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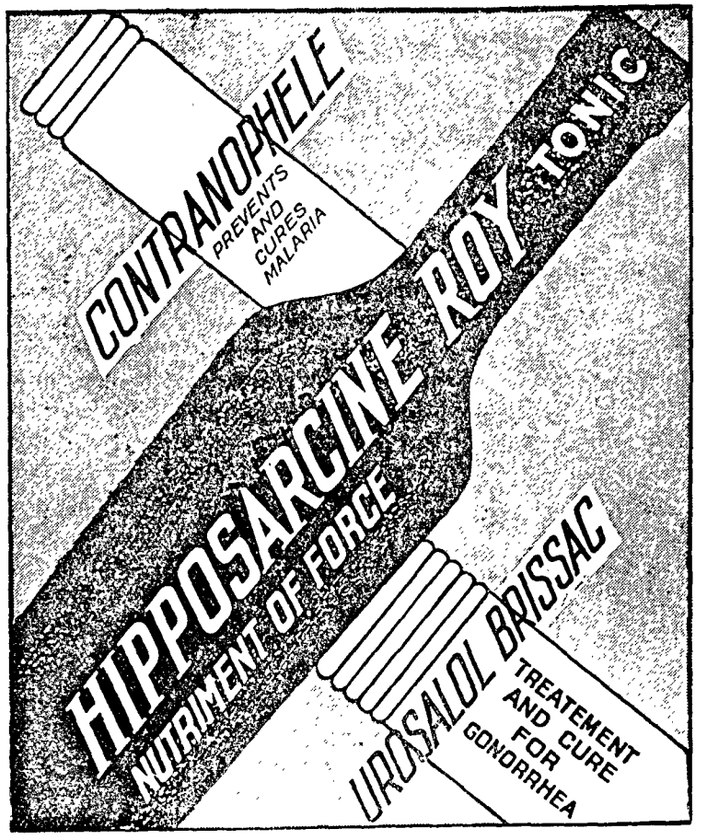

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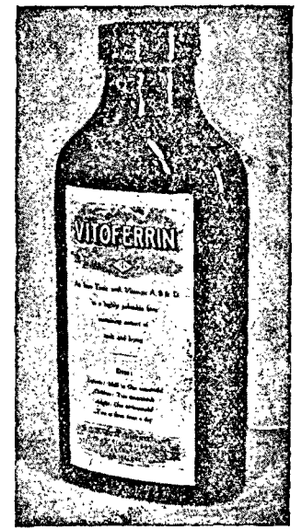

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MEDICO-SURGICAL SUGGESTIONS

VOL. VII JANUARY 1938 NO. 1

CONDUCT OF LABOR IN REGARD TO OPERATIVE INTERVENTION.

HENRY C. GERNAND, M. D.
Los Angeles, California.

The conduct of labor can be simple ; many women deliver spontaneously with little trouble ; on the other hand, I know of no other branch of medicine where a doctor can get into greater difficulties when unrecognized pathology exists or complications arise. It is with the expectancy of difficulty that every effort should be made during antepartum care or at the begining of labor to note and evaluate the conditions present that may or will have a bearing on the confinement.

All patients should have thorough general physical examination, including external and internal pelvimetry. The use of x-ray pelvimetry is of value in border-line pelvis to determine if disproportion exists. If distocia is expected from cephalo-pelvic disproportion or other pathology exists, such as severe toxemia, heart disease, placenta previa or pelvic tumors, the patient should be sent to a well equipped hospital for delivery.

Briefly, the routine at the Los Angeles General Hospital when a patient enters in the first stage of labor is a shower, enema, public shave and a preliminary, soap preparation. Then the following data are determined and recorded on the chart and labor record board; time of entry and examination, blood pressure, presentation and position, fetal heart tones, frequency and character of uterine contractions, station of the presenting part (relation of the most dependent part to a line drawn between the spines of the ischii), dilation and effacement of the cervix and the position of the os.

We have found when the position of the cervical opening is far posterior or lateral, that a posterior position or deflection of the head may be the cause and a long labor may be expected ; if the opening is accessible the pronosis for a labor of average length is good. A note is also made if pathology exists or is suspected. Subsequent examinations and treatments are recorded so that the progress or status of cases in labor can be determined quickly.

Rectal examinations are routine with vaginal examinations only when progress is unsatisfactory or questions of diagnosis are raised.

These are done in the delivery room with the patient's legs in stirrups using the usual operative preparation, 3½ per cent iodine first being applied and then removed with 70 per cent alcohol.

In regard to analgesia, recently a questionnaire was sent to 78 of the leading obstetricians in the country. The results indicate increase in the use of barbiturates and a decrease in the use of morphine and the complete Gwathmey technic. We are using nembutal grs. 4ss by mouth and, in 20 minutes, 20 c.c. of paraldehyde mixed with 20 c.c. of starch paste per rectum. It is sometimes necessary to repeat nembutal grs. 3 and also the paraldehyde depending on the patient and length of labor. With this it is rarely necessary to use a tracheal catheter as most babies cry spontaneously; nor is restraint necessary as the patients are not unduly excited.

All patients are given liquid food at regular intervals. Solid foods are not given because of the hazard of aspiration of particles into the lungs when the patient vomits during or after the administration of an anesthetic. The fluid intake is watched, especially in long labors, and if necessary the intravenous route is used to combat dehydration.

Frequent urination is advised to keep the bladder empty. If there are signs of distension, the bladder is drained per catheter; the bladder must be emptied before operative extraction.

The anesthetic chosen in operative obstetrics depends on the condition of the mother and the type of operation to be performed. If deep relaxation is necessary, ether is best. The selection also depends on the expertness of the anesthetist Local anesthesia s gaining favor with many doctors.

Indications for operative intervention have been defined as those conditions which require or make advisable a given operation.

Contra-indications are conditions making a given procedure dangerous.

Necessary conditions are those which must be present before a given operative procedure is carried out, but whose absence does not contra-indicate the procedure, but rather indicates the necessity of preparatory operation. The indications are of 3 classes: (1) those conditions which determine the necessity of operative interference to terminate labor; they are composed almost entirely of general conditions indicating danger to mother or child; such conditions of the mother as heart disease, abruptio placenta, placenta previa pre-eclamptic and eclamptic toxemia, exhaustion of the mother, (insufficiency of expulsion power), impending rupture of the uterus and previous cesarean section; those of the fetus are persistent irregularity in the fetal heart rate or a heart rate over 160 or below 100 per minute; the presence of meconium in cephalic presentations or prolapse of the umbilical cord; (2) those conditions which require espisiotomy or manual dilation of the cervix, if the cervix is soft

and easily dilatable; with adherent membranes just rupture of them may cause dilation or it may be necessary to use a bag; if the cervix is well effaced, Duhrrsens' incisions may be used, otherwise vaginal cesarean section, (when the baby is small) is necessary; in a contracted pelvis, no operation is practical to increase its diameter and if a fetal-pelvic disproportion exists indicated by pelvic measurements or a test of labor, cesarean section is indicated; and (3) the station of the presenting part, the type of presentation whether it be cephalic, breech, or transverse, the presence of unfavourable attitudes in cephalic presentations producing face or brow presentations, the position of the presenting part as occiput or mento posterior or transverse, and when the hand has prolapsed, whether the membranes are intact or ruptured, the presence of contraction rings or a thinned out lower segment of the uterus, tumours of the uterus or its appendages, or malformations of the fetus as anacephalus or hydrocephalus.

These depending on the condition of the passage, indicate the type of operative extraction to be performed—forceps, version and extraction, mutilating operations, or cesarean section.

In a given case then we must consider: do the conditions necessitate termination of labor? If they do, then the condition of the passage and the local conditions indicate the type of operative extraction to be performed.

Forceps are indicated when the head in normal flextion attitude is well engaged in the pelvis (greatest diameter of the head has passed the pelvic inlet). They, however, may be used in face presentations and during a breech extraction on the after-coming head. The cervix must be completely dilated, the membranes ruptured, and an accurate diagnosis of the position of the head should be made. If palpation of the sutures and fontanelles does not give sufficient data, it is best to pass the hand along the head until an ear is felt, to determine the point of direction of the occiput.

In occiput-posterior positions it is best to do a manual rotation of the head to an anterior position and then apply the blades. It has been my practice in occiput-right-posterior positions to insert the left hand, grasp the occiput, rotate it to the right-anterior position and then apply the right blade before withdrawing the hand to keep the head from rotating back. In occiput-left-posterior positions, the right hand is used to rotate and the left blade is applied first. If it is impossible to do a manual rotation then the less preferable Scanzoni maneuver may be used.

In occiput-transverse positions, manual rotation is again the method of choice. However, if the head is too tightly fixed the blades are applied obliquely on the head. After a few tractions are made the head is rotated anterior and the blades are readapted to the sides of the head.

In the occiput anterior positions the left blade is always applied first so as to make it unnecessary to cross the handles of the blades to lock them.

Before any traction is made the blades should be checked in relation to the sagittal suture and also to be sure that they are inside the cervix. Traction is made at 30 to 60 second intervals and should be down in the long axis of the birth canal until the occiput stems under the symphisis. Then the pull should be up to extend the head, imitating the normal mechanism of labor. Undue force should not be necessary in a forcep extraction as much is not intended to overcome cephalo-pelvic disproportion. Their main function is to provide traction to replace deficient or lacking uterine force, and for rotation.

Podalic version and extraction is indicated in transverse presentations ; in cephalic presentations with the head floating or high and especially when deflection of the head exists, causing brow or face presentations, or when the hand is prolapsed. The pelvis must be adequate, (true conjugate of 8·5 cm. or more). The cervix must be completely dilated, either naturally or artificially and the membranes should be intact or recently ruptured. It may be contra-indicated if the membranes have been ruptured for sometime and the uterus is tightly contracted around the child. Deep anesthesia and the use of 10 minims of adrenalin by hypodermic may relax the uterus enough to make the operation possible. The possibility of rupture of the uterus, however, should always be borne in mind and the uterus explored following the operation.

If one expects to do a version as in shoulder or other transverse presentations, a rubber bag may be placed in the vagina and distended to make counter pressure and preserve the membranes intact until the cervix dilates enough to make version and extraction possible.

Podalic version is also indicated when there is prolapse of the cord. If the cervix is not dilated or dilatable manually, a Vorhees bag may be used to complete dilation. The patient is kept in the Trendelenburg position until delivery is effected. In a primigravida with a thick cervix, it may be best to do a cesarean section.

Braxton Hicks version may be indicated in placenta previa such as, the partial or marginal type as a method to control hemorrhage. If possible, however, a Vorhees bag should be used, first rupturing the membranes and distending the bag inside the amniotic sac. Then by traction on the bag enough counter pressure can be made to stop the bleeding. When dilation is complete, podalic version and extraction may be done with a fair chance of getting a living baby, while with the Braxton Hicks method the baby is nearly always sacrificed.

In the marginal or low implantation type of placenta previa it may only be necessary to rupture the membranes so as to let the

presenting part come down and make enough compression to control the bleeding. In the central type, cesarean section is indicated. The bleeding is controlled by packing the vagina tightly with pledgets of cotton dipped in ½ per cent lysol (Dublin pack).

Mutilating operations are indicated in fetal monstrosities or malformations such as hydrocephalus, in neglected cases of transverse or shoulder presentations and when the fetus is dead.

The possibility of cesarean section should be thought of in any case and the conduct of labour should be such, if possible, not to create conditions making it contra-indicated or hazardous. Unsterile vaginal examinations should not be made. Extreme care and judgment should be used in the evaluation of conditions before making an attempt at delivery from below which may be unsuccessful. A review of the mortality in cesarean section indicates that in those clinics where the incidence of cesarean section is low the mortality is high and *visa versa*, where the mortality is low, the incidence is high. The mortality varied from ·78 to 10 per cent. This means just one thing and that is where the mortality was high, cesarean section was done only as a last resort. A proper evaluation of conditions indicating section were not made early enough ; or improper handling of the cases may have been the cause, such as frequent unsterile vaginal examinations or attempts at delivery from below before section was done.

Conditions making delivery through the pelvis impossible or hazardous are fetal-pelvic disproportion, obstructing tumors, certain anomalies of the uterus, previous operations of the uterus such as, Watkins interposition operation, carcinoma of the cervix or an extremely rigid cervix that will not dilate after an adequate test of labor. Indications of imminent danger to mother or child are abruptio placenta, pre-eclamptic toxemia becoming progressively worse under medical management or central placenta previa. These call for cesarean section even though the conditions calling for delivery from below are present. Previous cesarean section, I believe, should also be included in this class because of the danger of rupture of the old scar. Malpresentations such as transverse, brow or shoulder, if the baby is alive, may indicate cesarean section, when a cephalo-pelvic disproportion is suspected, especially in elderly primigravida.

In border line pelvis with normal presentation a test of labor is indicated to determine whether cesarean section should be done. Much has been said about what constitutes a test of labor. Some men define a test as 2 hours in the second stage with strong contractions and without engagement or progress of the head. Others give an arbitrary time limit of 25 hours in labor without engagement of the head as justifying a cesarean section. I feel that no arbitrary time limit can be made to constitute a test, but rather that it depends

on judgment in evaluating the strength and frequency of the uterine contractions in proportion to the progress made. In regard to the length of time, I am influenced by the condition of the mother and the baby, and whether or not the membranes are ruptured.

The desire for a child must be taken into consideration.

The low cervical cesarean section should always be done when possible in preference to the classical because of the protection afforded against peritonitis, better healing of the incision and an easier convalescence. The mortality is 50 per cent less than with the classical operation.

The Hirst operation may be advisable when cesarean section is indicated and the patient is potentially infected either by unsterile examinations or unsuccessful attempts at delivery through the pelvis. In this operation after the abdomen is opened the parietal peritoneum is sutured to the visceral, covering the uterus around the area through which the incision is to be made into the uterus—preventing spill into the abdominal cavity during extraction. The uterus and abdomen is closed in the usual manner, leaving the uterine peritoneum still attached to the visceral. The original Porro operation may be indicated in the frankly infected or septic cases, In this operation after the abdomen is opened the uterus is eventrated, the broad ligaments and tubes clamped, cut, and sutured. Then the peritoneum is sutured to and around the lower uterine segment. If the baby is alive the uterus may be opened and the child extracted. The body of the uterus is then amputated and the stump sutured, leaving an opening for a drain. The abdomen is closed in the usual manner except that the cervical stump is sutured to the fascia and an opening left for the drain from the cervical canal out through the skin. This operation is not to be confused with the so-called modern Porro which is simply a cesarean section followed by hysterectomy in the usual manner and is indicated with tumors of the uterus, ablatio placenta with marked destruction of the uterine musculature and for sterilization.

I have tried to give briefly :

1. The importance of an early evaluation of conditions indicating an easy or difficult labor.

2. The necessity of a careful check and collection of all data as to the progress of labor to determine what course to pursue.

3. Keeping the patient in good condition for operation by frequent liquid feedings, analgesia for rest and rigid asepsis in vaginal examinations to minimize the danger of infection.

4. A simple plan for evaluating the indications and conditions to make a given operation advisable or contra-indicated.

5. A short description of some of these operations.

(*South Western Medicine, July, 1937.*)

THE INJECTION TREATMENT OF INGUINAL HERNIA.

REUBEN J. BOESEL, M.D.
Cheyenne.

Surgical treatment of all types of hernia leaves much to be desired. Recurrences are not uncommon, four to six weeks' work is lost by the average patient, two to three weeks' hospitalization is required, and in the past few years many sufferers with hernia have not been financially able to have them repaired surgically. There is always an appreciable mortality rate that must be taken into consideration. With the injection method patients may continue their work while being treated, and the procedure may be carried out in the office. It is for these reasons that the injection treatment has been tried.

HISTORY

Valpeau in 1835 used irritants in order to produce proliferation of connective tissue in the inguinal canal. In 1842 Heaton of Boston used tincture of iodin through a crude type of instrument; he published his results in 1843. In 1844 Pancost reported thirteen cases of hernia in which he used a cannula through which he introduced iodin, or tincture of cantharides into the inguinal canal. In 1877 Heaton described his method in a book which he published, and while his work was recognized in Europe, it was accepted with little enthusiasm in this country. In 1877 Schwalbe reported cases treated with irritants. Janney in 1880. Warran in 1881. Lannelongue in 1909, and Ripley in 1923 followed with similar reports : Mayer of Detroit used the injection treatment in over two thousand cases from 1899 to 1927, using zinc acetate solution. Pina Mestre of Barcelona, Spain, used the method very successfully from 1907 to 1927 in over ten thousand cases. In the last seven years improvements have been made in technic.

The purpose of the injection is to cause adhesions between the muscle layers in the neighborhood of the inguinal canal, by depositing irritants between them, and holding them constantly together with a truss until sclerosis takes place and the resultant scar tissue obliterates the sac. The fluid is deposited outside of the sac. The tissue reaction extends for some distance because of the diffusion of the irritant. This intermittant stimulation of connective tissue formation by irritants causes a foreign body granuloma which gradually fills up the inguinal canal and the contraction of this tissue binds the three layers of muscle firmly together and also compresses and obliterates the sac.

SOLUTIONS USED

There are two classes of fluids used for injection. In one the active ingredient is phenol in from 12½ to 50 per cent strength combined with some organic or inorganic astringents. These solutions are caustic in action and are used in small quantities, 2 to 10

minims. Mayer's, La Rochelle's, and McDonald's solutions are examples of this type. In the other type alcohol, a small amount of tannic acid, and an extremely small amount of other organic astringents are employed. These solutions are not caustic and a relatively large amount, from 2 to 5 c.c., may be used.

Indications and Contraindications

In general, any reducible hernia that can be held in the abdominal cavity at all times with a comfortable truss is amenable to treatment by the injection method. Cases in which the hernia is not completely reducible or those complicated by improper descent of the testis, or other conditions rendering the satisfactory fitting of a truss impossible should not be so treated. Active venereal disease, tuberculosis, hemophilia, untreated diabetes, and general debility are contraindications.

It is not recommended in children. It should not be used in extremely obese patients.

Technic

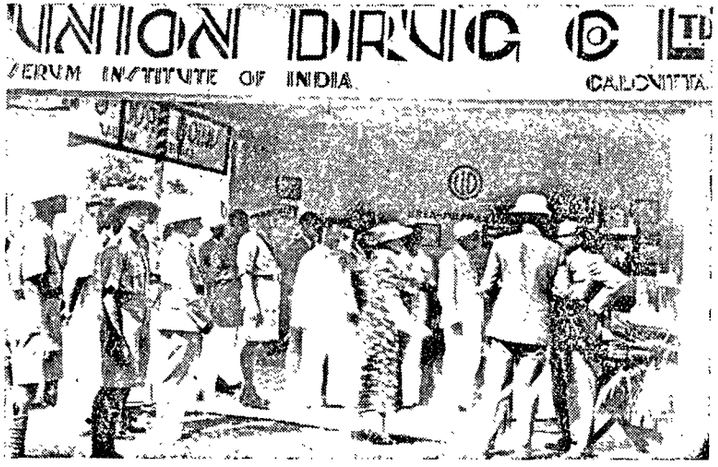
Any truss that holds the hernia in the abdominal cavity at all times is satisfactory, but a spring type truss is best. It should fit properly, be comfortable, and be free from irritation and chafing. It is advisable to have the patient wear the truss for a week before beginning the injection to determine whether a truss can be worn constantly. If it does not retain the hernia at all times, the injection should not be commenced. After starting the treatment the truss must be worn night and day until the canal and openings are closed, and in the daytime for from one to six months after the last injection.

The oblique inguinal hernia is the most common form, and in this type the injection should begin at the internal ring.

The patient is placed in a slight Trendelenburg position so that the viscera gravitate away from the internal opening. The internal abdominal ring is located by palpation or by anatomical landmarks one cm. above the midpoint of a line drawn from the spine of the pubis to the anterior superior spine of the ileum. A small wheal is made here with 2 per cent novocain using a wheal needle. A large needle, 23 gauge and 3 cm. long, is inserted at this point and directed toward the inguinal canal. The resistance of the external oblique and its facia can be felt and after piercing it the needle seems to have entered a cavity. This is the inguinal canal. If on withdrawing the plunger of the springe colorless fluid or blood are aspirated, the needle should be withdrawn and reinserted. If no fluid or blood can be aspirated, a few drops of the solution are slowly injected. General or local abdominal pains suggest that the solution is inside of the peritoneum, and the

(*Continued to page 41*).

THE XIV ALL—INDIA MEDICAL CONFERENCE AND EXHIBITION—MADRAS 1937.



Hon'ble Dr. T. S. S. Rajan, Minister, Public Health, Madras with the Surgeon-General to the Government of Madras visited the booth.

Union Drug Co., Ltd., is one of the Premier Companies in India. Since its very inception in the year 1925 in Calcutta, Bengal, it has been carrying on its business manufacturing genuine medicines to the benefits of the suffering public. Union Drug Co., Ltd., has the credit of producing some new Drugs, the immediate wonderful results of which has, just on application been noted with extreme pleasure and satisfaction by the eminent physicians of India. Its Urea Stibamine which has brought under control the Kala-Azar in Bengal, its Kurchibine highly advocated for its use in the Tropics by Col. Green-Armytage, its Cascara Purgens etc., have earned an unblemished and never fading reputation for itself. All credit for this should be given to Dr. B. N. Ghosh, D. Sc., (Lond.) P. R. S., (Cal.) whose abilities have raised the institution to such an elevated position.

The Biological Department of the Company styled as "SERUM INSTITUTE OF INDIA" have added a glorious feather to its crown. The main object of this department is to produce Serum and Vaccines of better qualities and higher potency without any increase in the cost of manufacture. It has specialised in Sulphonamide and added to the Serum line some new serums which are yet unknown in Indian Serum Manufacture. Urea Sulphazide both in Tablet and Injection (in the case of Streptococcus infections) Sterodin, (a non-specific immunising agent) Neo-Livacon (Highly concentrated Liver Extract) etc. can be mentioned in this connection. These achievements of the Biological Department have been made possible by the abilities of the renouned serologist, Dr. B. B. Sen, M. Sc., M. B., who has earned recognition of many foreign experts in this line. We wish the Union Drug Co., Ltd., blooming success in its enterprise.

MEDICAL CONFERENCE MEETS.

DR. T. S. S. RAJAN OPENS SESSION.

The Fourteenth All-India Medical Conference commenced its sittings on 26th Dec. 1937 at a special pandal erected in the Medical College grounds with Dr. Bidhan Chandra Roy of Calcutta, in the chair.

A large number of medical men from different parts of India were present.

The Hon. Mr. Nausher Ali, Minister of Public Health, Bengal, was among the distinguished guests seated on the dais.

The Hon. Dr. T. S. S. Rajan declared the Conference open, after a prayer.

DR. RAJAN'S SPEECH.

Dr. Rajan, Minister for Public Health, in his opening address said :

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

Although it is fourteen years since the inception of this Association, its activities have not been brought before the public eye except during the last four or five years. Personally speaking, my attention was particularly drawn to the existence of this Association and also to the imperative necessity of all Indians taking a due share in the activities of this body by the late lamented Col. Bolanath. I might say that he spent the last two years of his life as an ambassador of this Association, travelling to every nook and corner of the Province, trying to canvas as many medical men as possible to become members of the Association. It is a great tragedy that such a valuable service as the one he rendered was denied to us by his passing away suddenly from our midst. He was a seasoned soldier, having had an unblemished record of service to the State and to the country during his long association as a doctor and as an administrator. I am sure that those of you assembled here will be one with me in recording the great services he has rendered for the Association.

PROVINCIAL MINISTRY'S AIM.

I am glad you are meeting here at the headquarters of a province which is now under the Congress Ministry under the new scheme of

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

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

It is my earnest desire, as the late Col. Bolanath has put it so very often, that this Association should be a representative body of all medical men in this country. It must secure a place and position equal to that of the British Medical Association in the United Kingdom. I am afraid that the membership of the Association is still not

proportionate to the large body of the medical men in this country. To make it a really representative body must be the endeavour of the Association and to enroll all possible qualified medical men in its register. Time and money spent in that direction will certainly be a very good investment. I would suggest that a full timed officer be appointed for each province so that in the course of the next year it might be possible to rope in almost all available medical men into the register of this Association and when we meet next year, it may be said that "you are really the Indian Medical Association." While saying this, I am not unaware of the fact that there are a number of medical organisations, each having its own independent existence. There is the All-India Medical Licentiates Association which is indeed a very powerful body and of greater antiquity than this Association and which has been rendering yeomen service for that particular class of medical men. There is the Provincial Medical Association which consists mostly of University Graduates, both in service and outside. There are then again branches of the British Medical Association in India comprising of men of Indian qualifications as well as of Britishers who are doing work in India in various capacities.

LICENTIATES.

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

It is very regrettable that the United Provinces Medical Licentiates Association should have felt constrained to carry on a campaign against this Association. Whatever may be the justice or otherwise of the charges laid by them against this body. I cannot certainly congratulate them on the destructive separatist activity which they have advocated.

With regard to the Provincial Medical Association, which comprises mostly of service men who are University Graduates. I would like them to merge themselves in the All-India body while they are

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

Task before the Medical Association.

Besides being a protector of the claims of Indians both in and outside the Services, this body should, like the British Medical Association, develop a robust existence by its contribution to the science of medicine. In this world of to-day, no country or civilisation could ever hope to exist unless it has a part to play in contributing to the general knowledge and general welfare of humanity. India is a peculiar country, peculiar in its traditions and peculiar in its wealth, peculiar in its climate, and peculiar also in the way in which she has solved problems in the past. That we have made some contribution in the past is not an asset on which we could continue to draw for long. We have got to contribute to the knowledge of the world from the peculiar conditions and circumstances in which we have lived and evolved all these years. We should make living contributions in the field of practical medicine, a subject which will be entirely our own and to which we should contribute to an extent which other nations may not be able to do. I presume that the activities of this Association shall be so co-ordinated and made fruitful not only for us in this country but also to others outside ours so that it shall be given to us to give to others to the same extent that they are giving to us. We shall not be beggars for all time with our bowl extended beyond our territories so that other nations might drop what they desire. It must be open to us also to give them and share with them what we have got to give. It is only then we should have deserved well of our existence and also be worthy recipients of a great heritage.

Prevention of Disease.

You are all medical men of great learning and reputation. I shall not digress into those fields of academic knowledge which

many of you possess in a much greater degree than I claim to know and I shall not venture to tell you as to what you should or should not do. But I would just like to remind you of one fact which all of you know—that disease is really the outcome of deviations, ignorant or wilful, from laws of nature and when we could restore our life to natural conditions, probably there will be no need for us to exist, but it is an impossible Utopia with which we are not concerned at present. Disease has come into our midst, partly through our ignorance and partly through our neglect and partly through conditions over which we have no control. We have developed medical men not so much to prolong life which we cannot do, but only to give relief from pain. The function of medicine, pure and simple, does not extend beyond the relief of pain and suffering. But the prevention of disease is a nobler aim, and service rendered in that direction is certainly more lasting than the spasmodic or organised efforts at relief of pain. Therefore, curative and preventive medicine have got to work hand in hand, and the two may not be bifurcated to an extent where one ceases to be operative on the other. Modern tendency has been to isolate the practitioner or the healer of diseases into a groove as if his function terminates with curing ailments. I hold the view that the medical man is pre-eminently a worker in the preventive field, and his medical service will be worthy of public recognition only to the extent that he is able to battle with the preventible epidemics which afflict our population. It is my belief that sanitation and medical relief should ordinarily go hand in hand and should become part and parcel of the whole system of medical service in this country. A medical man tackling disease, should also see and render help in preventing large epidemics by working as a sanitary officer. We have to-day in our province a large army of subsidised rural medical practitioners, over 500 in number, who are carrying help to all out of the way-villages. If these could be made also sanitary officers in their particular locality and their service utilised for dealing with epidemics and also for looking after water-supply, village sanitation, vaccination, inoculation, etc., they would indeed be a useful army of men to the ultimate advantage of the village population.

Indian Systems of Medicine.

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

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

Favourable Auspices for Conference.

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

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

THE XIV ALL-INDIA MEDICAL CONFERENCE, MADRAS—1937.

WELCOME ADDRESS.

By Lt. Col. K. G. Pandalai, M.B., C.M., F.R.C.S., I.M.S.,
(*Chairman of the Reception Committee.*)

Mr. President, Ladies and Gentlemen,

On behalf of the Reception Committee of the XIV All India Medical Conference, I have great pleasure in welcoming you to this ancient city. The Medical public may be aware that this is the first time that this Conference is held in Madras and many may wonder why we did not extend an invitation to the Conference to our city earlier. It is not the case that neither ourselves in Madras nor the authorities of the Indian Medical Association had thought of holding the Conference in the Southern Presidency, but on account of the circumstances prevailing at the time, chiefly our diffidence and doubt about its success if the Conference was invited here, in view of the existence of a number of sectional organizations with divergent view points, we hesitated to suggest such an idea before. We feared that the official section of the Profession might not be with us as the Indian Medical Association was known to hold views, which were critical of the ways of Government and the Independent Medical Profession did not feel strong enough to command the allegiance of a majority in their own ranks. A reaction was already beginning to be noticeable when about three years ago, the late Colonel Bholanath of the I M. S., in his advanced age and at his own expense came on a tour to South India to deliver the message of the Indian Medical Association to the medical men of these parts. Many of us who heard his eloquent speeches were convinced at once of the pressing need for a common organization which would bring together the diverse elements in the profession of this Presidency. Very soon and directly as a result of his mission, branches of the

Indian Medical Association were opened in this city as well as in the Districts but the roll of its membership remained small and its influence and usefulness were not in proportion to its position as an All India Organization. It was at this juncture that my esteemed friend and a former President of the Indian Medical Association, Dr. U. Rama Rau made bold to invite the Conference to this city. His courage and foresight were great for he saw that an Indian Medical Association in which the Southern Presidency did not have its due share could never exercise its full influence in the affairs of the country as a whole. We have thus to thank Dr. U. Rama Rau for the good fortune of holding this meeting in Madras.

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

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

During the few days that you sojourn in our midst, it is my earnest hope that you will not fail to visit the large Hospitals which are the boast of Madras. These are, to mention only a few, the General Hospital, the Ophthalmic Hospital and the Hospital for Women and Children. These Hospitals were organized and brought to their present state of popularity by European members of the Indian Medical Service who have now left the Province and have handed over these institutions to their successors to carry on. I am sure you will be impressed by the work that is going on in these Hospitals.

LT.-COL. K. G. PANDALAI, M.B., F.R.C.S.,
Chairman, Reception Committee,
XIV All-India Medical Conference, Madras.

This City has already an old Medical College which celebrated its centenary last year. A second Medical College in the city is in process of formation. Thanks to the foresight and courage of the Hon'ble Dr. Rajan, the large Medical School at Royapuram which, for years has prepared several hundreds of Licentiates, is to cease producing Licentiates and is to be converted into a Medical College from April next. It may be remembered that about 15 years ago, we had as many as 6 Medical Schools in this Province, all of them producing Licentiates. Gradually, as a result of agitation by the Licentiates themselves who laboured under the stigma of an inferior Diploma, these Schools have been closed one by one and the credit of closing the last one goes to Dr. Rajan. When this School ceases to exist the system by which a separate and inferior grade of medical men was produced to meet the growing demand for increased medical relief, will disappear in this Province and we shall have only one grade of Medical men—the University graduates. It has at last been realised that adequate medical relief can only be administered by men of high standards and that mere increase in numbers of the Profession will not meet the country's demand for efficient Doctors. I wonder if other Provinces in India have such a number of Medical Institutions as here for, in addition to the two Medical Colleges above mentioned in the city, we have one at Vizagapatam and yet another in Mysore under a separate University. Also, it is not unlikely that the newer Universities of Annamalai and Travancore would, in time, have their own Medical Colleges with Hospitals attached. The Vizagapatam Medical College is still in a state of development and having survived extinction during the recent financial depression is now having a difficult time in the matter of official recognition of its Degrees by the Indian Medical Council. It is known that the Teachers of the Vizagapatam Medical College are holders of approved Indian or Foreign qualifications and are considered competent enough to be examiners of the Madras University whose Degrees are recognised but the strange position is that the Vizagapatam students trained by such Instructors are not fit for the approved practice of Medicine in the eyes of the Indian Medical Council. The Vizagapatam Medical College, a creation of the Madras Ministry of some 10 years ago, was never too popular with the latter Governments of the Province and was consequently left in a state of semi-starvation. But when the time came to account for these omissions, the new Congress Government happens to be in power and has to answer for the sins of its predecessors. With the best of wills the new Government must have time to carry out essential reforms and we hope that in the meanwhile the students of the College would not be penalised for the short-comings of a former Government.

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

INDIGENOUS SYSTEMS.

Another problem in medical education in India, no less important than the removal of class distinctions in the Profession by abolishing the Licentiates' Course, is the equally difficult one of approximating the large amount of clinical and therapeutic knowledge available in the indigenous systems of Medicine to the more modern systems which we call scientific and rational. We cannot afford to ignore the great benefits rendered by the ancient systems to the poorer people of the country-side. The question for the future will be whether it is possible to incorporate into the National Medical Service of India, all the advantages claimed by the different systems, now in vogue, and not to allow any medical practitioner to remain in ignorance of the practice of any system of the healing art, whatever its origin. I do not think it is impracticable to let our students of Medicine acquire a general knowledge of the various system now prevailing in the country, as this is easily ensured by the provision of adequate Teachers in existing Medical Colleges. As matters stand, the student of Ancient Indian Medicine is taught a great deal about modern medicine, including the basic sciences, while the student of western medicine grows up in ignorance of the system which is extensively favoured by millions of his country-men and which is most probably favoured by his own parents. The modern

student should also be told about Ancient Medicine; otherwise, he will develop into a man without a national background.

MEDICAL RELIEF.

One hears everywhere complaints of the inadequacy of medical relief both in the cities and in the country-side. The position here is not so bad as in certain other Provinces but even here in large cities, we often come across cases where the existing provision for rational medical relief is not taken advantage of through ignorance or prejudice of patients or relatives. A great deal of public education is necessary before people learn to use the facilities provided for them. It is, therefore, of the greatest importance for the future well-being of the nation that due attention be paid to the proper education of the future citizen in the school-going age in matters relating to health and prevention of disease and particularly to seek relief at the proper quarter before health is seriously undermined. This process should go on alongside the provision of Medical Officers for treating the sick of rural parts and the expenditure of large funds for erection of buildings and provision of equipment should follow the demand of the public for increased medical benefits.

NURSING.

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

SERVICES.

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

of popular Governments in the Provinces will be anomalous and the prospects of the other members of the Medical Profession throughout the country will continue to remain as deplorable as ever. We have no objection to special arrangements being made for the treatment of British officials by Doctors of their own race, if they wish it, but not at the public expense. Reservation of the best appointments in the Civil Medical Departments of Provinces for the sake of a handful of European officials cannot be reconciled with the Autonomy which has been granted to the Provinces and certainly, there is no longer any justification for perpetuating a practice which might have served some purpose in the years gone by.

THE FUTURE.

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

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

In conclusion. I wish to tender the grateful thanks of the Reception Committee to the Hon'ble Dr. Rajan for the willing hel

DR. B. C. ROY, M.D., M.R.C.P., F.R.C.S.,
President,
XIV All-India Medical Conference, Madras.

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

I must not omit to mention that the Exhibition, which has by now become a normal accompaniment to this Conference and which will be opened this morning by the Surgeon-General with the Government of Madras, is a comprehensive one illustrating the conditions prevailing in India as regards medical and surgical requisites. This exhibition amply indicates the steady advance in the standards of medical supplies as obtainable in India and I feel sure that as we go on, future Exhibitions will be utilised by the Indian manufacturers and Exhibitors in greater numbers than at present.

SPEECH OF THE PRESIDENT, INDIAN MEDICAL CONFERENCE AT ITS 14th SESSION HELD IN MADRAS.

DR. B. C. ROY.

Mr. Chairman of the Reception Committee, members of the Committee, Fellow Delegates and friends, I have been called upon to preside over the deliberations of the Conference for the second time. I am sensible of the great honour thus conferred on me and I hope I shall have opportunities to serve the cause for which the Indian Medical Association, under whose aegis this Conference is called, stands.

Since we met last year, great changes have taken place in this country of ours, a bloodless revolution has come about, the Congress, the predominant political party has withdrawn its opposition and taken up the reins of Government in 7 out of the 11 provinces; and who can say, that the ideal to which Congress is wedded, and for which its members are pledged to work, is not silently but effectively influencing the activities of the remaining four provinces?—And

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

So much for efficiency at home. What about abroad? The Medical Act says "The Indian Medical Council may enter into negotiations with the authority in any state, outside British India, which is entrusted by the law of the State with the maintenance of a Register of medical practitioners, etc." In all cases of such approach by the Indian Medical Council, these countries must have found it curious that the Indian Medical Council *maintains no* register and wondered how was it possible for the States possessing a register to have a scheme of reciprocity with the Indian Medical Council "without" a register. And the enquiries by the Indian Medical Council showed that most countries refused to deal directly with the Indian Medical Council, as they were satisfied with dealing with the General Medical Council in England, which is all that matters to them. Here then is the "honour abroad" maintained? And why should any country bother about the Medical Council of a country which does not possess the status of an Independent State? The Indian Medical Council has not even the elementary power of protecting the interests of the Indian Medical profession by prohibiting or disallowing non-nationals from practising in this country.

MEDICAL EDUCATION.

The next important subject that we have from time to time discussed in these Conferences is the question of medical education. I have incidentally referred to it in my discourse on Indian Medical Council. We have stressed the necessity of having a suitably arranged pre-medical course in Biology, Chemistry, Physics, so that students after admission into a medical institution are able to take full advantage of the training they receive. All the world over, educationists have felt that with the growth of medical science, the type of instruction hitherto given to students should materially change. Everywhere it is agreed that of the five year course, two

should be devoted to Fundamental Sciences, three to clinical work, that subjects like Hygiene and Medical Jurisprudence, however important they be, should not be given any extra attention in the education of an average medical student, as they should form special subjects for experts that Applied Anatomy and Physiology, Pathology and Pharmacology should be continuously studied during the clinical period, that, *in effect*, all subjects of medical education *should be organically* linked together and not grouped in such water tight compartments as to make the student feel that, as he progresses on in his studies, he should forget what he has learnt in one year before he goes on to the next.

POST-GRADUATE STUDIES.

But I urge that even after he has satisfied the examiners in the final test, the graduates, under a recognised teacher should have at least 6 months' *course of post graduate* studies, during which period he will be given the option to choose any special subject he is interested in. On receipt of a satisfactory report from the teacher concerned, the graduate is admitted formally to the degree. It may be urged that there is not enough room for giving such post graduate training to all who have passed the final test. Such argument, however, cannot be allowed to prevail in view of the necessity and desirability of giving post graduate instruction to all persons on whom *the responsibility* for human lives would rest. Provision for such instructions, therefore, must be made.

MEDICAL TEACHERS.

But any scheme, however, perfect, will fail in producing effective results unless teachers are appointed who can really teach. I can say with all the emphasis I can command, that every person who possesses a degree—even a high degree—cannot be a teacher, that it takes years, *even for a person of superior qualifications* and intellect, *to learn* the art of teaching, that in medicine a man must have devotion and affection for his subject before he can properly teach it, that every medical teacher must have an aptitude for and experience of research before he can fully discharge his trust. But what do we find to-day? By the fiat of the Government it is decreed that members of a certain Service must occupy certain important teaching posts in the Medical Colleges in India and that the Research Departments should always be under the control of members of that Service. I have no quarrel with individual members of the Service, nor do I grudge the prospects such fiat gives to them. Some amongst them, I am proud to say, have been my guide, friend and teacher. It is the system which I deplore. It is a tragedy that teaching appointments should be reserved for members of a Service which admittedly exists for two main purposes—namely, to serve as a War Reserve, and, *secondly*, to secure for Europeans in Government Services, medical help from members of their race. For a man

in the service, continuity of work in a particular department or post cannot be ensured, and in the absence of such continuity, teaching, research, and even efficient treatment are bound to be defective. I will deal more fully with this subject presently. But it has been my experience that as a result of such an arrangement one I. M. S. man successively served as Resident Surgeon, Resident Physician, Physiologist, Chemical Examiner to Government, Ophthalmologist, finally as a Consulting Physician; he had to occupy different posts in the College, as he had to remain in Calcutta; so the posts were made to suit him and not he the posts. And what about research? Whether it be malaria transmission enquiry, cholera enquiry, whatever be the nature of research, the choice falls first on the European member of the Indian Medical Service. We deplore communal considerations affecting affairs of our daily life; we deplore, thousand times more, that they should enter the sacred sphere of teaching and research.

INDIAN MEDICAL SERVICE.

It is but a natural sequence that I should discuss this service next.

On numerous occasions, in public and in the press, in Conferences and Committees, members of this Association have commented on the mode of recruitment to this service, on the differential racial treatment meted out to the members of the Service particularly regarding salary and allowances, on the way in which they are allowed to usurp important teaching and research appointments; in fact, the Association have often declared that this Service need not exist at all. Various branches of the Association, in different Provinces in India, have also urged on Provincial Governments, the need for a reorientation of the present policy of Government regarding the Services; the latest of such memoranda is the excellent one presented recently to the Minister in charge of Local Self Government of Bombay. I will not repeat those arguments, convincing as they are, but merely discuss this question from the point of view of the masses of India who suffer patiently and pass on to the life beyond, silently and uncomplainingly.

We have in India to-day according to latest report available, 220 members of the Indian Medical Service transferred to the Civil Side. This transfer is justified financially because it is said to form a "war" reserve. This transfer is further justified on the ground that without this tempting prospect, the right type of medical men will not enter the Indian Medical Service. One wonders how they get candidate for the R. A. M. C. to look after the European army in India who have no such prospect.

Out of the 220 posts, 166 are reserved for Europeans, because they are required to look after the European members of the Services in India. A large number of specialists', research and teaching

posts are reserved for Europeans "in order that specialists' attendance shall be available for European Government servants and families." On a rough calculation, the number of Europeans in the Services in India and their families, would not exceed 20,000 and for them we have 160 European I.M.S. officers with facilities for specialists' posts and overseas allowances and travelling allowances. Speaking about introduction of insurance provision against sickness for industrial workers, numbering millions in India, The Royal Commission on Labour in their report of 1931 stated "There is a difficulty in that the industrial workers form only a small fraction of the population and it is difficult to justify any elaborate and expensive extension of State services for their exclusive benefit." I wonder what the Royal Commission will say to justify the expenditure of over 20 lakhs a year and more for 20,000 Europeans. As I have indicated above, service conditions are always inimical to the making of proper teachers and research workers. On the other hand, it is well recognised that the quality of service which a medical man can give to the patient, depends a great deal upon the personal relationship of the doctor to the patient. Liability to transfer is the usual rule in case of all services, according to the needs and exigencies of the services as a whole. Such frequent transfers of a medical man from post to post cannot, therefore, be in the interest of the people who might have developed a personal liking for him. Therefore, it is clear that the system of appointing a few men on high salaries and allowances, avowedly to satisfy the sentimental needs of a particular community cannot, in the interest of the suffering millions, be continued in India as she is not capable of affording the luxury of such highly paid services.

HOSPITAL AND DISPENSARY SERVICE.

There are over 6,000 hospitals and dispensaries, either maintained by the State and statutory bodies or aided by them; a few are maintained by private agencies, 200 members of the Indian Medical Service, a few belonging to women's medical service, 1750 belonging to the Assistant Surgeons' service and about 6,000 licentiates, work in these Hospitals. The smaller hospitals and dispensaries are generally maintained by district or local boards and they constitute more than 3/5th of the total number. It is calculated that, on the average, a small dispensary in a rural area is expected to serve 50,000 to 60,000 persons living in sparsely situated villages. The remaining 2000 odd hospitals, most stituated in urban areas, have 72000 beds in all and treat on the average, according to the official report, one million people annually. But we are unable to find any scheme behind this hospital system. In Britain to-day, hospitals work under a definite scheme which provides for general and special services to the community, prevents overlapping and affords opportunities for intensive research work. The hospitals in India though

mainly maintained out of public funds are yet the close preserve of the services. The Civil Surgeon is in administrative charge of the district hospital with, say, 200 beds; he may also be the Superintendent of the school situated in that district for training doctors, nurses and compounders; he is in administrative charge of the branch dispensaries in the district covering hundreds of square miles; he is also the medical adviser of the higher Government Officers and their families; he is the official medico-legal expert of the district and has often to appear in courts to give evidence; and then he has to treat patients in the hospital and engage in private practice. Therefore, he must be a teacher, a research worker, a medical authority, an expert medico-legal adviser and administrator, all rolled into one. It is true that he gets a decent salary, but he would not be human if he did not demand a return commensurate with the huge responsibility which he bears and the work which he has to do. He and his assistants have all the same human failing. The patient, a member of the public, puts more faith—and rightly so—in the service men, because they have the unique opportunity of gaining experience and practice in the healing art in these hospitals with the immense materials available therein. The private practitioners thus find it hard to compete with them. Hospitals are being multiplied to provide for the medical treatment of the poor. Any increase in their number, however, correspondently lessens the chances of private practitioners of earning sufficiently. It may be some compensation to the private practitioners if they get equal facilities in the hospitals with the service men, (if services are to be maintained), because in that case the private practitioners can compete with the service men on equal terms. Be it remembered, also these very practitioners now and in future, are called upon to look after the welfare of a much larger number of people than are treated in the hospitals to-day, as at no time can it be possible for the State to provide accommodation and treatment for the millions that suffer every year from diseases in this country. In order that these private practitioners can give efficient service to the people at large, it is essential that they should keep themselves up to date and for that purpose they should have opportunities of getting experience such as are only available in a hospital. Therefore, while the hospitals have to be maintained to give free service to the poor, the opportunity to work in them should be open to all, both in the interest of the suffering public and the practitioners themselves.

What then should be the hospital system in India? Many of these institutions owe their inception to the generous instinct of private donors in whom the agony of suffering humanity has evoked a ready response. But the bulk of the money spent on these hospitals still comes from the funds of the State or of statutory bodies. If that be so, it is wrong, to my mind, to regard or to designate these

hospitals as "charity" institutions. The State or the statutory bodies are merely spending public money—money contributed by the people for their benefit and relief. Therefore, the services given by the hospital staff, and the treatment provided in these institutions cannot be regarded as charity work. The staff of these institutions should not belong to any specially privileged or protected class but as many of the practitioners as can find a place there, should be allowed and encouraged to gain experience therein; every member of the staff must always consider himself as a servant of the people. These hospitals should be placed under the control of local Committees consisting of representatives of the people, of the Government and of the Statutory Bodies who are and might be contributing towards their upkeep. They should no longer be under the complete control of the department of the Government as heretofore. If this step be taken it should be possible, to a large extent, to create local efforts and enthusiasm to supplement the contribution of the Government or of the Statutory Bodies towards the upkeep of the hospitals. Experience teaches us that if such control be given to a properly constituted body, the members of that body rise to the occasion and take living interest in such activities. The memorandum of the Bombay Branch of the Indian Medical Association, above referred to, gives the example of the Vadilal Sarabhai General Hospital at Ahmedabad or the Country hospitals in England. I may also quote the instances of the Chittaranjan Seva Sadan and the Jadavpur Tuberculosis Hospital in Calcutta where these institutions, with suitable contributions from the Corporation or the State, are giving very effective and efficient service to the people. I dare say there are more of such instances in India. Therefore, it is safe to premise that power coupled with responsibility always evokes responsive activity on the part of those on whom the responsibility is placed. The institutions should be classified as General and Special. The General Hospitals should be properly equipped with nurses and efficient staff and should have a fairly large number of paying beds, so that these hospitals will ultimately be maintained more by contributions from the people, made directly to the Hospital, than indirectly through the State. The Special Hospitals on the other hand, should be provided with facilities for teaching students, for research and for treatment on special lines. No effort should be spared to make them efficient; and these institutions should also be the training ground for post graduate work. At present we have no arrangement for post-graduate training anywhere in India. The Research Department as I have stated above, is kept a close preserve for the benefit of the few; Teaching and Specialists' posts are likewise preserved. Naturally, those Indian students who desire to pursue higher studies in Medicine and to improve their status and prospects in life have to go to foreign countries. There again,

difficulties have arisen. In England, where the students might naturally expect sympathy and aid, they get none. The India Office do not give any help except to members of the Services, particularly those belonging to the I.M.S.; officials of the Indian House and the High Commissioner also give no effective aid, because they have no real power, although they display pomp and show. In numerous instances, to my knowledge, they could not give to the students even such help which any one of us individually could give by influencing and interesting the authorities of the Institution with which we were at one time associated. This fact was brought home to me very forcibly during my recent visit to Europe. Many students complained to me of the difficulty of joining any institution in England because of the indifference or unsympathetic attitude of the authorities of those institutions. Even in the institutions under the control of the London Country Council, which is dominated at present by the Labour Party in England, the Indians fare no better. No one can marvel at the attitude of the authorities of such Institutions, much as we may deplore it. I found that there are in England, to-day, a large number of Indian practitioners settled in the country and carrying on a fairly lucrative practice. The success of the Indian practitioners, even when they possess ordinary qualifications, naturally re-acts on the minds of Englishmen. If the Indians were to take higher degrees and then settle to work in England, their success would be more marked. Naturally such success cannot be viewed with equanimity by those whose interests are affected. Incidentally, I may mention that the success of the Indian practitioners in England is a fit reply to the argument of those who always raise the side issue in India, namely, that Europeans always desire to be treated by persons of their own race. Our boys, in their anxiety to get post-graduate training, resort to other countries of Europe or go to America. In Paris, Rome, Berlin, Munich and in Vienna we see a large number of Indian students taking post-graduate training. In Vienna, perhaps, we have a larger number of Indian students than in other places. Austrians, as a rule, have a warmer heart than the people of other countries and Vienna has numerous institutions where ample materials and efficient staff exist. We welcome the presence here, amongst us to-day, Professor Rudolf Demel, Professor of Surgery in Vienna and a well-known Surgeon in that city. He is a teacher himself and a large number of Indian students know him personally. He has travelled six thousand miles from home, to convey the sympathy of the University of Vienna to the cause of Indian Medical students. He has come to India also to obtain a first hand knowledge of the medical students in India and of the educational institutions here. I hope and trust that we in India would soon be able to develop the Institutions where efficient post-graduate training would be given so that, in future the students may not be forced to go to other countries to get such training.

PUBLIC HEALTH SERVICE.

The Public Health Service in any country has to deal with all aspects of the problem affecting the health of the people. It generally initiates and carries out all manner of preventive work, e.g. vaccination; it carries on propaganda and publicity work; it appoints medical officers to look after the health of the school children and give them health education. It is responsible for sanitary arrangements, mainly for rural areas where masses congregate during fair and festivals; it also gives expert advice to sanitary authorities in urban areas. This department has also to take cognisance of industrial hygiene and health condition of workers in the mines. It is responsible for the welfare of labour in factories. The health problems in connection with railways, shipping and air services are also within the orbit of its jurisdiction; it supervises the birth and death registration and the preparation of mortality statistics. In India, all these functions have to be performed by sanitary authorities, perhaps under less helpful conditions than those obtaining in other countries. It is admitted that elementary ideas of sanitation are lacking among the ignorant poor in this country and the development of national health services is still in its infancy. Illiteracy, want of proper educational facilities lead to ignorance. Ignorance makes people cling to encrusted habits. Age-long customs, however insanitary and unscientific they be, become irremovable; superstition and blind faith in them serve to petrify them. And further a bad habit which in a village is inocuous may become positively harmful, if persisted in, when the villager migrates to a town. During the last two decades, due to causes we need not enter into now, thousands of villagers are migrating to towns carrying with them insanitary habits and unhygienic customs. This adds to the difficulty of effective health service in India. If 6.8 millions of people die every year in India, it is safe to assume that 10 times that number actually suffer from diseases requiring treatment. In point of fact, however, the report of the Public Health Commissioner of India shows that while from fevers alone, a million people die annually, the actual number of sufferers, from fevers, like malaria, is many times more. Col. Sinton, Director of the Malaria Survey of India, in his recent report, states that "there seems to be little doubt that malaria is responsible for at least one million deaths each year. There is very considerable evidence to show that at least 100 millions of people suffer from malaria in British India, and even that is probably a moderate estimate. In addition to this, there is indirect morbidity, predisposed by this disease, which may be between 25 to 75 millions cases." Col. Sinton further states that there is some reason to believe that "not more than 1/10th of the persons suffering from malaria in India actually receive treatment at the hospitals and dispensaries. Major General Megaw, Director General, Indian

Medical Service, on the basis of an inquiry made by him in 1933 states: "The number of persons who suffer every year from malaria in India is not less than 50 millions and may reach 100 millions in some years." These are staggering figures of two experts in this line. From the mortality table, we find that 2 lacs of people die every year from cholera and there is not the slightest doubt that 3 to 4 millions of people suffer from cholera each year. It is safe to estimate that one million persons suffer respectively from plague and small pox every year. Dysentery and diarrhoea takes a toll of nearly 3 laks of people every year and there is no doubt that 3 millions of people suffer from these diseases. It is estimated, and perhaps the estimate is a moderate one, that not less than 2 millions of people suffer from Tuberculosis in India to-day. I will not mention other diseases which cause death or from which people suffer. It would appear, therefore, that our problem is to find medical relief for 110 millions of people. By organising our public health departments, we can prevent the incidence of diseases, and the number of the sufferers will then fall correspondingly.

It seems to me that the best way to solve the problem is to organise the public health service in the following manner:

The service should be divided into Rural and Urban.

RURAL HEALTH CENTRES.

There should be a rural health centre in charge of an official of the Health Department. Each such centre should be in charge of an area of not more than 100 square miles on the average. In Bengal, at present, each such centre coincides with a thana area. It is a wrong method to mix up administrative units with health units. Each rural centre should be responsible for the following :—

(1) Vaccination
(2) Registration of births and deaths
(3) Conducting educational propaganda
(4) Holding school clinics and giving health instructions in schools
(5) Generally looking after sanitation, of the area, particularly in cases of fairs and festivals
(6) Protection of sources of water supply
(7) Enquiring into the plague spots within that area, whence epidemic diseases start every year and providing facilities for observation and investigation in all cases of epidemics.

Peripatetic dispensaries may also aid the work of the village health centres. They would not only give help to the suffering villagers, particularly in times of epidemics, but will also be very powerful agencies for propaganda against diseases such as we need urgently. In Bengal, a scheme of giving relief to the sufferers from Kala Azar and Eye Diseases, with the help of mobile dispensaries,

has been in operation for several years with remarkable results. People not only have benefited by the work of the men employed, but the consciousness of the people towards the method of prevention of some of these diseases has considerably been aroused.

URBAN CENTRES.

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

SERVICE FOR EPIDEMICS.

Besides these rural and urban centres, there should be, to my mind, a special staff trained to work for the control of epidemics. Epidemics means mass infection. On a reference to a mortality table it will be seen that preventible diseases like Malarial Fever, Plague, Small Pox, Cholera, Dysentery, Tuberculosis, Ankylostomiasis, Rabies, Leprosy, Kala Azar constitute 66 per cent. of the total deaths in the year. The incidence of these diseases is also correspondingly high. The treatment of cases of malaria and cholera and, to a certain extent, of plague has become more or less stereotyped. We know that in these diseases, prevention is better than cure. We also know the seasonal incidence of some of these diseases for each area. It is asserted that an epidemic starts almost invariably from one particular centre in a district and then spread to neighbouring areas. If we can, adopt early and effective measures, as soon as the first case appears in an area, we may prevent the disease spreading and the need for providing treatment of a large number of such cases will not arise. Hence my suggestion is to have an epidemic staff as a part of health service, trained to treat particular diseases, who will be stationed at different convenient centres. Fortunately, the seasonal prevalence of most of these diseases does not coincide, so the same staff can in many cases deal with several types of epidemics. It would be the duty of the epidemic staff to be ready for emergency summons at any moment like the fire brigade officers, and at the earliest opportunity proceed in a body to the seat of origin of the epidemic and try to exterminate it.

MEDICAL RELIEF SERVICES.

If we are able to stop the spread of epidemic diseases, which cause the largest number of morbidity and mortality in India, we are left with a comparitively smaller problem, namely, that of provision of treatment of about 10 to 15 millions of people for the whole of India, suffering from diseases other than those dealt with by the epidemic staff as mentioned above. A small proportion of this number would be treated in the existing hospitals and dispensaries. But what about the remainder? How to met the huge problem of finding medical relief for such a large number who reside mostly in rural

areas and are to-day practically without any suitable or adequate medical treatment? There are three alternative courses which can be suggested to meet this situation. It is a fact that it is difficult to get trained doctors to go and practice in village areas. They do not find it paying enough to go there, there are no social amenities, the sanitation is very poor, and they have to remain near a town to get the best return for their labour. The first suggestion is, therefore, to create an inferior grade of medical men who will spend a period of three years in a school, just to learn the elementary principles of scientific medicine and will then be sent out to the rural areas to supply the medical needs of the people. I do not think this suggestion at all helpful and I believe it to be a retrograde step. Even to-day every village area has got quacks, inadequately trained persons or charlatans who treat patients. As I have said above, no person who has obtained less than five years' training can practise scientific medicine. And it is this type of person that villagers want. It is not that they do not now get any treatment, but to-day they know enough of their illness to understand the value of scientific medicine. On the other hand, the village practitioner, when in a dilemma, would like to have the advice of a trained physician. Often a patient in the village may be unwilling or unable to journey down to a city and obtain scientific medical aid. Therefore, I say, the creation of a new type of village practitioners by giving them a three years' training would not meet the situation.

The second suggestion is to devise a scheme whereby it would be worthwhile for a scientifically trained doctor to go to a village area. I admit that it is not very easy to suggest a complete scheme for all parts of India. During the last decade, in the Punjab and the Madras Presidency, a scheme has been followed, namely, that of 'subsidising' private practitioners intending to practise in rural areas. A dispensary is opened in a village. A private practitioner is placed in charge of the dispensary and is given Rs. 25 per month by way of subsidy. Such a practitioner is not liable to be transferred to another dispensary without his consent, but in other respects he is subject to the same conditions of service as the whole time medical officers in charge of rural dispensaries. A grant of Rs. 500 per year is given for drugs and instruments and the total cost of up-keep of such dispensary is about Rs. 1,000 or Rs. 1,100 a year. The doctor is entitled to charge for medicines supplied to the patients except to the very poor, in accordance with the scale which lays down a maximum chargeable in this manner. To my mind, this scheme requires further development and each province of India may modify it to suit local needs but the objective of such a scheme should be, (1) to do away ultimately with the present type of medical services and replace it by independent medical practitioners, who will be helped in the earlier stages of their career, by contributions

capital or recurring, from the State, and (2) to develop a sort of penal system, whereby the State subsidy, which often represents indirect contribution by the people, may be replaced by direct contribution from the patients. This will restore the individualistic traditions of medical practice and will improve the relationship between the patient and his doctor. At present an ordinary rural dispensary costs the Government or the District Board about Rs. 2,500 a year, so the expenses to the State on the present that "Rural Dispensary" system are two and half times as much as on the "subsidy" system. In justification of the subsidy system, therefore, it may be said that it is cheaper to maintain a centre of this type when the cost is borne partly by the State and partly by direct contributions, however small, from the patients themselves. This system makes the patients feel that they have not to accept charity; it increases their sense of self-respect and it also removes the "service" mentality from the mind of the medical practitioner. This system also brings the patient in close and direct touch with the doctor. Each such village practitioner, so subsidised, will be encouraged to develop a "voluntary" system of insurance which would form the nucleus of the "compulsory" insurance system which is now in operation practically in every country in the world.

SICKNESS AND UNEMPLOYMENT INSURANCE.

From what I have said above it is clear that our problem is vast. It is not easy to devise a scheme of giving efficient medical relief to millions of patients living in villages isolated from one another, with means of communication between them difficult and in certain periods of the year absent. The marshy deltaic districts of Bengal, the dry parched area in the North, the unfavourable weather conditions in India, the polluted sources of drinking water, are physical factors which enhance our difficulties. There are 50,000 villages in India, of which 425,000 have population of less than a thousand. Therefore, poor as they are, the villagers cannot afford to maintain a doctor in a village or even in a group of villages and any form of concerted action amongst them to establish a "voluntary" system of insurance against sickness and unemployment is out of the question.

Let us look to the other side of the picture. With the increasing poverty in the land, the starving poor is becoming more and more a victim of diseases which are and have been found to be preventible in other countries and lands. And yet the poor by themselves cannot arrange for proper treatment in case of illness. The tragedy lies in the fact that while poverty in this country is increasing, medical practice is getting more and more expensive. There are many reasons for it. Improvement in training and progress in science, forces the medical students now to invest more money in education and equipment than has hitherto been found necessary; even within the last two decades such investment has increased by

hundred per cent, if not more. On the other hand, with the increasing knowledge and progress in medical science, there is a greater tendency to specialise, and specialisation means greater cost. Even a patient promotes a tendency to such specialisation. The more learned he becomes in medical matters, the more is he likely to attempt diagnosis of his own case and the more will he have the tendency to run to specialists. The latter may find it necessary to send the patient to another specialist, and so on, with the result that the more efficient a physician becomes, the more costly becomes his services. But this is not all. The profession is caught in the current of times. The young doctor, who went into debts in order to pay for efficient training and equipment, sees round him businessmen who acquire wealth and status and sets up a high standard of living. The physician feels that he has worked harder and sacrificed more than the businessmen. Why should he not have as much return as they? To the city, migrates the businessman; to it also goes the young doctor; both of them anxious to earn his utmost. While the medical service have admittedly become more costly, the lay public have recognised the dramatic advances that have been made in medicine, and, therefore, they are anxious to secure the services of medical experts, although they are not able to pay for the same. The question arises, therefore, is society in general, and the medical profession in particular, in a position to meet this growing demand? In educated minds, an argument such as the following suggests itself: "Medical science can now prevent or cure certain major diseases. Many people continue to suffer from such diseases. Ergo, medical science does not serve the people as it should." The more people long for medical aid, the less can they afford to have it. This is a serious impasse in the relation of the public to the profession. It is natural that we should try to find out some method of solving this problem. In the West, during the last two centuries, various guild funds or benefit organisations have developed, the basis of which is, that those who cannot afford to pay the heavy expenses of medical aid in serious illness, can meet these costs if they are spread over years by premium payments. Gradually various types of insurances developed in these western countries. Before going to discuss these various types, I should draw your attention to the fact that it is conceded that there are some obvious disadvantages in this system of insurance against sickness. It has been argued that this system might lead to malingering. It is also said that this system would lead to dimunition of substantial reward to the medical practitioner for his services and would naturally tend to decrease the physican's personal interest in insurance cases. After all, doctor is only human, and it is just likely that he would pay careful attention to those who pay well in the course of private practice and treat somewhat indifferently the insurance patients for whom only small

fees are paid in a routine manner. But the most serious criticism of a system of this type is that it does way with the individualistic tradition in medicine. The patient loses the personal touch of the doctor and the whole profession becomes a sort of business. On the other hand, the great advance of this system lies in the fact that those who are weakest economically, can avail of medical aid, no matter what their station in life is, without being, "charity" cases. Such a co-operative system would provide aid during illness as it provides mass education for the poor. Remembering the difficulties of the medical practitioner towards getting a decent sum for their living, as also the fact that the large bulk of people in all countries cannot afford to pay for medical services in these days, the League of Nations at Geneva adopted a Draft Convention in 1927, recommending to the Governments of all the different nations, a system of health or sickness insurance. This system, the Conference of the League urged, should be operated by self-governing societies under the administrative and financial supervision of competent public authorities and in consultation with medical experts. They should not be carried on for profit. In case no such society existed, the Governments were urged to provide a State system. Every country in the West to-day has adopted some system or other of national insurance. They argue that it is as important to save the life of its citizens as it is to protect forests and preserve the animals in them. Admittedly, reduction of mortality means conservation of national wealth. In America, before introducing the scheme of Insurance, a committee of One Hundred was appointed by the President to report on "National vitality, its wastes and conservation." Prof. Fisher of the Yale University who drew up the Report of the Committee declared it "to be both bad policy and bad economy for the State to leave protection against disease either to the weak and spasmodic efforts of charity or to the philanthropy of physicians." In India, no other system exists except doling out charity to the suffering poor. We have the different services, and there are the hospitals. From what I have said above, it is clear that the services and the Hospitals alone cannot solve the problem. The recommendation of the League of Nations for formulating health Insurance schemes came to India. The Royal Commission on Labour discussed certain aspects of the question and submitted its report 1931. I am indebted to my friend Dr. Chaube of Delhi for the supply of information on the question.

The Report of the Royal Commission says "By common consent, the incidence of sickness is substantially higher in India than in western countries. Medical facilities are much less adequate, and the wages generally paid, make it impossible for most workers to get through more than a very short period of illness without borrowing." In another part, it states: "The question of making provision for

them during sickness, even if it had not been raised by the Government, would have been forced on us by what we found in every industrial centre." The Provincial Governments in India all argued that it was not possible to introduce such schemes now. The Labour Commission, therefore, naturally concluded that it was impossible to introduce the system in India, particularly as there was no reliable statistics as to the incidence of sickness amongst workers, nor any estimate as to the cost involved, of any benefit that is desired to provide. The Labour Commissioners, therefore, suggested the formation of a Committee for collecting statistics in order to come to a decision. Meanwhile, the Commissioners suggest the formation of a central non-contributory medical aid society, whose funds would be provided by the employers and the employees, and from which medical aid would be given to the workers. In other words, the Government would not do anything, leaving the workers and the sufferers to help themselves.

While every country in Europe and America has adopted some form of compulsory sickness insurance to protect the poor people against disease and unemployment, India still lags behind. Even a type of agricultural insurance has been introduced in Great Britain, Germany, Irish Free State, Norway, Poland, Bulgaria, Austria and Russia. Ordinarily, there are three types of insurance met with in these countries. Firstly, there are the voluntary institutions, depending on the help they receive from various social and religious associations. These institutions are of no use for the general masses in India. Secondly, there are the Company insurances which have a limited scope, because they are applicable only for those cases where the insured are able to pay sufficiently to the Companies for them to make profits in the transaction. Lastly, comes the compulsory form of health insurance. The principle behind this system is that a sick person is always a burden to the rest of the members of the oommunity, and, therefore, he should be forced to join some form of insurance scheme by which he gets relief in cases of illness. It is recognised that this form of insurance is most easily worked out among industrial workers, But as I have mentioned above, this system has been in vogue among agricultural population also in many countries. The employers and the employees would each make their own contributions towards this scheme and the State will do the rest. The employer pays because a healthy and contented employee is an asset to him. The employee pays because he gets back a portion of what he pays, in the way of medical treatment and he virtually pays for such medical treatment on a deferred basis. In those cases where the people are not able to pay at all, because they are not wage earners, the State must make necessary contributions for them.

No one at this stage, without further information, can lay down any scheme which is suitable for India, nor can one assert that any particular system would be suitable for all parts of India. But I desire to emphasise that some step must be taken immediately to prevent this great waste in men and money. Therefore, I suggest that the Central Government should take early steps to appoint a Committee to inquire into the whole problem. They must not stand on ceremonies and consider their own experts as infallible guides in such matters. Failing the Central Government, the Provincial Governments should take necessary steps as early as possible. The question remains as to what part the medical profession in India is going to take in this matter. In England, the British Medical Association has given constructive suggestions at every stage of the introduction of health insurance scheme in that country, and I see no reason why the members of this Association, individually and collectively, should not give all possible help towards the solution of this great problem. I do not conceal the fact that there are difficulties in the way of introducing any form of health insurance in India. Those who are in the Service to-day, and who, in the eyes of the people outside India, materially count, would object to any step being taken towards this end which might jeopardise their interests. Any scheme which proposes to bring the private medical practitioners into the National Organisation of State Medicine would be opposed by those who have now got the monopoly of position in the State The solution of the problem is thus beset with difficulties but with determination and perseverance it would not be difficult to find a solution. Friends, let us band together and help to make this dear country of ours a land of health and affluence and to rehabilitate it in its pristine glory.

MAJOR-GENERAL N. M. WILSON'S ADDRESS.

OPENING THE EXHIBITION.

Major-General N. M. Wilson, I.M.S., Surgeon-General with the Government of Madras in declaring the exhibition of Surgical appliances and medicinal preparations attached to the Conference open, said :—" I am thankful to the Chairman and members of the Reception Committee and the Indian Medical Association for asking me to perform this pleasant function. Exhibitions throughout the world, played a very important part and in a great measure contributed to the success of the Conference under the auspices of which it was organised. In India, medical exhibitions are more necessary and certainly will be more appreciated than in other countries. All their manufacturers and supplying agencies are being scattered over this large continent and the long distances have to be covered by railway travel. It is not easy, therefore, for

the profession to get into direct contact with the manufacturers. This difficulty is not experienced in the West where travel is quicker and easier and agencies exist in all big cities for almost every known drug or appliance. It is through such exhibitions like this, that the profession at large is able to keep in touch with the latest medicinal preparations. surgical instruments and hospital equipments which change from day to-day. These exhibitions are the means of bettering the knowledge of members of the profession with a view to better treatment of disease. It is very gratifying to see Indian firms so well represented in the Exhibition. The names of the manufacturers are too numerous for me to mention in detail. But, I would like to mention the Bengal Chemical and Pharmaceucal Company of Calcutta, and I think I am correct in saying that they are the pioneers in India of Drug manufacture. (Cheers.) The firm was started in 1892 by Sir P. C. Ray, and had steadily progressed. It has now reached a very high standard of efficiency and reliability and is much respected by the whole profession in India. I am sure that the other Indian firms will follow the fine lead given by the Company. I am glad to see firms like Messrs Burroughs Wellcome, Parke Davis, May and Baker are also represented in the Exhibition. I am sure that they will continue to help them. It is very gratifying, to see Messrs. Hebbar Bros. represented. They are manufacturers of surgical instruments, and hospital furniture. Their work is of a very high standard (cheers.). If I may be allowed, I would like to say that India, as a country, is rather backward', in the manufacture of surgical instruments. This industry should be encouraged in India by all of us. Indians are well-known for their very high standard of workmanship. There are in this country many first-class mechanics and as such, I see no reason why India should not hold its own in future. in the manufacture of surgical instruments. We should strive to maintain the very highest standard of efficiency whether in medicines, vaccines or instruments. I must congratulate those responsible for making the exhibition, a success. I feel sure that the Medical Profession represented at the Conference, will be greatly benefited by the proceedings of the Conference. I now declare the exhibition open."

(*Continued from page 8*).

needle should be slightly withdrawn. Pain referred to the testicle indicates that the fluid is being injected into the cord. If no pain or discomfort ensues after the injection of 5 to 10 minims, more should be slowly injected until from 2 to 3 c.c. have been deposited in the canal just external to the internal ring. The needle is withdrawn, the site gently massaged and cleansed with alcohol, dried, talcum powder applied. The truss is replaced before the patient moves, and after a few moments he is allowed up and goes about his business. At intervals of from four to seven days subsequent injections are made along the inguinal canal and later at the external ring. As a rule six to ten injections are sufficient to close the rings and canal completely. Sometimes as many as twenty are required. It is better to make a few extra injections than too few. After one is satisfied that the canal and rings are completely closed, the patient wears his truss continuously for one month, then is examined carefully. If there is no evidence of weakness, and no impulse present he is allowed to remove his truss at night after going to bed and he is instructed to replace it before arising. At the end of the second month he is again examined and if there is no weakness in the wall he is allowed to discard his truss. If any recurrence is noted, the treatment is continued.

Direct Inguinal Hernia.

A direct inguinal hernia is the result of weakness of the posterior wall of the inguinal canal medial to the inferior epigastric artery in the space designated as Hasselback's triangle. It is never scrotal, and is usually associated with an exceptionally large external ring. Here it is necessary to deposit the fluid in the transversalis fascia overlying Hesselback's triangle, and in the proximity of the external ring. If one is in doubt as to whether a hernia is direct or indirect he should close the internal opening first, attempt to strengthen the transversalis fascia next, and then close the external ring.

Results and Conclusions.

Very rarely are there any complications following the injection method. Occasionally edema of the scrotum follows for about forty-eight hours, but this usually occurs after operations. Tenderness of the testicle chiefly confined to the tail of the epididymis has been reported, but has disappeared in from two or three weeks. A few cases have developed thickening of the cord for a week or ten days.

According to statistics recurrences are less than 4 per cent. This compares favorably with the results following radical operation. Should hernias recur after injection, further treatment usually effects a cure, but with a radical operation, recurrence lessens the likelihood of cure.

(*Colorado Medicine July 1937.*)

Scientific Section.

XIV ALL INDIA MEDICAL CONFERENCE, MADRAS, 1937.

ABSTRACTS OF PAPERS.

Acute Intestinal Obstructions Complicating Pregnancy.

BY DR. R. G. KRISHNAN, F. R. C. S.,
Govt. Hospital for Women & Children, Madras.

This is a relatively very rare condition. Only four cases occurred in the Govt. Hospital for Women & Children, Madras, out of 34,642 cases, over a period of 10 years.

They are divided into two main classes: those in which pregnancy is the determining cause and those in which the cause is accidental and bears no relation to pregnancy.

Causes of intestinal obstructions due to pregnancy: –

1. Adhesions
2. Fibroids
3. Extra-uterine gestations
4. Direct pressure
5. Parietic obstructions
6. Acute dilatation of stomach.

A pregnant woman may suffer from a strangulated hernia, a volvus, an intestinal growth as one not pregnant.

Diagnosis:—The most important point in the diagnosis is the distinctions of obstructive vomiting from toxaemic vomiting.

Treatment:—Abdominal section is the best course.

Report of three cases that were admitted during 1936 into the Government Hospital for Women & Children, Madras, with comment.

Nutritional Problems in Early infancy

BY DR. M. B. PRABHU.

The young infant— Its nutritional needs—Its calorific requirements—Breast milk—Difficulties in breast-feeding— Its nutritive value—Difficulties with artificial foods—Place of proteins, fats, carbohydrates and vitamins in the infant's diet—Infection and nutrition.

Etiological Factors of Infantile Biliary Cirrhosis

BY DR. T. KANAKA, RAJU, L. M. & S.

1. Present knowledge—purely clinical. Though mortality is high, it is difficult to get autopsies in these cases, as most of these are generally from the rich and middle classes.

2. The infantile liver is normally palpable below costal margin till 2nd year—sometimes mistaken—treated and classified as cures.

3. A brief historical survey of the disease from etiological point of view. Sen in 1897 described it as a peculiar syndrome suggesting the improbability of Syphilis, Malaria, and Kala-azar as causative factors. Pathological findings of Gibbon's—views of subsequent workers.

4. Endemic areas and their climatic conditions. Eastern plains of Madras Province, West Coast and Lower Bengal. Not found 1000 ft. above sea level. Endemic to certain houses, towns and cities.

5. Castes and classes of people in which it occurs—Hindus, rarely Muhamadans, mostly Brahman Vishnavites, not seen in Anglo-Indians and Europeans: Rare in poor classes.

6. Age incidence, at dentition when rice diet is begun.

7. Irritants from Gastro-intestinal tract—Gibbon's view—Toxins whether bacterial, or chemical whether of a vegetable or of a mineral origin.

8. Whether external conditions like a humid climate, and a study of the habits, diet and the ways in which children are brought up in endemic areas.

9. Whether congenital. Why it tends to occur in families, child after child of the same mother succumbing in a year after attack.

10. Mother's milk, cow's milk and wet nursing. Artificial foods, late weaning. Sudden introduction of rice diet into the menu of the child and sweet-meats composed of flour, ghee, sugar etc., regardless of intervals of time.

11. Overfeeding combined with confinement to the heated stiffy closed apartments of females and suckling children without out-door exercise. Very hot baths to children.

12. Routine use of Opium in children. Coffee and tea habit.

13. Houses with mud-flooring and children eating mud and chunam.

14. Vegetarian or non-vegetarian diet.

15. Whether it is a manifestation of congenital syphilis.

16. Castor oil administered as a routine to children by itself or with ghee or gingelly oil. Recinolein, mixture of Glycosides of recinoleic and isorecinoleic acids acting as an irritant to liver cells and causing inflammatory changes.

17. Abuse of crude calomel administered in doses ranging from ¼ tola to 1 tola, acting as a metallic irritant.

18. Avitaminous diet to the child.

19. Avitaminous diet and malnutrition. Abuse of chillies, condiments and other foodstuffs straining the liver of the mother during her antenatal period.

Infantile Biliary Cirrhosis

BY DR. A. V. S. SARMA, M.B.B.S.

1. Clinical enlargement of liver and spleen in children also means general viceral damage—particularly of lungs and heart. The hereditary and evolutionary aspects of the disease are discussed. Three clinical types of the disease are discerned.

2. Clinical data is supplied to prove the existence of a hormone in spleen.

3. Preventive treatment consists in proper treatment of Tuberculosis, Syphilis, efficient and cereful ante-natal treatment of pregnant mothers, enrichment of the general nutritional standards of the public, and avoidance of areas noted for several microbal and protozoal diseases. Treatment of carriers is imperative in the case of microbal and protozoal diseases, as also preventive vaccinations.

4. *The specific uses of the Splenic Hormone in Toxic Cases, and of Vitamin C and Adreno-Cortical Hormone in cases of Endocrine Origin are discussed. The existence of a potent substance (hormone) in spleen and its specific action in hepatic derangements are emphasised.*

5. A regime of dietetic and medicinal treatment is suggested after clinical study of forty cases of Infantile Liver. The role of vitamins in the former, and of Kalmeghi and Gulvel in the latter, is stressed.

Trigeminal Neuralgia

BY CAPTAIN E. S. GOPALAN, M.S., A.I.R.O.

A review of the Surgery of Trigeminal Neuralgia in the General Hospital, Madras, during the years 1922 to 1936. It contains abstracts of Case Reports of all the cases which underwent treatment.

Treatment of Congenital Talipes Equino Varus.

BY DR. N. S. NARASIMHAM, F.R.C.S. (Eng.) and (Irld.).

A study of relapses of one's own and others' cases makes one lay down some rules. The following procedure is outlined :—

(1) Treatment is to be begun at the end of first week.
(2) Manipulation upto 6 months.
(3) Manipulation and correction under anaesthesia after six months.
(4) Upto 2 years manipulation and correction under anaesthesia and retention in plaster.
(5) 2 to 5 years—open correction.
(6) Above 10 years—bone operations.

After treatment is outlined.

Some Aspects of Deep X-Ray Therapy

BY DR. P. RAMA RAU, D M.R., (VIENNA.)

Modern conception of the biological effects of radiation are submitted—effects on normal and malignant tissues, particularly, blood changes are studied and the remedies to counteract the effects are discussed. Two cases of lung tumour treated by Deep X-rays are reported

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Demonstration of Specimens and Slides

PATHOLOGICAL DEPARTMENT, MEDICAL COLLEGE.

1. Chordoma.
2. Amyloid degeneration of conjunctiva.
3. Xanthoma of Abdominal wall.
4. Rheumatic Carditis.
5. Legg-Perthe-Calve Disease.
6. Glioblastoma Multiforme.
7. Lympho-Haemangio Endothelioma of Brain.
8. Tuberculoma of Cerebellum.

Some Observations on Appendicitis

BY RAO BAHADUR DR. S. P. SARMA, M.B.C.M.

Appendicitis properly so called. The term limited to the inflammation of the tissues of the appendix within its peritoneal coat. Signs and symptoms in relation to morbid anatomy—its early diagnosis and treatment.

If the inflammation spreads to the peritoneum of the appendix, it is appendicitis with localised peritonitis—Signs and Symptoms—Treatment.

If the inflammation spreads further, it is appendicitis with generalised peritonitis. Its varieties: pelvic, iliac, umbilical and universal—Signs and Symptoms—Treatment.

What not to do in a case of suspected appendicitis.

Experiences in the Surgery of the Biliary Tract

BY CAPTAIN E. S. GOPALAN, M.S., A.I.R.O.

A review of Cases in the wards of Lt. Col. K. G. Pandalai, I.M S., during the years 1930—1936, in the General Hospital, Madras. It contains an analysis of the lesions in the different parts of the biliary tract, an analysis of the etiological factors, and the results. It also contains a few illustrative case reports to emphasize the line of treatment which the authors consider are indicated under certain conditions.

Radium versus Operation in the Treatment of Malignant Disease

BY DR. N. S NARASIMHAM, F.R.C.S., (Eng.) & (Irld.).

Radium has been in use in the Madras General Hospital since 1928. There are two other Radium centres in the Province and it is available in a private clinic.

Even ignorant people have come to know of Radium and demand radium treatment. Radium is a powerful weapon and requires careful pathological knowledge, correct dosage and sound surgical opinion to be used as an ally in the treatment of malignant disease.

The hope that Radium treatment will bring sufferers early to the doctor has not been realised. Education of the members of the profession as regards early diagnosis is urgent and is still a very important step Radium is not a rival of operative procedures, apart from surgery of abscess, operations are required to deal with lymphatic glands.

Definite indications for the use of radium and operative procedures are outlined.

Haematemesis

BY LT.-COL. M. M. CRUICKSHANK, F.R.C.S , I.M.S.

Much literature of recent years but still no clear conceptions. Review of clinical points with regard to:—

(1) Relationship of hæmorrhage to vomiting.
(2) The features of the vomitus.
(3) The character of the hæmorrhage.
(4) The examination of the patient.
(5) The importance of a correct diagnosis.

TREATMENT :—1. *Medical.*—The welter of calamitous statistics and paradoxical statements. What is a severe and what a moderate hæmorrhage? The danger of treating the hæmorrhage and forgetting the patient. Blood transfusion—not a hæmostatic; but the body demands fluid. Starvation versus Feeding—Meulengracht's reasons for feeding cases of bleeding.

2. *Surgical.*—Conflict of opinions. Clarity essential on the points at issue. Is the hæmorrhage from an acute or a chronic ulcer? Are we comparing comparable issues when we state that Medical gives better results than Surgical treatment? Are we not rather comparing conditions completely different as regards degree of severity? Are there or is there one indication of the type of a case in which Medical treatment is likely to fail? Ogilvie gives one indication—the Burrowing ulcer: but prophylactic operation is discountenanced.

Questions demanding consideration :—1 Should a first active hæmorrhage from a known chronic ulcer be treated surgically?

The answer draws us again into a maze of statistics which may prove anything but do give us ground for dircet and honest thinking.

2. The recurrent hæmorrhage.
3. Should operation be carried out in the presence of active bleeding?

The answer though arrived at in a round about manner is in the main in the affirmative.

Finally, what are we to do when faced with such cases and what are the indications for surgical intervention?

Conclusion.

Prontosil Album in the treatment of Gonococcal Infections

BY DR. V. GOVINDAN NAIR, M.R.C.P., F.R F.P.S.

For about three years a new Chemotherapeutic agent for the successful treatment of Bacterial infections has been synthesized. The original preparation, Prontosil and a number of its derivatives, have been tried both experimentally and clinically in streptococcal, staphylococcal, colon, enteric, meningococcal and gonococcal infections. Though it is considered to be a specific for hæmolytic streptococcal infections, particularly puerperal sepsis, equally admirable results have been obtained for other bacterial infections including gonococcal. The paper is a record of the experience of the writer on Prontosil album and a newer preparation of it named 'Uliron' in gonococcal infections. The results are very encouraging and corroborate with the observations of others which are daily increasing in volume. This new treatment will revolutionise the treatment of gonococcal infection.

An Operation for the Congenital Variety of Reducible Inguinal Hernia

BY DR. RAO BAHADUR S. P. SARMA, M.B.C.M.

Where the abdominal wall is not weakend and the ring is not stretched and where no plastic operation is required for strengthening the abdominal wall, and where the only defect is the presence of the unobliterated funicular process of the peritoneum, a small transverse incision above the inguinal ring is made, and the operation is proceeded with just as in the gridiron operation for appendicectomy, thereby exposing the abdominal aspect of the internal abdominal ring which is closed by a purse string stitch, after the interior of the sac is rubbed with carbolic and rectified spirit to obliterate it. The closed internal abdominal ring is exteriorised and the peritoneum is closed as also are the several layers of the abdominal wall in the usual way.

This operation is easy to perform, devoid of any complication, and seems to provide against future recurrence.

Choice of Anaesthesia for cases in South India

BY DR. P. V. FRANCIS, B.A., M.B.B.S.
Anaesthetist, General Hospital
DR. F. DE NETTO, M.B.B.S.
Second Anaesthetist, General Hospital.
and
DR. M. KRISHNAMURTHY, M.B., B.S., B.S. SC.
Honorary Anaesthetist, General Hospital, Madras

1. The opinions expressed here are based upon our practical experience as Anæsthetists. During the last six years alone we have administered about 24625 cases of general anæsthesia and 11925 cases of spinal analgesia.

2. Choice of anæsthesia is governed by three considerations :—
   (*a*) Safety to the patient.
   (*b*) Suitability to the operation.
   (*c*) Facilities available locally.

3. Methods of anæsthesia :--
   (*a*) For operations below the level of the umbilicus, except in children, spinal analgesia is the method of choice.
   (*b*) For operations in the upper abdomen high spinal analgesia is preferred provided the anæsthetist is a person of experience.
   (*c*) For thoracic surgery nitrous oxide, cum oxygen with ether to be used when available.
   (*d*) For thyroid and brain surgery the routine method is basal narcosis with Avertin supplemented with N_2O, O_2 and either.
   (*e*) For all other operations general anæsthesia using mixture of chloroform and ether has proved most satisfactory.

4. Factors which contribute to the success of anæsthesia :—
   (*a*) Preliminary examination of the patient by the anæsthetist.
   (*b*) Careful and effective premedication.
   (*c*) Judicious combination of different methods in suitable cases.

A Clinical Study of Pulmonary Suppuration

BY DR. R. VISWANATHAN, B.A., M.D., M.R.C.P.,

Clinical, radiological and bacteriological studies of 28 cases of abscess of the lung are reviewed. It is interesting to note that all of them were cryptic or idiopathic abscesses of unknown etiology. It is suggested that some cases may be due to disseminated focal pneumonia of Spadding. Pain over the chest is noticed as a very common phenomenon irrespective of the anatomical situation of the abscess. Medical treatment ought to be given a fair chance in acute cases.

Orogenital Syndrome

BY Dr. V. GOVINDAN NAIR., M.R.C.P., F.R.F.P.S.,

Amuco-cutaneous affection involving the mouth and the genitalia is described. It is a fairly common condition though not recognised hitherto as a separate clinical entity. This symptom completely differs in many respects from the manifestation of the other recognised deficiency diseases. A balanced diet rapidly cures the condition. No other line of treatments adopted had any appreciable effect. Hence an ill-balanced diet including deficiency in vitamins is most probably the aetiology of the disease. From the sites primarily affected the name " Orogenital Syndrome " is suggested.

Biliary Hepatic, Sclerosis

(Cholangitic and Mixed Types)
A Morbid Anatomical study with Case Reports

BY DR. P. RAMACHANDRA RAO, M.B., B.S., (Mad.) Ph. D. (Lond).
and
DR. M. V. RADHAKRISHNA RAO, M.B., B.S., Ph. D., (Andhra).
Department of Pathology, Medical, College, Vizagapatam.

Case Reports—Autopsy and historical findings in five cases with photomicrographs.

Definition.—Only conditions with widespread chronic inflammation of the bile passages with disorder of the function are to be designated " Biliary " and fibrosis of inflammatory origin in the liver as Sclerosis. A biliary sclerosis may often accompany Cirrhosis of other kinds—the mixed type.

Morbid Anatomy.—A wide-spread intra-hepatic non-suppurative pericholangitis or 'cholangitis lenta' is the pre-sclerotic condition. Uniform hepatomegaly, fine granularity, intense wide-spread sub-epithelial peri-cholangitic round cell infiltration with narrowing of the lumen and peri-cholangitic sclerosis and fibrous thickening of the glisson's capsular sheaths of the portal ramification, bile staining and histological evidences of bile-capillary stasis without pseudo-lobulation and distortion of the characteristic pattern of the Porto-hepatic venous network are the principal characteristics of a pure case of cholangitic hepatic sclerosis. The peri-cholangitis varies in intensity and in the level of distribution in the bile-duct tree in different cases. The biliary lesion is often seen in the autopsy room combined with other hepatic lesions, notably toxic cirrhosis and results in a mixed picture.

PATHOGENESIS.

Hepatomegaly.—The hepatic enlargement in cholangitic sclerosis is inflammatory—congestive and exudative and not a true hypertrophy. Psuedo-lobulation and portal obstruction is absent in the absence of sclerotic distortion of the Porto-hepatic venous trees and

their mutual alignment. Bile duct proliferation is more pronounced in the active stages and is confined to the afferent bile channels or 'Canals of Hering'. It is a response to the obstruction to the flow of bile offered by the inflammatory narrowing of the lumen of the bile ducts. Icteric necrosis occurs around aneurysmal dilatations of the afferent bile channels and is the result of increased pressure of bile excretion.

Endocrine Growth Factors

BY DR. S. SANKARA RAMAN, M.B.B S.

There are three periods of growth and development in an individual—Babyhood, Second Dentition and Puberty or Adolescence. The nature of the factors responsible for growth is not definitely understood, but as a result of study the Endocrines have come to great prominence.

Of all the endocrine glands, the Anterior Pituitary claims the pride of place. Thyroid, though under the influence of the Anterior Pituitary, exerts its own action on growth. Its presence is required for normal development.

Sex Hormones produce growth indirectly by inducing maturity and controlling the time of fusion of the epiphyses. Sex hormones also are under the iufluence of the Anterior Pituitary.

One association exists between Eosinophile Cells and Growth and another between Basophile cells and the Gonads. Growth precedes sexual maturity and when the Basophile cells assert over the Eosinophile cells, puberty occurs.

Recent researches have given the credit for Growth to the Eosinophile cells of the Anterior Pituitary.

We have to conclude that growth factors mainly depend on endocrine activity, which depends on the Anterior Pituitary, which again acts because of its predominent Eosinophile cells, which are influenced by genetic factors.

Gastric Analysis—Clinical Significance

BY DR. A. S. Mannady Nair, M.A., Ph. D.

1. Anatomy and Physiology of the Stomach.
2. Chemical technic of gastric analysis.
3. Normal gastric function. Its relation to gastric analysis.
4. Evidence of Pathology.
5. Gastric analysis in pathological conditions.
6. Limitations and fallacies of fractional test-meal.
7. The Alcohol test-meal.
8. The Histamine test.

Histidine and Peptic Ulcers

BY DR. M. NARASIMHA RAO, M.B.B.S.

Researches of Aron of Strasbourgh in 1933 have revolutionised the treatment of Peptic Ulcer. The introduction of parenteral therapy of Histidine was claimed to have even replaced all the other methods of treatment in establishing a cure of Peptic Ulcer. Conflicting reports of the clinical trial of the new method of treatment have appeared in the medical press during the last three years. The present paper describes the experience of the author in the treatment of Peptic Ulcer with Histidine. In the present series of cases, the results are not encouraging.

Typhoid and its treatment

BY CAPT. R. L. H. MINCHIN, M.D., (Edin.), I.M.S.

Certain of the signs described as regularly pesent in enteric are very rarely seen in this country and symptoms that are not mentioned in text-books are often seen.

The treatment of the fever consists of good nursing, the anticipation and correction of complications and the regulation of normal bodily functions in the diseased state of tissues.

It is generally agreed now that a high diet is advisable and that milk should only be given in limited quantities. Lactose has many advantages.

Sera, Vaccines and Bacteriophages have been used in the treatment of the fever but the results have proved uniformly disappointing. Recently, the Sulphanamide group of drugs has been tried but the results have been unconvincing.

The commonest minor complication is constipation and unless it is rigorously treated it leads to the very serious and often fatal hæmorrhage or perforation. Enemata are generally used to relieve the condition but these only empty the lower gut and leave toxins in contact with the inflamed small intestine. The open bowel treatment, in spite of theoretical disadvantages, has great practical value and the daily administration of small doses of castor oil appears to produce uniformly favourable results.

Bac. Pyocyaneus Infection simulating Cholera and Acute Dysentery

BY Dr. H. GHOSH.
Director, Department of Bacteriology,
Indian Institute for Medical Research.

A few cases have been recorded by the author showing the virulence of some strains of Bac. Pyocyaneus. During the month of September, 1937, nine cases were admitted in the author's Cholera Ward of the Chittaranjan Hospital. The culture of the stool showed in five cases presence of B. Pyocyaneus. Three stools were sent to

the author from a place where Dysentery, particularly in children, broke out in mild epidemic form. Usual treatment with Emetine, Anti-Dysentery Serum, Dysentery Bacteriophage did not show any improvement. All the stools contained large number of B. Pyocyaneus as indicated by the number of colonies grown on the culture medium. Several cases were fatal.

A Note on the Importance of a thorough Bacteriological examination of all Cases of Leprosy.

BY DR. V. GOVINDAN NAIR, M.R.C.P., F.R.F.P.S.,
and
DR. N. G. PANDALAI, M.D., M.R.C.P., D.T.M.

An unselected series of 227 cases of leprosy were examined for the detection of M. lepræ and the results are given. 57·2 per cent of the 147 neural cases showed M. lepræ—a fairly high percentage. Apparently healthy areas have yielded positive results in a number of cases though only a single examination was made. Failure to detect bacilli by a single examination is not enough to establish a contrary diagnosis in doubtful cases. There is no evidence to prove that paucity of bacilli in a case argues for its non-infectiousness. Hence it is safe to treat all cases as infectious. In view of the above findings, it is considered necessary to lay special emphasis on the point that long and repeated bacteriological examination is essential in all cases whether neural or otherwise. Either there are multiple points of entry or there is wide cutaneous dissemination of bacilli long before active localised lesions appear.

Diagnosis and Treatment of Anaemias in General Practice

BY DR. S. K. SUNDARAM, M.D.

In order that treatment may be effective, classification of anæmias must, as far as possible, be etiological. A complete etiological classification of anæmias has yet to be attained. The best in the present state of our knowledge is into (1) those due to deficient production, (2) those due to excessive destruction, (3) those due to deranged hæmopoiesis and (4) those of unknown mechanism.

Different clinical entities under these four main headings will be discussed and the treatment appropriate to each presented. Special stress will be laid against indiscriminate mixing up of all known hæmatinic remedies. Treatment must wherever possible be specific. Limitations of treatment must be recognised.

Psoriasis

BY Dr. S. THAMBIAH, B.A., M.R.C.P.

Etiology.—Incidence of the disease in Madras and the Presidency; effect of climate ; certain therapeutic measures as Enesol, colloidal mercury sulphide, protein shock series as T. A. B., milk, colloidal manganese etc. External applications as medicaed baths, tar acetone, etc. What can be done with regard to relapses.

Eye Symptoms in General Diseases

BY DR. T. S. DURAISWAMI, L.M. & S.

Importance of the examination of the eye and the fundus in all general diseases, because of its intimate relationship with the general and special functions of the body. The living Pathology, functional and organic, of circulatory and nervous diseases can be observed only in the eye.

A. Subjective Symptoms:
   - I. Corneal Sensitivity.
   - II. Scintillating Scotoma.
   - III. Nystagmus.
   - IV. Diplopia.

B. Ocular diseases as manifestations of systemic disorders :—
   - I. Iritis—almost always secondary to constitutional diseases as Syphilis, Tubercle, Rheumatism.
   - II. Constitutional factors predisposing to Glaucoma apart from the predisposing anatomical conditions in the eye.
   - III. Phlyctenular Conjunctivitis and Keratitis.

C. Fundus changes observed in Systemic diseases:
   - I. Optic Neuritis.
   - II. Chocked Disc.
   - III. Optic Atrophy.
   - IV. Arterial sclerosis.
   - V. Hæmorrhages.
   - VI. Anæmia.

Motor Anomalies of the eye as symptoms of constitutional diseases.

Paralytic Squint.

Variations in the size and reactions of the puplis in the various constitutional diseases.

Argyll Robertson Pupil.
Wernicke's Pupillary reaction.
Hippus.

Ocular symptoms in Pregnancy, in pernicious vomiting of pregnancy and in Eclampsia.

Ocular manifestation of Thyroid Dysfunction.

Eye signs in General Anæsthesia.

The Care of the Diabetic; its Rationale

BY DR. P. GOPALACHARI, M.B.B S.

The nature of the disease is gone into. The role of vitamines and changing habits in human diets are brought out. Is there a here. ditary factor in Diabetes? Practical difficulties in dieting a patient-Palat and Dhar's researches in respect to oxidation of the mixture of the 3 proximate principles in diet.—Modern principles of dieting dates from Allen. Various systems of dieting with a view to increasing the carbohydrate tolerance are discussed. The Bengali and Madrasi diets compared. The place of medicinal treatments. Treatment of Diabetes with complications—Coma, Hypertensive heart, Surgical complications, Tuberculosis. In the choice of food articles—the allowed and the forbidden. A hygienic life—Exercise and Sex. Conclusions.

Medical News & Notes.

Resolutions Proposed and Carried at the XIV All-India Medical Conferene, Madras, 1937.

I. This Conference puts on record its appreciation of the step taken by the Hon'ble Dr. T. S. S. Rajan, Minister for Medical and Public Health Departments, in having decided to abolish the Medical Schools and the L. M. P. Course and in having one uniform minimum degree of M. B., B. S. for the Madras Presidency."

II. This Conference requests the Provincial Governments in the other Provinces of India to take early steps to abolish the Medical Schools giving L. M. P. or equivalent courses of Instruction; and thus unify Medical Education with M. B., B S., as the minimum qualification throughout India (as in Madras)."

III. "That this Conference requests the Indian Medical Association to arrange (through the authorities of Medical Colleges and Schools of the different Provinces), for special and regular refresher courses for all Registerable Medical Practitioners; as also provide post-graduate course enabling specialisation in various subjects."

IV. (*a*) "That this Conference protests against the action of the Indian Medical Council in withholding recognition to the Degrees granted by the Andhra University."

(*b*) "That this Conference thanks the Madras Government for its assurance of doing all that is necessary to have the Andhra University Degrees recognised and hopes that they will effect the necessary improvements in the Vizagapatam Medical College at the earliest possible moment so as to expediate the said recognition."

V. "That this Conference re-iterates the resolutions Nos. 3, 4, and 12 of the last Conference and desires that the provincial Sub-Committees should take up these questions immediately."

[The following are the resolutions of the last Conference referred-to above:

(3) "This Conference regrets the action of the Punjab Government in not withdrawing the ban on the Medical Officers in Government Service to join the Indian Medical Association while allowing them to join the British Medical Association and requests the Punjab Branch of the Indian Medical Association to arrange a deputation to bring the facts to the notice of the Punjab Government."

(4) "This Conference resolves that Provincial Governments be requested to amend the Local Medical Acts so as to give adequate representation to the Licentiates in the Provincial Medical Councils."

(12) "This Conference requests the Government of India (*a*) to amend the Indian Medical Degrees Act of 1916 in such a way as to make it unlawful for the unqualified persons to write any letters or words with their names, which may denote in a direct or indirect way the resemblance of these letters or words to be genuine or *bona fide* medical Degrees, (*b*) to declare it an unlawful practice for such unqualified persons to place or write the designation of "Doctor" before their names."]

VI. "This Conference resolves that the local Governments of different provinces be requested to take effective steps for controlling and regulating the manufacture and sale of Patent and Proprietary medicines. This Conference holds the opinion that in addition to the name of the Patent medicines and manufacturer's name, their composition must be mentioned on the labels, but no description of their properties should be allowed to be advertised excepting in the Medical Press. The Conference is of further opinion that advertisement of patent medicines should only be made in Medical periodicals"

VII. "This Conference condemns the Government of India's scheme of re-organisation of the I. M. S. as announced in the recent resolution No. 205 dated 25th March 1937, which instead of abolishing the Civil side of the I.M.S., as recommended by the Services Sub-Committee of the first R.T.C., has thought fit to perpetuate the Civil side and thus has hampered the legitimate growth of the medical services of India as envisaged in full Provincial Autonomy,"

"Further resolved that this Conference lodges its emphatic protest against this retrograde scheme as it

(1) maintains gross racial discrimination;

(2) perpetuates the doctrines introduced by the Lee Commission;
(3) almost doubles the personnel of the British Officers in proportion to the Indians, whose number has been correspondingly reduced, and.
(4) perpetuates unfair and distinctive system of recruitment to the I.M.S. by nomination and selection instead of by competitive examination."

"This Conference also re-iterates the oft-repeated demand of the complete abolition of the Civil side of the I. M. S. and the administrative post of Inspector-General or Surgeon-General."

VIII "That the Central Council of the I.M.A. be kindly requested to approach the various Provincial Governments to appoint, wherever available, as Honorary Surgeons, Physicians and such other specialists only those persons who practise as specialists in that particular subject exclusively but this shall not apply to Assistant Honorary Surgeons."

IX. "This Conference recommends to the Government that free medical advice to Government Officers by Government Medical Officers should be discontinued.

X. "This Conference requests the Central and Provincial Governments to take immediate steps to impart training regarding the treatment of prevention of gas poisoning from air raids. Military training of Medical students be made compulsory."

XI. "This Conference requests the Indian Medical Association that a Committee might be formed, to prepare, in collaboration with competent economists, a National Health Insurance Scheme for the whole of India.

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

(1) Open Physical Culture Centres under trained instructors in all Municipalities and. District Boards, and make Physical Culture a compulsory part of the Educational System of the country.
(2) Open Scientific Cooking Demonstration Centres in all Municipalities and District Boards.
(3) Open Women Welfare Centres under proper medical supervision in all Municipalities and District Boards.
(4) And formation of a Volunteer Corps in each local area for educating the masses and doing propaganda in matters of sanitation, preventive medicine and proper curative treatment with the co-operation of the Rural Medical Officers of those areas concerned".

MEDICAL ASSOCIATION, BOMBAY NORTH AND THE ALL INDIA MEDICAL LICENTIATES' ASSOCIATION, BOMBAY BRANCH.

The following Resolutions were passed at a meeting held at the National Medical College, Bombay, on Sunday the 19th December 1937 under the Presidentship of Dr. D.H. Dudha, M.D.M.R.C.P.

1. Whereas the present system of dual water-tight compartments of Medical Education existing in the Presidency, is not in the best interests of the Medical Profession or the Public, this meeting requests the Hon'ble Minister of Health and Excise Dr. M. D. D. Gilder, M.D., F.R.C.S. to immediately take steps to abolish the L. C. P. S. Course as it exists in the Medical Schools at present, and raise the existing Medical Schools to the University Standard as has been decided upon by the present Madras Government.

2. This meeting further requests the Government, to so amend the Bombay Medical Act as to give adequate representation to the Licentiates in the Bombay Medical Council in proportion to their numbers and to have an elected President from amongst the members of the Council.

3. This meeting further urges that the existing code of Medical Ethics be revised after duly inviting the opinions of various Medical bodies and Medical Profession.

4. This meeting supports the proposed move by the Hon'ble Minister of Health, Bombay, to have a separate Register for practitioners in Ayurvedic and Unani Systems of medicines as it will tend to stop quackery.

5. This meeting authorises the President to forward copies of the above resolutions to :—

(1) Hon'ble Dr. M. D. D, Gilder, M.D., F.R.C S., Minister of Health, Bombay.
(2) Hon'ble Dr. T. S. S. Rajan, M.R.C.S., Minister of Health, Madras.
(3) President, Bombay Medical Council.
(4) Surgeon-General with the Government of Bombay.
(5) President, College of Physicians and Surgeons, Bombay.
(6) Medical and Lay Press.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION PALAMCOTTAH.

(Tinnevelly Branch of the Indian Medical Association)

NINTH ANNIVERSARY

The Annual Reunion will be celebrated on Saturday the 22nd January 1938, at the St. John's College Hall, Pallamcottah, under the Chairmanship of Rao Bahadur Dr. T. S. Tirumurti, B A. M.B. & C.M., D. T. M. & H. (London). Professor of Pathology, Medical College, Madras.

NOTICE.

I

All those who possess the qualification 'Licentiate of the College of Physicians and Surgeons of India' or any other qualification registered in the past on the Madras Medical Register, may apply to the Registrar, Madras Medical Council for registration within one year from the date of this notification.

The application should not, however, be accompanied by the fee for registration, which should be remitted to the Registrar of the Council, only after receipt ot instructions from him.

(By order of the Madras Medical Council,
P. KRISHNA RAO,
Ag. Registrar, Madras Medical Council.

II

A prize of value of Rs. 50 will be awarded to the contributor of an approved article on " Medical Practice in India " and a price of value of Rs. 50 will be awarded to the contributor of an approved theses on " Tuberculosis ".

1. Articles should be submitted in English.
2. The articles will be judged by a small Board of Examiners.
3. The decision of the Board will be final on all matters.
4. The articles should reach the Editor, the Punjab Medical Journal, Banga, (Punjab), on or before 15th April, 1938.
5. The Editor has a right to publish articles received.

Editor, The Punjab Medical Journal.
Banga (Punjab).

When ordering please mention *Medico-Surgical Suggestions.*

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Regd. No. M. 2853.

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