can replace morning exercises. "Oil bath" with not too much of aquatic play is certainly very useful. Cold bath is to be avoided if it produces no exhilaration.

A weekly purgative (more than three broad motions undesirable) is helpful. The interval may be 10 days. If the subject feels exhausted either through poor health or through the effects of weather, this may have to be stopped. A small dose of calomel the previous night followed by a mild saline aperient such as "Eno's fruit salt" is all that is needed. Once in seven to ten days, a day of complete silence and partial fast may be observed. The diet may consist of diluted milk, coffee, tea, juice of orange and if need be small quantities of congee made rather watery. Liberal use of butter-milk may replace coffee and tea. As far as possible abstinence, physical fatigue and mental restlessness are to be avoided.

DIET: The modern trend of thought leans towards cutting off the quantity of food taken rather than quality. Unless the kidneys are damaged, protein intake may be normal in amount. Considering the climate of our province, a vegetarian diet is more suitable. Fat in excess is ill-borne. Unless carbohydrate dyspepsia exists, the bulk of the food may be one of carbohydrate. Root vegetables are best omitted. Leafy vegetables are useful. Meals should be taken in small quantities and as dry as possible as a loaded stomach embarrasses the

heart further. Rest before food and more of it after should be enjoined.

The following diet may be advised.

7 to 9 P.M.—coffee or tea (half the usual strength) with one or two small biscuits or just one idli—the latter should not contain too much of black gram.

About 11 A.M.—some drink such as Marmite (2 teaspoonful) tea or orange juice made into a sherbet or watery butter-milk.

Between 1 and 2 P.M.—small quantity of rice, sambar, rasam, butter-milk, boiled vegetables, with occasional salads.

About 4-30 to 5 P.M.—some dilute coffee or tea or fruits.

Night.—an early feed of conjee.

(If hungry at nights, some light drink such as watery Horlicks)

The following scale is advised for those who have adopted an occidental type of dietary.

Chota.—A small cup of coffee or tea in bed if used to it.

Breakfast 8 to 9 A.M.—(1) a small or moderate quantity of oat meal porridge, Force etc., with a little milk and sugar.

Or bread, a couple of thin slices ($\frac{1}{2}$ " thick) toasted with $\frac{1}{4}$ to $\frac{1}{2}$ an ounce of butter and orange marmalade or some fruit juice. One or two eggs—poached, half-boiled or buttered may be added.

(2) A small cup of coffee or tea.

11 A.M.—A small cup of Marmite or half an ounce of orange juice made into a sherbet.

1 P.M.—Soup (European type) curry, semisolid well-boiled rice 4 ounces.

There is no hard and fast rule in the choice of the curry.

Dholl curry (4 ounces) or "Rasam" or watery Sambar.

Rice and butter milk often restores the appetite. Water or any other drink may be taken an hour after the meal. Two slices of bread may replace the rice.

4 P.M.—Tea or Coffee, If one so desires one or two biscuits may be taken along with the tea lest the appetite be lost for supper.

6 P.M.—An early supper, conjee made of sago, rice, arrowroot or tapioca etc. One or two biscuits.

A few people who have hitherto lived to eat may be utterly disappointed with this menu; but, without a *bonafide* gesture of diet restriction, no relief from the miseries of hypertension is possible. Now and again slight relaxations have to be made, for example, after a poor supper, sleep may be denied to a gourmet. Then he may be permitted an extra feed.

Other facts that should be borne in mind are:—

1. Attention to dentures.
2. Proper mastication.

Fried articles are not well borne. Alcohol is best given up but if it is inevitable an ounce or two of whisky (brandy appears to quicken the heart hardly necessary a procedure in hyperpiesia) well diluted with soda water in which the gas has been expelled by a fizzer. Beer is bad. Sherry rather than Port may be permitted. Tobacco is said to be even worse than alcohol. But a reasonably minded patient may be advised upon cutting the quantity smoked limiting the act to certain hours.

DRUG TREATMENT OF HYPERPIESIA.

Any suggestion of drug is likely to create a false sense of hope in the mind of the sufferer and even worse, he may fail to realise the importance of following some regimen as detailed in previous pages. However, a prescription written mostly in illegible writing and a few latin suffixes and prefixes tailed on to the prescription have their own psychical effect upon the mind of the patient and

why then deny this small service to the person. Further most of the drugs do little harm if no good at all.

Iodine, once again takes the place of pride. A pinch of Sodium Iodide in about an ounce of cold water at bed time has at times acted very well. Organic Iodine has its adherents. Lipo Iodine 5 grs. 1st day; 10 grs. 2nd day; 5 grs. the 3rd day; 10 grs. the 4th day and so on for 10 days. Then give rest for 10 days and begin again a second time. In this way not more than 3 courses are desirable.

Nitrites are certainly very efficacious especially when anginal pain demands quick and if possible lasting vaso-dilatation. One of the best of the series is the chocolate coated Trinitrin Tablets (dose 1/100 gr.) which is kept under the tongue till it dissolved. According to that great worker—Sir Thomas Lewis an anginal patient can rely on this drug to the extent that he can undertake to get through a busy day's work without dreading any catastrophe. B. W. & Co's compound nitrite tablets may be taken daily—about 2 or 3 a day for about 2 weeks at a time. The result of such a course is not conclusive. Amylnitrite capsules—5 minim dose crushed in a handkerchief and inhaled during the fit may avert serious consequences.

Empirical remedies are as numerous as the number of sufferers themselves. Bismuth Subnitrate capsules of ten grains can be taken thrice a day an hour or two after food. Liver extract for reasons not known, has done well in improving the morale of the patient.

Gipsim ($\frac{3}{4}$ grain) pills can be taken one T. D. S. either before or after food and definite reduction in the pressure readings has been noted by some authentic workers.

Excessive headache with vomiting is at times controlled by auto-haemotherapy. 5 to 10 c.c. of patient's own blood injected into the gluteal muscles—once a week for 6 weeks is all that is necessary.

Morning injection of 8 ozs. Magsulph (25%) into the colon after a plain water

enema over night has been of service in the immediate reduction of pressure. It can be repeated once in four days. Glucose 25%, 25 c.c. given intravenously acts very well and can be given daily for about 5 days. Venesection up to 15 ounces is another emergency measure. Likewise Sodium Chloride 40 c.c. of 30 per cent solution intravenously administered is of great help. Lumbar puncture with the foot of the bed raised and the procedure stopped when the individual drops do not run into each other or when the total quantity of C. S. F. does not exceed 20 c.c. may offer relief to a person with hypertension encephalopathy.

If Wassermann reaction is found positive, anti-syphilitic treatment should be immediately begun with mercury. Later any of the safer preparations of Neoarsphenomine group should be cautiously administered.

Colonic wash is said to reduce auto-intoxication and can be done as follows:

The patient is put in left lateral position. Saline (102° F) one or two pints is run in slowly with the water head at 18" above the cot. The patient is then helped on to the knee and elbow position and then on to the right lateral position. He should retain the water as long as possible.

Radiant heat and other measures to stimulate the skin to act (Turkish Bath—pucca one or with an improvised one as stated in the early part of the paper) is useful. But these measures should not flag the patient's strength.

Whatever the drug be, it is wise to lay emphasis upon the desirability of strictly adhering to a regimen and to remember that the drugs have even less value than a glass of hot water drunk before retiring to bed and directly on rising from bed.

Reference: Lewis—Diseases of the Heart.

East and Bain—Recent advances on Cardiology.

Price—Text-book of Medicine.

DYSENTERIES

By

DR. K. NARAYANAMURTI, M.D.

AMOEBIASIS.

(Continued from the last issue).

In an earlier article Amœbiasis was defined as an infection occurring with a protozoon—*Entamoeba histolytica* at any part of the body and when the infection is solely confined to the intestinal canal, it is termed Amœbic dysentery or primary Amœbiasis. When metastatic lesions develop in the Liver or elsewhere the term secondary Amœbiasis is used. The most common form of secondary Amœbiasis is hepatic Amœbiasis or Liver Abscess, Tropical Abscess of the Liver.

HEPATIC ABSCESS. ★

GEOGRAPHICAL DISTRIBUTION: Liver abscess occurs in warm climates where Amœbic dysentery is common. But in Central Africa, a tropical country, Amœbiasis is unknown. The Indians though they suffer from Amœbic dysentery for a long time do not so easily develop abscess in the liver; while the Europeans who catch the infection are very much susceptible to Amœbic infection of the liver. The cause for such a variation is not known definitely. Perhaps alcohol may be a predisposing factor. Probably also the indigenous population resist against all tropical diseases in general than the new comer from Europe as could be evidenced from the fact that infection from small-pox, cholera etc., usually take a more severe form in the European than in an Indian. Mention was made in the previous papers as to who are liable to get the Hepatic Abscess.

ÆTIOLOGY: There is a close and intimate relationship between Amœbic dysentery and Liver Abscess. Well authenticated statistics as well as every day experience attest to this statement. Out of 3,680 autopsies made in Amœbic dysentery in various tropical countries,

Woodward found 779 cases having Amœbic abscess of the liver. This works out to 21 per cent of the total number of cases. It is worthwhile to remember that extensive Amœbic infection of the gut may exist without any subjective symptoms. There are cases where abscess of the liver is discovered without the patient mentioning that he ever suffered from dysentery. On close examination and questioning one might elicit the history of an attack of mild 'diarrhœa' occurring long time ago. Low cited a case of an Amœbic abscess of the liver occurring 20 years after an attack of Amœbic dysentery. Therefore one is to be cautious in diagnosing hepatic involvement.

RACE, SEX AND CLIMATE: Liver Abscess is proportionately rare among natives as compared with Europeans. According to statistics of 1894 the mortality rate in the Indian army from Liver abscess was only 0.6 per cent, whereas in the European army it was 7.4 per cent. Man for man the relative liability of the European soldier and the native soldier was 95.2 to 4.8. This proportion holds in spite of the fact that a larger proportion of natives are infected with *E. histolytica*.

European women though they may suffer from Amœbic dysentery as European men, seldom develop abscess in the liver; and their children hardly ever. There are records to show that an Egyptian child of 3 months suffered from Amœbic abscess of the liver while in India, boys of 10 years were reported to have suffered from Liver Abscess. Manson-Bahr reported a case of liver abscess in an English girl of sixteen. Hepatic Abscess is usually common between 20—45 years of age.

PATHOLOGY: There will be general congestion and enlargement of the liver during the course of an attack of dysentery the lobular structure of the gland cannot be made out as there are greyish ill-defined anæmic circular patches which on expression exude out a drop or two of a reddish gummy pus. Still later the centre of the patches liquify and ragged abscess cicatrices are formed. An abscess thus formed extends partly by molecular breaking down, partly by the formation of additional foci of necrosis in the neighbourhood, and the subsequent breaking down of the intervening septa. The wall of such an abscess has a ragged appearance. The character of the pus contained therein also changes during the evolution of the abscess as it frequently becomes infected with streptococci and other organisms when the pus might assume a brownish or grey colour.

Liver Abscess may be either single or multiple: when single it attains a large size; if multiple they are much smaller. There may be an abscess as big as a cocoanut. When multiple, the individual abscesses may range from the size of pea to that of an orange. The seat of election of the single abscess is the upper part of the right lobe of the liver. Adhesions form with the surrounding tissue when the abscess approaches the surface of the liver. Such adhesions prevent the danger of intra-peritoneal bursting. Intestinal ulceration may be found extensively occurring in the neighbourhood of the caecum or there may be no visible lesions on the mucous surface.

The naked eye appearance of the liver pus is peculiar and almost characteristic. It is thick, usually of a chocolate colour and streaked or mixed with blood. Here and there we may find clear mucoid or yellowish material; the pus is so thick that it can hardly soak into the dressings and it is found to adhere to the gauze like treacle on bread, spreading out between the skin and the dressing. When the pus is quite fresh, brown masses may be made out as little islands. Sometimes on account of admixture of bile the pus is green tinged. The pus is rarely offensive.

When the abscess is near the colon it may have a faecal odour. Under the microscope the pus reveals red blood cells, much broken down liver tissue large granular pigment cells, leucocytes, oil globules, haematoidin crystals and occasionally Charcot leydin crystals and less occasionally Entamoebae. When the pus is secondarily infected streptococci and staphylococci and *B. coli* are found. The experience of tropical workers in India and Egypt is that Amoebae may be detected in only half the number of cases. Usually the Amoeba is not found in aspirated pus or in the pus that escapes during operation. They appear generally in large numbers in the matter that comes out from the drainage tube 4 or 5 days after the operation. These are found on the walls of the abscess cavity. The patient though treated with Emetine, the Amoebae may persist in the discharge until the abscess is healed. The longer the abscess persists the larger is its size and more difficult it will be for the pus to find a way out. In a large proportion of cases the pus is sterile, but occasionally it may become secondarily infected by *B. coli* or haemolytic streptococci. Cysts of *E. Histolytica* are never found in the pus.

The abscess in the liver may at times get encysted, but this is rare. The cyst wall is thick and fibrous. The contents of the abscess become ultimately cretified and the cyst shrinks up and contracts to a small size. Rogers is inclined to believe that in India, Cirrhosis of the liver is a frequent sequela to Liver Abscess. But there is no general agreement on this point.

THE GENESIS OF LIVER ABSCESS: The amœbæ are let out from the ulcer in the intestines, into the portal circulation. Though there is said to be heavy infection in the right sector of the abdomen *viz.*, in the caecum or the ascending colon it is believed that the liver gets infected through portal circulation and not due to the contiguity of the infected area. In fact what happens in the body is a portal "pyaemia" the infected blood infecting a congested and enlarged liver.

It is possible that a great majority of amoebæ are destroyed by the tissue; those surviving multiply and cause necrosis of the liver cells. It is at times found that the amoebæ themselves are destroyed by the products of their activity. The sterile Amoebic abscess at this stage becomes secondarily infected. The cells in the vicinity of the portal vessels are the least affected by the necrotic process while those at the periphery are undergoing vacuolation.

SYMPTOMS: Symptoms vary a good deal. The patient always gives a history of having resided in the tropics but the history of suffering from dysentery may be absent. A sense of weight and fulness on the right side of the chest is felt. Later stabbing pains are felt over the liver area and sometimes a dry cough may be present. In a considerable proportion of cases a sensation of pain is felt over the right shoulder—rheumatic in character—especially at night time. Usually the pain and tenderness are in the skin around the acromial end of the clavicle. It is reflex in character due to irritation of the phrenic nerve which arises from the fourth cervical route from which the supra-acromial and supra-clavicular cutaneous nerves arise from the cervical plexus. The same sort of pain is felt over the shoulder when condition of the lung and pleura over the diaphragm are inflamed as a result of diphtheragmatic pleurisy. If there is an abscess in the left lobe, the pain is referred to the left shoulder joint. Fever starts with sharp rigours, morning temperature being either subnormal and the evening temperature reaching up 104° or 103°. The patient begins to lose flesh and he has a muddy tinge over his body. The high temperature is accompanied by profuse sweats, the tongue becomes furred, extremities become cold and the breathing is mainly thoracic. Sometimes we notice actual fulness on the right side of the chest and on palpation and heavy percussion tenderness can be elicited. In a majority of cases the liver is enlarged and can be felt below the costal margin. It may be further observed that the dulness is arched over the upper border

of the liver. Deep inspiration gives rise to acute pain. The skin outside the liver area may become red and oedematous. On auscultation a pleuritic rub may be detected. Or sometimes inspiratory crepitations, decreased breath sounds may be noted. Pain is relieved by lying on the affected side. It is peculiar to note that the spleen is not enlarged. An abscess on the left lobe of the liver may be palpated in the epigastric or hypogastric region. The left lung may sometimes be involved. Sometimes the enlargement of the left lobe of the liver may be due to a compensatory hypertrophy without any abscess forming therein.

The patient becomes thin each day: hectic fever with drenching nocturnal sweats continue. The pain increases and if the pus is not drained by operation, the patient may die after months of illness by exhaustion or the abscess attaining enormous dimensions may burst into the right lung or pleura and the pus may be discharged from the mouth as a result of which recovery or death from intercurrent complications may take place. The blood shows increase in the polymorpho neuclears, leucocytosis of 15,000 to 40,000. In some rare cases, no such rise is found which is always indicative of bad prognosis. The differential count in a series of cases is found to be as follows: 70 per cent polymorphs, 22 per cent lymphocytes, 6 per cent large mono-neuclears and 1 per cent Eosinophiles. With a large Liver Abscess of long duration secondary anæmia may result. Occasionally we find a blood picture of pernicious anæmia.

There are many instances where the initial symptoms are more urgent and the disease progresses more rapidly. In other instances the subjective symptoms may be almost not being felt and it is not strange in those cases an abscess bursting through the lung or bowel or a fluctuating tumour appearing on the side of the chest. It is also common feature to discover abscess of liver in unsuspected cases on the post-mortem table.

Sometimes the initial fever is very high, distinctly quotidian and of an

intermittent type. Large collection of pus has been detected in cases where no fever of any description is noted. Marked rigours are rare, but when they are present, they are indicative of threatened rupture of the abscess into some viscus. The sweating associated with temperature is found about the head and neck. Enlargement of cervical and axillary glands on the affected side may be present. Pain of some description is the commonest symptoms of the liver abscess. Stabbing and stich-like pains are felt on pressure or these pains are aggravated by deep inspiration and coughing. Localised area of pain if felt over the costal margin is indicative of the abscess pointing in that direction. If there be pain on swallowing particularly at the moment when the bolus traverses the lower end of the œsophagus it is possible to localise the abscess with the finger tips pressing on the area of pain. Shoulder pain is present in about 1/6 of the cases and may be the only symptom complained of. This will be the earliest symptom which we can note before the onset of fever.

Cough of a painful character due to the irritation of the diaphragm may be a prominent symptom. The respiration may be rapid and shallow. The patient lies on his back slightly inclining to the affected side. The digestion is disturbed. Flatulence and diarrhœa are generally noted. There may be sometimes concurrent dysentery.

The area of liver dulness is extended upwards or downwards and very rarely horizontal. The upper line of dulness is not horizontal as is found in hydro-thorax; usually on approaching the spine it turns downwards. When the abscess is of a large size the heart may be displaced but laterally. Rapidity of the heart and sometimes irregularities of the heart may result from toxic absorption or from pressure.

The liver abscess may simulate closely intra-abdominal tumours and in cases where there is no temperature, their nature may not be suspected until they are aspirated. Sometimes one can

observe varicosity of the epigastric veins; local œlema over the intercostal spaces may at times be noted and if there is any local bulging, it is usually indicative that the abscess is pointing in that direction. The abscess may burst into any neighbouring organ and thereby produce a spontaneous cure. Most commonly it ruptures into the lung or the pleura. When it bursts into the lung the pus is coughed up in mouthfuls. Sometimes this process is more gradual, a few drams being brought up at a time. In favourable cases the expectoration becomes less and the patient is cured. The abscess of the liver when it bursts into the lung is liable to be mistaken for pulmonary T. B. Amoebæ are not found in the expectorated pus but a few striated muscular fibres from the diaphragm were noted by Manson-Bahr.

Arrest of the discharge may not mean recovery. Cessation of cough may once again be followed by temperature and night sweats. This is due to the alternate emptying and refilling of the abscess cavity and such a phenomenon usually occurs many times before recovery finally takes place. In some cases expectoration never comes and is accompanied by other signs of absorption of the toxins such as respiratory distress and clubbed fingers. Sometimes the expectorated liver pus without being chocolate brown in colour may be hæmorrhagic. In such cases it may be mistaken for tuberculous hæmoptysis.

Rupture into the pleura may give rise to the symptoms of Empyema. Aspiration above the line of pus may yield a clear yellow fluid highly albuminous in character.

A liver abscess may burst into the stomach and the pus may be vomited out, or pass into the bowel causing diarrhœa and discharge of pus in the stool, or it may burst into the pericardium or peritoneum with fatal results, almost immediately. Finally a spontaneous rupture may take place through the skin of the abdominal wall and the patient may recover and this is the most favourable and natural cure of a Liver Abscess. It is strange to find that

the skin is infected with Amoebæ though the pus from the liver may not contain them.

MORTALITY RATE: The mortality rate was as high as 50 to 80 per cent. formerly. But now, the use of Emetine combined with early recognition of the intimate connection of Liver Abscess with Amoebic dysentery and the adoption of improved methods for evacuation of pus, has brought down the mortality rate practically to nothing. Death when it ensues may be due to rupture into the neighbouring viscera, due to the gangrene of the abscess-wall, pneumo-thorax, pneumonia or to other intercurrent diseases. Recovery may follow encystment and subsequent absorption of the abscess.

From the study of 50 cases the following table is set out by Manson—Baehr relating to Liver Abscess:

	Per cent.		Per cent.
History of previous dysentery ...	60	Shoulder pain, right ...	44
Entamoeba histolytic or cysts present ...	45	do. left ...	4.4
		Pyrexia, intermittent ...	77
		do. remittent typhoid like... 8	
		do. with sudden onset of rigors ...	4
		Pyrexia absent ...	13
		Night sweats ...	82
		Dysenteric infiltration of bowel sigmoid flexure ...	24
		Dysenteric infiltration of caecum and sigmoid flexure ...	8
		Enlargement of liver upwards ...	24
		do. downwards... 75	
		Pain and tenderness in liver ...	57
		Displacement of heart ...	8
		Associated signs at base of right lung ...	75
		Pleuritic rub ...	12
		Rupture of abscess into lung ...	11

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Abstracts.

GONORRHEA IN THE MALE.

HARRY O. LEPSKY, M.D., CINCINNATI, OHIO.

In February, 1931, a paper was read before this Academy on the treatment of gonorrhea in the male. In the years which have elapsed between that time and the present, there has been no word mentioned concerning this infection and its treatment; not even a case report. What can be the explanation for the lack of discussion concerning this important phase of medicine? It certainly cannot be due to the fact that we are not called upon to treat gonorrheal infections in the male! Nor can it be due to the fact that we know everything which is to be known concerning this disease and its treatment. The only answer which can be given for this paucity of discussion concerning gonorrhea seems to be the fact that we are neglecting the discussion of this very important topic. I hope sincerely that we are not, in like manner, showing a similar amount of neglect in the treatment of patients whom we see with gonorrhea.

The local neglect which is very evident in the discussion of gonorrheal infections is only a part of a similar neglect which exists throughout this entire country. The various programs of the American Medical Association, as well as other medical societies, are conspicuous by the infrequency of gonorrhea as a subject for scientific papers. Recently, due to the efforts of the United States Public Health Service, this country is being made "venereal disease conscious." The lay press is full of propaganda for combating venereal disease and attempts are being made to make the medical profession aware of this vast problem. In speaking of venereal disease, however, all of the stress is being laid upon syphilitic infections. Only on the rarest occasions is gonorrhea even mentioned as a part of the venereal disease problem. It is impossible to underestimate the importance of gonorrhea as a part of this vast national problem. Whereas statistics concerning gonorrhea

and syphilis are, for the greater part, unreliable, it is known very definitely that the incidence of gonorrhea is from two to four times that of syphilis. The average patient who receives a gonorrheal infection is in the second or third decade of life, when he is most active and most productive financially, and has dependents for whom he is responsible. I can see only two instances which may be brought forth in favor of syphilis as against gonorrhea, so far as their relative importance from a public health point of view is concerned. These two conditions are: first, syphilitic infections of the new-born, and second, the late sequelae of syphilis. In all other respects gonorrhea and its attendant problems is at least as important as syphilis and should receive our attention in at least an equally forceful manner.

The medical profession has been guilty so far as gonorrheal infections are concerned, of improper treatment, maltreatment and a general disregard for the patients who harbor a gonorrheal infection. Even to day we have practitioners who will inform a patient that his infection is no worse than a "cold in the head," and who will give him treatment which is in accordance with the above expressed view. Can we blame the laity therefore when many of them are convinced that their gonorrheal infection cannot be completely eradicated, or when they accept chronic recurrent infections as a matter of course and thus become carriers in the long and endless chain of gonorrheics?

There is one type of pseudo practitioner, however, who is not without guilt because of his attitude towards gonorrheal infections. I am referring to the corner druggist who in his little back room, will dispense treatment whether in the form of medication by mouth or locally, and

who, undoubtedly, does far more harm, promotes many more complications, and makes the burden of the honest practitioner more difficult than it would be otherwise. His guilt, however, usually consists of an error of commission and it is very difficult to determine whether his error is greater than the medical practitioner's error of omission.

I wish this evening to discuss merely the treatment of gonorrhea in the male. This is the only province in the treatment of gonorrhea which has been reserved to the urologist in this city. The gynecologists have taken unto themselves the treatment of gonorrhea in the female. In male gonorrhea we have an acute inflammation. One of the cardinal principles of therapy in acute inflammations in any portion of the body, is gentleness and diligence during treatment. Any method of therapy which disregards gentleness is an improper method of therapy. The practitioner who assumes the obligation of treating a gonorrheal infection in the male, has responsibility to give his patients the best available treatment known at that time in a gentle manner without jeopardy to the patient's life or limb and a method of treatment by which the patient can be assured a complete cure.

Every patient with a gonorrheal infection can be promised a complete cure. In a simple acute anterior gonorrheal urethritis we divide our therapy into two portions, first: that which we do for the patient; second: that which the patient does for himself. I wish to mention first what the patient can do for himself. It is incumbent upon us to instill forcibly in the mind of the patient the necessity for his complete abstinence from alcoholic beverages and sexual excitement. Here is a pitfall which is not appreciated by the medical profession as it should be. Pelouze, who has probably made more contributions towards the treatment of gonorrhea in the male than any other single individual both past and present, has proven time and again the futility of the very best methods of treatment in the face of alcoholic and sexual transgressions by the patient. It is the art of medicine

which is necessary to convince the patient that alcoholic and sexual abstinence are absolute necessities. The patient must be constantly reminded of the importance of these prohibitions and it is only too easy for him to prove to himself how much greater is the incidence of complications when abstinence is forgotten.

The sheet anchor of our treatment in acute anterior gonorrheal urethritis in the male consists of mild low pressure anterior irrigations with potassium permanganate. We are still old-fashioned enough to retain those methods which have proven of value in the therapy of gonorrhea during the past four or five decades. It would be wise for us to heed the advice which Polonius imparted to his son Laertes: "Those friends thou hast, and their adoption tried, grapple them to thy soul with hoops of steel"; potassium permanganate irrigations given by the physician with care and gentleness will in the vast majority of cases eradicate all anterior urethritides and obviate any complications. I am saying nothing of the various types of azo dyes which are taken by mouth, nor am I saying anything of the various preparations which will render the urine any color in spectrum. The only rationale for the use of these preparations is the psychological effect upon the patient or the particular type of color with which we wish to stain the patient's underwear. This opinion is not merely a personal one, but receives whole-hearted approval from those who wish to use some scientific basis in their therapy of gonorrhea.

In speaking of therapy we are at the mercy of the various detail men and of the drug houses they represent. At fairly regular intervals we are assured that a new remedy is at hand which is specific for the cure of gonorrhea. These so called specific medications may be vaccines, filtrates or phages. At other times these specific therapeutic measures may be various dyes, coloring materials, so called germicides or any therapeutic agent which may have shown some success in the treatment of infections caused by organisms similar to the gonococcus.

Most of the agents which have been recommended, and their names are as familiar to you as they are to me, have been tried, tested, used under carefully controlled conditions, and have been found to be useless. A few words are in order here concerning the newest "panacea for all evils," i.e., sulphanilimide. Here again we are offered a "specific cure for gonorrhea." At least some drug manufacturers say so. However, we have here a very potent drug whose said actions are not thoroughly understood, a drug which has been used for practically every known organism which afflicts the human system and a drug which has already caused such severe secondary complications that its use must be guarded very carefully. I need only mention the occurrence of sulph-haemoglobinemia, aplastic anemia, violent gastrointestinal upsets, diffuse muscular aches and pains and erratic pyrexia in order to acquaint you with a few of the side actions whose causes remain to be determined as being due to the use of sulphanilimide. The use of sulphanilimide has become so widespread that where formerly a travelling salesman would enter the office and request a prostatic massage followed by a No. 24 sound, he now comes in asking for a haemoglobin determination and a red cell count so that he may juggle the number of tablets per day accordingly.

It would be folly to absolutely discourage the use of this drug in the treatment of gonorrheal infections because we have all obtained some brilliant results with it, however, at the present writing, its use is merely empirical and we are still ignorant of its *modus operandi*. We are neither prepared to condemn it nor to discard it, but we are anxious to know more of its therapeutic mechanism so that if we wish to use it we may do so intelligently. In speaking of the use of any methods of therapy for the treatment of gonorrhea, Pelouze has stated the following: "Above all things, we should demand of its originator more than high sounding words and poor clinical investigation. Nor should we subject the traditional one hundred patients to a plan of treatment that cannot show results on the first five patients

far beyond those obtainable with the plans of treatment upon which we have learned to rely."

Thus the majority of patients who are seen with an acute anterior gonorrheal urethritis can be completely cured without the development of complications. We have found that these permanganate irrigations given carefully, gently and under low pressure, together with cooperative behaviour on the part of the patient will bring a happy and successful result to both the patient as well as to his physician. It is unfortunate but true that even with the best therapy on the part of the physician and good behaviour on the part of the patient, complications will nevertheless occur. The most common of these is the development of a posterior urethritis.

With the development of a posterior urethritis all local treatment is immediately stopped. The patient is instructed to take hot sitz baths and is given bladder sedatives by mouth, the purpose of which is to counterbalance the frequency and urgency on urination and the spasm at the vesical neck. With the subsidence of the posterior urethritis potassium permanganate irrigations are again instituted under very careful technique. A few words are in order at this point concerning the "two-glass test." This consists of voiding approximately one-half ounce of urine in the first glass and voiding all of the remainder of the urine in the second glass. In a simple acute anterior urethritis the first glass is cloudy and the second glass is clear. With the development of a posterior urethritis both glasses will show cloudy urine. There can be no intelligent treatment of gonorrheal urethritis without the routine use of the two glass test together with an understanding of what its variations imply. This simple test is an accurate barometer of the progress in treatment as well as a means of prognosis.

The next most common complication is the development of an acute prostatitis, with or without an accompanying seminal vesiculitis. Fortunately the vast majority of prostatic and vesicular complications can be handled very easily in a manner

similar to the handling of a posterior urethritis. As a matter of fact, the majority of posterior urethritides are accompanied by a certain amount of prostatitis. The very acute fulminating types of prostatitis are rare and each case must be handled individually. When all of the acute phases of prostatitis with or without seminal vesiculitis have subsided, gentle massage of the prostate gland and seminal vesicals is in order. This is continued until the physical and microscopic examinations indicate eradication of the prostatic and vesicular infections.

This brings us to a very distressing complication which is accompanied by much pain caused by edema and infection of the affected epididymis, elevation of temperature, generalized symptoms consisting of malaise, fatigue and mild toxemia. I am referring to the development of acute epididymitis. It is safe to say that the development of an epididymitis as a gonorrheal complication is practically always due to vigorous treatment on the part of the physician or the patient or to an alcoholic or sexual spree on the part of the patient. Study of our records, together with similar studies by others, shows conclusively that gonorrheal complications such as epididymitis, posterior urethritis, prostatitis and seminal vesiculitis occur due to transgressions by patients or violent therapeutic methods by the physician or the patient. With the occurrence of an epididymitis, again all local therapy must stop. About fifty per cent of patients with epididymitis must be put to bed for two, three or four days. The scrotum is elevated, an icebag is applied over the affected area and the use of various calcium salts intravenously in the form of calcium gluconate, levulinate or chloride have been found to be the most effective measures. Oral medication is given symptomatically. No local therapy is instituted until all of the acute phases of the epididymitis have subsided. Occasionally it is necessary to institute surgical procedures in the treatment of epididymitis.

The next most frequent complication of gonorrhea is arthritis. The diagnosis of

acute gonorrheal urethritis is a rather obvious one and I shall not bore you with its signs and symptoms. However, once the diagnosis has been made, the most effective therapeutic measures which we have found for this condition has been the use of hyperpyrexia, or fever therapy, as induced by the Kettering Hypertherm. This again raises the question of newer methods of therapy. In the case of fever therapy, however, statistics have proven conclusively, and these statistics are uniformly obtained throughout the United States, that we have here the most effective method thus far proposed not only for the complete cure of gonorrheal arthritis but for a cure without ankylosis or joint deformities. It is true that fever therapy does not yield one hundred per cent cures in gonorrheal arthritis. But the percentage of cures without ankylosis is so much greater than with any other method at our disposal that this medium of therapy is definitely indicated.

A few words are in order at this point concerning fever therapy. This therapeutic medium is still in the experimental stage. Nevertheless, a striking uniformity of good and excellent results with the use of this procedure warrants its definite acceptance for certain conditions. Among these latter conditions gonorrheal arthritis may be included. When a patient is subjected to fever therapy, he receives a treatment which usually lasts for approximately six hours, during which time the body temperature is raised to approximately 106.5 degrees Fahrenheit, and maintained at this temperature for approximately four or five hours. The selection of patients for fever therapy must include thorough physical and laboratory examinations to assure us that all of the vital organs are in perfect functional and organic condition. Fever therapy is unquestionably a procedure which should be carried out only in hospitals and under the constant supervision of an adequately trained personnel. This calls for the constant attention of the patient by a nurse and resident physician who can detect danger signals and discontinue a treatment at any moment. It is fairly obvious that fever therapy is not an innocuous

procedure. Deaths have been reported both during and shortly after fever therapy. While the number of these fatalities has been very few, nevertheless the precautions which should be taken must be most elaborate.

I will mention in passing only a few of the very rare gonorrheal complications such as ophthalmia, endocarditis and skin lesions. These latter complications must be handled in individual fashion and no specific therapeutic course can be outlined for them.

There remains to be discussed the patient who harbors the so-called chronic gonorrheal infection. In each and every one of these patients there must be some focus of infection which is responsible for the chronicity of the infection. This focus may be found in infected Littre's glands, a stricture in either the anterior or posterior urethra a seminal vesiculitis, Cowperitis or an unrecognized prostatitis. Regardless of where this infective focus may be, with diligence on the part of the physician and patient on the part of the patient, each one of foci can be detected, treated and eradicated. I wish to stress here the fact that chronic gonorrhea is an admission of defeat on the part of either the patient or the physician or both. It is only through the complete elimination of the so-called chronic gonorrheal infection that any success may be had from a public health point of view in treating gonorrhea.

The limitations in time and the fact that these meetings are attended primarily by general medical practitioners have prevented me from entering into elaborate discussions concerning either diagnosis or treatment. I have tried to state a few simple facts in a few simple words. There is much knowledge to be learned in the handling of gonorrheal infections and considerable research is being carried on at the present time, so that our methods of treatment can be more effective within a shorter period of time. Until the results of these researches can offer us conclusive experimental and clinical proof that they are an improvement over these methods which are in use at the present time, we must not be ready to accept them to use

them routinely in the treatment of gonorrheal infections. We must remain openminded and be ever alert to accept new methods of therapy which have proved their reasons for existence, but until they have done so it is folly to discard those methods which are yielding gratifying results at the present time.

DISCUSSION.

DR. ARTHUR W. WENDEL: The essayist has given us a concise and very instructive resume of the present status of gonorrheal therapy. Such a subject is a timely one in view of the present day venereal disease propaganda spreading throughout the nation. Our statistical data concerning the incidence of gonorrheal infections is wholly inadequate; however, if there are two to four times as many Neisserian infections as there are those due to the treponema pallida, we must conclude that approximately thirty per cent of our people suffer from this infection in the course of their lifetime. Certainly something of a national scope should be undertaken to educate the public against this precursor of mental and physical torture.

We believe that more than sixty per cent of gonorrheal infections in the male are cared for by the general practitioner of medicine. This is, as it should be; however, if this is the case, it behooves these practitioners to thoroughly acquaint themselves with the fundamental principles of therapy and cure. Only too often do we see the catastrophic results of poor therapy directly or indirectly referable to the many sins of omission and commission within our ranks.

Among the many phases of the subject brought before you this evening, there are a few which cannot be over-emphasized.

We consider acute gonorrheal urethritis a self-limited, highly infectious disease from which the patient can recover. This recovery depends upon four cardinal factors:

1. A local tissue immunity response brought about by the patient's ability to develop certain anti-body formation. We do not know the exact mechanism of this response, but it is an observable fact that

certain individuals develop immunity less rapidly than others. For example, blondes respond less satisfactorily to infection and are more susceptible to complications than brunettes.

2. Good dependent drainage is a prerequisite toward minimizing complications. At the very onset, an abnormally small meatus should be enlarged surgically; likewise a phimosis requires a dorsal slit or circumcision. Only too often do we see a misinformed patient plugging up an oedematous discharging urethra with a ward of cotton.

3. The patient's full cooperation during his illness. We cannot over emphasize the importance of abstinence from alcoholic beverages, sexual excitement and strenuous exercise.

4. Local and systemic therapy given and directed by the physician. The old axiom that it is wise to undertreat rather than overtreat still holds good. We cannot hope to sterilize an infected urethra without destroying the histological structure. Gentle irrigations under low hydrostatic pressure should be used, except when contraindicated. Irrigating solutions should consist of weak solutions of potassium permanganate, acriflavine, chlorazene, etc. At times in sub acute and chronic infections, mild silver nitrate solutions are beneficial. Irrigating solutions, in addition to their cleansing effect, should merely stimulate a wholesome local response on an infected mucous membrane. Retained injections of Neosilvol, Protargal and various other silver salts are beneficial specially in combating secondary invading organisms.

Sulfanilamide given by mouth in adequate doses is offering us, in some cases, favorable and in others discouraging results. It is by no means a panacea. We have seen purulent specific anterior urethritis clinically cured in seven days under

adequate dosages of this drug. More often, however, the results are less satisfactory. If a patient does not exert a favorable response to the drug in one week, the drug is discontinued. Under sulfanilamide therapy remissions frequently occur. Gonococci have been isolated several weeks later in shreds from patients who have reacted favorably to this form of treatment. In the future, we may see more cases of chronic gonorrhea in patients who have been supposedly cured by sulfanilamide therapy.

In closing may I read a paragraph from a recent publication by Dr. Charles P. Mathe of San Francisco. In order to secure first hand information about the clinical results of this new drug, Dr. Mathe addressed one hundred and fifty questionnaires to the leading urologists throughout the United States and Europe, asking for a report of their results in order to contrast them with those obtained in his own private practice and in the out-patient dispensary of the University of California and St. Mary's Hospital. Quote: "An analysis of the replies to our questionnaire and our experience in private practice and in the out-patient department of the University of California and St. Mary's Hospital leads us to conclude that the use of sulfanilamide in the treatment of acute gonorrheal urethritis is a beneficial adjunct to the former methods of treatment. The period of cure is definitely lessened, the side reactions are few and with intelligent management they can be easily controlled. The drug should always be administered under close observation over a short period of time and one can usually repeat its use without danger to the patient. It is not specific for the cure of Neisserian infection but, up to the present time, it is beyond doubt one of the best adjuncts to the treatment of this disease."

—The Journal of Medicine, May, 1938.

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.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

THE USE AND ABUSE OF ERGOT AND PITUITARY.

Because of the disastrous results due to the indiscriminate use of ergot and solution of posterior pituitary, M. Edward Davis, Chicago (*Journal A. M. A.*, November 13, 1937), reviews the indications for the use of oxytocics in obstetrics. Although solution of posterior pituitary will cause some contractions and tonicities of the uterus of the nonpregnant person, it is rarely indicated. The pathologic cause for the bleeding should be determined and treated. It is never justifiable to give ergot or pituitary extract as a temporary expedient unless one is absolutely certain that the underlying pathologic process causing the abnormal bleeding can await treatment. Oxytocic drugs will not terminate a normal gestation in the first trimester of pregnancy. Although oxytocic drugs fail to initiate an abortion in a normal pregnancy, ergot and pituitary may be used to hasten or to complete the process once it has begun. In inevitable and incomplete abortions, solution of posterior pituitary can be used in 0.5 to 1 cc. doses intramuscularly with benefit to the patient. This will cause increased uterine motility which may result in a complete and rapid termination of the process or the evacuation of portions of the products of conception still in the uterus. Following the completion of an abortion, ergot can be given orally for several days to limit the bleeding and favor normal involution. The medicinal induction of labour is rarely successful until term is approached. If, therefore, it is necessary to induce labour for some complication prior to term, one usually has to resort to mechanical means. The method of medicinal induction of labor at or near term at the Chicago Lying-in Hospital consists of the following procedure: Castor oil, 1½ ounces (42 cc.), is given early in the morning, followed two hours later by quinine in 3 grain (0.2 gm. doses at) hourly or half hourly intervals for four or five

doses, followed by graduated doses of solution of posterior pituitary, beginning with half a minim (0.03 cc.) and increasing half a minim at each dose fifteen minutes apart until 3 minims (0.02 cc.) is given. The latter dose can be repeated until a total of 1 cc. is used. The uterus should be carefully observed, and if it exhibits tetanic contractions so that the fetal heart tones are interfered with, solution of posterior pituitary is discontinued. The oxytocic drugs are almost never indicated during the first and second stages of labor. It is dangerous to interfere with the normal uterine motility. Oxytocic drugs are rarely indicated in stimulating uterine contractions. The underlying condition that is responsible for the inertia should receive proper treatment. Thus, physical exhaustion on the part of the patient from a long, arduous labor may be best treated by sedatives. A period of complete rest will often result in a recurrence of normal uterine activity and a rapid completion of the labor. Solution of posterior pituitary and ergot find their greatest usefulness in the third stage of labor. Used judiciously and with the proper indications, the oxytocic drugs may often prevent the occurrence of Postpartum hemorrhage and the serious results that may be caused by it. In the normal conduct of the third stage of labor it is usually advisable to await the complete separation of the placenta, after which its expulsion can be aided. Immediately after the birth of the placenta, 1 cc. of solution of posterior pituitary can be given intramuscularly. In the event that the patient has had no anesthetic, fluid extract of ergot can be given by mouth or ergonovine can be given parenterally. These oxytocics should help to maintain the uterus in a contracted state, avoiding any unnecessary bleeding. If excessive bleeding occurs after the delivery of the baby and prior to the placental separation, one should administer 1 cc. of solution of posterior pituitary intramuscularly. The placenta can then be expressed by Crede's method. If this procedure fails to separate and expel the placenta, one should consider its manual removal in the face of continued hemorrhage. Should

excessive bleeding occur after the expulsion of the placenta, one must determine the cause for the bleeding. When the hemorrhage is the result of uterine atony, solution of posterior pituitary in 1 cc. doses should be given subcutaneously or intramuscularly. Small doses, from 2 to 3 minims, can be administered intravenously in an emergency regardless of the possible reaction. Ergonovine is the ideal drug because of the rapidity of its action and the sustaining character of the effect. It can be given in 0.2 mg. doses intravenously. If the patient is awake, fluid extract of ergot can be given by mouth. The use of oxytocic drugs in the puerperium has enjoyed almost universal popularity. Ergot has been the therapeutic bulwark for this period. It has been credited with hastening normal involution, decreasing the likelihood of the late postpartum bleeding, limiting the probable spread of intra-uterine infection if present, and helping to maintain the genital organs in the best state possible. Normal uterine involution is the physiologic process by which the puerperal uterus is rapidly reduced to about one-twentieth its size and returned to the normal nonpregnant state. It has been the accepted practice at the Chicago Lying-in-Hospital to prescribe ergot in the puerperium for delayed involution. Fluid extract of ergot, from 30 to 60 minims three times daily, or ergonovine maleate, from 0.2 to 0.4 mg. three times daily, can be given to patients who have had a postpartum hemorrhage, a difficult forceps delivery, intra-uterine manipulation, abnormal lochia, fever regardless of the cause or delayed involution without cause. This therapy is kept up for at least three days or as long as is necessary; this medication should be rarely continued beyond a week or ten days, however, because of the danger of ergotism. If uterine contractions become too painful, the dose of the drug is reduced or entirely omitted. The prophylactic use of ergot to assure a normal involution is probably of some value, although further studies will be necessary to confirm this impression. The physician who wishes to serve womankind conscientiously and honestly must allow labor to take its normal

course, rarely resorting to expedients which might hasten the process but which inevitably carry in their wake injury, mild or serious, and even death to mother and baby.

(*The Journal of Medicine*, July 1938.)

1. MODE OF ACTION OF SULFANILAMIDE.

Since sulfanilamide was first introduced in therapy, investigators have attempted to explain its mode of action. Numerous theories have been advanced, only a few of them being tenable in the light of more recent reports based on actual chemical data. The studies of Osgood seem especially interesting and valuable because they approach the problem in a rational manner. Osgood investigated the destructive action of sulfanilamide on the toxin of streptococci. "The toxins of hemolytic streptococcus are highly destructive both to erythrocytes and to leukocytes, and recovery from massive invasion of the blood stream by this organism is very rare. It seemed possible that, if the action of sulfanilamide were the neutralization, destruction or prevention of formation of these toxins, the organism would resemble a harmless saprophyte and be readily vulnerable to the ordinary defense mechanism."

Osgood found that the formation of toxin was prevented or that toxin was destroyed. His observations showed further, that a major action of sulfanilamide is the neutralization of the toxins of the streptococcus organism. The drug does not, however, permanently alter the toxin-producing ability of a strain of streptococci exposed to it over long periods of time.

Does sulfanilamide affect phagocytosis? Although this possibility was previously suggested by certain workers, experiments seemed to prove an absence of "direct action which favors phagocytosis either on the beta hemolytic streptococcus or on the cells of the marrow." Quantitative strides led Osgood to conclude that sulfanilamide itself does not kill bacteria but that it does, after a period of four hours, slow their rate of multiplication

and render them vulnerable to attack by human serum and cells.

It is probably superfluous to state that further studies of this character will greatly enhance our knowledge of the mode of action of sulfanilamide. "The possible effectiveness of and the mode of action of sulfanilamide on all other organisms known to produce human disease should be determined by the methods described as soon as possible. Cultures of human marrow should aid materially in the study of the mode of action of both noxious and therapeutic agents."

2. VITAMIN D AND MYOPIA.

Progressive myopia remains one of the unsolved problems in ophthalmology. The encouragement given by some eye specialists that vitamin D is helpful in retarding the condition has led to studies to prove or disprove this claim. Laval found from an investigation covering a period of six years that all the dietetic and hygienic measures instituted were of no avail in arresting the progress of the myopia. He gave his patients vitamin D and milk continuously and made observations periodically.

One should be conservative in promising results with any therapy which has not been proved conclusively to be beneficial. Medical articles with positive claims are taken up promptly by the lay press. Individuals seek the treatment advised and generally find someone willing to administer it. While it is true that much of our therapy is empiric, even empiric measures must possess some rationale. The fallacy of anticipating the impossible from vitamins which are now advocated for nearly every human ailment requires correction in no uncertain terms. Vitamins, no doubt, have a place in our therapeutic armamentarium. Specific indications exist, but let us demonstrate them scientifically and with proper evidence.

Kœpcke has recently pointed out that the past few years have witnessed a worth while change in vitamin therapy.

Development of accurate tests to determine vitamin content of body fluids has aided this change. "Contributions from workers versed in sound clinical medicine and physiology are rapidly clarifying the problem of vitamin needs and the relationship between vitamin deficiency and disease."

In ophthalmology vitamins have been found useful in corneal ulcers, sensitivity to light, herpes zoster ophthalmia and certain other affections. The field will be widened as time goes on. We have no desire to deprecate the possibilities with vitamins in ophthalmic diseases, but we are opposed to publishing claims which cannot be supported by clinical trials.

3. TRACHOMA.

One of the best ways to copperize the lids in this disease is to ionize them. The technic is to employ a positive electrode of pure copper metal, connected with the positive pole of the battery, with a negative electrode at the back of the neck, and to apply the copper electrode to the everted lids with a current of 3 or 4 ma. for three to five minutes.

4. ATROPHIC RHINITIS.

For the relief of this distressing condition try a 3% aqueous solution of ichthyol. The mixture is not really a solution, but rather a suspension, and cannot be sprayed. It must be swabbed on to the nasal membranes. The effect is rapid and satisfactory. The membranes recover a considerable degree of normal vascularity.

5. BLEPHSROSPASM.

For some reason or other, not easily explained, blephsrospasm is usually relieved by the instillation of atrophine into the conjunctival sac. One application is usually sufficient, and the effect of the treatment is lasting.

(Above 1, 2, 3, 4 and 5 are extracts from *The Eye, Ear, Nose and Throat Monthly*, September, 1938.)

ALOPECIA: ITS CAUSES AND TREATMENT.

Alopecia may be of congenial origin or due to senility, premature or normal secondary reactions of poisons, fevers, tuberculosis, diabetes or local causes such as fevers, ulcerating syphilides, lupus, or burns. One of the most common causes, however, is dandruff or seborrhoe. The endocrines play an important part in the ætiology of the condition and for this reason treatment on these lines frequently produces good results. L. F. Herz advocates glandular treatment combined with vitamins, iron, arsenic, liver extracts, and local applications. Pituitary extracts have produced the most satisfactory results, especially if the condition is treated in the early stages (2 c. cm of anterior pituitary extract thrice daily). In cases of hypothyroidism administration of thyroid hormone frequently causes an improvement in the condition. As regards local treatment the following method is suggested: The patient's hair is shampooed twice weekly with tincture of green soap, the hair thoroughly dried and vigorously massaged. This is followed by treatment with an air-cooled mercury arc lamp to the point of erythema. A lotion is used morning and evening, the formula of which is as follows:—

R
Sulphur precipitate 30 grs.
Spirit camphor 60 mins.
Glycerine 30 mins.
Aqua destil ad 1 ounce.

M. Sig: shake the bottle and sprinkle over the scalp before brushing.

A useful ointment to rub in at night is the following:—

R
Sulphur precipitate 15 grs.
Acid salicylic 10 grs.
Paraffin moll ad 1 ounce.

M. Sig: To be rubbed in at night (Ormsby).

The hair should not be shampooed too frequently as this tends to make it dry and brittle. When the condition of the scalp is oily and seborrhoeic a dusting powder for the scalp is useful, and the following formula is recommended by the author:—

R
Sulphur precipitate
Amyli aa 10·0

M. Sig: Dust on scalp every two to three days (Kro nayar)

In a young person, if alopecia is treated in the early stages, the prognosis is good, but in the advanced stage it is poor, as also in elderly people in all stages.

(The Practitioner, June 1938.)

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THE Medical Practitioner

Vol. X]

OCTOBER, 1938

[No. 1

OURSELVES.

The Medical Practitioner ushers in the tenth year of its birth this month and it is gratifying that the month of its birth brings the good news that its aims and policy are being recognised by Government and are given effect to. Last year this month the Government of Madras announced the abolition of the I. M. P. course with the object of having one uniform standard of University Medical Education and we have no more Medical Schools in this province and an additional Government Medical College, has been brought into existence in Madras. This reform will ultimately put an end to the caste system in the medical profession, which has been a great obstruction for the growth of a homogeneous and contended medical fraternity. It cannot be denied that this reform is likely to affect the existing Medical Licentiates and it is highly creditable that the Medical Licentiates instead of grumbling, have reconciled themselves to their lot in the larger interests of the profession. The Public Health Minister who has the gift of courage in his convictions and who is himself a medical licentiate, did anticipate the feelings of the Licentiates and has assured them that he would favourably consider any scheme which is likely to bring them equality of status with the Medical Graduates. As mentioned in these columns a few months ago, we hope to publish a scheme in the near future with the help and co-operation of our readers especially the Licentiates' section of it, which while giving the Licentiates the status and prestige that are due to them, will not in any way bring down the Medical Graduates.

This year the month of the birth of The Medical Practitioner brings the news

that the Government of Madras have decided to restrict the privilege of private practice to the full time Government Medical Officers. Our readers must be aware of the persistent agitation conducted in the columns of The Medical Practitioner on this subject ever since it came into existence. This reform was long overdue and the readers of The Medical Practitioner with whose patronage and co-operation it was possible for the journal to command influence, may feel proud of the achievement of The Medical Practitioner in this direction. The small minority of the members of the medical profession in service will surely suffer so long as they are in service but we trust they too would take into consideration the larger interests of the entire profession and would not take into account the temporary loss of private income bearing in mind that the moment they leave service or retire they will have no room for complaint. On the other hand their past experience in service under Government would bring them proportionately more income under the changed conditions than it would have been possible for them to earn during the period of their retirement. That we have been advocating this reform not in partisan spirit, will we hope be realised by our readers in Government service if they peruse the second Editorial on this subject appearing elsewhere. The most important aim of The Medical Practitioner is the uplift of the medical profession in India and all the reforms it has been advocating in the past and will be advocating in the future are entirely for the purpose of achieving this end. We have been doing our best to make the profession realise that "Self Help" is the best help and that the profession should try to get itself

out of the control of the Government, in other words be independent. In no other civilized country the medical profession is under the thumb of the Government as it is the case in India. The profession as well as the Government should realise that for the healthy evolution of the profession, it should depend upon itself and not on the politically minded members of the Government however progressive they may be.

Now that the equality of status and equality of opportunities of service are assured to the profession in Madras Presidency there cannot be any hindrance for all sections of the profession to sit together and evolve schemes for public good. It is futile to depend upon the Government to find out fields for service. The profession should depend upon the public and disburse from its mind that efficient medical relief can be procured only in State Hospitals. The largest section of the medical profession now depends upon dispensary practice and the general practitioners have not been able to conceive the idea of institutional treatment for their patients. There is a real danger to the general practitioner these days on account of Specialists and Honorary Service in State Hospitals with the result that even for minor surgical ailments and obstetrical relief people are admitted in State Hospitals. The general practitioners must have realised that for dispensing practice the tedious scientific course extending for over six years is not necessary at all and that they have very little scope in the dispensing practice to exercise their professional skill to the extent they can. It is therefore necessary that members of the profession should educate the public regarding the benefits of scientific medical relief and impress on them by good work that it is possible for the general practitioners to look after their patients with as much skill and responsibility as obtaining in State Hospitals.

There is therefore a great need for publicity and propaganda and this work could be done only through the Press. The Medical Practitioner is the only journal in the Madras Presidency

if not in India which has been devoting its columns for the discussion of problems concerning the life and prosperity of the members of the medical profession and has been able to achieve something substantial in this direction. With the additional help from the profession it hopes to achieve more in future years. The journal reaches all the Governments in India including the Central and the reforms inaugurated by the Madras Government are sure to serve as an eye opener to other provinces. We take this opportunity for thanking our readers for their help and encouragement in the past and trust they will move with the times and supply the necessary sinews to The Medical Practitioner so that it may continue to serve the profession with still more vigour and zeal worthy of the causes it has been espousing fearlessly.

PUBLIC SERVICE AND PRIVATE PRACTICE.

In the last issue we showed how the private practice allowed to the Government Medical Officers is an anachronism that is out of tune with the changed times. Nay, more, the concession—for it is nothing more than a concession—even interferes with the healthy growth of an independent profession. That this is not a partisan view is clear from the fact that two leading papers of Madras like 'The Madras Mail' and 'The Hindu' whose policies cannot be said to be identical, agree in this point *viz.*, that this privilege should be restricted. Certain observations of 'The Mail' with which we are not in agreement will be dealt with later on in the proper place. Suffice it to quote here from rule 13 (d) of the Madras Medical Service rules (Vide G. O. No. 2232 Public (Services) dated 22.11.37) which says that *members of the service shall not as a matter of right, be entitled to engage themselves in private practice* and provides that the "Provincial Government may in the case of any particular officer or class of officers restrict such private practice to such extent as they think fit." How far the private practice should be restricted will depend upon the considerations which should guide the Government

in ordering such restriction. So far as we can see they are given below and will be taken up seriatim.

First, Government which employs the medical officers must have full value for the money spent on them. Then we must mention that Government officers are whole-time servants. Private practice is therefore a concession allowed in the interests of the public for as G. O. No. 275 F. D. dated 8.8.1938 puts it, "a Government servant can be called upon to do Government work at any time according to the exigencies of public service". The G. O. proceeds to observe that "the main objection to private work is that it must always be more or less to the detriment of Government work as every man's capacity for work in a way is limited and the more time and energy he gives to private work for remuneration the less he has for Government work. If holidays and leisure hours which are intended for recuperation are given to earning remuneration by other work there is less recuperation and so ultimate detriment to the public service". Human nature being what it is, we need hardly remark that when it comes to the point the detriment will be to the public service and not to the private patient for there is competition in private practice and it will not do to stint service in that field. The medical profession is of an exacting nature. Further, science takes such strides almost from day to day that unless a person keeps a constant touch with the current literature he is bound to be soon out of date. A conscientious discharge of a medical officer's duties and the study of the progress made in the science will just leave him sufficient time if it does that, for recuperation and for attention to his private affairs.

Secondly, a competition has grown between the medical officers and the independent profession on account of this private practice. The advantages that the former derive by virtue of their official position has given them a leverage which is unfair to the private practitioner—a result that could not have been intended at the time and in the circumstances when private practice was allowed by Government. Dealing with this point

says, 'The Hindu' (dated 14.9.1938), "It (i.e. private practice) had its origin in the days when doctors were few and were absorbed in the Government Service as a matter of course for that has changed now". Again the same paper observes "It is only natural that in tackling it (i.e., the problem of private practice) radical changes have to be made in the arrangements made under different circumstances." With reference to the state of things brought about by the artificial advantage conferred by Government service, we have the following remarks from 'The Hindu' "Side by side with the large and growing number of private practitioners burdened with too much leisure we have a small body of Government doctors overworking themselves to meet calls on their time and professional skill. We need not here go into the reasons for this public preference, except possibly to refer to the increased contacts and opportunities for handling cases afforded to Government Medical men by virtue of their official position. This lopsided development of a profession so vital to the welfare of community could not but be taken notice of by the Government with a view to its rectification".

It should therefore be the aim of Government to organise and strengthen the profession which is so vital to the welfare of the community. One of the ways of achieving this end would be to extend to the profession the advantage of the Government Hospital. In other words to develop and expand the honorary service. The addition of honorary medical officers to the stipendiary incumbents employed in Government Hospitals to be shortly made seems to be in furtherance of this idea. It may not be out of place to state here that the honoraries should not themselves become a caste. In this connection we are reminded of a caustic remark of a social reformer that the caste system is so ingrained in the Indians that any one who forms a society to abolish it only succeeds in adding one more to the existing number of castes. In the case before us this tendency has been overcome by the Government who have limited the period of honorary service to five years so that all young men of whatever qualifications may have a chance of gathering the requisite

experience. The point we wish to make is that by the proper encouragement of medical profession and suitable changes in the system, the weightage that the paid service gets must be counterbalanced, and an honorary service organised in view to the gradual extinction of the former.

The fourth consideration that should weigh with the Government in this matter is that the patient must have the benefit of expert's services. As 'The Hindu' puts it "*while the withdrawal of the provision to engage in private practice may be expected to make for a more even distribution of work among all available medical men, care must be taken to see that the patient's right to get the best medical attention be not taken away.*" In a sense the patient in the capacity of a citizen pays the salary of the Medical Officer. It is therefore proper that he should get services of that officer in the hour of need consistently with the public interests. We say "consistently with public interest" because otherwise if the patient were made the sole determining factor it is possible to thwart the reform altogether. Individual considerations must give way to the larger interests. In their order dated 8th August 1938 already referred to, Government permit their servants to undertake private work "in those rare cases where the *rare qualification possessed by any one and the public importance of the work demand the utilisation of such service*". It is to be noted that public importance and not private advantage is an essential condition precedent to the granting of the permission. Even in such cases permission of Government should be obtained for doing the work and accepting the remuneration.

The fifth and the last point that we would suggest, should be considered in the determination of this question of private practice, is that the officers now in service should as far as possible not be subjected to undue hardship. Every reform generally hits hard some class or other, but this consideration should not stand in the way so long as the reform is a step in the right direction. And what can be done is to see as far as possible that it does not press hard on the persons concerned.

In our opinion the requirements of the situation and consideration mentioned above would be met if the private work of the Government Medical Officers is restricted to consulting practice in the hospitals. Consulting practice as defined by Government in their notification, G. O. No. 2232 Public (Services) dated 22.11.37, seems to be too wide for the present purpose. In this order the explanation given relating to Consulting Practice is such that the intention of the Government to restrict practice is likely to be frustrated. In addition, the spirit of G. O. No. 275 dated 8.8.1938 will be vitiated as it is not possible to restrict even "Consulting Practice" to reasonable limits with the result that the over-working Government specialist will be lacking in energy for his legitimate official work. We therefore suggest that the Consulting Practice should be allowed only in the very institutions where the officers are on duty, special hours being set apart for consultation by the well-to-do class of patients. A separate register must be maintained in the institution for this purpose. The consulting practice should be allowed to all the members of the Madras Medical Department from the existing Sub-Asst. Surgeon upwards. As a consequence if this change is introduced the working hours of the officers will have to be increased and adjusted in such a way that the consulting practice does not interfere with the usual routine. The fees charged for their practice may be treated as overtime fees, with this difference that a fraction of the fees to be fixed by Government should be credited to Government for the use the officers make of the instruments and other hospital equipment. This scheme is suggested as an interim arrangement applicable to the present incumbents. The honorary officers must of course have every facility enjoyed by the stipendiary officers. If facilities could be offered to a private practitioner of a certain status to use on special terms the Government operation theatre and instruments it would be a distinct encouragement to talented persons who are not fortunate enough to get into service, Government or Honorary. Provision

will also have to be made for cases in which patients are not able or willing to go to the hospitals and want the services of the medical officers in their houses. Each such case has of course to be dealt with on its merits and the officer concerned may be allowed to attend on the patient if it appears to be a fit case to the superior officer whose previous permission should be sought. If in any case it is not possible to obtain previous permission the fact of the case should be reported and permission sought for accepting remuneration.

'The Madras Mail' in its issue of 23.9.1938 suggests "consulting practice" though while doing so it has a fling at some members of the Madras Branch of the Indian Medical Association who appear to have suggested at a meeting of the Association on 22.9.1938 that "*State medical officers should be inspired by the ideal of service and not require the privilege of private practice.*" Our contemporary suggests that the plea was disingenuous and that the members were not actuated by altruistic motives. It proceeds to remark that "*there is no apparent reason why an ideal of service should be incompatible with payment for the service*". Without meaning to controvert the statement we may remark that State Medical Officers do get their pay and can afford to be contented with it and if they render free service for the pay they get our hospitals would be models of their kind. The whole question is whether a person places service first or payment first. If he does the former thing and regards payment as a by-product being content with what he gets we may safely say that he is moved by the spirit of service. Such a man may be expected easily to forego private practice adjusting himself to the chang-

ed conditions and finding full scope for service in the restricted sphere. To take a concrete example, in pre-Congress days the ministers drew a pay of over Rs. 5,000 each per month and stood out against any suggestion for a reduction in the pay. The Congress ministers voluntarily reduced the sum to Rs. 500 each which is barely a living wage. Nobody denies that these gentlemen are moved by the spirit of service and sacrifice simply because they accept a pittance for their services. Is it contended that the pay of medical officers is less than a living wage? And what can be said for the other side is that when a person gets a certain income he orders his expenses in proportion and when there is a fall in the income it is fair to make it as gentle as possible.

It seems to be generally agreed that reform projected by Government is desirable. We would even say it is overdue. It would enable the State medical officers to devote more attention to their legitimate work and at the same time strengthen the independent medical profession, confining private practice to private practitioners. The present ministry is preeminently fitted to introduce the change. By their own example they have showed the way to sacrifice private interests to public good. They have shown vision and courage in enacting legislature and executive measures intended for public good undeterred by the out-cry raised by vested interests and the unpopularity resulting therefrom. Opposition there is bound to be for a scheme which destroys an age-long practice. There is all the more reason therefore that the advocates of the reform should mobilise their forces and support the Government.

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News and Comments

A Thunderbolt: The Rural Medical Practitioners subsidized by the Government of Madras are shocked and dumb-founded not being able to answer one way or the other, the three questions which they have been asked to do through the respective District Board Presidents under whom they serve. The sum and substance of the three questions seems to be to substitute Honorary Service in the place of Subsidized Service. The questions are:

1. Whether they are willing to receive only half of the amount of subsidy which at present is Rs. 500/- for the medical Licentiates and Rs. 600/- for the medical graduates.
2. If they agree to give medical relief in the villages without receiving any subsidy, the District Board supplying only medicines to the total value of Rs. 360/- a year.
3. Whether they are willing to serve in the villages without subsidy or supply of medicine in which case they will have the services of a midwife to be paid for by District Board or Government.

The Government more than anybody else must be aware of the conditions prevailing in villages regarding medical relief. Quacks and charlatans are still holding a sway over the credulous villagers. The few that have recourse to scientific medicine at the last stage of any illness after all the known quackery has been tried, are not in a position to pay. The rich and well-to-do class of villagers who are usually members of Local Bodies or partisans of one or the other local political faction do not pay and the Subsidized Practitioners feel nervous to demand from such people as experience had taught them that their position is not secure after such demands. There may be a village here and there in some Districts where a few subsidized practitioners are above want. The Government know that in such a village attempts are made by some District Boards to convert the existing Subsidized Dispensaries into pucca L. F. institutions with the ostensible intention of providing better facilities of medical relief, the real underlying object being to drive away the popular Subsidized Practitioner from out of the village. Such a practitioner is usually competent and

efficient and it is not possible to oust him from the village by any cock and bull story.

It is too early to think of introducing honorary system of medical relief in the villages. The proper time will be when qualified practitioners belonging to the Scientific System of medicine settle in villages where there are at present Subsidized Dispensaries. The helplessness now prevailing in the scientific medical profession is such that there is a large number of practitioners having little or no private practice and it is just possible that at least some amongst these are likely to take up subsidized village medical service on the 1st two conditions mentioned in the memorandum under reference. But it will be most unfair for the Government to displace those already in Subsidized Service on the principle of demand and supply. The Government should realise that the existing Subsidized Practitioners were the pioneers to do rural medical service and but for them the villagers would not have been educated to understand the benefits of scientific medicine. Unwholesome rivalry in the medical profession especially amongst starving, semi-starving practitioners will lead to disastrous results and the intention of the Government to supply efficient medical relief to the village folk will be frustrated. We do not wish to say anything more on this aspect of the subject for obvious reasons. The Hon'ble the Public Health Minister was till recently a very successful practising doctor and knows the relationship of a doctor and a patient especially in villages. There are a little over 450 Subsidized Practitioners at present. They are accustomed to village life. They have an organised Association. A large majority of them are congress minded. If the Government take them into their confidence, allow them all possible facilities to exercise their profession and devise ways and means to infuse in them the true spirit of missionary medical service there is every hope for enlarging the extent of rural medical service, the Government spending proportionately very much less on this account. We appeal to the Government not to hesitate any further to give

effect to the tentative proposals decided upon during the interview which the Health Minister was pleased to grant to the representatives of the Provincial Subsidized Rural Medical Practitioners' Association on 25-1-1938 and which the Minister said at the Manachanalloor Conference he would do early. The undue delay of nearly ten months and the recent circular foreshadowing drastic changes in the Subsidized Rural Medical Service have upset the practitioners to such an extent that many of them are confused not being able to understand the *bona fides* of the Government in issuing the memorandum instead of issuing the new agreement form.

Subsidized Public Health Work: A Government order relating to the training to be given to the Subsidized Practitioners, and the remuneration to be paid to the practitioner for doing Public Health Work has been published in the Correspondence Columns. The course is to last for one month both in the theory and practice of Public Health. It is said that the Subsidized Practitioner is to get Rs. 25/- as an honorarium during the period of one month when he is deputed to undergo the training and will be paid Rs. 15/- per month for doing Public Health Work in the villages within a radius of five miles from the Subsidized Dispensary and lesser area in case of more thickly populated villages.

Subsidized Practitioners have been doing Public Health Work in some selected villages and are paid Rs. 15/- a month. This amount was considered by them not adequate for the work they did at present and the representatives of the Subsidized Practitioners who met the Hon'ble Minister of Public Health at the Secretariat on 25.1.1938 discussed this subject with the Public Health Minister. It was agreed that the practitioners should not be asked to do actual vaccination operations. The Minister told them that till the Public Health Act was passed they might receive the remuneration at the current rate and that soon after the Public Health Act came into operation, he (the Minister) would reconsider the question of higher remuneration. There cannot be any doubt that

the Rural Medical Practitioner will have to play an important and responsible part regarding Public Health after the Public Health Bill becomes law. This will necessarily interfere with his private practice. It will be therefore just and reasonable if the subsidy for doing Public Health Work is fixed at Rs. 30/- a month a very modest amount taking into consideration the responsibilities of the work and the loss the subsidized practitioner is likely to incur due to loss of private practice at the time he is engaged in Public Health Work. It is expected that the vaccination will be done by vaccinators under the control of the Subsidized Practitioners as already agreed to. The G. O. is silent regarding the payment of the usual subsidy to the practitioner deputed for Public Health training. Majority of Subsidized Practitioners are married persons many of whom have children also. During the period of one month they are in Madras for training they have to maintain their house-hold in the villages and it is expected that in addition to the honorarium of Rs. 25/- referred to in G. O. the Government would pay them the proportionate monthly subsidy.

Time-Honoured Corruption: The Ministry of Public Information, Madras had published a Communique (extract published elsewhere) relating to deck passengers' grievances at Negapatam, a port on the east coast from where a very large number of emigrants ranging from nearly 14,000 to 50,000 embark seeking employment in the rubber estates in the Federated Malay States. The Communique deals with three methods of victimisation of deck passengers. The first relates to their accommodation at Negapatam before they embark; the second is in regard to the disinfection of the belongings of the emigrants by the Port Health staff and the third describes the hardships of the emigrants to procure vaccination certificates. We are not concerned with the first method of victimisation and we agree with the Government that the Health Department of Negapatam Municipality were guilty of culpable negligence in not making suitable arrangement for the hygienic accom-

modation of a large number of emigrants, numbering as many as 49,383 last year but mercilessly relegated them to the exploitation of unscrupulous and greedy touts or agents and persons of such and similar denomination. In the second category of victimisation the staff of the Port Health Department was entirely responsible so also in the third of the series relating to vaccination which till 1932 was supposed to be done by the Civil Surgeon, Negapatam but actually done by a Sub-Assistant Surgeon directly under the Civil Surgeon, the latter not even signing the certificates but permitting his subordinate to affix the facsimile. The Communique is silent regarding the state of affairs of vaccination of deck passengers for 17 years before 1st January 1932 when this process was transferred to the control of the Director of Public Health from the Surgeon-General with the Government of Madras. The process of procuring vaccination certificates for passengers embarking for Strait Settlements, in the shipping department of M/s Benny & Co., in Madras, who have till this day the sole monopoly of issuing these certificates was first observed by us in 1928 a year before The Medical Practitioner came into existence and soon after we did observe in these columns that the exercise of such a monopoly by a shipping firm through only one practitioner under their employ was not fair to the medical profession. In 1930 when we had to embark at Negapatam to go to Penang we discussed with the then Manager of M/s Madura Company, Shipping Agents at Negapatam that the privilege of issuing vaccination certificates should be enjoyed equally by all the registered medical practitioners and not only by one who was for the time being the Civil Surgeon of Negapatam. We suggested that safety and responsibility of vaccination could be assured if the vaccination operations were done in the premises of M/s Madura Company by a panel of private registered medical practitioners in whom the Company had faith. We presume that the appointment of a private medical practitioner in the place of Civil Surgeon for the purpose of issuing vacci-

nation certificates, after the Port Health work was transferred to the Public Health Department must have something to do with our suggestion. The fact that the Civil Surgeons of Negapatam had been enjoying the privilege of making money on account of vaccination certificates without themselves doing the vaccination operations, must have encouraged the first Port Health Officer of Negapatam (from Public Health Department) who took charge of the port, to press the Madura Company to allow him a share in the fees collected by the company for vaccinating the emigrants. How and why this procedure which is now condemned as a victimisation and a corrupt practice escaped the notice of the then bureaucratic Government and later that of the Diarchic Government from the year 1915 to 1937 and which the present Government considered to be grave offences punishable with the highest administrative action of dismissal is beyond our comprehension. It is even said that the then Director of Public Health intervened in the dispute between the Health Officer and the Madura Company and suggested that the Port Health Officer should receive more than 1/3 fees collected for vaccination performed by the private practitioner engaged by the Madura Company. The Director of Public Health a responsible officer of the Government evidently considered that the fees earned this way was not illegitimate as he must have known that this procedure was in vogue for full 17 years when the port was under the administrative control of Civil Surgeons who were earning the vaccination fees without actually performing vaccination operations the only difference being that the certificates bore the facsimile of the Civil Surgeon till 1932 whereas later certificates bore the signature of the private practitioner with the countersignature of Port Health Officer till 1936. The Assistant Director of Public Health who was directly in charge of vaccination must have also thought likewise. The successor of the first Health Officer from the Public Health Department walked into the groove of his predecessor quite innocently.

The communique contains also grave charges against the private practitioners. It is said that some had been issuing ante-dated vaccination certificates and that some even employed touts who were furnished with signed vaccination certificates on which they got the names of the passengers entered. The Government action against the time-honoured corruption resulting in the dismissal of two Health Officers who had the approval of their immediate superior officers to do what the Civil Surgeons did for 17 years was at first considered to be rather harsh. For reasons explained in the communique the Government compromised justice with mercy and have been pleased to reinstate the two Health Officers to their old positions reducing the pay they were now getting and stopping their increment for a period of three years. The Assistant Director of Public Health who was in direct charge of vaccination has been also punished and we should say that the Government have been merciful to this officer to a large extent. But the action of the Government in punishing the entire medical profession by refusing its members their rightful privilege of granting vaccination certificates at Negapatam will be very much resented. We learn that after the Government instituted an enquiry about this affair at Negapatam some of the practitioners who are alleged to have granted ante-dated vaccination certificates have been reported to the Madras Medical Council. We are sure the Council will deal with them suitably. May we ask the Government why they did not condemn the entire Public Health Department for the sins committed by three or four officers belonging to this department applying the principle adopted in the case of other registered practitioners? There is a statutory body to enforce discipline over the entire medical profession including the Government Medical Officers in the Medical and Public Health Departments. The administrative disciplinary action usually taken by the Government in suspending, reducing and even dismissing their officers will not be as much salutary as the action of the Medical Council which

can erase the name of any registered practitioner if found guilty in professional respect. The Government cannot do this. There is nothing to prevent the Council to try all concerned in the Negapatam episode. We trust the Government will be pleased to reconsider their decision regarding the ban on the medical profession.

We take this opportunity and inform the Government that the affairs of Port Health work in Madras may also require scrutiny.

D. G. O. Diploma:—A diploma in Obstetrics and Gynaecology to be known as D. G. O. is instituted by the College of Physicians and Surgeons of Bombay. Full details of the course of studies etc., were published in the Correspondence Columns last month. The first examination will be held in August 1939 and will be open to all registered practitioners in Bombay. As the Bombay Medical Act permits the registration in the Bombay Register of all practitioners registered in other provincial Registers on the basis of reciprocity, practically all the registered practitioners in India will be entitled to appear for the D. G. O. examination. But in case of Medical Licentiates in addition to the special training in Obstetrics and Gynaecology they are required to undergo 12 months post-graduate training in Medicine and Surgery or should hold house appointments in recognised hospitals for a period of six months. Nobody can object to the additional course in general Medicine and Surgery demanded by the College of Physicians and Surgeons from the Medical Licentiates. But a fairer test would have been to fix a period of 5 years practice for Medical Licentiates and a lesser one in the case of those possessing the M. C. P. S. Diploma or M. B. B. S. degree after they qualified themselves. Dubbing specialist qualifications on medical men before they had opportunities to practise as general practitioners has been doing more harm than good. There are instances where general practitioners made a mark in a special branch of medical science without holding special qualifications in a particular branch. It is so particularly relating to Obstetrics and Gynaecology. A

practitioner who specialised himself taking advantage of special practice either in hospitals or outside must be far cleverer than a young graduate or licentiate who is artificially made a specialist by appearing for special examinations. So all the institutions who wish to grant diplomas or degrees in the special branches of medical science, will do well to insist that those who wish to qualify in specialities should be in actual practice for a minimum period of 5 years. The Medical Licentiates will have better opportunities for qualifying themselves for D. G. O. diploma if the College of Physicians and Surgeons demand from them a period of private practice as General Practitioners in lieu of extra post-graduate training in medicine or surgery or house appointment of six months in hospitals. Such a concession would be reasonable in the interest of the speciality as well.

Registration of Dentists: It is reported that the Punjab Government who are running a Dental College will soon enact legislation to register Dental Surgeons. In Bombay there was a proposal to start a Dental College and it is said that from the contributions given by a private donor a building was actually built for the purpose but the Government would not start the College for want of funds. A few qualified dentists are now running a private Dental School giving four years training both in theory and practice. The Dental Surgeons in the Bombay Presidency have organised themselves into an association. This association has drafted two Bills one for the recognition of the Dentists and the other for their Registration and submitted them to the Bombay Medical Council for approval. The object of the Punjab Government and the activities of the Bombay Dental Association are in the right direction. We have no idea of the scope of the proposed Bills in both the Provinces. We hope the effect of these Bills will be to prohibit quacks to practise the art of Dentistry. If this purpose is not served there will be little or no use of adding a few more pages to the Medical Registers of the Punjab and Bombay and make these Registers

a bigger volume. As it is, the Provincial Medical Registers do not actually serve the purpose for which they were meant and in Bombay there will be two rival Registers for identical purposes one for the qualified practitioners belonging to the scientific system and another for practitioners of all other systems. The practitioners in both the registers will be entitled also to enjoy identical rights and privileges. The possibility of having a separate Register for Dentists of indigenous systems of medicine will, we hope, not arise especially in Bombay.

A Happy Combination: Ever since the Congress took the reins of the Madras Government we have been wondering why the Public Health Minister, a medical man is saddled with the responsibility of management of Hindu temples. We had a long-looked-for opportunity of going on pilgrimage to Tirupathi quite recently. Our companion was another invalid. The infirmity being in different parts of the body each of us could keep the other in enjoyable company. It was natural the main topics of our conversation were about holy places of worship one such being the place of our destination. From the foot of the hills up till the top of the last hill where the sacred temple is situated we were noticing a stream of beggars a large number of whom were lepers in different stages of the diseases blind men or maimed persons who lost one or other of their limbs. There was also a good number of able-bodied men, women and children. Some amongst the latter kept by their side clay models and pictures of gods of all description. They belonged to the usual variety with the name of God on their lips and bitterness in their heart. They beg, they praise, they importune and finally abuse if disappointed. We reserved our charity for our return journey down the hills, as we wished to make a study of this problem, the time and patience for which we could only find on our way back. We walked a good distance of our way with this object. We saw a few amongst the beggars pointing to their maimed limbs which appeared to be gangrenous. We naturally doubted if it was possible for a beggar to sit up and

move his gangrenous limb in all directions as these did. We boldly approached two such beggars and stripped their clothing and were astonished to see that both of them had their limbs sound. The limb looking gangrenous was a piece of wood moulded and charred and fixed at the knee or the shoulder joint to resemble a gangrenous limb. Treacherous and most deceptive methods are being employed both by the beggars as well as those who are the servants of the temple especially the priestly class to decoy the pilgrims many of whom fall an easy prey due to blind devotion to God. We had very good accommodation in the temple Choultry down the hills and we asked one of the brahmin clerks wearing three marks on his forehead why the pilgrims were looted by all concerned in a holy place of worship. He replied, "Venkateswaran is fond of us and in His fondness He has settled in Tirupathi. We have His sanction to loot everybody so that all of us, His favourite children may live well." The nearer the church, the farther from God. The Tirumalai Hill where the sacred temple is situated is considered to be 'Vaikuntam' that is Heaven. In fact we saw the Heaven made into a hell. It is generally said by those not educated in the English language that persons educated in this language have no faith in the Hindu temples. This may be true to a certain extent. But if an English educated Commissioner was not at the head of the executive administration at the Tirumalai Hills, we are afraid things would have been much worse than what we saw them. We began to feel on the Hills that the Public Health Minister in the person of the Hon'ble Dr. T. S. S. Rajan is the fittest person amongst the Ministers to be in charge of Hindu Temples being a medical man and a Hindu at the same time. We were very happy to read the head lines about the Health Minister's recent visits to two famous temples in Tinnevely District in the Madras Mail on 25-7-38: 'Everything Else But God in Them', 'Temples Have Lost Magnetic Power', 'Government Preparing Legislation to prevent Crime'. Tirupathi temple is one of the richest if not the

richest temple in India. Population is flowing to Tirumalai Hills from all parts of India full of devotion otherwise known as 'Bhakthi'. It can be made a model place for the demonstration of both physical and mental cleanliness. The surroundings of the temple are in a most insanitary condition and any amount spent to make the surroundings clean and sanitary will not be too much. A large number of tidy dwelling places for the pilgrims have been recently constructed but, for want of water supply and a sanitary staff to look after them they are likely to deteriorate. There are a large number of infective lepers in fact almost all of whom we saw were of this type. They are found mixed with the pilgrims even inside the temple. The temple funds will be laudibly spent if a home for lepers is established immediately. These unfortunate people should be segregated and kept in an asylum. They can be easily maintained by public charity which must necessarily be diverted to these institutions in the absence of stray beggars such straying being absolutely prohibited and made penal if necessary. The Tirupathi Temples may thus become a model to attract the attention of other temples throughout India. Dr. Rajan has proved by example that medical men can be the best of devotees of Hindu temples. Spiritual devotion combined with scientific knowledge of the ailments of human body is the highest ideal for a medical man. We trust Dr. Rajan will make it possible for the members of the medical profession to serve God and man by working for Hindu temples. A man of thought, devotion and action in the position of a Minister as Dr. Rajan makes a happy combination of a Karmayogi guided by Jnana and Bhakti. Cleanliness is truly next to Godliness. Let Tirupathi temple which has at present a devoted Commissioner and large funds begin the work of purifying body and soul of the pilgrims with the help of the members of the medical profession. There cannot be a greater opportunity for the Madras Government than the present one when they have the Hon'ble Dr. Rajan in charge of Medical and Temple Portfolios.

Correspondence, Reports, Etc.

DECK PASSENGERS' GRIEVANCES.

NEGAPATAM ENQUIRY

Extracts from Government's Communique

The attention of the Government was recently drawn to the grave irregularities corrupt practices and victimisation of deck passengers which were alleged to have been prevailing at the Negapatam Port for a number of years in connection with the embarkation of passengers to Malaya. On receipt of information the Government immediately ordered an enquiry by a Special Officer and the enquiry confirmed most of the allegations which had been made.

Unlike the assisted emigrant the unassisted emigrant has no responsible persons at Negapatam to protect and aid him on his arrival. He has to shift for himself, and a large number of persons, consisting of rest-house keepers, brokers touts and medical men have many opportunities to prey on him.

Passengers who have to embark at Negapatam have usually to stay from 1 to 4 days awaiting for the steamer. There are no convenient rest houses to accommodate them. Instead there are certain houses called, "vidudies" most of which lack sanitary arrangements. Excepting a few owned by the shipping company the rest are maintained for profit and it was found that the owners of these "vidudies" employed agents to bring the passengers from distant stations to their "vidudies" where men, women and children were huddled together like cargo. These unscrupulous owners of "vidudies" were found to be making lucrative business trading upon the ignorance of illiterate passengers. The Government regretted to observe that the Negapatam Municipal Council who had it in their power to prevent overcrowding in the rest houses took no steps to do so.

A second form of victimisation disclosed by the Special Officer is in connection with the Quarantine Rules. Under these rules

disinfection is compulsory when the Port is infected with plague but it is left to the discretion of the Port Health Officer when the Port is infected with diseases other than plague. As the process of disinfection involved the changing of clothes in open sheds where there was no privacy, the procedure was naturally unpopular and those who could afford to do so were naturally not unwilling to pay for exemption.

The vaccination rules gave opportunities for a third and even worse form of victimisation. A Straits Settlement Ordinance of 1915 required that no emigrant from any part of India who had not suffered from small-pox or had not been successfully vaccinated or revaccinated within five years immediately preceding should be permitted to land in the Colony until he had been vaccinated or revaccinated. For some time after this enactment came into force, the passengers were vaccinated before embarkation by the Assistant Port Health Officer, Negapatam, the facsimile of the Civil Surgeon, Negapatam, who was then the Port Health Officer, being affixed to the vaccination certificate issued by him. This arrangement was in force till 1st January 1932 when the Port Health work was transferred to the Public Health Department, the Municipal Health Officer taking the place of Civil Surgeon as Port Health Officer, Negapatam. The Madura Company then appointed their own medical officer to vaccinate deck passengers. The Port Health Officer and his assistant resented this arrangement and the Assistant Port Health Officer continued to vaccinate and issue certificates holding that it was the privilege of the Port Health Officer to vaccinate deck passengers. The Madura Company refused to accept certificates issued by any one other than their own medical officer with the result that several persons vaccinated by the Assistant Port Health Officer had to get themselves revaccinated by the Company's doctor on the payment of a further fee before they could get passage tickets. Misunderstanding and

confusion followed till in March 1932 the Medical Officer of the Madura Company and the Port Health Officer came to an 'agreement' in the matter. Under this 'agreement' which was signed by both on 12th March 1932, the passengers were to be vaccinated by the Company's doctor assisted by the Assistant Port Health Officer but the Municipal Health Officer was to receive one-third of the income derived by him from vaccination fees.

Following a decision arrived at the Regional Conference of League of Nations held at Cape Town in 1932 a rule was framed in 1934 under the Indian Ports Act to the effect that "a passenger may, before sailing, be required by the Port Health Officer to satisfy him that he has been vaccinated or revaccinated against small-pox not less than 12 days or not more than three years before the date of sailing or that he has scars of small-pox." This rule came into actual operation from August 1935. Any registered medical practitioner might issue a vaccination certificate and it had to be countersigned by the Port Health Officer free of charge. This counter-signature was, however, dispensed with in 1936.

With the enforcement of the above rule the practice of issuing ante-dated vaccination certificates appears to have been started. Most of the emigrants arrive at Negapatam only two days before the departure of the steamer and many of them are not in possession of vaccination certificates. In order therefore to avoid a long stay at Negapatam the passengers are anxious to get certificates dated at least 12 days before. The medical practitioners appear to have taken full advantage of this and to have issued ante-dated certificates charging as large a fee as they could extort from the unfortunate passengers. Some in their anxiety to get more clients seem to have employed touts supplied with signed vaccination certificates in which they got the names of passengers entered!

The special officer who was deputed to investigate into the Negapatam Port disclosed in his enquiry that the conduct of the officers of Public Health Department

are most reprehensible; under the rules a port health officer is not permitted to accept vaccination fee unless he himself does the vaccination and issues a vaccination certificate. In spite of these rules the Municipal Health Officer entered into agreement with a company's doctor and received a share of vaccination fee from 1932, a third of the vaccination fee collected from the emigrants. The income derived from them may be judged from the number of Deck passengers who sailed from Negapatam during 1932—37.

One of the Municipal Health Officers has admitted that he made Rs. 14,490 from his share of the fees and the other Rs. 7,260.

It was highly improper for officers of the Public Health Department to make such incomes under an illegal and irregular agreement for work actually done by private medical practitioners in the Companies' employ. In accepting this "remuneration", these health officers were clearly guilty of receiving illegal gratification. Moreover, they could hardly have been unaware of the exaction of large fees for ante-dated vaccination certificates by the private medical practitioners and of other abuses and scandals shown to have been existing at Negapatam Port. Certain superior officers of the Public Health Department also were shown by the Special Officer to have been aware of the illegal agreement and of the fact that the Port Health Officers were continuing to receive a share of the vaccination fees, but to have taken no steps either to cancel the agreement or to put a stop to the practice.

The Government, after considering all the facts which the enquiry had brought to light, came to the conclusion, in which conclusion the Madras Public Service Commission concurred, that the offences committed by the Health Officers were serious and accordingly ordered the dismissal of the two Health Officers from service and reduced an Assistant Director of Public Health to a Health Officer's grade. Subsequently, however, the Health Officers admitted their guilt and expressed regret. They also made amends by pay-

ing into the Government Treasury the amounts of their illegal earnings. The Government, in view of this and in consideration of the fact that the acceptance of these irregular fees was done openly, have decided to show them clemency and have accordingly reinstated them in service on a lower scale of pay with a bar on increments for three years although the Madras Public Service Commission was still of the opinion that the order of dismissal should not be modified. Extenuating circumstances in the case of the Assistant Director of Public Health have also been taken into consideration and the rules have been relaxed in his favour and on reduction to a Health Officer's grade he has been permitted to draw a personal pay of Rs. 400 per mensem so as to bring his emoluments upto Rs. 1,000 which is Rs. 200 below his present salary.

With a view to remove the defects in the existing system and improve the general efficiency of the Port Health Administration the Special Officer has made suggestions which are under the active consideration of the Government. In regard to vaccination which afforded the greatest scope for corruption the Government have under consideration a proposal to amend the rules to the effect that in the case of deck passengers no vaccination or revaccination before embarkation shall be insisted upon, except when, on account of the prevalence of smallpox, it is considered necessary to adopt special precautions, in which case all deck passengers except those who have scars proving that they have suffered from a previous attack of smallpox, shall be vaccinated or revaccinated before embarkation by the Port Health Officer or his Assistant and by no other whether he be a Government or a local board servant or a private registered medical practitioner. The fee for vaccination will be charged when such vaccinations are performed, and it will be credited to Government. The Government have also decided to stop the disinfection of clothing and have asked the Director of Public Health to examine the rules and suggest suitable amendments.

**GOVERNMENT OF MADRAS:—
EDUCATION AND PUBLIC HEALTH
DEPARTMENT.**

(Public Health)

G. O. No. 2639. 21st July, 1938.

Medical Institutions Rural (subsidised) deputation of Medical Practitioners for training and performance of Public Health Work. Orders Passed:

Read the following papers:—

From the Surgeon-General Dated 17th December, 1937 No. 1591, Mis.

From the Director of Public Health Dated 24th March, '38 No. 3445 I. P. H.

From the Director of Public Health Dated 9th May, '38 No. 12488 I. P. H.

From the Surgeon-General Dated 30th May, '38 No. 2548 H.

Order No. 2639 P. H. Dated 21st July, 38.

The Conference of Public Health Ministers held at Fort St. George, Madras on 29th December 1937 passed a resolution to the effect that Rural Medical Practitioners should have special course of training in the theory and practice of 'Public Health' to enable them to discharge efficiently their duties as Sanitary Officers. The Government have considered the resolution in consultation with the Director of Public Health and the Surgeon-General and have decided that it should be given effect to.

2. The training which will be in Madras will last for a month exclusive of Sundays and will be confined to medical practitioners in charge of Rural Dispensaries of allopathic medicine subsidised by Government. A detailed syllabus for the course of training is printed as an appendix to this order. The Director of Public Health is requested to arrange for the training of the subsidised practitioners in batches in consultation with the Presidents of Local Boards concerned. During the absence of the Practitioners while undergoing training the rural

dispensaries may be placed in charge of substitutes on Government subsidy. The practitioners deputed for training should be paid from the funds of the Local Boards concerned.

(a) Travelling allowances as on tour for their journey to Madras for undergoing training and for their return journey and

(b) an honorarium of Rs. 25/- a month during the period of training.

After the completion of training a remuneration of Rs. 15/- a month should be paid from the funds of the Local Boards concerned to each rural medical practitioner for doing Public Health Work. No separate travelling allowance or additional honorarium for inoculation or festival duty need be paid. The Rural Medical Practitioners will when doing Public Health Work be under the control of the District Health Officers. The area for purpose of Public Health Work should not as a rule extend to villages beyond a radius of 5 miles from the dispensary. Where this area is too heavy a charge as in delta tracts it may be reduced in consultation with the District Health Officer.

3. The Presidents of Local Boards are informed that in future those medical officers who have undergone training in Public Health should be given preference for appointments as Rural Medical Practitioners.

(By Order of His Excellency the Governor.)

(Sd.) C. H. MASTERMAN,
Secretary to Government.

**THE MADRAS PROVINCIAL
SUBSIDIZED RURAL MEDICAL
PRACTITIONERS' ASSOCIATION.**

1. TRICHINOPOLY DISTRICT BRANCH.

Proceedings.

At a meeting held at the Head Quarters Hospital, Trichinopoly on 17-9-1938 presided over by Dr. S. Sethurama Rau, Vice-President of the Madras Provincial Subsidized Rural Medical Practitioners'

Association the following resolutions were passed.

1. That the Trichy District Rural Medical Practitioners' Association be converted into the Trichy Branch of the P. S. R. M. Ps'. Association.

2. That Dr. N. Sundararajulu be elected as the representative to the Provincial Committee of the P. S. R. M. Ps'. Association and also as the Secretary of the District Branch.

3. That the Resolution No. 2 be communicated to the General Secretary of the P. S. R. M. Ps'. Association.

4. That the District Secretary be requested to enlist all the Subsidized Rural Medical Practitioners of the District as the members of the P. S. R. M. Ps'. Association.

5. That the District Secretary be requested to prepare a memorandum consistent with the rules and objects of the Association and to place the same before the next meeting of the District Branch.

6. That the District Medical Officer, Trichinopoly be requested to give to the members of the Association facilities to attend the operations and study such clinical material as available at bed side in the Head Quarters Hospital and arrange for post-graduate lectures on every penultimate Saturdays.

7. That the Secretary communicate the resolution No. 6 to the District Medical Officer, Trichinopoly and take such steps to give effect to the objects of the said resolution.

8. That the Secretary arrange periodical clinical meetings at the Head Quarters Hospital and visits to X-ray institutes, nursing homes and other existing medical institutions in the town with the help of directors or managers of such institutions as the case may be.

[We are informed that the D. M. O. Trichinopoly has been kind enough to give effect to resolution No. 6 and the practitioners had the first clinical meeting on 15-10-'38. Ed.]

**2. THE BELLARY DISTRICT BRANCH.
Proceedings.**

The members of the Madras Provincial Subsidized Rural Medical Practitioners' Association of Bellary District organised a Conference to inaugurate the District Branch, which was opened by Dr. R. Nagana Goud, M.Sc., Ph.D., President, District Board, Bellary on 20-10-1938 at Hospet. Sri. M. Raghavendra Rau, B.A., B.L., President, District Congress Committee presided. Sri. B. Ananthachar, B.A., B.L., M.L.A., was one amongst the distinguished visitors.

Dr. M. Krishna Rau, of Thambrahalli village introduced his comrades to the distinguished visitors and expressed his pleasure that almost all the subsidized practitioners were present not minding the inconveniences they were put to. He welcomed the guests and expressed his gratitude to Sri. M. Raghavendra Rau, for having taken up the responsibility of presiding over the function at very short notice. As previously arranged Dr. V. Rama Kamath, President of the Provincial Subsidized Rural Medical Practitioners' Association could not preside due to some unforeseen domestic inconvenience. Dr. Rau, eulogised the services of Dr. Kamath to the Subsidized Practitioners as the President of their Association and also in his capacity as the Editor, *The Medical Practitioner*. Dr. Rau said that but for his untiring efforts the Association would not have been as active as it was now. He then expressed his gratitude to Dr. R. Nagana Goud for having taken the trouble of going over to Hospet to do the inauguration ceremony of the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association. Addressing Sri. B. Ananthachari Dr. Rau said that he and his comrades were very much encouraged by his presence being the popular representative in the Legislative Assembly.

Regarding the necessity of organising the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association Dr. Krishna Rau said it was not so much for redressing their grievances that they wished to have a branch Association as fortunately they had none but they felt the need of having a branch for exchanging views and experiences in different villages so as to be able to do good service to the village folk.

Dr. Rau then traced the origin and growth of the Subsidized Rural Medical Scheme and said that the purpose of the scheme was to attract qualified practitioners to the villages and make them settle there permanently. Success of the scheme said Dr. Rau was to a great measure due to the self sacrificing attitude of the practitioners who with the hope of being able to stick to one place did not

mind material gain and lived the life of the villagers. The masses in the villages were miserably poor; the few rich were not paying and the practitioners did not demand from them as the very existence of practitioners in the villages depended upon their grace. Thus the practitioners were forced to be philanthropic both to the poor as well as the rich. He added that the Hon'ble Dr. Rajan's advice to the newly passed graduates not to count their services in rupees, annas and pies could be translated only by the Subsidized Practitioners in the villages.

Relating to the memorandum recently circulated by the Government asking the opinion of the Subsidized Practitioner if he was willing to serve on 50 per cent less subsidy or no subsidy he would say that time was not ripe yet to conceive the idea of practitioners giving medical aid to the villages depending upon private income. The Government should not be guided by the example of a very few practitioners who might be able to maintain themselves independently of Government subsidy. Dr. Rau opined that it was not fair on the part of the Government to oust the existing Subsidized Practitioners in case they expressed their inability to serve on the new conditions. They were promised fixity of tenure of service when they settled in the villages and after spending nearly 13 years in the villages it would be very hard for them to leave them. He concluded by saying that the Government would be digging the grave of Rural Medical Relief Scheme and would inflict a serious blow on the existing practitioners if they contemplated to give effect to the conditions mentioned in the memorandum under circulation. He then requested Dr. R. Nagana Goud to declare the Conference 'open'.

Dr. N. Nagana Goud thanked the organisers of the conference in requesting him to open the conference which he was glad to do and which afforded him an opportunity to know almost all the practitioners of the District. He was of opinion that the rural medical relief scheme has not worked according to the intentions of the framers of the scheme and a situation analogous to what could be termed

as putting the cart before the horse had been created. The people who could afford to pay and were expected to pay the practitioners were not doing so and hence the practitioners were unable to stand on their own legs. From his experience he was of opinion that voters, and members of the District Board and rich people who had some influence with the District Boards unduly exerted pressure on the practitioners to their advantage. In his capacity as President, District Board he was receiving many applications from various villages for the establishment of a rural dispensaries and his answer to them all was that the villages should maintain a private practitioner in their village for one or two years and then he would consider the payment of subsidy or supplying medicine for the benefit of the poor. Similarly if any medical man approached him for a job he would ask him to go to a particular place and begin private practice and then he would think of addressing the Government for the sanction of a rural dispensary. He was in agreement with the views expressed by Dr. M. Krishna Rau in his welcome speech that the practitioners were not getting any private practice worth the name and were subjected to all sorts of caprices of local factions. Regarding the circular he said that the Government was finding ways and means of spending as little as possible and benefitting as many people as possible. He then declared the conference open.

Sri M. Raghavendra Rao, B.A., B.L., President of the District Congress Committee in his presidential address said that in the unavoidable absence of Dr. V. Rama Kamath of Madras the honour of presiding over the deliberations fell on him and he was thankful to the organisers. He congratulated the Subsidized Practitioners of the District for organising themselves into an association and felt glad that he was to inaugurate the association on the eve of its first conference. He had heard the speeches of Dr. N. Nagana Goud and Dr. M. Krishna Rao and he had also travelled a great deal in the villages of the District as a Congress worker for the last six or seven years and he was convinced that the rural medical practi-

tioners have their own difficulties to cope with. But he might be excused for suggesting certain things in his own way as a Congressman. He wondered at the fact that everybody asked the Government not to cut short the emoluments received, to reduce the taxes and to introduce prohibition, compulsory primary education etc., and nobody came forward with any suggestion regarding the raising of any fresh taxes and indicating the sources of money required for the undertaking of the ameliorative measures. His advice to the doctors assembled would be that they should simplify their ways of living eschew all ideas of imitating the westerners in the matter of dress, food, habits etc., and thus they would be able to economise in their personal budget and would thus be able to meet the new situation created by the Government circular. He advised the practitioners to help the Government in rural reconstruction work being educated persons and by taking more interest in the welfare of the villages.

Then Sri. B. Ananthachari, B.A., B.L., M.L.A., addressed the gathering. He said that the enthusiasm displayed at the time of inauguration of associations as evidenced by group photos, refreshments and speeches by eminent persons gradually diminished and many associations died a premature death as the Indian children do. He wished that such a thing did not happen to this association. He was under the impression that doctors as a rule were well off and had no necessity to form an association to fight for the redress of the grievances and only the lawyers to which category the speaker belonged were subjected to the grievances such as overcrowding of the profession, no income etc., etc., but now he had to revise his impression and admit that doctors had also certain grievances. He wished the conference success and felt glad to be among their midst that day.

The following resolutions were then passed unanimously:—

1. Resolved that an association of the Subsidized Rural Medical Practitioners for Bellary District be formed.
2. Resolved to request the Madras Provincial Subsidized Rural Medical Practitioners' Association to affiliate this association to it.

3. The following office-bearers of the Bellary District Subsidized Rural Medical Practitioners' Association are unanimously elected:—

1. **President**:—Dr. M. Krishna Rau (Thambrahalli).
2. **Secretary**:—Dr. C. T. Krishnamurthi Rao (Narayanadevarakeri).
3. **Member of the Executive Committee**: Dr. K. V. Govindarajulu (Moka).
4. **Representative to the Provincial Committee of the P. S. R. M. Ps' Association**:—Dr. M. Krishna Rau.

After interesting discussion the following two resolutions were also passed unanimously:—

5. This conference expresses its inability to accept any of the alternative proposals made by the Government in the memorandum circulated to individual Subsidized Practitioners.

6. This conference requests the President, District Board, Bellary to represent the grievances of the Rural Medical Practitioners of this District and make suitable recommendations to the Government to redress the same.

After a vote of thanks moved by Dr. C. T. Krishnamoorthi Rao, the gathering had an enjoyable lunch party and then the conference was dissolved.

(The Subsidized Practitioners of the Bellary District are to be congratulated on their

achievement in organising the District Branch and availing themselves of the advice and guidance of popular leaders of the District one of whom being a person having direct control over the practitioners as the President, District Board. We trust the proceedings of the Conference will not escape the notice of the Government especially the address of Dr. R. Nagana Gond. It is hoped that the Subsidized Practitioners belonging to other districts will follow the lead of their comrades in Bellary District. Ed.)

3. SPECIAL CONFERENCE OF THE SUBSIDIZED PRACTITIONERS, GUNTUR DISTRICT, HELD ON 22-10-1938 UNDER THE PRESIDENSHIP OF SRI. KONDA VENKATAP-PIAH GARU, M.L.A.

Resolutions.

(a) This conference resolves that in reply to R. C. No. 270 Sup. of '33 dated 17-10-'38 of Guntur District Board, that a memorial by everyone of the subsidized rural medical practitioners of the District be submitted to the President, District Board, Guntur, and to the Government through the District Medical Officer, Guntur, or the Principal, Government School of Indian Medicine, Madras, as the case may be.

(b) This conference resolves that in response to the suggestion made by the President of the Provincial Rural Medical Practitioners Association, Madras, Mr. C. V. Subba Rao be elected to

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be a member of the body of the representatives chosen to appear before the authorities to discuss on matters relating to the grievances of the subsidized rural medical practitioners of the Province.

4. SPECIAL MEETING OF TINNEVELLY DISTRICT SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION UNDER THE PRESIDENSHIP OF DR. P. R. VENKATARAMA AIYER, RETD. CIVIL SURGEON.

The following reply from the subsidised practitioners to the District Board

regarding the Circular No. 2-87/37 dated 7th October, was unanimously approved.

"In giving a negative reply to the items 1, 2 and 3 mentioned in the Circular dated 7th October, 1938, we beg to submit that the existing difficulties under which the R.M.Ps' are labouring are not unknown and to be forced to work under the new scheme contemplated in the Circular under communication, will only augment our financial and social difficulties and entail serious hardship and jeopardise our position and interest in every respect. It is therefore our humble and fervent request that we may be allowed to work under the G. O. governing us at present."

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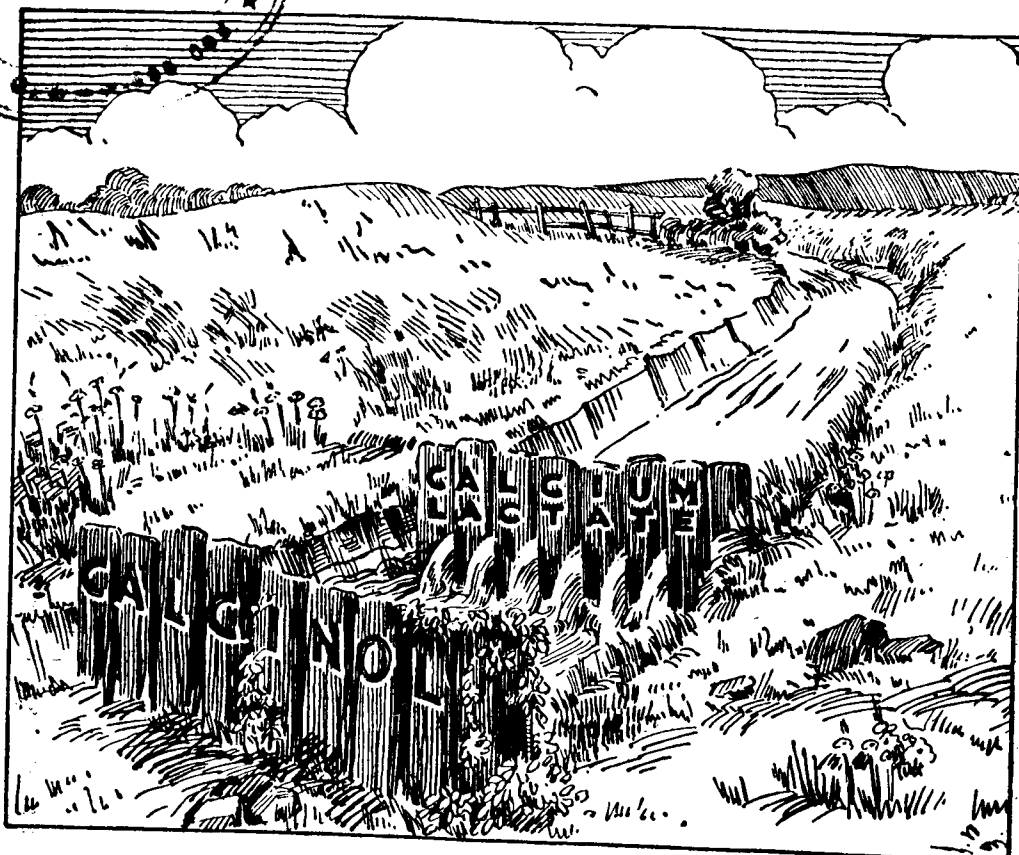
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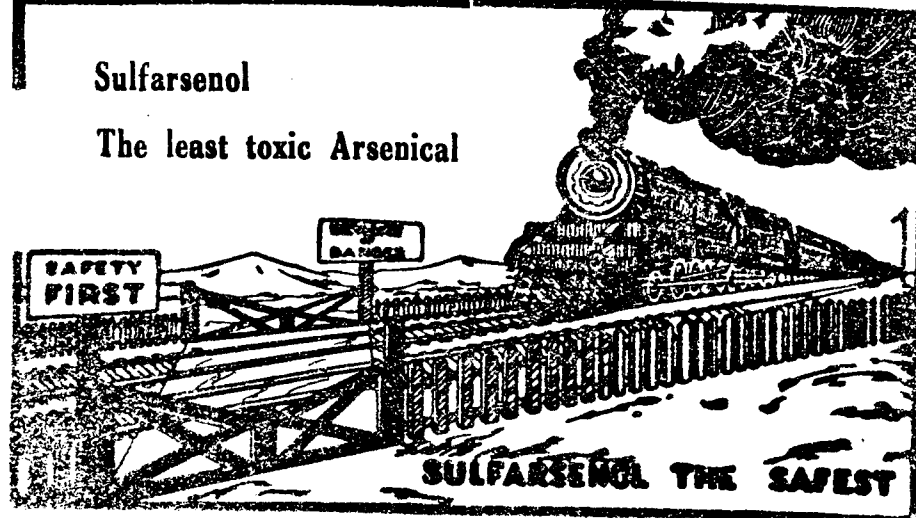
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Vol. X] NOVEMBER, 1938 [No. 2

Original Articles.

DYSENTERIES

By

DR. K. NARAYANAMURTHI, M.D.

AMOEBIASIS: DIAGNOSIS AND TREATMENT.

(Continued from the last issue).

DIAGNOSIS: In the tropics Amoebiasis is a grave disease which is often overlooked. In acute cases there is the possibility of recognising the condition but in chronic and insidious cases it is very difficult to diagnose the abscess of the liver. It is often possible for a man to have an enormous abscess of the liver without the history of his having suffered from dysentery. A second difficulty is the misrepresentation of a basal pneumonia a condition often accompanying hepatitis. The third will be the presence of fever which is often hectic and which is mistaken for malaria. Mistakes are often possible to diagnose abscess of liver from syphilitic disease of the liver softening to a gunmata which is often attended with fever, pyelephlebitis, suppurating hydatid, inflammation of the gall-bladder, subphrenic abscess due to ruptured gastric or duodenal ulcer, appendicular abscess of the abdominal or thoracic wall, pleurisy, encysted empyema, pyelitis of the right kidney, Bilharziasis, scurvy and similar blood diseases associated with the enlargement of the liver, ulcerative endo-

carditis, Kala Azar, undulant fever, tuberculosis and malignant disease.

Any of the above diseases are attended with a hectic type of temperature, increased area of hepatic dullness and pain in and about the liver. Cantic originally classified pus in the neighbourhood of the liver into (a) supra-hepatic abscess (b) intra-hepatic abscess (c) infra-hepatic or sub-hepatic abscess. Supra-hepatic abscess is not synonymous with that of sub-diaphragmatic abscess. By supra-hepatic abscess is meant the formation of the pus between the two layers of the broad ligament of the liver.

To arrive at a correct diagnosis repeated and careful study of the case in all its aspects is necessary. In the tropics we shall not be committing a mistake if we think hepatic abscess in all cases of progressive deterioration of health associated with hectic temperature pain in the hepatic area, and with or without a history of a recent attack of dysentery. In all obscure abdominal cases the blood should be



examined for leucocytosis. A low type of pneumonia of the right base may be regarded with suspicion; for it may mean an abscess of the subjacent liver. The existence of the cysts of *Entamoeba histolytica* in the stool is suggestive, but by no means be conclusive of an Amoebic abscess.

An X-ray examination may show an upward enlargement of the liver and the bulging of the right dome of the diaphragm which does not move with respiration. However if the abscess in the liver be situated in the middle of the liver substance and even if it grows to a considerable size no definite conclusion could be arrived at by radiography; possibly in such exceptions when the abscess becomes partially encysted the wall of the abscess becomes apparent to X-rays. Occasionally after aspiration there is accumulation of gas in the abscess cavity which is opaque to X-rays. In America Thorotrast an opaque preparation of thorium dioxide is injected intravenously. It is said to assist the diagnosis in outlining the abscess cavity. Thorotrast is a dangerous substance for such uses as there is no possibility of its being excreted out from the body. Frequently it is found also unnecessary to adopt such heroic measures for arriving at diagnosis. A blurring of the outline of the diaphragm occurs if an abscess is situated near the upper surface of the liver and in such cases the cardiophrenic angle becomes less acute approaching a right angle. This may give a valuable indication in the X-ray appearances of hepatic amoebiasis. In abscess of a long duration the margins of the cavity may become cretified and thus become opaque to the X-rays. The Bromo-sulphalin and other liver function tests as indicative of the hepatic disease and liver abscess are very disappointing. The most common error is to mistake the hectic fever of liver abscess to malaria. The daily occurrence of fever with chill or even rigors coming about the same hour with profuse sweating is likely to be mistaken for malaria. So common is the error that Osler said he hardly ever met with a case of Liver

abscess which had not been drenched with Quinine. This has been also the experience of several others working in the tropics. Medical men have made this mistake not only in their patients but in their own persons. The periodicity of the fever and the polymorpho-neucliar increase should often obviate such an error. To mistake other forms of suppuration for Liver abscess is not much of a serious import because in all suppurative conditions the treatment is the same as for the liver abscess and no bad result need be anticipated if diagnosis is not quite accurate.

Intrahepatic suppuration may occur in ascaris infection as the result of ascending pylephlebitis and as a metastatic phenomenon to diverticulitis; large abscesses have been reported secondary to duodenal ulceration. Cancer of the liver unaccompanied by jaundice may simulate Amoebic abscess and occasionally a suppurating gumma. A right perinephritic abscess is often mistaken for an abscess of the liver which was in one case opened by Manson-Bahr himself on the belief that the abscess was primarily hepatic in origin. Sub-diaphragmatic abscess is most commonly caused by perforation of gastric or duodenal ulcer. An abdominal swelling can usually be recognised in such perforated ulcers as the area occupied on the affected side will be triangular in shape. Gas in such cases is usually present and by percussion a note of resonance on the upper part of the swelling can be easily recognised to distinguish the latter condition from a liver abscess.

A serious error however is to overlook Splenomedullary Leucaemia, Kala-Azar, Pernicious anaemia or Scurvy and to proceed to aspirate an enlarged liver with the belief that the symptoms are due to an abscess.

Amoebic abscess of the liver which has burst through the diaphragm may have to be differentiated from the conditions like Broncho-Pneumonia, Tuberculosis, Actinomycosis and malignant diseases of the lung. In order to make

the diagnosis of the Liver abscess certain aspiration is the only method of choice left in our hands. When the needle enters the liver an up and down movement will be communicated to its exterior extremity corresponding with the rise and fall of the liver during respiration. If the needle does not exhibit this movement one can presume that the point is in the abscess cavity.

TREATMENT: In all those conditions not resulting in the formation of pus, Emetine is the drug of choice. Application of poultices, rest, low diet, mild saline purgatives and small doses of Emetine resolve an impending suppurative hepatitis. If there is much pain relief may be afforded by either wet or dry cupping over the liver or by the application of leeches. Amonium chloride in 20 gr. doses three times a day is usually prescribed. If rigors occur with local bulging associated with persistency of the fever active medication should be suspended and active measures are to be taken to locate the pus by means of the aspirator. When the physician uses the aspirator he should be prepared to repeat the process till all the pus is evacuated or under exceptional circumstances an operation might be necessary. Deep Novacaine anaesthesia usually suffices but in nervous subjects one should have recourse to general anaesthesia. If signs such as a tender spot, oedema, friction sounds, could all be localised an exploratory puncture at the spot indicated will be of great help. If none of those localising signs are present one has to insert the needle in the 8th and the 9th inter costal spaces in the anterior axillary line about 1 to 1½" from the costal margin below the limit of the pleura. This position must be borne in mind as in the majority of cases the Liver abscess is situated in the upper and back part of the right lobe of the liver.

The needle should be directed inwards and slightly upwards and backwards and if found necessary it can be thrust to 3 to 3½" depth. It is necessary in all cases to wash the exploring syringe with boiled water to obviate the mistake of the intrac-

ted blood and carbolic lotion in the syringe for the chocolate coloured pus. At least six punctures should be made before the attempt to find the pus is abandoned. Provided there is complete absence of breath sounds and resonance over the lower part of the right lung a puncture may be made anywhere below the line of the nipple and angle of the scapula or wherever the physical signs suggest. It is an established fact that some patients rapidly improve even when pus is not detected by exploration. "Hepatic Phlebotomy" as designated by Harley, that is, the removal from the liver of a few ounces of blood by an aspirating needle from the liver is a measure of proved value in hepatitis. With a certain amount of care, risk of hæmorrhage is small and this risk is certainly very much less than the risk in allowing hepatic abscess to remain unopened and undiscovered. Some surgeons prefer to put a short incision over the liver area and then explore through the abdominal or chest wall.

DRAINAGE BY ASPIRATION: As in a great majority of cases there will be a single or solitary abscess in the liver or the pus may be loculated, evacuation by means of Potain's apparatus is usually done. The death rate has been reduced almost to nil, the shock to the patient is almost negligible and several pints of pus can be evacuated by this method. Occasionally the pus reaccumulates in the abscess cavity when it should be again evacuated. The methods and use of Potain's aspirator is so simple that it can be used at the patient's house. The rate of recovery is remarkably rapid and if in a hospital the patient's stay is also equally short. After aspiration fresh serum may accumulate in the abscess cavity but the serum will gradually get itself absorbed. Sometimes it is possible to get effusion of serum into the pleural cavity immediately adjacent to the liver abscess.

In cases with cardiac or pulmonary embarrassment aspiration can be done under local infiltration of skin and muscles with 2 per cent Novacaine and 1 in 1000

Adrenalin in the proportion of 10 drops of the latter to an ounce of the former. The passage of the needle through the substance of the liver is painless. Should however the abscess point towards the abdominal cavity an open operation may become necessary under general anaesthesia. If the pus is viscid a complete evacuation of it takes an hour or more and in such a case one can inject a solution containing equal quantities of Eusol 50 per cent saline 50 per cent into the abscess cavity with the idea of making the pus less viscid. Should a continuous drainage is necessary a drainage tube may be transfixed with a safety pin inserted close to the skin of the abdomen and the superfluous tubing cut off. Cantlie, Rogers and others have modified their methods in various ways all with the object of a using flexible drainage tube so as to ensure efficient drainage without injury to the liver.

As an after-treatment to aspiration a thorough course of Emetine, Emetine Bismuth Iodide and Yatriin should be given in order to completely eradicate the infection from the bowel.

OPEN OPERATION: Transperitoneal route, transpleural route are the commonest ways to approach the liver abscess. The choice of the routes and the anaesthesia should be left to the surgeon. For any symptoms of hepatic insufficiency due to extensive destruction of liver tissue as indicated by the presence of diacetic acid or high ammonia coefficient in the urine, oral, rectal or intravenous methods of administration of glucose and sodium bicarbonate has to be carried out depending upon the urgency of symptoms. These drugs can be injected in 5 to 10 per cent solution. In Manson Bahr's experience 28 per cent of cases diagnosed as hepatic abscess resolved with Emetine therapy alone followed by Bismuth Emetine Iodide. In 47 per cent of cases aspiration combined with Emetine is successful. There still remains 25 per cent of cases in which open operation has to be resorted to and Emetine was found to be of no value. These are the cases where a large amount of pus is found

which is secondarily infected. It is not easily understandable why in spite of adopting rational treatment for dysentery there are found cases of Hepatic abscess.

In the case of abscess discharging pus through the lung where Emetine has been administered if things are not progressing favourably one has to resort to drainage of the abscess by surgical means. There are two possibilities which render surgical interference desirable:

(1) Continued discharge of pus and blood with or without temperature persisting and where in all probability without surgical interference the patient cannot be saved. Prolonged discharge might lead to extensive fibrosis of the lung or it might give rise to an abscess or pneumonia with attendant dangers such as thrombosis or abscess of the brain. In all cases of the abscess discharging pus through the lung, one should carefully record the fourth hourly temperature, daily amount and character of expectoration and once a week the weight of the patient. If the temperature persists and the pus is not diminished in quantity and if the patient continues to lose weight, the abscess should be drained from outside. Medical treatment with Emetine should be carried and almost miraculous effect sometimes may be noticeable.

(2) If the abscess ruptures into peritoneum or into the pleura or into the pericardium the particular serous cavity involved must at once be opened and treated on surgical lines. Otherwise the patient is sure to die within a very short time. In these circumstances the surgeon is justified to take all risks.

PROGNOSIS: The prognosis is good if the abscess is operated early. If there are multiple abscess with symptoms of uncontrollable dysentery or other serious complications the prognosis is bad. If there are more than 2 or 3 abscesses the prognosis is usually grave. The question of completely eradicating the infection of the bowel after the treatment of the liver abscess should be borne by the physician or otherwise there will be a recurrence of liver abscess even after a period of seven years or more.

AMOEBIIC ABSCESS OF THE BRAIN: Armitage recorded in Egypt 48 cases of Amoebic abscess of the brain. It is more common in men. It is generally solitary and may be regarded as a metastasis of hepatic abscess. During life it gives rise to several cerebral pressure symptoms and these cases are invariably fatal.

Amoebic abscess of the spleen and epididymis are reported to have occurred in China.

PRIMARY PULMONARY AMOEBIASIS: The type of case designated under this heading is not the one starting secondarily to the rupture of a hepatic abscess into the bronchus. In primary amoebiasis, the

amoebae reach the lung tissue by embolism direct from the gut wall. Having reached the pulmonary circulation they form nodules which later break down into small abscesses. These cases resemble closely broncho-pneumonia or some form of Tubercular infiltration. It is very difficult to diagnose accurately the primary amoebiasis. Radiography is of little avail in diagnosis in these cases. The Entamoebae have so far not been found in the sputum. But a distinct leucocytosis is seen. The response to Emetine or Ipecacuan treatment is rapid and is remarkable. A full course of Emetine injections are to be given in every case.

(To be continued.)

YAWS.*

By

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What induced me to write on this subject is its rarity in Southern India. Though I too had an occasion to see only two cases about five years back, I had an opportunity recently to investigate and treat a number of cases in a fairly big village in one of the Taluks of the Tinnevely District. During the course of a month in the village I came across 81 patients exhibiting all stages of the disease. Details of the same I shall give at the end of this paper.

Now coming to the subject proper, Yaws (Framboesia) is a specific disease infective in nature occurring in the Tropics. It is widespread and endemic in nature being caused by an organism of the Spirochaeta group called the Spirochaeta Pertenuae. The disease may also be stated as a specific infective granuloma as it looks like that. This spirochaeta is morphologically indistinguishable from

that of Spirochaeta pallida causing Syphilis. But both the spirochaetae are histologically different. Spirochaeta pertenuae is a thin motile organism measuring about 18—20 μ in length with about 15—20 small undulations. This organism is not as virulent as the spirochaeta pallida. It is believed that both the spirochaeta pertenuae and spirochaeta pallida undergo some functional mutation in some human host. The organism causing Yaws or Framboesia gains entrance through an abrasion, cut, insect-bite, wound or the site of an old ulcer or scar. This disease is neither congenital nor venereal though it resembles the latter. Some call this disease as Stoneage Syphilis. Yaws and Syphilis are said to be brother and sister but the former is easy for treatment unlike the latter.

Dirty houses, dirty habits and unhygienic surroundings are causes of this disease. In my experience in addition to the above causes people who deal

* Paper read before the Tinnevely Independent Medical Practitioners' Association.

with and consume rotten fish also get infected and it is more common in sea-coast villages and among fishermen. Infection may exceed 95% of population if care is not taken. The disease is essentially one of infants and young children but adults are not exempt. Both sexes are affected. The disease confers immunity against a second infection. The lesions that are mostly affected are the extremities and more so the lower part of the leg. Face too is at times affected. Scalp infection is very rare.

Like Syphilis this has also three stages *viz.*, Primary, Secondary and Tertiary.

The primary stage of Yaws is rare in adults and very common in infants and children. The primary sore occurring in this condition is always extragenital.

PRIMARY STAGE: The primary lesion differs decidedly from syphilis in its histological features. In this stage the disease occurs as a growing papule or granuloma about 2" in diameter generally at the site of inoculation or old skin lesion on the lower extremity. This may also occur in buttock, thigh, knee, arm, leg or breast but rare on the scalp. In women the breast, ante-cubital area and waist are more affected on account of the suckling of the child while the child is in her waist being held with her arm. The primary lesion may be so small as to escape notice. When this lesion gets larger it is covered with yellowish secretion or scab without any pain unless pressed firmly. This is called Mammalian or Mother Yaws. A month after the appearance of this lesion the Wassermann is generally positive. A child suffering from Yaws may infect its mother but not a syphilitic child. The lesion in this stage may not be sensitive even when touched with acid. The spirochaetae are found in the thickened epidermis.

SECONDARY STAGE: This stage begins four months after the primary stage. It is common between the age of 1 to 15

years. In this stage small or large, circular or oval papules attended with great itching appear about 20 to 200 in number all over the body in the course of a few days or weeks. These are called 'Daughter Yaws'. Corresponding to this there is painless enlargement of glands. These papules differ from that of Syphilis, but sometimes resemble it. They are common in the angles of the mouth, groin, anus and axilla. They affect mostly the face in clusters by the side of the nose and inside nostril. They rarely occur in muco-cutaneous junction of lips, eyes, etc., but the majority may appear on trunk and limbs. In moist surfaces such as axilla and anus they give the appearance of condylomata. These ulcers are covered with dry scabs which tend to coalesce in some places. When scabs or crusts are removed from them they form raspberry granuloma and exude yellowish serum which contains the spirochaeta. These ulcers look like small tumours having everted, overhanging rounded edges. Some of these undergo resolution and dry up after three months, forming patches of desquamation leaving discoloration of skin. The skin becomes harsh, dry and loses its natural gloss. This condition may last for years. The ulcers may remain at times without shrinking for several weeks. In this stage of the disease deformities in bones and joints and periosteal changes such as Sabre Tibia and Club fingers occur. The Wassermann is markedly positive in this stage.

TERTIARY STAGE: In this stage the tumours break down and ulcerate lasting for years. In certain cases ulceration extends deeper and circumferentially give rise to sores. These ulcers so much resemble Syphilitic ulcers that they cannot be differentiated at all from the latter. They occur to a great part in limbs, legs and ankles. Pitting in the palms of hands and scaly condition of palms occur and they persist for years. The condition known as Foot Yaws may last for a life time and the soles of the feet are pitted as in the case of palms. The soles of the feet have a worm-eaten appearance. Several corn-like things known as Crab

Yaws are seen in the soles of the feet which is slightly painful. Puffy tumours of the scalp and distortion of fingers occur. The Cerebro-spinal fluid is not involved and it is negative for Wassermann.

GANGOSA AND GONDOL: These are the two varieties of Yaws. Gangosa starts as an ulcer on soft palate. It is rare in adults but seen in children between 3 to 9 years of age.

Gondol occurs chiefly in childhood. In this symmetrical swellings about the size of a bean form at the side of the nose associated with sanguino-purulent discharge. This enlarges in the course of a few months to the size of an orange. This condition may last for six to eight months. Hard palate is affected and nose is more or less obstructed.

I have had no occasion during the one month of my investigation to see a single case of both the above varieties.

DIAGNOSIS: In the absence of facilities for Bacteriological and Microscopic examination clinical finding alone with their characteristic appearance of the ulcers should be relied on. In my short experience I had to depend mainly on clinical diagnosis.

LABORATORY DIAGNOSIS:—If the serum that exudes after scraping the margin of the lesion with a blunt blade of a scalpel and examined by the dark ground illumination under the microscope, the spirochaeta will be found. Or a thin film of the serum stained by Fontana's method if examined under a microscope will show the Spirochaeta Pertenuae.

CLINICAL DIAGNOSIS: Smaller or larger, circular or oval, painless, insensitive, encrusted, red, granulomatous ulcers accompanied with painless enlargement of glands occurring in an endemic area is characteristic of Yaws.

DIFFERENTIAL DIAGNOSIS:

YAWS.		SYPHILIS.	
Primary stage.	Not congenital. Sore. Never genital, always extragenital. Affection. Children more.	Primary stage.	Congenital. Sore. Genital always. Affection. Adults more.
Secondary stage.	Itching. severe. Mucous membrane is not affected. Alopecia. No. Rapid profuse growth of hair in hairy areas after healing. Eyes Not affected.	Secondary stage.	Itching. Rare. Mucous membrane affected. Alopecia. Common.
Tertiary stage.	Visceral lesions—Not affected. Nervous system—Not affected. C. S. F.—Negative for Wassermann. Blood vessels—No endothelial proliferation. Constitution, resistance and vitality—Not affected. Never yields to treatment by Mercury. Easy for treatment.	Tertiary stage.	Visceral lesions—Affected such as Gumma of Liver, Kidney etc. Nervous system—Affected Genl. Paralysis of Insane. C. S. F.—Positive for Wassermann. Blood vessels—Endarteritis Obliterans. Constitution, resistance and vitality—Much affected. Yields to treatment by Mercury. Difficult for treatment.

TREATMENT: Treatment by preparations of Arsenic and Bismuth has an undoubted effect in producing a cure. Neosalvarsan, Novarsenobillon, Neoarsphenamine are, and the Sulfarsenol preparations of Arsenic generally used.

Neosalvarsan given weekly by intravenous injection.

For adults—0.6 - 0.9 grm. will be required for a cure beginning from 0.3 grm.

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Tertiary stage.	Visceral lesions—Not affected. Nervous system—Not affected. C. S. F.—Negative for Wassermann. Blood vessels—No endothelial proliferation. Constitution, resistance and vitality—Not affected. Never yields to treatment by Mercury. Easy for treatment.	Tertiary stage.	Visceral lesions—Affected such as Gumma of Liver, Kidney etc. Nervous system—Affected Genl. Paralysis of Insane. C. S. F.—Positive for Wassermann. Blood vessels—Endarteritis Obliterans. Constitution, resistance and vitality—Much affected. Yields to treatment by Mercury. Difficult for treatment.

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Neosalvarsan given weekly by intravenous injection.

For adults—0.6 - 0.9 grm. will be required for a cure beginning from 0.3 grm.

For children up to ten years—0.3 gm. is required for a case beginning from 0.15 gm.

Children under 2 years—0.1 gm. is required.

For children and for those in whom it is difficult to find out the vein, Solusalvarsan (Bayer) or Sulfarsenol (A. F. D.) in doses according to the age is given intramuscularly every week.

In the early stage the cure is effected on an average in 15 to 18 days. Novarsenobillon and Neoarsphenamine are also used in the same manner and in the same doses of Neosalvarsan.

It is said that Sodium Tetra Bismuth Tartarate is very useful in the Secondary and Tertiary stages of Yaws.

Intramuscular injections of Bismuth preparations every week or 4th day such as Bismostab (Boots), Casbis (Bayer), Bivatol (A. F. D.) and Benzobismuth (A. F. D.) are used in conjunction with Arsenic treatment or alone. But a combined treatment always produces an earlier cure. Bismostab is used in doses of 0.3 gm. up to 6 gm. Casbis is used in doses of 0.5cc. to 1cc. up to 12 to 15cc. Bivatol is used in doses of 1 to 2cc. up to 16 to 20cc.

FOR MASS TREATMENT AND FOR CHILDREN: Stovorsol (May & Baker) and

Spirocid (Bayer) are used. The former is costly but not the latter. The treatment is given orally.

STOVARSOL: Given before food on alternate days. For adults 1 gm. daily increasing by 0.5 gm. for a week. For children daily 0.5 to 1 gm. for five days.

SPIROCID: Available in 0.25 gm. tablets. Adults may be given 2 to 3 tablets daily for three days on an empty stomach with an interval of three days. This is continued till 15 grms. are consumed. By that time the condition gets better. For children for every 20 lb. body weight 2.5 gm. is required. This is given powdered in milk or water in doses of 2 grains per day for three days. A pause of 3 days is allowed and then treatment continued for 3 days and rest allowed for 3 days and so on.

For ulcers and crab yaws external application of a 2 per cent ointment of Tartar Emetic is useful.

In my short experience both Stovarsol and Spirocid produce good results. The former is quick in action whereas the latter takes some time to produce a cure.

It has been stated that oral treatment by Castallani's mixture consisting of Tartar Emetic 1 grain, Pot. Iodide 1 dr. Soda Salicylas 10 grains, Soda Bicarb. 15 grains Aqua to 1 oz given once a day produces excellent results.

STATISTICS SHOWING THE NUMBER OF CASES SEEN.

Primary stage	... 36	Males, children & adults	... 50
Secondary stage	... 28	Females	... 31
Tertiary stage	... 17		
Total	... 81	Total	... 81

Below 12 years of age.	Between 12 to 25 years.	Over 25 years.	Total all ages.
49.	23.	9.	81.

Areas affected.	No.	Percentage.
Scalp	1	1.25
Forehead and face	3	3.5
Chin	2	2.5
Neck	2	2.5
Axilla	3	3.5
Trunk	5	6.250
Arm and Forearm	9	11.25
Palm	1	1.25
Buttock	2	2.5
Thigh	5	6.25
Knee	3	3.75
Leg	19	23.5
Foot and Toe	20	25.0
Sole of feet	6	7.0
Total ...	81	100.0

THE FORENSIC DIAGNOSIS OF DEATH BY DROWNING.

By

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(Asst. to the Professor of Forensic Medicine, Madras Medical College.)

Of late Forensic Medicine has come to be of growing importance and interest to all medical men, in Government service whether honorary or paid, since from last year the latter has also been allowed to take up medico-legal work. Hence, I have ventured to write a few lines on the subject of drowning with the hope that the views expressed by me may be of use to the readers. I have chosen the subject of drowning, since that is the most common form of unnatural death of forensic importance. The essential post-mortem appearances which would enable one to arrive at a conclusion, whether death was due to drowning or not, will be described.

EXTERNAL APPEARANCES.

1. The features are usually described to be pale. This cannot often be made out in India especially when the individuals are of a dark complexion. The pupils are usually dilated, with subconjunctival haemorrhages in some cases, and the nails may be blue (signs of asphyxia).

2. The presence of a fine white or occasionally blood-tinged foam, or froth

at mouth or nostrils is a valuable sign indicative of death due to drowning. If it is not present, it may be made to appear by pressure on the chest. With the onset of advancing decomposition it disappears. The foam is due to the churning together of blood, air, mucus and water, during the violent efforts at respiration made by the individual on immersion into the water.

3. *Cutis anserina* or goose skin is the name applied to a puckered appearance of the skin, imparting a rough feel to sensitive hand; the papillae of the skin are seen to stand out, above the ordinary level of the skin. This is due to the involuntary contraction of the arrectores pili muscles, and that could occur only if the body is immersed in water during life, or immediately after life is extinct, when the molecular death of the tissues has not yet taken place. This condition has been observed in a large percentage of cases occurring in Madras, though it is considered by some that the water in the tropics is not sufficiently cold to produce this condition.

4. Washerman's hands and feet: This is ascribed to the sudden, wrinkled

and pale cuticle of the hands and feet. It is seen on the hands or feet of any person, after prolonged immersion in water. The occupation of the washerman being one which necessitates prolonged immersion of hands and feet in water, this appearance is usually found in him and hence the name. As this is caused only by the action of the water on the thickened epidermis, this could be found even if the body was immersed in water after death. This only indicates that the body has been submerged in water.

5. The presence of objects as weed, grass etc., firmly clasped in the hands, due to the onset of cadaveric spasm is a valuable sign indicative of death by drowning.

INTERNAL APPEARANCES.

1. Heart: The appearances are varied. More often all chambers are distended with dark watery fluid blood. The watery condition of the blood is very noticeable.

2. Lungs are greatly distended ballooned and completely cover the heart. They are inelastic and pit on pressure on the surface with a finger. They are usually congested and water logged. On section lot of watery frothy, sanguinous fluid drains out.

The presence of foreign bodies such as sand, mud or tank moss etc., in the bronchi would be a positive evidence of drowning, and is looked for by opening the larger bronchi with scissors, and running the finger along the mucous surface of the bronchi. The presence of froth in this situation also is a conclusive evidence. The other conditions in which froth is found here being oedema of lungs from clinical causes and opium poisoning. In opium poisoning the contracted pupils will help in the diagnosis and in oedema of lungs there will be other evidence of disease, such as diseased heart etc.

3. The presence of water in the stomach. This is due to the swallowing of water during the efforts at respiration. The water has same characteristics (same colour, presence of mud, sand, tank moss or other vegetable or animal material) as the medium in which drowning has taken

place. This is a conclusive evidence of drowning, since water cannot enter the stomach after death. Water may of course be present in the stomach due to the person having drunk a large quantity of water just before death. But muddy water or one mixed with clay tank moss etc., no individual would have drunk voluntarily. With advancing decomposition any water present in the stomach would be driven out by the increasing pressure of the gases due to putrefaction and hence no water would be found in the stomach.

4. The other organs, liver, kidneys and brain usually show a varying degree of congestion. There will be food material in the air passages. When the stomach is full, vomiting is set up during the efforts at respiration and the vomited material aspirated.

In this presidency many of the cases are in a state of advanced decomposition by the time they are brought to the medical man, when most of the above signs may be absent. In such cases, the only appearance which if present, would warrant one to conclude that death was due to drowning is the presence of foreign bodies such as sand, mud, tank moss etc., in the air passages, larynx, trachea and bronchi.

SUMMARY: The internal and external appearances found in a case of death by drowning are described. The points which would warrant a definite opinion of drowning are:—

1. The presence of fine foam or froth and foreign bodies such as sand, mud, weeds, tank moss etc in larynx, trachea and bronchi.

2. The presence of water in the stomach.

3. The presence of weeds or other things floating in water found grasped in the hands.

4. The presence of regurgitant food material in air passages in cases when the stomach was full at the time of immersion. This indicates that the person was alive at the time of immersion.

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Abstracts.

WHY THE HIGH MORTALITY IN DIABETIC COMA?*

By

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Cincinnati, Ohio.

The mortality of diabetic coma is undoubtedly high. Even with the introduction of insulin and after its use for fifteen years in the treatment of this condition, there still exists a mortality of around 50 per cent among the type of coma patients admitted to general hospitals. In a study of patients admitted to the Cincinnati General Hospital with diabetic coma during the years 1922 to 1926, we have found a mortality rate of 47 per cent, and with patients admitted during the years 1932 to 1938 a mortality of 57.9 per cent. Among the more important causes for this high mortality rate, delayed admission to the hospital takes first rank. As the acidosis is prolonged without adequate treatment, and as the mental condition of the patient becomes one of unconsciousness, the mortality sharply increases. Patients in coma over twelve hours before adequate treatment is begun *seldom recover*, while those in coma less than twelve hours when admitted *seldom die*.

We have carefully studied the records of cases admitted to the Cincinnati General Hospital during 1932-1938 with a diagnosis of diabetic acidosis and coma. The standard for selection of coma cases for this study was a CO_2 -combining power of 20 volumes per cent or less. A total of 57 cases met this requirement, with a mortality of 57.9 per cent. The onset of acidosis was taken at the time of vomiting and drowsiness which continued. Three cases were from the pediatric service while the others were

adults from the medical and surgical services.

The most important factor which we have found to be associated with high mortality from coma is the duration of the acidosis before active treatment is instituted. We found that only two cases who had been in acidosis over twelve hours recovered, and that none died who had been in coma less than twelve hours before admission. With the progression of acidosis, the mental status of the patient changes rapidly. We have taken as a conscious patient one who could answer questions and take fluids by mouth. The semi-conscious group were those who responded to deep peripheral stimulation but could not answer questions or take fluids by mouth. The unconscious were those who did not respond to any stimulation. Of the 57 cases, 32 were completely unconscious on admission, their average number of hours in coma before admission was 14.7, with a mortality of 81.2 per cent. The average number of hours for the existence of acidosis in the semi-conscious group of 20 was 11.4, and the mortality rate 30 per cent. The conscious group of 5 had been in acidosis for an average of 6.5 hours and showed a mortality of 20 per cent. In the whole 57 cases studied the average number of hours of acidosis before admission was 12.9.

The average age of the patients was 33.7 years. The oldest was 65 and the youngest 19 months. The age of the oldest case to recover was 58 years and that of the youngest 4 years. There seemed to be a great difference in coma mortality depending on the age of the

* Read at a meeting of The Academy of Medicine of Cincinnati, May 10, 1938.

From the Diabetic Clinic and Department of Medicine, University of Cincinnati and the Cincinnati General Hospital.

patients admitted. Fewer young patients died, although there were a number who had been in coma 12 hours on admission, and here was found also the only ones who survived after a pre-admission coma of more than 12 hours (14 and 18 hours). The mortality rose toward middle age, but after age 40 it became uniformly high. After this age all 12-hour cases died. Of the total 57 coma patients admitted, 18 were below 25 years of age, with an average duration of coma before admission of 12.3 hours and a fatality rate of 22.2 per cent; 14 were from 25 to 40 years of age, with an average coma duration of 12.5 hours and fatality of 50 per cent. Of the 25 patients 40 years or more of age, with an average pre-admission coma duration of 14 hours, 88 per cent died. Of the total 21 cases in coma only 12 hours before admission, there were 12 under 40 years of age with only 3 deaths, while all of the 9 in the older group died. These findings clearly show that, although diabetes may be mild in patients above 40 years, coma is for them extremely dangerous.

Of the cases studied, there were 18 males and 40 females. Several years ago it was thought that males were more predisposed to diabetes than females, but in recent years the reverse has been shown to be true. Attending our outpatient diabetic clinic in 1937 were 124 males and 213 females, or a slightly higher proportion of females than in the coma group. Among colored patients the proportion of females is very much higher. Thus of the 337 diabetics attending the clinic in 1937, there were 92 white males and 126 white females—a ratio of 1:1.37. But there were only 32 colored males to 87 colored females—a ratio of 2:72, or more than double that for white diabetics.

There were 29 colored and 28 white patients. In the general outpatient dispensary and diabetic clinic for ambulatory cases, white patients outnumber the colored two to one, while here with diabetic coma admissions there are more colored than white. Whether this represents a greater severity of the disease among the

colored, or only greater neglect in handling, cannot be said. It is of interest, however, to note the greater severity of the disease in northern colored reported by Mills, who found the diabetes death rate actually higher among colored than white in the North.

All of the patients in our series received the generally accepted methods of treatment. Each being an individual problem, the treatment varied to a certain degree. Large and frequent doses of insulin were always used. Large quantities of fluids, normal saline solution by infusion, or intravenously, or water by mouth when possible, have been a routine part of the treatment. Glucose and alkalis intravenously have been used in some cases. The general treatment of the patient included stimulants, attention to the gastrointestinal tract and external heat as indicated by individual needs. However, the trend of the treatment has not varied greatly and has been quite similar to that used in general among other clinics. A critical study of our case records fails to reveal any treatment variation that might account for the mortality difference here described.

The treatment of diabetic coma before the advent of insulin was most limited and the mortality extremely high. With insulin the results from treatment instituted in the *early stages* of coma are good and the mortality low. However, the mortality in large city hospitals is still too high. Joslin made the statement that the "conquest of coma is in sight," reporting a mortality of 11.9 per cent among a group of private hospital type of patients who had been, or were, under his supervision. Many of these had received early treatment before their admission to the hospital. Dillon reported the results of a study of the mortality of diabetic coma at the Philadelphia General Hospital. This mortality was 43.7 per cent.

A very important cause for the high mortality of diabetic coma at the Cincinnati General Hospital is shown to be delay in hospitalization. The long lag

between onset of symptoms and institution of treatment, with the appearance of unconsciousness, makes treatment much more difficult and less hopeful. There may be various reasons for this delay. There are patients who pay little attention to the instructions given them for living as diabetics. When acidosis occurs, they do not become concerned until it is well advanced, and then they are frequently unable to help themselves. By the time diagnosis is made and transfer to the hospital is accomplished a state of unconsciousness may have occurred and the chances for recovery become very limited. Other situations occur in which the patient, not knowing the facts of diabetes, may develop acidosis and go into coma before anything is done. This group consists of those who have not known they had diabetes, or knowing it, had not received sufficient instruction. Still another group is composed of those in whom the symptoms may simulate other conditions, leading to failure of early diagnosis and treatment. In this way semi-consciousness or complete coma may occur before the definite diagnosis is made.

Certain fundamentally important facts stand out in the statistics we here present. Of primary importance is the fact that after fifteen years of insulin use by the medical profession, the mortality from diabetic coma in general hospitals is still around 50 per cent. Practically no advance seems to have been made since the early days of insulin in the handling of coma. Great advance has, it is true, been made in the treatment of *early acidosis* and the *prevention* of coma. But, once coma has developed, it still carries a very high fatality rate. Particularly among elderly diabetics does it become almost uniformly fatal.

Coma of over twelve hours duration, with unconsciousness, carried an 81.2 per cent fatality rate in our series. Even with the patients who were conscious on admission, but with a blood CO_2 -combining power of less than 20 volumes per cent for an average duration of 6.5 hours, a 20 per cent fatality rate was found.

These facts provide sharp emphasis for the seriousness of diabetic acidosis and the vital importance of early treatment. All but two admitted after being in coma over twelve hours died, while of those brought for proper treatment before twelve hours had passed *none succumbed*. What stronger argument could there be for more prompt hospitalization of these unfortunate individuals?

In the past few years the medical profession has come to realize the marked lowering of fatality rate that comes in acute appendicitis when cases are promptly hospitalized and operated. Even more striking would be the reduction in diabetic coma mortality with early institution of proper handling. We do not yet know why death seems so prone to follow coma duration of over twelve hours. So far the only hope of life saving seems to be either coma prevention or early institution of adequate treatment. The 50 per cent fatality rate in a condition that is wholly preventable is surely a sad commentary on prevailing medical care for this class of patients. Even though patient negligence may often be to blame, it remains the duty of the medical profession to take active measures to lessen this loss of life.

Education of every patient by his physician is one of the most important factors in the attempt, not only to prevent the occurrence of acidosis and coma, but to be able to start early treatment when coma does occur. It is necessary that the patient be taught how to take a certain diet and how to administer insulin properly, its dosage and the facts concerning insulin reaction, how to examine the urine and to keep a record of the four daily examinations. These are the routine points of instruction to every patient. But this is not enough. It is also important that the patient be taught what acidosis is, why it occurs and the danger of its presence. He must be taught the symptoms of acidosis in order that immediate recognition can be made and early treatment instituted. There are also minor points concerning daily hygiene, the care of the feet and skin

and other facts which the patient must know.

The elderly diabetic needs unusual care in the matter of education. In most of them the disease is mild, but when acidosis occurs the mortality is high. So often little attention is paid to this group of patients as to teaching them the necessary facts about their disease, because it is mild. They are the ones who have frequent low grade complications, especially of the feet, and yet go rapidly into acidosis and coma when the infection becomes a fast spreading one. The younger diabetic presents a more difficult control problem because his disease is more severe, but, for the same reason, is given more attention and more education. It would seem, however, that the elderly patient, because of the greater dangers of acidosis, should have fully as detailed education as is found necessary for the younger ones.

The early diagnosis of acidosis by the physician is a vital necessity. Every hour of delay in treatment lessens the chance the patient has for recovery, and brings a rapid rise in the mortality rate. Whenever a private physician sees a patient presenting subnormal temperature, persistent nausea and vomiting, slight drowsiness, indefinite muscular pains, more or less definite abdominal pains and few if any physical findings to account for this, a suspicion of diabetic acidosis should immediately come to his mind. The suspicion of mild acidosis can easily be decided by examination of a specimen of urine for sugar and ketone bodies. This

should be done at once. So often this is delayed until the next visit when the patient is still deeper in acidosis, with slow deep respirations marked drowsiness even to semiconsciousness, and with a sweet odor to the breath. This picture of severe acidosis now presents a serious situation. There has been a change from a condition in which early treatment is effective and the mortality low, to one in which treatment is much less effective and the mortality very high.

Early diagnosis being so important, and yet often so difficult when the patient is seen for the first time in the home, might it not be wise to advise immediate hospitalization in all suspected cases at the first suggestion of impending coma? Frequent determinations of the blood sugar and CO_2 -combining power could then be made and proper treatment immediately instituted. Non-diabetic cases would certainly not be harmed by such prompt hospitalization, while for those found to be drifting deeper into diabetic acidosis, it would be a life saving measure.

We believe that the mortality of diabetic coma, which is now above 50 per cent, can be reduced by thorough education of the patient. The mortality can be further reduced by careful attention of the physician towards early diagnosis and immediate hospitalization so that early and adequate treatment can be given. This mortality rate can be reduced, not only at the Cincinnati General Hospital, but wherever diabetic coma exists.

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PSYCHOTHERAPY IN GYNECOLOGY AND OBSTETRICS.

The role of psychogenic factors in functional disorders is now widely recognized. Such symptoms as leukorrhea, dyspareunia and frigidity (often associated), vaginismus, dysmenorrhea, hyperemesis gravidarum, pseudocyesis, and even amenorrhea and menorrhagia, often have their origin in psychopathologic states. Disturbances in puberty and in the menopause bear a distinct psychopathic stigma. Far too frequently women undergo radical operation for relief of symptoms without obtaining improvement. Sixty per cent of a group of clinic patients studied by Johnson were not improved after various pelvic operations. Of these women 76 per cent subsequently had pain in the lower part of the abdomen, 34 per cent had a sense of weight in the pelvis and backache, 24 per cent had menstrual disturbances, and 52 per cent had chronic endocervicitis. Johnson considers them to be "inadequate individuals," 50 per cent having family histories of nervous disorders or insanity, 32 per cent a history of tuberculosis and 14 per cent a history of thyroid dysfunction; 84 per cent had been pregnant with an average of three pregnancies, and less than 24 per cent had had more than a grade school education. Economic and social disturbances, malnourishment, the fear of repeated pregnancies, and marital discord were important factors in causing the symptoms of these fifty women.

The difficulty of proving such symptoms to be of psychic origin by experimental means was brought out by Horney. Dysmenorrhea, for example, may not be the result of a single emotional strain or conflict but of a series of them, perhaps spaced over several years. The logical approach to a successful solution of the problem is a historical one. A careful, sympathetic elicitation of the woman's emotional and psycho-

logic biography may often reveal the connection between such conflicts and her present complaints.

Mayer believes that pelvic symptoms are exaggerated more readily than others because many emotional conflicts of woman resulting from personal and social restrictions, besides the normal processes of menstruation, defloration and childbirth (all associated with pain and bleeding), centre attention on the genital zone and predispose to undue anxiety in connection with local symptoms. The functional cycles are under endocrine control, which is influenced by changes in the sympathetic nervous apparatus, increasing the vulnerability. Acute or chronic psychologic influences, such as fear of frustrated hopes, are associated not only with symptoms but with organic change. Amenorrhea may be a symptom of mental disorders of wide range. Irregular or excessive bleeding may have a psychopathic basis, although here diagnostic curettage should precede the drawing of such a conclusion. Prolonged mental treatment may be needed in dysmenorrhea, in which psychogenic factors are responsible or at least contributory. Certainly expert psychotherapy is indicated before radical operative intervention is attempted. Dyspareunia is usually psychogenic in origin; after the patient's confidence has been secured, psychotherapy in addition to local treatment often accomplishes brilliant results. Pruritus vulvae and leukorrhea respond to psychotherapy when there are mental contributory factors. Often the chief symptom is found to be one of many symptoms appearing in sequence or in groups. To the patient they are "useful" symptoms, defending her against whatever is threatening her, even though she is not cognizant of this. Other gynecologic problems have psychologic factors which require insight and careful handling, such as in the field of contraception, the treatment of sterility, the prevention of cancerophobia and the treatment of endocrinologic and congenital gynecologic abnormalities.

When the determined organic changes fail to explain a gynecologic complaint,

the physician must consider the possibility of a psychogenic cause which may be accessible to himself or to one more expert in psychologic methods. Some objections have been raised as to the propriety of the administration of psychotherapy by one who is treating organic ills as well, but in the great majority of cases no ground for such objection exists. Most of these patients do not require formal psychoanalysis but perhaps only simple suggestive treatment, which is best received from their own physician. What is obviously required is the gaining of the patient's complete confidence, an intelligent psychanamnesis, the removal of anxiety where possible, assistance in the acceptance of reality, instead of a retreat from it, perhaps a change of environment, a building up of the general resistance, local treatment with its suggestive potency, and the judicious use of sedatives, with recourse to a psychoanalyst familiar with these problems when necessary.—

(*Jour. A. M. A.* 1937).

1. SULFANILAMIDE IN TRACHOMA.

The scope and usefulness of sulfanilamide are constantly broadening. Recently Lian treated 32 patients afflicted with trachoma with sulfanilamide and obtained very satisfactory results. The "conjunctivitis and corneal complications responded especially well, while photophobia and continuous lacrimation were greatly lessened." Pannus, keratitis and corneal ulcer were all "favorably influenced" and once counteracted they "rarely recurred." It is obvious that no single drug will cure a disease like trachoma because of the varied complicating factors. For these, however, the treatment is more or less established. With sulfanilamide as an aid the value of the usual methods is greatly enhanced.

While trachoma has been largely stamped out in those quarters where it formerly existed on a wide scale, there are still epidemics of the disease which have to be combatted. The present study is of special interest since it may afford a reassuring remedy for a stub-

born, menacing infection. It is hoped that ophthalmic specialists who practise in places where trachoma is prevalent will give the new drug a thorough trial. One must be open-minded in passing upon the therapeutic possibilities of sulfanilamide. It is not far-fetched to believe that it may eventually be shown to have as wide a use in ophthalmology as in other specialties.

2. HEADACHES OF NASAL ORIGIN.

Of all the conditions which the rhinologist is called upon to diagnose and treat, headache is probably the most difficult. The causes of true headache are so varied that obvious factors are frequently overlooked. The general practitioner is now more alert than ever in differentiating the local and systemic etiology. When the rhinologist is asked to assist in arriving at some conclusion, the problem is by no means simplified.

Headaches of nasal origin are classified by Burgess as follows: (1) Those associated with suppurative sinus infection; (2) those associated with nonsuppurative or hyperplastic sinuses; those without any involvement of the sinuses. The latter group may be further subdivided into vacuum headaches, and the neuralgias. It is doubtful whether this classification is sufficiently comprehensive to include every possibility in this connection.

The so-called Sluder syndrome must be considered in any rhinologic discussion of headache. In this syndrome the sphenopalatine ganglion is involved. Therapeutically, cocaine applied to this region will relieve the symptoms. The older therapy of injecting the ganglion is now only occasionally employed.

The possibility of more than one cause of headache must constantly be borne in mind. This is especially true of persistent headache. One writer states that the causes which should be entertained are: (a) allergy, (b) psychologic and neurologic conditions, (c) endocrine imbalances, and (d) focal infection. When any of these causes coexist with sinus

disease, diagnostic difficulties are increased.

The association of coexistence of migraine with sinus headache has been encountered. Here, too, the problem of an absolute diagnosis is baffling. One must be able to exclude the existence of migraine by the four cardinal components of the syndrome: recurrent headache more or less hemicranial in type, associated visual symptoms, classically scintillating scotomas, temporary gastrointestinal phenomena, usually nausea or vomiting, and hereditary migraine diatheses, occasionally an epileptic history. When these symptoms are present in addition to definite nasal or sinus disease, both affections must be treated. Relief of one may lessen discomfort but symptoms of the untreated condition will persist. The error is occasionally made of emphasizing the presence of the most obvious symptom without due regard for the other.

When the rhinologist is the first to be consulted for relief of headache, even though nasal or sinus pathology is observed, a general physical examination should be advised. Rhinologic causes of headache do not exclude the influence of systemic factors. Just as two local causes may coexist, so too, local and systemic factors may be intermixed. In every instance when suspicion of some bodily ailment suggests itself, the co-operation of the internist is essential and to the best interests of all concerned.

The problem of headache is one with which the rhinologist is almost daily brought into contact. It behooves him to have a broad comprehension of the situation, to study every phase and to consider every potentiality. The rhinologist must not assume the responsibility by himself if the case is serious. As

already stated, co-operation should be sought from the borderline specialties. An exhaustive laboratory and clinical analysis will in most instances throw much light on the subject at hand.

3. COMPLICATED CORNEAL ULCER.

When a corneal ulcer complicates a case of purulent conjunctivitis or trachoma the lids should be painted with silver nitrate even during the progressive stage. But in trachoma the use of the copper stick should be temporarily abandoned, owing to the irritative effect of copper on the cornea.

4. IRITIS

Many patients are so hypersensitive to atropin that it is impractical to administer this drug. In such cases hyoscine, scopolamine, or duboisine can be substituted and dionin given in conjunction.

5. MYDRIASIS.

A very powerful mydriatic effect is obtained by the subconjunctival injection of five drops of mydrician, which is a mixture of atropine, cocaine, and suprenin.

6. VASCULAR STIMULATION

One very efficient drug which, being a derivative of opium, has marked sedative, analgesic effect, and at the same time acts as a powerful vasodilator and glandular stimulant, is dionin, in 2 to 5 per cent dilution. For the first twenty-four to forty-eight hours it produces intense hyperemia and smarting, but this passes off and does not recur as tolerance is established.

(1, 2, 3, 4, 5 and 6 are extracts from "The Eye, Ear, Nose and Throat Monthly" October, 1938.)

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[No. 2

NURSING SERVICE IN MADRAS.

It looks as if the Hon'ble Dr. T. S. S. Rajan, the Public Health Minister of the Government of Madras has an insatiable desire to introduce reforms in all the departments under his control. As we are concerned with only the medical profession we have been discussing in these columns about his activities relating to the medical profession only. Soon after Dr. Rajan took charge of his office the Madras Provincial Medical Service underwent reorganisation. So did the Honorary Medical Service. He introduced a uniform standard of University Medical Education and abolished the medical schools in the province. Substituting honoraries in the place of stipendiary medical officers is being gradually worked up. Another latest innovation he has announced was relating to Nursing Service. We wish to mention one more subject which has been engaging the attention of Dr. Rajan perhaps from the very moment he assumed office and that is, the introduction of a legislative measure relating to Public Health. An all comprising Bill relating to this subject is now on the anvil of the Legislative Assembly. Though the details of reforms introduced by Dr. Rajan so far may be faulty here and there and even inconsistent with the very principles of his own reforms, the medical profession and the public must admire Dr. Rajan for his courage in tackling questions which involve serious responsibilities on the State, the public and the medical profession. Dr. Rajan's predecessors were either nervous or callous to handle these subjects satisfactory solutions for which were long overdue. Nursing forms the most important part of the treatment of sick patients and

adequate nursing service is as complicated and knotty a subject as the Medical Service itself in all its aspects. The fact that the Nursing Profession is controlled entirely by the Government as is the Medical Profession, has made matters of the former profession more complicated as was evidenced at a meeting of the European and the Anglo-Indian communities which was held in Madras on 16.11.38 to protest against the Government scheme of reorganising the Nursing Service. The Government was charged with the most uncharitable motives regarding their intention for effecting changes in the Nursing Service. One of the speakers went to the extent of expressing that the reorganisation of nursing service was a device on the part of the Government to solve "Social-injustice" by helping the widows of a particular community. Though nothing is mentioned in the preamble of the Government communique on this subject as to the immediate causes that led the Government to have recourse to the training of male nurses and reducing the scale of pay and other emoluments which the nurses were so far enjoying, we presume that it is the intention of the Government to increase the nursing staff in state hospitals and proportionately reduce the unskilled nursing service now rendered by uneducated nursing orderlies and ward boys. The existing financial condition of the Government would not perhaps permit the Government to increase the nursing staff to the requirements of the scientific treatment of diseases in state hospitals. When it is known that in the Madras Government General Hospital, the only ideal institution worked by the Government there is one nurse for 14 patients one could conceive the state of nursing service in the Government hos-

pitals especially in the mofussil. It was possible for the Government in the past not to mind the comforts of the mass population resorting to hospital treatment even in the City hospitals. Times are changed and the Government cannot be deaf to the complaints of inadequate nursing nor could they afford to make invidious distinctions in the treatment of sick irrespective of their status or the community to which they belong. It is possible for a woman past 50 to be motherly to all and for the patients of the other sex of whatever age to treat her as a mother but taking the society as what it is, it will be to the best interests of the nurses as well as the patients to train male nurses to look after male patients, special attention being paid to the necessity of teaching male nurses gentle feminine manners peculiar to the fair sex. We have heard of cases of "gambling of tax-payers lives" in the hospitals even under the present system of nursing; many a time the "gambling" ended in happy comedies. It may be too early to say one way or the other about the capacity of males in nursing but those who doubt the wisdom of this step may be consoled by the opinion expressed by the Organising Secretary of the trained Nurses' Association of India who in a letter addressed to the 'Hindu' says that "the standard of a few men nurses already trained in India is very high, they have a natural aptitude for the work and great ethical ideals." Regarding the preliminary general qualifications for the entrants to the Nursing Service we should say that the Government were not justified in their apprehension that there will be a dearth of candidates with S. S. L. C. standard. Though it is the intention of the Government to train nurses in the vernaculars of the Province, it will certainly take a few years to get ready books and teachers who could teach in the five vernaculars Tamil, Telugu, Kanarese, Malayalam and Urdu. There will be yet another difficulty of locating training schools to teach nurses in Kanarese and Urdu. So the best and the most economical thing to do at present is to make English as the medium of instructions. The Government

will therefore do well to fix one uniform standard not below the S. S. L. C. There will be another loophole against efficiency and in favour of pressure and favouritism which will be brought to bear on the selecting authorities if the III Form standard finds a place amongst the qualifications though it is mentioned in the Government Order that S. S. L. C. candidates will be preferred.

The pay of nurses in the Madras Government General Hospital, prior to 1918 ranged from Rs. 30 to 70. During the Great War they were given 25 per cent increase and in the year 1922 new grades were first introduced as Ward Sisters and Staff Nurses. The former were given a pay of Rs. 150-5-200 and the latter 75-2½-125. In 1933 there was a reduction on account of general retrenchment, Ward Sisters pay being reduced to 125-10/2-175 and of the Staff Nurses 65-5/2-120. The general retrenchment effected by the Congress Government early this year brought down the pay still further and the Ward Sisters have been getting 120-9/2-165 and the Staff Nurses 65-5/2-95. In future the newly entertained Ward Sisters would get 60-6/2-90 and Staff Nurses 40-4/2-60 and they will not get ration allowance which ranged from Rs. 35 in case of Sisters and Rs. 26 in case of Staff Nurses in the City Rs. 30 and Rs. 21 in the mofussil. The uniform and dhoby allowance will be allowed as in the past. We have mentioned the details of the past and the present pay of the nurses to enable the readers to have an idea of the measure of the sudden lift in the pay in 1922 from Rs. 30 to Rs. 150 and as sudden a drop in 1938 from Rs. 65 to Rs. 40. Even with the better scale of pay in the past it cannot be said that Nursing Service attracted women in high position in life nor those with the educational qualifications of higher level than S. S. L. C. The quality of nursing service is not likely to suffer taking into consideration the standard of nursing service we are now having in India generally. That the spirit and ideals of service do not depend upon pay and emoluments only has been demonstrated in

the missionary medical institutions both by the Medical and Nursing Services and the conditions in India are such that if the Government wish to extend nursing service equably to the poor and the rich so as to enable them to have the benefit of treatment, they should equip nursing staff at least 10 times the number they are in service just at present. The Government who are the only agency to train nurses even to serve the public outside the hospitals cannot lose sight of the fact that sick nursing is very inadequate at present and very few people employ qualified nurses to attend on patients requiring the attention of a qualified nurse. Qualified nurses now charge Rs. 7 for day and Rs. 8 for night duty, amounts which very few could afford to pay. Up till the year 1918 when the pay of the nurses ranged from Rs. 30 to Rs. 70 services of nurses could be had for Rs. 3 for day duty and Rs. 5 for night duty. With the increase of pay and emoluments in the State Hospitals the private nurses naturally increased their rates. There are a very few qualified private nurses in the City of Madras who are above want. Majority are struggling for want of work. In the mofussil towns it is difficult to get qualified private nurses because they cannot get work. We should say that the past policy of the Government in raising the pay of nurses in State Hospitals has been the cause to infuse in private nurses a false idea of status and prestige and many of them would prefer starving rather than accept a remuneration less than what is in vogue. There are not enough private hospitals and nursing homes to employ qualified nurses on monthly wages. So naturally the Nursing Profession has to depend upon Government to find them jobs as was the case with the members of the medical profession till the Congress sat on the saddle of the Government. As the nurses cannot offer honorary service as the doctors can and as it is likely that more private hospitals and nursing homes will come into existence in future matters are likely to adjust in much a way that both the nurses as well as the doctors will have to mind service more than money.

It is not a sound principle to permit the nursing staff to make their own arrangement regarding their food. Human nature being what it is, nurses at least some amongst them are likely to stint their food to lay by more money and very hungry nurses at times are likely to share the diet with their patients. Government would do well to supply the ration making a suitable cut in the pay.

We wonder if the Government are aware that there are no suitable schools to train nurses nor competent staff to teach this art. The verandahs of hospitals are utilised as lecture rooms with little or no equipment. The missionary medical institutions who pay the doctors and the nurses much less than is contemplated in the re-organisation scheme of the Madras Government run the training classes more methodically and efficiently. The Government have to learn more and more from the Missionaries relating to the management of hospitals under the present conditions and the Public Health Minister did frankly express his admiration for them. Virtues of the missionaries have become a necessity.

We cannot close our comments without reiterating our considerate opinion that the healing art should be outside the control of the Government. We trust the Government have noted the furious outbursts at the meeting of the European and the Anglo-Indian communities referred to above attributing all sorts of motives to the Government out of political considerations and not one amongst the audience came forward with constructive proposals to meet a very complicated and difficult task of supplying cheap yet efficient nursing service to the masses. This would not have happened if the Government were not the agency to supply nurses. Nothing could prevent these two communities to put forth a scheme of starting a School for Nurses of the type they see in other richer countries and request the Government or the universities to afford facilities for the purpose.

RURAL MEDICAL SERVICE.

It might be remembered that the then Interim Committee of Management of the Provincial Subsidized Rural Medical Practitioners' Association waited on the Public Health Minister on 25.1.1938 in deputation and made certain suggestions for amending the form of agreement to be executed by them and represented to the Minister about the desirability of introducing certain changes for the satisfactory working of Subsidized Rural Medical Relief Scheme. The representations made and action taken by the Government is embodied in a Government Order which has been published in the Correspondence Columns. We shall discuss about the changes *seriatim* as they appear in the Government Order. As per the old form the District Board could at the very outset when the practitioner agreed to settle in the villages fix a period of service to any extent. For a few years after the starting of the Scheme the District Boards did not press the practitioners to renew the agreement, on the other hand there prevailed an unwritten understanding that the practitioners should not be disturbed. In recent years there was pressure on the practitioners to renew the agreement every year and there were instances where practitioners already in rural service were quietly got rid off on the strength of one year term of agreement. This is why the Interim Committee requested the Government to fix at least five years term. This suggestion was left undecided on the day the Committee met the Minister. The Order contemplates two separate agreement forms, the first for a period not less than one year and the other for a period not more than five years. This is not likely to improve matters and will give a handle for a District Board President to get rid of an unwanted practitioner unless another sub-clause is added to the effect that the District Board should obtain previous permission of the Government before they terminate the services of the practitioner either after one year or five years or else the original idea of the Scheme to encourage the practitioners to settle in villages will be set at naught.

The request to grant 30 days leave in a year was modest and reasonable. Full time medical officers are entitled for this leave on full pay, they can also accumulate the leave. Relaxation from work is necessary on principles of health. The Government Order granting 30 days leave including the public holidays does not bring more leave as the practitioners could in the past, enjoy the public holidays which number about 15 days in addition to 15 days casual leave.

Clauses 8 and 9 which prohibited practitioners from taking part in the election to local authority or legislative body have been done away with.

Clause 10 in the old agreement protecting a practitioner from transfer was in consonance with the principles and spirit of Subsidized Rural Medical Relief Scheme. This clause has been amended so loosely as to include all possible contingencies. Transfers made on account of unsatisfactory working of a dispensary or its superfluity being close to other medical institutions will be not grudged by any practitioner. But the closing of the dispensary after giving three months notice to the practitioner for converting it into a dispensary of Indian System of Medicine or a regular dispensary is a most retrograde step and recent history where the Government agreed to such a conversation even when it was not contemplated in the old agreement necessarily raises a suspicion if this amendment is meant to legalise a mistake and give further room to the Presidents District Board to give vent to personal bickerings at the cost of the welfare of the villagers. It is mentioned in the amended clause that previous consent of the D. M. O. should be obtained either to close a dispensary, transfer a practitioner, to convert the dispensary into one of another system or transform the same into a regular dispensary before applying to the Government for sanction. This sounds well and reads also well but the Government know what they did regarding a recent conversion in the Tanjore District referred to above. The D. M. O. was against the conversion and said all good things that could be said about the working of the

dispensary. Nay even the people of the particular village were against conversion excepting perhaps the President District Board. We refer to this episode to prevent further victimisation of practitioners on this account. We are second to none in our appreciation of the good work turned out by the Government for the medical profession. This is why we are very much concerned that there should not be blots in the administration of Rural Medical Relief Scheme which we consider as the back bone of other bigger schemes of medical relief. Conversion of Subsidized Dispensary into a regular dispensary is certainly against the very purpose for which the Subsidized Rural Medical Relief was brought into existence and is not at all consistent with the policy of Government relating to Honorary Service. It is most uncharitable not to permit a Subsidized Practitioner to enjoy the benefits of his labour in popularising scientific system of medicine in a rural area. We have mentioned in these columns more than once that when a local body considers that a particular village has outgrown in importance and better facilities of medical relief should be provided, it may do so by equipping the Subsidized Dispensary with additional requirements for the purpose. What is there in a name if the object of medical relief is fulfilled? Generally proposals go to the Government for converting a Rural Dispensary into a regular dispensary if the practitioner who is very popular with the villagers cannot be got rid of by a party in power in a village as they cannot bring any charges against a popular medical man. This is why the deputationists pressed the necessity of not converting Subsidized Dispensaries into regular dispensaries.

There seems to be some misconception on the part of the Government relating to the request of the Subsidized Practitioners that they should be given the status of gazetted officers for the purpose of drawing travelling allowance and daily allowances. This was not in connection with public health duties only but for all purposes when they are required by the Government or private parties to give evidence

in Courts. They thought that if the Government give them the status of gazetted officers they could claim the allowances from private parties also at the higher rate. The Government have been pleased to raise their status from class XII to class IX grade officers for the grant of travelling allowance while on public health duty. The practitioners must be grateful to the Government for small mercy and the Government may kindly extend this concession for all purposes.

We have all praise to the Government for amending the old clause 13 making it obligatory on District Board not to terminate the services of a Subsidized Practitioner till the appeal against the order of the President, District Board is disposed off by the Government provided it is preferred within one month from the date of the order of the President. Drift delay and procrastination were the prominent features which guided some of the Presidents, Districts Boards when the Subsidized Practitioners preferred appeals against their orders and there were instances when practitioners had to wait starving for over six months though they eventually succeeded in their appeals. Apart from the terms of agreement, the Interim Committee made other suggestions to the Minister all of them appear in the G. O. published in the Correspondence columns with the answers from the Government.

We advise the Subsidized Practitioners not to bother themselves too much regarding the details of the working of the Scheme. They should concern themselves about the fundamental principles guiding the Scheme and when once they are set right the details get right automatically.

The Subsidized Practitioners have now a well organised Association to look after their interests. They should strengthen the Association numerically financially so that the sinews of the Association grow stronger and stronger when it will be able to meet any eventuality at a moment's notice. The representatives of the Provincial Subsidized Rural Medical Practitioners' Asso.

ciation made exhaustive suggestions to the Minister touching not only the form of agreement but the working of the entire scheme as could be seen from the Government Order. Transfer of control of the Scheme to an agency outside local or Legislative political parties would have been a step in the right direction. The omission of the Government in this direction is felt more keenly after the transfer of control of Subsidized Midwives from the District Board President to the District Medical Officer. The Association has submitted another memorandum to the Government while forwarding the resolutions passed at their conference held in Manachanalloor last June making further representations on the working of the Scheme and we trust the G. O. under reference will not be the last word of a progressive Congress Government. In the meanwhile we hope that the Subsidized Practitioners will not be wanting in courage and enthusiasm to organise themselves into a strong union. The representations made by the office-bearers of their Association has not been in vain altogether. Government have their own

limitations at times more than those of a humble individual. The Government cannot but yield to the opinions of a well organised Association provided that such opinions have the public support and sympathy. We learn from the General Secretary of P. S. R. M. Ps' Association that he intends summoning a meeting of the Working Committee and of the Provincial Committee of the Association in Madras next month. It is therefore urgent and necessary that all the Subsidized Rural Medical Practitioners of the Districts where the District representatives have not been chosen so far meet without losing time and elect their District representatives to the Provincial Committee. Apart from the non-compliance of the requests made to the Government by the Association through its office-bearers there are some misconceptions in the order of the Government relating to the new form of Agreement which have to be cleared soon such as the Vaccination and Leprosy work and the Subsidized Practitioners should not lose time in striking the iron when it is hot, always remembering that union is strength.

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.

ZAMA is in the market for the last six years and the Clinical Reports so far received are very satisfactory. A fair trial in inveterate cases will convince those who did not know about **ZAMA** as yet about its wonderful action.

Available at all Chemists in Madras

Messrs. P. M. ZAYERI & CO., Princess Street, Bombay.

„ BHARATIA MEDICAL STORES, Canning Street, Calcutta.

Or at: THE ORIENTAL RESEARCH LABORATORY, Yepery, Madras.

News and Comments

Ambulance work and Medical Profession: We are glad that the Head of the Medical Department in the Madras Presidency, Major-General N. M. Wilson is evincing great interest and enthusiasm in the Ambulance Work in his capacity as the Chairman of the St. John's Ambulance Association. We learn that he has been sending personal appeals to the members of the medical profession in service as well as in private practice impressing on them that it is the legitimate duty of the profession to train the members of lay public in the art of rendering "first aid" in medical or surgical emergencies, be it during the days of war or peace. General Wilson's enthusiasm is bound to be "infectious" and Dr. T. S. Tirumurthi, Principal of the newly opened Stanley Medical College formed a Stanley College Division which was inaugurated by General Wilson on the 6th instant. We cannot do better than quoting a few sentences from the address of General Wilson delivered by him to the students of the Stanley Medical College to convince the medical men that they can serve their country and profession if they form themselves into small teams to organise and keep in readiness Ambulance Corps. General Wilson said amongst other things:

"He was very much interested in this work because he realised that the people of India were all out for social work and there was no finer form of social service than looking after the sick and the wounded."

Our King-Emperor is the sovereign head of this Order. Our Princes not only of the Royal family in Britain but most of our ruling Princes in this country are Knights of this Order. It is not a Christian Order; but it is an Order whose chief object is to give succour to the sick and the wounded. Our work is never sensational or even conspicuous; but its value is great and is appreciated by those who pass through our hands. Our object is to work for the sacred cause of humanity and our reward is the knowledge that we have done our best."

Why I am so keen that you all should belong to this Order is that I feel that it is primarily a Medical Order and that if we are going to build this Association up in this Province, our foundation must undoubtedly be the Medical Profession, because we are in a position not only to administer to the wounded and the sick but we are in a far better position to teach the common people of our province how to look after the sick."

At this period of our life, the whole world is upside down. We do not know where we are at present. We have no medical organisation in Madras or anywhere in this presidency that could cope with any catastrophe, be it an act of God or an enemy."

The Japanese were bombing Canton and other areas. They were probably hoping thereby that people would sue for peace. That was apparently the new method of waging war. Such a thing might not happen in Madras. But we would be wrong if we are not prepared for any eventuality as war". I feel that if we had units like the Stanley Medical College Division, we would immediately 'form in' and would be given opportunities for bandaging people, getting them out of debris and that sort of thing".

After congratulating the students for the splendid response given by them General Wilson said:

"I feel certain that other colleges throughout the presidency will quickly follow your lead and it would be one way of stamping your college as second to none, though it is a new college."

Public Health Bill: The Hon'ble Dr. T. S. S. Rajan may take credit of one more achievement which though it may appear last in the least so far announced is of first rate importance. It is true that there were haphazard attempts both in this province and outside by the old Provincial Governments to introduce Public Health Bills. But nothing came out of these attempts, and we congratulate the Government of Madras on their having been able to introduce the Public Health Bill at the earliest opportunity when the provinces have been enjoying autonomy practically in all respects. The object of the Bill is to advance public health in the Province of Madras and the Bill contains 144 clauses dealing with every aspect of public health. It is said that the Bill will be introduced by the Public Health Minister in the Legislative Assembly on the 28th instant. The salient features of the Bill are as follows:—

1. The constitution of a Public Health Board for the Province:

2. The statutory recognition of the Director of Public Health and the vesting of adequate powers in him for the effective discharge of his duties.

3. The taking of power—

(a) to compel the employment of Health Officers by important local authorities; and

(b) to fix the scales and the conditions of service of the public health establishments employed by local authorities;

4. Provision that local authorities should earmark a definite percentage of their income for public health expenditure ;

5. The imposition of an obligation on local authorities at the discretion of the Government to provide a sufficient supply of drinking-water ; and provision for the compulsory levy of a water-tax for financing water-supply schemes ;

6. Effective provisions for securing proper drainage and a sufficient number of public latrines etc ;

7. The prevention and abatement of nuisances ;

8. Adequate measures for the prevention and eradication of infectious diseases ;

9. The prevention, treatment and control of venereal diseases ;

10. Maternity and child-welfare measures ;

11. Mosquito control ;

12. The reservation of areas for residential purposes control over insanitary buildings and the abatement of overcrowding ;

13. Registration of lodging houses ;

14. Food control ; and

15. Special provisions regarding fairs and festivals, including the levy of a pilgrim-tax in the case of water-borne traffic and of tolls on vehicles.

The Director of Public Health and those serving under him in the Public Health Department cannot have any more excuse for not being able to enforce health laws and prevent diseases as from the highest to the lowest officer in the Public Health Department have been given statutory powers to execute their duties satisfactorily. There are bound to be practical difficulties in carrying out measures contemplated in the Bill when it gets into the Statute Book. Education and persuasion by all possible ways will have to be resorted to before the Health Law is put into action or else in a country like India where ideas of cleanliness and well-being are being inculcated as rules of religion more than that of health laws, people are likely to misunderstand the intention of legislature. There is likely to be some trouble relating to the prevention, treatment and control of venereal diseases in localities where the provision of the Bill relating to these diseases will be enforced in future, as it is not mentioned in the Bill who are competent to certify about the venereal patients and if the

practitioners belonging to the indigenous systems of medicine could function as doctors for the purpose of the Public Health Act. After the constitutional reforms were inaugurated the Madras Government have taken a lead in introducing reforms in the Medical and Public Health Departments and have thus demonstrated that entrusting of Public Health portfolio to a medical man is certainly an advantage though the prevailing tradition in democratic cabinets seems to be not to entrust the portfolio relating to subjects to a Minister who has expert knowledge of these subjects. With a majority which the Congress has been fortunate to command in this province and with a history of the Bills of contentious nature having been passed into Acts with little or no delay, we trust that the Public Health Bill will have very smooth sailing, as there cannot be two standards of well-being though there may exist any number of political parties.

Functions teach Lessons: The distribution of prizes to the students of the Stanley Medical College was held on 10—11—1938. Major-General N.M. Wilson, Surgeon-General with the Government of Madras presided and Mrs. Wilson distributed the prizes. Advantage was taken of this function and a portrait of the Hon'ble Dr. T.S.S. Rajan, the Public Health Minister was unveiled by Sir Alladi Krishnaswami Aiyer, the Advocate-General. There was a very good gathering the like of which was not seen on similar occasions when the institution was a school. The representative nature of the audience was also a feature which was conspicuously absent in the past. It was a happy and as grand a sight that the officials and non-officials belonging to all grades counting amongst them practitioners with foreign qualifications, Doctors of Medicine and Masters of Surgery Graduates and Licentiates assembling in a common hall and mixing freely with each other which they rarely do for want of opportunities. Similar functions in an old sister College could not boast to have had a mixed gathering of medical fraternity perhaps due to hotter academic atmosphere than that prevailing in an

younger college which started from a school. All credit is due to the Principal and the staff of the College. We learn with pleasure that the old students who presented the portrait to the College materially added to the success of the function.

The first lesson the authorities of medical institutions may learn from this function is that such mixed gatherings of the members of the medical fraternity help the growth of harmony and cordiality in the profession which are rare commodities at present for various reasons. Such a gathering has also a curative effect on the obsession of inferiority and superiority complexes and serves also as an exhilarating relaxation.

The second lesson we noted at the function coming from the lips of Advocate-General worthy of the attention of the medical profession which has been given a good shake by the Hon'ble Dr. Rajan by introducing all round changes, was that the profession should not sit in judgment over every item of Dr. Rajan's actions but 'take the man as a whole' as he had done a great deal to the profession.

The third lesson (though addressed by General Wilson to the Medical Students and newly passed Licentiates) which may be learnt by the entire medical profession we have put in the words of the author himself :

"Just as a man who would cast a spear far must first find solid footing, so must you set your feet firmly on the ground of best tradition, truth, loyalty and selflessness, so that your spear will go straight and far to future generations.

An year or so ago, I heard Sir S. Radhakrishnan, a fine nationalist or I may say, internationalist, addressing the students of the Mayo College, Nagpur, and the tenor of his speech to them was the road to true democracy. He begged them to rid themselves of superstition and to seek truth along the pathway of brotherhood. He emphasised the quality of humility, 'let him who

would be great among you, let him serve'.

The highest and cleverest in all nations are proud to join with the lowliest and, shall we say, the most 'immature', in common service to humanity. You all want to be doctors, the finest profession in the world, and you must begin now to show yourself to be above factions, if you are to keep that noble profession up to be revered by all the world. I will conclude these few words with the ever true reminder that there can be dignity in labour, no matter of what kind."

Premature Sectional Activities: We doubt very much if the affairs of the medical profession in India have reached a stage of advancement as to start independent sectional activities with little or no regard to General Medicine which is the basic science on which the development of all allied branches of Medicine rest and depend upon even for the treatment of special diseases pertaining to Surgery, Midwifery, Gynaecology and the diseases of special sensory organs. If a surgeon is not a cutting physician, if an obstetrician or gynaecologist is not a physician of very ripe experience and if specialists dealing in the diseases of eye, ear, nose and throat are not efficient physicians, they cannot be considered to be true to their art they profess to know and practise. Though the success of specialists is measured in money by the lay public the measure used by scientific medical profession to gauge the knowledge of the specialists is of a different type. This is why specialists are not popular with the general practitioners and the starting of sectional societies such as the Surgical, Obstetric and Gynaecologic and Ophthalmic have been pulling the profession asunder and increasing the cleavage in the profession. There is at present a well organised All India Medical Association under whose auspices annual conferences are held in the important towns and cities of India and nothing prevents those practising special branches of medicine to give the benefit of their knowledge collectively at such conferences, either for

their own benefit or for the benefit of the profession as a whole. We learn from Newspaper reports that the Hon'ble Dr. M.D. Gilder, the Public Health Minister of Bombay who till recently was practising only medicine inaugurated the first session of the Association of Surgeons in India of which Lt.-Col. K. G. Pandalai was the President. It is said that the latter Surgeon is the founder of the Association and that the idea of this Association first struck him at Madras last year when the All India Medical Conference met in Madras during X-mas. It is reported that the Surgeons' Conference confined itself to a small circle the total number that attended the conference being only 70 out of whom half were from Bombay and the other half hailed from outside and that some eminent surgeons of Bombay were conspicuous by their absence. The only physician that was invited by the surgeons was the Minister of Public Health. The history of Scientific Medical Profession in this country on western lines is not as long as that of the profession in foreign countries where the specialists are growing less popular and the medical press has taken up the cause of general practitioners and pressing the specialists to give the general practitioners their rightful place. We wish the zealous enthusiasts who are the promoters of the special sections will note what is going on in other civilized countries. The idea of specialist practice in surgery has gone to such a pitch that the general practitioners have little or no chances of even opening of abscesses especially in cities where the general practitioners have to depend entirely on dispensing practice. We wish the general practitioners are alive to the situation and bring into existence group hospitals by combined efforts to treat their own patients requisitioning the services of specialists as and when the occasion demands.

U. P. & C. P. Ministers' Views on Medicine: It is but natural that members of the medical profession practising different systems of medicine look to the Government for their encouragement and support of particular systems as the Government is the sole agency in this country to run institutions for medical

relief. On 22-10-1938 those belonging to Scientific System in Agra requested the Hon. Mr. Hafiz Mohamed Ibrahim, the acting Public Health Minister of the United Provinces to inaugurate the fifth session of the U. P. Medical Conference. The Minister said that he agreed to visit Agra specially for the purpose as he wanted the doctors to feel that Government were anxious to know the views of the profession on the Public Health of the Province. He impressed the need for greater co-operation of the medical profession with the Government. He observed that it was wrong to say that the allopathic system of medicine was a foreign one. The unani system was once as much foreign as the allopathic but those responsible for introducing the latter system into this country translated and converted its literature to suit the requirements of the country. He therefore emphasised the need of imparting medical education in the language of the country. He assured the audience that the Government were anxious to encourage all systems including Homoeopathy but all these systems should be first brought on a proper footing.

On the same day when the U. P. Minister addressed the members of the Scientific Medical Profession at Agra, the Hon. Pandit D. P. Misra presided over the annual celebrations of an Ayurvedic School in Nagpur and in the course of his speech stated that the report of the Special Committee appointed by the Govt. to consider the indigenous systems of medicine had been circulated among the *Vaidyas* and it was found in the report that the existing *vaidyas* practised more of Allopathy than Ayurvedic or Unani. The Committee had only two members belonging to the Allopathic System, the Chairman, (Inspector-General of Civil Hospitals) and another allopath the rest (the majority) belonged to the indigenous systems of medicine.

Excluding the hereditary *Vaidyas* all the rest of the practitioners belonging to the indigenous systems of medicine, who are self-made *vaidyas* usually practise more of allopathy. The more we

discuss on the medical relief the more we are convinced that the only safest and economic way to handle this question would be for the Government to entrust Medical relief to the votaries of particular systems, the Government taking care that only qualified practitioners of the particular systems, practise medicine. It will be an utopian task to hold hopes to the public that the Government would support and encourage every system by establishing State institutions belonging to every system.

Expectant Hopes: We trust the Government would have noted the disappointment and dissatisfaction displayed by the Subsidized Practitioners individually and collectively through the District Branches of their Association relating to three proposals conveyed to the practitioners in the memorandum No. 34730.1-D2 P. H. dated 30.9.1938. As already expressed in these columns once before time is not yet ripe for the Government to think of curtailing either the Subsidy or other emoluments now granted to them. On the other hand there is more justification to spend money in equal proportions in rural and urban areas depending upon the collection of revenue by the Government. Things are topsyturvy at present in regard to expenditure incurred for medical relief. The ignorant masses in the villages will not and cannot realise the benefits of the preventive medicine unless they are convinced about the good effects of the curative medicine. It is often said that the object of Government in spending lavishly for medical relief is to make the people realise the benefits of Preventive Medicine. This argument should also hold good relating to the welfare of the villages. The Government are just introducing an all comprising Public Health measure. The Public in urban areas being more educated and less ignorant than the village folk it behoves the Government to extend medical relief in the rural areas expeditiously. This the Government can hope to do through Subsidized Rural Medical Service and the service should be made more attractive and not less as the Government propose to do. If we remember right Mahatma Gandhi considers that Rs. 75 is a decent living wage for a village

worker. Is a subsidy of Rs. 500 per year too much for a medical man who spends 4 to 5 years for his medical training with considerable expense? It is hoped that the Government will drop the idea expressed in the memorandum under reference.

Congratulations: We congratulate Rao Bahadur Dr. A. Lakshmanaswami Mudaliyar on his being confirmed as the Principal, Medical College. Dr Mudaliyar who spent almost all the period of his service in teaching institutions and who has been evincing keen interest in medical education deserves the promotion and the honour conferred on him by the Government. The claims of the Madras Provincial Medical Service are thus recognised by the Government to hold the post of the Principal, Medical College which was reserved for the members of the Indian Medical Service. The time is now ripe for the Government to consider seriously the suggestion made in these columns repeatedly that the Principal of a Medical College should be in sole charge of the training of the Medical Students both in the college as well as in the hospitals. It is a happy coincidence that the two Principals of the two Government Medical Colleges in the City are under two Indian Principals both of tried merit as educationists having occupied though temporarily the position of Vice-Chancellor of the two Universities in the Province. Advantage should be taken of this circumstance and the Government should relieve both these Principals from all other duties so that they can concentrate all their time in raising the status and usefulness of the two Colleges in the training of the medical students and concert measure for the post-graduate training of the members of the medical profession so that there will be little or no need for medical men to go and spend large amounts of money for special training, in foreign countries. We wish to point out to the Government an anomaly which has now arisen, the Head of the Madras Medical College having to serve under the Head of an institution which trains medical students in one of the branches of Medical Science. If our suggestion is carried out by the Government this anomaly will also come to an end.

Correspondence, Reports, Etc.

THE PROVINCIAL SUBSIDISED
RURAL MEDICAL PRACTITIONERS'
ASSOCIATION.PROCEEDINGS OF THE DISTRICT
BRANCHES.

1. TANJORE DISTRICT BRANCH.

At the special invitation of Dr. K. Govindan, Treasurer and Member of the Working Committee of the P. S. R. M. Ps.' Association, the Subsidised Rural Medical Practitioners of Tanjore District met at Aduthurai on 6.11.38 at 2 P.M. Owing to the unavoidable absence of Dr. V. Rama Kamath, the President of the Association, the chair was taken by Dr. V. Subramanyam of Ammayapuram. Twenty-two Rural Practitioners were present.

Dr. Govindan welcomed his comrades and thanked them for their co-operation by being present at the meeting with considerable inconvenience and for their financial help. He very much regretted for the callousness of some of the brother practitioners and exhorted those present to take lively interest in the affairs of the Association as without a strong organisation their voices regarding their grievances would be in wilderness. He thanked Dr. V. Rama Kamath, the President of the P. S. R. M. Ps.' Association who seemed to him to be more vigilant than the members of the Association themselves, as could be evidenced by his personal guidance at a time when all of them were perturbed to receive a memorandum from the Government enquiring from them whether they were willing to continue in subsidised services on 50 per cent of the present subsidy or no subsidy. He hoped that almost all his comrades must have sent a reply to the memorandum on the lines suggested by the President. He reminded his comrades that the Hon'ble Public Health Minister did promise them at their last conference to continue the support from Government till such time it could be said with certainty that the help that the Government gave to the Subsidised practitioners was superfluous. So it was for them now to point out to the Government

that they were not in a position to maintain themselves honourably much less to spend from their private resources to run the Rural Dispensaries without the help of the subsidy and other facilities now accorded to them by the authorities.

The written address sent by Dr. V. Rama Kamath was then read to the audience.

After a heart to heart talk regarding the recent memorandum and other affairs of Subsidised Rural Medical service the following resolutions were unanimously passed :—

(1) Resolved to accept with regret the resignation of Dr. S. Viswanathan of Koradachery as Secretary of the District Association and to place on record, appreciation of his services so far rendered by him during the time of his office.

(2) Dr. V. S. Subramanyam of Ammayapuram was elected unanimously as Secretary.

(3) Resolved to inform the Government that the Subsidised Rural Medical Practitioners will not be able to work on the conditions mentioned in the Government's Memorandum No. 34730. I. D. 2. P. H. dated 30th September 1938 for the following among other reasons :—

(a) The conditions of people in the village at present is such that they are not in a position to pay for the services of the rural medical practitioners. (b) The practitioners find that they are unable to get any private practice worth mentioning and have consequently to depend upon the present subsidy which is hardly sufficient to maintain themselves with the minimum comfort.

(4) Resolved to request the Government to pay such of those subsidised practitioners deputed for public health training their usual monthly subsidy in addition to the honorarium of Rs. 25 as stated in G. O. No. 2639, P. H. dated 21st July 1938.

(5) Resolved to request the President District Board Tanjore to present the grievances of the Rural Medical Practitioners of the district and make suitable recommendations to the Government on the lines indicated in resolutions Nos. 3 and 4.

(6) Resolved that the following five practitioners do wait in deputation on the President District Board Tanjore and request him to make favourable recommendations to the Government in regard to the recent memorandum No. 34730. I. D. 2. P. H. dated 30th September 1938; Drs. (1) R. Kuppuswami, (2) S. Nityanandam, (3) S. Govinda Seshan, (4) V. Ponnuswami Thevar, and (5) L. T. Appadurai.

(7) Resolved to convert the Tanjore District Association of Rural Medical practitioners into the Tanjore District Branch of the P. S. R. M. Ps.' Association.

(8) Dr. K. Govindan was elected to represent the Tanjore District Branch in the Provincial Committee of the P. S. R. M. Ps.' Association.

(9) Resolved to request the President, District Board, Tanjore and the District Health Officer Tanjore not to open separate Child Welfare Centre in the villages where there are qualified midwives attached to the Rural dispensaries entrusting the maternity and Child Welfare work to the subsidised midwives by paying them additional subsidy from the District Board funds, and to transfer such of the superfluous centres to villages where subsidised midwives do not exist.

(10) This Association views with great concern the news regarding the conversion of the rural allopathic dispensary at Killayur into an ayurvedic dispensary and requests the President, District Board, Tanjore and the Government to allow it to continue as allopathic dispensary.

(11) Resolved to request all the rural medical practitioners of the district to remit Re. 1/- immediately to Dr. Govindan, Aduthurai as the donation to carry on the activities of the District Branch as the present resources of the branch are very meagre.

2. THE KISTNA DISTRICT BRANCH.

A special meeting of the subsidised rural medical practitioners of the district was held at Bezwada in the Government Hospital at 3 P. M. on Sunday 6.11.38. As Dr. V. Rama Kamath, the President, who was specially invited could not attend on account of some unavoidable domestic inconvenience, Dr. H. C. Halge, the Medical Officer in charge of the Local Hospital was requested to preside.

Dr. N. Rama Rao, Secretary, read the minutes of the previous meeting and they were passed. Dr. Rama Rao then read to the members a written address sent by Dr. V. Rama Kamath. Dr. Kamath in his address referred to the Memorandum No. 34730. I. D. 2. P. H. dated 30th September 1938 and said that the Government were not justified to convert subsidised service into honorary service, as it was impossible for majority of the rural medical practitioners to have any private practice worth the name. Dr. Kamath specially urged the necessity of organising the association and expressed his disappointment that majority of the

practitioners did not return the membership forms duly signed by them as the form contained valuable information which would help the Association to keep in readiness facts and figures about the service history of the individual medical practitioner and also of individual districts so that by comparison and contrast the Association would be able to present the case of an individual practitioner or a group of practitioners in a particular district when occasion demanded. Dr. Kamath in conclusion suggested that the first concern of the subsidised practitioners should be to strengthen the association both with men and money.

After some preliminary discussions the meeting passed unanimously the following resolutions :—

(1) This association expresses its deep sorrow on the death of Dr. K. Venkiah, R. M. P. Chennur and resolves to convey its sympathies to his family in bereavement and authorises the Secretary to communicate the same to the family of the deceased.

(2) This Association resolves that the Kistna District S. R. M. Ps.' Association be converted into the Kistna Branch of the Provincial Subsidised R. M. Ps.' Association and that Dr. S. S. Rama Rao of Kannmole be elected as the representative to the provincial committee of the P. S. R. M. Ps.' Association.

(3) This Association views with great concern the Government's move as per their memorandum 34730-I. D. 2. P. H. dated 30th September '38 to curtail or abolish the subsidy and medicines now given to the R. M. Ps. and requests the Government to drop the idea as such a step would be a hardship both to the R. M. Ps. as well as to the poor villagers.

(4) This Association is of opinion that the honorarium fixed for the R. M. P. doing public health work in G. O. No. 2639 dated 21-7-38 is too low and requests the Government to so alter the G. O. as to fix the honorarium not lower than Rs 30 per mensem with a vaccinator to assist him. It further requests the Government to give the usual subsidy to the practitioners while deputed to Public Health training in addition to the proposed honorarium of Rs. 25/- for the period.

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

(6) Resolved to request the District Board Kistna to sanction a uniform amount of Rs. 5 as a fixed contingency per month for each dispen-

sary and do away with the present practice of granting of the actual expenses incurred and that too up to Rs. 3/- supported by vouchers and certificates as such a procedure is most cumbersome.

(7) This Association brings to the notice of the Government the delay and irregularity in the supply of medicines and the resultant dislocation of work in the dispensaries and requests the Government to so arrange the supply as to reach the R. M. Ps. not later than a date fixed and also see that all medicines indented for are supplied in one lump and not in instalments as is at present done.

(8) This Association thanks the Government for having done justice by reinstating the R. M. P. of Pallevada who was thrown out of service for no fault of his and resolves to request the Government to sanction his subsidy for the intervening period.

(9) Resolved to request the Government to give effect to the Resolution No. 18 of the P. S. R. M. P. passed on 10-7-37 as such a course would cause an atmosphere in which the R. M. P. would be able to do more useful work.

3. WEST GODAVARI DISTRICT BRANCH.

Dr. D. V. Ratnam, Ganapavaram organised the conference of the Subsidised Rural Medical Practitioners belonging to the West Godavari District, which met at Bhimavaram on 13.11.38. Dr. H. V. J. Sarma, Chairman Municipal Council, Ellore was voted to the chair. Dr. Sarma thanked the practitioners for the honour given to him and advised them to organise themselves into a strong union and agitate incessantly and untiringly till their grievances were redressed. Dr. Ratnam, the organiser welcomed the delegates and while criticising the recent Government memorandum gave a detailed account of the present and past conditions in the Rural Medical Service. He argued that it was impossible for a practitioner in a village to depend upon private practice.

The following resolutions were unanimously passed.

(1) That an association by name "The West Godavari District Subsidised Rural Medical Practitioners Association" be formed.

(2) That this Association be affiliated to the Madras Provincial Association the Secretary, Dr. D. V. Ratnam to be the representative on the Provincial Committee.

(3) Resolved that the Government be informed that it cannot be possible for the Subsidised Rural Medical Practitioners of this District to work on any of the conditions mentioned in the

Memo. No. 34730-1-D-2, P. H. dated 30th September 1938.

(4) Resolved that the Government be requested to pay the usual subsidy in addition to an honorarium of Rs. 25 and T. A. to the Rural Medical Practitioners when they are deputed for Public Health training.

(5) Resolved that the Government be requested to fix the remuneration for Public Health work at Rs. 30 per month instead of Rs. 15 as proposed in the G. O. as the later amount is too meagre.

(6) Resolved that as it is found to be very difficult to run the dispensaries without a sanctioned rent for the building and the assistance of a male-nursing orderly, the President, District Board be requested through the District Medical Officer to sanction an adequate rent for each dispensary and a male nursing orderly in addition to the fixed contingencies now granted.

(7) Resolved to request the President, District Board through the District Medical Officer to sanction an amount of Rs. 5 per month to those that run Leprosy clinic as is given in Chengleput and Salem Districts to meet miscellaneous charges.

(8) Resolved that the District Board be requested to supply medicines to the value of Rs. 360 excluding railway freight and packing materials etc.

(9) Resolved that the Government be requested to give the assistance of vaccinators to the Rural Medical Practitioner's doing Public Health work as promised by the Public Health Minister.

(10) Resolved that the Government be requested to arrange to pay some extra allowance and T. A. in addition to the subsidy to the Rural Medical Practitioners when deputed for refresher course.

4. RAMNAD DISTRICT BRANCH.

On the personal invitation of Dr. N. Krishnaswami of Rajasingamangalam, the Subsidised Rural Medical Practitioners of Ramnad District met on 19th November 1938 at Ramnad in the Sowartz High School. Dr. S. Natarajan (Neikuppai) occupied the chair.

The following resolutions were passed unanimously :—

(1) Resolved that an association of Subsidised Rural Medical Practitioners for the Ramnad District be formed.

(2) Resolved to request the Madras Provincial Subsidised Rural Medical Practitioners Association to affiliate this Association to it and the Secretary be requested to enlist all the subsidised R. M. Ps. of this District as members of P.S.R.M:Ps'. Association and to collect Rs. 2-4-0 (Rs. 2 for the annual subscription for the "Medical Practitioner" being an official organ of the Association and annas four being entrance fee).

(3) The following office-bearers were elected unanimously :

President :—Dr. S. Natarajan.

Secretary and Treasurer :—Dr. N. Krishnaswami.

Member of the Executive Committee :—Dr. P. Somasundaram.

Representative to the Provincial Committee of P. S. R. M. P. Association :—Dr. N. Krishnaswami (Secretary of this Association).

(4) Resolved that the subscription for each Member shall be Rs. 3 payable in advance for the first half-year ending 31st March 1939, the payment to be remitted to the Treasurer before the end of November 1938 and for the second half-year it shall be Rs. 2.

(5) This Association regrets its inability to accept any of the alternative proposals referred to by the Government in the Memo. No. 34730-1-D-2, P.H. dated 30th September 1938 circulated to the individual R.M.Ps.

(6) This Conference while thanking the Government for certain concessions shown to them as per request of the interim Managing Committee of R. M. Ps'. Association requests the Government most respectfully to allow them leave of absence for 30 days in aggregate in a year excluding the public holidays.

(7) Resolved to request the Government to treat R.M.Ps. as on duty and allow them their usual subsidy in addition to the honorarium of Rs. 25 referred to in G.O. when they are deputed for Public Health Training at Madras, as during that period, they have to maintain their family in villages in addition to the expenses to be incurred by them at Madras.

(8) The Association thanks the Headmaster of the Sowartz High School, Ramnad, for having kindly permitted to have the meeting in the building.

5. SOUTH ARCOT BRANCH.

The Subsidised Rural Medical Practitioners of South Arcot District met on 19.11.38 at the Government Head Quarters Hospital, Cuddalore with Dr. Sankararaman M. B. B. S. as President. The following resolutions were unanimously passed.

(1) That this association be called the South Arcot District Rural Medical Practitioners' Association.

(2) That this association be affiliated to the Provincial Subsidised Rural Medical Practitioners' Association.

(3) That this meeting of the South Arcot District Subsidised Rural Medical Practitioners emphatically protests against either the lowering or abolishing of the subsidy paid to the R. M. Ps. and requests the Government that the R. M. Ps.

be allowed to continue to work under the existing conditions, exist at present. Passed unanimously.

(4) Resolved that these resolutions be communicated to the President District Board, South Arcot, and to the Minister of Public Health Madras, to the President of the Provincial Subsidised Rural Medical Practitioners Association Madras, and to the District Medical Officer, Cuddalore.

Drs. K. Rangasami Aiyangar and Dr. S. Ananthakrishnan were elected as Joint-Secretaries, the former being the correspondent.

6. TRICHINOPOLY DISTRICT BRANCH.

The members of the above branch met at Government Head Quarters Hospital, Trichinopoly at 4 P. M. on 19.11.1938 under the Presidentship of Dr. S. Sethurama Rao (Vice-President, Provincial Association). The following resolutions were unanimously passed :

1. This District Branch of the Madras Provincial Subsidised Rural Medical Practitioners' Association respectfully submits that necessary conditions and facilities do not now exist for introduction of appointment of honorary men to Rural Dispensaries. The subsidy now paid and supply of medicines at the present rate cannot be said to be superfluous as it is the experience of the practitioners invariably that they now maintain themselves and meet the needs of the necessitous poor with great difficulty in as much as the income from private practice is negligible to augment their subsidy owing to the poverty of the people and therefore any reduction of subsidy or supply of medicine will materially affect the practitioners as well as the poor sick if the Government insist on any one of the three conditions envisaged in their memorandum No. 34730-1-D-2 P. H. dated 30-9-1938 and respectfully suggests to refrain from enforcement of these conditions.

2. Resolved to request the Government to pay such of those deputed for Public Health training their usual monthly subsidy in addition to the honorarium of Rs. 25, as stated in G.O. No. 2639 P. H. dated 21-7-1938 and Rs. 30, per month after training for doing Public Health Work.

3. Resolved to reiterate resolution No. 11 of the VII Provincial Conference dated 26-6-1938 viz., '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 7-8-1937 and amendments thereon which now forms clause No. 12 of the agreement executed by the Subsidised Practitioners in either not appointing Subsidised Practitioners to the vacancies in preference to others or not appointing the Subsidised Practitioners in charge of Subsidised Dispensaries which Dispensaries Government sanctioned to be converted into L. F. Dispensaries consequent on increasing demand of medical relief in localities where the Subsidised Dispensary existed, the Confer-

ence 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 for L. F. Dispensaries 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 temporary or permanent vacancies in the cadre of medical officers in L. F. Dispensaries in a District arise the seniormost Subsidized Practitioner of approved merit should be selected to fill in the vacancy.

4. Resolved to request the District Board that in modification of its order R. C. No. 5886 P. H. dated 19-5-1934 to sanction an uniform fixed contingent allowance of Rs. 3 per month to each of the Medical Practitioner in charge of Rural Dispensary under the Board.

5. Resolved to request the Board to sanction a uniform rate of Rs. 10, per month for each Dispensary towards house rent.

6. Resolved to approve the Memorandum prepared by the Committee appointed for the purpose to be presented to the District Board President when the Committee waits on him in deputation.

The following bye-laws were adopted for the working of the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association as per resolution No. 5, dated 17.9.38.

1. *Name*: The Madras P. S. R. M. P.'s Association—Trichinopoly District Branch.

2. *Location*: Within the District of Trichinopoly.

3. *Objects*: (a) To carry out the aims and objects of the Parent Association and co-ordinate with it in all its activities.

(b) To deal with local affairs and with the local authorities in consultation with the Parent Association.

4. *Constitution*: The Association will consist of members in the District who are on the roll of the Provincial Association.

5. *Office-Bearers*: (1) Secretary-Treasurer (Honorary).

6. *Administration*: (1) Day to day administration to be conducted by the Secretary-Treasurer who shall be in charge of books, records, documents, properties and funds of the Association.

(2) The Secretary-Treasurer shall enrol members of the association and shall receive from the Provincial Association the quota from the membership fee as per Rule 14 (f) of the Provincial Association.

7. *Funds*: (1) Provincial contribution.

(2) Donation or other subscriptions.

8. *Official Year*: Financial year—1st July to 30th June.

[We wish other District Branches adopt their Bye-laws on the above model—Ed.]

7. COIMBATORE DISTRICT BRANCH.

A meeting of the Subsidized Rural Medical Practitioners of the Coimbatore District was held in the District Medical Association hall on 12-11-38 under the Presidentship of Dr. Hari Rao of Kunnathur. The following resolutions were passed:—

1. Resolved to form a Rural Medical Practitioners' Association for the District.

2. Resolved to request the District Medical Association to charge a composite subscription which should include

(a) Contribution of each member to the Provincial S.R.M.P. Association.

(b) A subscription of Re. 1-0-0 per annum for the District Medical Association proper.

3. Resolved to elect the following office bearers provisionally:

President:—Dr. Ramanathan of Pongalur.

Vice-President:—Dr. Kuriappan of Chittore.

Secretary and Treasurer:—Dr. Jesudasan of Ammapet.

Associate Secretary:—Dr. Hari Rao of Kunnathur.

Members of the Committee:—Dr. V. Balasubramaniam, Somanur. Dr. G. V. Rama Iyer, Dr. S. Balasubramaniam of Perumanallur.

4. *Resolution*:—In giving a negative reply to the items 1, 2 and 3 mentioned in the Government memorandum No. 34730-ID 2 P. H. dated 30th September 1938 we the members of the Subsidized Rural Medical Practitioners of Coimbatore District beg to submit that the existing difficulties in which the R. M. Ps' are labouring are not unknown, and to be forced to work under the new scheme contemplated in the circular, under communication will not only augment our financial and social difficulties, and entail serious hardship and jeopardise our position and interest in every respect, but also deprive the poor villagers of their free medical aid they were so far getting.

It is therefore our humble and fervent request that we may be allowed to work under the G. O. governing us at present.

THE EAST GODAVARI DISTRICT R. M. Ps. ASSOCIATION.

An extraordinary meeting of the Association was held on 30.10.1938 in the Town Hall, Cocanada under the Presidentship Dr. V. C. Kamaraju L. M. & S.

After discussing about the Government Memorandum No. 34730/1 D. 2. P. H. dated 30th September 1938 the meeting

came to the following conclusion which was to be communicated to the authorities.

That the conditions proposed in the Memorandum are unworkable as it was found from the collected statistics that the average monthly income of the Subsidized Practitioners in the District was Rs. 17 only and that even after the working of the Scheme for 13 years, the Practitioners were not able to stand on their own legs due to ignorance and poverty of the masses in the villages. The meeting requested the District Board President to recommend to the Government to drop the idea conveyed in the Government memorandum.

THE SOUTH KANARA DISTRICT MEDICAL ASSOCIATION.

A special meeting of the Executive Committee of the above association was held on 6.11.38 in the Wenlock Hospital with Dr. K. Vittal Shetty, President in the Chair to consider Memo. No. 34730/1 D 2 P. H. dated 30.9.1938 regarding the future pay and prospects of Rural Medical Practitioners.

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

"Resolved that in view of the arduous, prolonged and expensive course that Medical Practitioners have to undergo; and the fact that the Rural Medical Practitioners have to settle down in remote villages with absolutely few amenities; and the fact that the villager is so poor that he cannot possibly pay anything tangible for the services rendered which naturally led the Government to grant subsidies and free medicines, though admittedly meagre; this Association is emphatically of opinion that in the best interests of Rural Medical Relief, the Rural Medical Practitioners should not be forced to work under the new scheme, Memo. No. 34730/1 D2 P. H. dated 30-9-1938 which is sure to cause hardship to the Practitioners, and considerable difficulties to the obviously poor suffering villagers."

GOVERNMENT OF MADRAS

Education and Public Health
Department

(Public Health)

G. O. No. 3510. 4th October 1938

Medical institutions—Rural—(Subsidized)—
Form of agreement to be executed by medical practitioners—Revised.

Order—No. 3510, P.H., dated 4th October 1938.

The Interim Managing Committee of the Rural Medical Practitioners' Association made certain suggestions for amending the form of agreement to be executed by medical practitioners in charge of rural dispensaries subsidized by Government. The Government have carefully considered these suggestions and they have decided to make the following changes in the existing form of agreement:—

(1) *Preamble*.—This does not indicate clearly the wording to be adopted when the agreement is entered into for the first time as well as when it is renewed subsequently. The Government have decided that a separate form of agreement should be prescribed for renewals. The minimum period for which an agreement may be made for the first time is now one year. It has been suggested that this minimum should be fixed as five years. The Government consider that the minimum period should continue to be one year but that presidents of local boards should enter into agreement with a rural medical practitioner for longer periods than one year, wherever possible, subject to a maximum period of five years. They should also take steps for renewing the agreement entered into with a rural medical practitioner in time so that the renewed agreement may come into force on the expiry of the existing agreement and there may be no break in the contract entered into with the medical practitioner.

(2) *Clause 7*.—It has been suggested that a rural medical practitioner should be granted leave of absence from duty for thirty days in a year instead of fifteen days and that if a substitute is found necessary during the period, the Government should pay subsidy to the substitute. It has also been suggested that a rural medical practitioner should be allowed to accumulate his leave for a period not exceeding three months during the period of his service, in case he has to undergo special training in medical science. The Government have decided that leave of absence from duty should be limited to thirty days in the aggregate in a year, including the public holidays, that a rural

medical practitioner should not be granted leave for more than fifteen days at a time and if this is exceeded a substitute should be appointed and he should be paid the subsidy due for the period he is in charge of the dispensary. They are of opinion that if the absence of the medical practitioner for more than the period specified in the agreement is due to his undergoing a refresher course he may be allowed to have a lien on his appointment for a period of six months. He cannot, however, be permitted to accumulate leave of absence from duty for the purpose.

(3) *Clauses 8 and 9.*—Under these clauses rural medical practitioners are prohibited from standing for election to any legislative body or local authority and taking part in any political movement. It has been pointed out that rural medical practitioners should be treated as general medical practitioners and they should not be deprived of their civic rights. The Government have decided to remove the disabilities and to delete the two clauses referred to above.

(4) *Clause 10.*—There is no provision in this clause for the closure of a rural dispensary when it is considered necessary to establish a regular local fund dispensary in the village or when it has to be shifted to another village on account of its proximity to other medical institutions. The Government have decided that provision should be made for such contingencies.

(5) *Clause 11.*—The Managing Committee of the Rural Medical Practitioners' Association has suggested that a subsidized rural medical practitioner may be given the status of a gazetted officer for purposes of drawing travelling allowance and daily allowances and that he should not be required to perform routine vaccination when entrusted with public health work. The Government have decided that in future rural medical practitioners should be treated as officers falling under Grade IX for the grant of travelling allowance in connexion with epidemic or festival duty instead of grade XII. They accept the suggestion that rural medical practitioners should not

be required to perform routine vaccination subject to the modification that a rural medical practitioner should do vaccination when smallpox breaks out in any of the villages within five miles of his headquarters.

(6) *Clause 12.*—Owing to the abrogation of the Madras District Boards (Communal Representation) Rules, 1935, in respect of the appointment of local fund medical officers, sub clause (b) of clause 12 has become unnecessary. It will therefore be deleted. The wording of the clause will also be altered so as to be in conformity with rule 1 of the rules relating to appointment of officers and servants of local boards.

(7) *Clause 13.*—A rural medical practitioner has a right to appeal to Government against the order passed by the president of a local board without reference to Government, but there is nothing to prevent the president from giving effect to his order before the appeal is disposed of by Government. The Government have decided that the services of a rural medical practitioner should not be terminated by the president of a local board before orders are passed by Government on his appeal provided it is preferred within one month from the date of receipt of the order of the president. The Government have also decided that the agreement should be terminated only in the manner provided for and that when it is not possible to do so before the expiry of the subsisting agreement it should be renewed for the minimum period of one year and action should then be taken to terminate it after observing the prescribed formalities.

2. The form of agreement as revised with reference to the changes indicated in paragraph 1 above, is appended to this order. Presidents of local boards are requested to take fresh agreements in the revised form from all the rural medical practitioners working under them.

3. The Government have also considered the other requests made by the Interim Committee of the Subsidized Rural Medical Practitioners' Association and they proceed to pass the following orders:—

(a) (i) *Employment of a nursing orderly (ward attendant) in each rural dispensary in addition to the midwife.*—The Government consider that it is sufficient to employ a dispensary servant in every rural dispensary where the daily average attendance during the last two years has been over 50. Presidents of local boards are requested to take steps to employ dispensary servants in those dispensaries if they have not already been employed;

(ii) *Rate of subsidy to the rural medical practitioner to be fixed at Rs. 600 per annum.*—The Government regret that they cannot increase the present rate of subsidy.

(iii) *Payment of Rs. 5 per mensem for postage, stationery and contingent charges.*—In G. O. No. 167, P. H., dated 17th January 1938, the Government have directed that the system of paying a fixed allowance should be discontinued and that contingent charges should be paid up to a maximum fixed by the local body with reference to the circumstances of each case. Local bodies are requested to fix the maximum at Rs. 3 per mensem.

(iv) *Payment of remuneration for leprosy work.*—The Government consider that leprosy work should be included in public health work and that no separate remuneration should be given for leprosy work.

(v) (a) *Exemption of rural medical practitioners, from the age limit prescribed for their appointment as medical officers in regular local fund medical institutions.*—Under G. O. No. 714, P. H. dated 4th March 1936, the Government may exempt rural medical practitioners from the age limit prescribed for their appointment as medical officers in regular local fund medical institutions.

(b) *Transfer of control over medical relief scheme from the local bodies to a body to be constituted by Government in each district.*—The Government are not prepared to accept the suggestion.

(c) *The professional work of rural medical practitioner not to be interfered with. He should be made the appointing authority*

in respect of the staff who are to work under him.—The Government decline to accept the suggestions.

(d) *Official control over rural medical practitioners in respect of public health work should be one of guidance and not dictation.*—In G. O. No. 2639, P. H., dated 21st July 1938, it has been laid down that rural medical practitioners will when doing public health work, be under the control of District Health Officer.

(e) *Survey of the Presidency for the proper location and distribution of rural dispensaries.*—The Government have already communicated to local bodies a list of villages where medical relief is urgently required and which are suitable for the opening of new rural dispensaries. They have also issued instructions in regard to the location of rural dispensaries and for the removal of the rural dispensaries which are considered to be superfluous to other centres where medical relief is urgently required. The Government therefore consider that there is no need for undertaking the proposed survey at present.

(f) *Under no condition a subsidized rural dispensary should be converted into a regular local fund dispensary.*—The Government are not prepared to accept this suggestion.

(g) *Preference should be given to rural medical practitioners when honorary medical officers are appointed.*—The claims of rural medical practitioners will be duly considered when they apply for appointment as honorary assistant medical officers as and when applications for such appointments are called for.

(h) *Rural medical practitioner to be recognized as the advisory head in the village in matters relating to public health and to be nominated to the local panchayat board.*—The Government decline to accept these recommendations.

(i) *A leave reserve to be constituted for filling up vacancies among rural medical practitioners.*—The Government are not prepared to accept the suggestion.

(i) Excise rules relating to the stocking of excisable drugs by the rural medical practitioners to be the same as those that apply to drugs supplied to Government and local fund medical institutions.—The matter

is under consideration separately and orders will be issued in due course.

(By Order of His Excellency the Governor)

C. H. MASTERMAN,
Secretary to Government.

NOTICE.

Recent events should it is requested wake up the Subsidized Practitioners to their sense of responsibility and such of those who have not as yet enrolled themselves as members of the Association are earnestly requested to do so without delay. Every District must have a Branch of the Parent Association and the District Branches must elect a member from each District to represent it in the Provincial Committee and unless the members in the Districts enrol themselves as members of the Association they cannot elect their representative in the Provincial Committee. The Provincial Committee and the Working Committee have to meet as early as possible to discuss affairs relating to the Government Memorandum No. 34730-1-D2 dated 30.9.1938 and the recent Government Order No. 3510 dated 4.10.'38 dealing with the new Agreement Form. It need hardly be said that the stronger the Association the better the chances of success either now or in the future. Application forms for membership were sent enclosed in the September issue of The Medical Practitioner. If any member wants one he may apply to the General Secretary, P. S. R. M. Ps' Association, Vepery, Madras.

M. R. BHAT,
General Secretary,

P. S. R. M. Ps' Association.

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Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the period from 31st July 1938 to 31st October 1938.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance with the President on 31-7-38 (as per previous statement of account) ...	106 2 9	Postage for correspondence ...	9 7 3
Subscriptions received from Members from 31-7-38 to 31-10-38 ...	111 0 0	Stationery ...	0 15 6
Entrance fee received from 8 new members ...	2 0 0	Remuneration paid to the part-time Clerk for July, August and September 1938 (at Rs. 10 per mensem) ...	30 0 0
		Travelling allowance paid to the Members of the Working Committee which met at Madras on 31-7-38 ...	55 12 6
		Amount credited to the 'Medical Practitioner' from the subscriptions received from 36 Members at As. 8 each ...	18 0 0
		Balance:	114 3 3
		With the Savings Bank at Vepery Post Office. 94 2 0	
		With the President ... 10 13 6	104 15 6
Total ...	219 2 9	Total ...	219 2 9

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A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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Original Articles.

DYSENTERY

By

DR. K. NARAYANAMURTHI, M.D.

(Continued from the last issue)

RARE TYPES: BALANTIDIAL DYSENTERY.

It has long been known that *Balantidium coli* causes dysentery as it is found occurring in close association with dysenteric diarrhoea. Strong and Musgrave found out that this organism caused a particular type of colitis resembling in many respects the dysentery caused by *Entamoeba histolytica*. Though cases have been reported all over the world, that *Balantidium Coli* was the sole organism causing a specific type of the dysentery, this infection is extremely rare in India. In Germany, Russia, Italy, China, Egypt, and France the infection of *Balantidium coli* is very common and particularly in those individuals that rear pigs. However it is not known how this organism gets into the human intestines. It is established that it is a parasite on the pigs and the apes in which it causes a fatal form of dysentery. *Balantidium coli* can live outside the intestinal tract of these animals and the organism can live in water or faeces for many days. In liquid stools it exhibits marked activity. It can be grown on artificial media of a mixture of inactivated human serum with salt solution.

PATHOLOGY: There is nothing to distinguish macroscopically or microscopically between the ulceration of Amoebic dysentery and that of the dysentery caused by *Balantidium coli*. The organism can be discovered more easily in the substance of the mesenteric glands rather than in the ulcers. The inflammation varies from that of a catarrhal congestion to that of a Diphtheritic inflammation. The *Balantidium coli* was demonstrated not only in the exudates on the surface of the bowel but also in the lumen of blood vessels and lymphatics. The whole colon is affected uniformly, the lesions resembling those of Amoebic dysentery.

SIGNS AND SYMPTOMS: The symptoms caused by this parasite is indistinguishable from those of Amoebic dysentery. The disease is chronic in type and it is only discernable on microscopic examination of the stools. There are no blood changes, there is no leucocytosis and the polymorphs may be about 70 per cent. Severe colic, tenesmus, thirst, loss of appetite and cachexia are the characteristics in the disease.

TREATMENT: Walker from his experimental work discovered compounds of silver are the most active substances in eradicating the disease. Thymol, Oil of Chenopodium have been also reported to be useful.

HELMINTHIC TYPE.

The third type of dysentery as described in the previous issues of the journal is Helminthic form of dysentery.

BILHARZIAL DYSENTERY: Ulceration of the large intestine caused by the passage of spined eggs through the coats of intestinal canals is found commonly occurring in infections with *Bilharzia mansoni*, *Bilharzia japonica* and very rare with *Bilharzia haematobia*. The form of dysentery produced by these helminths is met with in those countries where the parasites occur. These parasites are not indigenous in India.

The stools contain yellow or bile stained mucus with clots or streaks of blood in which the eggs of the parasite can be discovered even under the low power of the microscope. A high Eosinophilia in blood together with symptoms of dysentery in a locality where the organisms are found is highly suggestive of the existence of that particular parasite and the diagnosis should be confirmed by the discovery of the characteristic eggs in the faeces of the doubtful cases; a sigmoidoscopic examination will also be helpful. In making a microscopic examination of the faeces it is of interest to remember that the eggs are more easily found in the outer zone of the solid faeces than in the more fluid portions inside.

There is another helminth other than the above three, called *Oesophagostomum apiostomum*. This is an intestinal parasite of man in northern Nigeria and Central Africa and when present in large numbers in the host causes dysentery. The adult worm consists under the submucosa of the intestines and may together with its eggs be discovered in the dysenteric discharges. The occurrence of this infection is not reported in India and therefore the practitioners here need not know anything

about the parasite. *Fasciolopsis buski* occasionally does occur in India (Lal Chandler 1923) causing dysentery but it is so rare to contribute an exceptional curiosity.

DIFFERENTIAL DIAGNOSIS: In endemic areas mixed infections of all the different forms of dysentery may occur. Double infection of Amoebic and Bacillary dysentery are the most common. Such cases do not usually occur in temperate countries nor during the course of several epidemics of Bacillary dysentery. Usually bacillary infection supervenes upon a long standing Amoebic ulceration of the bowel. On the other hand a Bacillary infection may be followed by an Amoebic infection which makes the matter more difficult. It is common to see Bacillary dysentery as a terminal event in intestinal Bilharziasis and sometimes Amoebic ulcers are recognised as a concurrent infection in the same condition.

GIARDIASIS OR LAMBLIASIS: This is an infection caused by a protozoa found commonly in the intestinal canal of man. The usual habitat of the parasite is in the upper part of the small intestine but at times we may find it heavily infesting the duodenum. In fresh stools the cysts of the protozoa appear in large numbers and are often associated with those of *E. histolytica*. They are generally found in about 4 to 16 p.c. of cases of dysentery in India. In American school children this infection is found to occur in 48.1% of them. In children *Giardia* infection is 3 times as common as in adults. In Britain and in Canada the parasite has been found in the intestine of a large percentage of the normal children. Boyd and Silverman have demonstrated this parasite in the duodenal contents removed by Einhorn's tube as well as in the bile. The occurrence of the parasites in the stomach contents has also been recorded.

Infection with *Giardia* is associated with recurring diarrhoea accompanied by abdominal discomfort. The stools are peculiarly clay coloured and of a pulsatious consistency and may resemble

the stools in Sprue or in Children in England may resemble coeliac disease. On microscopic examination the cysts of *Giardia* may be discovered. Relapses of a periodic type always tend to occur but eventually a tolerance to the parasite is acquired by the patient. Flatulence is the most commonest symptom. In the acute stage of the disease the abdomen is tender and there is general discomfort. The attack is not accompanied by emaciation and symptoms are thought to be due to the mechanical action of the parasite. No lesions are discovered where this parasite is found exclusively though in mice the parasites cause severe diarrhoea and ulceration and the parasites are found in the submucosa in the sections of the gut. Infection with *Giardia* is intractable and may be present for years. Hegner considers that the number of these parasites is dependent on the diet of the individual

as he discovered that in meat dietary the parasite completely disappearing.

TREATMENT: Manson-Bahr reports complete disappearance of the parasites by the administration of yatriin by mouth as well as by a rectal retention enema. It is however extremely difficult to be certain of a complete eradication of the parasite as it is discovered reappearing in large numbers in stools after an absence of several months. This makes one think if this parasite has periods of activity alternating with periods of quiescence. Large quantities of fluid as a high colonic lavage with a solution of chamomile is found to be beneficial. This is usually combined with a high protein diet and Bismuth Salicylate in dram doses three times a day.

(In the next issue of the Journal Pseudo-dysenteries will be discussed.)

TRACHOMA*

By

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This is a subject that every doctor knows and that is why it is selected for discussion. We shall take that trachoma is a chronic affection of the inner surface of the upper eyelid. This disease is also known as Granular lids. As to its cause a real specific organism is not yet discovered and infection from persons suffering from it, is the direct cause for its spread. It may begin as acute Conjunctivitis or may develop in an incipient way without apparent signs and symptoms. The chief locality for these granules is the upper fornix of the eye and unless the lid is doubly everted the affected portion may not be visible. Generally the cases that go to a qualified doctor are those that have lapsed a long time under the treatment of quacks by

various native leaf juices and other metallic preparations. As a result they are found badly resistant to ordinary lines of scientific treatment because also the cornea is involved either by ulceration or by fleshy pannus producing the appalling signs and symptoms of constant watering redness, photophobia and ptosis of the eyes. Generally that is the condition of the cases that go to us. But in some rare cases in spite of large granules the eyes look normal just as persons having large tonsils live without trouble. Before proceeding to begin treatment I always divide the cases on broad lines into two groups:

1. The cases that require simple external treatment without operation.
2. Cases that require both external and internal treatment including operation.

* Paper read on 8-12-38 before the Guntur District Medical Association.

In all these cases the constitutional state of the patient greatly influences the progress of the disease. In children scrofulous diathesis is a factor for a bad prognosis and in adults mostly syphilis and such other conditions. Of course unclean habits are understood to be common predisposing causes in almost every case. I always prefer sedative line of treatment. If there is no discharge of pus and the eyelids do not stick in the morning, no washing of the eye is ordered. In every case as a routine zinc drops are used, because by experience I find that *Morax bacillus* also is present in granular lids for which zinc is the specific. Next I apply chloretone ointment with a drop of Atropine on the first day. No silver or copper is applied until all the acute symptoms are reduced to a minimum. It is to be remembered that the cases have already had lot of copper and silver preparations before they go to us and to repeat the same to start with will shatter the faith of the patient in the treatment. So the non-irritative line of treatment is not only rational but will have a psychic effect. In three or four days the condition will be much better. Then under Cocaine drops two or three times (to be instilled at an interval of 5 minutes), the lids are scrubbed with silver solution weekly twice. In about two weeks, the eyes become nearly normal. If no such improvement is seen, I apply Roller Forceps and scraper as well and remove all granules. This procedure is found excellent and the patient generally need not have many further applications of silver and may go home early with sedative zinc and boric drops. I advise the patient to put a drop of Chalmoogra Oil daily at bed time for some days just to keep the lids lubricated. This oil is reputed to possess some properties of curing Trachoma. In cases where cornea is damaged by ulceration, Dionine drops also are applied besides Atropine, Zinc, and Sedative ointment with Calomel dusting which has got a good property in healing the ulcers on the cornea. In these cases, I do not adopt the silver rubbing method but undertake operative procedure as deep peritomy for the pannus or complete cleaning of granules by scraping

with instruments under local Cocaine anesthesia. This is done after the eye is free from pus. Irrigating the eye with Mag sulph solution twice daily serves well in checking discharge of pus. In about three weeks, the patient leaves the hospital with necessary advice to look after the eyes at home. Before discharging the patient, I repeat the brushing of the eyes with silver solution at least once or twice to ensure against the reappearing of the granules. No copper is used because I do not see better results with it. It is not that I have prejudice against copper preparations. My only fear, by experience, is that copper application often brings about involvement of corneal ulcerations, and more care and attention are necessary for its use. Coming to general treatment in children I prescribe some palatable preparations of cod liver oil rich in vitamins A and D and also advise them to avoid all near work until the eyes are free from inflammation. In adults if blood is found positive for syphilis the specific treatment is given along with local eye treatment besides iron and vitamins prescribed in combination. To quicken the healing process of the corneal ulceration it is found that Yatrini 105 and milk injections are very helpful and in some select cases Campolon injections also have given encouraging results specially where anaemia is predominant.

Before closing my paper I wish to point out that the end result in neglected cases of Trachoma is nothing short of blindness due to total corneal opacity. The blind cases that we see at the bus stand, in the railway carriages and elsewhere are mostly the horrible results of this disease. For these blind cases no treatment is available except replacing opaque cornea by a healthy one taken from the living or the dead. This operation is now reported as being practised in foreign countries. From what I have mentioned already, it is seen that it is the complications that ruin the vision rather than the disease itself. So our aim should be first to prevent complications before cure of the disease is attempted. Towards achieving this object the patient

is to be strictly prohibited from attending to cooking work in the case of females to avoid smoke and heat and in the case of males and school children should avoid bright sunlights, road dust and reading. Goggles are advised. Correction of errors of refraction should be made and suitable glasses should be prescribed. I wish to point out that I have definitely found that sedative treatment is more effective and long lasting than a caustic one by copper or silver in combination or single. Copper is never to be used when corneal ulceration is present because the ulcers get worse on account of copper getting

into the ulcer but silver has not got such penetrating bad effect. When pannus and ulcers of cornea are present it is better that scraping of the lids and deep peritomy are undertaken without delay or else the complications do not get better soon. Lastly I wish to mention that I treat by operation, Entropion and Trichiasis which are the sequelae of Trachoma by shortening or widening the lid according to the merits of each case and rarely I resort to epilation for Trichiasis. As I never prescribe patent medicines, I have not made mention of them.

POST-MORTEM EXAMINATION OF THE NEW-BORN

By

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Though the postmortem examination of the newborn for medico-legal purposes, is conducted on similar lines to that of an adult, the appearances to be noted are peculiar to the new born, in as much as in the adult the chief object is to ascertain the cause of death, whereas in the newborn there are two more points on which information is required *viz.*, (1) whether the child was born alive or not and (2) what is the age of the foetus. Hence an outline of conducting a post-mortem examination on the newborn will be described.

EXTERNAL EXAMINATION: A good deal of information is available in the external examination and this should be carried out in a detailed manner.

SKIN: (a) the color of the skin whether it is pink or rosy or presents the greenish coloration of decomposition all over.

(b) whether fine downy hair is present or not.

(c) whether the skin is covered by the white greasy material, vernix caseosa

or not. The absence of vernix caseosa would indicate that the child has lived for some time after birth or that it has been given a thorough wash or bath.

INJURIES: Look for them specially in the scalp neck and around the mouth. Marks of finger nails around mouth or neck would form a valuable evidence in cases of suffocation and strangulation. Homicide of infants in this presidency is very often caused by these methods *i.e.*, strangulation of the neck by the hands, and by suffocation by gagging the mouth with mud, rags etc. Look also for the presence of any such foreign body in mouth or throat.

MEASUREMENTS: (a) Length of foetus as a whole and the length of each limb and the circumference of the head; (b) The weight of the foetus and also of the placenta if present; (c) the length of the cord if present.

UMBILICAL CORD: Note whether the placenta is present attached to the cord, or not, and in the latter case note how the cord has been severed, torn, clean cut, etc. A clean cut cord would show

that the body has been attended to after birth and cord cut by a sharp instrument; a torn cord would indicate that a sharp instrument has not been used or the tearing may be due to violence or precipitate labour.

The point of insertion of the cord with reference to the mid point of the body must also be noted. The mid point of the body is over the sternum in the earlier months and shifts downwards till at the full term it is close to the navel.

EYES: Note whether the lids are adherent or separate, eyelashes formed or not, membrana pupillaris, (membrane covering the pupil) distinguishable or not, pupils dilated or contracted. A contracted pupil may be suggestive of opium poisoning and a widely dilated pupil to poisoning by datura.

NAILS: Note the development of nails, whether they reach to the tip of the fingers and if there is any blueness of nails.

CHEST: Note the shape of the chest, whether it is flat or arched. Flat chest would indicate that respiration had set in, whereas a flat chest would point towards the non-occurrence of respiration.

GENITALS: Note whether external genitals are distinguishable or not and if so in the case of the male whether one or both testis are found in the scrotum.

INTERNAL EXAMINATION: The chest and abdomen is opened in the usual manner by an incision from the chin to the pubes and after a preliminary examination of the abdominal organs in situ during which the presence or absence of meconium in the intestines and the extent to which it is present is noted, as also the level of the diaphragm. The level of the diaphragm would be indicative of live birth or not. Usually in unexpanded lungs it is at the level of 3rd, 4th or 5th ribs but when the lungs are expanded it is at the level of the 5th, 6th or 7th ribs.

CHEST: (a) Note the colour of the lung. An uniform reddish brown colour indistinguishable from that of the liver

would be indicative of an unexpanded lung. After respiration the colour is pinkish, light red or bluish red, or may present a mottled appearance of light red areas mixed with the foetal livid areas.

(b) Expansion of air vesicle. These appear as silvery spots composed of a number of polygons on the surface, of the lung, not raised above the surface and the air in them could not be moved from place to place. The bullae due to decomposition are large irregular bubbles containing gas, projecting considerable above the surface, collapsing on pricking. If they are burst by pressure under the surface of water gas escapes as large irregular bubbles whereas if air is present due to respiration it escapes as uniform small bubbles.

(c) Note whether the lungs are distended and cover the heart to some extent and occupy a greater portion of the chest, or whether are unexpanded, retracted and lie in a recess of the chest, and whether they are crepitant or not on handling.

(d) Tardieu's spot: These are small points of haemorrhage under the surface of the pleura, of a blood red colour, varying in size from a pin point to a pin's head or larger, indicating asphyxia as the cause of death when present.

(e) Hydrostatic test: The lungs are taken out together with the heart and placed in a vessel preferably a glass one full of water to find out whether they sink or float. Due to the buoyancy of the contained air, they float up together with the heart if the lungs are expanded to a sufficient extent. Next the same is repeated with each lung separately and again after cutting each lung into 10 or 12 equal sized pieces. If they float in water firm pressure is applied to each piece and the test repeated.

(f) On sectioning the lungs, note the amount of blood contained in it the contents of the bronchi as froth, foreign body, mud, sand, etc.

HEART: Examine the surface for the presence of Tardieu's spots.

STOMACH: Examine for the presence of food as milk, or drugs, poison etc., the presence of which would indicate live-birth.

INTESTINES: Examine whether the valvulae conniventes have appeared or not in small intestines and for the presence or absence of meconium and if present to what length of the intestines. If the meconium is completely absent in a viable child it is usually due to expulsion after birth and would indicate live-birth except in the rare cases in which it may be completely expelled during a difficult labour.

HEAD: Note any haemorrhage in the scalp. Haemorrhage in the scalp may be due to a difficult labour or due to injury inflicted on the head and this will have also to be differentiated from a caput succedaneum. This is usually a serous effusion which may be mixed with a varying amount of blood and is found over the presenting parts.

Look for any fracture of the skull and on opening the cranial cavity for haemorrhage or injury to the brain.

OSSIFICATION IN FEMUR: This is looked for by opening into the knee joint and making horizontal shavings in the Femur with a knife. The ossification centre would appear as a circular reddish brown spot on the milky white background of the cartilage, varying from 1/4" to 1/3" diameter in the full term child. The centre makes its appearance first about the beginning of the 9th month.

The essential appearances of the foetus during different age periods which would help one to estimate the age of the foetus are given below for ready reference:—

END OF FIRST MONTH: Length of the entire ovum 3/4". Eyes are just distinguishable. The extremities are represented by bud-like processes.

END OF SECOND MONTH: Length of entire ovum 1 1/2 inches. Limbs are more distinct. Mouth and nose could be made out. Kidneys have appeared.

END OF THIRD MONTH: Length of foetus 3 inches. Placenta formed. Neck and lips of mouth could be made out. Sex organs just apparent but sex indistinguishable.

END OF FOURTH MONTH: Foetus 6 inches. Weight 3 ounces, sex distinct.

END OF FIFTH MONTH: Foetus 10 inches. Weight 11 ounces. Hair appeared on head. Down over whole body.

SIXTH MONTH: Foetus 12". Weight 1—2 lbs, eyelids adherent. Pupils covered by a membrane. Skin is of a reddish colour. Testicles found in the abdomen lying below the kidneys. Nails slightly formed.

7TH MONTH: Length 14 inches. Weight about 3 pounds. Skin covered with vernix caseosa. Nails do not reach tip of finger. Valvulae conniventes appear in small intestine. Meconium present in caecum and colon.

8TH MONTH: Length 16 inches. Weight about 4 pounds; eyelids separated, membrana pupillaris absent. Meconium present in whole of large intestines. Testis in inguinal canal.

9TH MONTH: Full term. Length 18". Weight 5-6 pounds. Testis in scrotum. Nails reached tip of fingers. Meconium present in rectum. Ossification centre has appeared in femur and is about 1/4" to 1/3" in diameter. Hair on scalp 1" long.

It may be noted for easy remembrance that the length of the ovum is 3/4" at the end of the first month, thereafter it doubles its length upto the fourth month. Thereafter the length of the foetus is indicated by double the number of the age of the foetus in months i.e., for the first four months it is 3/4", 1 1/2", 3", 6". Thereafter say the 7th month it is 7 x 2 i.e., 14 inches.

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RURAL MEDICAL RELIEF

By

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THE IMPORTANCE OF VILLAGE IN INDIAN NATIONAL LIFE.

By instinct and tradition our forefathers chose the village as the foundation for their national life. Our immortal vedas, puranas, epics and kavyams were written amidst the ascetic surroundings of villages and isolated hamlets in the jungles of this continental Hindustan. Towns there were, mighty universities like Nalanda, there were, but the village was the fundamental structure which contained in essence every aspect of the then existing national life. Not only in India but in every other country in the remote past was village centred. Washington Irving's "Rural life in England" is a realistic picture of English rural life at the time of Irving. I often compared his description of the English rural life with the Indian rural life and I was struck by the similarity in human nature of the unsophisticated villager in both countries. But times have changed and in England 8 millions out of a total of 45 millions are huddled together in Greater London alone—a phenomenon which is an unmistakable target for a future enemy of England. This modern civilization, which is growing at the expense of the villages, may be doomed by any international catastrophe. So far as India is concerned, this wretched urbanisation brought about by industrialization and a bureaucratic heritage, may not land us in such a vulnerable position as the Greater London is at present on account of enormous extent of the country, but the development of the towns at the expense of the villages must be prevented now and now alone by bringing to the villager every essential amenity needed for his healthy physical, intellectual, material, and moral existence.

The villagers provide us our food, our raw material for clothing (Annam and Vasthras respectively) and the revenues directly or indirectly derived from the villages go to make up the Provincial and Central revenues, 50 per cent of which go towards the salaries of those in Government service. The major portion of the remaining 50 per cent of the revenue is spent in urban areas whether it be for medical relief or other amenities which the Government is bound to provide for the public, the people in rural areas having the benefit of the revenues in the inverse ratio of the amount collected from them. The unfortunate villager is made to feel that the Government exists for everybody else excepting himself who is the real feeder of the Government and who pays proportionately more revenue than his fortunate brother in the urban area. Since the advent of provincial autonomy, there is a genuine feeling on the part of the ministers to redress this legitimate grievance and in almost all the provinces village re-construction is engaging the attention of the Governments. Thanks to the patron saint of Wardha, Mahatma Gandhi, the villager has a mighty friend and philosopher in him and he, the villager looks forward with hope for a better national existence.

The problem of restoring the ideal village life is very very difficult indeed steeped as we are in traditions fundamentally unsound. Only a negligible portion of the revenue collected from villages go to the benefit of the villages. Unless and until the Government spends 50 per cent of the revenues for the material, moral and physical needs of the villages, there is no hope for improvement. This will entail revolutionary changes in the method of the Government. As the purpose of this

article is to discuss about medical relief in rural areas I shall confine my remarks regarding the necessity of the changes to be brought about by the Government in matter of rural medical relief.

The care of the physical bodies of the villagers by scientifically trained men, the medical practitioners, is such an important question relating to village reconstruction that it should be discussed with fundamental considerations and not in terms of the existing Scheme of Subsidized Rural Medical Service which does only some patch work here and there.

VILLAGE SANITATION.

The Medical Relief in rural areas as in urban should be curative as well as preventive. The primary and the most important items in Sanitation is water-supply, drainage and conservancy. Large scale measures that are adopted for cities and towns will not suit the conditions in the villages for obvious reasons. Village sanitation should be based on a plan, wherein the sanitary measures must be simple and capable of automatic working by the villagers themselves. To provide extra staff for water-supply, and conservancy, will not be practicable in the majority of villages. The spoon feeding in sanitary services obtainable in towns will increase the irresponsibility of the villagers. Except for water supply each house-hold must be held responsible for draining the water into a kitchen garden for the disposal of house-hold rubbish and for some dry earth system of conservancy. The ideal thing for each village household should be in the direction of building houses or huts in the midst of a plot of ground about half an acre in extent. Out of this about 5 cents can be reserved exclusively for a sort of trench latrine which may be

shifted from place to place within the area allotted. Water used in the house-hold can be profitably drained into kitchen garden with succulent plants. Water for all other purposes than drinking may be derived from a well in the plot if the sub-soil water level is within a reasonable depth. Though this may be ideal and may be practicable in dry districts it may be well nigh impossible in the delta villages with very little space for human habitation. In compact villages with very little space for providing at the rate of half an acre for each household, communal or common latrine accommodation must be provided at suitable reserved localities. Whatever device is adopted, the principle must be to impound the night soil into the soil and cover it immediately with earth. All house-hold rubbish must be incinerated in a common village incinerator or safely deposited under the soil. Every village must have a bacteria free supply of water for drinking and cooking purposes and at no stage until the actual distribution to the villagers, must there be slightest chance of contamination. The source will vary from place to place but purity must be the prime consideration.

THE PRESENT SO-CALLED SUBSIDIZED SYSTEM OF MEDICAL RELIEF.

The Subsidized System of Rural Medical Relief obtaining in the Madras Presidency at present is in many respects, demoralizing to the independence of the independent medical profession. The present Minister of Public Health may proclaim that he is fundamentally a private medical practitioner and may even allow him to stand for election on the ticket of a political party. But this privilege is purely theoretical. I shall put in a tabular form the difference between a private practitioner and a Subsidized practitioner.

No.	Items.	Private Practice.	Subsidized Practitioners.
1	Independent.	Really independent.	Independence a myth.
2	Choice of locality.	Can choose any place.	Must apply for an advertised post and then adopt it believing he chose the same.
3	Who are the masters?	His patients are the masters whom he tries to please by his best services.	The masters are many. 1. The Government. 2. The District Board. 3. The D. M. O. 4. The D. H. O. 5. The Public.
4	Has he freedom to leave the place temporarily?	Theoretically has, but practically a private practitioner seldom leaves the place for trivial reasons.	Emphatically no. Must get permission from the superiors.
5	Can he be sent away from the place?	Never, without his will.	Can be sent away for even frivolous reasons. The poor man must go on appealing to Government for months and months.
6	Has he liberty to choose and purchase drugs at his discretion?	Yes.	Has liberty perhaps to choose but cannot obtain them from the market. Has to indent on the Govt. Medical Stores with its proverbial delay.
7	What does he think of himself?	He behaves as an independent gentleman.	Thinks he must somehow try to please the superiors and has thus an undeserved inferiority complex.
8	Can he appoint his own subordinates?	Yes.	No.

In this table, I have enumerated one, some of the important difference between an independent private practitioner and the so-called independent Subsidized Practitioner. In the actual working the difference told and untold will be numerous. This wonderful subsidy is the chief factor in bringing down an independent self respecting gentleman to the level of a dependent self reproaching half-paid servant, thankful for the mercies of the powers above, such as putting them in Grade IX from Grade XII and giving them all told one month's leave. What a fall? I have no hesitation in characterising this system as a pucca official system in which the officers are to work on a famine ration, or on an unemployment dole. To proclaim that a subsidized practitioner is essentially an independent practitioner is far from truth. It will be as well to tell these practitioners plainly that they are pucca Government servants on a

pensioned salary. It will be well also to provincialise the rural service and transfer the officers every three years. To bring this service to such a low level, I must blame the subsidized practitioners also to a certain extent. They have not attempted to tackle the fundamentals. They have all along petitioned for this favour and that favour and have never jointly asserted their independence. If they had done so, they would have got rid of the 5th wheel of the coach (I mean the Local Board). they might have obtained liberty to purchase their drugs from any source, got freedom to appoint their own midwives, and might have put the plan of subsidy on an equitable basis, without surrendering a bit of their independence. It is not too late even now, and our responsive Minister of Public Health may yet restore their position as primarily a private practitioner with certain obligations to the poor patients.

PRACTITIONER SUBSIDIZED OR SUBSIDIZED PRACTITIONER.

Before this system is allowed to stabilize one way or the other the Government and the medical personnel of the system must clarify between themselves this fundamental question *viz.*, Is the rural medical man a practitioner who is subsidized to treat poor patients or is he a subsidized medical servant who is allowed to have remunerative practice with paying patients. Whether it is the former or the latter must be settled. If this is settled the so called grievances can be made to disappear. By all past and recent pronouncements the Government declare they stand by the former interpretation but in actual practice they adopt the latter interpretation. If the Government really mean the latter thing, they ought to provincialise the system on certain fixed principles, and must be prepared to spend an enormous amount.

Undoubtedly provincialization is out of question. The cost will stagger the most optimistic finance minister. So the Government must stick and act up to the former interpretation and treat the rural practitioners as independent gentlemen who are given a certain grant to treat poor patients free. This is on a par with the Government giving grants to private institutions like the Madanapalle Sanatorium, private schools, private colleges, and autonomous universities, where the Government does not concern itself with the internal management so long as the purpose of the grant is fulfilled. Does the Government, for instance, insist that the Madanapalle Sanatorium should purchase drugs only from the Government Medical Store, or that the Madras University should purchase its stationery from the Indian Stores Department? The Government give a grant and do not bother further. In the same way the English voluntary hospitals are or will be getting grants from the British exchequer but will the voluntary hospitals surrender an iota of their independence and voluntariness? Even in the case of private elementary schools and teacher manager schools, the Government give a grant and do not concern

themselves with the minute details. They only satisfy themselves through their inspecting agency, whether the attendance is satisfactory and whether the teachers are qualified. Why should they, in the case of medical men alone frame rules and regulations as if they are full time Government servants?

So the whole system must be recast on the basis of a simple formula, like this: (1) The Practitioners can choose their own places which must be situated at a distance of not less than 4 miles from the nearest centre of medical relief private or public. (2) Having chosen the place the practitioner must have put in at least six months' practice in the locality, before he applies for subsidy to an authority. (3) The authority should pay at the rate of two annas per poor patient treated subject to a maximum of Rs. 75 per month for each practitioner. (4) The authority shall pay an additional Rs. 25 per mensem if the practitioner has engaged a full-time qualified midwife. (5) Injections or vaccinations done at the time of epidemics may be treated as extra and a suitable remuneration given perhaps at the rate of 1 to 2 annas. School medical inspections also may be treated as extra and a suitable remuneration offered. Besides this the practitioner need not be paid for any advice given to the village panchayat regarding sanitation or for doing propaganda on sanitation etc. If the practitioner is unpopular he automatically gets nothing and goes away or starves. Even supposing there are two practitioners in a village, and if both of them apply for subsidy, both of them should be given. The practitioner must decide and work out his own destiny.

Elsewhere when discussing the question of medical relief in India as a whole, I have pleaded for the abolition of all Municipal and Government dispensaries and for establishing a system of national medical relief by paying subsidies to any private practitioner practising in towns and villages. I want the same principle to be adopted in the case of rural medical relief.

INSPECTING AUTHORITY.

The District Medical Officer must inspect the offices and registers of these practitioners once in a quarter and certify to their accuracy. He must be the authority for disbursing the grants. Between the medical practitioner and the Government, this must be only officer who should act as the connecting link. The Local Boards must be relieved of any form of responsibility or voice in the matter, but may pay their grants through the District Medical Officer.

MEDICAL RELIEF IN VILLAGES IN CONTIGUITY TO TOWNS.

Private practitioners settled in towns

should individually or jointly open medical relief and health out-posts and visit them at stated times every day or on alternate days depending upon the needs of the locality. This is a very practicable measure. In the case of these out-posts the authorities can give the same measure of subsidy or grant.

CONCLUSION.

I do not believe in small mercies. I want the fundamentals to be tackled. I want the rural medical practitioner to assert his independence even at a temporary disadvantage.

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Abstracts.

DIGITALIS: ITS INDICATIONS AND CONTRAINDICATIONS.

BY

JACOB BURSTAN, M. D., NEW YORK.

Digitalis, U. S. P. XI, consists of the dried leaf of digitalis purpurea; the crude drug, the powdered leaf and the tincture are official. The potency of official preparations is adjusted so that 0.1 gram, approximately $1\frac{1}{2}$ grains, when assayed, shall possess an activity equivalent to not less than 1 U.S.P. digitalis unit which is the equivalent of the International Digitalis Unit.

Standardization of digitalis is accomplished by the frog and cat method. In the cat method of Hatcher, digitalis in the form of a hydroalcoholic extract is injected intravenously into the femoral vein and the amount per kilogram of body weight that is required to produce systolic standstill of the heart in one hour, is termed a "Cat Unit." This is really a measure of toxicity but it serves as a very useful guide to dosage.

Under the best methods of preservation which include keeping the drug in water-proof, air-tight containers protected from light, properly standardized digitalis tends to lose approximately 20 per cent of its potency in 18 months. Thus it will be seen that in the official preparation, wide variations in therapeutic activity may be encountered. There is an official note in the Pharmacopoeia which states that: "owing to the many variable factors in the standardization of digitalis, all assays which are within 20 per cent above or 20 per cent below the official standard are acceptable."

Digitalis depends for its action upon the content of the so-called "Cardiac Glucosides." These or similarly acting glucosides are found in many plants other than digitalis, of which Strophanthus, Squill, Adonis, Convallaria, Oleander and Apocynum, form the most important group. Apocynum was labeled by the older

clinicians "The Vegetable Trocar" owing to its efficacious reduction of dropsy. In addition to the above mentioned plant sources, poisons isolated from the glandular secretions of toads have been found to possess a digitilis-like action.

The cardiac glucosides occur not only in the leaves, but in the flowers, fruit, seeds, bark, and roots of the various plants. The digitalis leaf, however, is the most popular and best studied source of these active principles, although of recent years squill has been receiving an increasing amount of attention.

Squill and apocynum form the chief ingredients of one of the popular preparations for use in cardiac failure and dropsy. The earliest mention of squill in a medical preparation is found in a prescription in the Papyrus Ebers, dated about 1500 B. C. In the sixth century, a manuscript of Dioscorides contains a characteristic drawing of the squill plant. In the middle of the 18th century, van Swieten emphasized the importance of squill as a remedy for dropsy. However, full credit for the introduction of cardiac glucosides into modern medicine must be given to William Withering, who in 1785 published a monograph entitled "An Account of the Foxglove and Some of its Medicinal Uses with Practical Remarks on Dropsy and Other Disease." This monograph is to this day considered a very instructive work on the subject of digitalis.

Three glucosides have thus far been isolated from digitalis in a chemically pure state. First and most important is Digitoxin, second Gitoxin, and third Gitalin. The old digitalein crystals "Nativelle" were probably an almost pure form of digitoxin introduced by the

French about 1870, and used by the older clinicians until the earlier years of the present century.

Digitoxin, at present the most important of the cardiac glucosides, is sparingly soluble in water and on hydrolysis, one molecule of digitoxin having a formula of $C_{41}H_{64}O_{18}$ with the addition of three molecules of water yields one molecule of digitoxigenin $C_{29}H_{44}O_4$ plus three molecules of digitoxose $C_6H_{12}O_4$.

According to Christian, the digitoxin of digitalis, on the circulation through the heart becomes fixed chemically to the heart muscle and although for a few seconds the fixation is a loose one and under experimental conditions is capable of being washed out by saline or blood; clinically, however, it soon becomes fixed and cannot be removed from the heart muscle either physically or chemically. This is an important fact in the consideration of the toxic action of digitalis.

After glucosidal fixation, digitalis action begins in the heart due to the splitting of the digitoxin by the living protoplasm into its genin and sugar, namely, digitoxigenin and digitoxose. The digitoxigenin is the cardioactive and toxic fraction of digitoxin. The digitoxigenin is not permanently fixed, which accounts for the gradual elimination of digitalis from the heart muscle.

Another explanation, that of Stroud is that the cardiac glucoside and cholesterol combine to form a cholesteride and it is completely utilized in this form. Still another explanation is the association of the muscular action of digitalis with changes in the creatine content of the heart muscle (Herman and Dechard).

Digitalis action may be classified as pharmacologic, therapeutic and toxic. Pharmacologic studies of digitalis by Cuchny published in 1925, give a very excellent description of the action of this drug on frog and mammalian hearts. The action of digitalis on normal hearts is of great importance. It is well established that it causes a decrease in the size of the heart and a decreased ventricular out-

put, and is detrimental to the normal heart. The same process occurs in the hearts of persons with congestive failure, but with beneficial results.

The chief problem regarding the muscular action of digitalis relates to its clinical effects. McKenzie and Lewis early emphasized the influence of digitalis upon the ventricular rate especially in cases with auricular fibrillation, and they attributed the benefits from it chiefly to the slowing of the ventricular rate. Later it was found of great value in cases of myocardial insufficiency with normal cardiac mechanism. This was conclusively demonstrated by Luten in a study of a series of cases to determine if rest in bed rather than the digitalis was responsible for the improvement in cases without auricular fibrillation. After a preliminary period of carefully controlled observation, large amounts of digitalis were administered to patients with varying degrees of heart failure, and he felt that the resultant benefit could only be attributed to the digitalis.

Digitalis acts on the heart in a complex manner. It tends to depress the pace-making function of the sino-auricular node and the A-V node, thereby slowing the heart rate. This is partly due to a vagal action and cutting the vagus or paralyzing the vagus with atropine will remove the vagal inhibition. In addition to vagal action, slowing of the rate is also in part due to sensitization of the carotid sinus and the aorta, which results in a reflex increase in vagal tone with a decrease in sympathetic tone.

Another digitalis effect on the conduction system occurring throughout the heart muscle, causes an increase in the refractory period of both the auricular and ventricular muscle. This is most marked in the A-V conduction system affecting the A-V node and bundle with degrees of A-V block varying from slight prolongation of conduction time to partial and even complete A-V block. This depressant effect on conduction which is probably a toxic one, is really one of the ways in which digitalis benefits the heart since it tends to produce a greater diastolic

volume by prolonging the time of diastolic filling, and it is usually associated with marked relief of the symptoms and signs of congestive failure.

Still another effect of digitalis on the heart is on contraction. The *modus operandi* is not thoroughly understood, but the force of ventricular systole is increased. This has been demonstrated experimentally in cats. The heart of the digitalized cat averaged an intraventricular pressure of 22 millimeters of mercury higher than the non-digitalized cat.

The indications for digitalis, according to White, are:

1. Congestive heart failure, with or without auricular fibrillation, auricular flutter or heart block.
2. Auricular fibrillation or auricular flutter with rapid ventricular rate.
3. As a therapeutic test when it is uncertain whether or not there is a slight degree of congestive failure or perhaps as a means of warding off impending failure, as in the case of old people with dyspnoea or exertion or of victims of chronic pulmonary emphysema with a higher degree of dyspnoea than is attributable to the lung condition alone or of patients with pneumonia.

In discussing the indications for digitalis, the differential diagnosis between circulatory failure due to disease of the heart and that due to peripheral vascular collapse is of the utmost importance. This has been outlined by Fishberg in his recently published volume as "The Cardinal Circulatory Syndromes":

Heart Failure	{ Hyposystolic	Failure of left heart
	{ Hypodiastolic	Failure of right heart
	{	
Peripheral Circulatory Failure (shock)		

The clinical picture of peripheral circulatory collapse or failure is characterized by weakness, ashen pallor, cold, clammy skin, tachycardia, weak pulse, and diminished blood pressure which may be so low that it is almost unobtainable. In this type of emergency, digitalis is of no benefit and tends to demonstrate the fallacy of the once prevalent procedure of administering digitalis in cases of post-operative peripheral circulatory failure.

In addition, digitalis has proved of little or no value in routine treatment of tachycardias associated with fever, with thyrotoxicosis and with hypersensitivity of the sympathetic nervous system. Its use is contraindicated unless there is associated evidence of congestive failure or auricular fibrillation.

In pneumonia especially, digitalis has long been used by many as a routine procedure, however, numerous investigations, notably those of Cecil and Wykoff, have shown that its use in pneumonia is dangerous and the mortality rate is definitely higher than when the drug is not given. Even the occurrence of auricular fibrillation in the presence of pneumonia cannot be regarded as an indication for digitalis.

In diphtheria, digitalis is definitely contraindicated except in the presence of positive evidence of congestive failure.

In the treatment of rheumatic fever, it is well to bear in mind that auricular fibrillation is often a result of the disease and the presence of auricular fibrillation and tachycardia is not to be considered an indication for digitalis. In many cases of rheumatic fever with evidence of heart failure in the presence of active rheumatic carditis, the response to

Pulmonary Circuit	Systemic Veins	Size of Heart
Engorged	Not engorged	Increased
Not engorged	Engorged	Increased
May or may not be engorged	Engorged	Diminished
Not engorged	Depleted	Diminished

digitalis has proved to be slight or none at all (Schwartz and Schwedel).

The routine use of digitalis as preoperative measure, especially in elderly individuals was long a common practice.

It was given in the hope that it might prevent postoperative shock and lessen the strain of the operation on an otherwise normal or nearly normal heart. This theory has proved fallacious and in addition, the fact that the efficiency of a normal heart may be impaired by digitalis makes its preoperative administration a greater danger than benefit.

There are many differences of opinion as to when in a given case digitalis therapy should be instituted. Christian feels that as soon as the diagnosis of cardiovascular disease has been made, particularly when hypertension or a valvular lesion is present, which in turn places an added burden on the myocardium, the patient should be digitalized and a maintenance dose given throughout life.

Studies by Kuntz and Stroud and Van der Veer at the University of Pennsylvania suggest that in accordance with the all or none law of Starling there is a point in the progressive hypertrophy and dilatation of the heart muscle where a certain optimal length of the individual fibers is exceeded with a resultant diminished cardiac output followed by gradual or sudden development of signs of heart failure. On this basis it becomes the physician's duty to estimate by history, physical examination and fluoroscopic studies which are particularly valuable in estimating the variation in the size of individual chambers of the heart, plus electrocardiographic tracings, when this stage has been reached for this is the point where digitalis will preserve optimum cardiac output through increase in myocardial tonicity and ventricular contractions.

Digitalis therapy, as a preventive of subsequent attacks of heart failure in patients who have recovered from an initial attack, is of great value as established by Gold and De Graff some years ago. Digitalis

is likewise used to prevent an initial attack of heart failure in those patients in whom it might be expected to occur. Although it is impossible to predict that heart failure will develop in such cases, the work of Cloetta and Christian indicates that in cases of enlargement with hypertension or valvular disease unaccompanied by myocardial insufficiency, digitalis has been of definite value as a prophylaxis against future heart failure. It is possible that in some of the cases thus benefited, so called occult heart failure may be present.

The dosage of digitalis and the method of administration for best therapeutic effect are subject to many variations and among the numerous factors that must be considered especially, are absorption and the influence of the state of the gastrointestinal tract. Absorption of digitalis administered orally does not occur in the stomach but in the small intestine and to some extent in the large intestine.

The major absorption occurs in about 2 hours and is complete in about 6 hours. The time required to obtain a digitalis effect depends on the method of administration and the size of the dose. Slowing of the ventricular rate in auricular fibrillation has been observed within 5 minutes following a large dose intravenously.

A full therapeutic effect from oral medication usually requires from 8 to 24 hours, and from intravenous administration in large doses from 2 to 4 hours. After administration of the estimated total amount required it is well to wait 24 hours before giving additional smaller amounts. In rapid digitalization, dangerous overdosage when it occurs, is usually due to failure to allow sufficient time for the full effect of earlier doses to develop. Ventricular tachycardia and fibrillation are not uncommonly due to failure to observe this precaution.

"The matter of persistence of action is of great importance whenever large amounts of digitalis are thought to be indicated in the case of a patient who has recently received amounts of the drug which may have approximated the total

tolerated dose. It is upon just such occasions that the danger of serious digitalis poisoning is particularly to be kept in mind" (Luten).

Elimination of digitalis is not well understood. It is known that part of it is destroyed in the intestine. A small amount is destroyed by the blood and the remainder undergoes fixation in other tissues and is later slowly eliminated. In experimental animals, elimination of the drug occurs through the liver and kidneys. The rate of elimination in humans is variable but averages approximately 1.5 cat units per day after full digitalization. The method of computation of the amount of digitalis is roughly to estimate the total amount administered less the average daily elimination times the number of days administered. This gives the amount left in the body. Gold and De Graff feel that the amount eliminated varies with the amount of digitalis fixed in the tissues.

The intravenous injection of cardiac glucosides is dangerous, particularly when the patient may have previously been given some digitalis, since overdosage may easily occur and end in a fatality. The subcutaneous or intramuscular injection of an appropriate digitalis preparation may at times be advisable although the presence of anasarca may prevent absorption and render this method of dosage ineffective. Parenteral medication should be reserved for urgent and well considered cases in which oral dosage is rendered impracticable through vomiting, delirium or other condition.

Rectal medication with digitalis is quite satisfactory and may well be employed for patients who do not tolerate oral dosage. It is claimed that following this method of administration the drug is carried more directly to the heart than when it is given by mouth.

Tablets, capsules or pills of powdered digitalis leaves are the most commonly used dosage forms of this drug and because of their weighed accuracy they are more dependable than the tincture which

is not easily measured reliably by the patient. An average adult who has not recently had digitalis, will require about 30 grains of this drug by mouth in the course of several days to secure digitalization. The exact amount however, will vary from case to case. The large dose method is seldom necessary but occasionally may be needed in urgent cases. In an emergency when there is no vomiting, full digitalization can be accomplished with standardized digitalis in tablet form or with the equivalent amount of a glucoside preparation by the oral administration in $4\frac{1}{2}$ to 6 grain doses every 6 hours, within 24 to 36 hours.

In the average case of congestive failure, complete digitalization usually requires from 48 to 72 hours if the digitalis is given in 3 grain doses 3 times a day. For cases of mild or moderate failure, the same effect can be obtained in the course of 6 or 7 days by giving $1\frac{1}{2}$ grains of digitalis 3 times a day. After digitalization an average maintenance dose of $1\frac{1}{2}$ grains daily is usually sufficient, always bearing in mind the possibility of individual variations.

The choice of preparation is usually an individual matter. Any good standardized digitalis will and should serve the purpose. It is probably a good plan to choose one preparation and use it exclusively. Stroud and his co-workers obtained the following results with various preparations:—

Name of preparation	1 Cat Unit Grains	Full Digitalization Grains
American Heart Association whole leaf tablet.....	$1\frac{1}{2}$	18-30
Burroughs, Wellcome & Co. whole leaf tablet.....	$1\frac{1}{2}$	18-30
Digalen.....	$1\frac{1}{2}$	18-30
Verodigen.....	$1/240$	$1/20-1/12$
Digitalin (Nativelle).....	$1/600$	$1/50-1/30$
Digoxin.....	$1/160$	$1/13-1/8$

Several years ago the late Dr. Nemet of Montefiore Hospital suggested the use of Digilanid which is a stabilized preparation of the crystallized glucosides of the yellow digitalis leaf, *Digitalis lanata*. We also tried it for several months on the

cardiac wards at Fordham Hospital with uniformly satisfactory results.

The use of glucosidal preparations is advocated by some because they are uniformly potent and stable, however, the clinical results are similar and equal to those obtained with standardized digitalis and there is probably no definite superiority.

The toxic manifestations of digitalis are of great importance in considering its action. Clinically, symptoms such as arrhythmias, anorexia, nausea, vomiting and visual disturbances such as cloudy or colored vision should be looked for and when detected require reduction of dosage or perhaps withdrawal of the drug.

The effect of excessive doses on the heart will produce premature beats, A V block, S-A block, auricular standstill, auricular paroxysmal tachycardia, ventricular paroxysmal tachycardia (either uni- or bi-directional), and rarely ventricular fibrillation and death.

Electrocardiographically, early signs of digitalis action are T wave changes with a depression of the R-T segment, paintbrush effect on the descending limb of the R wave, negativity of the T wave and prolongation of the P-R interval. Multiple Premature Ventricular Beats occurring as a bigeminy, is usually an indication of severe digitalis toxemia.

The intravenous administration of calcium in patients to whom digitalis is being given is a dangerous procedure. It seems to cause an additive or increased digitalis action.

SUMMARY

1. The therapeutic effect of digitalis is a result of its action upon the ventricular muscle.
2. It is of value only in cases of actual or potential heart failure.
3. It does not cause increased work by the heart but tends to lessen the energy requirement of the failing myocardium and enable it to work more efficiently.

4. Evidences of cardiac improvement are in general abatement of signs of heart failure, easier breathing, edema diminishes, congestion of the viscera decreases, the urinary output is increased and the heart rate is slowed.

5. It should not be given in the presence of the above signs in the absence of heart failure.

6. Tachycardia does not call for the administration of digitalis.

7. Failure with normal rhythm and tachycardia will show improvement from digitalis.

8. Auricular fibrillation with heart failure calls for digitalis which usually brings about a slowing of the ventricular rate.

9. Auricular fibrillation due to toxic action does not call for digitalis.

10. Alterations in rhythm are not always indications for digitalis therapy.

11. Valve lesions alone do not call for digitalis.

12. The diuresis which occurs as a result of digitalis is not due to direct action on the kidneys, but results from the action on the myocardium and improvement in the general circulation.

13. Hypertension is not a contraindication for digitalis.

14. Pneumonia and other toxic states do not call for digitalis.

15. Neither shock nor septicemia are indications for digitalis.

16. Anginal Pectoris is not an indication for this drug.

17. As a rule, oral administration is the dosage method of choice. The powdered leaf or its glucosidal equivalent is the best form of the drug to use.

18. Intravenous injection is rarely called for and may be dangerous.

19. Rapid digitalization is an emergency measure rarely needed.

20. Evidences of therapeutic effect may be seen within a few hours,

maximal effect may require from 12 to 24 hours.

21. Large doses should not be repeated more frequently than 12 hours apart.

22. Electrocardiography is often an excellent guide to the proper administration of digitalis.

23. Nausea is usually of reflex origin and a toxic manifestation. It may be absent in severe digitalis toxemia.

24. Excessive slowing of the heart is an indication of excessive dosage.

25. Unexplained conspicuous acceleration of the ventricular rate in a patient taking digitalis, calls for withdrawal of the drug.

26. The average full therapeutic dose for an adult is about 20 cat units or 30 grains.

27. The optimum dose is that which gives the best effect; it is subject to great variation and must be determined individually in each case.

28. Elimination of digitalis is poorly understood. The amount eliminated daily is variable.

29. The maintenance dose is that which maintains a certain effect. It is approximately the amount eliminated daily and is subject to variations.

30. Knowing when to stop digitalis is just as important as knowing when to give it.

31. Some individuals with heart failure do not respond to digitalis.

32. Uncertainty as to recent digitalis administration calls for guarded digitalis therapy and is a contraindication to large dosage.

It is well to conclude any discussion on digitalis with this quotation from Wenckebach: "Digitalis treatment is one of the most important and serious duties of the general physician; it demands a great deal of skill, power of observation, keen interest, and experience. A long life is too short to learn enough about this wonderful drug."

CASE HISTORIES.

1. M. d G., aged 70. Admitted February 24, 1938, discharged May 1, 1938. On physical examination she was obese with dyspnea, and orthopnea, moderate cyanosis. Examination of the chest showed basal rales on both sides. The heart was enlarged and there was auricular fibrillation. The liver was enlarged. There was a history of having been a known cardiac and hypertensive patient for many years with precordial pain and dyspnea of late.

Blood chemistry was normal. Blood pressure ranged from 230/110 to 160/110. X-ray suggested a cardiac lesion of the aortic type with enlargement of the left ventricle and aortitis.

Treatment consisted of the Karrell Diet for a few days with sedatives. Digitalis was administered with 9 grains as an initial dose and $4\frac{1}{2}$ grains 8 hours and 12 hours later, following which 3 grains was given daily for 10 days. Ventricular tachycardia developed. The digitalis was discontinued. The tachycardia persisted and on the 3rd day quinidine therapy was instituted, beginning with 3 grains 3 times daily, then 6 grains 3 times daily then 6 grains 4 times daily for 5 days. This was gradually reduced and at the end of 10 days, 3 grains quinidine once a day was given. On this dosage Ventricular tachycardia reoccurred and the patient was put on 6 grains quinidine 3 times daily which was continued until discharged.

2. M. C., aged 62. Admitted in congestive failure. Had been treated for heart trouble for 2 years with symptoms of weakness, dyspnea, edema of ankles and distension of the abdomen.

Past History—There was rheumatism in 1923, a slight stroke in 1929, and pneumonia in 1935. On examination she was dyspneic, orthopneic and cyanotic. Marked pulsation of the veins of the neck. There was dullness and altered breath sounds at both bases. Heart examination showed auricular fibrillation with PMI displaced downward and to the left. Abdominal exami-

nation showed ascites and marked enlargement of the liver. There was marked edema of the lower extremities. X-ray was suggestive of a mitral lesion with decompensation. Blood chemistry was normal.

Treatment—On admission 6 ampules of digitan were given intravenously and the following day 3 grains by mouth twice daily. Electrocardiographic tracings were taken as follows: The day following admission; bigeminal rhythm, auricular fibrillation, alternate premature ventricular beats. Two days later auricular fibrillation with multiple PVB. Five days later auricular fibrillation with multiple PVB. Three days later auricular fibrillation with slow ventricular rate. Ten days later auricular fibrillation with slow ventricular rate. Ten days later auricular fibrillation with ventricular rate of 75. Several electrocardiograms were taken during the month of February and all showed auricular fibrillation with a rate of 75. After 2 months, mainte-

nance doses of digitalis, 1 cat unit daily, was given and the patient was discharged improved on April 11, 1938.

3. N. G. aged 65. Admitted with fractured ribs due to a fall. Chronic alcoholism and auricular fibrillation. Moderately obese elderly white male with a definite tremor of the hands, twitching of the face and slightly irrational.

Heart examination showed enlargement to the left and downward, a double mitral murmur with a rapid irregular rate and a pulse deficit. Blood pressure was 160/86.

Treatment—He was given digitalis therapy beginning with 6 grains digitalis powdered leaf 4 times daily on admission followed by 3 grains 3 times a day, followed by $1\frac{1}{2}$ grains daily. Death occurred 5 days after admission.

(*The Journal of Medicine, October 1938*)

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BRITISH MEDICAL ASSOCIATION.

One Hundred and Sixth Annual Meeting, Plymouth, 1938.

PRESIDENT'S ADDRESS.

THE PROFESSION AND THE PUBLIC

BY

COLIN D. LINDSAY, M.D.,

Emeritus Physician, Prince of Wales's Hospital, Plymouth; Consulting Physician, Royal Eye Infirmary, Plymouth; Consulting Physician, Tavistock Hospital.

In the first place I wish to thank you for the honour you have done me in electing me President of the B. M. A. Specially I wish to thank my colleagues in the Division who by nominating me have given me a token of friendship that I prize above most things. I consider this honour one of the greatest within the profession, and my sense of inadequacy is at its height at this moment when I am faced with the problem of delivering an address that will be worthy of the head of this great Association. Previous holders of my office have often been pre-eminent in one or other branch of medical science and they have made this address the vehicle of some valuable addition to or survey of medical knowledge. I can claim no such pre-eminence. For forty years I have been in practice both as a general family doctor and as a consulting physician. They have been eventful years in the development of medicine as a public service, using this expression in its widest sense. One might almost say that they cover the evolution of our work from a purely private affair between individuals to one of the vital public services of the community.

An Age of Planning.

It is some aspects of this evolutionary process that I have chosen to form the subject of my address and to consider once again the relationship between us doctors and the public, for it is by those we cure, and even more by those we do not cure (so long as they are not dead), that we are ultimately judged. It was Mr. Bernard Shaw who proclaimed from the mouth of one of his characters that

the medical profession was not a "profession" but a "conspiracy," though he hastened to add that all professions were a conspiracy against the laity.

This is rightly said to be an age of youth, but I still think that there is a lot of truth in the old Latin tag, "Experientia docet." I think that I can lay claim to that experience—experience, moreover, as a working member of the rank and file of the profession. The rank and file from their very nature are singularly "unvocal." For that reason if for no other I welcome the opportunity that your action in making me your President has given one of them to speak publicly on their behalf. I have said that this is an age of youth. It is also an age of planning. *Laissez-faire*, that principle beloved of our fathers, has done great things but it has outlived its time. All the signs and symptoms point to the fact that, whether we wish it or not, in every field of human activity some form of control, of planning, is necessarily coming. We may not like the thought, but it is useless to kick against the pricks, and it rests largely with us what form that control is going to take.

Medicine as an Industry.

I want you to look for a moment on medicine as a great industry: an industry whose product is the health, both physical and mental, of the community which it serves. I have a moment's hesitation in using this simile, as the word "industry" has come to have a meaning that throws the emphasis on the indirect product—money—rather than on the direct product of the labour involved. This emphasis

is, and I hope always will be, foreign to our own work. As I see it this industry is one which is provided with a plant that is excellent, efficient, and up to date in practically every way. I do not think, however, that the best use is made of this plant. It has grown up haphazardly and piecemeal. There is great want of correlation, great duplication of effort.

General Practice.

First look at what we may call the selling end of the industry. If you want to buy some unusual article you go to a retail shop and make use of their experience with wholesalers and the like to get what you want from the most appropriate source. Some such arrangement is necessary in medicine, and as things are at present this arrangement is not working smoothly. The fault is perhaps largely an administrative one, but I believe clear thinking on the exact nature and function of the medical practitioner is also lacking. The matter of health and its maintenance is so essentially a personal thing that the personnel of this (retail) division of our health industry must have a close personal relationship with the public as individuals. This relationship is only possible in a family doctor, either in his present form or in some altered, but essentially similar, form. At present there is a tendency for this branch of the profession to sink lower and lower in the estimation both of the public and of the student body from which the profession itself is recruited.

The practice of medicine itself has been brought into disrepute by the indiscriminate administration of medicines. The faith of the public in a bottle of medicine is pathetic. I grant it may be used on account of the psychological effect, but often it is quite unnecessary and is only prescribed because the public expect and insist on it. On the other hand, there is even a section of the public which considers that the training, knowledge, and ability of even the best doctors in the land ought not to be used in helping the sick; that in fact their talents should be hidden in a napkin and reliance placed solely on prayer, and not to do what I believe

the Almighty wishes and expects us to do ourselves. The principle which I have learned to follow is to avoid drugs if possible, but when necessary to give them in adequate doses—often in much bigger doses than those suggested in the text book—until a definite effect is produced. I possess a very interesting work on *The Practice of Physick* written by Dr. Willan 257 years ago, in which the author recommended all physicians to follow what he invariably did and take a dose himself of every medicine he prescribed for others. I imagine this is hardly practicable in these days—especially in the case of panel practitioners in the midst of an influenza epidemic!

A Family Doctor Service.

The credit of the general practitioner I have said is sinking. A reaction from this attitude is inevitable. The more the public is educated and the more the health services extend and intrude into the lives of the people the more will there be required an active and an intelligent family doctor service. It will be no corps of clerks. It will require a wide professional training to ensure the early recognition of diseased states and the proper co-ordination of the specialist services, becoming daily more abundant.

A good general education will be essential, also personality and mental agility, so as effectively to inspire confidence and assist in the education of a public which is rapidly becoming more enlightened. Again, it is in this sphere that the Cinderella of the medical sciences, medical psychology may well come into its own. The amount of minor and major functional nervous diseases in the community is admittedly very large. The earlier they are recognised and treated the more hopeful is the outlook, and owing to the lack of any obvious disability, except in the later stages, it is only the general practitioner who can lead the attack. His position as trusted counsellor and family friend lends itself admirably to the purpose, and it is true even now that all general practitioners are, to a greater or lesser extent, psychotherapists. They would be much more effectively so if their training

included some instructions in the principles of medical psychology. 'This family doctor is the obvious connecting link for our medical industry. All direct contact with the public as individuals should be in the first instance through the family doctor. There should be no short-circuiting or duplication of his services.'

Specialism.

At the back of this family doctor service there must be a specialist service. Medicine has grown so enormously that it is quite impossible for any one person to be proficient in every branch. The specialist is concerned more with one branch of disease, but in these days of specialism when the tendency is to dis-sever the various organs of the body it is wise to bear in mind the truth of the ancient saying, "If one member suffers all the members suffer with it." That great surgeon the late Lord Moynihan is reported to have said that he liked to consider himself a physician who had sometimes to employ surgery to cure some of his cases. There is, moreover, a lot of mistakenly loose thinking on the subject of specialism. The family doctor when all is said and done is also a specialist—a specialist in the recognition of disease in its early stages and in the helping of his fellow men in the many little ills and troubles that beset them; and these may be important, for a serious breakdown in health in later life may have its origin in trifling and unrecognized ailments of twenty to thirty years before. To take a case in point. The intensive research into the origin and development of cancer points to the probability that malignant growths rarely develop suddenly, but there is a precancerous stage usually lasting for years in which cancer has developed from minor ailments which might often have been rectified if their significance and possible danger were recognized.

I would like to see more attention paid to the treatment of the so-called "minor ailments." It has been estimated that 40 per cent. of all sickness is due to the patient's own action. If this be true (and from my own personal experience I have found it so) think what a vast

amount of sickness and ill-health might be avoided; but this requires a willingness on the part of the patient to talk over his minor ailments with his doctor instead of going in for self-medication assisted by the chemist. Remember it is the general practitioner who sees the beginning of disease; the specialist mainly the end. There is no real reason why one branch should be from its nature more eminent than the other. They are essentially complementary, and each requires for its proper performance attainments of the highest order.

Now in order to get material for practising his art and facilities wherewith to treat them the consultant specialist is inevitably associated with a hospital. With the entry of the local authorities into the hospital field things are in a state of chaos in many areas. There are strong points in both voluntary and municipal systems and each can learn from the other. The one thing that is absolutely essential is the will for exponents of both sides to get together and work out for their own particular areas a scheme that will ensure this co-operation of both systems, taking the best points of each and not allowing one to swallow the other. It is this will "to get together" that is all too often lacking.

Public Health and Co-operation.

Apart from the curative specialist services there is another specialist service which is necessary to the modern community—the medical officer of health service, or the specialist in social and legislative medicine. While the knowledge necessary for this branch is in many ways different from that necessary for the successful practice of individual Medicine, it is dependent on and very closely related to that branch. This correlation as things are at present is often 'extremely deficient, and for any smooth working of the medical services in a community more effective measures of amalgamation must be applied between the two branches. I believe that this can be supplied by the provision in each administrative locality of a Medical Advisory Board consisting of representatives of each branch of the medical ser-

vices—administrative, specialist, and general practitioner.' Even now in a small way there are regulations which permit of some such council, and in the few neighbourhoods in which it has been tried it has been an unqualified success.

Financial Consideration.

I have already said that the main emphasis in this industry of ours is rather on the results in the nature of the better health that it brings to its members. The real reward to the good doctor must always be the knowledge of having served the cause of humanity. Do we not all know how often the cases that give us most satisfaction are those that bring us least money?

The B. M. A. is an Empire-wide association of doctors for the advancement and dissemination of knowledge and the maintenance of a high standard of honour in the profession, and secondarily for a just and fair remuneration from Government and public bodies. This is where the difference is found between the medical profession and a trade. In the former the primary motive should be to help the public, with profit as a subsidiary factor. There are few indeed who could practise so time- and soul-consuming a work on a purely honorary basis. The vast majority of us must depend on our work for the expenses of living and the upbringing of our families.

I do not think I am wrong in saying that the whole subject of our remuneration is one that is more and more pre-occupying members of every branch of the profession. The correspondence columns of our journals and the agenda papers of our Divisions, Branches, and Committees will bear me out. I do not presume to offer a solution for problems the complexity of which has taxed the brains of multitudes much more financially experienced than myself. There are, however, one or two principles which are to my mind fundamental.

Free Choice, and Other Principles.

The first point, which is at the same time the least controversial, is what is

known as the principle of "free choice" of doctor. You may say that this is hardly a question of remuneration. That is true, but indirectly it is of enormous importance because its acceptance makes extremely difficult the provision of any sort of salaried family doctor service. This I believe must be remunerated on a capitation basis as under the present National Health Insurance system. We as an Association have just prepared a revised version of our proposals for a General Medical Service for the Nation, in which the two vital principles of free choice of doctor and of payment on an insurance basis are reaffirmed and their wide extension advocated.

The first great extension we propose is the inclusion in the system of all members of all families within an income limit of £250 a year. We are seeking to double—no less—the number of individuals who receive medical service through N.H.I. The second extension we propose is that the service given should be medically complete—that is to say, that it should include all forms of specialist, consultant, and auxiliary service as well as that provided by the general practitioner. I should not like to say which of these changes can do most for the public health.

Such is our official policy, far-reaching in scope and well suited to secure the full co-ordination of each and all of the country's health services. Our proposals would bring three-quarters of the community within an official system of medical service. Illness is not a steady event from season to season or from year to year, and for this reason it lends itself particularly to treatment on an insurance basis. Both patient and doctor must surely prefer regular to irregular outgoings and incomings.

Within the last six months the Association has been instrumental in forming a National Federation of Provident Association, which extends the insurance method up to a maximum income of £500 according to the number of individuals in the family, or to a maximum of £550 in the case of London, also taking into

account the family income. I suggest to you that the principle adopted is one which, in the future, may well be much more widely applied. It is, of course, the amount of the premium that is the difficulty. No man enters the profession of medicine with the idea of making a fortune. Equally no man can possibly fulfil the responsible and difficult role for which the family doctor of the future is surely cast without the possibility of sufficient remuneration not only to provide the necessities of life but also the cultural and social activities on which his full usefulness so much depend. Any capitation payment must provide this minimum, and provide it on a basis of a number of patients per doctor which is not too large to prevent his giving the necessary time to each. This time is becoming increasingly more as our knowledge of therapeutic and diagnostic methods increases.

Fees for Consultative Work.

The remuneration of the consultative branches is subject to rather different conditions. Present consultative fees are high relative to those in the other branches. The reason for this is that the consultant has a relatively short earning period. He has to serve a long and practically unpaid apprenticeship. It is hard to justify this. I would prefer a system where the status of consultant depended on hospital and clinic appointments carrying a reasonable salary which would vary with their responsibility. Were this so the payments for outside consultative work could be considerably lowered and would allow the young consultant, while always assured of a livelihood, to look forward to an improvement in his circumstances as his reputation grew. These salaries would come from the funds of the hospitals, whether these were supported by the State or by "voluntary" contributory schemes. The days when the hospitals could be regarded as pure charities are gone. Very few hospital patients could not afford to join some sort of contributory scheme.

Publicity and Education.

Let us return a moment to our simile. Every industry, apart from its productive

side, always has in addition a public relations or publicity side. Hitherto it has always been a keystone of medical policy that publicity or advertising is in direct antithesis to the best interests of the profession and of the public alike. The truth of this in regard to advertising by individuals is, I think, still undisputed. I think, however, that some form of group advertising by the profession as a whole is seriously overdue. In fact, this publicity side of our industry, hitherto neglected, could be developed to the benefit both of the industry itself and of the public which it serves. Consider a moment this public. Taken as individuals and in times of sickness and stress, we all know that there can be nothing quite so touching as the almost blind trust which they repose in the science of medicine and in the particular practitioners that happen to be giving them the benefits of that science. This is true of the public as sick individuals, but the public taken in the mass and in health does not trust either medicine or the medical profession. Their attitude is an extraordinary blend of ignorance and superstition, in which they have unbounded confidence. Everybody thinks he knows all about medicine, without training or instruction. Test it by telling a group of friends that you have a pain in your hip and at once you have it diagnosed and half a dozen different suggestions of treatment given, all of them "infallible," from carrying a potato in the pocket to wearing a ring of elephant's hair. Next day tell the same friends that you have trouble with your neighbour, whose apple tree has blown down across your wall, and as he will not remove it you propose to do so yourself. These same friends will at once advise you to do nothing rash, but to consult your lawyer first. Thus they think they know medicine, but are not ashamed to admit a complete ignorance of the law.

The public want the ailment or disease to be definitely named, and then ask why they cannot be cured by such-and-such a treatment which did so much good to their friends. "What is good for one is good for another," they say. This is where the greatest mistake is made—no

two people are exactly the same. There is much truth in the old saying, "One man's meat is another man's poison." I remember the case of a man who took five grains of aspirin (a very common and useful remedy), but in this case it was followed in half an hour by acute swelling of the face, tongue, and throat, and he was in great danger of suffocation until relieved by the appropriate remedy.

Countering Credulity.

What opportunity is there at present for the public to outgrow this ignorance and superstition? In the long run I suggest that education of the people must be the basis of any effective remedy. I think that this theme of public education in health is particularly apt at the moment. The health of the nation is very much in the public eye, and unless we guide the enormous enthusiasm that lies behind this campaign there is a real danger that it may do more harm than good. I think we should go further than that. I think that teaching in elementary biology, anatomy, and physiology should be an essential and important part of all education, however elementary. Surely, it is up to us and to no one else to see that it is included in the curricula of our schools? Similarly courses of popular lectures could be arranged, if not officially, possibly by Branches and Divisions of our own Association. I have very little doubt that were they provided there would be no difficulty in finding audiences for them.

Secondly, I would suggest that there is a great opportunity awaiting both the Press and the B.B.C. to do more in the educational field. Members of the medical profession could do much to help them in that task. Surely it should be up to us to see that a supply of well-informed and informing articles is available to whatever papers wish to use them, and equally that the B.B.C. should be given all possible help in the provision of talks which would satisfy these two same conditions? Yet, I do not think that we must expect too much. We have to remember that both the Press and the B.B.C. are limited by the educational attainments of those they serve. They can help and to

some extent anticipate improved education on these matters in the schools. They cannot, I am afraid, take its place. That is why I have given first place to education in what I have said.

Thirdly, I feel sure that it is only through education of the public that the public credulity in regard to advertised remedies can be removed. You all know what I mean when I speak of the evil of patent medicines. There are good proprietary medicines as well as bad. Some we make use of ourselves, others we could on no account condone or recommend. What matters is that because of the superstitious ignorance of the public there has grown up an enormous mass of advertisement literature for remedies that are famed to cure not only every disease known to the profession, but also many diseases invented purely for the sake of being cured by some particular remedy. It may be true that many of these remedies are in themselves quite harmless or even beneficial when properly used. That is not the point. The advertisement is designed to create a demand, and the demand can only lie in ill-health, imagined or real, of (more insidiously) by the suggestion that a certain product is necessary for the maintenance of health. These advertisers know their job. Their writings are carefully couched in pseudo-scientific terms, and we see daily in our practices how enormously receptive and almost universal is their audience. It may be unreasonable to criticize unduly those who for their own profit play the tune which the public wants. As I have said, by no means all of these advertised remedies are intrinsically undesirable. It must be in the interests of the reputable manufacturers that the demand for their products should be based on sound knowledge and not on ignorance and fear. For the rest, the trade as it is now conducted could only flourish in a public which knows little or nothing of the true principles of health and healing. The schools can educate the public and we as a profession can tell the public. The more the public trusts us the more we are able to help and the sooner they will believe that we are truly endeavouring to protect them against themselves. It is by measures

such as these, and not by restrictive legislation, that the true cure of the evils which I have mentioned will come.

Medicine in the World of Science.

I believe further that there is another sphere of education in which our entry might be of incalculable value. I like to believe, and in doing so I do not think I am entirely governed by prejudice, that the scientific world as a whole is to a large extent free from most of the jealousies which poison the interrelation of humanity in the world to-day. Scientists as a body approach nearer to the ideal world community than any other large division of mankind. Who has ever heard of class warfare between workers in any field of science or of an embargo on the exchange of knowledge, whether intra- or international? Even when something of the latter kind has been imposed from some political sphere it has been met with prolonged and emphatic protests from the entire scientific world. The medical profession forms one of the most

important division, both numerically and influentially, of the world of science. The profession as a whole is really working for the common good of the community and not with the idea of screwing the last penny out of them. It is a true brotherhood, and in ordinary practice the individual doctors continually assist one another and pool their knowledge and advice to an extent quite unknown to the patient and the public at large; but it is also unique in that world because of its close relationship with the lives of the non scientific laity. Are we not, then in an ideal position to bring the ways of life and thought of one world to the benefit of the other?

I do not presume to dictate a programme, but I humbly suggest that there are possibilities in the idea that at least merit our consideration, both as individuals and as an organized profession. I would like to suggest that as members of this great profession we have possibly an important missionary function in this cause.

—The B. M. J., July 1938.

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THE Medical Practitioner

Vol. X]

DECEMBER, 1938

[No. 3

NEW YEAR GREETINGS.

With great pleasure we send our hearty good wishes to the members of the medical profession and we pray that the New Year may bring them prosperity and happiness. In the Madras Province, the whole of last year from the beginning to the end was one of speculations relating to the affairs of the medical profession as the Hon'ble Minister for Public Health had been busy re-organising almost all sections of the department under his control step by step and in a regular order. He began with the medical education and his latest activity was the re-organisation of the nursing service. He is not quiet. He has introduced an all comprehensive Public Health Bill in the Legislative Assembly and at the beginning of the year this Bill will be entered in the Statute Book. The immediate effect of the reforms so far introduced in Madras by the Public Health Minister whether it be relating to the paid medical service honorary medical, service or the nursing service has been a feeling of disappointment as the reforms far from bringing prosperity did actually reduce the pay and other emoluments of those in service and in the case of honoraries the reforms have disappointed all as their tenure of office was fixed at five years. Members of the medical profession doing subsidized service in rural areas have had their share of uneasiness being asked by the Government if they were willing to continue subsidized service on 50 per cent less subsidy (which now they get) or no subsidy while the full-time officers belonging to Provincial Medical Service are bewildered at the announcement made by the Government about its intention to restrict private practice enjoyed by them

so far. The New Year might not be bright apparently. So long the profession depends on the Government, it cannot but be affected by its policy. The medical profession should therefore bestir itself and find out ways and means to depend upon its own resources. If the present Congress party were to continue in power for a decade which is not unlikely, the paid service in the medical department on the curative side will dwindle down to perhaps 50 per cent. of the present strength. To this extent the place of the reduced paid staff will be taken by the honoraries. There being no continuity in honorary service it is not likely that the honoraries will form a separate section in the medical profession and such of them who are discharged being accustomed to institutional treatment will feel the necessity of having private institutions. What is to come being inevitable, the members of the profession in whatever surroundings they are, will do well to train themselves to be self reliant and make a good beginning in this direction during the New Year. There is now a tendency of cornering of practice whether it be dispensing or institutional and the specialist practice has taken such a turn that the public are misguided in their notions of speciality. We would suggest to the younger generation in the profession that they should work in teams consisting of as many as can feel and think as one man and organise themselves in such a way as to be most useful to a locality serving the public on terms which would induce them to have the benefit of scientific treatment without straining their resources over and above their means. In other civilised countries which are governed by those born in those countries themselves, the members of the medical profession have

a variety of fields for the exercise of their profession apart from those for the curing of diseases such as school medical service, factory medical service, the industrial medical service etc., and well organised medical associations are seriously engaging their attention in introducing National Medical Service independent of Government to supply cheap yet efficient medical relief to the middle class and upper middle class people on easy terms. The Indian practitioners should adjust themselves to the conditions obtaining in their country and instead of keeping quiet in a spirit of helplessness and despondency should begin work in teams in localities or scatter the members of the team in different localities pooling their resources and income in a real spirit of co-operation—one for all and all for one. The inherent spirit in the medical profession which is uncommon in other professions, of doing free public service while exercising the profession should be kept in mind and this spirit will eventually turn out to be a good capital and yield as good a return automatically. We do not suggest that service without a return should be indiscriminate. The welfare of a nation depends to a great extent on the members of the medical profession and existing conditions of society and the Government policy of regulation and control over medical relief demand that the members of the profession should be imbued with patriotic feelings more than their brethren practising in countries which are advanced socially and materially and which have their own national Governments. It is therefore necessary that the medical profession should take upon itself the responsibility of educating the public so as to impress on them certain essential personal relationship with the members of the medical profession in connection with medical care. To that extent the members of the medical profession should be thoroughly conversant with medico-social matters of a particular locality or community and of the country at large. India is a continent in itself and the conditions of the people are so different in different provinces, in different districts

in a particular province and even in different villages in the same district that it is too much to expect guidance from distant places however valuable and the safest and at the same time most congenial method of meeting the public demand relating to medical relief is to form voluntary teams of medical service. Such teams should first establish the true spirit of fraternity amongst themselves before they make up their minds to treat the public with this feeling. Basing on the spirit of service the members of the medical profession will be in a strong position to determine the form of collective plans designed to promote a wide distribution of medical care. Particular methods of establishing medical service will vary with different localities but the plans are likely to be sounder than those designed by the Government which naturally will lead on to ever changing political control. The inability of the Government to cater to the needs of medical relief is an opportunity to the profession to be self-reliant. The Government has so far been an intermediary between the public and the profession to the extent it provided medical care to those who resorted to Government institutions. A Government which is really earnest about the welfare of the public should help the profession in its efforts to serve the public and not directly or indirectly compete with it by providing cheap institutional treatment to the rich. Unless the gates of the Government hospitals are closed against the rich, the Government will be following the "dog in the manger" policy by preventing the independent medical profession to do the work which the Government cannot do and have not been able to do so far. The contemplated ban on private practice now enjoyed by the Government medical officers will not bring more practice to the private practitioners if the rich are treated in the hospitals. We pray that the New Year will bring more wisdom to the Government and as much strength of mind to the medical profession so that it may exercise its primary and traditional function of service to the public.

BRITISH IDEALS OF THE PROFESSION AND THE PUBLIC.

When we just finished writing our "New Year Greetings" to the members of the medical profession and were musing about another Leading Article quite accidentally by an involuntary act we opened the July 23rd edition of the British Medical Journal and it was a very happy coincidence that the page we opened contained a prominent head line "The Profession and The Public". The subject matter was an address by Dr. Colin D. Lindsay, M.D., the newly elected President of the British Medical Association delivered at Plymouth containing ideas on topics which are the routine items of discussion in the columns of The Medical Practitioner whose primary policy is to help the profession to be above what to be able to serve the public to the extent expected from its members. Dr. Colin Lindsay spoke from an experience of 40 years as a general practitioner and consulting physician and his views and opinions on the affairs of the profession are worth the serious consideration and respect of the members of the medical profession in India. The President of the British Medical Association laid great emphasis on the urgent need of educating the public on the medical care and advocated publicity of the activities of the members of the profession doing team work though not activities of the individuals. He rightly says Medicine is also an "Industry" 'whose product is the health both physical and mental of the community it serves'. He compares the general practitioner to a retail division of health industry and presses the need of the general practitioner having a 'close personal relationship with the public as individuals'. He deplores the present tendency of the credit of the general practitioner 'sinking' and says,

"This family doctor is the obvious connecting link for our medical industry. All direct contact with the public as individuals should be in the first instance through the family doctor. There should be no short-circuiting or duplication of his services."

We wish the specialists and the members of the profession serving in the

Public Health Department to note the words of wisdom of Dr. Colin Lindsay himself a specialist. He says the general practitioner is no less in prestige, status and even in his knowledge of medical science than the specialists or the officers in Public Health Service. He describes the general practitioner as, 'a specialist in the recognition of diseases in the early stages.....' and he wishes the profession to remember that, 'it is the general practitioner who sees the beginning of the disease; the specialist mainly the end'. Dr. Colin Lindsay's advice to the members of the Public Health Service was not less trenchant. He regrets that the correlation of the staff of Public Health Service with the general practitioner is at present 'extremely deficient', and opines, that 'for any smooth working of the medical services in a community more effective measures of amalgamation must be applied between the two branches.' He believes 'that this can be supplied by the provision in each administrative locality of a Medical Advisory Board consisting of representatives of each branch of the medical services—administrative, specialist, and general practitioner'. There is also a reference in the presidential address that the general practitioner has lost his true estimation even from medical students though majority of them have to choose the life of the general practitioner after qualifying themselves. This perhaps may be due to the impression created by their teachers all of whom are specialists of one branch of medicine or other. The reference is perhaps intended to the teachers in the medical schools to warn them that such an impression will be unfavourable and detrimental to the prestige of the general practitioner. He concludes his address by saying,

"I do not presume to dictate a programme, but I humbly suggest that there are possibilities in the idea that at least merit our consideration, both as individuals and as an organised profession. I would like to suggest that as members of this great profession we have possibly an important missionary function in this cause."

We wish India could boast of a leader in the profession of the type of Dr. Colin Lindsay to guide the destinies of the medical profession.

News and Comments

English Doctor defies Law: Dr. Aleck Bourne, a leading obstetric surgeon and gynaecologist attached to St. Mary's Hospital, London, defied law a few months ago by causing abortion in a girl less than fifteen years of age who was assaulted by some soldiers and raped under most revolting circumstances. She became pregnant. The parents who belonged to a respectable society took the girl to their family doctor who consulted Dr. Bourne and requested him to keep the matter secret. Dr. Bourne had very strong notions of his own regarding artificial abortion in cases when a woman became pregnant under the circumstances like the one under reference and desired to commit abortion with the knowledge of the Government Department dealing in crimes. But in this case he was barred by a promise of secrecy to guard the respectability of the girl and her parents. He did not care to obtain a 'second opinion' as was required by law to justify abortion in the interests of the mother which he could have easily done and satisfied the technicality of the law on abortion. He felt that in cases like this the best had to be done for the patient. He must have also felt that the true interpretation of law must allow abortion even without a 'second opinion' and he took the first suitable opportunity of making the legal interpretation clear. So he risked his own reputation and his liberty by submitting himself to a criminal prosecution in which he was charged under Sec. 58 of the Act of 1861 (England) with unlawfully using an instrument with intent to cause abortion. The trial took place on July 18 and 19 at the Old Bailey before Mr. Justice Macnaghten. The whole case turned on the interpretation of the word 'unlawfully'. The accused was treated throughout by the prosecution and the Judge with admiration and respect he deserved as his motives were regarded to be pure and in the interests of the public and the profession. The law permitted abortion in cases where pregnancy if allowed to reach the full term, the life of the mother would be in danger. As the accused in this case was a respectable member of the medical profession and not

a professional abortionist he was tried by the Judge with the consideration he deserved and even the Attorney-General who conducted the prosecution for the Crown co-ordinated with the Judge and the whole atmosphere in the court was one of co-operation with the accused in establishing the interpretation of the word 'unlawfully.' It has to be said as could be seen from the proceedings of the case that the Judge went even a bit out of way to define the word 'unlawfully' and based his interpretation from the (English) Infant Life Preservation Act 1929 relating to the prevention of killing of a child in the short interval when it was capable of being born alive before it acquired an existence independent of that of its mother and therefore could not in law be murdered. Hence this law did not apply actually in a case of abortion. Sec. 1 of that Act contains a proviso that no person shall be found guilty of the offence of murdering a child unless it is proved that the death of the child was not done in good faith for the purpose of preserving the life of the mother. The learned Judge while addressing the Jury wished them to stretch their imagination and interpret the word 'unlawfully' found in Sec. 58 of Act of 1861 (relating to abortion) taking into their consideration the motive in the case and to find out for themselves whether the prosecution proved to their satisfaction beyond reasonable doubt that the act which Dr. Bourne admittedly did was not done in good faith for the purpose of only preserving the life of the mother. The most important step to determine was the meaning of the phrase 'preserving the life of the mother'. The Attorney-General admitted that the mental effects on the patient in this case were grave but he only doubted whether they justified the termination of pregnancy. In answering that question the learned judge observed that no line could be drawn from danger to life and danger to health and that no doctor could know whether life was in danger until the patient was dead and that if on reasonable grounds based on adequate knowledge, after consulting with colleagues, a doctor came to the opinion that the probable consequences

of the continuance of pregnancy, would make a woman wreck mentally or physically it was the duty of the doctor to perform an abortion. Preservation of life being not merely to save from death but also to save from illness which would eventually destroy life or make it hardly worth living, the Jury agreed with the view expressed by the Judge and gave a verdict that Dr. Aleck Bourne was not guilty. This trial *Rex. v. Bourne* though it has clarified legally the views held by conscientious members of the medical profession on the subject of therapeutic abortion, is not likely to suppress the legal conscience or the honest public feeling on this subject on religious grounds as was evidenced from the questions asked on the floor of the House of Commons by some of the members of the Parliament of the Minister of Health. It is said that the Ministry of Health, has appointed in May 1937 an Inter-Departmental Committee on abortion to consider the subject on abortion and the report of this committee is expected soon. It is also said that the committee consists of men and women with wide knowledge of the technical, scientific, and psychological aspects of the question and it is hoped that the medico-legal implications of abortion will be clarified more elaborately by this committee. Basing on the report of this committee and on the judgment in the case of *Rex. v. Bourne* there is bound to be changes in the Law of Abortion. Whatever changes are likely to be effected in the British Isles will have healthy repercussions in the whole of British Empire.

The Public Health Bill: As was expected by us the Public Health Bill as a whole was not opposed in the Legislative Assembly though some sections in the Bill were severely criticised even by the European group. The attitude of the Government was conciliatory regarding this measure compared with that demonstrated by them during the introduction of other measures most of them were passed by both the houses at times with the lightening speed. This was the only measure where the Congress Government did not fix a time limit (which usually did not extend more than a day)

for a Select Committee to make its report to the Assembly. Another noteworthy feature was, that no definite terms of reference were fixed by the Minister so that the Committee could be at liberty to discuss the Bill in all its aspects. It was mentioned on behalf of the Government during the preliminary discussion of the Bill that the medical profession was in entire agreement with the details of the Bill. We wonder if the Government sent copies of the Draft Bill to the existing District, Provincial and All-India Medical Associations. There is no such evidence before the public nor could we see signs that these Associations took the initiative themselves to submit to the Government their views on the Bill which after it becomes a Statute, has to depend to a great extent on the members of the medical profession for its working apart from the paid specialist department of Public Health. To our knowledge the only association which discussed this Bill is the Tinnevely District Association of the Independent Medical Practitioners, which suggested that the proposed Health Board should have an elected representative of the medical profession to be chosen by the entire profession, the Provincial Medical Register being utilised as the electoral roll for the purpose of the election. We entirely agree with this suggestion and the other Medical Associations might have followed the lead of the Tinnevely Independent Medical Practitioners' Association. We would go a step further and point out to the Government the necessity of instituting 'Medical Advisory Boards' consisting of representatives of each branch of medical services—administrative, specialist and general practitioner', as suggested by Dr. Colin Lindsay in the Presidential Address delivered at the annual representative meeting of the British Medical Association at Plymouth published elsewhere. Even during non-democratic days in this country there was representation of the medical profession in the local and legislative bodies the person representing the profession was the Head of the Medical Administration of the locality in the case of local bodies and the Head of the Medical

Department of the Province in the Legislative Bodies. The Public Health Bill introduced by the Hon'ble Dr. Rajan, the Public Health Minister of Madras is idealistic as it is radical and the measure contemplates as ideal and as radical executive authority to carry out the purposes for which it is intended. The experience of the public relating to the existing Public Health Department whether belonging to Local Bodies, or the Government, has been such that even the representatives of the European Community in the Legislature feel as was evidenced on the floor of the Legislative Assembly during the discussion of the Public Health Bill recently that the Health Officers and the Director of Public Health are saddled with enormous executive authority which may have a tendency to be abused. The relationship between the officers of the Preventive Medicine with the official and non-official element dealing with the Curative Branch of Medicine is at present not quite cordial; the Public Health Minister knows this himself both as a general practitioner and as a member of the Government. It is want of harmony between the agencies of Curative Medicine and Preventive Medicine more than anything else which must have been the cause for persuading some to say that the report of cases of venereal diseases was unethical all of them forgetting that medical ethics was for the benefit of the patients themselves. So long venereal diseases and other infectious diseases are dangerous to the public it is absurd to say that the reporting of these diseases in the way contemplated in the proposed Bill is unethical. There is a general complaint that the record of statistics of diseases is very imperfect in India and therefore cannot be trusted. That it is so nobody can deny and if the reporting of diseases including the venereal diseases is not made compulsory before death how can deaths be prevented and where is the place for Preventive Medicine much less for a Public Health Act?

Confusion Worst Confounded: On 2.11.1938 in connection with the 'Health Day' of the Education Week held by the Educational Department of the

Madras Corporation a public meeting was held in a Corporation High School with the Hon. Dr. T. S. S. Rajan, Public Health Minister on the chair. The speech made by the Public Health Minister relating to Medical Inspection of School Children must have evidently confused some. We received two letters soon after, criticising the views expressed by the Hon'ble Dr. Rajan and one of the correspondents said that the Public Health Minister was against the system of Medical Inspection of School Children. There are a few sentences here and there in Dr. Rajan's speech which if read separately are likely to convey an idea to a casual reader of newspaper reports that Dr. Rajan is not in favour of Medical Inspection of School Children and even condemns the same. But if the whole speech is carefully read unbiased remembering what was said in the beginning, during the course and at the end of the speech adjusting the sequence of the thoughts expressed by Dr. Rajan, it is possible to understand that Dr. Rajan is not against the Inspection of School Children but that the readers of the reports of his speech are evidently confused.

"Dr. Rajan said that he held strong views in regard to health of school boys and the longer he was associated with health services, the stronger became his views in the matter. As one who, not long ago, had been medical examiner for a number of institutions and as one who now happened to go through the records of medical inspection of schools, he could say that the last decade had not witnessed the slightest improvement in the health of school boys. If anything, there had been some *deterioration*. The whole subject of health of boys at school had to be re-examined. His own personal view was that many boys were admitted to schools who ought not to be admitted there and who could not stand the strain of the learning. Indeed, the education imparted contributed materially to the physical deterioration of the boys; for intellectual education was imparted in utter disregard of the physical condition of the boy. Another factor in connection with the problem was that no rational endeavour had been made either by educational institutions or the Government to seriously tackle this vast problem.

It was the responsibility of the State, the Minister said, to realise the place of the citizen as a unit in the national life, and the importance of educating him for the place. No pupil below par in point of physical fitness ought to, the Minister suggested, be admitted to school as otherwise the

economic loss to the nation would be immense. Many a serious problem of after-life could be avoided by the precaution he suggested of not admitting to school boys whose physical condition was below par. They should be medically examined before admission and should be admitted only if found fit. Secondly from the time of admission, during the five or ten years that the boy remained at school, if the boy got ill, the institution should consider itself responsible; for if a boy who at the time of admission was physically fit got ill during his schooling, it would mean either that the curriculum was too much for him or his health had been neglected while at school. The aim of education should be to fit out the boy not only intellectually but also physically."

Later in the course of his speech he said,

"Referring to medical inspection of boys at school, Dr. Rajan said that he was 'sceptical about it'. His own belief was that proper health and physical fitness should be made part of the curriculum and count for promotion of boys as the marks they obtained in their classes and at examinations did. Personally his view was that medical inspection of boys, carried on as it was to-day, was 'a tremendous waste' and he was not in the least sorry that the Government had refused to finance 'this farce of physical examination of boys'."

Referring to the responsibility of teachers towards the Health of the pupils Dr. Rajan said,

The teacher should consider it his duty to begin the day's classes with a physical health parade of the boys of his class and examine their teeth, mouth and eyes and insist on these being kept clean. It was an easy thing to do, would take but a few minutes and would be more effective in promoting health among boys than all the medical inspection reports now sent up. The teacher should be trained for the work by the Teachers' College.

It could be seen from the above extracts that it was the sequence of the ideas and not the ideas themselves that made the Minister's speech worst confounded. Regarding the school inspection conducted by the Madras Corporation we made some enquiries and learnt to our satisfaction that the system

adopted by the Madras Corporation is tolerably good. We could make out from Dr. Rajan's speech that he is making a 'rational endeavour' 'to seriously tackle this vast problem' and he will do well to send for the reports on this subject from the Health Officer, Corporation of Madras when we hope the statistics collected by the Corporation Health Department will convince the Public Health Minister the importance and usefulness of the inspection of school children if done methodically by those who know this work.

Though many are not likely to agree with Dr. Rajan's views that the promotion of the school children from a lower to a higher class should also depend upon the physical well-being of the pupils all will agree with him that school medical inspection should begin not after the children are admitted into the school but before they are admitted and that children not physically fit to stand the strain of education should not be admitted at all till they are made fit by the parents. It is indeed a strange coincidence that in the provinces of Madras and Bombay where the Medical Portfolio is under the control of medical men no attempt has been made so far to introduce medical inspection of schools at least in the elementary schools. If this system is introduced and pushed on methodically to begin with in the elementary schools, we are sure that with the active co-operation of school teachers with the medical inspectors of school as envisaged by Dr. Rajan the problem of following up of this work in the High Schools and Colleges will not be so much taxing regarding finance and labour. We should also say that the haphazard way of getting this work done by the honorary medical inspectors however enthusiastic must not be encouraged.

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THE PROVINCIAL SUBSIDIZED
RURAL MEDICAL PRACTITIONERS'
ASSOCIATION.

COIMBATORE DISTRICT BRANCH.

The inauguration of the Coimbatore District Branch of the Provincial Subsidized Rural Medical Practitioners' Association was performed by Lt. Col. A. I. Cox, I.M.S., District Medical Officer on 22.12.1938 at 4 P.M. at the Head Quarters Hospital, Coimbatore. Sri. T. A. Ramalingam Chettiyar, B.A., B.L., M.L.C., presided. The proceedings began after tea.

Dr. G. J. Dawson, the Secretary-Treasurer of the Association welcomed the guests and before requesting Col. Cox to open the District Branch said that the purpose of the function was not publicity as could be judged from the choice gathering consisting of eminent members of the medical profession and a few members of the lay public who are interested in the village uplift work such as the revered president of the day. He did not wish to tell them anything regarding their hardships in the villages on an occasion like that. The chief aim of their Association was to co-operate with the Government and Local Bodies to render all possible help to the suffering village folk to the best of their abilities and this they could do with the guidance of eminent members of the profession as Col. Cox whose kindness in associating with the function would greatly encourage him and his comrades, and it was therefore most appropriate that Col. Cox should bless their Association by inaugurating the District Branch.

Col. Cox before formally opening the District Branch thanked the subsidized practitioners for giving him an opportunity of meeting them in such a large number. He said that the service rendered by the subsidized practitioners in the villages had to be appreciated and the authorities should help them to render such service without the practitioners losing their self-respect. He advised them not only to train themselves as efficient medi-

cal men for which purpose he would permit them all facilities in the District Head Quarters Hospital but they should also cultivate high ideals of ethics and he expected the practitioners in urban areas would do the same in their relationship with the village practitioners. He thanked the members of the District Medical Association for encouraging the subsidized practitioners by their presence. He also expressed his gratitude to Sri. Ramalingam Chettiyar for associating himself in that day's function as his valuable advice in matters relating to villages would be a great asset to the subsidized practitioners. He appreciated the good work done by Dr. V. Rama Kamath to the subsidized practitioners who has come all the way from Madras to guide them to organise the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association of which Dr. Kamath was the President. He assured the subsidized practitioners that they might depend upon his sympathies and goodwill in their work in the villages.

Dr. V. Rama Kamath, President of the parent Association said that he was very much benefited in going over to Coimbatore as he had splendid opportunities of having a heart to heart talk with the Head of the Medical Administration of that District from whom he learnt so many things regarding the affairs of the subsidized practitioners in that District, the knowledge of which will be so useful to him in running the Association for the benefit of the village folk. He expressed his gratitude both on his behalf and on behalf of the Association to Sri Ramalingam Chettiyar who was kind enough to consent to preside over the function at a very short notice. He then gave a brief account of the history of the Provincial Subsidized Rural Medical Practitioners' Association. Referring to the Government Memorandum circulated amongst the subsidized practitioners enquiring from them whether they were willing to serve receiving only 50 per cent of the subsidy they were now given or no subsidy at all he said it had alarmed the subsidized practi-

tioners and he was of opinion that it was too much for the Government to expect honorary service in the villages where the average villager could not have a meal a day and the few rich would not pay expecting free service from the subsidized practitioners. He said something should be done by the Government and the Local Bodies to make the few rich in the villages to pay the practitioners for the supply of medicine and his services or else the Subsidized Rural Medical Relief Scheme would soon be a failure.

Regarding the new Agreement Form he said some of the new conditions incorporated in the agreement such as fixing of tenure of subsidized service from one to five years and transfer of subsidized practitioners from one place to another was likely to nullify the spirit and the underlying principles of the Subsidized Rural Medical Relief Scheme. He said that the right thing for the Government to do especially when the subsidized practitioners would have to be saddled with the responsibility of Public Health Work in the rural areas after the passing of the Public Health Bill was to have recourse to Subsidized Rural Medical Service more extensively and to that extent curtail the expenditure on paid staff in the urban areas where the possibilities for private practice were certainly more than in rural areas.

Capt. E. S. Gopalan, M.S., M.B., A.I.R.O., read an interesting paper on Rural Medical Service. (Published on page 88).

Sri. T. A. Ramalingam Chettiyar in winding up the proceedings agreed with the lecturer Capt. Gopalan that there was a need for changing the very fundamentals of rural medical service and the Government would be well advised to review the whole situation before they effected any changes in the existing Scheme. He said that after the passing of the Public Health Bill there would be a greater demand on the services of the subsidized practitioners and how far they could render such service was problematic. He congratulated the Association on

being lucky in having Dr. V. Rama Kamath as its President and he suggested to Dr. Kamath that he would do well to draft a Scheme of Rural Medical Service keeping in view the present financial stringency of the Government and the bulk of medical service required to meet the demand of rural areas.

The meeting terminated with a vote of thanks to the guests proposed by Dr. S. Ramanathan.

BUSINESS MEETING.

After the formal inauguration of the Coimbatore District Branch by Lt. Col. A.I. Cox, I.M.S., the business meeting was conducted at the Municipal Travellers' Bungalow with Dr. V. Rama Kamath in the Chair.

Dr. G. J. Dawson was unanimously elected to represent the District Branch in the Provincial Committee.

2. Resolved that the Associate Secretary, Dr. K. V. Hari Rao should act for Dr. G. J. Dawson as Secretary-Treasurer and also as representative to the Provincial Committee, when due to any unforeseen circumstances Dr. G. J. Dawson wants relief.

3. Resolved that the District Medical Officer be requested to arrange clinical classes for the benefit of the Subsidized Rural Medical Practitioners in Medicine, Surgery and Midwifery, posting them in batches in any convenient and suitable way so that every practitioner has a turn in the course of one year.

4. Resolved to rescind the resolutions No. 1—2 (a & b) passed by the District Branch at its meeting held on 12-11-38.

5. Resolved that the Coimbatore District Medical Association be requested to affiliate the Coimbatore District Branch of the Provincial Subsidized Rural Medical Practitioners' Association on payment of Rs. 5, a year.

6. (a) Resolved to request the Government that the Subsidized Practitioners for Public health training be paid their usual subsidy in addition to Rs. 25 sanctioned by the Government and that the Rural Practitioners subsidized by the local bodies be also given the benefit of public health training.

(b) Resolved to request the Government that a remuneration of Rs. 15 per month for doing the Public Health Work be raised to at least Rs. 30 a month.

7. Resolved that while the members of the Association are at liberty to remit their yearly subscription direct to the Treasurer Provincial Subsidized Rural Medical Practitioners' Association, the subscription collected by the Secretary-Treasurer of the District Branch should be remitted by him to the Treasurer of the parent

Association on or before the 25th of every month deducting at the rate of Re. 1 out of Rs. 3 paid by each member.

8. Resolved that the total expenditure incurred for the inauguration ceremony of the District Branch on 22nd December 1938, be equally divided amongst the members of the P. S. R. M. Ps. Association, Coimbatore District and that the Secretary-Treasurer be authorised to prepare the bills in consultation with Drs. Ramannathen and Hari Rao.

9. Resolved to thank Dr. V. Rama Kamath, President of the P. S. R. M. Ps. Association, Madras, for having gone over from Madras to take part in the inauguration of this District Branch and conducting the business meeting successfully.

KURNOOL DISTRICT BRANCH.

The Subsidized Medical Practitioner of Kurnool District met at the District Head Quarters Hospital, Kurnool on 14-12-38 when Dr. Raghavendra, the D. M. O. inaugurated the Kurnool District Branch of P. S. R. M. Ps' Association.

RESOLUTIONS.

1. The following office-bearers were elected unanimously.

President.—Dr. M. Suryanarayana Rao.

Secretary and Treasurer.—Dr. S. Narasimha Rao.

Member of the Executive Committee.—Dr. S. Madhava Rao.

2. This association regrets its inability to accept any of the alternative proposals, referred to by the Government, in the memo. No. 34730-1-D-2. P. H. dated 30th September '38, circulated to the individual R. M. Ps.

3. This association, while thanking the Government, for certain concessions shown to them, as per request of the Interim Management Committee of the R. M. Ps' Association, requests the Government, most respectfully, to allow them, leave of absence, for 30 days in aggregate in a year, excluding the public holidays.

4. Resolved to request the Government to treat R. M. Ps. as on duty and allow them their usual subsidy in addition to the honorarium of Rs. 25 referred to, in G.O. when they are deputed for public health training at Madras, as during that period, they have to maintain their family, in villages, in addition to the expenses, to be incurred by them at Madras.

5. Resolved that the Government be requested to fix the remuneration for public health work, at Rs. 30 per month instead of Rs. 15 as proposed in the G. O. as the latter amount is too meagre.

NELLORE DISTRICT BRANCH.

The inauguration of the Nellore District Branch was performed on 17-12-38 by Dr. R. Ganapathi Aiyar, the District Medical Officer Sri. Oruganti Venkatasubbiah B.A., M.L.A. presided.

After tea, the proceedings began with the welcome address read by Dr. A. V. Seshiah who said amongst other things that the Rural medical Practitioners were the important persons in the village uplift work and they were of immense use to the rural population. The rural population were now getting accustomed to the rural dispensaries where they got scientific treatment. And he also dealt at length the working of the rural medical scheme and the idea with which it was started.

The President while addressing the gathering dwelt on the need of increasing the number of Rural Dispensaries as the existing ones were not able to serve a reasonable area and that the R. M. Ps' plight in the rural areas was miserable since they did not get any practice worthy of name. He disapproved the conditions mentioned in the recent Govt. Memorandum as they would affect the poor villagers.

RESOLUTIONS.

1. Resolved to form the Nellore District Branch of the Provincial Subsidised Rural Medical Practitioners' Association.

2. Resolved that a membership fee of Rupee One and Rs. Three should be collected from the members towards the District and Provincial associations respectively.

3. Resolved that the Secretary should be authorised to spend the amount collected for the purpose of the association.

4. Resolved that in view of their being out of way places and consequent inability to get in touch of the up-to-date treatment the District Medical Officer be requested to allow the Rural medical practitioners to attend the Head quarter Hospital on penultimate Saturdays every month to witness operations and the D.M.O. be requested to give bed-side clinics and Post graduate lectures.

5. Resolved that the Secretary may be requested to communicate the resolution to the District Medical Officer.

6. Dr. A. V. Seshiah was elected as the Secretary and the Treasurer of the association.

7. Resolved that Dr. K. Raghaviah, be elected as the member to represent on the Provincial Committee.

8. This conference views with grave concern the Govt. Memo No. 34370 1-d 2. P.H. dated 30-9-'38 and expresses the inability of the practitioners to accept to any of the proposals made by the Government and requests the Government to continue the Subsidy and all the other facilities now existing undisturbed, in the interests of the practitioners and as well as the villagers.

MADURA DISTRICT BRANCH.

On the personal invitation of Dr. C. K. B. Menon of Thandikudi the Subsidized practitioners of the Madura District met at Iyyampalayam Rural Dispensary on 17-12-1938. Dr. R. Ramaviswanathan occupied the chair.

The following resolutions were unanimously passed:

1. Resolved that an Association of the Subsidized Rural Medical Practitioners for Madura District be formed.

2. Resolved that this District Association be made the Branch of P. S. R. M. Ps' Association.

3. Resolved that Dr. R. Ramaviswanathan of Chinnamanur be the Secretary and Treasurer for this Association.

(b) That Dr. C. K. B. Menon be the representative to the Committee of the P. S. R. M. Ps' Association.

4. This District Branch of the Madras Rural Subsidized Medical Practitioners' Association respectfully submits to Government that they find it difficult to work even under the existing conditions of the Subsidized Rural Medical Scheme and requests the Government not to give effect to the proposals contained in the memorandum No. 34730-1 D. 2. P. H. dated 30-9-1938.

5. Resolved to represent to the Government that the remuneration of Rs. 15, a month for doing Public Health duties is inadequate and that the Government be pleased to grant a subsidy of Rs. 30, a month for the Public Health Work.

6. This Branch expects that the Government will kindly pay the subsidized practitioner deputed for Public Health training the monthly subsidy in addition to the honorarium of Rs. 25, sanctioned by the Government.

7. While thanking the Government for considering the suggestions and the requests submitted to them by the then Interim Committee of Management of the P. S. R. M. Ps' Association this Branch respectfully wishes to point out to the Government (a) that an Allopathic Subsidized Dispensary should not be converted into one of Indian systems of medicine unless the former is not working satisfactorily and certified to that effect by the District Medical Officer; (b) that the subsidized practitioners be

granted 30 days leave excluding public holidays, (c) that the appointment of the Subsidized Practitioners be done jointly by the District Medical Officer and the District Board President and when there is a difference between the two; the matter be finally settled by the Surgeon-General with the Government of Madras; (d) that a servant for the dispensary be provided for by the District Board in a subsidized dispensary where the daily average attendance is above 30.

8. Resolved to request the President, District Board Madura, through the D. M. O. Madura that the contingency sanctioned as per proceedings No. 150/38—39 dated 19-11-1938 by the President, District Board, Madura is too little and to enhance the same to Rs. 5, per month.

9. Resolved to request the District Board, Madura to sanction a uniform rate of Rs. 10, per month for each Dispensary towards the dispensary building rent.

10. Resolved that the District Branch of this R. M. Ps' Association to meet at Madura next.

11. Resolved that the Secretary of this Association is authorised to enlist other R. M. Ps' of this District as members of this Association.

TINNEVELLY DISTRICT BRANCH.

The Subsidized Practitioners of the Tinnevely District met on Sunday the 18th instant at Tinnevely to congratulate the newly elected District Board President Sri. M. C. V. Pillai, B.A., B.L. The District Medical Officer Lt. Col. T. S. Shastri and the President Dr. P. R. Venkatarama Ayyar of the local Branch were present.

After tea Dr. Venkatarama Ayyar congratulated the chief guest and Lt. Col. Shastri gave at length an account of the Rural Medical Relief Scheme. Sri Pillai wished to have the hearty cooperation of the R.M.Ps. for the working of the Rural Medical Relief Scheme and he promised his sympathetic consideration of the affairs of the subsidized practitioners after he made a study of the whole scheme.

After a vote of thanks to the guests the practitioners met and conducted the business meeting of the Association and passed the following resolutions:—

1. That the Tinnevely District Rural Medical Practitioners' Association be converted into the District Branch of the P.S.R.M.Ps. Association.

2. That Dr. C. Krishna Iyer be unanimously elected as the District representative to the Provincial Committee of the Parent Association.

3. The rules and bye-laws passed by the Trichy District Branch for the running of the District Branch were adopted for the Tinnevely District Branch.

NORTH ARCOT DISTRICT BRANCH.

The Subsidized Rural Medical Practitioners of North Arcot District Branch met at the Government Pentland Hospital, Vellore on 20-12-1938 at 5 p. m. when Major J. F. Shepherd, F.R.C.S., I.M.S. inaugurated the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association. In requesting Major J. F. Shepherd to inaugurate the District Branch Dr. V. Rama Kamath, President of the Provincial Subsidized Rural Medical Practitioners' Association said that though it was not possible for the Subsidized Rural Medical Practitioners of the District to arrange a spectacular gathering which was far too uncommon on occasions like the one they were having that day, the small audience consisting of a band of village workers in the field of medical relief in the presence of the seniormost and as eminent a member of the medical profession Major Shepherd was a picture of a happy family gathering which met in an atmosphere of affection and cordiality. The purpose of the Subsidized Practitioners in requesting Major Shepherd to participate in the function was not to place before him a list of their grievances on this occasion as the Subsidized Practitioners knew where and when they should trouble Major Shepherd for this purpose. The Memorandum and Rules of the Association had been so framed that the Provincial Subsidized Rural Medical Practitioners' Association could not be run on 'trade union' spirit. The Rural Practitioners were made to realise that they belonged to a particular order of service and as such could not compare and contrast their lot with their brethren practising medicine in quite different surroundings. The position in villages was such that they had to be self-reliant and self-sufficient in their knowledge of medical science and their responsibility in the villages being mainly relating to the welfare of the village folk they could not pitch upon anybody else except Major Shepherd to bless their Association on this day when it was to be formally opened in the District. So saying Dr. V. Rama Kamath requested Major Shepherd to inaugurate the District Branch of the P. S. R. M. Ps' Association.

Major J. F. Shepherd expressed his pleasure in associating himself with the function and said that his sympathies were always with the Subsidized Practitioners and they might depend upon him any time. He did not relish the idea of too much philanthropy that was demanded from the Subsidized Practitioners who had responsibilities not only to themselves but to the profession and the public in the evolution of economic civilisation. The subsidized practitioners who received a small subsidy from the Government and a limited supply of medicine from the Local Bodies could be expected only to treat necessitous poor and not the richer folk in the villages. He regretted that many cases have come to his notice where the life of a subsidized practitioner was made rather cumbersome when he demanded remuneration for services rendered to any well-to-do villager. It was his opinion that if the Subsidized Rural Medical Service should work satisfactorily the Subsidized Practitioner should have free hand in the matter of receiving fees from the well-to-do class.

He advised the practitioners to be well up in the professional knowledge. He said he would give them any amount of facilities at the Head Quarters Hospital to train themselves as efficient medical men. Major Shepherd then formally opened the District Branch and left the meeting.

The business meeting of the District Branch was then conducted with Dr. V. Rama Kamath, President of the Association on the chair. Before the business meeting commenced Mr. Ubedulla Sahib, the Vice-President, North-Arcot District Board when asked by Dr. Kamath why the District Board had affected a cut in the extra subsidy of the R. M. Ps in the District, the Vice-President said that the financial condition of the Board was not bright and as soon as matters improved the Board was likely to restore the extra subsidy.

Dr. P. Palani Nattar was elected Secretary of the District Branch and Dr. N. Sambandam was elected as the member of the Provincial Committee of the parent Association to represent the North

Arcot District Branch. The following resolutions were then unanimously passed:

1. The North Arcot District Branch of the Subsidized Rural Medical Practitioners' Association express their gratitude to Major J. F. Shepherd for have kindly consented to inaugurate the District Branch at a very short notice.

2. With reference to the Government Memorandum No. 34730, 1. D. 2 P. H. dated 30th September 1938 the District Branch resolved to inform the Government that the conditions in the villages are such that it would not be possible for the Subsidized Practitioners to work on any or all of the three conditions mentioned in the Memorandum.

3. Resolved to request the Government to pay the subsidized practitioners deputed for the Public Health training their usual subsidy in addition to the honorarium of Rs. 25/- stated in the G. O. No. 2639 P. H. dated 21st July 38, and it was also resolved to request the Government that the Subsidized Practitioners belonging to local bodies should have also the benefit of Public Health training.

4. Resolved to request the Government to pay a subsidy of not less than Rs. 30/- a month to the Subsidized Practitioners who are entrusted with the Public Health work.

5. Resolved to request the D.M.O., North Arcot District to arrange clinical classes in the Pentland Hospital in a way found suitable to the D.M.O. convenient batches of subsidized practitioners being posted so that all the practitioners have the benefit of clinical training within a period of one year.

6. As majority of the Subsidized Practitioners find hard to pay the usual fee for the membership of the District Medical Association resolved to request the District Medical Association, to request the District Medical Association, North Arcot District to affiliate the District Branch of the Provincial Subsidized Rural Medical Practitioners' Association to the District Medical Association on payment of an yearly subsidy of Rs. 5.

7. Resolved that Drs. V. Sheshagiri Rao, Palani Nattar, V. G. Bhujanga Rao, G. M. Annamalai Nattar and V. S. Ranganatham be requested to wait on deputation on the Presidents District Board, North Arcot District and submit to him a memorandum relating to the local grievances of the Subsidized Practitioners.

MALABAR DISTRICT BRANCH.

The inauguration of the Malabar District Branch of the P. S. R. M. Ps' Association was performed by Major S. T. Davies, I.M.S., District Medical Officer on Friday at 4 P. M. on 23-12-38 at Jayananda Hall, Calicut. Dr. V. Rama Kamath, President, P. S. R. M. Ps' Association presided.

After light refreshments Dr. C. Kunjunnai Nair, Joint Secretary, P. S. R. M. Ps' Association welcomed the guests.

He said that the Memorandum and Rules of the Parent Association had been so formulated that far from running the Association on 'Trade Union' spirit the Subsidized Practitioners would form a strong corps to be an integral part of any village uplift work which could not be satisfactorily done unless with the help of medical men and to do this work the village practitioner should be efficient in his knowledge of medical science. A Branch of the Association in the District would afford them opportunities to meet each other and exchange their views and experiences so as to be able to benefit themselves and to be able to discharge their responsibilities in the villages satisfactorily. The Association had therefore requested the seniormost member of the medical profession by experience and position though not in age who was Major Davies, the Head of the District Medical Department whom he formally requested on behalf of the Association to inaugurate the District Branch. Dr. Nair added that it would have been most appropriate if the District Board President Sri. Kalappan presided on this occasion and if he did not do so, it should not be construed that he had no sympathy with the R. M. Ps. Sri. Kalappan was requested to preside and he agreed but as Sri. Kalappan promised to be elsewhere that day the chair had to be occupied by the President of the Association, Dr. V. Rama Kamath.

Major Davies while inaugurating the District Branch advised the practitioners to realise the important part they could pay in the future with the help of their organisation under the leadership of an able exponent of their cause Dr. V. Rama Kamath. He added that the practitioners could depend upon him for any profession help.

Dr. V. Rama Kamath speaking next mentioned some of the hardships experienced by the rural medical practitioners especially relating to private practice in the rural areas and unless the Government and the Local Bodies found out ways and methods to educate the well-to-do classes in the villages that the rural practitioner was not a servant of the Local Body but a person belonging to a noble profession

who had settled in the village and the Government and the Local Bodies paid him a grant to look after the necessitous poor in the village on an average, 30 a day. He said that the object of inviting a few choice members of the lay public and the local members of the medical profession was not to get publicity but guidance and advice on an occasion when the subsidised practitioners were organising themselves into a District unit of the Parent Association.

After the public meeting the business meeting of the Branch was conducted under the presidentship of Dr. V. Rama Kamath and the following resolutions were unanimously passed:

Dr. C. Kunjunnai Nair was unanimously elected as the Secretary-Treasurer of the Malabar Branch of the P. S. R. M. Ps' Association.

1. Resolved that Dr. C. Kunjunnai Nair, R.M. P. Koduvayur be the representative of the Malabar District Branch of the P.S.R.M.Ps' Association.

2. (a) Resolved to request the D.M.O. to give facilities to the R.M.Ps to attend operation and study cases at the bedside in the Head Quarters Hospital, Calicut on penultimate Saturdays.

(b) Resolved that the Secretary-Treasurer be requested to arrange such meetings.

3. Resolved to inform the Government that the Subsidized Practitioners of Malabar District will be able to work on any one or all the conditions mentioned in the Memorandum No. 34730-1.D.2 P.H. dated 30th September 1938.

4. Resolved to request the Government to pay the Subsidized Practitioner deputed for Public Health training his usual monthly subsidy in addition to the Honorarium of Rs. 25/- per month.

5. Resolved that the R.M.Ps doing Public Health work after training be given at least Rs. 30/- a month as remuneration for doing Public Health work.

6. Resolved to request the Government to permit the R.M.Ps deputed for Public Health training to run the Dispensary by a nominee of the practitioner who is deputed for such training.

7. Resolved to bring to the kind notice of the President, District Board, Malabar the recent G.O. that whenever there are vacancies permanent or temporary in pucca L.F. Medical institutions the claims of the R.M.Ps of the District have to be preferred.

8. Resolved to express the heartfelt gratitude of the R.M.Ps of Malabar District to Major S. T. Davies, I.M.S. for inaugurating the District Branch and to Dr. V. Rama Kamath for conducting the deliberation of the District Branch successfully.

9. Resolved to thank Dr. C. V. Narayana Iyer, Secretary, District Medical Association Malabar, for his having rendered all help in connection with the inauguration ceremony of

the District Branch of the P.S.R.M. Ps' Association.

10. Resolved to thank the proprietor of the 'Jayananda Hall' for having kindly placed the 'Jayananda Hall' at the disposal of the District Branch of the P. S. R. M. Ps' Association for holding its inauguration meeting.

11. Resolved that the expenditure incurred this day for the inauguration ceremony be equally divided amongst the members of the Association of the Malabar District.

SALEM DISTRICT BRANCH.

The inauguration of the Salem District Branch of the P. S. R. M. Ps' Association was performed at the Head Quarters Hospital on Saturday, the 24th instant in the presence of Major Sanghamlal, District Medical Officer, Dr. Madava Naik, Asst. District Medical Officer and Dr. V. Rama Kamath, President, P. S. R. M. Ps' Association.

The business was then conducted with Dr. V. Rama Kamath in the chair. Dr. R. S. Kothandaraman was unanimously elected as Secretary and Treasurer.

Dr. R. S. Kothandaraman was unanimously elected to represent the District Branch in the Provincial Committee of the parent Association.

1. Resolved to inform the Government that it is not possible under present conditions in the villages to serve under any one or all three conditions mentioned in the Government Memorandum No. 34730-1 D. 2. P. H. dated 30-9-'38 circulated to the subsidized practitioners by the President, District Board, Salem.

2. Resolved to request the Government that the subsidized practitioners deputed for Public Health training be paid their usual subsidy in addition to Rs. 25, the honorarium proposed by the Government to be paid to them for one month during the period of their training.

3. Resolved to request the Government to pay the subsidized practitioners an additional subsidy of at least Rs. 30, per mensem for doing Public Health work after undergoing the training.

4. Resolved to request the Government that rural medical practitioners subsidized entirely by District Board be also given the benefit of the Public Health training.

5. Resolved to request the District Medical Association to affiliate the District Branch of the P. S. R. M. Ps' Association to the District Medical Association on an annual payment of Rs. 5, by the District Branch.

6. Resolved to request the Medical Officer, Salem to afford subsidized practitioners facilities for clinical bedside study and also to witness operations.

7. Resolved to thank Major Sangham Lal, the District Medical Officer and Dr. Madava Naik, Asst. District Medical Officer, Salem to their kindness in attending the inauguration ceremony of the District Branch.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Month of November 1938.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash Balance on 31-10-38 ...	104 15 6	Postage and Telegram ...	6 2 6
Subscription received during the month ...	59 8 0	Remuneration paid to clerk for October 1938 ...	10 0 0
Entrance fees received from 10 new members ...	2 8 0	Amount credited to The Medical Practitioner, from the subscriptions received from 18 members at As. 8 each ...	9 0 0
		Excess Subscription remitted by Dr. J. Narasimham of Cuddapah refunded to him ...	0 8 0
			25 10 6
			Rs. A. P.
		Cash Balance:—	
		With the Saving Bank 94 2 0	
		With the President 47 3 0*	141 5 0
	166 15 6		166 15 6

* Amount with the President to meet the printing bills etc.

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

N.B.—We regret due to some mistake in our office, the proceedings of the Chingleput District Branch of P. S. R. M. Ps' Association have not been published. They will be published in the next issue. (Ed.)

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