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Original Articles

SYMPTOMATOLOGY OF PULMONARY TUBERCULOSIS

COUGH AND HAEMOPTYSIS—II

By

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(Continued from the last issue)

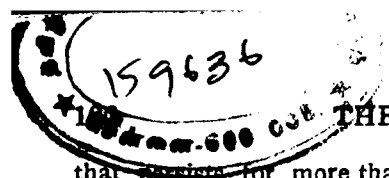
COUGH.

General Consideration:—In many cases of pulmonary tuberculosis, cough is the first thing to make its appearance. Very many cases go through the whole period of the disease from start to finish without there being any evidence of cough at all. Absence of cough is not inconsistent with a diagnosis of pulmonary tuberculosis. Cough as a symptom need not be present at all in pulmonary tuberculosis; clearing the throat is as good a symptom. The tendency to cough is greater among the young than in the aged persons. It is more marked among the neurotic and especially among the younger women than in men.

In many cases when cough is persistently absent it is a good sign and the recurrence of cough is always an indication of the spread of the disease. As the disease gets better, cough also decreases and it automatically disappears with the healing of the lesion. At times one may come across people having cough of a

neurotic type in houses where there was a death due to phthisis. This condition is known as phthisophobia as such people imagine that they too suffer from tuberculosis. The moment they are examined by a competent doctor and declared to be absolutely free, cough automatically disappears. There are certain peculiarities which must be noted with regard to cough in pulmonary tuberculosis:

1. That cough due to tuberculosis rarely starts with any symptoms of acute nasopharyngeal catarrh. Hence any cough that starts with nasopharyngeal catarrh of an acute type must be generally looked upon as not due to tuberculosis. Usually the onset of cough in tuberculosis is very insidious. The common history that is given is that with each change of weather, especially during the winter months, there is what is usually known as catching of a cold, sometimes called as chest cold, which has not yielded to the remedies which would usually relieve the condition. It can generally be said for the purpose of safety that any cough



that persists for more than four weeks must be looked upon as tuberculosis.

2. That the types of cough we get in pulmonary tuberculosis should be divided into three varieties depending upon the stages of the disease: (a) the incipient stage, (b) the spreading stage and (c) the terminal stage.

The incipient stage: Cough in this stage is often unnoticed by the patient himself, but often noticed by his friends and relations. Sometimes it is nothing more than clearing of the throat, which may persist only for a few hours in the early hours of the morning. The cough in this stage is most marked during the colder parts of the day and night, that is at the time of just before getting up from bed and just at the time of going to bed. It becomes also well marked when the patient emerges from a hot to a cold atmosphere. In my experience I have noticed that any one who usually coughs when coming out from a warm room to the outside atmosphere, is to be looked upon with a certain amount of suspicion as tubercular, provided heart disease could be excluded. Usually cough of incipient tuberculosis is not productive. To bring out a small pellicle of sputum the patient has to cough for sometime till he is relieved. In certain other cases there is absolutely no sputum at all in spite of hacking cough which is more predominant towards the colder parts of the day. In addition to this there are certain unusual types of cough which become marked towards the early stages of pulmonary tuberculosis. Those are: *Paroxysmal cough and Emetic cough.*

Paroxysmal cough is attributed to: (1) ulceration of the trachea at its bifurcation, (2) enlargement of the tracheo-bronchial glands, (3) the adherent pleurisy, (4) periodical evacuation of cavities and (5) fibroid phthisis with emphysema. Though these are the causes, yet long before these conditions make themselves apparent either by physical examination or by X-Ray paroxysmal, cough sets in. This paroxysmal cough may be so tiring as to give very little rest to the patient. Sometimes the paroxysms are so severe

that there is very little of sleep and the first thing that the patient often craves for, is relief from the paroxysms.

Emetic cough is also very characteristic of pulmonary tuberculosis. If disease like whooping cough, influenza, cancer of the lungs and the cancer of larynx, dilatation and chronic gastritis are excluded, emetic cough is almost pathognomonic of pulmonary tuberculosis. This sign was first observed by Morton, and hence known as Sign of Morton. Its value in the diagnosis depends upon exclusion of other conditions which produce this emetic cough. What usually occurs in this condition is that the patient has his well relished food. Then after a lapse of a certain period, he has a bout of coughing, which ends in vomiting. The essentials to be satisfied before a cough could be an emetic are the following:—

(1) There should be no previous gastrointestinal trouble, in other words the gastric condition should be good. (2) It is always preceded by spells of cough. (3) It always occurs at a particular time after taking food. (4) It is not preceded by nausea. (5) It is not succeeded or followed by giddiness or retching. After vomiting the patient feels very much relieved and he often begins to learn the condition of his stomach and feels that he ought not to overload his stomach. The causation of this peculiar condition, has been explained in different ways by various writers. The opinions of some is that it is due to the compression of the abdominal muscles by frequent coughing due to some other local irritation of the stomach but the most accepted view appears to be that it is a condition attributable to the reflex irritation of the nerve endings of the vagus by the food particles and not due to dilatation of the stomach by food giving rise to this reflex irritation.

In progressive cases, cough has a direct proportion to the condition of the disease. When there is greater amount of caseation with cavity formation, there is also a larger amount of sputum brought out with little or no exertion at all. During this

stage, the tiresome hacking cough of the early incipient stage gives rise to the productive type of little or no exertion. Unless there is a tendency to unproductive cough it is not a good thing to have recourse to measures to prevent cough as stagnation of the secretions inside lead to more severe toxæmia. In tuberculosis there is very little room for the use of expectorants. Iodides and iodine are said to muster the tubercle bacilli in large numbers and thus lead to a greater and acute spread of the disease. The use of iodine or iodide is not therefore recommended in cases where the expectoration is thick and not easily excreted except when for diagnostic purposes a larger quantity of sputum is required or if no sputum is available for examination. As the disease gets better, the quantity of the sputum also decreases and the cough also decreases. If, on the other hand, the condition gets worse cough also increases.

In advanced cases, cough becomes to a certain extent controlled by will. In a straightforward case the quantity of the sputum increases by the advancing of the disease. Especially when cavities are formed the quantity of the sputum is greater. In this stage secretions of the sputum becomes more marked in certain postures and less marked in other postures. By experience the patient will find out which posture it is that helps him to bring out this sputum. It is easy to understand that in the lying posture there is a great amount of sputum being out than in the erect posture. During this stage when the sputum accumulates in the cavities for sometime there is a tendency for the sputum to undergo fermentation and with it smell also may start. So in conditions where large cavities are present foul smelling sputum is also not inconsistent with tuberculosis though usually foul smelling sputum is associated with a lung abscess, bronchiectasis and gangrene of the lung.

Even in advanced conditions when there is plenty of sputum in the lungs it may not be brought out for various reasons:—

(1) When there is catarrhal condition of the bronchi occluding the lumen,

When this happens there is swelling of the mucous membrane which to a certain extent occludes the lumen of the bronchus and leads to a temporary retention of the discharges. This shows itself by the rising of temperature and a certain amount of pain over the region where the cavity is present. The cough becomes less and no sputum is brought out at all. On the whole the patient does not feel comfortable. This condition lasts for about four or five days and after a severe bout of cough in which a large quantity of foul smelling sputum is brought out the patient feels comfortable, his temperature drops down and the general health also improves.

(2) In spite of there being a large amount of sputum yet it cannot be brought out in certain cases as when laryngitis starts. Cough is only a reflex condition of the larynx. When this reflex is lost the cough also becomes limited or disappears.

PROGNOSIS: Cough by itself is of no value in the prognosis of the disease. Nor does cough tell us the extent of the disease. Absence of cough is always a good sign except in certain conditions which will be mentioned below.

When the condition is getting better, there is bound to be a proportionate decrease in the cough as well. Abrupt disappearance of cough is always a bad sign. When it does occur you must think of one of the following conditions: (a) Onset of severe laryngitis, (b) occurrence of spontaneous pneumothorax and (c) last days of the patient's life with tubercular meningitis, and advanced tubercular peritonitis.

The treatment of cough is not an easy one as various factors go to play in its occurrence. It must be remembered that to a large extent tuberculous cough could be controlled by the patient's will-power. It is a common sight to see that patients in their own houses cough more than when they are in institutions. When brought to institutions they see around them patients who do not at all cough and they also think that they should not cough,

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Hence the tendency to cough is to a large extent decreased. Unless the cough is of an excessive irritable character where there is always a tendency for spread of the disease it is not a good indication to decrease the cough. Because in the natural course of events no tuberculous lesion will heal once it has gone to the stage of caseation unless the caseated material is thrown out. Formation of cavities by the throwing of the excretions is but a natural process in healing and therefore when there is sputum available it must be brought out. No drugs should be given to relieve cough when there is a large amount of sputum to be brought out. Hence unless it is expected that this unproductive cough is the cause of the spread of the disease or has been robbing the patient of rest that is essential, it is not usually necessary to treat him by drugs. Very often certain amount of mental reservation and the change in surroundings especially to a better atmosphere and climate lessen the cough. There is also one other condition which should not be forgotten namely that in cities where there is greater amount of dusty atmosphere the tendency to cough is greater than in rural areas where the atmosphere is of a purer nature. I very often see patients who were all through in the mofussil while coming to Madras have bad cough which does not disappear with any treatment but disappears the moment the patients get out of Madras. The same thing has also been observed with regard to temperature in these patients. Very frequently we must also take into consideration any other focal sepsis that may be present in the nasopharyngeal region to account for this cough.

HAEMOPTYSIS.

Haemoptysis is often considered to be one of the characteristic symptoms of pulmonary tuberculosis. At the same time it should not be forgotten that haemoptysis occurs also in many other non-tuberculous diseases. Though about 60 to 70 per cent of cases of haemoptysis are due to pulmonary tuberculosis, yet the significance of this has not been well understood by the general public and the doctors. The safest thing would be that

no case of haemoptysis should be looked upon lightly and it should be treated as one of tuberculosis until the contrary is proved. Though this may not look as a very scientific method to be looked at yet from the point of view of differential diagnosis, it helps a good deal. If further investigations prove that it is not due to tuberculous then the provisional diagnosis can easily be changed.

Haemoptysis in tuberculosis may be of various grades. From slight blood tinge in the sputum, it may vary to a profuse haemorrhage. From the diagnostic point of view small amounts of blood in the sputum should also be looked upon with the same significance as large quantities of blood. To understand the exact significance of haemoptysis in pulmonary tuberculosis, it is necessary to have a clear understanding of the pathological changes that are responsible for this bleeding.

PATHOLOGY: There are four ways in which the pathology of haemoptysis is explained. They are:

1. That the exudation of blood is a manifestation of the acute local inflammatory reaction that takes place around a focus of tubercle. During this acute inflammatory reaction the exudated material that is brought out is thrown out of the lung as blood stained sputum. This is well seen in acute pulmonary conditions, viz., the blood stained sputum of pneumonia, broncho-pneumonia or influenzal pneumonia.

2. That there is certain amount of tubercular ulceration of the tunica of the vessels, especially tunic adventitia media. When ulceration goes deeper it might lead to haemoptysis of a severe nature. This occurs when any of the branches of the pulmonary vessels become eroded.

3. That when caseation is taking place in the lung tissue, large cavities are formed by the extrusion of the caseous material. The tissues that resist caseation to a large extent are the blood vessels and therefore it is not an uncommon sight to see blood vessels bridging over large

cavities. Certain changes take place in the vessels and the surrounding tissues. They are:

- (a) The blood vessel itself is injured and becomes subsequently weakened due to the ulceration by the formation of tubercles.

- (b) That the support given to the blood vessels by the surrounding parenchyma of the lung is lost. Subsequently the blood vessel becomes unsupported.

In addition to these two factors operating, there is the third factor of increased intra-vascular pressure occurring during periods of strenuous cough. The result of these three factors, loss of support, ulceration of the blood vessels with consequent weakening plus the increased intra-vascular pressure leads to aneurysmal dilatation of blood vessels. These dilatations are frequently known as Aneurysm of Rasmussen. When these become thinned further, they rupture and lead to profuse haemoptysis.

4. That during process of reformation of fibrous tissue especially in cavities when they are closing, a large amount of granulation tissue is formed. This granulation tissue consists of a large amount of small capillary vessels. Any irritation is enough to rupture these small vessels and thus lead to bleeding. Occasionally it has also been stated that haemoptysis could be explained by the frequent localisation of tubercles in the lymphoid tissue at points of bifurcation of the pulmonary blood vessels especially the veins, and this might be the cause of active invasion which might lead to haemoptysis.

Whatever may be the explanation of the pathology of haemoptysis, haemoptysis is a very characteristic symptom of pulmonary tuberculosis. The quantity of blood may vary with different stages of the disease, yet it is difficult to define exactly the stage of the disease of the lung by haemoptysis alone. Various writers believe that in early stages of tuberculosis, haemoptysis is mainly due to the local inflammatory action and therefore it is very small in nature and stops

fairly quickly without much harm to the patient. In advanced cases where haemoptysis is an indication of ulceration, the quantity of blood brought out is greater and it takes a longer time for the haemoptysis to stop. Whatever may be the stage of the disease it is found that haemoptysis once it starts it never stops all at once. When a history of haemoptysis is given by a patient which has stopped abruptly after one two bouts of blood one must be very careful in making a diagnosis of tuberculosis. Usually it takes at least four or five days, if not longer, for the blood to completely disappear from the sputum. Day by day the quantity of blood in the sputum decreases and it completely stops after about four or five days. The only condition where there is an abrupt stopping of the blood after one or two bouts of haemoptysis is heart disease especially Mitral Stenosis.

CAUSES OF HAEMOPTYSIS: Haemoptysis often occurs when patients are practically at rest. They are more frequent during the early parts of the day and later parts of the night than the rest of the time, thus showing that exertion by itself is no factor in the causation of haemoptysis; yet exertion may increase the tendency of bleeding when once bleeding has started. It has been found that there is great tendency for haemoptysis to occur among men than in women especially among those who are tall and thin rather than among those who are stout and short. Haemoptysis often varies with mental condition of the patient. Occasionally you find that the neurotics have a greater tendency for haemoptysis than those of a more robust temperament. There is a certain amount of seasonal variance in the occurrence of haemoptysis. My experience in the Tuberculosis Hospital at Royapettah has been that it is of greater occurrence during the hotter parts of the year from April to July than in colder months. During the last two months, November and December, there have been practically no cases of haemoptysis at all in the hospital though during the months of May and June we are having a large number of cases. In

addition to this seasonal variance, there appears to be some sort of automatic co-ordination in the condition. When one patient gets haemoptysis in a ward there is a tendency for the other patients to get it in the same ward. At the same time when once a patient starts with haemoptysis, the tendency for the haemoptysis to recur during the course of the disease in the same person is greater. Many may be the exciting factors but the actual cause of haemoptysis—excepting the pathological condition—has not been definitely ascertained.

Haemoptysis occasionally occurs in cases where pneumo-thorax treatment has been adopted especially when the pneumo-thorax has been incomplete due to a large cavity being kept patent. In these cases any rupture in the cavity might make the bleeding worse because the irregular pressure that is produced on the cavity by the incomplete collapse may keep a blood vessel open and thus continue the haemorrhage.

THE SYMPTOM OF HAEMOPTYSIS: Of all the symptoms in pulmonary tuberculosis haemoptysis is one that frightens the patient to a large extent. The moment he sees blood in the sputum his mental equilibrium is completely upset. There is a look of distress and an outlook of despair. This look of despair and mental excitement are also entertained by the inmates of the house. The patient is highly excited, the temperature drops down, pulse rate goes up and the volume of the pulse becomes small. Restlessness begins when the quantity of the blood brought out is very great, otherwise there is not much restlessness. Symptoms of the collapse that set in usually disappear in the course of a few hours. Occasionally death takes place as a direct result of haemorrhage. It may be safely said that in the initial stage haemoptysis rarely ever produces death, but when haemorrhage occurs in advanced cases, death may result when it is of profuse nature. Occasionally you find that in these cases, the blood vessel that has ruptured is a large one, and the blood fills up the whole of the cavity and before

the patient could cough out the sputum he is drowned in his own blood. These are the cases where the patient dies within a few minutes after haemorrhage. There may be no outward sign of haemorrhage at all and only a post mortem reveals the presence of a large cavity filled with blood. This is frequently known as internal haemorrhage or masked haemorrhage. Roughly it can be said that about less than 2 percent of the cases who are bleeding die from haemorrhage directly. In certain conditions the tendency to haemorrhage is greater than in certain other conditions. In fibroid phthisis the tendency to haemorrhage is greater than in the ordinary chronic condition; then again the tendency to haemorrhage is greater in acute pneumonic tuberculosis than in the chronic tubercular condition. In miliary tuberculosis you very rarely meet with haemoptysis as a symptom. There is one other condition which is frequently known as haemorrhagic phthisis of old writers. Here the bleeding occurs at irregular intervals mostly in chronic cases and this bleeding appears to have a salutary effect upon the patient. If the bleeding does not occur periodically the patient feels below par and the moment the bleeding occurs he gets his normal condition. At the same time when bleeding occurs it has no ill-effects at all.

THE CLINICAL MANIFESTATIONS OF HAEMOPTYSIS: In cases where haemorrhage takes place various changes may take place in the lung substance. First there is aspiration of the blood to other portions of the same lung itself or to the opposite lung. During this process of dissemination of blood, if it happens to be an acute case, tubercular bacilli are carried to the rest of the lung through this blood and there occurs a broncho-pneumonic spread of the disease around the whole focus. This shows its clinical manifestation by a rise in temperature which may persist for a week or ten days after the blood has completely stopped. In a few cases there is no rise of temperature at all and in those cases it may be presumed there is no spread of the disease. If there is no rise

of temperature, the prognosis is better than in cases where there is high temperature. From the diagnostic point of view haemorrhage has to be looked upon with care. There are very many other diseases which produce haemorrhage of the same type and character as in tuberculosis. A few of them are:—

Haemorrhage in respiratory diseases acute—acute pneumonia, lung abscess, gangrene, chronic diseases of lung like bronchiectasis, pleurisy. Diseases of blood like haenophilia, purpura, and anaemia. Diseases of blood vessels—like high blood pressure, atheromatous condition of blood vessels, and cardiac disease like mitral stenosis congenital heart disease, right side heart failure; growths in the lung—like cancer, syphilis; certain other diseases like cirrhosis of liver; other diseases of the central nervous system like loco-motor ataxia etc, familial haemorrhage, certain other conditions due to upper respiratory diseases like ulceration of the esophagus, varicose condition of the sublingual and lingual veins, ulceration of the nasopharyngeal region and very rarely the so called vicarious haemorrhage. In the diagnosis of haemorrhage the commonest pitfall is to mistake a haematemesis for haemoptysis. If sufficient care is bestowed very rarely is this mistake committed. Usually the differential points are:—

1. In haemoptysis there is always a persisting cough of a hacking nature. It is not present in cases of haematemesis.

2. In cases of haemoptysis the blood is present in the sputum for at least three or four days after the bout whereas in cases of haematemesis there is no further tinging of sputum after the first bout.

3. The blood that comes from the lung as haemoptysis is bright red in colour whereas the blood that comes from the stomach as haematemesis is dark red in colour.

4. The reaction of the blood that comes as haemoptysis is alkaline whereas the blood in haematemesis is acid in

reaction due to mixture with hydrochloric acid of the stomach.

5. In haemoptysis there will be symptoms of involvement of the lung whereas in cases of haematemesis there would be some history of gastric trouble.

In the exact diagnosis of this symptom greatest amount of reliance must be placed upon the physical, X-Ray examination and bacteriological examination of the sputum and excreted blood. If no visible symptom is evident and yet the haemoptysis is present with no detectable cause, it is always safe to look upon it as a potential case of tuberculosis. In addition to the examination of the lungs, examination of other organs of the body especially the upper respiratory passages should be done, but it must be remembered that during the prevalence of haemoptysis, classical methods of examination cannot be allowed. The patient must be disturbed as little as possible and no percussion is allowed as this may dislodge the clots at the bleeding points which dislodgement may renew the bleeding.

LOCALISATION OF THE SPOT OF HAEMOPTYSIS:—It is becoming more and more important to decide exactly the part of the lung where the haemoptysis is occurring because when the haemoptysis could not be controlled by the ordinary methods, it could nowadays be controlled by having recourse to artificial pneumo-thorax. Hence it is necessary that we should make a fairly accurate decision as to the side from which the blood is coming. For localisation of haemoptysis, I always prefer to base it on three points.

1. *The Intuition of the Patient:* Even the most illiterate person when asked to point out the spot from which the blood is coming in his lungs, he very frequently points to the exact spot. It is only in a very small percentage of cases that the patient is not able to do this.

2. *Auscultation* will show larger and coarser rales over the area where bleeding is taking place. It is natural to expect in these cases a certain amount of

moisture over the bases on both sides due to aspiration.

3. X-Ray Examination of the Patient: When X-Ray is not available on the spot it is not advisable to shift the patient even for a short distance for the purpose of taking the X-Ray picture. Even if an old picture is present that is enough because haemoptysis is more frequent over areas where cavities are present.

By the above three points you can definitely come to the conclusion as to the side from where the blood is coming. And then we can collapse the lung if other methods of treatment for haemoptysis have failed.

PROGNOSTIC SIGNIFICANCE OF HAEMOPTYSIS: From the point of view of prognosis haemoptysis could be divided into two categories:—

(1) When haemoptysis is the first sign that ushers the disease and,

(2) when haemoptysis occurs in a diagnosed case of tuberculosis.

In all cases where haemoptysis is the first sign, the prognosis has often been very good. This is due to the fact that when haemoptysis occurs in a person who appears to be healthy he seeks the aid of the doctor quicker than one whose attention has not been drawn to the presence of the disease. Otherwise in a large number of cases the disease would have advanced sufficiently long before it could be detected either by the patient himself or by his friends. Hence it is that when haemoptysis does occur it is an eye-opener to the patient and his relations and no time is wasted in seeking the aid of a doctor. This leads to very early detection of the disease and early detection always leads to very good end result. Therefore from the point of view of prognosis haemoptysis occurring as a initial symptom usually imports good prognosis.

In other cases when haemoptysis does occur it often leads to a certain amount of retrogression in the disease

and it may also be a source of the spread of the disease to other portions of the body. The exact fate of any person is difficult to be judged and it is impossible to say in whom the haemoptysis will occur and in whom it will not. Even patients who are apparently cured and in whom the disease is arrested may have a sudden attack of haemoptysis which may even end fatally. This is mostly due to a large vessel breaking or bursting during some sort of exertion. But in the majority of cases there is very little influence on the ultimate result on account of haemoptysis. I could say that hardly one out of 1,000 deaths is caused by haemoptysis. Death is exceedingly rare in early cases but in advanced cases it is not uncommon. Once haemoptysis occurs in a patient he always harbours the idea of the repetition of this symptom. And even if you assure him that he will never get haemoptysis he is not satisfied. And unfortunately the clinical history of very many patients shows that once haemoptysis occurs there is a tendency for the recurrence of the symptom. The complications that may occur as a result of haemoptysis are also responsible for certain end-results that may follow as a result of haemoptysis. The greatest danger is always due to the spread, especially the broncho-pneumonic spread of the disease. Hence if there is no increase in temperature during periods of haemoptysis, the prognosis in these cases is much better than in cases where, there is rise of temperature during periods of haemoptysis.

The division of haemoptysis into streaked sputum, stained sputum, clots of blood in sputum, small free haemoptysis, profuse haemoptysis is to my mind quite unsuitable. Any of this may occur in any patient but in earlier stages it is uncommon to find a profuse haemoptysis. During periods of haemoptysis various writers have attributed various deficiencies in blood constituents which might keep on the haemoptysis like deficiency in the calcium content of blood, a decrease in the thrombokinase content of the blood etc., but investigation have shown that there is no truth in any of these

statements and that the calcium content of a tuberculous patient while bleeding is of the normal standard. Hence it is difficult to understand exactly the significance of calcium therapy in this condition. There is no denying the fact that in tuberculosis there is a decreased tendency for coagulation. The cause of the decreased rate of coagulation is not well understood.

Both during haemoptysis and when haemoptysis has stopped, examination of sputum is exceedingly important in the diagnosis of this condition. It should be pointed out that in conditions where haemoptysis is present there is always a tendency for the sputum to be negative for tubercle bacilli or in other words when blood is mixed with sputum or when sputum is mixed with blood it is often negative for tubercle bacilli. The moment the bleeding disappears and the sputum is free, bacilli again reappear in the sputum. Hence sputum examination during periods of haemoptysis is not a conclusive evidence of the absence of the tubercle bacilli in the sputum. The examination of the sputum must be done on systematic lines. For this purpose it is necessary that 24 hours sputum is taken for examination. Because in certain specimens, bacilli may be present and in certain other specimens the bacilli may not be present. Hence a collection of 24 hours sputum is more reliable than sputum taken at one sitting. The examination should be done both by the ordinary methods and by the enrichment method. When ordinary methods are negative enrichment method often leads to positive result. Hence no sputum should be

said to be negative for tubercle bacilli unless concentration methods either by means of antiformin or by sulphuric acid is done. Occasionally it may require that the sputum must be sent for animal inoculation to be absolutely certain of tuberculous condition. Occasionally it is said to contain certain granules which are usually known as Much-Granules which are the predecessors of tubercle bacilli and thus when inoculated into guinea-pig, give rise to tuberculous disease. The presence of elastic tissue which was said to be a frequent occurrence in tuberculosis is not always correct as it does make its appearance also, in cases where there is destruction of lung tissue. Occasionally a certain amount of improvement is attached to the presence of albumin in the sputum. Roughly speaking albumin is absent in the ordinary sputum of respiratory diseases. It is present only in two diseases: acute oedema and tuberculosis of the lung. Acute oedema is an acute disease which can easily be diagnosed. If in a chronic condition albumin is present in the sputum, a certain amount of suspicion should be entertained and the case should be looked upon as one of tuberculosis. The presence of tubercle bacilli is always a very conclusive proof but if diagnosis is delayed till bacilli are found in the sputum we would have waited till the disease has fairly advanced. Hence it is necessary that every attempt should be made by these symptoms to arrive at a conclusion as to the presence of tuberculosis long before tubercle bacilli have appeared in the sputum.

(To be continued.)



**THE PERFECT
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THE GENERAL PRACTITIONER AND COMMON EYE DISEASES—VI.

BY

(G. J. G.)

DEFICIENCY DISEASES OF THE EYE.

Whatever may be the cause, whether poverty or malnutrition, affections of the eye due to hypovitaminosis are very common in our country, especially in South India. Apart from the question of national degeneration, the incidence of blindness resultant on some deficiency diseases is a problem which must have our early attention. It is not purely a medical problem. It is to a large extent an economic question. It is also a question of educating the public on proper, well balanced diet. It is gratifying to note that modern research workers and even politicians in India are directing their attention towards proper nutrition and we hope, at no distant date, the incidence of diseases due to hypovitaminosis will be much less than it is at present.

Deficiency diseases of the eye, in my opinion, should be more under the management of the general practitioner than the eye specialist. It is not because it is easy to diagnose and to treat. It is mainly because the treatment is for the general system and it does not consist of treatment at the moment, but for a considerable while. Such treatment is not with drugs mainly but with proper diet. If the patient has to be prescribed a proper diet for a good length of time, it must then be in accordance with his economic position and other environments, and it is the general practitioner on the spot who has knowledge of local conditions and circumstances that can do it.

Deficiency diseases of the eye are caused by defect in food or in assimilation of vitamins, especially vitamin A. The symptoms are varied, but are not complicated to confuse the diagnosis. While the shortage of vitamin A is the main factor in the causation of ocular disorders from avitaminosis, it is possible other vitamins also are involved, especially

vitamin D. Calcium deficiency also plays a great part.

NIGHT BLINDNESS.

The earliest sign of vitamin A deficiency in the system, before any other noticeable symptom shows up, is the delayed adaptation of the eye to perception in darkness. By means of a dark adaptation test, we could measure the time taken by the normal eye to see in darkness, as compared with the delayed adaptation in some eyes, which under treatment with vitamin A are quickly restored to normal. In practical life, you can see people with such eyes groping for a seat when they enter the darkened talkie hall.

This delayed adaptation, if allowed to develop, leads on to night blindness, or diminished ability to see when things are dimly lighted. Vision is normal in day time. The fundus also is normal. It will not be surprising if accidents should occur when such people are in charge of a motor car or a fast vehicle after dusk. This difficulty to see after dark is more marked during the earlier part of the night than during the later part. Though the depth of darkness may be the same at 10 p.m., and at 2 a.m., the sight is better at 2 a.m., than at 10 p.m.

XEROSIS.

Another early sign of avitaminosis is the appearance of a whitish patch on the conjunctiva of the bulb on the outside of the cornea. It is usually triangular in form with a sort of an oily, whitish foam on it. The base of triangle is towards the cornea. It first appears on the temporal side of the cornea and later on the medical side. In advanced cases, many irregular patches might be seen in various parts of the bulbar conjunctiva. The conjunctiva of the bulb and the lower lid may also be slightly discoloured and smoky. In some, this condition lasts for many years. Usually, it is seen

in children but adults are not exempt. Conjunctival smear may show Xerosis bacillus, but that is not the pathogenic organism causing the condition.

While it is not necessary for the symptoms mentioned by me to appear in the order given here, the next stage is further pigmentation in the conjunctiva and then, a slight dryness of the corneal epithelium. The cornea appears lustreless and devoid of its usual brightness and shine. This is only a prelude to the ultimate stage called keratomalacia.

KERATOMALACIA.

This is a condition which is the foremost cause of blindness in children in South India. The cornea which had a dry appearance soon softens down and practically melts away. There is no inflammatory reaction or pain, unless some secondary infection supervenes. The appearance of the eye is typical. The conjunctiva of the bulb and lower lid is smoky, almost black. The congestion around the cornea is dirty red. Xerotic areas are seen all over the conjunctiva. A whitish, ulcer like patch is seen on the cornea occupying either a part or whole of its surface. Very often we see the case in a stage when the whole cornea is lost and the iris with the lens behind is protruding out. One or both eyes may be affected.

The general condition of the patient is also typical. The child is emaciated and in the case of older children and adults the skin especially of limbs is horny, dry, pigmented and keratosed. Diarrhoea is a frequent associated symptom, also bronchitis. Liver may be enlarged with a typical pot-belly. If not treated in time, the patient dies of deficient nutrition and marasmus or broncho-pneumonia.

The condition is seen most in under-nourished people. It is most common in children, especially motherless babies fed on cow's milk. Women in pregnancy are also affected, due to insufficient nutrition. People with chronic diarrhoea also develop keratomalacia.

Though we see it mostly in poverty stricken villagers, children of the richer

class are not exempt. Either there is malnutrition because of an ill-balanced diet, or the nutrition given is not sufficient for the growing age. Keratomalacia is most common among the rice eating population of the country, especially in South India.

Cause.—Though the deficiency symptoms were not recognised as now, people of ancient days seem to have been familiar with some of the ocular disorders in defective nutrition. Hypocrates is said to have recommended raw ox liver for night blindness. People in our country have been using sheep's liver for the condition.

Through therapeutics mostly, we have come to know these affections are chiefly due to vitamin A deficiency with probably also deficiency in vitamin D and consequent defective calcium absorption. Administration of vitamin A or preferably still, the crude cod liver oil has marvellous effects. Of late, we have had extensive researches in Coonoor and other places and we have now been able to locate the cause of keratomalacia on a scientific basis.

Of all vitamins, deficiency in vitamin A affects the eye most. In fact, as mentioned earlier, its earliest symptom is first in the eye. On account of its effects on the eye, vitamin A is called the ophthalmic vitamin.

Deficiency in other vitamins also, except perhaps vitamin E, shows some characteristic features in the eye, but they give rise to a variety of general symptoms which the general practitioner cannot easily overlook. It will be beyond the scope of this paper to discuss them here.

Prognosis is good if the patient is seen before the cornea is destroyed. The response to treatment with vitamins, especially cod liver oil, is quick and marked. If the patient keeps up the nutrition, recurrence does not occur.

Diagnosis is easy. The general as well as local appearance is typical and once seen, it is never missed. Examina-

tion of the patient should be very carefully done. Children do not open their eyes from photophobia and fright. Any attempt to separate the lids with the fingers to have a look at the cornea exerts pressure on the bulb and if the cornea is weak, out come the contents of the bulb and the eye is irretrievably lost. I have seen a doctor spoiling an eye when trying to apply silver nitrate solution imagining the case to be one of ordinary sore eyes. Examination of the eyes of children, if they are resistant, should be done with the aid of eye lid retractors. Put the child on the table and ask your assistant to hold it well. Gently pull the lower lid down, insert the retractors and pull them apart and away from the bulb. Then, you have a good view of the cornea and how much of it is affected.

Treatment is simple. It ought to be in the hands of the local general practitioner. The reader may remember, in a previous paper, it was said, any case of corneal ulcer must at once be sent on to the specialist. But here, my advice is otherwise. Deficiency diseases of the eye must be treated by the local doctor himself. I say so for many reasons. First of all, the treatment is for the general system and very little for the eye. Secondly, when a case of avitaminosis is sent to the specialist, he is able to relieve the condition in a few days with costly drugs and diet, but as soon as the patient comes home to his poor surroundings and ill-balanced food, he gets back his old trouble. If, on the other hand, the local doctor treats the case, he can easily study the local conditions and patient's status and environment and prescribe a course of treatment suitable for the particular case and which will prevent a recurrence of the affection of the eye.

After all, the diet available even to the poor man is not without its nutritive value, sufficient to prevent avitaminosis. But, what he requires is proper advice. Health Bulletin No. 23 published by the Government of India gives an excellent review of the nutritive value of various

articles of diet in India and one must be able to prescribe a cheap but well balanced diet from our usual food-stuffs, which will have a curative as well as preventive effect.

For example, most of our deficiency cases are seen in people using mill polished rice. They must be advised to use hand pound or still preferably chakki-ground rice, which is said to be nearly as nutritive as Punjab diet. Kambu, ragi, curd, butter, butter-milk, green leaves, vegetables, tomatoes, eggs, etc., are articles which a villager can better afford than Osteomalt and things of that sort. One can thus see how much more effective and humanitarian it will be if the local doctor himself undertakes and treats these deficiency cases instead of passing them on to a far-off specialist.

Coming to individual deficiency conditions, night blindness requires in addition to general nutritive diet rich in vitamin A, daily in-take of sheep's liver cooked in any form and oranges and tomatoes two or three every day. No local treatment is necessary for the eye. Cod liver oil also may be given, preferably the crude oil.

Xerosis of the conjunctiva is treated with cod liver oil internally, and locally with application of yellow oxide of mercury ointment 2% once a day now and then. It must be remembered it takes a long time to clear and one should not get disappointed that the treatment does not produce any appreciable result. Diet rich in vitamin A, B and D should be prescribed for regular use.

Keratomalacia requires vigorous medical treatment in addition to special dieting. Diet alone does not help because of the damaged condition of the intestinal epithelium and defective absorption and further, quick relief is urgently necessary to save as much as possible of what is so far not destroyed.

First of all, if there be diarrhoea, as is very often the case, it has to be brought under control by regulation of diet and if necessary with small doses of Bismuth

salts. Along with that, two or three drops of Super D concentrate solution or Adexolin by mouth twice or thrice daily are tolerated by many, but if these cause increase in the diarrhoeic stools, subcutaneous injections of Sodium Morrhuate (if the lungs be free) may be given twice a week starting from 0.10 or 0.25 c.c., according to age and going up by 0.10 c.c. up to 1.00 c.c. If there be no diarrhoea, teaspoonful doses of plain cod liver oil are the best and cheapest. In very small babies, the oil may be rubbed into the axilla and groin. As mentioned earlier, the affected children are often those that are artificially fed. Here, the doctor should see the milk given has sufficient nutritive value. Older children may be asked to take one or two oranges or tomatoes every day regularly, in addition to regular proper diet. Fat should form an important part of the diet. Where the patients can afford, Adexolin, Halivercl, Ostelin, ultra-violet ray exposures have all their own value.

The general health of the patient should also be examined and treated for any associated trouble. Congenital syphilis, worms in children, malarial cachexia, etc., delay relief in the eye condition in spite of treatment and might cause frequent recurrence.

Personal hygiene is also important. Clean habits and clean surroundings help in the progress of treatment.

Local treatment.—Keep the eye clean and apply atropin 1% and Argyrol 20% drops and zinc sulphate ointment once a day. When applying the medicine, be careful no pressure is exerted on the bulb, especially in children. Draw the lower lid down away from the bulb and with pressure on the malar bone and put in the drops. When the eye begins to show a healthy appearance and the ulcer on the cornea is covered with epithelium, yellow oxide of mercury ointment 1% in the beginning and later 2% ointment may be applied once a day. In children, it is marvellous to see how much of the affected cornea clears. If a central leucoma is left, an optical iri-

dectomy will give sight, but it is better to do it as late as possible to give Nature time to clear as much of the opacity as possible. This operation has to be done by the specialist.

When the whole of the cornea is lost and there is an iris staphyloma protruding out, there is intense pain and discomfort for the patient. The eye cannot be properly closed and there is watering, irritation and discharge. In such cases, after anaesthesia, make an incision with a cataract knife right across the protruding iris. The lens will jump out followed by a little vitreous. Close the eye immediately with a drop of Argyrol 20%. Dress the eye daily with Argyrol drops. The eye should be under bandage till the wound heals. Generally it is all right in about two weeks.

As our experience advances, we find a number of ocular affections are directly or indirectly caused by avitaminosis. For example, persistent phlyctenular conjunctivitis in this country is probably more a nutritional than a tubercular affection. Trachoma, certain type of optic atrophy, defective vision in the young without any apparent cause and many such affections make us feel that in addition to a certain aetiological factor, avitaminosis and consequent (?) glandular dysfunction play an important part in the causation of such affections. It will be too much to discuss them here, but mention may be made of a condition called angular conjunctivitis.

ANGULAR CONJUNCTIVITIS.

Here though the definite causative organism is a particular diplobacillus, radical cure is effected only by treatment of the general deficiency.

The symptoms are characteristic. There is a chronic inflammation of the corners of the lids and an associated angular stomatitis. We see it most in children in boarding homes. There is much photophobia especially to artificial light, watering and itching. Sometimes, the whole border of the lid is inflamed

and looks raw and red. The specific for the condition is zinc. It is applied in the form of zinc sulphate ointment twice daily (for prescription see part III). Addition of Rivanol to the ointment brings about quicker relief.

Zinc Sulphas	...	0.50
Tumenol Ammoniata	...	0.50
Rivanol	...	0.20
Lanolin	...	50.
White vasile	...	50.

(Eucerinum is also good as an ointment base).

When the Md margins look raw and red, or if there be conjunctival discharge, application of silver nitrate solution 2% on the first day is indicated, followed by zinc sulph. ointment on the following days, with or without Rivanol. For the mouth condition, zinc paste is good.

Zinc oxide	...	10
Amylum	...	10
White vaseline	...	20

All this is not enough if the general health is not attended to. The patient is in need of drugs and diet rich in vitamins. In this condition, concentrated administration of vitamin B is indicated more than vitamins A and D. Yeast, sour cold rice, ragi, kambu, millets, unfermented toddy are all useful.

PREVENTION.

A well balanced diet maintains the body in a healthy condition and when the body is in a healthy condition, there is no cause for any deficiency disease occur.

ring. From the food-stuffs available to the average labourer, a well balanced diet can be prescribed and it is the general practitioner who has to advise every patient of his a well balanced diet. Besides the valuable information given in the health bulletin No. 23, each one of us has to experiment on the nutritive value of the articles of diet available in his locality and give advice to his patients. This might sometimes mean shedding off many of modern ideas and habits. It will be very difficult to convince the patient that the sour cold rice is better for the health than coffee. Unless a doctor advises, and that very strongly, people will not care to take to hand pound rice. People require advice as to the conservation of the valuable material in our ordinary food stuffs and as to the form in which certain articles have to be taken without injury to their vitamin content. All this can be done only by a doctor. If the doctor could make a study of these and advise every one of his patients, friends and relatives, the knowledge is sure to spread and help to improve the health of the community.

But, one should not forget the poverty of the country and the inability of many to obtain more than one meal a day. That is a question which does not come within the purview of this article, but at the same time, it should be borne in mind, that the diet available to these people can, on proper advice, be so balanced and arranged as to be of maximum nutritive value possible.

Keratomalacia is a preventable disease. Some one is responsible for the eyes of the young getting blind. Let us try our best to do our bit to reduce the incidence of blindness.

NOTICE.

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

MADRAS MEDICAL COUNCIL

REVIEW OF PROCEEDINGS.

October 1939 Session.

BY

DR. V. RAMA KAMATH,

Member, Madras Medical Council.

ELECTIONS TO THE REFORMED COUNCIL.

It might be remembered that in the Review of the proceedings of the Madras Medical Council published in The Medical Practitioner in August 1939 it was said that at the instance of the Government the Council at its meeting held on 6-1-1939 provisionally fixed the dates for the various items of the election proceedings so that the elections to the Council could be over on the 22nd August 1939 and that the Government did not pass orders till the latter date though the resolution of the Medical Council on the subject was communicated to the Govern-

ment duly. The Government order on the elections was published in the Fort St. George Gazette on 22-8-1939 calling on the Returning Officer (The Surgeon-General) to report the results of the election on or before the 1st November 1939. It is said that the Returning Officer intimated to the Government the practical difficulties to conduct the elections within the prescribed time and at the October meeting of the Medical Council, the President, the Returning Officer, placed this subject before the Council and the Council suggested the following dates for the various items of Election Proceedings which have been since approved by the Government.

1. Publication of Draft Electoral Rolls.	13th Feb. 1940.	13th Feb. 1940.
2. Confirmation of Electoral Rolls.	27th " "	" "
3. Issue of Nomination papers.	8th Mar. "	1st Mar. "
4. Last date for receipt of Nomination papers.	13th " "	15th " "
5. Scrutiny of nominations.	14th " 4 p.m. 1940.	20th " 4 p.m. 1940.
6. Publication of nominations.	19th " 11 a.m. 1940.	26th " 11 a.m. 1940.
7. Issue of voting papers.	27th " "	30th Apr. "
8. Last date for receipt of voting papers.	3rd Apr. 4 p.m. 1940.	21st May. 4 p.m. 1940.
9. Scrutiny and Counting of votes.	5th " 11 a.m. 1940.	23rd " 11 a.m. 1940.
10. Publication Election Results.	9th " 1940.	28th " 1940.

The dates marked A are for the proceedings of election to the constituencies of three Medical Colleges in the Presidency mentioned under sec. 5 (1) (c) to (e). The dates marked B are for the proceedings of the election to the general constituency mentioned in sec. 5 (1) (f) of the amended Madras Medical Act of 1938.

Relating to the election to the General Constituency which now consists of all registered practitioners, licentiates, graduates of the Madras and Andhra Universities and those registered in the British Register, Dr. N. Venkataswami Chetty moved the following resolution which was seconded by Dr. U. Krishna Rao.

"This Council reiterates its resolution passed at its meeting held on the 18th November 1937 and requests the Government of Madras to institute the single transferable method of voting for the next Medical Council elections".

Before the resolution was put to vote I appealed to the Council that there was no need to adopt the procedure suggested in the resolution as unlike in the University elections where this procedure was adopted to safeguard the interests of various professions constituting the University, the interests of voters in regard to the elections to the Medical Council were uniformly the same and the very purpose of the amending of the Madras Medical Registration Act would be frustrated by adopting the procedure suggested in the resolution. Moreover, I said there was no need for any apprehension for proportionate representation as the two members to be returned by the Universities would be graduates and so also the three members to be elected by the staff of three Medical Colleges, in the province, thus ensuring the return of 5 graduates by very easy methods. My appeal had no effect and the resolution was pressed and a poll was demanded by me with the following result:—

For: Drs. N. Venkataswami Chetty, U. Krishna Rao, M. R. Guruswami Mudaliyar, Miss. Ida S. Scudder.

Against: Drs. T. S. Tirumurti, V. Rama Kamath, Y. Suryanarayana Rao.

Neutral: DR. (Mrs) O. M. Monahan.

REGISTRATION.

Registration of foreign Medical Missionaries: Dr. (Miss) B. Siebers, M. D. who was refused registration but who was permitted by the Government to do teaching work in the Vellore Missionary Medical School for women and whom the Medical Council recommended extension to teach for a further period till the Government decided the desirability of registering foreign missionary doctors (in spite of the Reciprocity clause in the Madras Medical Registration Act prohibiting registration of foreign medical qualifications), has been permitted by the Government to continue

the teaching work for a further period of three years without being registered.

The resolution of the Council to register foreign medical missionaries conditionally so as to enable them to serve in medical missions with no privilege of private practice for private gain, is still under the consideration of the Government.

Registration of Foreign Medical Practitioners: Due to Hitler's persecution of Jews there had been an influx of German Jews in India and amongst them there were many medical men who settled in all the important cities. A question was raised some time ago in the Central Assembly that the settling of German medical practitioners in India would be detrimental to the interests of the Indian medical practitioners and the Central Government were requested to have recourse to legal measures which would prevent the foreign medical practitioners to practise in India. It may be mentioned that in Germany and a few other foreign countries foreign nationals are debarred from practising though they may possess medical qualifications granted by the local universities. The Central Government shelved this question and said that the Provincial Government had to be approached primarily. Accordingly the Delhi Medical Association referred this matter to all the Provincial Medical Councils and the Madras Medical Council at the April 1939 session passed a resolution endorsing the views of the Delhi Medical Association and requested the Madras Government to take necessary steps. The Madras Government have since communicated to the Medical Council their order on the subject which runs thus:

"The Madras Medical Council is informed that immigration is not a provincial subject and falls under item 17 in list I in the seventh schedule to the Government of India Act, 1935. The question of maintaining the *status quo* in the current schedule of immigration of foreign medical practitioners is therefore one for consideration by the Government of India".

The indifference of the Central Government is indeed regrettable.

Sri V. V. Krishnayya of Cocanada, L. P. C. & S. (Bengal) has been refused registration by the Government.

DISCIPLINARY CASES.

Issue of Irregular Vaccination Certificates: The readers may remember that in the review of the proceedings of the Council relating to April 1939 session, a case against a private medical practitioner of Negapatam was commented upon. This case was reported to the Medical Council by the Special Officer deputed to enquire into Port Health Administration, Negapatam. The Officer alleged that the practitioner had issued ante-dated vaccinated certificates to three passengers bound to Malay. All the members of the Disciplinary Committee of the Medical Council individually came to the opinion that the case against the practitioner should be gone through. But when the case came for final decision before the Council, the Council decided to drop the proceedings. I was the only member who voted against the resolution and commented in these columns last August that, "it was an important case which if gone through would have given lot of information to the Council about the affairs relating to the issuing of vaccination certificates and the part played by the Public Health Department and the Shipping Company apart from the guilt or innocence of the practitioner complained against."

At the October 1939 Session three more practitioners of Negapatam were reported against by the Port Health Officer, Negapatam alleging the issue of irregular vaccination certificates. In all the cases the Council decided to drop the proceedings. Even in regard to these cases I suggested to the Council that the matter be referred to a special committee contemplated in section 17 of the Madras Medical Registration Act. Whatever might be the allegations complained against the practitioners it is beyond any reasonable comprehension why the Port Health Officers did not detain the passengers who possessed irregular vaccination certificates. They had statutory power to detain passengers if the latter transgress Port Health regulations. The Medical Council exists not only to condemn practitioners violating medical ethics but also to protect the practitioners who are

complained against on wrong or insufficient grounds. If, as stated by me once before, the Medical Council went through these cases, it would have been in a position to point out to the Government that the irregularities of vaccination certificates complained against by the Public Health Department was its own making though indirectly.

Recommending Proprietary Medicines by Testimonials: Two registered practitioners Drs. W. J. Fernandes and N. V. Govindaswami Pillai were complained against for issuing recommendatory testimonials relating to St. Antony's Balm, manufactured by G. Martirosi and Co., Madras. The letter addressed by the Registrar to the former demanding explanation was returned by the D.L.O. and the latter practitioner requested the Council to excuse him as he was not aware of the rules of governing Medical Ethics. The Council passed the following resolution on the subject:

"Resolved that the medical practitioner be warned and that a notification drawing the attention of registered medical practitioners to the provisions of the Code of Medical Ethics, especially to this form of advertisement viz., the giving of certificate for proprietary medicines which are published and circulated to the public, be published in the newspapers and medical journals."

Complaint against Dr. Kondal Rao, L. M. S. (Hyd.), Anakapalle: One Mr. Lingum Lakshminarayana Nayadu of Anakapalle complained alleging that Dr. Kondal Rao distributed hand bills through his agent and patients publishing his professional skill, issued a false certificate to a person appearing in a criminal case and issued a 'chit' prescribing a secret remedy viz., 'bottle for invalids'. The practitioner while asked to explain denied all allegations and mentioned that about five years ago that a patient of his on his own accord published hand bills about his professional skill and the Medical Council after demanding an explanation from him excused him. Regarding the medical certificate he said that the injuries mentioned therein were abrasions which perhaps did not leave any trace at the time the person who had the abrasions appeared

in the Court. Regarding the secret medicine he mentioned that though he wrote in the "chit" "a bottle for invalids" he told the patient that it was a bottle of sanatogen. He added amongst other things that the complainant was a sub-post master at Kallikot who was convicted for embezzlement and who after finishing the term of imprisonment was running a chemist shop. It was also mentioned by the practitioner that complainant was a relation of his and bore a grudge against him. Regarding the "chit" containing the words "a bottle for invalids" the practitioner added that his patient went to the complainant's shop where sanatogen was not available and the complainant supplied "essence of chicken" instead and as the same was returned the complainant took advantage of the "chit" and made much of it.

After the explanation from the practitioner was received by the Registrar the complainant wrote to the Registrar the following letter withdrawing the complaint:

"I beg to state that I had submitted a complaint, dated 22nd June 1939, to you against one Dr. R. Kondala Rao, L.M.S., Anakapalle, due to pressing circumstances of some party. I regret very much for my hasty action. There is nothing to complain of. The complaint is groundless, and therefore, I do hereby withdraw my complaint against Doctor R. Kondal Rao, who neither printed nor circulated the printed notices in Telugu which I had enclosed in my complaint, dated 22nd June 1939."

It was also said that the complainant did tender an apology to the practitioner.

The Council lodged the papers relating to the case.

Evidently the complaint is not *bona fide*. All the same it has to be said that the practitioner might have prevented the third handle against him if the "chit" contained the word Sanatogen as it is instead of 'bottle for invalids'.

Complaint against Dr. K. Suryanarayana Rao, L.M.P., Anakapalle: Reference was made in the August 1939 number of The Medical Practitioner that the District Medical Officer of Vizagapatam

reported to the Registrar alleging that Dr. K. Satyanarayana associated himself with an unqualified practitioner and furnished wrong and false information involving another registered practitioner and a registered midwife. The Council at the April session decided to proceed with the case. In the meanwhile the practitioner complained against sent his explanation to the Registrar. He said that the person with whom he associated was his own father who possessed L. H. M. S. (HOM) qualification of the Bose's College, Calcutta and duly registered by the Central Board of Indian Medicine on 1st February 1933 and denied the allegation that he furnished wrong and false information against another practitioner or midwife.

The Council decided to drop the case without assigning any reasons. Such a decision is likely to be misinterpreted by interested parties.

Complaint against Dr. (Miss) M. K. Saraswathi, M.B.B.S., D.G.O., Cannanore:—One C. C. Mammath of Balia-patam, N. Malabar, complained alleging amongst other things that the practitioner attended on his wife for confinement on 19th May 1939 and had to apply forceps to extract the baby which was dead and that she requisitioned the services of her motor driver for extracting the baby. He added that the practitioner refused to accept Rs. 10/- the fees offered to her and did not attend on the patient after delivery with the result that the patient got septic and had to be attended to by another practitioner and that she eventually died. The practitioner in her explanation denied the allegations. She said that she asked the midwife to pull the forceps for a little while and as the midwife faints she asked the husband of the patient to take the midwife to an adjoining room and attend to her and as the latter would not do so she asked her driver to do the same. She added that she visited the patient the following morning and as the husband of the patient was very poor advised him to admit his wife into Government Hospital. She received from him only Rs. 6/8/- as petrol charges. In the end she said that the complaint was an inspired one.

The Council decided to drop further proceedings.

Complaint against Dr. K. Bhimeswara Rao, M.B.B.S., Tenali:—Dr. V. Appa Rao, Medical Officer, Kollur preferred a complaint against Dr. Bhimeswara Rao, alleging that a patient of the former was removed from Kollur to the clinic of the latter at Tenali without getting his permission or without settling his fees. Dr. Bhimeswara Rao in his explanation mentioned that the patient was brought to his clinic by the patient's brother who did not like the idea of consulting Dr. Appa Rao and that Dr. Appa Rao was informed that his services were no more required and that his fees would be paid. The brother of the patient and a friend by two separate letters to the Registrar endorsed more or less what Dr. Bhimeswara Rao mentioned in his explanation.

The Council dropped further proceedings.

Case against Dr. G. Sampson, L.M.S. (Hyd) and Dr. (Mrs) G. Olara Samson L.M.P., Chirala:—The following is a translation of a Telugu hand bill distributed by the two practitioners and which was received by the Registrar:—

With the experience and reputation gained by serving in big hospitals, like Ongole, Hanumakonda, Nellore and Vuyyur Mission hospitals, Dr. G. Sampson and Mrs. Sampson have established their hospital in Chirala nearly sixteen years back. In this hospital, treatment can be had for all varieties of diseases. Patients are seen at all hours. Major operations are conducted without the necessity of going to Madras. Diseases of pregnant women are cured, and difficult deliveries are conducted by easy methods. Wound certificates required by Law are given to the injured.

Toxic fevers, Pneumonia, Tuberculosis, Asthma, and venereal diseases are cured by allopathic and Ayurvedic methods.

We have gained reputation of being specialists in the diseases of Eye, Nose, Ear and Mouth and Abdomen. We are curing the diseases, and removing easily the tumours of the uterus. There is separate accommodation for patients. There are nurses and compounders in attendance. Patients are treated at all hours. Details can be had on application. Treatment free for the poor."

The practitioners were asked to explain. Both pleaded ignorance of rules of Medical Ethics and begged to be excused.

The Council found both guilty and directed the Registrar to remove their names from the Medical Register, the period during which their names should be omitted in the Register being six months.

Miscellaneous items.

As this was considered to be the last meeting of the old Council, I made a short speech about the past work of the Council with Major-General N. M. Wilson as its President and moved the following resolution which was unanimously passed.

"This Council at the close of its term of Office desires to place on record its deep sense of gratitude for the valuable services rendered by Major-General N. M. Wilson as its President by showing uniform courtesy to the members of the Council and conducting its meetings in an impartial manner."

Medical Practice—Reciprocity with French India: Registered Indian medical practitioners who are not in the medical register maintained in French India are not allowed to practise in French India. This affects seriously the practitioners practising near about Pondichery. In 1936 at the October session of the Madras Medical Council I moved the following resolution:

"This Council resolves to request the Medical Council of India to recommend to the Government of India to correspond with the French Government in order that registered medical practitioners in the Provincial Registers may be allowed to practise in French India, and in case the French Government refuses to comply with this suggestion, that the Government of India be requested by the Medical Council of India to enact suitable legislation to prevent practitioners of French India from practising in British India unless they are in the Provincial Registers."

The Executive Committee of the Medical Council of India at their meeting held on 4th November 1936 directed that the views of the other Provincial Medical Councils be obtained and all the councils endorsed the resolution of the Madras Medical Council. The Secretary, the Medical Council of India wrote to the

Government of India on the 13th May 1937 on the subject and got the following reply dated 17th February 1939:

"With reference to the correspondence ending with your letter No. F. 9-C-38/1938, dated the 21st January 1939, I am directed to say that as remarked in your letter No. F. 15-C-37/223, dated the 13th May 1937, the matter mostly concerns the Madras Medical Council. Provincial Governments are competent to undertake legislation prohibiting practitioners of French India, who are not on the Provincial Registers, from practising medicine in the Provinces and legislation by the Central Government is not at present contemplated."

The above letter was placed before the Council and the following resolution moved by me was unanimously passed:

"The Madras Medical Council requests the Government of Madras to undertake legislation prohibiting practitioners holding the French qualifications who are not on the provincial medical register from practising medicine in the Presidency. This Council also requests the President to send copies of the correspondence between the Madras Medical Council and the Medical Council of India on this subject to the Provincial Government."

It is hoped that the Madras Government would do the needful in the matter.

Reciprocal Agreement for erasing names from Medical Registers: The Registrar, South African Medical Council, Pretoria referred to the Secretary, Medical Council of India for the opinion of the latter council about the necessity of erasing the name of a registered practitioner from all Registers in countries having reciprocity in case the particular practitioner was found guilty of infamous conduct in a professional respect by any one of the reciprocating medical councils. The Registrar of Pretoria mentioned that a registered practitioner whose name was erased by the Medical Council of Pretoria got himself registered in another country and was practising.

I wonder if the South African Medical Council is aware that the Medical Council of India does not maintain a Register and it is a Council without legitimate functions of a medical council existing in all other countries. I equally wonder if the

Secretary, Medical Council of India realised the humiliation of the existence of a council without a Register. The Medical Council of India having no register of its own had to refer this letter received by its Secretary to the Provincial Councils in India. The following resolution moved by me was unanimously passed by the Council:

"That the Secretary, Medical Council of India, be informed that under the circumstances which now prevail when there is no legal relationship between the Provincial Medical Councils and the Medical Council of India, it will not be possible for the Provincial Medical Councils to take notice of the judgments of foreign medical councils unless and until the Medical Council of India has a medical register of its own and the reciprocity of the Medical Council of India with the foreign medical councils is based on the Medical Registers and not on the medical qualifications."

Payment of Fees for Life Insurance Certificates: The Maymyo Medical Practitioners' Association referred to the Council for its opinion about the desirability of uniformity of payment of fees to medical men for examining persons for insurance irrespective of their qualifications or amounts assured.

The Council was of opinion that this matter was outside its purview.

Advertisement of Proprietary Medicines by Registered Practitioners: One Dr. K. Pangunny Nair asked the opinion of the Council whether he could advertise an hair oil without violating the Code of Medical Ethics. He said that he would not solicit patients but would advertise only for the sale of his scientific product. The following resolution was unanimously passed:—

"That Dr. M. K. Pangunny Nair be informed that the Code of Medical Ethics recognised by the Madras Medical Council cannot permit a registered medical practitioner to associate his name with any trade dealing in specialities but there cannot be any objection to his owning the business or taking part in their preparations."

As usual, items of proceedings which are not of interest to the medical profession have been omitted in the Review.

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FUTURE OF THE MEDICAL PROFESSION.

Unlike other professions the future of the medical profession depends to a great extent on itself and the causes of pessimism which now prevail in a large section of the profession are entirely due to the fact that the evolution of scientific profession in India was not a natural one. Though it is difficult to say what would have been the state of affairs of the growth of scientific system of medicine in India if the British did not introduce into the country the system of medicine prevailing in their own country primarily for the treatment of the military and civil departments, we can judge from the history of Japan, a country which was never under foreign rule that India too if it existed as an independent country would have had a system of scientific medicine. Consequently the votaries of the system who evolved the scientific system would have been able to guide the Government of the country as in other civilized countries, instead of the Government controlling the destinies of the profession. Even during the short period of two years and odd when an ultra National Government was in the saddle of the Government of this province and other seven provinces in India the members of the independent medical profession did feel that matters concerning the scientific system of medicine did not improve on the other hand, the very existence of this system was threatened by the

Governments encouraging the growth of a hybrid system of medicine. The irony of the situation was felt the more in the Bombay Presidency where an Act was passed to perpetuate the growth of the hybrid system at the very cost of the indigenous systems of medicine to encourage which the Act seems to have been passed as those trained in the former system preferred to practise the western system and not the indigenous. And all this happened when the Bombay Cabinet had an eminent member of the profession belonging to the scientific system of medicine in the person of Dr. M. D. Gilder, M. D., F. R. C. S. In Madras matters were bad enough but not as bad as in Bombay and the medical profession did feel that the Public Health Minister in the Madras Cabinet was helpless to have his own ways in the Cabinet regarding the growth of hybrid system though he could have them over the Scientific System of Medicine. In the United Provinces affairs were as bad as in Bombay. The Medical Portfolio was in the hands of Srimati Vijayalakshmi Pandit, the sister of the ideal Indian patriot, Pandit Jawaharlal Nehru who is one of the very few Indian politicians whom we know and who would not barter his convictions for political popularity. The readers of The Medical Practitioner might remember the comments appearing in News and Comments columns about four years ago when the Congress made up its mind to enter legislative bodies and when Pandit Jawaharlal was having whirl-

wind movements from one province to another to canvass support for the Congress. It was then reported that the students of the Unani College in Delhi founded by the late Dr. Ansari waited in deputation on Pandit Jawaharlal and requested him that the hospital to be started in Allahabad to commemorate the memory of the late Mrs. Jawaharlal Nehru should be staffed by medical officers belonging to Unani System passed out of the Delhi College and the Pandit flatly refused the request. This hospital was recently opened by Gandhiji and is staffed by medical officers belonging to scientific system. All this we have to mention to convince our readers that politicians who form the democratic Government have to pocket science in favour of political power. Dr. T. S. S. Rajan, the ex-Public Health Minister of Madras, while addressing the Trichinopoly District Medical Association on 21-1-1940 referred to Ayurveda and 'warned the members of the positive danger with regard to the trade which was going on in the name of patriotism and nationalism much to the deterioration of scientific thought'. What he said at Trichy as a member belonging to the independent medical profession he could not act upon as a Minister in charge of Medical Portfolio and he will never be able to do it even after he re-enters the Madras Cabinet of the Congress Government which Dr. Rajan said was likely to resume office in the near future. On the face of Rajan's bitter experience as a member of the Government when he was not able to convince his colleagues chosen 'by popular electorates' about 'science' as against 'trade' his statement 'that the entire control of the medical profession must be in the hands of the Ministers controlled by popular electorates' is not likely to convince the members belonging to the scientific system of medicine unless

Dr. Rajan and a few more eminent medical men like him educate the popular electorates and ensure the return to the legislative bodies of persons who are able to discern 'trade' as against 'science'. Is this a practical proposition? We wish Dr. Rajan answers this query in the near future when he has an opportunity.

In the meanwhile can the members of the medical profession keep quiet? Did political leaders in India keep quiet after making prayerful pious suggestions to the British Government year after year? Political independence did not dawn till some of the leaders made personal sacrifices even courting life in jails. Then only the sincerity of the people in India for attaining political freedom was realised by the British Government. To us politics looks as good a trade as any other, with the only difference that this trade can wield control over all other trades. It may look highly presumptuous when we say that the medical profession is not a trade. At least such of the medical practitioners who are registered, can realise that the profession cannot be a trade to the extent others are. Its members are prohibited from advertising their professional skill and even their names and qualifications. They cannot prescribe secret remedies much less encourage their publicity. They cannot make false statements regarding their professional opinions. In fine they have to follow a Code of Medical Ethics on pain of their names being removed from the medical register which means depriving them of the rights and privileges enjoyed by the registered practitioners. So the medical profession not coming under the nomenclature of trade has to thrive without being influenced by outside agencies. But unfortunately majority of the members of the

profession have not as yet realised the virtues inherent in the profession which if they are exercised by its votaries uniformly, the profession can hope to get out of the grip of the public and even of the Government. To exercise uniformity in the virtues there should be well organised union amongst the members of the profession and the spirit of comradeship should prevail in the place of unwholesome cut throat competition. It will be suicidal for the profession to depend upon any Government for its scientific evolution or prosperity. Recent history should guide the profession. Unfortunately all the well equipped hospitals in India belong to the State and there is therefore a glamour for service in hospitals even in honorary capacity. The ban on private practice by State paid practitioners and five years' tenure of office of the honorary medical officers is a blessing in disguise taking the interests of the profession as a whole. If no mean advantage is taken by all concerned in giving effect to the new policy of the Government, the official and the independent section of the medical profession have much to gain to build up and organise the scientific medical profession in this province. There is likely to be initial difficulty which can be tided over if a few practitioners who are above the level of competition and a few retired officials exert themselves in bringing about healthy understanding between private practitioners and Government medical officers in the interests of the profession as a whole. The State hospitals are not enough both in the big cities and towns in the mofussil to

cater to the needs of the public for institutional treatment. We visited almost all the important towns in Andhra Desa last April and in the Tamil Nadu recently, had interviews with the Government medical officers including the retired Civil Surgeons and District Medical officers, saw a large number of private practitioners some of them owning clinics, laboratories, and X-ray plants and we could say that all with whom we came in contact favoured the idea of establishing mutual contact between the official and independent practitioners to the best interests of the profession and the public. There are also possibilities in some town for establishing private polyclinics with arrangement for institutional treatment not inferior to that obtaining in mofussil State institutions. The Madras City cannot be far behind in this respect.

What struck us most was that the idea of some sort of panel system of practice which the Association of Independent Practitioners had been entertaining in the northernmost town of Vizagapatam was also thought about by the Independent Medical Practitioners' Association in Tinnevely, the southernmost District in the Presidency. This should convince our readers that there are latent ideas of constructive work everywhere for the good of the profession and there should come forward a cementing force which should combine these ideas and make them manifest. The future of the profession is not gloomy. It can be made bright and the members of the profession have to depend upon themselves for this task.

NOTICE.

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

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the Month of December 1939.
(Up-to 20-12-1939).

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 30-11-1939. ...	190 12 5	Postage including V. P. P. charges etc., ...	6 13 6
Subscription from members (including V. P. charges). ...	41 12 0	Pay to Clerks for November 1939. ...	15 0 0
Entrance fee from two new members ...	0 8 0	Amount credited to The Medical Practitioner from the subscription paid by 16 members ...	30 0 0
Amount advanced by the President to meet the office expenses ...	15 0 0	Paid to Dr. K. Govindan (Treasurer) towards postal charges incurred by him (from 26-2-39 to 21-10-1939). ...	1 15 6
		Rs. A. P.	53 13 0
		Cash Balance : with Savings Bank 189 3 7 with Office 4 15 10	194 3 5
	248 0 5		248 0 5

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

BENEFICIAL IN THE COMMON INFLAMMATORY DERMATOSES

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News and Comments.

Surgical Profession: The term surgical profession is likely to sound queer in the ears of the members of the medical profession yet we could not think of any other caption to comment on the news gathered by us from newspapers. We read all the available newspapers to have an idea of what the surgeons nearly eighty of India who gathered in Madras on the 28th December and the following day said and did under the leadership of Lt. Col. K. G. Pandalai, a Surgeon of Madras. The head lines under which we read the news relating to the meeting of the Surgeons differed in each newspaper prominence being given to Surgery and not to Surgeons' Conference. Col. Pandalai was reported to have stressed the need of a Surgical Profession and that the members of the profession "should cease to be practitioners of all things at the same time". Col. Pandalai would have done well to be more explicit in his advice or expressions as his appeal was for the younger generation. The older generation in the profession have been noticing with pain the abuse of specialisation especially in India. It has been made possible for young graduates fresh from the Universities to appear for examinations either here or in British Isles and get degrees or diplomas to indicate a speciality. It may be that in a country like India where the public are not educated to the extent of understanding law of torts, the proficiency and other accompaniments of the specialists has not been questioned in law courts to the extent it is being done in Great Britain where the members of the Medical Profession felt the need for establishing "Medical Protection Societies" to defend them in courts. They say that the age of specialists known as consultants also in other civilized countries is near about fifty years. In India the specialists begin their work at present when they are thirty or very near this age. The public are guided either by the hall mark of the qualifications and more by the position occupied by the persons in State hospitals. We will not be far wrong when we mention that majority of Sur-

geons who met in Madras belonged to the latter category including the President. We have been mentioning in these columns very often that it is not desirable nor is it possible to divide the medical profession and that the surgeon is only a cutting physician. A Surgeon who is not a physician can only display the skill of a carpenter and not of a person belonging to the healing art. We wish the surgeons speak less of the dexterity or skill of having performed so many operations on the stomach, brain and other vital parts by various up-to-date methods but co-operate more with the general practitioners and share with them in the pride when the medical profession in a co-operative and co-ordinating skilful practice has found the causes of diseases which are now styled as "surgical" being beyond relief by the physician as persons suffering from majority of such diseases can hope only relief but not cure. Not only the general surgeon and the bone-surgeon but all the rest doing the cutting work be it on the eye, ear, nose and throat or those practising obstetric and gynaecology should first be efficient physicians before they take up special work. Specialists and consultants should evolve themselves as such by merit and experience and not by artificial means of examinations or accidental positions in State institutions. In this respect, the profession would do well to follow the example of Vienna where there is only one medical qualification, M. D. and only practitioners who devote their lives in study and then in writing and speaking of what they have studied and later standing the test of their knowledge before the seniormost Professors (by which name they are known as specialists or consultants) evolve gradually stage by stage as Professors. It is rather difficult to gauge the purpose of so many qualifications now in vogue in Great Britain. To follow Great Britain in this direction will be hazardous though it may benefit a few. There are well established Universities in India and the Surgeons in India will do well to co-operate with the Universities instead of starting any new enterprise.

Dr. Guruswami Mudaliyar Speaks: The affairs of the medical profession have drifted to such an extent that medical men who had a tendency for the "negative quality" of "keeping aloof" are now coming forward to give expression to their pent up feelings. Dr. Guruswami Mudaliyar who, we are told went on a pilgrimage to the Sacred temple at Trichendoor, was attracted by the Independent Medical Practitioners' Association of Tinnevely District and was the chief guest of the Association at a social held on 14.12.1939 at Palamcottah. The function was presided over by Dr. M. R. Sundaram, M.D., retired Civil Surgeon who is the President of the Independent Medical Practitioners' Association, Tinnevely. Dr. Mudaliyar in the course of his speech referred to the honorary system and made observations regarding the future of the medical profession. He said that the Honorary System which was adopted to give some training to the private practitioners and at the same time effect economy in the medical administration did not serve the purpose for which it was intended. He pointed out that the system created first 'antagonism' between the honoraries and paid staff in a hospital and now the 'antagonism' had extended between the former and the private practitioners outside the hospitals. The physician who diagnosed the disease was expected to give out the cause and a rational treatment which Dr. Mudaliyar omitted as could be seen from the newspaper report. Readers of The Medical Practitioner must be familiar to the defect in the Honorary System as pointed out in these columns very often and also the remedy which is to close the gates of the State Medical Institutions to the public who can afford treatment outside these institutions and whose gates and even their walls echo the demand of money. Government have so far not been able to find out the source from where the echo starts. A physicist of the fame of a Raman should venture to do what the Government was unable to do.

Regarding the future of the medical profession, Dr. Guruswami Mudaliyar said that the Government had now an

opportunity of extending medical relief on account of the Sale Tax which was expected to yield a handsome revenue, collected from the poor and the rich alike. Perhaps it was the idea of Dr. Mudaliyar that many private practitioners would get appointments if the medical relief was extended and the problem of unemployment in the profession would be solved to a great extent. We wonder if Dr. Mudaliyar at the time he addressed the independent practitioners remembered that the Sale Tax and other new taxes introduced by the Congress Government have been earmarked to meet the deficit in revenue due to the prohibition and even otherwise no Government in any civilized country with large resources at its command has been so far able to tackle the huge problem of medical relief by paid service. The panel system was ruled out by Dr. Mudaliyar as impracticable.

During the discussions on the speech made by the chief guest Dr. T. N. Govinda Aiyar, M.B.C.M. one of the oldest private practitioners in Tinnevely District gave out a practical suggestion for solving the future problem of employment of the members of the profession and that was grouping of 500 families in a unit each family paying a rupee a month to the medical practitioner who ran the unit for giving medical relief. We cannot appreciate the term "co-operative" used by Dr. Govinda Aiyar if it was used to indicate the Government system of co-operation which has not been a success but we could use the term 'co-operate' as it appears in the dictionary and commend the idea of Dr. Govinda Aiyar to the medical profession where the co-operation should be between medical practitioners themselves and the practitioners the profession should infuse the co-operative spirit in the lay public who should be made to realise that for a rupee they pay to the health unit they could get the benefit of multiples of a rupee if they co-operated with the medical man running the unit. In the same way specialist services could be pooled by the spirit of co-operation amongst medical men themselves.

Correspondence, Reports, Etc.

THE MADRAS PROVINCIAL SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

EXTRACTS OF THE PROCEEDINGS OF THE MEETING OF THE PROVINCIAL COMMITTEE WHICH MET IN TIRUPATHI

On 26th, 27th & 28th December 1939.

The Provincial Committee of the Madras Provincial Subsidized Rural Medical Practitioners' Association, which has a representative for each District met in Tirupati and transacted business for two days on 26th and 27th December 1939, the Working Committee of the Association having met on 25th and 26th for drafting the programme work of the Provincial Committee. On the 26th at the earlier part of the day there was an informal discussion about the affairs of the Subsidized Rural Medical Service and resolutions were drafted to be placed before the Provincial Committee the following day at its open session; after breakfast the same day the Proceedings of the Provincial Committee began and came to an end late in the afternoon on the 27th. There was an enjoyable dinner on the 27th to which were invited medical men and women at Tirupati and the mission medical staff belonging to A.E.L. Mission Hospital, Renigunta. On 28th morning the members of the Provincial Committee went up the Tirumalai Hills to have *darshan* of Sri Venkateshwar, came down that very night and dispersed.

WELCOME ADDRESS

BY

DR. R. DORAISWAMY.

Dr. Doraiswamy, subsidized practitioner of Penu Moor, Chittoor District welcomed the guests by a neat little speech. He appreciated the idea that the venue of the meeting was Tirupati, one of the most holy places in India, which would inspire the Committee to place before the Association lofty ideals of service. He stressed the necessity of

unity amongst the members belonging to subsidized service which he said would ensure successful representation. He added that the strength of the Association lay on the sacrifices made by its members which sacrifice was exhibited at the meeting by the members of the Committee coming from distant parts of the Presidency. The beginning of their united efforts, said Dr. Doraiswamy, might look like a tiny river at its source but their work would increase in scope and bulk and would look like the same river in its final course.

Relating to the work of the practitioners in the villages, Dr. Doraiswamy said, it was a thankless one. To add to this, he mentioned that the Government were pressing them to do Public Health work which was an hindrance to their legitimate work of curing. He compared this combined work to that of the proverbial drill and drawing master in the educational department. He added proportionate to the additional work demanded of them they were deprived of their emoluments whether it be during the period of training for Public Health work or after when they would have to lose private practice while on Public Health duty.

REPORT OF THE GENERAL- SECRETARY.

Dr. M. R. Bhat, the General Secretary of the Association read the report of the working of the Association from 31.3.1939 till 20.12.1939. The report explained at the outset why the Working Committee decided not to have the annual conference during Christmas as was decided at the last Samalkot Conference. Though the Committee actually did some preliminary work for the holding of the Conference in Chittoor District, the idea had to be given up on account of the war conditions which forced the then existing Government of the Province to resign. Yet another reason was stated in the report for not holding the conference and it was that judging from the activities of the past conferences, the Association had little or

no time to think of constructive work during the sessions of the Conferences which, though they added to the spectacular value did not bring much towards any constructive work for the Association. The suggestion of the Working Committee was circulated to the members of the Provincial Committee and all approved the action of the Working Committee except one member from Kistna District. The report referred to the following important changes brought about in the constitution by the General Body last year.

1. The President to have a working committee, the members of which being of his own choice from among the members of the Provincial Committee.

2. The Working Committee with the President to be the executive of the Association.

3. The annual rate of subscription for the membership of the Association and the official organ were combined and made compulsory for every member.

4. The subsidy at the rate of annas eight per member paid to the funds of The Medical Practitioner was withdrawn.

5. The contribution to the District Branches was enhanced from Re. 1/- to Re. 1/8/- per member enrolled.

6. The financial year was changed to the 1st of January to the 31st of December of each year.

It is said in the report that there are now on the roll 325 members against 269 as on 31.3.1939 just before the General Body met at Samalkot last April. One of the resolutions passed at Samalkot related to the canvassing of the members and it was resolved to request the District Branches to do intensive propaganda to canvass members and the amounts collected to be distributed between the District Branches and the Provincial Funds in the proportion of 1:2. The President suggested to the Working Committee at its first meeting that from his experience of such work in two Districts, the Association was not bene-

fitted much. Therefore he suggested to send appeals to the non-members who had been receiving The Medical Practitioner gratis informing them that one of the issues of The Medical Practitioner would be sent V. P. P. to recover the membership fee. The Working Committee approved the suggestion and by this means the strength of the Association which was 269 rose to 325. The report briefly mentions about the advantages accrued by combining the subscription of the membership and of the journal which is the official organ especially for economising the expenditure for communicating any information to all the members at one and the same time. The Journal is open to the members to express their views, apart from the scientific knowledge the members derive from its pages. The Secretary expresses his gratitude to the Proprietor of The Medical Practitioner for his response in foregoing the subsidy and supplying the journal at a concession rate. It is mentioned in the report that the change in the financial year without any specific mention of the date when the change is to take effect brought in its train certain difficulties to the executive and the President gave a ruling that this change over should take effect as from 1.1.1940. The failure of the most of the District Branches to act upon the General Secretary's circular calling upon them to hold meetings to elect their representatives to the Provincial Committee on the eve of the last Conference, compelled the President to give another ruling that the Provincial Committee which existed on the eve of the Samalkot Conference should continue to hold office. The rulings of the President on both the subjects were approved by the Working Committee at its first meeting held in Madras on 2.7.1939.

CENTRAL OFFICE: The work at the Central Office has naturally increased and though the Provincial Committee gave a discretionary sanction to the President to spend Rs. 30, a month for the payment of the staff, the work was managed at a cost of Rs. 15, a month.

ACCOUNTS: Dr. K. Govindan, Treasurer of the Association gets all help

from the President and a monthly statement of accounts showing receipts and expenditure is being published in The Medical Practitioner.

CORRESPONDENCE: Though according to the constitution all the correspondence is vested in the General Secretary, to secure speedy dispatch and avoid unnecessary expenses much of the routine is done at the Head Office and passes through it. The convention has so far worked well and it is hoped will continue to be so.

BRANCH ACTIVITIES: It is regrettable that except a few branches majority have not been very active. It will be profitable to all concerned if a monthly report is sent to the Central Office by the Secretary-Treasurers of the District Branches. It is essential the work of the branches should reflect the strength of the Association. The Provincial Committee it is hoped will chalk out a line of action to be adopted.

The Executive of the Association have been doing their best not only to increase the strength of the Association but to increase its activities also. A large number of the practitioners have received help and guidance from the Executive and there were certain cases which required the interference of the Government and all such cases have been reported in the columns of The Medical Practitioner in the form of Government Orders. The most important achievement in this direction was the kindness on the part of the Government to sanction remuneration to a subsidized practitioner in Kistna District for doing festival duty in his village which was refused by the District Board and not recommended by the concerned District Health Officer on the plea that the subsidized practitioner was not disturbed from his village while on festival duty.

REPORT OF THE TREASURER OF THE ASSOCIATION.

The Treasurer, Dr. K. Govindan in his report expressed his regret in not being able to attend the Provincial Committee

meeting due to an unforeseen domestic event. But he said that he went to Madras on the 23rd December 1939, scrutinised the books maintained in the Central Office page by page and found accounts correct after verifying each item of receipt and expenditure both of which were supported by vouchers maintained in the office. The Balance-sheet for eight months ending 20.12.1939 was, it was mentioned in the report, prepared by the Treasurer and also a provisional budget for the next official year. He expressed his gratitude to the President who took on his shoulder the brunt of the Treasurer's work as it was not possible to maintain the accounts of the Association at the transitory period of its life anywhere except at the Central Office. The report then makes mention of the V. P. system adopted at the suggestion of the President to canvass members which got 62 new members after 31.3.1939 up till 20.12.39 involving an expenditure of Rs. 26-5-3 all told. The 62 members brought to the Association Rs. 201 in addition to the collection of arrears from 45 old members. About personal canvassing by the District Branches, the report mentioned about the experiment in two districts, Malabar and Bellary which cost the Association Rs. 18-7-0 to canvass 26 members in Malabar and Rs. 8 to canvass seven members in Bellary, the expenditure claimed for being only for petrol. In the former case Dr. Kunjunni Nair, Secretary-Treasurer of Malabar District who actually spent Rs. 36-14-0 for petrol claimed only half the actual expenditure. The Treasurer commends the V. P. procedure even for collecting the yearly subscription in future. The report also mentions that there are at present 505 Allopathic subsidized dispensaries where 499 are actually working and six are vacant at the time the lists of the subsidized practitioners were received by the President from the respective districts. Out of 499 subsidized practitioners 325 are members and out of 325 members only 21 have not as yet subscribed to The Medical Practitioner and out of non-members 21 are subscribers to The Medical Practitioner and the Treasurer

hopes that if those who are already members of the Association co-operate with the Executive, it will be possible for the Association to have cent per cent subsidised practitioners on the roll as members within a short time. At the end he appeals to the President to increase his activities of doing propaganda for the Association through The Medical Practitioner.

Dr. M. Krishna Rao, Member, Working Committee and Joint Hon. General Secretary, Madras North read the report of the Treasurer, Dr. K. Govindan. The balance sheet, the provisional budget for the current official year were read item by item.

The Provincial Committee unanimously approved and passed the reports of the General Secretary and of the Treasurer on the 26th and the committee adjourned for lunch at 2.30 p.m. After lunch the President of the Association Dr. V. Rama Kamath delivered his address.

PRESIDENTIAL ADDRESS.

Dr. Kamath commenced his address by referring to the present war conditions and also the political turmoil and said that the medical profession had a serious responsibility on their shoulders in not only relieving human suffering, but also in bringing about communal harmony for which purpose the members of the medical profession were most fitted. He expressed horror that the so called civilised nations in the west have been utilising advanced scientific knowledge for destruction. It appeared to him that the western nations, at present engaged in war, had forgotten the existence of Lord Christ. He said the people in India were suffering on account of adverse economic conditions due to war and though India was outside the war zone at present the opulent merchants who had been cornering the markets had created a scare for the purpose of profiteering. Consequently the prices of even bare necessities of life had gone so high that the middle class and the poor felt it rather difficult to maintain themselves. The result would necessarily be a rise in the incidence of diseases. The fabulous rise in prices of drugs and chemicals which were imported

into the country would materially handicap the members of the medical profession, not to mention their hardship in getting remuneration for the services rendered. He deplored the helplessness of the Government in India to control profiteering as was done in the war zone where the people were protected against the greedy merchants.

It was likely, said Dr. Kamath that on account of the new mechanised methods employed for warfare there would not be a demand for the recruitment of the members of the medical profession for actual field activities to the extent it was in the last great war but the responsibilities of the medical profession had increased tremendously due to the science being made use of for wholesale murder of even non-combatant civil population. The purpose of referring to war, he said, was not to dishearten or discourage the members of the medical profession in India but to make them alive to their responsibilities. Dr. Kamath added that though it was true that the Indians were incapable of adopting brutal methods for destroying humanity by using bombers, poisonous gas through air, armoured cars, tanks on land, they had stood the brutality even from the ancient days and their stronghold was spirituality which could not be destroyed by any up-to-date methods of mechanised warfare. He appealed to the subsidised practitioners that in the exercise of their profession they should be more spiritualistic than they were during the times of peace as most of them were half-starving and likely to feel the brunt of the war conditions.

Dr. Kamath observed that the Government had been declaring that they were independent practitioners who had settled in the villages not entirely for personal gain but to make the villages healthier places to live in; yet it was an unfortunate irony that they were treated much worse than the menials whether in the service of the Government or local bodies. He added that it was not safe, not only for the subsidised practitioners but also for the entire profession to depend upon the

Government, and they should strive hard to organise themselves to be self-sufficient and self-reliant in the exercise of their profession and it was for this purpose, he said he took upon himself the responsibility of organising the P. S. R. M. Ps' Association. He felt glad that the Association was making satisfactory progress in its activities in spite of the several handicaps, the latest amongst them was the modification of the terms of the agreement which had completely changed the purpose and the object for which the Government initiated subsidised rural medical relief scheme fifteen years ago. It was not possible for the subsidised practitioners to leave the villages after having settled there for over a decade. The new agreement did not give them security of tenure for over a year if the District Boards were bent upon turning away unwanted subsidised practitioners. That was the very reason, he continued, that prompted him to direct the activities of the Association more for constructive work for making the subsidised practitioners efficient in their profession. If the practitioners endeared themselves to the village folk by concentrating their attention entirely in curing and relieving human ailments, many of their difficulties were likely to disappear and they could help the Government and the local bodies instead of depending on them. Apart from doing their legitimate duties in regard to the health of the village-folk, the members of the medical profession belonging to subsidised rural service could help the Government though indirectly in solving the present turmoil of communal and social disharmony brought about by the ambitious politicians and which the biggest among them were not able to tackle much less the Government. The members of the medical profession had exceptional opportunities of entering the households of their patients belonging to any community. Their profession was such that they could wield healthy influence over those with whom they came in contact as a Doctor was known to them not on account of his caste, much less his political inclinations. This fact had been recently acknowledged said

Dr. Kamath, by an eminent educationalist in the person of the Vice-Chancellor of the Madras University who had recently pointed out to the outgoing students of the Stanley Medical College, the responsibilities of the medical profession not only in curing human suffering but in bringing about social and communal harmony in the country. From the Viceroy down to the humblest servant of the Government, eminent socialists, politicians have been crying hoarse in season and out of season, that the salvation of the sub-continent of India depended entirely on village reconstruction and it was indeed very unfortunate that none amongst those, had realised the value of the help of the members of the medical profession practising in rural areas as an important unit in village reconstruction. In the end Dr. Kamath advised the Provincial Committee to conduct the deliberations thoughtfully, embodying constructive activities for the new year to make the subsidised practitioners more useful and efficient. He closed his address wishing the Association increased strength and a life of useful activities.

RESOLUTIONS.

1. Resolved that the reports of the General Secretary and the Balance Sheet prepared by the Treasurer be approved and adopted. Proposed by Dr. C. Kunjunnai Nair; seconded by Dr. K. V. Hari Rao and passed unanimously.
2. The Provincial Committee of the Provincial Subsidised Rural Medical Practitioners' Association resolves to express their sympathy to all who are suffering on account of war brought about by the greedy powers in the West and prays that God may give wisdom to all concerned so that righteousness may prevail in the place of aggression. Put from the chair and passed unanimously.
3. Resolved that a referendum be made to all the members of the Association in regard to the amending the memorandum and the rules of the Association as they now exist, calling upon them to send their approval or disapproval to the Central Office within a month from the date of the referendum and informing them that if no reply is received within the prescribed date, it will be decided that those who do not reply are in favour of the proposed amendments.

AMENDMENTS TO THE CONSTITUTION.

In rule 8 line 4 for the words "General Body" substitute "Provincial Committee"

COMMITTEES.

In rule 9 (a) add after "District Branch", "and the name of the Provincial Committee member be communicated to the Central Office on or before 10th of December of every year, such representative shall be the Secretary-Treasurer of the District Branch concerned and a Joint-Secretary-Treasurer who shall also be elected by the Branch shall act for him whenever necessary. The name of such Joint Secretary-Treasurer should also be intimated to the Central Office" and delete from the words "a month etc." to the end of the rule.

In rule 9 (c) add after the word "President" "one such meeting shall be convened before the close of the official year to consider the annual reports of the General-Secretary and the Treasurer and to prepare the budget estimates for the following year".

In rule 10 (a) delete "within 15 days..... Conference" and add "by the 15th of January of each year."

In rule 10 (d) for the words "once in three months" substitute "as often as necessary".

In rule 11 add after the words "Casting vote," "such decision may be obtained either at a meeting of the Committees or by circulation of the resolution among the members."

Delete Rule No. 12 from (a) to (d) clauses and add,

CONFERENCES.

12. (a) The President shall preside over the conferences which may be held annually in any one of the Districts among the following five regional areas :

- (i) South Kanara, Malabar, Salem, Coimbatore and Nilgiris.
- (ii) Tanjore, Trichy, Madura, Ramnad and Tinnevely.
- (iii) Chingleput, North Arcot and South Arcot.
- (iv) Nellore, Guntur, Kistna, East Godavari, West Godavari and Vizag.
- (v) Chittoor, Anantapur, Kurnool, Cuddapah and Bellary.

The venue and the date of the Conference shall be fixed and announced by the Working Committee.

12. (b) The Subject Committee of the Conference will consist of members of the Provincial Committee and such of the members of the Association who desire to move any resolution.

12. (c) The decisions arrived at the Conference which in the opinion of the Provincial Committee affect the constitution of the Associ-

ation shall be decided by the General Body through a referendum and the result of the referendum be announced by the Working Committee.

Delete rule 13 as it now exists and substitute in its place the following rule :

OFFICE-BEARERS.

The Working Committee shall announce a panel of three from among the members and Honorary members of the Association for the Presidentship of the following year by the 30th September of every year and the General Secretary shall communicate the names in the panel on or before 15th October each year to the District Branches which shall elect one among the three in the panel and communicate by registered post with acknowledgment that name to the Central Office on or before the 10th of December every year. The Working Committee shall then meet for the purpose of announcing the name of the President-elect of the following year. In case of two candidates getting equal number of votes the result will be arrived at by tossing. Vice-President shall act for the President.

Add to rule 14 the following:

14. (g) Travelling allowance for the representatives to attend the Provincial Committee meeting shall be met by the District Branches and that of the Working Committee members for attending the Working Committee meetings other than those that do not take place along with Provincial Committee meetings will be met from the funds of the Central Office. Proposed by Dr. M. R. Bhat, seconded by Dr. C. Kunjunni Nair and passed unanimously.

4. Resolved to bring to the notice of the Government that due to war conditions the economical conditions in the villages are seriously affected with the result that the subsidized practitioners are very much handicapped in regard to private income. Consequently the Provincial Committee is compelled by sheer necessity to request the Government to increase the yearly subsidy to Rs. 600, uniformly. It is also resolved to bring to the notice of the Government that such of the District Boards which had been paying extra subsidy to the practitioners and which were recently cut down be asked to restore the additional subsidies. Proposed by Dr. M. R. Bhat, seconded by Dr. M. Krishna Rau and passed unanimously.

5. Resolved to request the Working Committee to consider about the following proposals:

(1) Distribution of hand-bills in the villages about the duties and responsibilities of the Subsidized Practitioners making it known that only necessitous poor have to be treated free by them,

(2) organising a fund to help the dependents in case of death, temporary or permanent bodily infirmity of the Subsidized Practitioners,

(3) opening of a central medical stores in Madras to supply the needs of the Subsidized Practitioners,

(4) arranging a guest house to accommodate the subsidized practitioners or their patients when they come down to Madras,

and (5) encouraging and helping the subsidized practitioners who wish to start cottage hospitals,

and publish the report on the above proposals in The Medical Practitioner on or before June 1940. Proposed by Dr. M. Krishna Rao, seconded by Dr. M. R. Bhat. Passed unanimously.

6. As the resolutions passed at the last Samalkot Conference have not been submitted to the Government in the form of a memorandum, the Provincial Committee reiterates all the resolutions and requests the President to draft a memorandum which may be forwarded to the Government through the Surgeon-General. The Committee also resolves that in the memorandum any other matters concerning the affairs of the Rural Medical Relief Scheme which require solution be also incorporated. The Provincial Committee suggests to the Working Committee that if necessary to wait on the Surgeon-General in deputation as early as possible. Passed unanimously.

7. Resolved to request the Government that for the purpose of enquiry provided for in Clause 12 of the Agreement, to be executed by the Subsidized Practitioners the Inspector of Local Boards and Municipal Councils or his Deputy not below the rank of Deputy Collector be deputed. Passed by a majority.

8. Resolved to request the President, District Boards that in regard to the appointments of dispensary servants in subsidized dispensaries, it is desirable in the interest of all concerned that nominees of subsidized practitioners are entertained. Passed unanimously.

9. As the Government Medical Stores have increased the prices of drugs, chemicals, instruments, etc., by 20 per cent resolved to request the Government that the supply of medicines be proportionately increased so that the necessitous poor patients attending the dispensary may not suffer for want of medicines. Passed unanimously.

10. Resolved to authorise the General Secretary to print the Memorandum and Rules of the Association as amended and supply a copy of the same to all the members.

11. The Provincial Committee expresses its gratitude to the Secretary-Treasurer of Chittoor District Branch, Dr. R. Doraiswamy and his comrades for the splendid reception accorded to the members of the Committee and guests who attended the meeting. The above resolutions from 6 to 11 were moved from the chair and passed unanimously.

12. (a) The Provincial Committee thanks the Head Master, Government Training School, Tirupati for placing the school building at the disposal of the Reception Committee for the conduct of the meeting.

(b) The Provincial Committee thanks the Local Hospital Staff for co-operation with the Reception Committee.

(c) The Provincial Committee thanks the President, Dr. V. Rama Kamath for his zeal and devotion in strengthening the Association through his journal "The Medical Practitioner" and his guidance and help in the day to day administration of the Association and prays he may be spared to the Association many more years in good health to continue his activities and make every member self-reliant. Proposed by Dr. M. Krishna Rao, seconded by Dr. M. R. Bhat, and passed unanimously.

13. Resolved to depute Dr. Rajaram Rao as a representative of the Association for Anantapur District.

Proposed from the chair and passed unanimously.

14. Resolved to request the Government to treat the Subsidized Practitioners as servants of the Government in regard to their treatment in the State Medical Institutions.

15. The Provincial Committee requests the Government to sanction for such Rural Medical Practitioners doing Public Health work when deputed for Festival duty the usual allowance of Rs. 5. per day to compensate for the loss of private practice as in the case of those who are not engaged in Public Health work.

The above two resolutions were circulated and passed unanimously.

REFERENDUM.

Attention of the members of the Provincial Subsidized Rural Medical Practitioners' Association is drawn to the resolution No. 3 of the Provincial Committee appearing on page 131 of The Medical Practitioner and to the amendments suggested by the said Committee to the existing rules of the Association appearing on page 132.

The approval or disapproval of the individual members should be communicated to the undersigned on or before 29-2-1940 on which date the amendments will be considered depending upon the replies received.

V. RAMA KAMATH,
President.

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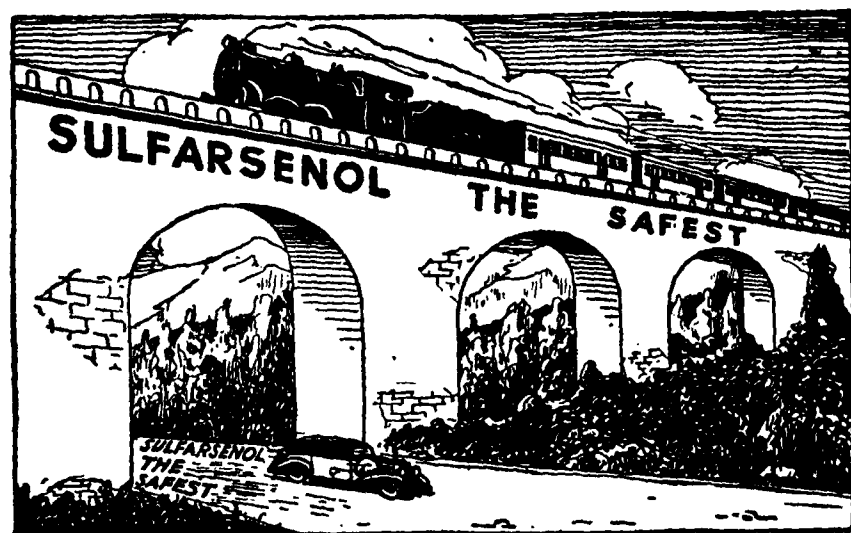
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The Medical Practitioner

A Monthly Medical Journal

EDITED BY

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Member, Madras Medical Council.

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FEBRUARY, 1940

[No. 5

Original Articles

SYMPTOMATOLOGY OF PULMONARY TUBERCULOSIS EMACIATION AND OTHER GENERAL SYMPTOMS—III

BY

DR. K. VASUDEVA RAO, M.D., M.R.C.P., (Edin.), T.D.D. (Wales),
(Superintendent, Tuberculosis Hospital; Director, Tuberculosis Institute, Madras,
& Superintendent, Tuberculosis Sanatorium, Tambaram).

(Continued from last issue).

The triad of Morton in the symptomatology of tuberculosis is (1) cough (2) fever and (3) emaciation.

Emaciation is a cardinal symptom of phthisis and it is easily recognised by the layman. Emaciation is proportional to the toxæmia of the disease. In tuberculosis emaciation is more rapid and progressive than in other acute conditions like pneumonia, typhoid, influenza, etc. This emaciation is very frequent in thin people and in children who had attacks of measles, whooping cough, etc., in whom tuberculosis may supervene. Emaciation is most frequently due to the toxic condition that is predominant and it is necessarily marked due to a certain extent of the super-imposed mal-nutrition, secondary to disorganisation of the gastro-intestinal functions.

Emaciation is mostly seen in the wasting of the subcutaneous tissue and in

the muscle fibres, in order of frequency in the muscles such as pectoral, scapular and the inter-costal waste on the diseased side. The wasting of subcutaneous tissue and the muscle fibres give rise to the characteristic hollowing of the chest both above and below the clavicles. This wasting is more marked on the side of the lesion and the contrast between the diseased and the normal is more evident, the moment the patient's clothes are removed.

The loss in weight goes hand in hand with the extension of the disease. Gain in weight is always a symptom of improvement. Except in certain cases gain in weight is always a sign of improvement and a persistent loss is a bad omen. Even when there is no persistent loss in weight, persistent stationary weight is not so good a sign so far as prognosis is concerned.

In a very few cases especially in women there is a tendency for obesity instead of

wasting. This is possibly due to the low toxicity of the disease and it is difficult to make others believe the diagnosis unless tubercle bacilli are demonstrated in the sputum. From the point of view of prognosis these obese patients are usually of a fibrotic nature and the course of the disease is slow. Even when cavitation takes place and the activity of the disease is increased, the tendency to progress is slow. Obese tuberculosis is mostly seen in women, among men who are alcoholics or those having syphilis. It is most frequently observed that these obese tubercular patients have a voracious appetite which is taxed to a large extent on the advice of the doctor.

In early stages of tuberculosis the loss in weight is imperceptible to the individual, but it is quite perceptible to his friends who observe a certain amount of thinness in the individual. Later when the disease has established itself, this becomes more marked and extreme emaciation of an advanced case of tuberculosis is always classical. During treatment when the patient is improving there is always an increase in weight, but this increase to be of value must be persistent gain for several months.

During recent years a great amount of discussion has taken place on the amount of weight that is usually allowable in tuberculous patients while under treatment in sanatoria. The old theory that they should be fattened with absolute rest is blown up as it has been found that the individuals who are discharged from these institutions are not capable of doing any hard work. Instead of turning out people who are capable of working it is found that sanatoria were turning out people who were lazy and not fit for any active work. Hence it has been observed that when patients are sent out of these institutions they should be capable of working. The standard that is usually followed in most of the sanatoria is that the patient's weight when he leaves the sanatoria must be at least 5 to 10 lbs. over his best weight in health, because when he returns to his normal work he is bound to lose a few pounds and at the end of this loss, he will

be just where he was when in his best health. With the same idea in view, namely, not to increase the rate in weight abnormally, regular exercises are always given to the patients. In addition to the so called autointoxication that takes part in these exercises, the abnormal increase in weight is also kept under control. The loss and gain in weight in a tuberculous patient is due to a certain of seasonal variance. In Madras the loss is more apparent during the hotter months of the year especially May, June, July and August and the best weight is to be seen during the months of December, January and February. That could be easily explained by the severity of the sun and also the condition of the gastro-intestinal tract during this period. During periods of every hot weather the loss in weight is more marked than during periods when the weather is not so hot. Most of the sanatoria have their own weight curves to indicate this seasonal variance.

Long before the loss in weight makes its appearance, there is a loss in the energy of the individual which is of greater importance in the diagnosis of the disease than mere loss of weight. In early tuberculosis it is often usual to see patients who towards the later part of the evening feel tired and are not capable of doing the usual normal work, e. g., a man who has finished his office work by about 4 in the evening and who plays two or three sets of tennis would feel that the moment he finishes the office work that he would like to go back home and take rest rather than play tennis. This loss in energy is especially evident in the early ages of life than in the older people and it makes its appearance long before any symptoms of pulmonary tuberculosis make themselves manifest either in the lung or elsewhere.

SWEATING: Sweating was frequent in olden days when hygienic conditions were not up to the standard. Now-a-days when institutional treatment has to a large extent taken the place of old treatment sweating has practically disappeared as a symptom of tuberculosis. Sweating mostly occurs during the later parts of the night, especially when the patient is asleep. Hence is usually termed as night sweats,

thus indicating that they occur during nights. This is not absolutely correct as sweating also takes place when the patient sleeps during any part of the day. It would be more accurate to describe the sweats in pulmonary tuberculosis as slumber sweats rather than night sweats, because it makes its appearance any time when the patient goes to bed. Usually sweating is more marked among people who live under unhygienic conditions and in people who disregard the cleanliness of the skin. Even in rich families the tendency to wrap oneself with a large number of clothes is very common. Due to excessive sweating, the skin undergoes various changes and fungi usually find a place. There is a certain amount of peculiar smell which is associated with this sweating. The smell can be compared to that of a ripe guava fruit. The sweet but at the same time acid smell is characteristic of pulmonary tuberculosis and I have noticed that whenever this smell is evident, the sputum is always positive for tubercle bacilli. This is a very useful guide in the diagnosis of tuberculosis provided one gets used to this smell. The moment the patient's conditions are changed to hygienic surroundings, the sweating automatically disappears. There is a greater amount of sweating seen in private houses than in institutions. This is to be explained possibly by the insanitary conditions prevalent more in private houses than in institutions.

From the point of view of prognosis sweating is not of very great value except when the sweating ceases abruptly, for example, when a case of pulmonary tuberculosis who has been having a fairly marked sweating every night reports that his sweating has abruptly ceased, the inference to be drawn is that the patient has got very few days to live. Sweating, as emaciation, is due to the influence of the toxic elements circulating in the blood which stimulate the sweat glands. When this stimulation is absent, sweating automatically decreases and this is absent only towards the last days before death. So from the point of view of prognosis abrupt cessation of sweating is always a bad omen.

SYMPTOMS REFERABLE TO OTHER ORGANS

Under this category are included symptoms referable to the following organs:—

1. Cardio-vascular.
2. The gastro-intestinal tract.
3. Respiratory excluding the lungs.
4. Skin.
5. Bones.
6. Lymphatic glands.
7. Nervous system.

CARDIO-VASCULAR SYSTEM: Palpitation, increased pulse rate that is tachycardia and hypotension are often present in early tuberculosis. Palpitation may be such as to be distressing and that may be the first thing to draw attention of the patient and make him seek the advice of the doctor. The presence of these three symptoms has often led to the wrong diagnosis of early cases of pulmonary tuberculosis mistaking them for cases of hyperthyroidism. Palpitation is due to the degeneration of the heart which has to work at greater speed. Palpitation has no influence on the course of the disease except when it is due to dislocation of the heart. In certain cases it makes its appearance two or three days before the onset of haemoptysis. In all cases there is a proportional rise in the pulse rate with fever. Usually there is a rise of 8 beats per one degree rise in temperature, but in tuberculosis the pulse is accelerated far above the proportion to the height of temperature. Even in afebrile and sub-febrile cases the pulse rate is far above the normal. The other very characteristic feature of pulse rate in tuberculosis is its unstability. Any slight exertion, like sitting up in bed or coughing or turning from one side to the other, may cause the pulse to rise by 10 or 15 beats.

Slow pulse is not usually seen in tuberculosis and when it is seen it is always a good sign. With rest and treatment when the patient's condition is improving tachycardia gradually improves. It may safely be said that no patient is free unless tachycardia completely disappears. In

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certain people even when the lung condition has improved and with it the general health the pulse rate does not drop down. In these people intestinal complication should always be suspected.

Blood Pressure: In the majority of cases the blood pressure is low and with the improvement in the blood pressure, the condition of the patient also improves. This low blood pressure is a very good diagnostic sign in differentiating early pulmonary tuberculosis from hyperthyroidism where the resemblance between the two is so great. In hyperthyroidism the characteristic is a high systolic pressure with a low diastolic pressure resulting in a huge pulse pressure whereas in pulmonary tuberculosis both pressures are low and the pulse pressure is never more than 30 or 40 m.m. When blood pressure is higher than the usual one for the age it is not safe to make a diagnosis of tuberculosis unless certain other conclusive symptoms are present such as consolidation, or tubercle bacilli in the sputum. As the condition gets worse the blood pressure naturally falls down. Patients with a diastolic pressures less than 60 are not good subjects for any chest surgery. Rise in blood pressure is always favourable indication of improvement.

GASTRO-INTESTINAL TRACT:—In some cases of early tuberculosis gastro-intestinal derangement sets in leading to loss of appetite, indigestion or vomiting. There is no one sign which could be said to be pathognomonic of tuberculosis. But any sign or symptom of the gastro-intestinal tract which sets in abruptly in a healthy individual for which no other cause can be attributed should be looked upon as of tubercular origin. On the other hand there are certain cases in whom the gastro-intestinal tract is not involved throughout the period. In fact in a few cases there may be a greater amount of hunger than before. The loss of appetite in many cases of early tuberculosis is of a special type. This point is of immense importance in the diagnosis of certain acute conditions which simulate tuberculosis, like typhoid fever, pneumonia etc. In acute conditions like—pneumonia

and typhoid there is complete abhorrence of food whereas in cases of tuberculosis in spite of anorexia there is a certain amount of craving for food. Another characteristic of the appetite in pulmonary tuberculosis is that it is of a capricious nature. Different kinds of foods being asked for every day and if the same food is supplied a second time the patients resent. Certain types of foods are disliked by these patients especially fatty foods and milk. This possibly may be due to a certain amount of forced alimentation by the physician the patient, being over fed with eggs and milk.

Diarrhoea, constipation or certain amount of pain in intestines—occasionally may be the evidence of tubercular disease of the intestines and may be the first symptom to appear in an individual. Constipation is not uncommon in the early stages of tuberculosis. Distension of the abdomen and pain after food etc., may be indications of tuberculosis of the intestines. It can be said roughly that any intestinal symptom without obvious cause must be looked upon to be tubercular.

RESPIRATORY: Pleura:—Disease of the pleura may be the first symptom of tuberculosis. In this connection remember the onset of pleurisy. It has been estimated that about 50 to 60 per cent of cases of pleurisy are tubercular in origin. The rest of them are not tubercular. It would be safe to treat all cases of pleurisy as tubercular because in the course of about five years a large majority of these cases show symptoms of pulmonary tuberculosis.

Larynx:—Weakness of voice or a certain amount of mild type of laryngitis must be looked upon with suspicion. It can safely be said that primary tubercular laryngitis is practically unknown. The first symptom to draw the attention of the patient or doctor may be the huskiness or hoarseness of the voice. Certain other diseases like chronic catarrh, naso-pharyngeal disease, respiratory diseases, syphilis, malignant growth may give rise to the same condition. But the predominant characteristics of tubercular laryngitis are its very insidiousness onset the symptoms

being worse in the early hours of the day especially during cold weather. When ulcers have occurred the voice becomes completely hoarse throughout.

LYMPHATIC GLANDS: Enlargement of lymphatic glands especially in the cervical region which could not be explained by any other reason must be looked upon as tubercular. Because it is through the lymphatics that tuberculosis spreads. The size of the lymphatic gland is no indication of the extent of the disease and the smallest gland has as much a significance as a large one. The old saying that the presence of tuberculous glands is a sure sign of there being no lung trouble or in other words tuberculosis of the lung and tuberculosis of the glands are at opposite ends is not correct. I have seen many cases where tuberculosis of the glands is present with tuberculosis of the lung, though to a certain extent there may be a tendency to great chronicity in people who have large glands.

SKIN: Tuberculous conditions of the skin may make themselves appear in various ways. The most frequent of them are so-called tuberculides. The appearances are almost suggestive of a syphilitic lesion. Sometimes they are suggesting of acne. These are usually present either at the back of the palms or over the face. Occasionally you find that they may be all over the body. Harpes may sometimes make its appearance as a symptom of tuberculosis.

NERVOUS SYSTEM: Neurasthenia or hypochondria may be the first sign to show itself and a large majority of neuras-

thenics are said to be tubercular. Occasionally they develop to melancholia. The hopeful outlook the so called optimistic outlook of tuberculous patients does not make itself appear in the early stages of the disease and hence it is of no use in the diagnosis. Later when lesions have advanced to a marked extent these mental conditions may manifest.

GENERAL: Menstrual Disorders: In women delayed or absence of menstruation is always a suggestive symptom of tuberculosis especially in persons who have just attained puberty.

Fingers: Clubbed fingers is an indication of a fibroid condition. Clubbing of fingers are present in other diseases also as in bronchiectasis, chronic heart diseases or chronic pulmonary disease. When present they always indicate chronicity and the rapidity of the onset of clubbed fingers is always a useful point in the prognosis of the disease.

Ischio-rectal abscess is most frequently said to be of tuberculous origin, and the presence of ischio-rectal abscess is always suspicious of some lesion in the lung also. The old conception that radical surgical treatment of ischio-rectal abscess is risky in a patient suffering from pulmonary tuberculosis is not correct. On the other hand the best thing to do in a case of ischio-rectal abscess is to examine him thoroughly for the presence of lung and intestinal tuberculosis and treat him according to indications.

Blood: Examination of blood by itself is not of much use in the diagnosis of the disease but it is of very great importance in the prognosis of the disease.

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IS PHTHISIS A SPECIALIST'S DISEASE ?

By

A General Practitioner.

These two years when Her Excellency Lady Linlithgow has assumed the role of the First Lord in the campaign against Tuberculosis and is making the public and the medical profession feel their respective responsibilities to combat the scourge, the whole of India from Himalayas to the Cape Comorin has been showing signs of activities to co-operate with Her Excellency in her efforts to prevent and cure Tuberculosis. Unlike other civilized countries India has her own history for the development of medical science and she is as dependent even in this respect as she is in other aspects of nation building activities and it is not a surprise that the medical profession should find a lead outside its own fold for its evolution and demonstration of its usefulness to the public.

From the forecast of the census which was recently published in the lay press, it is presumed that the population of India is likely to be nearer 400 millions and the special workers in Tuberculosis estimate the tuberculosis infection from 50 to 75 per cent of the total population. They also declare that climate, food, race, social environments and such and similar conditions have nothing to do with the origin and spread of the disease as such though they may tell upon the progress of the infection. This should convince all concerned about the seriousness and magnitude of work that lie before the public, the authorities in charge of the welfare of the public and the medical profession who are the actual instruments to work out any schemes in regard to the health of the people. Under these conditions can Tuberculosis be a specialist disease to be controlled by only specialists unless all the general practitioners turn out to be specialists?

I was once an active general practitioner and it was my lot to exercise my profession both amongst the destitute

poor and the affluent rich though the patients belonging to the latter category were very few and far between. As a medical student I had to learn many things by negative methods. The materials for clinical study were such that things like X-ray were unknown and the microscope was a luxury. All the same I was fortunate to have a teacher in medicine who insisted that medical students should have a very good knowledge of normalities to enable them to note abnormalities with precision. My additional luck was that there were in my class a large number of failed F. As whose general knowledge was far above the standard required for entrance into the medical schools. My association with the students of a medical college was yet another factor to compel me to know more than it was required for a medical school standard. Malaria was rampant in the city where the medical school and colleges situated. Open gutters and other conditions of bad hygiene could be seen in the city to a larger extent than now. So sore throats with persistent cough were in large numbers at the time and many such cases were admitted by the staff of the out-patient department, the diagnosis being marked as "bronchitis". My medicine teacher was a faddist and a severe critic. He diagnosed malaria by the history of fever and confirmed it by palpating and percussing the splenic area. There was no microscope in the hospital though it was indented at the time the school emerged out of the medical college. I saw it in the hospital a few months before I had to appear for the final examination. So the students as well as the teacher had to depend entirely on clinical history and examination of the spleen for diagnosing cases of Malaria and our teacher could feel an enlarged spleen so confidently that he used to din into our ears that if a spleen could not be palpated it is not enlarged, every patient suffering from Malaria had an enlarged spleen and that a spleen that

could be felt at the costal margin was enlarged four times its normal size. He would occasionally add that very few doctors take the trouble of learning the simple art of feeling a spleen. He would actually swear at medical men who prescribed the hospital expectorant mixture for cough due to sore throat and made every student to examine the chest of the patients thoroughly before the throat was touched with tannate of glycerine. If a student took first in his hand the stethoscope when he was asked to examine the chest of a patient he would be made to repeat, Inspection, Palpation, Percussion and Auscultation a dozen times and made to put the stethoscope into his pocket till its turn came. Having been trained in a rigid fashion in a teaching institution which could not afford to have even a single microscope, leave alone the other paraphernalia, I and my fellow students were forced to depend upon our senses only for the examination of diseases of the chest and we depended upon what we learnt in the school even after we entered the profession. Students of medical schools and medical colleges of later generation who have been general practitioners did nothing more than what we did though they could handle microscopes and might have visited the X-ray institutes. I mention all this to impress the readers that we made a necessity a virtue and this virtue stood us in good stead. The present tendency is to depend entirely on laboratory tests and X-ray and the virtue of training the senses is dwindling to a dangerous extent. I cannot for a moment deprecate the value of Bacteriology or Radiology in the diagnosis and treatment of tuberculosis of lungs. The generality of the practitioners cannot afford to have the benefit of the latter aid for diagnosis and so every practitioner should be well up in the diagnosis of diseases depending upon his observations arrived by the use of his senses which require a good deal of training and cannot be neglected. The laboratory and X-ray have their own value which cannot be underestimated.

The readers of The Medical Practitioner must have read in its columns the

authoritative statements made by the authors who recently contributed articles on Pathology, Bacteriology, and Radiology, in the lung tuberculosis. They said that in spite of typical pathological picture caused by the tuberculous infection, the tubercle bacillus may be absent in the sputum till late in the course of the disease and that X-ray cannot detect tuberculous lesion in the lung unless the lesion of consolidation is over 4 millimeter in diameter and that many a time the radiological findings could not be confirmed without a clear clinical history.

There is a scare at present that Tuberculosis of lungs has to be treated only by a specialist in a special institution and the moment a practitioner diagnoses or even suspects a case as tuberculosis, the patient gives up the general practitioner and runs to the specialist. It is not quite so easy to approach a specialist nor to get admission in the special institutions. These institutions are crowded and the waiting list is usually over full, with the result that patients neglect themselves all the while waiting and waiting at times perhaps till death. In the meanwhile they crowd to stations where the special institutions are situated and spread the infection.

Almost all the eminent authorities in Tuberculosis attained such position by practice and study and not by passing special qualifications which are of recent origin. The magnitude of Tuberculosis infection in India is such that all the available qualified medical practitioners should be capable of diagnosing and treating the disease at an early stage before the patient feels the effects of infection and before the case turns out to be an open one. The stage when surgical methods of treatment of Pulmonary Tuberculosis have to be resorted to, though assuring in selected cases, are far less economic and risky to a great extent. The aim especially in a poor country like India should be to launch an extensive campaign so as to prevent the disease to reach a stage requiring surgical treatment and for this purpose, the general practitioner should be en-

couraged to treat cases of tuberculosis and he should be given intensive training while at the College or School to diagnose cases of early tuberculosis not neglecting the use of his senses for his observations and using laboratory methods and X-ray for confirming the opinion arrived at by physical and clinical examination. In the meanwhile such of the practitioners who take interest in the treatment of tuberculosis should start private hospitals and co-operate with the existing special institutions so that the patients in the waiting list might be taken care of and

the spread of the infection prevented. They should requisition the help of the specialists working in the well established institutions in the mutual interest of the patients, the general practitioner and the specialist. Such a team work will eventually establish that Tuberculosis is not a specialist disease and if it is so every general practitioner can claim to be a specialist.

If the Editor permits me I may contribute an article on Physical Examination of the chest in Pulmonary Tuberculosis.

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XVI ALL-INDIA MEDICAL CONFERENCE, LAHORE.

Extracts of Proceedings,

27th, 28th and 29th December, 1939.

ADDRESS

BY

DR. DAULAT RAM, M.B., B.S.,

Chairman, Reception Committee.

Dr. Daulat Ram while welcoming the delegates referred to the fact that the All-India Medical Conference met in Lahore for the second time within a decade and said:

"During the sessions of the Conference, you will be called upon to apply yourselves to many problems, professional, social and medico-political, and I would not attempt to anticipate your deliberations. There is, however, one question which is uppermost in my mind and which I cannot resist the temptation of giving expression to. I refer to the economic position of the medical profession which lies at a very low ebb and is indeed getting lower every day. It is argued by some that the medical profession is not a money-making profession or that its votaries must work in a missionary spirit. These are certainly the highest ideals, but, to my mind, gone are the days of yore when the village teacher, i.e., the Moulvi was the giver of all wisdom, and the village doctor i.e., the Hakim was the purveyor of all health. Today, things are different, and metaphysical considerations have a very limited appeal. Spiritual attainments have lost their value, and standards are set by mere materialism. Economics have become the hub of life round which the ability, wisdom and honour of an individual revolve. And yet, it is in this respect that the medical profession has lost its ground. Conditions are so well known that they need not be repeated; yet they are so urgent that they cannot be over emphasized. They have also been brought home to us even by outside observers like Dr. Anderson, the Secretary of the British Medical Association, and Colonel Phipson, the former medical head of the Aden Colony. Is not it an irony

of fate that, though the problems are so chronic and serious, we have so far failed to find a solution? It is either that we have not hitherto sufficiently realized the gravity of the disease, or that we have not yet developed enough determination to effect a cure, or else that we have not so far discovered the right remedy. If the delegates from the different corners of India, assembled here, in their collective wisdom and combined resolve, succeed in showing the torch to the profession, the Lahore Conference will have made great history. To me, the panacea of all our ills is the introduction of the panel system of practice such as exists in most of the Western countries.

There are other important questions too, like the uniformity of medical education, public health, rural medical relief, indigenous systems of medicine, medical preparedness in the emergency of war, etc., etc., which still await solution. These will, certainly, loom large in your deliberations, and I do not propose to burden you with my views at this stage. I would only advise that mere paper resolutions will not carry us a step further. Words will have to be backed by action before any result is achieved, and whatever resolutions we pass at a conference must become our war-cry during the year. Here, I would like to refer to a matter of very deep gratification to the entire medical profession in the country, that, for the first time in the history of India, we have, as the President of the Indian Medical Council, one of our colleagues of the independent profession, and also a leader of great eminence, Dr. Bidhan Chandar Roy. We hope that under his able guidance and stewardship, the profession will achieve that efficiency at home and that honour abroad which was promised to us at the inauguration of the Council.

These annual conferences have become important milestones in the growth and

development of the Indian Medical Association under whose auspices they are held every year. It is sadly true that the Association has not yet achieved anything momentous or tangible in the various fields of its activities, but, let it be remembered, that institutions, like individuals, have also their periods of childhood. This period is essentially one of growth and evolution, and, from that point of view, the Association presents a record of which any child should feel proud. Whatever fraternity and fellowship we see in the profession today is all due to the efforts and labour of the Indian Medical Association. In this connection, I am glad to be able to say that the Punjab, in general, and the Lahore Branch, in particular, has always been in the forefront of its activities. It is the Punjab alone of all the provinces that has held nine annual provincial medical conferences. In this respect, it beats even Bengal which is the home of the Association. Again, it is the Punjab which has got the largest number of branches except only the United Provinces. Before judging the work of the Association, let it also be remembered that an Association is nothing but a collection of men and women joined together for a common purpose. It is like a biological entity—the more strength its individual units put into it, the stronger it becomes. There is still a great apathy on the part of medical practitioners to join the Association, and this is well reflected in the fact that, out of about 30,000 practitioners in the country, the Association claims only about 4,000 as its members. The Indian Medical Association must become the banner under which every medical man and woman, of whatever caste, creed, or colour, must muster. Then and then alone, it can become a virile body with that power which commands and that strength which conquers. I long for the day when such a Conference as this will be designated not as The All-India Medical Conference but as "The Conference of the Indian Medical Association."

I do not wish to pursue the usual practice of a long speech. Originally, I intended to follow in the footsteps of the late Doctor Ansari of revered memory

whose whole speech, as Chairman of the Reception Committee of the XII All-India Medical Conference held at Delhi in 1935, consisted of a few words of welcome only and nothing else. Such a brevity from a lesser man like myself would, perhaps, savour of rudeness. At the same time, I do not want to stand longer between you and the President. I, therefore, close by welcoming you once again in our midst. The city of Lahore is a fast developing town, and bids fair to rank with the presidency towns of Calcutta, Bombay and Madras. While it has its attractions, it has also its distractions, none the less being its severe December winter. We have tried to make arrangements for your stay as comfortable as we could, but it is possible that there may be shortcomings, or that we may not have been able to meet at the requirements of delegates from different climes. On behalf of the Reception Committee, I beg to crave your indulgence.

PRESIDENTIAL ADDRESS

By

DR. BHUPAL SINGH, B.A., M.B.

Dr. Bhupal Singh began his address by expressing his appreciation of the honour done to him by being elected to preside over the Conference which position, he said was the highest honour that the profession could bestow on an individual. He referred to the world war and said that the profession should be prepared to render service ungrudgingly. He pointed out that aerial warfare being a special feature it was incumbent that the members of the medical profession should train themselves in air-raid precautions so that they may be of help when emergency arose. He referred to the two pamphlets published by the Indian Medical Association one for the use of medical men and the other a house-hold guide for the public and suggested to the Association to draw up a practical scheme for training members of the profession in A. R. P. He gave out that the Government of India were preparing a scheme for emergency military service in the cadre of I. M. S. and I. M. D. and desired that the Government should pay the emergency services

the same pay drawn by these two services in the permanent cadre, a liberal gratuity being fixed for the emergency officers at the termination of their services.

MEDICAL EDUCATION: Regarding medical education in India he referred to the existing two grades of medical education one the graduate course controlled by the Universities and the other licentiate course controlled by the local Governments. He said that the respective superiority and inferiority complexes had been the cause of dissensions in the medical profession. He pointed out that in spite of persistent agitation by the leaders of the profession, the provincial Governments could not be induced to do away with the medical school education but he was glad to mention that soon after the Congress took up the reins of Government in some provinces, Dr. Rajan, the ex-Minister of Health of Madras was the first to abolish school education and to establish one uniform standard of medical education in the Madras Presidency. Dr. Singh added that the lead given by Dr. Rajan in Madras was followed by Mrs. Vijay, Lakshmi Pandit, the ex-Minister of Health, U. P. and that it was likely that other provinces under the Congress would have followed suit but for the present crisis.

POST-GRADUATE EDUCATION: Dr. Bhupal Singh deprecated that unlike in other civilised countries India had no facilities for post-graduate education and said that the D. T. M. course of Tropical School of Medicine, Calcutta, the D. P. H. diploma of the All-India Institute of Hygiene and the L. O. course of the Madras Medical College were the only three post-graduate courses now available in India. He suggested that the Universities should introduce special qualifications for the various branches of medical science and that it was a good idea to establish a post-graduate College in a central place like Delhi. Dr. Singh complained that suitable teachers with merit and experience were not found in the present teaching institutions, preference being given to the members of the service especially the I. M. S. and he condemned

strongly the policy of the Government in reserving specialists appointments to the British members of the I. M. S. He pointed out the necessity that the teachers should only devote themselves to teaching work only and should not have temptations to engage themselves in private practice which was likely to distract their minds.

MEDICAL RESEARCH: The President said that the Medical Research in India was a special preserve for the benefit of only those in Indian Medical Service. He pointed out the necessity of associating research with teaching institutions where capable and ambitious young men should be prepared to devote themselves to research.

MEDICAL AID: Dr. Bhupal Singh opined that the provision for medical aid was wholly inadequate in India and complained that the hospitals and dispensaries established by Government were understaffed and ill-equipped and did not come within the confidence of the people. He said that as the management of hospitals was kept too much under the officials, the public did not show any zeal to contribute towards the maintenance of charitable medical institutions with the result that the medical administration was top heavy, a large amount of money being spent for the pay of the staff and not for actual medical relief. To popularise medical relief he advocated that the hospital management should be entrusted to non-official committees and a large number of independent medical practitioners should be employed to do honorary work in the hospitals. He wished that the Indian Medical Association should institute schemes such as the National Health Insurance service to serve the public at large. He felt disappointed that the Association did not do any constructive work in this direction. He said that the rural areas should have dispensaries within five miles radius depending upon population and other circumstances and suggested that a cess might be levied for this purpose on village population. He appealed to the Association to draw up a practical scheme for rural medical service to be placed before the Government.

PUBLIC HEALTH: The President regretted that in spite of efforts on the part of the Government, epidemics such as Cholera, Small-pox played a havoc and the toll of deaths due to Tuberculosis was very heavy and it was therefore desirable from the point of view of national health that the Government should be more liberal in their expenditure for public health measures. He appealed to the medical profession to co-operate with Public Health Staff.

INDIGENOUS SYSTEMS OF MEDICINE: Dr. Bhupal Singh admitted that due to want of encouragement these systems could not expand to the level of scientific systems. He pointed out that though attempts were made to revive these systems on a scientific basis as in Delhi and Benares by establishing special Colleges, such as the Tibia College in Delhi and the Ayurvedic College at the Benares Hindu University much more had to be done to modernise the indigenous systems.

INDIAN MEDICAL SERVICE: In regard to this service Dr. Bhupal Singh made trenchant remarks and traced briefly the origin and growth of this service which he said though originally meant for the Indian Army, was gradually developed to such an extent that almost all the posts in hospitals and other medical institutions became the close preserve for this service and after the last great war a special war reserve was established which was actually serving now the civil population. He narrated that after the introduction of the Government of India Act of 1935 the I. M. S. service was expanded and special rights and privileges were bestowed upon the service for the ostensible purpose of providing a war reserve and for the medical relief of European population but actually the Secretary of State for India did utilise "his special powers to entrench the I. M. S. securely in the civil departments of the State". He pointed out that even in the new policy adopted by the Secretary of State, the Indian I. M. S. did not enjoy the same privilege as their European brethren as the basic pay of this service was reduced and the oversea

allowances which were as good as pay were increased with the result that the European in the service was benefitted more than the Indian. He concluded by saying that the only remedy for this ill was the transfer of power of the Government into the hands of the people of India. He made it clear that his remarks against the I. M. S. were aimed against the Government policy and not on the members of the service amongst whom he counted many good friends.

MEDICAL COUNCIL OF INDIA: This Council, declared Dr. Singh, was established to placate the General Medical Council of Great Britain in spite of the opposition by the medical profession in India. He referred how the idea of an all-India medical register without the medical licentiates in it, was stoutly opposed with the result that the maintenance of a Register by this Council was given up. He regretted that in spite of persistent agitation, it had not been possible to bring the medical schools within the purview of the all-India Council. He welcomed the unanimous election of Dr. B. C. Roy as the President of the Council and confidently hoped that during his regime matters would change for the better.

UNEMPLOYMENT: Dr. Singh was of opinion that unemployment among the medical men was mainly due to the defective distribution of available qualified medical men who naturally preferred to settle in urban areas with the result that many could not get on well. He said that the unemployment could be relieved to a great extent if facilities were provided for the members of the profession to settle in villages by offering them suitable subsidies. At the same time he pointed out that subsidized service was not a success in the provinces where it was introduced.

DRUG INDUSTRY: Dr. Singh said that it was shameful that India had to depend for medical and surgical supplies on foreign countries and that in spite of the experience gained by the profession and the people during the last war no persistent efforts were made in this direction to make India self-reliant. He said that

there was a great opportunity on account of war to encourage Indian firms to take the place of foreign manufacturers for the supply of the necessities to the profession. He pointed out that the Indian Medical Association had a great responsibility in this direction and suggested the appointment of committees to devise ways and means to make India self-sufficient in regard to medical and surgical requirements of the profession.

INDIAN MEDICAL ASSOCIATION: The President concluded his address by referring to the activities of the Association which was started with a small membership and which was now showing signs of life due to the untiring efforts of its General-Secretary, Dr. K. S. Ray. He said that within a period of eleven years the Association could count as many as 117 branches distributed all over India and could claim in its fold all classes of medical men graduates, licentiates, servicemen and independent practitioners. He appealed to the profession that the Association deserved the support of every member now existing in the profession. He eagerly wished that the Indian Medical Association in India should take the place of B. M. A. He informed that at least one provincial Government in India, i.e., the U. P. did recognise the representative capacity of the Indian Medical Association and officially recognised the same as the Advisory Body to be consulted by the Government in all matters concerning the medical relief and public health and expressed his gratitude to Mrs. Vijaya Lakshmi Pandit, the ex-Minister of Health, who was responsible to recognise the Association and expected that in course of time other provinces would follow suit. Before closing his address Dr. Bhupal Singh appealed to the members of the Association that it was necessary for every one of them to respect discipline without which no organisation could flourish. He said that the local branches of the Association sent representatives to the Central Council and all matters relating to the Association were decided upon by the Central Council depending upon the votes of the majority in the Council. He added

that some of the decisions arrived at by the Council might not be agreeable to a particular branch but it was desirable that the branches should respect the decisions arrived at by the democratic representative Central Committee which was in charge of the executive functions of the Association. He appealed to the delegates that they should frame resolutions of a constructive nature dealing with subjects of public utility.

RESOLUTIONS.

1. The Conference urged the Central and Provincial Governments to encourage the growth of factories in India for the manufacture of heavy chemicals, pharmaceuticals, drugs, surgical requisites, hospital equipments, instruments and other medical requisites. The Conference opined that unless measures lasting for several years were vouchsafed by the Governments it would be difficult to prevent dumping of drugs, chemicals, etc., at low prices by the huge foreign combines after the cessation of war.

2. By this resolution the Conference pointed out that even though stocks were available, manufacturers and importers of drugs and chemicals etc., raised the prices even over 200 per cent and urged the Government to take immediate steps to prevent the hoarding of materials required for the treatment of patients by whole-sale and retail dealers and make it penal to raise prices beyond a certain rate prescribed by the Government in consultation with the representatives of the Indian Medical Association.

3. The Conference suggested to the Central Government the appointment of a Committee to report within two months on measures to be taken for the development of drug industry in India and urged the necessity of having a representative of the Indian Medical Association in the Committee.

4. The Conference strongly urged that in the proposed medical college to be started at Delhi, Indian medical men with the necessary qualifications should be appointed as there was no dearth of

such medical men in India and protested against the appointment of non-Indians to some of the posts in the said college.

5. By this resolution the Government of Sind, N.W.F.P. and Delhi were urged to establish Medical Councils in the respective provinces on democratic lines.

6. The Conference appreciated the action taken in some provinces to improve the standards of medical education and hoped that other provinces would follow suit.

7. Medical Practitioners were advised by this resolution to observe at least one half day (preferably Sunday) as a holiday and further recommended the necessity of their having at least 15 days holidays during a year.

8. The Conference recommended to the consultants the observation of ethics not to visit patients whom they first saw in consultation with practitioners unless on an emergency or on the special written request of the practitioners.

9. The Conference deplored the policy adopted by several Insurance Companies in lowering the fees for medical examination and called upon the members of the profession not to examine cases unless the minimum fee was Rs. 8 or above.

10. By this resolution the Conference recommended to the authorities running hospitals to introduce Almoner system for the admission of patients into the hospitals so as to prevent the abuse of the rich patients taking undue advantage of hospital facilities.

11. The Conference deprecated the prevailing custom of the practitioners including consultants giving free professional advice to those who could afford to pay for advice and requested the local branches of the Indian Medical Association to fix a minimum fee to be charged for a consultation.

12. This resolution called upon the practitioners to obtain necessary training in the prevention and treatment of poison gas and air-raid casualties and pointed out the necessity for organising to meet war emergencies in co-operation with the existing organisations.

13. The Conference denounced the habit now prevailing in the profession to prescribe proprietary medicines indiscriminately and advised that as far as possible pharmaceutical preparations should be prescribed, preference being given to Indian products.

14. The Conference disapproved the proposed action of the Government of Sind to group the qualified and unqualified practitioners in one and the same Register and suggested the desirability of having a separate Register for practitioners of indigenous systems of medicine who should be registered after they passed an examination held under a Board of Examiners approved by the Government.

15. The Conference pointed out by this resolution that paid medical officers should not be allowed to have private practice on the hospital premises, the total fees charged for patients in the hospitals being credited to the funds of these institutions.

16. The Conference requested the Medical Council of India to suggest amendments to the Council of India Act of 1933 basing on the recommendations made by the Indian Medical Association so as to urge the Central Government to give effect to the proposed amendments. The Central Council of the Association was requested to take necessary steps in this direction.

By resolutions 17 and 18 the Conference thanked all concerned in making the Conference a success and also the manufacturers who entertained the Conference.

NOTICE.

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

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ALL INDIA MEDICAL CONFERENCE.

Under the auspices of the Indian Medical Association, the 16th All India Medical Conference was held at Lahore during the last Christmas. The extracts of the proceedings are published elsewhere. Dr. Daulat Ram, Chairman, Reception Committee said that he did 'not wish to pursue the usual practice of a long speech' and he actually did so. He concerned himself with the 'serious' and 'chronic' problem of unemployment in the medical profession and rightly deplored that the profession did not discover the right remedy' and suggested that 'the panacea of all ills in the profession would be the introduction of panel system of practice. He referred to the unanimous election of Dr. B. C. Roy as the first non-official President of the Medical Council of India and hoped that under his guidance the profession would achieve "that efficiency at home and that honour abroad which was promised to us at the inauguration of the Medical Council of India". The third topic of his address was an appeal to the profession to join the Indian Medical Association in large numbers and he longed for the day when the All India Medical Conference would be designated as the Conference of the Indian Medical Association.

The President of the Conference, Dr. Bhupal Singh dealt with eleven subjects concerning the profession beginning with medical education and

ending with the Indian Medical Association. He set down his feet in the same grooves left by his predecessors and repeated what they said about the affairs of the medical profession without showing a lead or a solution to any of the problems. We wish the yearly Conferences held by the I. M. A. attempt to have to their credit one achievement for the year which benefits the medical profession as a whole. All the energies are wasted in attempting to do impossibilities such as their activities against the Indian Medical Service knowing fully well, as mentioned by Dr. Singh in his address, "that these wrongs can only be remedied when real political power passes into the hands of our people".

Both the Chairman, Reception Committee as well as the President complained that the strength of the Indian Medical Association was somewhere near 3,500 though there were 30,000 qualified practitioners in India. But they failed to diagnose the cause of the apathy of the practitioners to join the Association. Throughout India there is a cry of unemployment in the profession as referred to by Drs. Ram and Singh. At the same time it cannot be said that there is no work nor fields for work. It is not quite correct to say that the medical profession is overcrowded just at present. But it may be safely said that neither the leaders in the profession nor the Government have been feeling their responsibilities to the public and to the rank and file in the profession. The first and foremost concern of all

who are interested in the profession should be to induce the State to close the doors of hospitals against those who could afford treatment in their own houses. We have been repeatedly dinning into the ears of the Government the necessity of this reform and the Madras Government did appoint an almoner as an experimental measure at the General Hospital, Madras, but prescribed such duties to him which were not expected of an almoner. In addition the Government did the fundamental mistake of choosing a person from the rank of the Sub-Assistant Surgeons. It was no surprise that the experiment failed miserably. In the meanwhile the newly appointed almoner fell ill and this worked as an immediate excuse to discontinue the office of the almoner. We are glad to observe that for the first time in the history of the All-Indian Medical Conference, the idea of introducing almoner system was conceived by the Indian Medical Association at the last conference and we wish that this useful decision of the Conference takes a definite shape. There is now a tendency throughout India for the substitution of paid service by honorary service and the President of the Conference did make a reference to this as did his predecessors and we have to warn all concerned that unless the admission into the hospitals is controlled by almoners of the right type, the honorary system will soon come to disrepute and more rapidly than the paid service did for obvious reasons and there will be an agitation in favour of paid service in the near future. Hand in hand with the restriction of indiscriminate admission into the State hospitals attempts should be made to cater to the needs of the public in regard to medical relief dependent upon the capacity of payment and not on the quality or quantity of work rendered. The Chairman, Reception Committee,

ought to have placed before the Conference a concrete scheme or at least a skeleton of a panel system suitable to India and if the Conference seriously sat at this work for three days and did nothing it would have done a good service to the profession. This question has been engaging the attention of some associations and individual members of the profession in the Madras Presidency and none could find a solution for want of encouragement. A feeling has been rampant everywhere whether it is in urban or rural areas amongst the members of the profession that the Indian Medical Association has not attempted to do more than what the humbler fraternities have been struggling to achieve.

Drs. Singh and Ram confidently hoped for better times to the medical profession during the regime of Dr. B. C. Roy as the President of the Medical Council of India. We did express in these columns soon after his election to the exalted position that Dr. Roy occupies an unique position being an eminent member of the medical profession and as prominent a politician occupying a place amongst those in Congress High Command. As the medical licentiates are admitted as members of the Indian Medical Association we presume that the 'efficiency at home' referred to by Dr. Daulat Ram in his address is applicable to the medical licentiates also. Dr. Bhupal Singh recollected amongst other things relating to the past agitation against the Indian Medical Council Act, the necessity of 'bringing the existing licentiates on the register.' On our own part we cannot make a secret of the views of at least a few leaders controlling the Indian Medical Association that it was their opinion that only such of licentiates who had training of the standard to be prescribed by the Medical Council of India might be brought within the purview of the Medical Council of

India. Now that the Medical Schools are abolished in the Madras Presidency and there are half-hearted or sincere attempts in other provinces to follow the lead of Madras, it may be argued that no good purpose would be served in bringing the medical licentiates under the purview of the Medical Council of India and there is a broad hint to this effect in the Report of the Indian Medical Association for the year 1938-39. All concerned conveniently forget that the very purpose of Medical Acts is to make the lay public know who is qualified and who is not and not to give publicity to the standard of medical qualifications. There is no use of hiding the fact that the sympathy shown towards the licentiates regarding this matter by some members of the profession who are recognised by the Medical Council of India, is luke-warm and in some instances deceptive. Yet we shall wait and see what initiative Dr. Roy takes in this matter and how far his colleagues especially such of them who are members of the Indian Medical Association co-operate with him.

If the Indian Medical Association concentrates its activities this year under the leadership of its President entirely on the two vital questions, one finding employment for the profession, other getting recognition of the licentiates by the Medical Council of India we can safely prophesy that the membership of the Association will grow double its present strength within one year and time will not be far that the Indian Medical Association in India will take the place of the British Medical Association in Great Britain. All other items mentioned in the presidential address will also find solutions with little or no efforts excepting the knotty question of indigenous systems of medicines. This is a stupendous task and the attitude of the public and the Government is one of drift. Politicians who talk loud on public platform about these systems

prefer to be treated by the recognised scientific system when they are ill. The votaries of the systems who are emerging from the Government recognised Schools of Indian Medicine do not seem to stick to the indigenous systems, the comparative study they make of all systems including the recognised scientific system allures them to take to latter in actual practice. The result of all this has been the encouragement of an hybrid system as against scientific system. A mere study of basic sciences such as Anatomy, Physiology etc., cannot give the students of indigenous systems a scientific outlook. The teaching of these subjects in a haphazard way has only produced a false security in the minds of the public and puffed up the brains of those belonging to the hybrid system. The right thing to do is to effect a synthesis and to establish a standard of medical education in India suitable to India, incorporating into it the healing art belonging to indigenous systems and have one Indian medical profession. The growth of hybrid system and its recognition have brought into the Register of Central Board of Indian Medicine in Madras 20,000 practitioners amongst whom could be counted homoeopaths of Postal Homoeopathic Colleges with whom about 6,500 qualified practitioners registered in the Provincial Register have to compete. The leaders in the medical profession belonging to consultant and specialist category might not have felt this unwholesome competition to the extent the rank and file are made to feel. This is perhaps yet another reason why the leaders did not so far feel the necessity of making strenuous attempts not to allow this serious matter to drift and consequently a dangerous situation has arisen which while retarding the growth of scientific medicine will bury the ancient glory of indigenous systems.

News and Comments.

Madras Corporation and Medical Licentiatees: For some years, the medical licentiatees both men and women working under the Madras Corporation have been complaining that they are not fairly treated in regard to their capacity of work as qualified practitioners. The Madras Branch of the All-India Medical Licentiatees' Association of which majority of Corporation licentiatees are members, formulated a scheme for the improvement of the Health Department of the Madras Corporation. Extracts of this scheme appeared in the Madras Mail last month with the Editorial comments thereon. In the scheme much stress was laid on the necessity of splitting public health from medical relief. It was also suggested that the Health Officer's control over the Corporation Medical institutions was not efficient and consequently the dispensaries were unpopular and that efficient control was only possible if the medical institutions were put in charge of a Government Medical Officer who had experience of hospital organisation or a separate medical officer belonging to the Corporation. There was also a proposal in the scheme to divide the whole City into 15 or 16 health units under the charge of second class Health Officers so that there could be co-ordinated activities and better contact with the public. It was also mentioned that the medical licentiatees who are at present doing the duties of medical vaccinators and medical registrars could without additional expenses be put in charge of these units after they were made to undergo the necessary training.

As the purpose of our comments is not for criticising the proposed scheme, we do not wish to say anything on its merits. But we cannot refrain from withholding our view in regard to the lessening of the executive authority of the Health Officer, over the Health Department of the Corporation, as we have some personal knowledge of the Corporation affairs. All the decentralisation schemes so far effected by the Corporation whether it be in the Health Department itself in regard to the Child-Welfare Scheme

or in the Engineering Department relating to Electric section, were to serve individuals and not the interests of the Corporation. There was a short period when even the conservancy section of the Health Department was transferred to a separate officer when the party then in power could not succeed to make the latter officer, the Health Officer and soon after his death conservancy was re-merged into the Health Department. We should say that the laudable work undertaken by the Madras Branch of the All-India Medical Licentiatees' Association would have had better effect on all concerned if the Health Officer was not made the target for the proposed reforms and that at the psychological period when the medical licentiatees in the Corporation were agitating against their grievances.

The Medical Licentiatees' Association felicitated Mr. S. Satyamurti, the new Mayor on the 12th January and gave him a dinner for the purpose. It is now a customary convention in public life that advantage is being taken of social functions for all kinds of purposes and the All-India Medical Licentiatees' Association in Madras took advantage of this function to ventilate the grievances of the licentiatees in Corporation service as the Chief Guest was well known for his democratic and social ideals. One of the speakers at the dinner was, it was said the classmate of Mr. Satyamurti and naturally as at such functions familiarity plays a good part, this speaker spoke in a general way about the grievances of the medical licentiatees in the Corporation. The Mayor, we were told, did not relish that the dinner table was made the platform to solve some of the problems of the Health Department and pointed out to his hosts that they should approach the officials concerned or the Deputy Leader of the Congress Municipal Party, who is a medical man. The tenets of discipline which the Mayor wanted only the medical licentiatees to observe strictly regarding Corporation affairs and the tone in which the Mayor gave out these tenets seem to have made the licentiatees and other guests resent and rightly so. For, we have seen addresses given to the Mayor by many interested in the Corpo-

ration affairs and the Mayor had been rightly saying at the public entertainments given to him that he was prepared to help the needy and the oppressed. The Congress party is an avowed democratic organisation with the highest ideals, leaning at times to rank socialism and this aspect of Congress activities must have induced the medical licentiatees to approach the Mayor on behalf of their brethren in the Corporation as they are rightly or wrongly made to feel that their position in the medical profession is akin to the Harijans of Mahatma Gandhi.

A recent item of the proceedings of the Madras Corporation as reported in the newspapers, drew our attention to the invidious distinction shown by the Congress Municipal Party to the members of the medical profession. We are astounded that this party completely forgot what the Congress Government attempted for abolishing the existing castes in the medical profession and made it possible for the licentiatees to aspire for the honorary posts in the grade of Assistant Medical Officer without making distinctions between graduates and licentiatees and recently a licentiate was appointed even as an Ophthalmic Surgeon in one of the City hospitals. Whereas, in the Madras Municipal Corporation, the medical licentiatees belonging to the fair sex were found wanting to be in charge of child welfare work which work till now was done quite satisfactorily by the licentiatees and so far we were not able to find in the administration reports of the Health Department that the child welfare work suffered for want of graduates in charge of centres. The reason which forced the Corporation to debar the medical licentiatees from holding the posts of medical officers in charge of child welfare centres is not known. We learn women medical officers with L. M. P. qualification who had been acting for long periods were sent home. We have no quarrel with the Corporation for selecting the graduates for the post. This may be done without casting a slur on the largest section of the medical profession whose members did make a mark not only in the sphere of their profession but even in public life

when they either acquired the opportunities on their own accord or when they were given to them. The Deputy Leader of the Congress Municipal party must know this fact being the son of a well known medical licentiate and the other two licentiatees belonging to the Congress party, one whom the Chairman of the Standing Committee, Health, must be feeling it within themselves. It is no wonder that the licentiatees felt desperate and tried to appeal to the democratic ideals of the Mayor but only to be humiliated. They rightly feel that their affairs were safer in the past when it was possible for a Diplomate of the Madras Medical College to get her merits recognised in preference to graduates and was promoted as the Lady Superintendent of the Child Welfare Scheme of the Madras Corporation and the person who championed her cause was the late Dr. C. Natesa Mudaliar, a medical graduate. The Congress party did not even conceive the awkwardness of the situation brought about by itself that when they claimed superiority for the medical graduates, they would be forcing the latter to serve under a Diplomate who according to the theory propounded by the party cannot be superior to the graduates. It is a pity that the Deputy Leader of the Congress Municipal Party who in another capacity of his, is expected to know all about the present standard of medical education prevailing in this Province with little or no difference between the Licentiate and Graduate Education (after the introduction of the five year course at least for the former) and when even the Government did change their vision and have even looking at both with the same angle, could not persuade his followers not to cast a slur on the medical licentiatees not even minding that by so doing Medical Ethics will be at discount.

Government Order Held Illegal:— We had been mentioning in these columns for the last two years as and when a subsidized practitioner at Kilayur, Tanjore District was harassed unjustly by the then President, District Board on the principle of a "wolf and a lamb" story on

one pretext or other and how after all the Congress Government respected politics and not justice and connived at the action of the President, District Board and terminated his services on the imaginary plea that the people in the village wanted an Ayurvedic Dispensary. The aggrieved practitioner sought relief in the District Munsif's Court of Tiruturaipundi, Tanjore District with success. The parties to the suit were Dr. R. Subbaroya Bhutt (Plaintiff); the Government represented by the Collector of Tanjore (1st Defendant); the District Board of Tanjore represented by its President (2nd Defendant). The judgment was delivered on 12-1-1940 and consists of 45 pages of typed matter. The suit was for a declaration that the notice dated 24-7-1938 issued by the President, District Board, Tanjore on the plaintiff terminating his services with effect from 1-2-1939 was illegal on the ground that it was contrary to the terms of his agreement and for an injunction restraining the District Board and the Government from giving effect to it. In the allegations made by the plaintiff against the defendants, the former gave a history of the subsidized rural medical relief scheme which encouraged private practitioners to settle in villages the Government paying a subsidy, the District Board the cost of medicine. The services of the practitioner could not be terminated except on reasons of financial stringency, violation of conditions of the agreement by the practitioner or on proof of misconduct. But the plaintiff averred that his services were terminated for some political reasons and in order to achieve that object the notices were issued on him one dated 30-6-37 mentioning that the Kilayur Dispensary was to be converted into an Ayurvedic one. In the second notice dated 6-1-1938 it was said that the Kilayur Dispensary being too close to two other dispensaries had to be closed and the last notice dated 24-7-1938, the reason mentioned in the first notice was repeated and it was expressed that such a conversion had the approval of the Government. The plaintiff added that the President did not obtain the previous sanction of the District Board before issuing the notice. The Govern-

ment stated that their administrative action over the District Board could not be questioned in a Civil Court and that the order on the subject was based on clause 13 of the agreement where it was said that on any reference made to the Government on the agreement executed by the subsidized practitioner, the decision of the Government was final and binding on the practitioner. The District Board contended that the plaintiff's agreement was not renewed after 21-2-1937 and as the agreement was not complete he had no right to sue and that the conversion of the dispensary into the Ayurvedic was due to popular demand and the action of the Board was *bona fide* and there was no personal or political motive behind the resolution passed by the Board. It further said that the action of the Board had the approval of the Government as seen in G. O. No. 2606 P. H. dated 19-7-1938. And therefore plaintiff was not entitled for any relief.

The following six issues were framed:

1. Whether there is not a valid subsisting agreement between the parties subsequent to 1937, and if not, is the suit maintainable?
2. Whether the order of the 2nd defendant terminating the said agreement is illegal, invalid and against its terms?
3. Whether the notice of discharge to plaintiff dated 24-7-1938 is valid, proper and binding on the plaintiff?
4. Whether the said notice has been approved by the 1st defendant? Is it not liable to be questioned in a Civil Court as being passed in an administrative capacity?
5. Whether the plaintiff is not entitled to the injunction prayed for?
6. To what relief is the plaintiff entitled?

After examining the plaintiff who filed over 60 exhibits to prove his case and Mr. Subbaroya Chettiar, President, District Board the Munsif discussed 1 to 5

issues together. While so doing he gave a brief account of the Subsidized Scheme which was started by the Government in 1925 as per G.O. No. 1522 P.H. dated 20-10-1924. From the exhibits filed in the Court, he found that the subsidized practitioners had been declared by the Government to be not the servants of either of the District Board or of the Government and their services could be terminated as per condition 12 in the agreement which contemplates termination of agreement on ground of financial stringency on the part of District Board or violation of conditions of agreement by the practitioner or any misconduct on his part. The Munsif opined that none of these causes existed to compel the District Board to terminate the services of the plaintiff. He then narrated the history of the notices served on the plaintiff on different dates mentioning different reasons. The first was for converting the existing Allopathic dispensary into Ayurvedic dispensary on the strength of a resolution of the Panchayat Board of Kilayur which Board desired to have a dispensary of the latter system. This notice was not approved by the District Medical Officer and also the Government both of whom pointed out that the services of the practitioner could not be terminated on that account. Then the Munsif said that advantage was taken of an existing Government order which said that the District Boards should see that the Subsidized dispensaries were not located within five miles distance from each other, and the Government also stated that in case of existing dispensaries the consent of the D.M.O. should be obtained before shifting. But the Tanjore District Board took advantage of the first part of the G.O. without observing the second with the result that the D.M.O. would not agree with the action of the District Board and that notice served on the practitioner as an excuse to transfer Kilayur Dispensary elsewhere was not given effect to. The Munsif discussed about the legality of the third notice which was similar to the first, the cause for termination of services being the conversion of Allopathic dispensary to Ayurvedic. This was dated 24-7-1938 and according to this notice the plaintiff had to leave the Kilayur Dispen-

sary on 30-1-1939 but he did not obey this order though the Government gave their consent to the same and he filed the suit on 30-1-1939 for a declaration that under his agreement the notice was irregular and for an injunction restraining the defendants namely, the District Board and the Government from giving effect to it. The plaintiff's case was as referred to by the Munsif was that Mr. Subbaroya Chettiar, President, District Board stood for the Assembly election in 1937 and requested the Plaintiff to work for him in the elections and that the plaintiff refused to do so as it was contrary to the terms of agreement and that therefore Mr. Subbaroya Chettiar wanted to get rid of him somehow or other and in proof of his allegation the plaintiff produced a letter written to him by Mr. Chettiar. But it was said that Mr. Subbaroyalu Chettiar swore that he never requested the plaintiff to canvass votes for him nor did he know the plaintiff. The Munsif had to believe the sworn statement but inferred from the letter that the plaintiff must be at least an acquaintance of Mr. Chettiar and if the latter did not personally request the plaintiff to canvass votes his supporters belonging to the Congress Party must have done so. It was also said that mahazars and petitions came from the people of Kilayur to Mr. Subbrayalu Chettiar, President, District Board complaining that the plaintiff was helping the opponent of the District Board President and that the President served a notice on the practitioner-plaintiff that his services would be terminated in case he worked for any candidate and that the practitioner replied by saying that he did not take part in the election and the petitions were concoctions as the practitioner refused to work for the District Board President. The Munsif observed that though the District Board President was not himself the cause of the mahazars etc., it was possible his partisans would have done it and would have also induced the Panchayat Board, Kilayur to ask for an Ayurvedic Dispensary. The D.M.O. did not agree with the proposal of the District Board to give effect to the resolution of Kilayur Panchayat Board and the Government held also that the termination of the agreement on this

ground was invalid. Regarding the second notice served on the plaintiff on the ground of proximity of his dispensary to other two dispensaries one at Tirupundi other at Velankanni, the Munsif said that the District Board failed to consult the D.M.O. as required by a G.O. on the subject and did not even mind the suggestion of the Government which was based on the recommendation of the Surgeon-General and Tahsildar, that the dispensary at Tirupundi might be shifted to Sembiamahadevi. The Government also advised the Board that instead of shifting the Dispensary at Kilayur it might be converted into Ayurvedic after giving the plaintiff three months notice. After the final notice was served on the practitioner-plaintiff the Munsif found out from evidence that the Kilayur Panchayat which first passed a resolution to locate an Ayurvedic Dispensary in the village passed a resolution that it was not the intention of the Panchayat to ask the District Board to close the existing Allopathic Dispensary and the Panchayat passed a resolution requesting the District Board to retain the Allopathic Dispensary. This was followed by resolutions from other neighbouring Panchayat Boards and the District Board received petitions from the people of Kilayur and adjoining villages protesting against the closure of the Allopathic Dispensary. The people even sent a memorial to the Public Health Minister. The D.M.O. also was against the closure. But the Government who at an early stage opined that the termination of the plaintiff's services on the ground of the conversion of the dispensary into an Ayurvedic one, was illegal acquiesced to the action taken by the District Board as mentioned above but advised the District Board not to start an Ayurvedic Dispensary if the practitioner continued to practise in the village. The Munsif observed that the plaintiff was prospering and was popular in the village and successive D.M.Os. had spoken well of his work so also non-officials and it was not likely that he would leave the village in spite of the Government order to terminate his services and the contention that the Allopathic dispensary was to be closed for

providing an Ayurvedic was not sound. Regarding the agreement the pleader for the 2nd defendant argued that the agreement was incomplete and that the Government had since added a provision in the agreement for the conversion of a dispensary of one system to that of another, the Munsif observed that though the agreement for 1937 was not complete not being signed by the President, District Board and the D. M. O., the concerned parties conducted themselves on the basis that an agreement subsisted as the practitioner-plaintiff was getting his subsidy from the Government and the supply of medicines from the District Board. As to the argument that there was a subsequent Government Order to incorporate in the agreement a provision for the conversion of a dispensary of one system to that of another the Munsif said that so long the plaintiff did not execute the agreement containing this condition it would not be binding on him. At the same time the Munsif pointed out that the practitioner-plaintiff could not claim to be a subsidized practitioner at Kilayur for ever as argued by the vakil for the plaintiff as it was clearly mentioned in the preamble of the agreement that the practitioner was to practise in the village for a period not less than a year at the beginning and later for such period as might be agreed upon by the parties. But the Munsif opined that the Government had stated that the rural medical practitioners should make the villages their home and should settle there permanently. So on account of the avowed policy of the Government it was expected that the agreements would be automatically renewed for a reasonable length of time. Relating to the ruling of the Government on the final notice served on the plaintiff the Munsif said that in the final notice the services of the plaintiff were sought to be terminated on the very same ground as on the ground mentioned in the first notice, that is, conversion of Allopathic dispensary into Ayurvedic. And if conversion was not a permissible ground for determination under clause 12 that clause was not applicable to the case and it must therefore be held that the final notice was invalid. In regard to

the contention of the Government that under clause 13 of the agreement their decision was final and could not be questioned in a Civil Court, the Munsif held that the final notice served on the plaintiff by the President had not the sanction of the Board as the party to the agreement was the Board as a corporate body and the subsequent action of the Board giving retrospective effect to the order of the President could not ratify the order of the President. Apart from this illegality, the position of the Government contemplated in clause 13 of the agreement was that of an arbitrator. They did not exercise any sovereign power in regard to the matter which was the subject-matter of the suit. They were one of the parties in the agreement and therefore a party in the suit. Any decision of the Government on the terms of reference made to them should be just. In this case no reference was made by the parties and the Government themselves took the matter as a reference and the direction of the Government to give the plaintiff six months notice could not be upheld as it was clearly against the terms of the agreement and manifestly unjust. The Munsif further stated that the Government acting only as an arbitrator surely could not legalise a thing which they had themselves declared illegal. They declared in unequivocal terms that the resolution of the District Board (regarding conversion of dispensary of one system to that of another) was invalid but immediately and in the same proceeding they directed by virtue of the powers vested in them under clause 13 the same invalid notice to be given again. The decision of the Government must be with reference to the terms of agreement only and if it was apart from the terms of the agreement and beyond their scope, the Civil Court could interfere and render justice to the plaintiff. In conclusion the Munsif decided all the issues in favour of plaintiff and declared that the notice dated 24-7-1938 given by the President, District Board, East Tanjore to the plaintiff terminating his services as rural medical practitioner, Kilayur was not valid and expected that the Government would see that the declaration would

be given effect to without the necessity of an injunction.

The learned judgment of the District Munsif who decided the case after going through all the issues raised by the contending parties speaks for itself and justified our comments which we made step by step as and when this unfortunate subsidized practitioner was put from one frying pan to the other, that politics more than justice had the upper hand even at the Secretariat. It was perhaps possible for only this practitioner to stand the agonies as justice which represents God was on his side. We trust this unfortunate episode will end with this suit and the authorities concerned will learn a lesson that in matters of medical relief politics should not play any part excepting the interests of suffering humanity.

Surgeon-General on Indian Medicine: The hostels attached to the Government School of Indian Medicine, Madras celebrated the "Hostel Day" on 15-2-1940 under the presidency of Major-General N. M. Wilson, the Surgeon-General with the Government of Madras. It was reported in the 'Hindu' that the Surgeon-General said amongst other things the following:

Major-General Wilson...referred to a letter from a student of the School which, he said, he had received the previous day, and read out from it a statement which said that the School was striking out a "Golden middle path" between Allopathy and Ayurveda. He added that, speaking as a doctor and not as the Surgeon-General, he could say with truth that this country must take the middle path. Those concerned with medicine must consider both the systems. After all, the doctors—in the East as in the West—were the servants of the public, and the patients would give them praise if they got cured, no matter by what system of medicine the cure was effected. If this was borne in mind he was sure the students of the School would have a very interesting afterlife and would be doing a lot of good to suffering humanity.

Major-General Wilson added that it was a very good suggestion that the students of the School should study in allopathic hospitals. That would train them both ways. Already women students of the School were being trained in the Gosha Hospital in certain subjects, and he was told they had benefitted and their knowledge had been widened. He hoped that as time went on

the students of the School *would be permitted to study* the allopathic methods of treating diseases in the hospitals. He hoped he might be able, during his tenure of office, to help in this.

On the 20th February 1940 the following letter appeared in The Hindu addressed by the Personal Assistant to the Surgeon-General with the Editorial comment at the end of it:

"Sir,—With reference to your editorial comment published in The Hindu dated 15-2-1940 on the speech delivered by the Surgeon-General with the Government of Madras on the occasion of the Hostel Day of the School of Indian Medicine, I am desired by the Surgeon-General to inform you that neither the report, nor the comment thereon by the Editor correctly represents the views actually held by the Surgeon-General regarding the system of Indian Medicine. I am to request that this fact may be published in your paper.

(Our Comments were based on our report of the speech the accuracy of which we have no reason to doubt.—Ed. II.)

Major-General Wilson is not only the Head of the Madras Medical Department but also the Head of the Madras Medical Profession being the President, Madras Medical Council and the profession naturally expects that he will take the earliest opportunity of letting the profession know 'the views actually held by him' regarding Indian Medicine or the 'middle path' between the two systems—one, the recognised scientific system and the other the Indian System. All the same knowing as we do at least some of the views of General Wilson we are inclined to say that the words appearing in italics in the second para of his speech as quoted by us from The Hindu might have been misconstrued for the words "would study". Omitting "be permitted to" in the words appearing in italics the Personal Assistant's disclaimer may be reconciled. It is just possible that the Surgeon-General had synthesis of all systems of medicine in his mind while addressing.

Co-operative Health Units: It might be remembered that the Madras Government published a communique last year in March of their intention to start rural dispensaries on co-operative basis charging annas two a month for membership and appointing a practitioner who

should do both curative and public health work on a monthly fixed pay of Rs. 50 with free quarters. The fee for his visit was fixed at annas four which should be credited to the funds of the Unit. The Government invited criticisms. Capt. E. S. Gopalan the Associate Editor of The Medical Practitioner contributed an article in March 1939 issue of the journal not favouring the scheme. The President, Provincial Subsidized Rural Medical Practitioners' Association in his address at the Rural Practitioners' Conference held in Samalkot in April 1939 condemned the Scheme as not suitable for the villages and said that the existing subsidized scheme served the purpose of medical relief very well and should be encouraged and extended on healthier lines. The subsidized practitioners' conference at Samalkot passed a resolution not approving the scheme and earlier, the Independent Medical Practitioners' Association at Vizag and Bellary passed resolutions pointing out to the Government the unsuitability of the scheme in the villages. So did the members of the medical profession in Ellore. Early this month a Government communique was published that the idea of introducing Co-operative Health Units had been given up. This is a great relief to the profession for at the time the Co-operative Health Unit Scheme was talked about, the then Minister in charge of Labour gave out that the Government was contemplating to introduce special legislation for this purpose. We wondered at the time whether the medical profession would be soon in Soviet Russia! We are glad it is not to be. We trust that the medical profession will realise that well meaning constitutional agitation if persistently conducted will bring about desired results. May we also add that bureaucratic dictatorship seems to be not less responsive to public opinion than the democratic dictatorship?

Saidapet Health Project:—It was indeed a great pleasure for us to go through nearly 80 pages of the Second Progress Report of Saidapet Health Project which is worth reading by the members of the medical profession to make them realise the potential opportunities

they have in the profession for service. We have been expressing in these columns in season and out of season how useful are the members of the medical profession in reconstruction work whether it be in urban or rural areas and we are happy indeed that the band of workers in the Saidapet Health Project have demonstrated that what we have been mentioning was not a dream. A health association was started in Saidapet in the later part of 1920 but had ceased to exist. After the Y. M. C. A. College of Physical Education was shifted to Saidapet, the staff of the College and its students conceived the idea that a health association was a necessary co-relating side activity and the old association was revived in 1932. As leprosy was a disease in which the people of Saidapet were interested at the time with the rest of South India, it was thought opportune to use this disease as a "lever which would lift the whole health level of the town." So, at the first meeting of the newly organised association it was decided to call the association under the name, "The Saidapet Skin and Leprosy Relief Association". Time was not far when the lever that was used raised the health conscience of the people and it was found necessary to have other co-relative health activities such as maternity and child welfare work which in its turn opened the door to yet other health problems and the Saidapet Skin and Leprosy Relief Association did not actually denote the magnitude of work it was turning out. So it was decided to change the name of this organisation to a comprehensive term and the association is now called the "Saidapet Health Project."

Saidapet is a typical small town which gives an idea of the people and their environments in South India—their economic conditions, habits and mode of living, their poverty and ignorance. This town of 33,000 population has a soil for almost all diseases which eat away the peoples vitals, such as leprosy, tuberculosis, filaria, and perhaps many other yet to be discovered by the Health Project. Municipality seems to be primitive, medical relief was not worth mentioning and apathy most conspicuous. In the midst of such difficulties

the work turned out by the Saidapet Health Project is as laudable as it is instructive. The motto of the Project seems to be "do one thing at a time and do it well." After narrating the work and scope of maternity and child welfare work the report gives a description of the work turned out at the Silver Jubilee Clinic for the study of Leprosy illustrated by 13 very interesting and educative tables under various heads making mention of different types of leprosy found in children at different ages and due to different causes. This is followed by a leprosy survey of a neighbouring village. Then comes a report of the survey of Tuberculosis conducted by the Staff of Arogyavaram Sanatorium under the guidance of Dr. P. V. Benjamin. This survey must be an eye opener to those interested in the welfare of the people of Saidapet. Investigations were conducted for six months. 41 per cent of children under 12 years of age should indicate the seriousness of the infection of tuberculosis. It was also demonstrated by the survey that at Saidapet Tuberculosis is not 'a poor man's disease' as is usually thought and that overcrowding plays a greater part in the spread of the infection. Economic and social surveys are also being conducted by the Project. In fact all that has to be done to reconstruct India is attempted and achieved. The progress of work cannot be spectacular and bound to be slow and a tedious task. It could be appreciated only by those who are sincerely interested in the uplift work. If the Project goes on as systematically and devotionally as it has been doing these few years, the organisers will certainly reach their ambitious goal in 1950 by converting Saidapet "The Cleanest and the Healthiest town in South India". We congratulate the silent workers and wish them luck in their up-hill task. In the meanwhile the members of the profession will do well to send for a copy of this valuable report which, while giving them an idea of what is being done at Saidapet will infuse in them the spirit of service which is a capital in itself. It will also give them an idea how useful they can turn out their profession to reconstruct India and make her people grow a healthy

nation. Professionally it will serve them as a useful guide to find out the causes of diseases, their prevention and the methods to be employed for their eradication to do which surveys as conducted by the Saidapet Health Project will serve as torch lights when they are in dark while about to begin such work.

Vedappatti Health Ashramam: It is indeed a happy coincidence that we have an opportunity of reviewing the work of another health activity under the name, "The Vedappatti Health Ashramam" founded by Capt. E. S. Gopalan M.B., M. S., A. I. R. O., who till recently was working as an Honorary in the Government Hospital, Madras and is now settled in Coimbatore Town. The Ashramam is located in the village, Vedappatti, five miles west of Coimbatore having about 10 villages within a radius of two miles. The Ashramam was formally opened by Rao Saheb Dr. Y. P. Vasudeva Aiyer, District Health Officer, Coimbatore on 14.4.1939. It has an out-patient dispensary, a night school for adults, a free reading room. The Ashramam has the benefit of an advisory committee consisting of 12 members with Capt. Gopalan as its Chief. A sanitary survey of all the villages under the jurisdiction of the Ashramam has been finished. Patients attending the dispensary are being given lessons on personal hygiene. Trench latrines are being worked out and a special sanitary spade has been invented to facilitate covering of the excretions soon after evacuation. The Chief has an ambitious programme to co-relate his health activities with the social and economic uplift of the village folk. His immediate needs for medical and maternity relief seems to be only Rs. 1,500/- a year and for a night school Rs. 200/-, a meagre amount for the bulk of work and we hope the well-to-do people in and around Coimbatore will co-operate with Capt. Gopalan in the laudable self-imposed work undertaken by him. Is it too much for us to appeal to the members of the medical profession in Coimbatore to join hands with Capt. Gopalan to popularise the department of medical relief in the Ashramam and make medical relief as a lever

to do uplift work in the villages round about Vedappatti. They have before them the example of Saidapet Health Project. Vedappatti is not so luckily situated as Saidapet having the co-ordinating service of the staff of a well known College of Physical Education, of the guidance of an experienced research worker in the field of leprosy, the Chief of the Lady Willingdon Leper Settlement, Tirumani, the advice of a Government Research Institute at Guindy and more than anything else the financial help from the Red Cross Society. Of course all this help came on account of the judicious use of a lever in the form of leprosy relief and if Capt. Gopalan concentrates his activities at first on one thing at a time, as is being done at Saidapet and if he does it well to attract public attraction his efforts in other directions will be easier and he is sure to achieve his life ambition of being useful to his country to the utmost of his capacity. We wish he pools help and co-operation from his own fraternity and first builds up in the Ashramam a missionary service for alleviating human suffering. While so doing there will be ample opportunities to teach the patients personal hygiene and preventive medicine and infuse in them the principles of public health by practical demonstration. If this temple of service gets popular which it is bound to be, its votaries will be the propagandists of the Ashramam and it is sure to serve the purpose for which it has been founded by Capt. Gopalan.

Misuse of Power: Before we could finish writing the last sentence of the comments on the judgment of the learned District Munsif of Tirutturai-pundi wherein the Munsif declared that the Government though the final authority to decide upon any reference made to them on disputes relating to the conditions of the agreement between the subsidized practitioner and the District Board, the Government had no power to legalise any illegal act of commission either by them or by the District Board, and the Civil Court had power to interfere in such cases, another decision of the Government under clause 13 of the agreement has come to our notice. A subsidized practitioner

working under the Madura District Board was suspended last March pending enquiry about an alleged misconduct in a professional respect. An ex-parte enquiry was held by a Committee appointed by the District Board and the Committee found the practitioner guilty. It is said that the District Medical Officer to whom a reference was made did not agree with the decision arrived at by the Committee and a reference was made to the Government. The Government did not give a ruling on the reference in regard to the guilt or innocence of the practitioner but merely advised the District Board that it was desirable that the practitioner should not serve under the Madura District Board. The practitioner petitioned the Government praying them to review their order. He pleaded not guilty and produced documentary evidence to prove that there was a party in the village who called themselves Congressmen and they bore a grudge against him for not submitting himself to their discipline and the same persons were the witnesses who came forward to give evidence against him. The petitioner seems to have suggested to the Government that he would even stand the test of an open enquiry. It was also suggested to the Government though not by the practitioner himself that the matter might be referred to the President, Madras Medical Council for his opinion, as the alleged 'misconduct' amounted to infamous conduct in a professional respect. But the Government regretted that they could not comply his request. The Government interfered in this case as an arbitrator between the subsidized practitioner and the District Board, Madura. It is not known from the papers before us if the President, District Board obtained the sanction of the Board before he suspended the practitioner pending enquiry. If he did all the members of the Board will be liable to any action which the aggrieved practitioner may have recourse to, as there is no condition in the agreement executed by him which empowers the Board to suspend him. In case the President did not get the previous sanction of the Board, the President's action will be doubly invalid. The action of the

Government as arbitrator is also questionable. As was observed by the learned District Munsif of Tirutturai-pundi in the case of another subsidized practitioner, the Government cannot legalise any illegal procedure which they did in this case also, by condoning the act of suspension of the subsidized practitioner which lasted for over nine months during which period he was illegally deprived of his subsidy and other emoluments as a private practitioner apart from defaming him on an allegation which the Board was not competent to judge. Regarding alleged misconduct all concerned seem to have forgotten that the subsidized practitioner is neither a servant of the District Board nor of the Government. He is an independent private practitioner and the alleged complaint against him related to his conduct in the exercise of the profession and there is a separate provision in the agreement contemplated for this purpose, that is, erasure of the name of the practitioner in the Medical Register. Distinction has been made in the agreement between misconduct in ordinary respects apart from misconduct in a professional respect and in the latter case till the name of the practitioner is erased in the Medical Register, his services cannot be terminated. The District Board might be excused for not having the sagacity to advise the complaining parties to prefer their complaints to the Madras Medical Council. But the Government in our opinion is certainly blameworthy in legalising the illegal action of the Madura District Board in suspending the subsidized practitioner and in advising the District Board not to employ him without even giving a ruling in regard to the alleged misconduct. They ought to have set aside the order of the suspension against the practitioner and directed the Board to send the complaint to the Madras Medical Council and after the Council came to any decision regarding the alleged infamous conduct they ought to have taken suitable action. As there are wolves as well as lambs in the villages, stories of the type we hear from Madura and elsewhere may add to the already existing 'Wolf and lamb' story and more lambs will be amongst the victims

unless the aggrieved practitioners in such cases pursue in getting British Justice elsewhere as did the subsidised practitioner belonging to the Kilayur village.

Entertainment by Mental Patients: Psychiatry has been making advances along with other branches of medicine. The Madras Mental Hospital demonstrated this fact on 8-2-1940 when the public and the profession were entertained by the patients in company with Major-General N. M. Wilson, Surgeon-General with the Government of Madras and Mrs. Wilson. After Mrs. Wilson distributed the prizes to the patients who took part in the games and sports of different variety numbering 24 items in a few of which the menial and superior staff of the Hospital took part, the audience was entertained by the patients with 12 items of music and dance of various description and it was rather difficult to say whether the actors had any mental defect. Each item was short but as sweet and at times thrilling. Radha-Krishna and Gopi Group Dance was acted in a way that it depicted the real spiritual Prem detached from lust as this scene is usually acted in a vulgar way by those who cannot distinguish pure love from lust. The Snake Dance was as exquisite as it was thrilling. The convalescent girl patient who we were told was once an actor, did her part so splendidly with the cobra by her side enjoying the fine flute music. The Folk dance enacted by the girl patients added much to the appreciation of those who had been enjoying the entertainment to their hearts content. We wish the Superintendent of the hospital could command larger number of guests counting amongst them the wealthy philanthropic so that they could personally see the possibilities of making the mental patients live as comfortable a life divinely destined to them. The rich could add to their divinity by distributing a portion of their wealth in making others happy and there is no other institution deserving the sympathy of the well-to-do than the one where unwanted human beings were admitted in the past to be got rid of and where advanced science has come to the rescue of medical men who are attempting to make the lives of mental defectives more tolerant and from where a

large number of patients are now sent cured or relieved.

Medical Profession Outside Madras:

The life of a critic is never pleasant and he should have relaxation. So we are occasionally forced to have a few days holidays but as a matter of fact only the pen has no work even these days as the eyes have to see and ears must do their function whether such functions bring something pleasant or unpleasant. But we made up our mind to see and hear only things pleasant. The subsidised practitioners who are having some trouble or other everywhere first forced us to go to Tirupati. From Tirupati we were wanted at Trichinopoly. The little leisure we had at our disposal we spent in visiting the local practitioners who owned special institutions. We saw the X-Ray Institute run by Dr. Raghavan and were glad to hear that the Institute caters to the needs of the local Headquarters Hospital also. The Surgical Clinic of Dr. Kalamegam gave an idea that even in moffusil it was possible to run such a clinic which comes to the level of the city clinics. Dr. Balu's private hospital demonstrated that there is no need for pomp to win popularity. But we wish Dr. Balu becomes the owner of the buildings occupied by his hospital so that he could make it look like a hospital. A recently started Clinical Laboratory owned by Dr. Iravatham, a Diplomat in Clinical and Laboratory Sciences who passed out of the Madras Medical College with distinction attracted our attention. The institution gave us a very good impression. We were glad to learn that Dr. Joseph Gnanadickam's private Eye Hospital had been progressing very well and he is in position to give his patients up-to-date eye treatment not inferior to that obtained in State hospitals. Our impressions at Madura were obtained without seeing the private institutions for we had very little time at our disposal after visiting the Government Head Quarters Hospital which appeared to us as a small village whose residents were all patients. The building proper being overfull we could see some patients even underneath the trees. Such is the popularity of this institution under Capt.

F. A. B. Sheppard. But our information as gathered from a reliable member of the profession is that Madura is self-reliant relating to the private institutions run by local practitioners. Tinnevely was the next town which we visited and even here we could be only for a few hours. This is a place of potentialities. Three Civil Surgeons have settled here the oldest amongst them Dr. Sundaram is the President of the Independent Medical Practitioners' Association which under his guidance is doing useful work though not as spectacular. We were glad to see an Eye clinic run by Dr. Mahadevan. He is a D. O. M. S. and had adjusted his special knowledge to suit Tinnevely conditions. There is a private X-Ray institute possessed by Dr. Kantayya. The Secretary of the Independent Medical Practitioners' Association Dr. Viswanathan has an ambitious plan for catering to needs of the public regarding medical relief. The fact that all the three retired Civil Surgeons are the members of this Association gives us hope that it may be possible for Dr. Viswanathan to attempt to do something in this direction. At Salem and Calicut all our time was taken by the subsidised practitioners' affairs but we have to admit that Salem does not seem to be as advanced as other moffusil towns regarding private enterprises. In Calicut some institution was started for giving private medical relief a few years ago, but nothing is heard about it now. Dr. Raman owns an excellent hospital; we wish he makes it possible for the private practitioners to co-operate with him in mutual interest and for the good of the public. In Coimbatore a few hours at our disposal were spent at Vedappatti Ashramam and we could not go about as we wished to do. There are materials in this town for enlarging the scope of private service to the public and there are practitioners to undertake such work efficiently. In fine we may say that the affairs of the profession are not as gloomy as they are said to be. What is wanted are organised efforts and cohesion in the medical fraternity.

Obituary: Rao Sahib Dr. G. Rama Rao passed away on 15-2-1940 at the age of 75. He joined the Madras Medical

College as civil apothecary student during which course he qualified for the M.B. C.M. Degree. He had a brilliant career in the College and was the Johnstone Gold Medalist. His first appointment as an apothecary was in the Royapuram Hospital in 1886 from where he was transferred to the Madras Medical College in 1890 as Assistant to the Professor of Anatomy which post he occupied till 1914 when he was made a Civil Surgeon and sent to Cochin. In 1916 he was re-called to Madras and was appointed as the Professor of Anatomy and he was the first Indian who held the professorial appointment in the Madras Medical College which position he occupied till 1920 when he retired. Though it may be said that Dr. Rama Rao left the mortal frame at the ripe age of 75 according to Indian calculation, his loss will be keenly felt not only by those who were near and dear to him but by all those who came in contact with him even once. He had not a commanding appearance, his body was frail and never robust yet his eyes had a peculiar lustre which inspired awe in those who deserved to be checked, instilled cheer and hope in those who were in need of them. The good saw in his face the godliness of the cow (according to Indian sentiments) or the meekness of a lamb but the wicked and the unruly saw in him the ferocity of a tiger. It looked as if God gifted him with these peculiar attributes as he was destined to be in the teaching staff of the Madras Medical College which had both the calm and boisterous elements and it was said at the time that Dr. Rama Rao of the frail frame was the only teacher that could keep his classes spell bound and did command awe and respect without using his tongue for the purpose. Dr. Rama Rao was as simple in his dress as he was in his food and habits. He was as happy as an apothecary as he was as an Assistant Surgeon and his elevation to the position of the professor of Madras Medical College did not make him change his mode of life and his environments. Though an Anatomist of very high order he did not forget medicine and surgery. He was the medical guardian of the students of the Medical College especially of those who hailed from his native district, South

Kanara and some of his old students, it is said, are even now carrying in their pockets the important recipes prescribed by their guardian. His predecessors in the Anatomy Department who have forgotten medicine and surgery the moment they entered this department are likely to be surprised at this news. The sense of duty of Dr. Rama Rao in whatever position he was, got him the admiration of even his superiors who treated Dr. Rama Rao, as their equal and not as a subordinate. Yet he had to leave the Medical College for two years before he was brought back as the Professor of Anatomy, the necessity of the then Great War had to be made use of by the Government to turn out their action a virtue. Dr. Rama Rao's personal life was not dissimilar to that of Gandhiji and Dr. Rama Rao, led such a life ever since anybody knew him certainly many years earlier than even they heard of Gandhiji and his world-wide fame. We wonder if all the students of the Medical College whom Dr. Rama Rao taught Anatomy knew his personal habits for he had a trait in him of Sri

Ramakrishna Paramahansa of not preaching anything to everybody unless they came to him for learning. If such of the medical men including his worthy son Dr. Dinper Rao, M.D., additional professor of Medicine, Madras Medical College, who had the good fortune of knowing Dr. Rama Rao, at close quarters follow him the medical profession would be largely benefitted by examples more than by precepts. May the departed soul rest in peace!

An Apology: We regret that with all of our efforts we were not able to publish the lectures on Tuberculosis as and when we received from the majority of lecturers in Madras as it was our intention to follow some order and we missed the earlier connecting links. We thank the contributors for sending us copies of their lectures as early as they did and request them to excuse us for withholding the publication for reasons expressed above. At the same time we hope our readers will bear with us for the delay in not publishing the articles speedily as it was not wanton and beyond our control.

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To
THE EDITOR,

Sir,

Please enlighten me through your valuable columns on the following:—

1. Can a Government Medical Officer examine cases for Insurance and accept remuneration for the same? If so, does it come under State paid duty or private practice?

2. Can he issue wound certificate on a private party direct and get remunerated for the same?

3. Can he hold another part time appointment elsewhere in addition to his State paid appointment in a private institution as a Medical Officer and get for the same a fixed monthly remuneration. Even if it is not proper now, could such persons be justified if they had been Medical Officers of certain Mission Institutions like the St. Xavier's College, Palamcottah even prior to 1940. If it is not proper should they not be asked to pay back the Government all the amount that they received on that account as a poor clerk of the D. M. O. office was asked a few years back to pay the Government all the money he got for having worked as part-time clerk of the District Medical Association, Tinnevely, on the ground that a Government servant should not get himself employed anywhere else and remunerated for the same.

Under the existing above circumstances, could the immediate controlling authority be justified in allowing this, knowing fully well and being completely aware of it?

4. Can a Government Medical Officer have private practice and attend upon private patients in their houses even to-day either as a specialist or as a general practitioner, himself being one attached to the general side in the Hospital wherein he is working?

If as specialist, who is to declare him so, whether the Government or the department or the lay public?

Tinnevely,
6th January 40.]

JUSTICE.

(The subject-matter of the correspondence has been referred to the authorities concerned and soon after we get a reply we shall publish the same—Ed.)

Government of Madras.

HOME DEPARTMENT.

G. O. No. M. S. 1805, Dated the
30th March 1939.

Read the following papers:—

From the Registrar, High Court, Madras, R.O.C., No. 5734/38/B-1, dated 5th March 1939.

Order:—

In exercise of the powers conferred by the proviso to section 224 of the Government of India Act, 1935 (26 Geo. V Ch. 2) and of all other powers hereunto enabling, His Excellency the Governor of Madras is hereby pleased to approve the following amendments proposed by the High Court to the Criminal Rules of Practice and Orders, as subsequently amended.

AMENDMENTS.

In part I of the said Rules of Practice and Orders:—

(1) after rule 379 the following rule shall be inserted, namely:—

"379 A. Rural Medical Practitioners when attending court to give evidence in their capacity as Rural Medical Practitioners shall be paid the same rates of travelling allowance and batta as would be admissible to Government servants belonging to Grade IX of the Madras Travelling Allowance Rules"; and

2. after rule 386 the following rule shall be inserted, namely:—

"386—A. Rural Medical Practitioners when attending court to give evidence in the capacity as Rural Medical Practitioners shall be paid the same rates of travelling allowance and batta as would be admissible to Government servants belonging to Grade IX of the Madras Travelling Allowance Rules."

(By Order of His Excellency the Governor.)

A. R. MAC EWEN,
Secretary to Government.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

G. O. No. 2569, 19th July 1939.

Medical Institutions—Rural Subsidized medical practitioners deputed for training in public health work—Visits to places around Madras—Payment of travelling allowance by local boards—Sanctioned.

Order—No. 2569, P. H., dated 19th July 1939.

Rural Medical Practitioners deputed for training in public health work under the scheme outlined in G. O. No. 2639, P. H., dated 21st July 1939, are paid travelling allowance as on tour, from the funds of the local boards concerned, for their journeys to Madras and for their return journeys. During the period of training they have to visit a number of places around the city. It has been represented that it is difficult for the medical practitioners to meet the travelling expenses connected with these visits from their own funds as they are in receipt of an honorarium of only Rs. 25/- a month during the period of training. Local boards are therefore requested to sanction the payment of travelling allowance as on tour to rural medical practitioners for journeys to various places in and around Madras in connexion with their training in public health work.

(By Order of His Excellency the Governor)

G. H. COOKE,
Secretary to Government.

G.O. No. 4727, 21st December 1939.

Order—No. 4727, P.H. dated 21st Dec. 1939.

Medical institutions—Rural—Subsidized—Practitioners deputed for training in public health work—Travelling allowance for visits around Madras—G. O. No. 2569, P. H., dated 19th July 1939, declared applicable to all practitioners deputed before the issue of the order.

Presidents of District boards are informed that the orders in G. O. No. 2569, P. H. dated 19th July 1939, regarding payment of travelling allowance to rural medical practitioners for their journeys to places in and around Madras during the period of their public health training should be considered to apply to all rural medical practitioners deputed for such training under G.O. No. 2639, P.H., dated 21st July 1938, whether the actual deputation was sanctioned before or after the date of the Government Order first mentioned above.

(By Order of His Excellency the Governor.)

G. H. COOKE,
Secretary to Government.

G. O. No. Ms. 18 P. H., dated 4th January 1940.

ABSTRACT.

Medical Institutions—Rural—Guntur District—Brahmanakodur—Stoppage of the subsidy of the rural medical practitioner—Orders passed.
READ—the following papers :—

From the President, District Board, Guntur, R. C. No. 781/-A. 4/- DB. of 39, dated 22-8-1939.

Endt. of the Surgeon-General, Ref. No. 17008-3. H., dated 15-9-1939.

From the President, District Board, Guntur, R. C. No. 2976-A. 4. DB. of 39, dated 1-9-1939.

Endt. of the Surgeon-General, No. 17008-4. Hospitals, dated 4-10-1939.

From the Surgeon-General, No. 17008-5. H. dated 8-11-1939.

Order :—

The President, District Board, Guntur, is referred to G. O. No. 507 Public Health, dated 8-2-1938 according to which he should have addressed the Government in the matter of disciplinary action against the Rural Medical Practitioner. On the merits of the case, the Government observe that the only proved charge is that the Rural Medical Practitioner attended the dispensary late on 7-4-1939; and that the other charges have not been substantiated. They consider that the warning administered to the Rural Medical Practitioner is sufficient and are unable to approve the action of the President, District Board in having withheld the subsidy for a month. The withheld subsidy should now be paid.

(By Order of His Excellency the Governor)

G. H. COOKE,
Secretary to Government.

The Madras Provincial Subsidized Rural Medical Practitioners' Association.

Malabar District Branch.

A meeting of the Branch was held on 24-12-1939. Dr. Achuthan Nair, L.M. & S. Rural Medical Practitioner, Kondotti occupied the chair and the following resolutions were unanimously passed.

1. Dr. C. C. Mathew, Parpanangady was elected as Joint-Secretary of the District Branch.

2. The Branch appeals to the Provincial Association to convey to the Government the dissatisfaction of the subsidized practitioners in Malabar District at their order declining to accept the recommendations of the Director of Public Health to authorise the R. M. Ps to exercise the powers and functions of the Health Inspectors referred to in the Public Health Act. The President of the Association was requested to take necessary steps so that the Government may reconsider their order.

3. The Branch requested the Government to direct the President, District Board, Malabar to appoint dispensary servants in rural dispensaries recommended by the R. M. Ps as contemplated in G. O. No. 3510 P. H. dated 4-10-1939.

4. The Branch requests the Government to direct the District Board to supply medicine to a subsidized dispensary of a net value of Rs. 360/- without deducting the incidental charges such as freight etc.

5. Resolved that each member of the District Branch should pay to the Branch Re. 1/- per year to meet the trainage of the Secretary-Treasurer for attending the Provincial Committee meetings.

Salem District Branch.

An ordinary meeting of the P. S. R. M. Ps' Association, Salem District Branch was held on 13-1-1940 at 4-30 P.M. at the Government Head Quarters Hospital. Major Sanghamlal presided. Dr. V. Rama Kamath, President of the Association in a short speech explained to the members the programme regarding the "future work of the Association", and said that the R.M. Ps. should be self-reliant and self-efficient regarding the exercise of their profession in which case he said all their difficulties could be withstood with courage and fortitude. He added; the medical profession being a healing art, it was easier for them to make even their enemies as their friends.

1. Dr. M. Nagappa Pai, rural medical practitioner, Valapady was unanimously elected as the Joint-Secretary-Treasurer.

2. Resolved to request the Superintendent, Government Head Quarters Hospital, Salem, to arrange for clinical classes at the Head Quarters Hospital on the penultimate Saturday of every month for the benefit of the Subsidized Rural Medical Practitioners working in the Salem District.

3. Resolved to send the heartfelt condolence from the members of the Provincial Subsidized Rural Medical Practitioners' Association of Salem Branch to the wife and family of Dr. S. Natesan who are now mourning on his death which took place on 3-1-1940.

4. Resolved that the members of the Salem District Branch should pay Rs. 2 per year as a contribution to the District Branch to meet the travelling allowance of the representative of the District for attending the meetings of the Provincial Committee of the P.S.R.M.Ps' Association and out of it Re. 1 to be paid on or before 30th April of every year and the balance to be paid on or before 31st October of the official year.

Madura District Branch.

An ordinary meeting of the Rural Medical Practitioners of the Madura District was held at the Head Quarters Hospital at 5 P. M. on 17-2-1940 with Capt. F. A. B. Sheppard, I.M.S., District Medical Officer, Madura in the chair. The following resolutions were passed unanimously:

1. Resolved that the District Medical Officer, Madura, be the Ex-officio President of the Madura District Branch of the P. S. R. M. Ps' Association and that Dr. M. Nagarathnam, Virupatchi, be the Vice-President.

Resolved also that Dr. Ramaviswanathan, Chinnamannur be the Secretary-Treasurer and Representative to the Provincial Committee for the official year.

The Secretary then read the proceedings No. 67 dated 11-1-1940 of the President, District Board, Madura, relating to the stoppage of additional subsidy, contingencies etc., impressed upon the R. M. Ps the importance of unity among the members and requested such of them who were non-members to enrol themselves immediately. A memorandum signed by the 12 practitioners present was presented to the District Medical Officer with a request to forward the same to the District Board with his recommendations.

Capt. Sheppard in his speech expressed his sympathies with the lot of the R. M. Ps and promised to do his best to help them. An interesting case of Appendicitis of three days duration treated outside was shown by Capt. Sheppard just before the meeting commenced. The excised appendix and the omentum which were gangrenous were shown and he impressed the necessity of early diagnosis in cases of appendicitis and advised the practitioners that as soon as they saw a suspected case of appendicitis they should make it a point to send the patient to the Head Quarters Hospital for immediate attention.

Tanjore District Branch.

An extraordinary meeting of the Tanjore District Branch was held at Aduthurai at 5 P.M. on 18-2-1940. The following resolutions were passed unanimously:

1. Resolution of condolence on the death of Dr. V. Ramaswami Pillai, Vidayapuram.

2. Resolved that para 8 of the new agreement was detrimental to the interests of the R. M. Ps. already settled in villages and the President of the Association was requested to take steps to rescind the new clause relating to the conversion of an existing subsidized dispensary of one particular system into a dispensary of any other system. It was also resolved to request the Government that the distant limit of 5 miles between the dispensaries should not be applied to the old existing dispensaries which commanded a large attendance.

3. Resolved to request the Government to direct the President, District Board, Tanjore that the servants to be appointed to the subsidized dispensaries should be the nominees of the practitioners concerned.

4. Resolved to request the Government that whenever a vacancy arises in any subsidized dispensary preference should be given to a practitioner belonging to the particular District.

5. Resolved to request the Government to increase the contingent charges to Rs. 6. per month.

6. Resolved to request the Government not to agree to the proposal of shifting the subsidized dispensary at Aduthurai to any other village in view of the long continued good service of the existing practitioner and the large daily attendance at the existing dispensary.

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Review.

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A GUIDE TO CLINICAL LABORATORY.

A neat little brochure to serve as a guide to the practitioners who wish to send materials for examination to the clinical laboratories, has been got ready by Dr. V. Irvatham, Diplomat in Clinical Laboratory Sciences. It may be had free from The Clinical Laboratory, Trichinopoly.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the period from 21st December 1939 to 31st January 1940.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance (as on 20-12-'39.)...	194 3 5	Postage including V. P. P. charges etc., Pay to Clerks for November 1939 ...	27 1 9
Subscription from members (including V. P. charges). ...	247 8 0	Stationery ...	15 0 0
Entrance fees from six new members ...	1 8 0	Amount credited to The Medical Practitioner from the subscription paid by members ...	9 5 9
Amount received from Dr. M. R. Bhat. (General Secretary) towards expenses incurred by the Association for the Manachanalloor Conference ...	9 13 3	Paid to Dr. K. Govindan (Treasurer) towards postage incurred by him from 22-10-39 to 31-12-39 ...	146 12 0
Amount advanced by the President to meet the office expenses ...	26 0 0	Contribution to District Branches:— Rs. A. P. 1. Tanjore 16 0 0 2. Salem 10 0 0 3. E. Godavari 5 0 0 4. Vizag 3 0 0	0 9 0
		Refunded to the President the amount advanced by him ...	34 0 0
		Cash Balance:— Rs. A. P. with Savings Bank 189 3 7 with Office 16 0 7	41 0 0
	479 0 8		273 12 6
			205 4 2
			479 0 8

K. GOVINDAN,
Treasurer.

V. RAMA KAMATH,
President.

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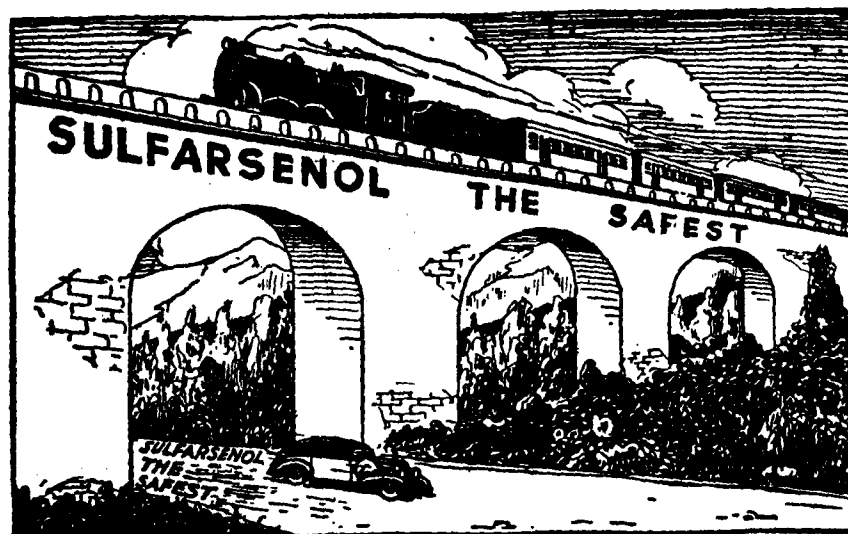
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The
Medical Practitioner
A Monthly Medical Journal

EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

ASSOCIATE EDITORS } Capt. E. S. Gopalan, M.B., M.S.; A.I.R.O., (Madras)
SCIENTIFIC SECTION } Dr. S. S. Rau, M.D., (Bombay).

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Madras Medical Council Elections.

EDITOR'S SINCERE APPEAL

To form a Golden Chain of Votes to be presented to the noble Profession.

MY DEAR READERS,

Such of you who are the regular readers of The Medical Practitioner and who are in the Madras Medical Register, must be aware that one of the many agitations conducted in the columns of the journal, was about the necessity of democratising the Medical Council. Thanks, to the Congress Government and its ex-Medical Minister for their having adopted almost all the reforms advocated in the columns of The Medical Practitioner including the one relating to the Medical Council. All this work we could do depending entirely on your good wishes and good will. Now you have an opportunity for demonstrating your appreciation of our devoted services for our profession. You can do it without any expense or labour. Please start a golden chain of votes the first link of the chain should be your own vote and add to this link as many links of votes as you can get from your personal friends and send these links of votes to us so as to enable us to make a present of this golden chain to the noble Profession to serve which we have dedicated our life. Everyone of you has seven votes, of which the first six votes should be given to our team of six and the remaining vote to any one most deserving out of the five candidates, all of whom belong to the Northern Circars. More about elections has been clearly explained by us in the Postal Address on the Madras Medical Council Elections, which you will get soon by separate post.

Yours ever in service,
V. RAMA KAMATH.

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Original Articles

PHYSICAL EXAMINATION OF CHEST IN PHTHISIS

BY

A General Practitioner.

I am grateful to the Editor of The Medical Practitioner for having permitted me to contribute an article on "Physical Examination of Chest in Phthisis". My only excuse in contributing this article is to do my bit in the campaign against Tuberculosis under the leadership of that benevolent Lady Marchioness Linlithgow, as it is my sincere opinion that unless the general practitioners become specialists in the early diagnosis of Pulmonary Tuberculosis as the tuberculosis specialists are in treating advanced cases of Phthisis with modern up-to-date methods especially surgical, the campaign against Tuberculosis will be a costly affair as to compel the Tuberculosis Association of India to limit their activities. There may be justification to have special maternity hospitals with separate blocks for the treatment of diseases of women and children, hospitals for the treatment of eye diseases and separate blocks in the general hospitals for the treatment of diseases of ear, nose and throat but to have separate hospitals or clinics specially to treat Tuberculosis will certainly hamper

the campaign against Tuberculosis when it is known that 50 to 75 per cent of population in India may have tuberculous infection. Treatment of Tuberculosis should be one of the activities of every general hospital, a separate ward or block being set apart for patients whose illness is diagnosed to be phthisis. *There is a stigma attached to institutions styled as special tuberculosis institutions and no patient would like the idea of being labelled as one suffering from phthisis.* The pathology of Tuberculosis especially of the lungs if properly understood, will make anybody to realise the magnitude of signs and symptoms of Tuberculosis which are as varying in different spots of the affected lungs as they are divergent in the mode of infection from one spot to another in the same lung, from one lung to the other, or from the lung to the other parts of the body or *vice versa*. So to me who has been a general practitioner, whose lot it was to practise amidst general population rich and poor and who has been feeling that a general practitioner should be a general administrator of the health of his

patients as the Surgeon-General is for the administration of the whole medical department, it looks that the Surgeon, the Obstetrician, and the Gynaecologist, the Ophthalmologist or any other 'igist' devoting himself to a speciality, should be the executive authority to do special work under the orders of the Surgeon-General of all diseases the General Practitioner. The present tendency of the Surgeon-General being made subordinate to his executive assistants should be deprecated not only in regard to campaign against Tuberculosis but all diseases, special or social. In a country like India which is poor and steeped in ignorance, dirt and disease and the proverbial apathy of all sorts unless every general practitioner feels or made to feel that he is really the non-official Surgeon-General over the administration of the health of his patients, the scientific medical profession will not advance and the diseases will keep on multiplying in spite of the spectacular grandeur of special hospitals, special clinics in the cities, the mortality rate remaining as steady as ever. So if I did not wish to publish my name it was because I thought that the very name of the general practitioner as an author of an article on a special disease may scare away the readers of The Medical Practitioner.

Physical Examination of the chest in Pulmonary Tuberculosis can be specialised by a practitioner anywhere even in the remotest rural dispensary. This is why perhaps the organisers of the special course of lectures on Tuberculosis did not find it necessary to include the item of Physical Examination of chest as one of the special lectures. This omission made me to request the Editor of The Medical Practitioner to permit me to add the most important connecting link in the course of lectures which is as important as it is neglected in diagnosing early cases of tuberculosis, the tendency being to rely on X-ray and other laboratory clinical methods which can only confirm the opinion arrived at by an intelligent history and as intelligent examination of the chest. The pit-falls of X-ray diagnosis have been lucidly and cleverly

pointed out by the X-ray specialist, Dr. Santanakrishna Pillai in his lecture. Dr. Vasudeva Rao in his series of lectures on Symptomatology of Pulmonary Tuberculosis, has forcibly stressed how even a look or smell of the patient suffering from phthisis could lead a physician to know the extent and course of tuberculous infection in the lungs. Dr. Tirumurti, the pathologist, did demonstrate in his contribution that though there are definite pathological changes in the lungs to indicate the several clinical stages of infection, there is generally a combination of all pathological developments in the lungs at one and the same time. Eminent authors on the subject did point out in text books that symptoms do not usually indicate the extension and severity of the infection. The following quotation from Osler is worth the attention of the practitioners.

"In discussing the symptoms it is usual to divide the disease into three periods: the first embracing the time of the growth and development of the tubercles; the second, in which they soften; and the third, in which there is a formation of cavities. Unfortunately, these anatomical stages cannot be satisfactorily correlated with corresponding clinical periods, and we often find that a patient in the third stage with a well marked cavity is in a far better condition and has greater prospects of recovery than a patient in the first stage with diffuse consolidation. It is therefore better perhaps to disregard them altogether."

Therefore the practitioner who has to treat patients afflicted with phthisis cannot rely on any one method either in arriving at diagnosis (which many a time will be provisional) or in the treatment. He must have an open mind and have recourse to all known methods, the most important, the most ancient and as reliable being the examination of chest beginning with Inspection, then Palpation, Percussion and ending in Auscultation.

Inspection: In all the four methods of physical examination, the practitioner should be quite familiar with normalities whether it be the appearance, the feeling of vibrations conveyed to the tips of his fingers or the hearing of a note of the sound while percussing the chest or hearing of the sounds conducted to his

ears through the stethoscope. If the five senses are properly trained to normal things the abnormal things could be detected with ease coupled with accuracy. The practitioner need not repent for not training his senses as a student for want of initiation or laziness. If he considers himself robust and healthy he may study normal sounds of breathing from his own chest especially at nights when everything is tranquil. He can train his sight by looking at the naked chest of every body he comes across. If in this way he trains the powers of his observation he will realise that inspection of the chest gives valuable information with little or no cost and with little or no strain either on the patient or the practitioner. For this purpose the patient's chest should be seen in broad daylight. The shape of the chest is often suggestive. A long narrow chest with wide intercostal spaces, with the costal angle being narrow, the scapulae and clavicles prominent is suggestive of the patient being tubercular. In another chest the costal cartilages will be found prominent and the sternum with a typical hollowing at its xiphoid end or there will be conspicuous hollowing at the root of the neck at the sterno-clavicular junction above or at the outer end of the clavicle and below, indicating wasting of muscles or the shrinking of the lungs. "A wide area of impulse especially in the second, third or fourth interspaces often reveals the disease of left apex." A symmetrical chest with the features above mentioned indicates that the patient is predisposed to phthisis or a subject already suffering from phthisis. Unilateral changes in the shape of the chest as a whole or a portion of it as indicated by bulging or retraction of intercostal spaces is another feature usually seen in phthisical chest. Unilateral enlargement or bulging is either due to the presence of fluid or of gas in the pleura or compensatory emphysema to make up for the loss of lung substance in a neighbouring area or in the opposite lung. Very often it is possible to see the whole of the right chest shrunk and fixed whereas the left is prominent and moving more freely indicating destruction in the right lung, with

compensatory construction in the left. Retraction of the costal inter spaces indicates either waste of intercostal muscles or adhesions due to pleurisy. To detect asymmetry in the chest it is necessary to look over the shoulders of the patient from behind. This position will enable the observer to notice not only relative bulging or retraction in both parts of the chest or in particular spots in the same chest. This will also help him to note the symmetry or asymmetry in the movements of the two halves of the chest and enable him to spot out the diseased area. To get a clear view of dissimilarity, a beginner will do well to ask the patient to take deep steady breath. While the patient does this the doctor should not only concentrate his vision on both parts of the chest but on the several parts of the two halves to note relative abnormalities. Deficient or absent movement is suggestive of pleurisy with or without effusion and if the chest or portion of it does not expand, consolidation should be suspected in that particular area. A peculiar slow movement of the head and neck from one side to the other resembling the outline of the crawling of the snake is suggestive of destruction of the lung tissue which necessitates a sub-conscious attempt on the part of the patient to move the dead along with living portions of the lung.

Palpation: Palpation is an additional aid to both inspection and percussion. During preliminary inspection and palpation of the chest, the position of the apex beat of the heart should be ascertained as any deviation from its normal seat which is the fifth intercostal space, one inch to the sternal side of the left nipple line, would indicate the diseased condition of the pleura or lung apart from the diseases of the heart itself. Pleural effusion will displace the patient's heart and emphysema of the lungs may also do so and in addition mark the normal position of the heart as could be detected by percussion. In case the patient complains of pain while breathing in any part of the chest, pressure on the painful spot would relieve the pain if the pain is of nervous origin and if inflammatory due to pleurisy the

pressure will increase the pain. Nature of respiratory movements is a very important clue in detecting tuberculous infection in the lungs. In healthy lungs the two sides of the chest move to approximately the same extent. Tracing and measuring of the expansion of the two sides of the chest can be made out with the help of the hands practically with as much accuracy as with instruments. "This is done by fixing the finger tips of either hand at the patient's sides, and making the radial borders of the thumbs meet in the middle line in front of the chest, the hands being kept rigid, the patient is directed to take a full inspiration, when the distance of departure of the thumbs from the middle line indicates the extent of expansion of either half of the chest." The movement at apices may be similarly compared. "Deficiency in expansion at the apices or bases is perhaps best gauged by placing the hands in the subclavicular spaces and then in the lateral regions of the chest and asking the patient to draw slowly a full breath. Standing behind the patient and placing the thumbs in the supraclavicular and the fingers in the infraclavicular spaces, one could judge accurately as to the relative mobility of the two sides." "Disease at an apex, though early and before dullness is at all marked, may be indicated by deficient expansion. Even from the student's days the practitioner is aware that "increase or diminution of vocal vibration or fremitus will be noted over any spot of altered resonance, by applying the hand and making the patient utter some resonant words, such as "ninety-nine." Vocal fremitus is increased by consolidation of lung (unless the bronchus be obstructed by growth or otherwise); diminished by much thickening of the pleura, by obstruction of the main bronchus, or by air in the pleura; annulled by fluid in the pleura.

N. B.—In many cases of fluid in the pleura some vibrations are felt, probably communicated from above. The loudness or feebleness of the voice must, of course, be taken into account in estimating fremitus, and corresponding parts on the two sides should always be compared.

Loud, coarse, bronchial *râles* may cause the chest walls perceptibly to vibrate,

producing *rhonchal fremitus*. Pleuritic friction may likewise be perceptible to the hand applied—*friction fremitus*. In cases of effusion into the pleural cavity, or in hyatid cyst near the surface, *fluctuation* may be elicited on palpation.

In connection with percussion, the trained observer can note difference of resistance as well as sound over diseased areas."

It should be remembered that the diminution or absence of vocal fremitus is not due to the fact that fluid is a bad conductor of sound waves (the reverse is the case) but that the lung tissue being in a relaxed condition fails to conduct the vocal fremitus to the fluid, so the vibrations do not reach the fluid. *It must be within the experience of at least a few that in a markedly dull area of pleurisy with effusion, vocal fremitus could be felt thus confusing the diagnosis.*

Feeling the surface temperature of the chest in different areas should also be cultivated using the thenar prominence. It is possible by this means to locate patches in the lung where active inflammatory process is going on, as could be felt by one spot being hotter than the other in the same lung or in the lung opposite. It should also be remembered that since the right bronchus is wider and shorter the vocal fremitus is somewhat greater in the right lung than in the left. *It is always necessary to use the right hand for feeling the fremitus in both the lungs in the same positions or in different positions in the same lung as there is a difference in the perception of touch in both hands.*

Percussion: As mentioned at the very outset of this article the practitioner should be familiar with the normal knowledge of the phenomena in regard to all modes of physical examination of chest and this knowledge is more essentially needed in the art of percussion. While palpating, percussing or auscultating the chest of a patient it is essential that the patient should keep his chest, head and arms in an uniformly symmetrical position. *Percussion should always be made from the wrist and not from the elbow*

as is usually done and the strokes should be vertical and not slanting. They should be as a rule light and always even on both sides and while comparing the note on two sides the pleximeter finger should be in a corresponding position and in the same way; for example the pleximeter finger should not be placed parallel with the ribs on one side across them in the other. As referred to under palpation, in experienced fingers the sense of touch while percussing determines the resistance of the part struck and want of resilience over thickened adherent pleura may thus be readily felt by the apposing pleximeter finger. Standard degrees of resonance over the lungs can be estimated by experience. This is the reason why doctors for want of experience differ in their conception of the physical examination of the chest in spite of their age. Normal percussion signs differ in different area of the same lungs and in the same area in both the lungs. So the practitioner while percussing the chest should keep in mind the topography of the lungs.

"Pulmonary resonance should commence $1\frac{1}{2}$ inches above the level of the clavicle. In the clavicular and sub-clavicular regions, on firm percussion, the note should be even on the two sides, low at the third rib. Below this level, on the right side, we still obtain full resonance until we arrive at the fourth space, where in the mammary line the note becomes slightly raised and shortened, becoming dull in the fifth space and downwards to the margin of the cartilages. On very light percussion the pulmonary resonance may be obtained half a space lower; and at least an inch to two inches difference in level may be obtained between the expiration and inspiration. In the lateral (axillary) region the limit of percussion-resonance reaches about an interspace lower. At the sternal margin it is a little higher, from the encroachment of the right side of the heart upon the inferior angle of the lung. Roughly, and for clinical purposes, a line drawn outwards from the base of the xiphoid cartilage may be said to define the upper border of the liver-dulness.

On the left side, in the line midway between the sternum and nipple, we already, at the third cartilage, obtain elevation of pitch and shortening of the percussion note; and at the fourth space dullness, from the underlying heart. Between this (mid-sterno-nipple) line and the sternum, and bounded above by the fourth cartilage and below by the level of the apex beat, is the normal area of superficial cardiac dullness. In the nipple line at the corresponding levels some deadening of percussion note may be obtained, but pulmonary resonance is otherwise clear to the sixth rib; in the lateral axillary region to the seventh. Below the sixth rib in front, and the seventh laterally, stomach resonance is obtained.

Over the sternum percussion is naturally somewhat wooden and resisting, within degrees varying with the condition of the bones. The first piece of the sternum is normally somewhat less resonant than the next two pieces, but it should be, on firm percussion, by no means dull. Below the level of the fourth cartilages the heart and liver cause the note to be dull, although even here a certain degree of resonance is in health communicated from the adjacent right lung.

In the posterior regions of the chest the degrees of resonance are almost entirely in accordance with the thickness and character of superjacent tissues. Thus in the scapular and inter-scapular regions increased force of percussion is necessary to elicit pulmonary resonance, whilst in the lateral and infrascapular region the percussion note is full and low-pitched. On the right side this resonance is replaced by dullness below the tenth rib, and deep percussion will elicit a certain impairment of resonance as high as the ninth rib, in the mid-scapular line. On the left side resonance should be good to the extreme base, except that in the posterior axillary line a small and restricted area of dullness may be sometimes made out, corresponding with the position of the spleen."

"Tubercles, inflammatory products, fibroid changes and cavities produce important changes in the pulmonary resonance. There may be localised tubercular infec-

tion in the lungs without inducing any alteration as when the tubercles are scattered and have air containing tissue in between them. Invariably tubercular infection starts at the apex of one lung and can be detected early by a practitioner who has trained his ears, who will be able to detect defective resonance upon and above a clavicle. Careful comparison should be made between two sides. If the patient is asked to hold the breath after full inspiration, the defective resonance in the early stages becomes more marked. The percussion note is also higher in pitch at this stage and requires a well trained ear for detection. It should also be remembered that in a recent consolidated patch undergoing caseation the percussion note will be tympanitic in nature. The untrained ears will mislead the owner of such ears. Wooden dullness is generally heard in lungs or patches of lungs undergoing fibroid change.

Effusion of fluid into the pleura as in pleurisy will also give rise to absolute dullness and this dullness note varies from consolidation dullness due to fibrosis, the former dullness otherwise termed "*flatness*," depending upon the peculiar pitch. This dullness may be distinguished from the dullness due to consolidation with thickened pleura usually heard below the clavicle in cases of phthisis. The sense of resilience is marked in these cases, the pitch high and duration of sound is short. *Amphoric* or *tubular* percussion dullness is elicited by percussing over a superficial empty cavity connected with adhesions to the chest wall. The pitch depends upon the size of the cavity and is always somewhat high. "The sound can be exactly imitated by percussing of the cheek drawn tensely over the teeth with the mouth slightly open." In such cavities a sound may also be heard resembling that 'produced by placing the two hands hollowed in apposition and striking upon the knee.' This sound is termed *cracked-pot* sound and is due to sudden displacement of air or the cavity opening into branches of moderate size. The pitch is raised if the patient is asked to open his mouth while

percussing. A peculiar resonance could be elicited on portions of lung just above the border of a patch of pneumonic consolidation or above the level of pleural effusion due to relaxed condition of lung tissue which still contains air due to the yielding of the inter lobular septa. This is called sometimes *Shodiac-resonance* and when the air enters pleural cavity the note is distinctly tympanitic and many a time confuses an inexperienced practitioner, there being a contrast between the signs obtained on auscultation and percussion, the breathing being tubular and the percussion tympanitic. In direct percussion of the chest especially over the pectorals one usually observes a chord-like contraction of the muscles underneath the tapping finger. This is known as *myoidema*.

Auscultation: Usually the stethoscope is pulled out of the pocket by a practitioner as soon as he gets a history of cough from his patient. A few may percuss after auscultation. Very few have the patience for inspection and palpation. It is therefore not surprising why the systematic examination of chest has gone into disuse as those who begin with stethoscope and finish their examination by hurriedly percussing the chest here and there in a slipshod way being not able to conceive the depth of information which systematic examination of chest can reveal. To realise the value of physical examination of chest one should follow the order, first *inspecting*, then *palpating* and later *percussing* and last *auscultating* the lungs. The breath sounds must be heard in the various regions that have already been examined by palpation and percussion and similar regions in both sides should be auscultated. Unless the observer has a knowledge of the natural vesicular breathing he can never appreciate the different shades of unhealthy breathing during the early stage of tubercular infection, the next stage of hyperaemia, initial consolidation, and caseation, cavity formation with or without exudation complicated still later with pleural effusion, which complication may precede rather than follow the degenerative inflammatory infection. The

observer should always bear in mind that the auscultatory phenomena has its origin in the *glottis* from where the breath sound is conducted from the main bronchi to their branches to reach the air vesicles. And so the conduction of the sound depends entirely on the materials through which they have to pass inside the main bronchi and the smaller bronchioles and last the alveoli. Feeble breath sounds are amongst the characteristic early signs in pulmonary tuberculosis since the breathing capacity is first impaired and as much air does not enter the tubes and air vesicles as when the lungs were healthy. When early the apex is attacked, the inspiration on quiet breathing may be scarcely audible and the expiration is usually prolonged. Cases may be seen when the earliest sign is a harsh respiratory murmur. When the patient is asked to take deep breath the inspiration is *jerky* and *wavy*. As the disease advances the inspiration gets harsher and with early consolidation the inspiratory murmur becomes bronchial and the expiration is prolonged—the *tubular breathing*. At the next stage soft rales are heard on deep inspiration which are *crackling* in character when the patient coughs. These moist rales when present with the change in the *percussion resonance* are characteristically suggestive of tubercular infection. When *cavities* form the rales are more audible more gurgling and resonant. The breathing gets *cavernous* when both inspiration and expiration are hollow, wavering and the *expiration* sound is lower in pitch than during *inspiration*. It is said that when the breathing gets *cavernous* there must be a cavity of the size of a walnut either empty or partially filled and communicating with one or more patent bronchial tubes. 'The abnormal sound is formed by the air passing to and fro into the cavity with respiratory movements, the conduction and modified reinforcement of the glottic respiratory sound within a cavity'. The *amphoric* breath sound is an exaggerated variety of *cavernous* breathing when the cavity is close to the chest wall.

Adventitious Auscultatory sounds denote roughly the stage of pulmonary tuberculosis. *Sonorous* and *sibilant rales* are

whistling sounds produced in air-passages. They are audible with both inspiration and expiration and are sonorous when the bigger air tubes are contracted due to inflammation or spasm and are sibilant when the smaller tubes are affected. *Dry rales* signify numerous minute *bronchial obstructions* and when such rales are heard all over the chest miliary tuberculosis may be suspected of course, if also other evidence is forthcoming. *Moist rales* or the *crepitant rales* heard during the latter part of inspiration and commencement of expiration are significant of liquification of tuberculous caseous nodules in communication with bronchial tubes when these rales assume the *gurgling note* of a *cavernous* type. The rales assume the metallic tinkling when the cavity is superficial.

"*Bellsound* is elicited by combined percussion and auscultation, and when present is characteristic of a very large thin walled cavity in immediate contact with the thoracic wall, and is most generally significant of pneumothorax. The stethoscope must be applied over the resonant part of the chest, and at another point within the same area a piece of metal, such as a coin, laid upon the chest, must be smartly struck with a second piece of metal. The auscultator hears a sound of a clear bell-like character within the chest, which is of quite different quality from that produced by the mere contact of metals. It is essential for the production of this sign that the stethoscope and the struck metal be both within the area of chest-surface corresponding with the air containing sac of the pleura. If, for instance, either be placed over a point below the level of any fluid effusion present the sound will be lost, to be recovered on altering the position of the patient so as to displace the fluid. By means of this sign, the limits of a pneumothorax may be accurately defined".

Succession sound is the splashing sound heard in the pleural cavity containing air and fluid when the patient is vigorously shaken while the ear is applied to the chest wall.

Bronchophony, Pectoriloquy and Aegophony are the phenomenal sounds heard during the course of phthisis. The first is heard when the consolidated portion of the lung is in communication with patent air tubes. The noise is loud and heard when just below the stethoscope. In *pectoriloquy* the consolidation has been converted into a cavity and the patent air tubes still communicating with the cavity. Here the noise is articulate and not hissing as in the former phenomenon. *Aegophony* is a modification of *bronchophony* where the voice-sound conducted through consolidated tissue has to pass through a thin layer of fluid as in pleurisy. Here the course vibrations are lost and a nasal twang added on to the note. This sound is heard only near the upper level of the fluid. It must be remembered that these and other sounds heard on the chest while auscultating are due to the conduction of sounds from the glottis and if there be any impediment in the connection between the glottis and lung tissue all these sounds are either muffled or absent. It should also be noted that all sort of sounds may be heard in the same lung or in the opposite lung depending upon the pathological condition of various patches as and when they are liable for infection. A thorough knowledge of pathology will materially help the observer in arriving at diagnosis while examining the chest of the patient.

As mentioned in the previous article last month it is not my intention to belittle the specialists or their special methods while I stress the need of a practitioner to be well versed in the physical examination of chest in pulmonary tuberculosis especially in a poor country like India where the up-to-date equipment of special clinics on a large scale cannot be thought of, yet the scourge has to be combated. So it is highly desirable that the general practitioners assume the role of specialists in diagnosing early cases of pulmonary tuberculosis in the mutual interest of their patients as well as themselves. To specialise in physical examination of chest no special instructions are necessary for the general practitioner. His own general clinic however humble even in the remotest corner of a village can be made his training ground and the initiation he had as a student in ordinary clinical methods of diagnosis would serve the purpose without the necessity of spending money to go to special clinics. All the same when opportunities occur for visiting special up-to-date clinics they must be availed of but not at the cost of the training of special senses in the physical examination of the chest. What I have said in this article is not original but a repetition of what I was taught 35 years ago which I have been practising faithfully and diligently as I could not afford to learn more elsewhere.

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ADDRESS DELIVERED BY

DR. P. GURUMURTI, L.M.P.,

The President of the VIIIth Andhra Medical Conference held at Vizianagaram on 25.2.40.

Gentlemen, and Friends,

I thank you wholeheartedly for having asked me to preside over this conference. This is the highest honour which the medical men of the Andhra Desa could confer on a fellow worker like me. I am, indeed, grateful to you for having conferred this honour on me. But when I think of the galaxy of Doctors who graced this chair before, I feel rather nervous about my capacity to occupy the chair so worthily filled before by them. But the call of your energetic and exacting Secretary was irresistible. I have therefore, taken upon myself to perform this task fully conscious of my own limitations. But I am sure that, with your kindness and co-operation, we can strive together to make this session of the conference a success.

We are assembled in Vizianagaram, the head-quarters of a renowned and philanthropic house, the presiding chiefs of which, not only contributed to the advancement of Andhra culture, art and civilisation, but also to the relief of the sick and suffering humanity. May their spirit pervade the atmosphere and instil into us a feeling of co-operation and brotherhood. Their example should remind us that our hospitals and consulting rooms are not houses of greediness and filthy lucre, but that they are temples of God—God, the Father of us all,—who has deputed us to minister to the needs of the sick and suffering humanity with the zeal of a missionary.

Brethren, there is but one temple in the universe, and that is the body of man. Let us therefore worship at this sacred shrine, and live in a visible course of religion, the one and only religion being service to humanity.

Gentlemen, since we met last at Ellore, the world with its competitive states, is

dragged into a war. The peace of the world has been given a rude shock. This is due to the present structure of Socio-political organisation which is based on competition and profiteering backed by force and violence. Until this present order is changed and the world is taught to recognise non-violent economics, there can be no enduring peace in this world. The evils of the present economic system have crept into every phase of human life. One of the evils which this order has brought about is antagonism amongst individuals though the natural order ordained by providence—is mutual aid. The underlying motive for doing anything, has been, unfortunately, profit, but not service or usefulness of the thing done.

To illustrate my point, I shall take up the question of health; and focus before you the possibilities for the creation of a social order different from that which now prevails. The knowledge of medical science which has been won through the sufferings of countless generations, is sought to be monopolised by a few, instead of being made available and accessible freely to one and all. Doctors acquire this useful knowledge—the heritage of all, and enter into competition with one another in selling it. It is neither good for the Doctor nor for the patient. The prevalent organisation makes the Doctor a tradesman. He has advice and service to sell. A society, which compels the Doctor to be a tradesman, to make the lives of the people a part of the trade, must take the consequences. Doctors have useful services to offer. Society causes them to be hungry when people are hale and healthy; and to be thriving when people fall a prey to disease. This is unsocial nay inhuman. Many doctors are poor and are worried constantly over the rent and grocer's bill. You can picture to yourself the state

of mind of such a doctor. It may be something like this—Alas! No sickness anywhere! I am starving! Is this not ghastly! "Sickness, suffering, and death should be nobody's advantage. Nobody should look to them as the hope of his livelihood. An injury to one should be felt as an injury to all. Nobody should be making profit out of the sufferings of others. There is enough medical knowledge for all. To bestow it freely cannot exhaust it. It is infinite. Only human and humane channels, through which it may flow out to those who need it, are all that are required. Neither the Doctor nor anyone else should be compelled to have as his aim of life the making of money—this is indeed deadly! In the present state of affairs eking out livelihood has become primary, and service to the patient secondary. Doctors must be recovered from this competitive practice. The health protection under individual economic competition should be ended. In some parts of the world it has become obsolete. We must wrest it from its secular moorings and endeavour to spiritualise it in lives. We want spiritualised doctors; Municipalities, Local Boards, and Co-operative organisations as in Denmark, and the State above all, should administer health agencies and supply medical relief to the civil population. The possibilities of true co-operative Medical Society are illustrated by the Volharding Society at the Hague in Holland. It was established in 1882. It has a department of insurance against sickness and death. In 1934 it had 1,20,000 members connected with its medical sections. The society employs 40 doctors, 45 nurses and many druggists and technicians. It has a well-equipped hospital clinic, polyclinic, dental clinic and two drug stores. There are united all facilities for diagnosis and treatment which make possible the team work so necessary to produce the best results in modern medical science. Experts in various fields bring the newest knowledge supplemented by modern scientific appliances to bear on medical research. Methods for the best treatment of the patient are provided. Everything is up-to-date. Each adult member must pay

5 to 20Sh. a year for full medical service of every speciality. Members' wives who are confined at childbirth have bread free for one week, and grocery free for 2 weeks. This service, we are told, is superior to that provided by the British Government at twice this cost. A high class of physicians are employed full time.

HONORARY SYSTEM

The honorary system which is being introduced into Hospitals and Dispensaries is, I am afraid, not at all a good substitute for the present order. The patient has disappeared from the picture in this as well as some other matters like consultation and treatment from Government Medical Officers. The welfare and the finances of the practitioner—private or public, if I may say so, bulk and loom larger in our minds than the welfare of the citizen. A man is put in charge of a Hospital or Dispensary without any emoluments. He is asked to eke out a living.

The Doctor will have to be constantly on the look-out for those who may be able to pay him, if he wants to drive away the wolf from his door. The result is that service, which should be the prime motive in his work, disappears from his mind. I would, therefore, urge that this system also should be abandoned being as bad as "private practice." The State should train year after year enough medical men to meet the requirements of the country and employ them on a decent living wage to look after the health of the people. Persons who are prepared to work in a missionary spirit alone should be recruited to this service on terms something like those of the members of the "Servants of India Society". They will then surely be members of "Indian Medical Service" and not otherwise.

Unless people are healthy and hale, the state cannot be efficient in any sphere of activity. It must deteriorate in all directions. The cost of ill-health will be enormous. "Nothing like a balance sheet can be drawn up to show the annual loss suffered by the nation through

sickness and accidents. In England, where health conditions are much better than in our country, the total economic burden of ill-health is estimated at something more than £ '6 per head of the population. This is apart from the misery and suffering which people are subjected to and which no statistician can ever compute. It was found in England, in the year 1935, that over 62 per cent of the prospective recruits were below the comparatively low standard of physique required for the army, and they have launched the national fitness campaign to ensure the adequate minimum standards of national nutrition. If any such survey is undertaken in our country I am sure the number of persons who can satisfy such standards of physique will be far less perhaps only 2 to 3 per cent would come to the required standard. This lack of fitness makes it impossible for them to lead full and useful lives; and they are always a potential liability to the country." Therefore, it is the duty of the state to look to the people's health covering every phase of human needs, like provision for the prevention and relief of sickness, water supply and drainage, proper housing and parks, maternity and child welfare, and good many other things.

All this means money. It may be questioned as to how we have to meet this enormous expenditure. My answer is the state has to find it in the interests of its people. The State collects taxes and it is the duty and primary concern of the State to provide free medical aid to all. To prevent drink evil, to restore people to saner and sobre life and to balance our budget, have not the Government resorted to fresh taxation? Are we not taxed for every service rendered by the Government including primary education? Let the Government resort to what I may call "Health-Tax," which will per head be less than the Doctor's fees. Demand it from the people in proportion to their incomes agricultural or otherwise, people below a certain income being exempt. Let free and up-to-date medical aid be provided to all people—rich or poor—displacing the present

arrangement where the rich and influential get everything; while the poor man goes to the wall.

"In private, general practice the average doctor cannot afford to give what is best and up-to-date and the average patient cannot afford to buy all that medical science could do for him. Here lies the social injustice. The poor man's son when he is sick with a serious disease is more apt to die than the rich man's child. I do not for a moment grudge the rich man having it; but let the poor man also have it in equal measure. Let the poor man have as good a chance as the rich man." So long as money is the link between the Doctor and the patient, this cannot be done.

ANDHRA MEDICAL COLLEGE.

Before I proceed further, I feel it my painful duty to recall to memory Major J. A. W. Ebdon M.S., M.D., F.R.C.S., a former Principal of our College, who was snatched away by the cruel hand of death while he was yet in the prime of life. He endeared himself to all by identifying himself with the Andhras and their cause. As put by Dr. C. R. Reddi, neither students nor public could have a better model than Major Ebdon on which to fashion their conduct. Peace be to his soul!

Regarding the College and its requirements, I cannot do better than quote Dr. C. R. Reddi from his valedictory address to the students of the Vizag Medical College on 19.2.1940.

"It seems to me that the nature and scope of our Medical College as a Provincial Institution has not yet been realised. I am told the Selection Committee sends Telugu candidates to this college. Well and good, I rejoice it is so. In practice therefore, this is an Andhra Medical College, a Provincial Institution. And what should be the range of activities of such an institution and its standards of staffing, i.e., the number of Professors, Lecturers and Demonstrators to be appointed and the facilities to be provided? Should it not be of the standing of the

institutions at Provincial centres like Madras and Calcutta? Could we not take advantage of certain factors that have newly appeared in South India to organise a Graduate or Post-graduate Department of Dentistry in this college? Viewed as a Provincial organisation, I deplore the lack of residential facilities. If it is our object to have men from the different Telugu districts here, surely ample hostel accommodation should be provided, more especially for the girls. The strength of the institution should be increased. And the expenditure, in the matter of staff and equipment incidental to such increase, should be incurred. We must make it possible for a larger number of girls to join. This cannot be done without a proper hostel and a highly qualified lady warden, for whom a residence should be provided within the compound. And such a Hostel might be made available for the girls reading in the Campus, so that the larger life from which higher culture springs, might be made available." It is up to the Government to meet the requirements suggested by the Vice-Chancellor.

RESEARCH.

There is still a vast field for exploration and research. Very few workers have been attached to this work. No facilities are provided for it. The Government is responsible for this negligence. Teaching institutions and Universities should make the necessary provisions to meet this imperative need. We are living on the work turned out by others in the field with no contribution of our own. Unless this is done our place in the medical world cannot be high or honourable. The authorities concerned will please note this and do the needful without any further delay in the matter.

POST-GRADUATE COURSES.

Medical Science is making rapid advances. The Medical practitioners all over should acquire this knowledge in the interests of suffering humanity; otherwise they will be stagnating. Refresher courses should be frequently held at Vizagapatam where there are all the facilities for teaching. Medical practi-

tioners should make it a point to attend these courses and enlarge their outlook and improve their scientific knowledge. At a previous session of the conference we requested the authorities to make such an arrangement. It has not been heeded so far. Let us once more request them to help us in the matter.

ALLOPATHY, UNANI, AYURVEDA AND HOMEOPATHY.

It must be admitted that every one of these systems is based on a scientific principle. It may be that those practising them have not had a thorough scientific training. It is necessary that they should be given a thorough training without which nobody should be allowed to practise medicine. There are as many "Pathies" as there are "ismas" Allopathy, Homeopathy and shall I say "Lakshmipathy" each parading its own goods and wares. This is distressing. The people are confused and confounded. It is, therefore, necessary that some investigation be made and a common system evolved in the interests of humanity.

INDIAN MEDICAL COUNCIL ACT.

In spite of repeated requests and protests from all concerned, the Central Government have not affected the necessary amendments in the Indian Medical Council Act. The Black Act has been on the Statute book for over seven years and our cry has been a cry in the wilderness. The Act should be so amended as to provide for (1) a majority of elected members, (2) for an All India Register and (3) for the inclusion in the Register the names of all persons included in the Provincial Registers as demanded in the last All India Conference.

In these days of democracy, to have nominated members on any body is odious; and to have them in a majority is simply obnoxious and undemocratic. To exclude from the Register 75 per cent of the medical practitioners in the country is equally undemocratic and illogical. I am afraid these wrongs can-

not be righted till political power is completely in the hands of our own representatives till Swaraj is attained.

DRUGS

It is a strange irony of fate that we should depend on foreign countries for the supply of cloth, food, medicines, and good many other necessities of life. Nature has been very kind and bountiful to us. Yet we have not adopted Swadeshi. We have enough drugs in our country. Yet money amounting nearly 2 crores is drained away every year. The Government which ought to have done something in this direction, does not move its little finger in the matter on account of vested interests. Patent medicines are imported into the country. God alone knows the composition and the component parts of these. The Minister for Health, Bombay, has recently pointed out that samples of Quinine pills and of Aspirin tablets sold in Bombay were found on analysis to be entirely devoid of these drugs. A packet of Seidlitz powder was found to contain Sodii bicarb in a blue packet and Oxalic Acid (a poison) in a white paper packet. These patents are largely used and freely prescribed by Doctors. Surely we cannot afford to experiment on human beings. In the year 1927, a resolution was passed in the Council of State to the effect that steps should be taken to control the indiscriminate use of medicinal drug and to legislate for the standardization of the preparation and for the sale of such drugs.

A committee was appointed by the Government in pursuance of this resolution. Ten years later, i.e., in 1937, a bill was introduced in the Central Assembly to give effect to the recommendations of this Committee (Drugs enquiry committee). Now three years after that, the Government of India have published a bill in the Gazette of India. The bill seeks to regulate and control the import, manufacture, and distribution for sale of drugs. It provides also for the establishment of a Technical Advisory Board in order to advise the Central and Provincial Governments on technical matters and to ensure that a uniform standard is main-

tained. It further provides for the control of the import of drugs into the British India. The Executive power under this chapter will be exercised by the Government of India. The Bill, the measure relating to Drugs has come at a very opportune moment. Foreign drugs are not available. The cost of those available is exorbitant and prohibitive. It is up to our Indian Industry to take this opportunity and manufacture drugs of the requisite standards. Men with the necessary qualifications have to be brought into being by the Government to engage themselves in this industry. We are under military control even in the matter of drugs and medicines. The Local Bodies and Municipalities have to purchase medicines from Medical Stores which is military stores. These bodies must have power to get supplies, at the cheapest rates, in the open market, from some certified firm if necessary.

INDIAN MEDICAL ASSOCIATION.

The benefits of having an All India organisation are many and need not be reiterated here. The Association which is now 11 years old has more than justified its existence. But the number of members on its rolls or the number of branches which are affiliated to it is not encouraging.

Every effort should be made to strengthen this organisation which is fighting our battles. It behoves us therefore that we should all join the association in larger numbers. Regarding the question of amalgamation of the All India Medical Licentiate Association with the Indian Medical Association, there seems to be some difference of opinion. I shall not enter into details here. The fact is there. It is because we have been brought up in water-tight compartments, each thinking of himself. Caste here as elsewhere, has to go. All customs die hard. So also caste. I shall say that it is only a matter of time. It shall die. Meanwhile let us try our best to maintain unity and bring out solidarity.

Gentlemen, a few words more, and I am done. Our country is a land of villages, which have been neglected for centuries.

There are a few "haves" and many "have-nots". The villagers are steeped in ignorance, illiteracy, indebtedness and superstition. The death-rate in the country is appalling. Mortality of infants and of women in child-bed is the highest when compared with any other country. Therefore, it is our duty to rouse the people from their slumber. We must rouse a passion for health in them. To preach health to the poor and under-fed may be a hypocrisy. But let us make the best of a bad bargain. The doctor should no longer be a "medicine-man" but be a "health-man". Few diseases can be cured. But many can be controlled and prevented. The doctor should become public-minded and carry the gospel of health and sanitation, the causes of diseases and their prevention, to the very doors of the people. Doctors should take an active part in public affairs. They should get themselves elected to the various Local and Legislative bodies. With their knowledge of men and things, with their knowledge of human mind and human psychology, they may be able to do something for the people. The Health-officers have

not been given sufficient opportunities or facilities to carry on their work with zeal and earnestness. The Madras Health Act—thanks to the efforts of our distinguished friend Dr. T. S. S. Rajan, who by abolishing the L. M. P. grade brought about a uniform standard of medical education—in the province, and democratised the Madras Medical Council by affecting the necessary amendments to it—empowers Health Officers to exercise the functions of the executive authority in matters relating to Public Health. I hope our friends will come to their own and do their best to improve things. Gentlemen, let us all strive our best to raise the standard of the nation's health. Let each one of us be a fountain sending forth the water of life, in a multitude of blessed manifestations. A lamp that fails to radiate light, is dead. A man or woman, who fails to send forth some vital quality, into the world, by which the world shall be brought little nearer to the great goal of the kingdom of God—that one is dead no matter how much noise he or she may make. Let us therefore do our best to humanity. May God help us!

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RESEARCH AND SYNTHESIS IN MEDICINE*

By

DR. B. TIRUMAL RAO, F.R.C.S., D.L.O.

The problems affecting the medical profession have been so often and so well thrashed out by men of eminence that I do not propose to attempt to enter into any detailed discussion about them. If I venture to make a reference in this short address to one or two outstanding questions it is only to remind you of their great importance and urgency and of the careful and serious consideration which they deserve at your hands.

The introduction of modern medicine into India roughly coincides with the birth of the British Medical Association in Great Britain. Its progress in India has been painfully slow. It is not, however, my intention to go into its etiology. What I want to emphasize here, is the fact that it has taken nearly one hundred years for the development of anything like a well organised medical profession in India. A few years back there was no medical organisation either provincial or all-India which we could boast of. It is only in recent years that the medical profession in India has attained the status of corporate existence. But still we must confess that our discussions cannot yet claim the high standard of excellence of the medical organisations in the west, and that our journals cannot compare favourably with foreign journals in point of original scientific output. We are painfully conscious that the Indian contribution to modern medicine is to speak the truth, practically nil. We should not allow our sentiments of national pride or self-respect to ignore this melancholy fact, nor in our desperate attempts to explain away the whole problem accept meekly the ingenious explanation that the pursuit of science is violently incompatible with the genius of our people. We are all easy-chair philosophers, it is said, who love to theorise, and speculate, and it is futile to accept such a sublimely philosophic and

perhaps, half drowsy intellect, to wake up to the realities of science. I should not have touched upon this flimsy explanation of failure to offer anything original in the field of modern medicine, but for the sad fact that it is sometimes offered with all the seriousness and confidence of a thesis, the logic of which is absolutely unquestionable and unimpeachable. It has been said that Indian Medicine died from natural causes, for the chances of its evolving itself into a scientific system of medicine, even granting that its progress is unimpeded by extraneous causes, political or economic, are very, very remote. We should still have remained theorising and philosophising. Apart from the question, is there any thing like purely philosophic brain with hundred per cent immunity to the charms of science, and apart from the honest conviction that the fundamental urge, the ideal and even the methods of both philosophy and science are one and the same, an unprejudiced study of our History would convince one that we have as glorious a tradition in Science as in Philosophy. And therefore a Raman or a Bose need not be looked upon as a freak creation divinely missent into a land of born philosophers, or as the traditional one swallow which will not make a summer. Given the proper facilities and opportunities, our young men will prove beyond doubt that they do not lack in either the aptitude or the intellectual equipment necessary for scientific research. "To take our rightful place in the world of science, we must labour to make as valuable a contribution to our present knowledge as our ancestors made in the past. We have the capacity and the ability to take a proper place in the world of science. We have already begun to make great contributions to the sciences of chemistry, physics, biology, etc., and I am sure we can similarly enrich the science of medicine if

* Address delivered at the VIIIth Andhra Medical Conference, Vizianagram on 25-2-40.

we will only labour hard enough. And therefore the creation of research facilities for our young men in all teaching institutions is the urgent need of the hour. "Research is the sap of the plant of science." Hence every teaching institution must encourage research work among its staff and students.

Another problem which is engaging the attention of our profession is the future of medicine in India. We have to-day several systems of medicine each claiming its own peculiar virtue. Which of them, it may be asked, will survive in the struggle for existence. There can, in fact, be only one answer, the future of medicine in India is the future of the modern scientific medicine in India. But it is perfectly obvious from the sincere and strenuous attempts now being made towards the revival of ancient medicine, that the public still have an abundant faith in its efficacy. It is said that modern medicine would not take root on Indian soil and the cost of its methods of treatment is too prohibitive for its even becoming popular in a poor country like India. Judged from the purely empirical standards of the pre-scientific era, the ancient system of medicine possesses a very high degree of excellence. But unfortunately the dawn of the scientific era caught it napping and before it could make up, the magic wand of science has transformed the entire outlook of medicine. A new system of medicine based upon the knowledge of the fundamental sciences of chemistry, physics, anatomy, physiology, pathology, etc., has come into existence. And ever since the excellence of our Hindu medicine has remained, where it was, but that does not mean we have even now nothing new to learn from it. On the other hand the entire question is, which of the two systems has got the greater potentiality to absorb the other.

Ancient medicine decadent as it is, is too static to absorb and assimilate anything new, while on the contrary, the Modern Medicine, young, virile and dynamic, has the capacity requisite to learn and to retain in itself all that is rational and valuable in the ancient systems of medicine. Science is progressive and the method of its progress is one of continuous search and research. There are in it absolutely no limitations of caste, colour, creed or country. The basic science is the same all over the world. Modern medicine is the outcome of the collective wisdom of the medical genius of all times and of all countries. It is absurd to label it as either western or eastern. Osler makes the following remarks with special reference to Homoeopathy, which have a significant bearing upon the point now under discussion. "It is too late in this day of scientific medicine to prattle of such antique nonsense as is indicated in the 'pathies.' We have long past that stage when a difference of belief in the action of drugs—the most uncertain element of our art—should be allowed to separate men with the same noble traditions the same hopes, the same aims and ambitions." If the main object, is confined to review and to reclaim of what is valuable in ancient Indian medicine, would it not be better attained by the institution of a chair or chairs for Indian Medicine in our Medical Colleges, which will deal with special emphasis on the historical aspect of it and at the same time conduct research in collaboration with the other departments, in pharmacology, dietetics, and the various other aspects of the indigenous systems of medicine. It is high time therefore we give up quarrelling about the special efficiency of this system or the peculiar emptiness of that, and that we should direct our efforts to the advancement and propagation of the modern scientific system of Medicine.

NOTICE.

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ELECTIONS TO MEDICAL COUNCILS.

Elections to the Medical Council of India is now in full swing; polling is going on throughout the Madras Presidency, the contending candidates being Dr. T. Satakopan the sitting member and Rao Bahadur Dr. T. S. Tirumurti. The successful candidate will represent those practitioners whose qualifications are recognised by the Medical Council of India. From the reports we learn that the election is fought on personal grounds as both the candidates did not place before the electorate what would be their policy and aim in regard to the activities of a Council which in reality cannot have a place in India as it seems to exist to placate the General Medical Council of Great Britain and nothing else. The existing Provincial Medical Councils have ample powers to control medical education of graduates for which purpose the Medical Council of India was brought into existence. The standard of medical education demanded by G.M.C. for the purpose of recognising Indian medical graduates could be as efficiently controlled by the Provincial Councils. It was said at the time when the Bill to establish a Medical Council of India was on the anvil of the Central Assembly that the Council would bring efficiency at home and honour abroad. But in actual practice while the Medical Council of India

has been demanding efficiency in University Medical Education only, it did not bring honour from abroad for itself but brought more honour to the G. M. C. For, all the foreign countries with whom the Medical Council of India has been trying recognition for Indian University qualifications on reciprocity basis, have been dictating that the G. M. C. should first recognise the medical qualifications of the countries with whom the Medical Council of India proposes to establish reciprocity. Is this honour abroad? The treatment accorded to the Andhra Medical College by the Medical Council of India is scandalously most humiliating. The very purpose of the Medical Acts has been conveniently forgotten by the G.M.C. under whose dictatorial protection the Medical Council of India wishes to exist. The object of the Medical Act as enunciated in the preamble of the Medical Act of Great Britain, is to help the lay public to find out who is qualified for the purpose of medical relief. The Medical Council of India did certify that the boys passing out of Andhra Medical College are in no way inferior to those passing out of the Madras Medical College, an institution recognised by this Council. This Council had also testified that the staff of the Andhra Medical College was quite efficient. All the same the M. B. B. S. qualification of the Andhra Medical College was not recognised because the buildings of

the College were not as grand as the Inspectors wished them to be. Thanks to the efforts made by the Congress Government, the Medical Council of India has since granted conditional recognition to M. B. B. S. Andhra degree granted after 30th November 1938. If want of grand buildings was the only excuse for withholding recognition till 30th November 1938 why should not the Andhra M.B.B.S. be recognised from the date when the degree was first established as the condition of buildings was just the same in 1938 as it was in 1927? Is this not a scandal? Should the scandal continue? The Government of the Country has not been able to protect the honour of the Andhra University. We suggest to the Indian Medical profession not to have much faith in the Government but depend upon itself to establish honour abroad. We very much regret that the medical profession in this presidency lost a good opportunity for demonstrating its protest against the Medical Council of India which it might have honourably launched by not sending the representative to the Medical Council of India to represent those practitioners whose qualifications are recognised by the Council. The protest would have had the desired effect. It is now too late to ask the two candidates who are now in the field to retire in favour of honour to the Andhra University. If the candidates really contested the election in the interest of the medical profession and not in their own interest, the successful candidate should be asked not to take his seat in the Council. Will he do it? If he does not, the entire profession should bring pressure on him. If Madras succeeds in demonstrating an effective protest, the other presidencies are likely to follow Madras if they mind the honour and prestige of the Indian medical profession.

Regarding the elections to the local Medical Council we appeal to the electorate to take keen interest and return to the Medical Council representatives whose merit should be judged by their past services and not by future promises.

The affairs of the Medical Council were far from satisfactory in 1929. It was possible for Dr. Kamath to detect at the very outset during his electioneering campaign in 1929 that there were a large number of practitioners almost all of whom were medical licentiates who possessed certificates of Registration granted by the Registrar, but whose names did not appear in the Register. The Medical Practitioner helped Dr. Kamath to detect the cause why the names of a large number of practitioners who possessed the Registration certificates were not found in the Register. It was due to the fraud played at the office of the Registrar on the practitioners. The Registration fees paid by such practitioners did not get into the treasury of the Medical Council but got into the pockets of those in office who played the fraud and the names of the practitioners were not entered in the Medical Register to escape detection of fraud. Suffice it to say that it was possible for Dr. Kamath to detect defalcation to the extent of over Rs. 5,000 with the result that the clerk in charge of office was sent to jail and the then Registrar's services were dispensed with.

The necessity of democratising the Medical Council was first found in the columns of The Medical Practitioner a few years ago and it was left to the Congress Government to give effect to the reforms advocated in these columns. Thanks to Dr. P. S. Srinivasan who sponsored the Bill to amend the Madras Medical Registration Act which work was later undertaken by the Congress Govern-

ment and we will have a Medical Council consisting of 15 members as in the past but there will be 12 elected members in the place of six as against three nominated members, the nominated members in the old Council being nine. The two Universities have to return two from the Medical Faculty, to be elected by the Academic Council and three Medical Colleges have to send one from each College to be elected by the staff and seven members are to be elected by the registered practitioners, found in the Medical Register and who are now grouped together in one list and not in three lists as in the past.

When the Amending Act was on the anvil of the local Assembly the medical schools had not been abolished and consequently the local Council was justified to have in it representation for teaching institutions though not for the Colleges or Universities as the Education of graduates is to be now controlled by the Medical Council of India. Though the local Medical Council did not surrender its control over the University Medical Education virtually, the Medical Council of India has usurped all the control. Therefore the Madras Council has now to function only as a disciplinary body and naturally all the twelve elective seats should be thrown open to the general electorate. There are signs of the need for this reform as could be judged by the results of election from the two Universities and three Medical Colleges which have been announced though the idea of reform must not have been the guiding factor in the uncontested returns from these institutions. Personal considerations more than anything else played a good deal in the uncontested elections relating to the teaching institutions. We brought to the notice of the Government as soon as we heard about the Amending Bill that it was not fair to

throw open the seats in the educational institutions to election as the very purpose of representation for teaching institutions were likely to be frustrated as no decent minded head of these institutions would care to contest and therefore we urged that the Principals of the three Colleges and Superintendents of Medical Schools which then existed should be nominated by Government and to safeguard non-official interests of the profession the elective seats in the general constituency should be proportionately increased so that there might be a non-official majority in the council. What we apprehended has now come to be true. The Medical Madras College returns without contest an official specialist. So does the Andhra Medical College. The Stanley Medical College returns without election an Honorary Surgeon. The Andhra University elected without opposition a non-official member and the Madras University sends the Vice-Principal of the Madras Medical College. We congratulate these members most heartily on their uncontested success and wish them a useful life in the Madras Medical Council. All the same, we should say the best person to be returned from a College is its Principal and in case the Principal finds no time, the next best person is the Professor of Medicine as the latter is expected to have a more comprehensive knowledge of the affairs of the medical profession and not a surgeon nor any other specialists who are the lieutenants of the physician.

Coming to the general electorate which now contains practitioners of all qualifications, the democratic principles demand proportionate representation especially in India where unfortunately the rights and privileges of registered practitioners do not depend upon their registration only as is the case in other countries. The

Government in India have not as yet realised that a Statute brought into existence by themselves is obeyed in its breach. The rights and privileges depend upon the official position of the registered practitioner not on the virtue of his being registered. Next to official position come the qualifications of individual practitioner or his social position. So the licentiates are justified to claim all the seven seats in the general constituency. They rightly aver that even in case all the seven seats are captured which is possible as their number in the Medical Register is in the ratio of 5 to 2 of other registered practitioners of all qualifications, they will be in minority in the Council as all the five members returned by three Colleges and two Universities will not be licentiates and in addition the three members to be nominated by the Government will also be outside the licentiate group. So the strength in the Council would be seven licentiates and eight practitioners who are not licentiates with an ex-officio President having two votes. Yet we appealed to the leaders amongst the licentiates to be magnanimous in spite of their number and have at least one graduate amongst seven to be elected by the general electorate so that the elective element in the Council be six licentiates as against six others. We express our appreciation to the licentiates for their gesture which we trust will bring about harmony in the profession.

The next problem we had to tackle was to see that the seven members represent the profession should be those who have by their past career proved their worthiness to represent the noble profession in the Medical Council. The life of a member in the Medical Council is for five years and for this long period there are only ten meetings provided by the Statute. But the work of the representatives of

the profession should be in a variety of ways so that the rank and file in the profession could live a contented useful life worthy of the profession to which they belong. So the representatives should be persons of status in public life who are able to command influence to do good consistent with the ideals of the noble profession. We rightly thought that they should be scattered and should not be from one district or a region so that they may be in touch with the members of the profession in proximate districts and more than anything else they should be popular in the districts which they represent. In addition to the qualifications mentioned above, all the seven representatives should have common ideals in them of service to the profession and not for their individual self. They should realise that their work for the profession is not only on the floor of the Medical Council for ten days in the course of ten years and that for a few hours. The affairs of the medical profession are such that their representatives should not allow any opportunity to miss which could be made use of for the benefit of the profession as a whole. After the abolition of Medical Schools the licentiates are fast disappearing and in the course of three decades or four at the most they will be nowhere in this presidency. So, soon after the nominations were announced, we took all the above circumstances into our consideration and did attempt to have a team of the right sort of representatives to be elected by the general electorate. Who they are and from where they come will be announced by means of a special manifesto to the electorate in the course of a few days. We regret that for want of proper understanding in the districts belonging to the Northern Circars, we could not announce the name of the practitioner to represent the districts in the Northern Circars. We trust better counsel

will prevail in the Northern Circars in spite of personal considerations and it will be possible for us to announce the happy team to represent all possible interests and the most important being the interests of the medical profession. We have faith in the patriotism of the members of the profession in Northern Circars and it is indeed a happy coincidence that the Andhra Medical Conference which met in Vizianagaram on 25-2-1940 did endorse the spirit and principle adopted by us in selecting the team though we were not fortunate to be in touch with the Conference. We appeal to the Andhra Medical Profession with all sincerity at our command to mind the interests of the profession as a whole and not of individuals who in a false garb may create dissensions even making it appear that the individual interests are the interests of the Andhra Desa. May God guide all the members of the noble medical profession and help them to elect the team of seven minding the noble cause for which they stand and not the stories specially concocted for election

purposes so that the profession may take its rightful share in controlling the destinies of the welfare of the Indian nation. The medical profession is best suited to do national service as it does not recognise castes and have to be masters of all languages to talk to the people whom they serve but not for claiming special representation on this account. We trust that our appeal will have the desired effect and all the candidates now in the field in the Northern Circars, will kindly mind the larger interests of the profession and retire in favour of the team which answers all interests not excluding the linguist so that there might not be a contest which is likely to bring about an unhealthy atmosphere detrimental to their own interests. The elections in the three Medical Colleges and two Universities have been uncontested and the general electorate will be most happy if they are not disturbed and their representatives are returned without contest. This will bring credit to the candidates and also to the profession to which they have the honour to belong.

Madras Medical Council Elections.

APPEAL TO ALL REGISTERED PRACTITIONERS

PLEASE VOTE SOLIDLY FOR THE FOLLOWING CANDIDATES

Each one of you has Seven Votes.

Kamath, Vaderbet Rama, L.M.P., (Madras),
 Krishna Menon, Vellore, L.M.P. (Malabar & Proximate Districts),
 Narayanamurthi, Kasthuri, M.D., (Northern Circars & Madras),
 Samuel Murtaty, Jonathan, L.M.P., M.L.A., (Ceded Districts.)
 Shennappa Shetty, Thonse, L.M.P., M.D. (Switz). (South Tamil Districts.)
 Brinivasan, Pattukota Sundaram, L.M.P., M.L.A., (Central Tamil Districts.)

They satisfy all possible variety of interests. Manifesto follows.

N. B.—The seventh Candidate will be from Northern Circars.

News and Comments.

Spiritual Conception of Medicine:

If there is any civilization to-day which is spiritual more than any other in the whole world it is the Indian civilization and if there is any country where it has not been possible for the members of the Medical Profession to exercise their profession as nobly and as usefully, it is India. The statement is indeed paradoxical, yet it is true. Excepting civilization all the rest of the things in India are as confusing as they are divergent whether it be religion, politics or anything else relating to human evolution and the confusion is worst confounded in the art of healing. The reason for this confusion is not far to seek. The art of healing in ancient India was part of the scriptures of the people. It was one of the Vedas and was called Ayurveda. So it is not dead nor obsolete as the four Vedas are. The Vedas are valued more than treasure in both the hemispheres except by those for whom they were originally meant. It is therefore that the Ayurvedic System of Medicine has been surviving in spite of its not being patronised by the British Government who introduced in India the Allopathic System of medicine the basic principle of which is curing a diseased action by introducing another action of a different kind as opposed to another system, Homoeopathy which sprang up later in the west, in Germany to begin with, whose principles of treating diseases are to introduce into the system drugs in very minute doses which if administered to a healthy person would cause in him symptoms akin to those produced by the disease. With the Mohamadan invasion another system of medicine was introduced in India much earlier than the day when the Britisher set his foot in this country. The principle of the latter might be perhaps the same as that of Allopathy though the modes and methods of preparing medicines are different. The ancient Siddha system prevailing in the Tamil Districts in Southern India seems to be an offshoot of Ayurveda, treatment of diseases with the metals and their derivatives laying a greater part than in Ayurveda. Unfortunately no attempt has been made

by the politicians who control the destinies of India to bring about synthesis of indigenous systems of medicine with the Allopathic system in spite of the fact that the Allopathic system assumed an all absorbing name the scientific system of medicine indicating that it is a system which recognises any method or mode of treatment of diseases basing on truth proved by science. It has also to be said that the scientific system of medicine often times adopts empiric methods not proved by science. This does not mean that the empiric methods of treatment are not scientific. It only proves that the scientists have not been able to demonstrate the hidden scientific truth in a special drug. So such hidden truths contained in the indigenous systems of medicine can be incorporated in the Scientific System of Medicine and India can afford to have a scientific system of medicine of her own without injuring the ancient glory of Ayurveda nor the advanced methods of scientific system and the healing art could be practised in the spirit it was practised in India in ancient days when the prevailing idea seemed to be that medicines lost their virtues when they were bartered for money. The vote catching genius of shrewd politicians belonging to whatever party not excluding the national organisation, the Congress party, has made them deaf and blind even to the interests of Indigenous Systems of Medicine and their misdirected zeal demonstrated on public platforms and on the floor of the legislative and local bodies, has been actually suicidal to the advancement of these systems. For these politicians know that the practitioners belonging to the Indigenous Systems excepting perhaps those who have been now identifying themselves as "hereditary Vaidyans" and who have no command of English language, actually practise the Allopathic system nay even adopt Allopathic methods for the preparation of medicines and not the Sastric methods of the Ayurveda. At least one Congress Minister in a sister province, who is an eminent member of the Scientific System of Medicine did betray the truths learned and taught by him to serve politics and not the welfare of the

public not even the welfare of the Indigenous systems themselves. When the members of the Scientific systems of medicine are aghast at what is happening to the scientific system, the Soviet method of medical relief is pressed on the profession by Dr. P. Gurumurthi, a Congress minded co-operator who presided over the Andhra Medical Conference at Vizianagaram on 25-2-40. Dr. Gurumurti confused the spiritual conception of medicine with socialism of the Soviet type on one side and with the ideals of co-operation on the other.

Dr. Gurumurti rightly says that religion is service to humanity and temple is the man. This is exactly the fundamental foundation of all religions but this fundamental truth cannot be divorced from the theory of evolution on which the religion of the Hindus is built. Evolution is Karma and the Karma makes the man and the woman; the apparent inequalities found in human society which cannot be explained or reconciled are due to the individual Karma of the man or the woman in their past or present birth. Service to humanity is the ideal of all religions and therefore it is desirable that the society should be made to realise its responsibilities to the individual component parts in it and this cannot be done by the State for it cannot have a religion or a conscience of its own and it is against the basic theory of evolution otherwise known as Karma. That the State should confiscate the rich for the sake of the poor and the members of the medical profession alone should be forced by the State to serve people on a wage just enough to maintain themselves is not reasonable. Service is infinite says Dr. Gurumurti. But he forgets that the Medical Service is not the only service required by humanity. The first service is to feed those who are in need of food. Then, comes supply of clothing and a residence to live in comes next. Again there are many other needs including service in litigation etc. Can the State provide all these facilities equally for those that are in need of them? Dr. Gurumurti, a Congress man as he is, might say that the Government can do anything they want basing upon his experience of the Congress

regime in this province for twenty months. But we have to tell him that the State is unstable as is a drop of water on a slippery green leaf and it is impossible for any Government in India to transform the Indian mentality to one of the Soviet type nor is it the ideal that should be placed before the people or the profession. We wish leaders who are anxious to lead the medical profession, do not mislead its members by placing before them high sounding slogans of socialism and co-operation but din into the ears of their brethren to be more spiritual and less materialistic and build a medical profession in this country of great religions, which would eventually solve the huge problem of medical relief on sound principles which should not be dictated by Government but should be cultivated in the hearts of the individual practitioners of medicine by themselves; then only the profession will evolve into a strong and powerful band not only to give medical relief to the masses but also make all concerned realise that Doctors wish to live to serve the people and not thrive on their sufferings.

VIIIth Andhra Medical Conference:

Rightly or wrongly the members of the medical profession in the Northern Circars conceived the idea perhaps in 1928 that there should be a medical fraternity in Northern Circars for the benefit of the members of the medical profession practising in the districts comprising the Northern Circars. Our Dr. Kamath who was invited for the second conference at Ellore and for the two or three following conferences did not find in these conferences a spirit of separation or division of the Medical Profession on linguistic basis as practitioners belonging to linguistic areas other than Andhra and who were taking keen interest in the medical profession were usually invited to these conferences till sometime later perhaps when the conference met in Guntur in 1932, where it was decided to have a separate Medical Association called the Andhra Medical Association. The recent activities of the Andhras to have a province of their own must have circumscribed the activities of the Andhra Medical Association to the

six districts in Northern Circars only as we have information that the members of the medical profession in the Telugu Ceded districts are not the members of the Association. Perhaps it is likely that the latter will join the former in course of time depending upon the political conditions. There are political leaders in Bellary and elsewhere in Ceded Districts who wish to have a Karnataka Province and in Kerala for a Kerala Province. It looks quite probable that are likely to be divisions in the Madras Presidency, but 'when' nobody can prophesy till perhaps Congress India is able to win independence. For our own part, we should say that a cleavage in the medical profession dividing it basing on the languages is most unnatural and as unhealthy. Associations do exist and must exist but their existence should depend upon not on languages but the areas where the medical practitioners exercise their profession and it is really dangerous to effect a change on political lines as it will be suicidal to the growth and evolution of the profession to depend upon politicians. The profession should depend upon itself for its evolution which must be on international lines. Even progressive politicians like Pandit Jawaharlal Nehru, have been conceiving about political growth on international lines. Then only medical science will develop. It was said by at least one Andhra medical practitioner who holds a responsible position in the Kistna District Medical Association that the Andhra Medical Association did not represent all the practitioners practising in Northern Circars and that he had no knowledge of what was transpiring in the Andhra Medical Association. We are alluding to the statement made to us on 20.3.40 when a representative of ours attended the meeting of the Kistna District Medical Association at Masulipatam and do so for what it is worth. All the same we know that the organisers of the VIIIth Andhra Medical Conference did not give sufficient publicity relating to the last Andhra Medical Conference. All the same they seem to have done good work at the Conference. The Presidential Address delivered by Dr. P. Gurumurti is a master-piece in its own

way so is the Address delivered by Dr. B. Tirumal Rao as the Chairman of the Scientific Section of the Conference though the ideology behind these two addresses are of different types. Dr. Gurumurti appears like a visionary characteristic of the political party to which he belongs. Even then his ideology leans more towards the Forward Block though his body is still with the rightists in the Congress. As at the time we received Dr. Gurumurti's address, we had no idea whether we would be able to get the complete proceedings of the Conference we had to comment on his address separately. Dr. Tirumal Rao has given expression to his ideas about Medical Research and Synthesis of various systems of medicine which are, we are happy to note, identical to those usually discussed in these columns. He has put forth his practical ideas so well that we do not feel any necessity to comment on them. But we regret that the Conference did fail to give expression to the idea put forth by Dr. Tirumal Rao relating to Synthesis of different systems of medicine, a subject which has been neglected by the Scientific Medical Profession and we are really afraid that in case this subject is neglected there is real danger ahead to Scientific Medicine as well as to the Ancient System of Medicine. We feel we should point out to the Andhra Medical Association to be more practical and less emotional in their activities. Almost all the resolutions passed at Vizianagaram did find a place in the proceedings of the VIIth Andhra Medical Conference held in Ellore last year. Was it not the duty of the leaders of the Andhra Medical Association to assess the value of its activities in the past so as to be able to know the capital value and sum total of the balance to be able to tax its zeal and resources in the future? To mention the value of one such activity in which at least a few interested are making a capital on account of sheer force of circumstances, we wish to refer to the resolution passed unanimously relating to the Elections to the Madras Medical Council. At Ellore last year a specific resolution on the Madras Medical Council Elections was passed which conveyed all the sentiments expressed

in the resolution on this subject passed at Vizianagaram. May we ask our Andhra friends whether there was a need to reiterate this resolution and whether one year was not sufficient to give effect to the resolutions on the same subject as passed by the Ellore Conference last year? The resolution was so catching as much alluring that at least one amongst the guests in the audience hailing from far Madras and talking Telugu jumped from his seat and requested the President at Ellore to enrol him as a member of the Andhra Medical Association. At Vizianagaram the effect of the resolution was not less attractive, a candidate to the Madras Medical Council Election who till then has been already representing as many as seven institutions was fortunate to be elected as the Secretary of the Andhra Medical Association perhaps in a joint capacity. We may mention that at least one institution of which this candidate avers he is the President does not find a place for him as a matter of fact as per the memorandum and rules of the Association of which he says he is the President. The candidate cannot be ignorant of this fact. The Medical Practitioner is an organ which does not identify itself to any region but concerns itself with the whole profession in this Province if not in all the provinces in India. And we trust the Andhra Medical Association will be most happy to learn perhaps for the first time that the journal was cradled in the very ancient and historic town, Vizianagaram where the Andhra Conference met last and it was Dr. C. Papa Rao who did the ceremony and muttered into the ears of the then baby Journal, the name The Medical Practitioner which the baby gladly adopted. May Dr. Papa Rao be blessed though unfortunately for the profession he can only hear at present what is going around him but not see. If we had the gift of a devoted Yogi, we would have quarrelled with God to restore his vision. All the same we take this opportunity publicly and express our sympathies to Dr. Papa Rao both on our behalf and on behalf of the profession. Whether we are invited or not it has been our habit to watch all that is happening around us relating to the

medical profession whether it be in Andhra Desa, Tamil Nad, Kerala, Karnataka though The Medical Practitioner cannot identify itself with any Desa or Nad nor its Editor who though has been forced to adopt Madras to live and practise medicine and later made journalism as his hobby, can be in a position to identify himself with any language as his mother tongue was originally Prakrath derived from Sanskrit, akin to Hindi and has at present been forced to know all languages in this province. We were at Ellore last year and we did note the feeling or rather the sentiments of our friends who gathered at Ellore in Conference when the resolution on the subject of Medical Council Elections was passed. And though nothing was done to carry out the resolution by those concerned we did attempt and that successfully to respect the sentiments of those who expressed them. So, soon after the valid nominations for the Medical Council Elections were notified and even earlier did spade work so that we might be able to carry out the desire of our Andhra friends. Dr. P. Gurumurti about whom we had not the least idea of being honoured by the Andhra medical profession by installing him as the President of the Conference at Vizianagaram held on 24th and 25th February 1940 was approached as early as 12th of the same month to get himself nominated for the contest in the Medical Council Elections of which he had no idea at all. Is it not a strange and most happy coincidence that our selection to have him in our team of seven to represent all variety of interests not excluding communal was exactly in consonance with the spirit of the resolution passed by the Andhra Medical Conference at Vizianagaram and though we had not the good fortune to be in touch with the Conference we actually carried out the wish of the Conference by selecting three Telugu speaking candidates in a team of seven. We trust the Andhra Medical Association will demonstrate that the Association exists for the noble profession and not for individuals and help the General Electorate to return the seven members who formed into a team to serve the profession and not the individuals in the team. There is a cloud of

misunderstandings and misinterpretations. No good purpose will be served by apportioning the blame. They should forget and forgive the authors whoever they are. We, on our own part, could safely say that we honestly wished and are still wishing to honour Dr. Gurumurti or else there is no purpose in our having approached Dr. Gurumurti, actually waking him when he was asleep at least relating to Medical Council Elections. We may add that though the Andhra Medical Association has an organ of its own The Medical Practitioner will also help and co-operate with its official organ in all matters concerning the welfare of the Medical Profession. We have faith in God when we conscientiously feel we are doing the right despite the strange irony of events.

Medical Profession Robbed: The affairs of the medical profession are so bad and the apathy of the Government towards the profession is so apparent in India that it has been made possible for everybody in authority to control the destinies of the members of the profession and the profession is so crippled that it has no voice to exclaim 'Save us from robbers'. Day after day we have been hearing sad accounts of the members of the profession being robbed of their rights and privileges which they ought to enjoy without invidious distinctions by virtue of their being in the Medical Register. But alas! the Government who brought a special statute in existence to enable the public to know who is qualified to render medical relief and by this Statute provided special rights and privileges to the registered practitioners, have been conniving at the robbery and when instances of robbery were reported to the Government at least through these columns they were condoned. Consequently it has been possible for the robbers to be at large.

The latest information we have is that the President, District Board, Salem has ruled that the physical fitness and vaccination certificates for new entrants to the subsidized medical service should be obtained only from official medical graduates or from graduates in honorary service. The readers might remember

about the ruling of the President, District Board, Coimbatore, reported in these columns a few months ago that subsidized practitioners were not competent to grant physical fitness certificates to motor drivers though the rules under Motor Vehicles' Act permit any registered practitioner to grant such certificates.

The President, District Board, West Godavari District, who is himself a medical graduate and a Congress man to boot has notified that he cannot entertain medical licentiates as honorary medical officers in L. F. Service though the Congress Government did order that the medical licentiates were competent to hold honorary posts in State Hospitals.

We learn that Dr. V. Rama Kamath has given notice of his intention to move the following resolutions at the next and the last meeting of the old Council to be held on 15.4.40 :

1. The Madras Medical Council is of opinion that it is derogatory and against the spirit of the Madras Medical Registration Act to use such expressions as 'L.M.P.'s need not apply,' 'above the rank of an L.M.P.' and similar expressions by the Government departments and local bodies while advertising for posts as such and similar expressions convey an inferiority complex.

2. The Madras Medical Council is of opinion that it is desirable to maintain a uniform standard relating to the Code of Medical Ethics and therefore the Government and the local bodies are requested to report to the Council all *bonafide* cases of infamous conduct in a professional respect reported against, official medical officers or against non-official practitioners under their control.

3. Resolved to inform the Government and through the Government the local bodies that subsidized practitioners on the Madras Medical Register should not be deprived of their rights and privileges conferred on them by virtue of registration.

4. Resolved to inform the Madras Public Service Commission through the Government that it is derogatory and against the spirit of the Madras Medical Registration Act to make invidious distinctions between official and non-official registered practitioners in regard to physical fitness certificates demanded by the Commission from the candidates applying for posts under the Government and that all registered practitioners who possess L. O. diploma granted by the Madras Government Ophthalmic Hospital or who possess the London D. O. M. S. Diploma should be considered as eye-specialists for the purpose of medical certificates without making any reference

to the Surgeon-General with the Government of Madras.

5. The Madras Council notes with regret that in spite of a special Government Order that when a Government Medical Officer is requested to give a second opinion on the certificate granted by a private practitioner, the former should request the practitioner who granted the original certificate to be present at the time the patient is being examined by the Government Medical Officer, instances are being reported when Medical Officers in the position of Presidency Surgeons having set at naught the G. O. on the subject. Therefore the Surgeon-General with the Government of Madras is requested to take notice of the conduct of officers concerned so that the G. O. on the subject is strictly adhered to."

The resolutions are comprehensive. They cover the wide field where the registered practitioners have been robbed of their rights and privileges day after day. 15th April is the last day when the existing old Council meets and it is hoped that the Council will be pleased to pass the above resolutions unanimously, and thus demonstrate their good will as a parting present to the entire profession.

Delhi Jealous of Madras: For nearly a decade and a half the Central Government has been picking high medical officials from the Madras Province to serve them at their seat. Major-General Symons, the then Surgeon-General with the Government of Madras was the first to be selected about fifteen years ago to serve as the Director-General, Indian Medical Service. When General Symons retired, Major-General Megaw, the Surgeon-General who succeeded General Symons was snatched away from this Presidency. Later Major-General Sprawson, had his turn and was made to succeed General Megaw. Next Major-General Bradfield, an officer who spent major portion of his career on civil side in the Madras Presidency and who by a mere accident had to leave Madras, was pitched upon by the Government of India to serve as Director-General, Indian Medical Service to succeed General Sprawson. Major-General Connor who succeeded General Sprawson as the Surgeon-General with the Government of Madras and Major-General Wilson, the successor of General Connor had each their turn to serve as Director-General, Indian Medical

Service though temporarily and we were very glad that both these two Generals were spared to serve the Madras Presidency till the end of their official career. For, it is during the regime of these Surgeon-Generals momentous changes took place in the Madras Medical Department and but for the appreciation by these two Departmental Heads of the views and comments expressed by us in these columns, The Medical Practitioner would not have been able to serve the medical profession with tangible good results to the extent it has been doing these years. We did cross swords with these two Military Generals but not with military spirit and a bit of it which we had to display in the earlier part of the career of The Medical Practitioner was made to disappear, for, both these Military Generals kept smiling and made us smile inspite of our crossing the swords. They as ideal Britishers could appreciate that our militant pen was serving the noble profession to which they too belonged.

The post of the Director-General, Indian Medical Service was not the only one to fill which Madras had to suffer and Delhi to gain. The Government of India had to look to Madras to find a capable Medical Officer to be the Chief Medical Officer, Delhi a few years ago and Lt. Col. Patton who had been doing good work in the most civil spirit though belonging to Military Service at the Madras Government Hospital for Women and Children had his turn to go to Delhi to serve as its Chief Medical Officer a few years ago and a couple of months ago it was the misfortune of Madras and good fortune of Delhi that Lt. Col. Cruickshank was carried away. Col. Cruickshank was able to demonstrate what it was to be the Superintendent of the biggest General-Hospital in India which he did even at the risk of his health. For we hope our readers in Madras would remember his toiling and moiling in the General Hospital with a carbuncle at the nape of his neck; to this extent he showed the military qualities of his service by sticking to his post inspite of his illness, which he did even at the risk of his health. He might have felt perhaps

that the affairs prevailing in such a big hospital demanded military discipline of holding to a post inspite of danger. Col. Cruickshank was to succeed in Delhi the late Major Ebdon who was forcibly removed from the field of his activities, the Andhra Medical College last year to serve only a few months as the Chief Medical Officer, Delhi which position he could not occupy long due to the cruel hand of death.

The jealousy of Delhi did not stop there. Madras has soon to lose a popular, yet disciplined and as capable a member of the Women Medical Service of India, Dr. (Miss) Hilda Lazarus, Superintendent, the Government Victoria Caste and Gosha Hospital and who was the Superintendent of the Willingdon Medical School for Women till it was abolished. She is to take charge of the Lady Hardinge Medical College, Delhi in September next. It may be perhaps superfluous for us to say anything about this lady; for she is so well known to the profession and the public from the highest to the lowest. It is no exaggeration to say that the clocks and the watches could be set right in timing by her routine daily rounds in the hospital. She usually met her friends in the evenings in the small open garden in front of her quarters and she would stand up at a particular time and run up to the hospital even in the midst of a most pleasant or as exciting conversation with her friends. Even paying patients could not deter her to go a minute late into the hospital for daily rounds. We at times seriously thought if the ban on the privilege of private practice enjoyed by State-paid medical officers was necessary at all if all such practitioners minded their duties and responsibilities in the hospital and did not enter the field of private practice with the only desire to add to their salaries which have been getting fatter and fatter in direct proportion to their activities in private practice. We were told that a few years ago Dr. Lazarus was offered the same post for which she has been now selected now and she thankfully declined the offer as she could not all at once give up her motherly affection to the two institu-

tions in the Presidency of her birth for the love of extra money she might have got by such promotion. It is too much for us to know the mind of the Central Government much less of the Lady Doctor of their choice. Yet it is possible for us to surmise that Dr. Lazarus might have agreed to leave her affectionate Presidency in the larger interests of the Medical profession as she is to be the Principal of the only Women Medical College in India. It is natural that her zealous regards for the members of the medical profession belonging to her sex that must have prompted her to leave Madras as she must have inwardly thought that she would be able to guide the destinies of Medical Education of Women in India on account of her experience which she gained in the Lady Willingdon Medical School in Madras. She did show her metal as an Educationist of a high order by the comparative better results in the Willingdon Medical School as against the Men Medical School of Madras, which her Women students were able to score on account of the team work of her lady colleagues inspite of several handicaps. We wish Col. Cruickshank and Dr. Lazarus long life of usefulness in the new fields of their activities where we are sure both of them will bring credit to the medical profession transforming the temporary jealousy of Delhi into a passionate zeal of service to the humanity.

Lt. Col. Shastri and Medical Council Elections: If a prize is to be instituted to be awarded for all pervading and omnipotent activities relating to District Medical Associations in the Madras Presidency, the recipient of this prize will be Lt. Col. Shastri, the present District Medical Officer of the Kistna District. He has a special aptitude to make the District Medical Associations very active wherever he is the District Medical Officer. Men and women practitioners, official, honorary and even non-official including the subsidised practitioners always vie with each other in attending the meetings convened under the orders of Col. Shastri. He seems to have a special knack to make his official position felt without demur wherever he acts as a

D. M. O. He is a master of languages, talks all the provincial languages fluently excepting perhaps Malayalam as he had no occasion to be in Malabar. The Government have not been blind to the activities of Col. Shastri as the Head of the District Medical Department. For, though it was once notified in the Government Gazette that Col. Shastri was going on long leave preparatory to retirement, the notification was cancelled later. Thanks to the wisdom of the Government, the medical profession can enjoy Col. Shastri's company as a D. M. O. to the full extent of his service as a member of that gallant service, the Indian Medical Service. The Government went a step further in appreciating Col. Shastri's services by removing him from the Southernmost district in Tamil Nad and transferring him to a central district of Northern Circars a region, having the birth place of Col. Shastri and it is but natural that Col. Shastri is showing tendencies to concentrate all his activities for the benefit of those who talk Telugu. It is a happy coincidence for Col. Shastri that the time of his transfer to Kistna District is most opportune so that he may share the struggle for establishing an Andhra Province. We are not capable to question the wisdom of the politicians in dividing this province on linguistic basis especially so when the politicians themselves are attempting successfully to make Hindi the common language for India. All the same, we should warn the members of the Medical Profession that the activities and interests of the profession should not be narrow but should be international. Then only the noble profession can thrive scientifically. The profession should not think in terms of Government Service and fortunately for the profession the attraction for Government Service in the medical profession is waning giving place to honorary service or private service and consequently it is possible for the members of the medical profession to conceive that there is no purpose in dividing themselves on linguistic basis on the lines which Col. Shastri has been pleading at least now when the heat of Medical Council Elections is naturally oscillating the mental equilibrium, the scales moving

up and down depending upon the persuasive tongue of the candidates or their agents. To the misfortune of the candidates as well as that of the electors the Government have fixed the period for conducting elections in the summer and God forbid any unforeseen accidents due to beastly heat of summer in Northern Circars superimposed on that of elections.

Col. Shastri convened a meeting of the Kistna District Medical Association in his residence at Masulipatam on 20th March 1940 exactly three days after the seven candidates in the list of valid nominations in regard to Madras Medical Council Elections formed into a team and fixed the programme of the work of the team. Dr. P. Gurumurti, a member in the team representing the six Districts in Northern Circars told the team on the 17th that Col. Shastri specially met him on the Bezwada Railway platform on his (Dr. Gurumurti's) journey to Madras to attend the meeting of the team and invited him to attend the meeting to be held at Masulipatam and that the very first item in the Agenda was about Medical Council Elections. Though in the interest of the team where Dr. Gurumurti was, the idea was considered by us not quite so bad, yet we questioned within ourselves with some misgivings whether Col. Shastri interested zeal in the Medical Council Elections was not likely to be questioned by the Government as Government servants' conduct rules prohibit even high officials in taking part in Elections however noble be the motive behind the zeal. So we made up our mind to attend the meeting, uninvited, which we did in company with Dr. K. Narayanamurti. By mere accident we met Dr. Gurumurti and a few more official and non-official practitioners on the Bezwada railway platform as the latter missed the early morning train to Masulipatam. When all of us reached the place of meeting, Col. Shastri was on his legs dictating resolutions one after the other and asking for show of hands. Of course, there was no controversy nor is it usually possible to have any controversy when the meeting is presided over by the Head of the

Medical Department of a District. There were three resolutions specially on the Medical Council Elections, two concerning the local Council, and one regarding the Medical Council of India. The pertinent resolutions appeared in almost all English dailies and they appear also in The Medical Practitioner, in the Correspondent Columns. The first resolution expresses the necessity of a convention which should press for three seats in the Madras Medical Council out of seven to be reserved for practitioners in Andhra Desa. The third resolution announces the Andhra candidates and the Kistna District Medical Association desires that the candidates mentioned in the resolution should be voted upon solidly; one of whom is Dr. P. Gurumurti and the other Dr. Suryanarayana Rao, the sitting member of the Medical Council. The resolution relating to the election to the Medical Council of India supports Dr. Tirumurti, the principle adopted in this resolution is that a candidate who had enjoyed five years term in the Medical Council should make room for another.

Apart from the propriety or the justification of a District Medical Officer openly taking sides in Elections, we were rather surprised at the conflict of principles adopted at the meeting. Col. Shastri has objection to the candidature of Dr. T. Satakopan in favour of Rao Bahadur Dr. T. S. Tirumurti on the principle of five years enjoyment of the term of office by the sitting member who is once again competing; whereas in regard to the local Medical Council elections, the same principle was forgotten—can we say conveniently—to make room for Dr. Suryanarayana Rao, a sitting member of the same Council. It is said that the latter candidate who practises in Tanuku, West Godavari District, is now a member of the Kistna

District Medical Association. The less said the better about the principles behind the resolutions. The principles did really assume the importance of motives. Whether these motives are in the interest of the General Electorate it is for the Electorate to decide by casting the sacred vote which the individual voter can cast without anybody's knowledge unless the voting papers are snatched by undue influence. Is this possible under the British Rule? We will wait and see.

Apology and Appeal: We regret that it was not possible for us to publish the March number of The Medical Practitioner in time. The journal was brought into existence in 1929 to serve as a special organ to publish the proceedings of the Madras Medical Council. The journal has therefore to interest itself about the impending elections to the Madras Medical Council. So we had to gather all available news personally by coming in contact with the electorate in almost all the districts, which we had to do from 18th ultimo till 8th instant and hence the delay. A special manifesto on behalf of a team of six will soon be in the hands of the electors. We request them to go through the Editorial on the "Medical Council Elections" and the News and Comments relating to the elections which appear in these columns and vote solidly for the team to enable us to serve the profession much more vigorously and usefully. Due to circumstances beyond our control the five candidates from the Northern Circars could not as yet make up their minds to serve the larger interests of the profession and not their individual interest. Or else the elections could have been uncontested and all troubles might have been averted by all concerned.

PHONE No: 3034

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)

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Elections to the Madras Medical Council.

An Appeal To My Telugu Friends

By

V. C. KAMARAJU, L.M. & S.,

COCANADA.

Dr. Rama Kamath whose services to the medical profession through the Medical Council, and outside it through his pen, needs no introduction to the electorate, comes forward with a scheme and requests the electorate to give him their backing and thereby consolidate his position in the Council.

There are about seven thousand voters of which the majority are from the Tamil and other linguistic areas while the Telugu area contains the rest.

Under the circumstances if things are left to themselves voting is bound to be erratic, inconsistent, and inconsiderate, the Tamils and others voting for their lot, first, and then, indiscriminately for the rest and the Telugus voting for all the Telugus first, leaving no vote for the rest! To avoid this pointless frittering away of the votes, Dr. Rama Kamath proposes that three seats be allotted by understanding to the other area and three for the Telugus leaving one for himself to represent Madras. Accordingly he tells us that with his influence he has fixed up with the other areas that they should nominate only three candidates and this we find is what has been done. But, whether owing to the fact that no one knew his scheme or his team in time, or that he did not make adequate previous arrangements with the Telugu area, seven candidates have got themselves nominated from the Telugu districts. It is fair to examine the objects underlying Dr. Kamath's scheme.

He wishes to have a team of seven to stand by him. That it is desirable, no one can deny and leaving aside the other three, and considering the team of three from the Telugu area, he likes to

have Dr. Narayanamurthi, the Hony. Physician to the General Hospital. We consider this is a very good choice for the following reasons. He is a candidate of whom we should be proud and do our best to push up. He will be at Madras like Dr. Kamath himself and will be able to be more in touch with the affairs of the Council than any of us from the moffussil can possibly be and he can also collaborate easily with Dr. Kamath. The second is Dr. Samuel—who is also an M. L. A. and who belongs to the Ceded districts, which for obvious reasons have to be provided for and there remains only one more place and Dr. Kamath has chosen Dr. Gurumurthi of Rajahmundry who is a senior practitioner, probably older than the rest, with a reputation as a national fighter and worker and with no other ambition liable to make him yield to fear and favour, than to serve the profession.

I have avoided reference to degree, diploma, caste and creed though these have been fairly well-looked after by Dr. Kamath. The less we think of them the better.

One question that is likely to be raised by some friends, I fear, will be "Who is Dr. Kamath and who is he to guide us?" I can only answer that Dr. Kamath is Dr. Kamath who has done some service already and as such in spite of his zeal seeming a weakness in this form, to some, he deserves to be considered and given his due. And as such his past services do demand our co-operation this time.

He requests that his team be voted for enbloc and considering there is hardly any time for us to be able to make our own selection from our candidates we appeal to the rest of our candidates to withdraw in favour of Dr. Gurumurthi and Dr. Narayanamurthi and thereby we will not be letting him or the Tamils and others down which we will be doing if our seven keep on facing the three candidates so considerably put forward by them, and in case our Telugu friends do not do so, we appeal to the electorate to give a kind consideration to Dr. Kamath's plea while voting.

COCANADA

26—3—1940.

V. C. KAMARAJU, L. M. & S.

Correspondence, Reports, Etc.

Memorandum submitted to the Government of Madras through the Surgeon-General with the Government of Madras by the President, The Madras Provincial Subsidized Rural Medical Practitioners' Association relating to some of the Resolutions passed by the Association at the Conference held at Samalkot on 22nd and 23rd April 1939 and by the Provincial Committee at Tirupati on 26th, 27th and 28th December 1939.

The Subsidized Rural Medical Practitioners met in a conference at Samalkot on 22nd and 23rd April 1939 and in the course of its proceedings the Conference passed amongst other resolutions some requiring the kind attention of the Government. But as the Government did not pass orders on the Memorandum submitted to them on 20th February 1939, it was considered not expedient to submit to the Government a memorandum relating to the resolutions passed at the Samalkot Conference till the Government were pleased to pass orders on the previous memorandum submitted to them on 20th February 1939. The Government were pleased to pass orders on the Memorandum referred to on 5th December 1939. The Provincial Committee of the Association met in Tirupati and passed the following amongst other resolutions:

"As the resolution passed at the last Samalkot Conference have not been submitted to the Government in the form of a memorandum, the Provincial Committee reiterates all the resolutions and requests the President to draft a memorandum which may be forwarded to the Government through the Surgeon-General. The Committee also resolves that in the memorandum any other matter concerning the affairs of the Rural Medical Relief Scheme which require solution be also incorporated. The Provincial Committee suggests to the Working Committee that if necessary to wait on the Surgeon-General in deputation as early as possible."

Accordingly the Working Committee of the Association waited on the Surgeon-General with the Government of Madras on 6th February 1940 and placed the Memorandum before the Surgeon-General requesting him to forward the same to the Government with his recommendations. I beg to point out at the very outset that the Association feels the necessity of approaching the

Government as and when the circumstances relating to the working of the Subsidized Rural Medical Relief Scheme compels it to do the same as the Scheme has no uniform rules or regulations to guide those running the Scheme excepting the conditions of the Agreement which have been changing from time to time depending upon the working of the Scheme. The Association, therefore, prays it may be excused in case it is compelled to make representations to the Government whenever a necessity is felt. The following two resolutions passed by the Association at the Samalkot Conference relate to the underlying principles and spirit of the Scheme and therefore are clubbed together.

"This Conference respectfully points out to the Government that there is no necessity of renewing the Agreement year after year or at varying periods as such a procedure is against the spirit of the Rural Medical Relief Scheme and in case a Subsidized Practitioner commits any breach in the terms of the agreement there is a specific provision provided in clause 12 of the agreement by which his services can be terminated.

This Conference respectfully represents to the Government that the transfer of Subsidized Rural Medical Practitioners from one Dispensary to another without mutual consent of the practitioners is against the principle and spirit of the Subsidized Rural Medical Relief Scheme, nor is the principle of converting a subsidized dispensary into either a L. F. dispensary or a dispensary of any other system is consistent with the spirit of the Scheme."

In the preamble of the Agreement to be executed by the practitioners it is mentioned that the practitioner is to settle in the villages permanently. A small amount of Rs. 41-10-8 per month which is paid to the practitioner is hardly enough to maintain himself and his growing family and he has to depend upon private practice for his livelihood. Depending upon the assurance made in the preamble that he had to settle in the village permanently, many practitioners who settled in the villages soon after the Scheme was inaugurated and have been adjusting themselves to their environments will find it indeed very hard if they were left to the mercy of ever

changing whims and caprices of the local bodies which bodies cannot be expected to view the principles and spirit of the Scheme in the way the Government do. The Association is made to feel on account of various acts of omission and commission of at least some of the District Boards that personal element plays to a large extent in either fixing the period of Agreement and in transferring of the practitioners and the recently incorporated condition which empowers the District Boards to transfer practitioners who have settled for a number of years, on the plea of converting a dispensary of the Allopathic System into a dispensary of Indian System of medicine, has completely run counter to the principle and spirit of the Subsidized service as originally started by the Government. I might mention that there was a specific clause 10 in the old agreement which was against transfers and transfers were not made possible for various purposes including the conversion of a dispensary of one system to another. It is true that the District Boards should consult the District Medical Officers and obtain also the previous permission of the Government before the transfer is effected. But the Government are aware that the District Board, North Arcot did effect transfers last year without consulting the District Medical Officer or the Government and when representation was made to the Government, and though the Government held that the transfers were irregular they condoned the irregularity. The Association therefore respectfully suggests to the Government that a clause be added in the Agreement to renew the Agreement for a period of not less than five years uniformly after the probationary period of one year, making it obligatory that in case there are no complaints against the practitioner of the nature mentioned in clause 12, the same practitioner should continue to serve in the subsidized dispensary as originally contemplated by the Government to encourage the practitioner to settle in the villages permanently. It is true times are changing rapidly and the villages are more attractive to the medical practitioners than they were in 1925 when

the Scheme was inaugurated. But the Government should take into their kind and sympathetic consideration that the pioneers who settled in the villages nearly fifteen years ago should not be victimised as these pioneers were solely responsible to make the villages more attractive now. This consideration holds good in case of transfers for any other purpose and so the Allopathic dispensary which commands popularity as could be judged from the daily attendance, should not be converted into one of any other system. In this connection the Association desires to bring to the notice of the Government that the practitioners who pass out from the Government School of Indian Medicine invariably practise the Allopathic system of Medicine and conversion of the Allopathic dispensary into one of Indigenous system serves only as a cloak and not a reality.

The Provincial Committee at their meeting held in Tirupati last December passed the following resolution amongst others:

"Resolved to request the Government that for the purpose of enquiry provided for in Clause 12 of the agreement, to be executed by the Subsidized Practitioners, the Inspector of Municipal Councils and Local Boards or his Deputy not below the rank of a Deputy Collector be deputed."

There have been many instances where the Presidents, District Boards assumed the role of a prosecutor as well as of the judge and the situation was worse still when the judgment was passed ex-party. The result of such slipshod enquiries has been miscarriage of justice and at times the Government might be forced to condone irregularities on public grounds and the unfortunate practice has consequently to suffer. I crave permission to refer to two such typical cases one in the Salem District and the other in Madura.

In 1938 the President, District Board, Salem, framed as many as seven charges against a practitioner then in charge of Dattadripuram Subsidized Dispensary. The alleged offences were of very grave nature, such as criminal misappropriation of moneys, falsification of records etc. An enquiry was conducted by the President who took written statements from

the parties interested in the complaint without either supplying such statements to the practitioner nor permitting him to cross examine the witnesses. The practitioner requested the District Board to have an open enquiry by a disinterested officer. Fortunately for the practitioner the term of office of the elected President expired at the time and the Ex-Officio President, the District Collector conducted an enquiry through the Divisional officer of the concerned area with the result that the Collector did not find the practitioner guilty of any charge. It may not be out of place for me to quote the concluding para of the Collector's decision:

"I accept the finding of the Revenue Divisional Officer that the case against the Rural Practitioner has been worked up by a faction headed by the karnam with the ward boy and the midwife as his supporters and I direct, in accordance with his recommendation, that the midwife and wardboy should be transferred elsewhere. Such portions of the charges as are proved, are unimportant and do not justify the imposition of any punishment. The Doctor cited 12 witnesses on his behalf all of whom are residents of Dattadripuram and adjoining villages. They spoke to his popularity and good behaviour. The Doctor appears to have done good work in connection with leprosy and the visitors to the dispensary generally speak well of the medical practitioner's work. The Vice-President of the District Board, as recently as November 1937, talked about the very good work that was being turned out at the dispensary. I, therefore, do not propose to take any action against the medical practitioner."

I now learn that the practitioner is still being harassed by the parties referred to by the Collector and the dispensary which was at Dattadripuram has been transferred to Elur, a place which was condemned by the District Medical Officer, Salem as he considered that it was a place of factions and it would not be conducive to the good working of the Dispensary to have it at Elur. The ward boy and the midwife whom the Collector ordered to be transferred are still retained in the same dispensary.

The case against the practitioner at Kalligudy, Madura District, is a recent one. The District Board president, Madura, suspended the practitioner on a charge of misconduct in a professional respect, and gave ex-party decision which the Government condoned. There is no condition in the Agreement which con-

templates suspension of the practitioner. His services could be terminated after an enquiry and after the Government passes final orders on the complaint either when a reference is made to them by the Board, Surgeon-General or after the hearing of the appeal of the aggrieved practitioner. The practitioner was deprived of his subsidy for over nine months till the Government passed final order on the case and even the village had to suffer for want of medical relief, during the period of suspension. There is another principle involved in this case which I wish to bring to the kind notice of the Government. The subsidized practitioner is a private practitioner and the Government have declared that he is neither a servant of the District Board nor of the Government. As such, he cannot be treated as a servant of the District Board. There cannot be any disciplinary action against him. The highest punishment and the only punishment contemplated in the Agreement is the termination of his services as per condition No. 12. He is subsidized to give medical relief to the necessitous poor. To this extent the District Board can question his conduct. But in case the Board receives a complaint against his misconduct in a professional respect the Board should advise the party to make a complaint to the Madras Medical Council, a statutory body specially brought into existence to try registered practitioners in matters relating to misconduct in a professional respect. The District Board did a great injustice to this practitioner by not only suspending him but also exposing him to public ridicule by holding an open enquiry without giving a chance for the practitioner to defend himself.

So, the request of the Association to depute the Inspector of Municipal Councils and local Boards to conduct enquiries contemplated in Clause 12 is modest and reasonable so also the suggestion that in case there is a complaint against the practitioner relating to infamous conduct in a professional respect, the concerned party should be asked to lodge the complaint before the Medical Council.

The following resolution passed by the Provincial Committee relates to supply of drugs etc,

"As the Government Medical Stores have increased the prices of drugs, instruments, etc., by 20 per cent resolved to request the Government that the supply of medicines be proportionately increased so that the necessitous poor patients attending the dispensary may not suffer for want of medicines".

In addition to the representation made to the Government by the Association on this subject that a large amount is deducted towards freight, packing etc., from Rs. 360 the amount sanctioned by the District Board for this purpose, the Government Medical Stores have increased the price of drugs, chemicals etc., by 20 per cent after the outbreak of war. Consequently the quantity of drugs etc., supplied to the dispensaries has suffered materially and it will be difficult to run the dispensary on a supply of Medicines worth nearly half of Rs. 360 about 25 per cent deducted for freight and 20 per cent due to war conditions. The economical conditions in villages is likely to be worse during the period of war due to rise of prices of food stuffs, clothing etc., and the incidence of the diseases will necessarily be higher. No charitable medical institution under local bodies or Government are made to suffer for want of medicines, for the supply depends upon demand but in case of subsidized dispensaries the supply of medicines have to depend upon the cost of medicines supplied, therefore, it is desirable in the interests of suffering humanity in the villages that the grant of Rs. 360 should be increased to a reasonable amount. It looks to me that the drugs to the net value of Rs. 500 will be a reasonable amount for treating the necessitous poor, for one year in Subsidized Dispensaries.

The grievances of the Subsidized practitioner in regard to the supply of Surgical instruments remains just the same in spite of the direction given to the District Boards by the Government in their Order No. 3483 P. H. dated 1st October 1938 and therefore the following resolution was passed by the Association at Samalkot.

"The Conference brings to the notice of the Government that notwithstanding the direction in G. O. No. 3483 P. H. dated 1st October 1938 the Presidents of Local Boards have been invariably reluctant to equip all rural dispen-

saries maintained by them with necessary surgical, dental and midwifery instruments in accordance with the recommendations made in G. O. No. 761 P. H. dated 7th April 1925 which if supplied are to remain as the property of the Local Boards concerned and form the permanent equipment of the Rural Dispensary".

Excepting one solitary District, Nellore, in all the rest of the Districts the grievance remains just the same. A list of Districts where the grievance continues is appended to the Memorandum. In some Districts as in Tanjore, Trichy, etc., the practitioners have been forced to get some important instruments including the same in the indent to the Medical Stores. There are dispensaries where midwives are attached but the instruments required for midwifery emergencies are not supplied. There cannot be any doubt that due to this handicap the work of Medical relief must have been seriously suffering.

Two representations made by the Association relating to the appointment of Subsidized Practitioners to L. F. Service did not as yet bring the expected result in spite of the sympathetic attitude of the Government and therefore the Association passed the following resolution at Samalkot:

"This Conference views with great regret that in spite of repeated assurances from the Government that suitable Subsidized Practitioners will be appointed to L. F. Service when vacancies arise, the Coimbatore District Board and also the Tanjore District Board did not adhere to the G. O. on the subject on the plea of having reserved Sub Assistant Surgeons."

The Government have been pleased to order in G. O. No. 4474 P. H. dated 5th December 1939 that specific cases must be brought to the notice of the Government. In addition to the District Boards mentioned in the above resolution, recently the North Arcot and Krishna District Boards overlooked the claims of senior practitioners in favour of junior while appointing medical officers to be in charge of L. F. Dispensaries. Quite recently in Malabar a very junior practitioner was selected in preference to many seniors. A reference to the records maintained relating to the subsidized practitioners in both these districts might convince the Government about the injustice complained against. I may respectfully

suggest that a seniority list of subsidized practitioners be maintained by the District Boards or by the Surgeon-General for the purpose of selection of subsidized practitioners to L. F. Service which may also serve as a reference to the Government.

The following resolution passed by the Provincial Committee at Tirupati speaks for itself:

"Resolved to bring to the notice of the Government that due to war conditions the economical conditions in the villages are seriously affected with the result that the subsidized practitioners are very much handicapped in regard to private income. Consequently the Provincial Committee is compelled by sheer necessity to request the Government to increase the yearly subsidy to Rs. 600 uniformly. It is also resolved to bring to the notice of the Government that such of the District Boards which had been paying extra subsidy to the practitioners and which were recently cut down be asked to restore the additional subsidies."

The Government are aware that the economic conditions prevailing in villages are worse at present due to war conditions, and the request of the Association to increase the subsidy uniformly to Rs. 600 is in keeping with the existing conditions in the villages and therefore the resolution may be sympathetically considered by the Government.

Regarding the extra subsidy which some of the District Boards have been giving to the subsidized practitioners on account of their being unable to attract practitioners to settle in the villages has been cut down in North Arcot, Anantapur and there is a move to the same effect in Madura and a few other District Boards. I should also mention that the District Board, Salem, have not cut down the extra subsidy paid to the practitioners settled in the villages in the past but do not grant the same to the new entrants. It is unjust to stop extra subsidy to those who were entertained with the promise of extra subsidy but for such a promise the practitioners might not have consented to settle in the villages especially in the backward districts where the benefits of scientific medicines were not known to the villagers before the dispensary were opened there. The practitioners who have been adjusting their lives to the provincial as well as the extra subsidy

paid by the District Boards find it very difficult to maintain themselves and it was not fair on the part of the District Boards to stop the subsidies especially at a time when the village conditions are worse than what they were before. Even in the case of regular service both under local bodies and the Government when retrenchment was effected those who were already in service were not made to suffer and suitable arrangements were made to pay them extra allowances etc. So I earnestly request the Government that the District Boards be instructed not to cut down the extra subsidy in the case of practitioners who had already settled in the villages and make the retrenchment policy applicable only to new entrants, as is done in the Salem District.

Contingencies is an item which has no uniformity either in the whole province or even in the same District. Personal considerations seem to weigh in granting contingencies. It may be remembered that the Government were pleased to pass a definite order regarding the items of dispensary servant and expenditure for stationery and stamps in their Order No. 3510 P.H. dated 4th October 1938 and in some districts such as North Arcot, Bellary, East Godavari, Salem and Vizag nothing is paid to the practitioners for stationery and postage and in other districts such as South Kanara, Madura, Trichy, Tinnevely, a small amount ranging from As. 8 to Re. 1 is being paid. In Tanjore, Tinnevely and South Kanara dispensary servants are not supplied at all even though the attendance is over 50. As requested once before the Association wish to represent that male attendant is a necessity to help the practitioner in the dispensary where daily attendance is 30 or over. It is said that in Krishna District the practitioners were not paid anything for postage or stationery from October 1938 till 1st July 1939 though they were paid for the same before and are being paid after 1st July 1939 and the Madura District Board had decided recently to stop the contingency charges from the beginning of the next official year. It may therefore be desirable that the Government may be pleased to instruct the District Boards referred to above to pay the sub-

sidized practitioners the cost of stationery and stamps to the maximum value of Rs. 3 as per the G. O. It is also requested that the District Boards may be advised to appoint dispensary servants who should be the nominees of the subsidized practitioners. This is desirable in the interest of discipline.

The members of the Association feel the necessity of attending the Headquarters Hospitals at least once a month and some of the District Branches of the Association did request the respective District Medical Officers to give them bedside clinical instructions in the Headquarters Hospitals on penultimate Saturdays and the District Medical Officers who were requested have been kind enough to hold clinical meetings. But the subsidized practitioners are very much handicapped as the penultimate Saturdays, Government Holidays and even Sundays are included in the maximum leave of 30 days allotted to them in a year. The Association therefore, passed the following resolution and it is desirable that the Government be pleased to comply the Association with the request in the interest of efficiency in medical relief as the subsidized practitioners have no other means of coming in contact with the District Hospitals to gain up-to-date knowledge in the treatment of diseases:

"Resolved to request the Government to delete the word 'including' appearing in clause 7 of the Agreement in line 3 in G. O. No. 3510 P. H. dated 4th October 1938 appendix 1 and 2 and substitute therein the word 'excluding' as otherwise the practitioners cannot attend the meetings of the District Medical Associations which are generally held either on penultimate Saturdays, Government holidays or Sundays or otherwise direct the local bodies to treat the days that the practitioners attend those meetings as working days".

The Honorary Medical Officers under the Government are being considered by the Government as Government servants for the purpose of giving them the benefit of treatment in State Medical Institutions. On the same principles the Association requests the Government by the following resolution to bestow on them the benefit of concession in the State Medical Institutions.

"Resolved to request the Government to treat the Subsidized Practitioners as servants of the Government in regard to their treatment in the State Medical Institutions".

In their Order No. 4474 P.H. dated 5th December 1939 the Government regret that they cannot accede to the request made by the practitioners to raise the remuneration of Rs. 15 per month for doing Public Health work. When a practitioner is posted on a festival duty he has to devote all his time to Public Health work only and he is deprived of private practice on the day he is on festival duty. Therefore the Association has passed the following resolution for the kind and sympathetic consideration of the Government:

"The Provincial Committee requests the Government to sanction for such Rural Medical Practitioners doing Public Health work when deputed for festival duty the usual allowance of Rs. 5 per day to compensate for the loss of private practice as in the case of those who are not engaged in Public Health Work."

Another memorandum had been also submitted separately on the 6th March 1940 to the Surgeon-General containing items of grievances of the subsidized practitioners which could be dealt with by the Surgeon-General himself. This will be published in the April issue.—Ed.

The Independent Medical Practitioners' Association,

TINNEVELLY.

The third Anniversary of the above Association was held on Saturday, the 9th March 1940 at Dr. L. Mahadevan's Eye-clinic, Vannarpet, Tinnevely. Proceedings began with the business meeting.

It was resolved to subscribe for "The Lancet," "The Practitioner," "The Medical Practitioner", for one year and also the following resolution was passed unanimously:—

This Association accords its support to the Government's Amending Bill to the Indian Medical Degrees Act of 1916 as it is very essential and requests the Government to bring the amending bill into force as early as possible.

After the business meeting there was a tea-party accompanied with music. After tea, the

Anniversary meeting began with Dr. R. Sundaram, in the chair. He welcomed the lecturer Dr. K. Vasudeva Rao, the Superintendent, Tuberculosis Hospital, Madras and other guests, who kindly responded to the invitation. The Annual Report of the Association was read by the Secretary. Dr. K. Vasudeva Rao, then delivered a very interesting and instructive lecture on "The Surgical aspect in the treatment of Pulmonary Tuberculosis" followed by the exhibition of X-Ray films. The function came to a close with a dinner party in the night which was attended by the members as well as by the guests.

RESOLUTIONS PASSED BY THE VIIIth ANDHRA MEDICAL CONFERENCE AT VIZIANAGRAM ON 25-2-40.

1. This Conference, while thanking the Indian Medical Council for conditional temporary recognition given to Andhra, M.B.B.S. degree, regret that an invidious distinction has been made by excluding degrees conferred before 1938 and urges on the Indian Medical Council to confer retrospective recognition on all medical degrees of Andhra University. This Conference endorses the memorandum on the subject by the Old Boys' Association of the Vizagapatam Medical College.

2. This Conference urges on the Andhra University to institute post-graduate refresher courses in the King George Hospital, Vizagapatam in general medicine, surgery and special subjects for practitioners.

3. This Conference urges on the Andhra University to amend regulations for M.D. and M. S. to permit L. M. S. degree holders of the Andhra University to appear for M.D. & M.S.

4. Resolved to form a Sub-Committee consisting of—Drs. P. Gurumurthi, (Chairman) Y.V. Ramanamurti, (Convener) G. Ramayyengar, D. S. Ramachandra Rao, Dr. M. Rangayya, and C. R. Krishna,—with power to coopt, to go into and report on the problem of the immediate and special needs of Andhra Desa in regard to organization of Medical relief and Public Health needs of the Andhras, the report to be submitted before 1-7-'40 to the Government of Madras through the Andhra Medical Association.

5. This Conference is of opinion that in view of the altered constitution of the Madras Council the 7 general seats of the Council should be allocated previously by mutual understanding between Medical Associations in the Presidency affording fair representation for the graduates and licentiates and all the major linguistic areas of the Presidency and authorize the President of this Conference to negotiate and settle the details in consultation with the concerned bodies.

6. Resolved to request the Government to provide the King George Hospital with amenities to bring it on a par with the General Hospital, Madras.

7. Resolved to request the Government to make provision for a nominee of the Andhra Branch of the Indian Medical Association to be on the Advisory Committee of the King George Hospital.

8. Whereas this is an opportune moment to form a Provincial Branch of the I. R. A. for the Andhra area, and whereas there are already a number of local Branches in the area, this Conference resolves that the Andhra Provincial Branch of the I. R. A. be immediately formed and request all the local branches to take immediate steps for the restitution of the same.

This Conference further resolves that the following Committee be empowered to bring the Provincial Branch into early existence with power to add to their number:

Lt. Col. T. S. Sastry, Drs. G. Ramayyengar, P. Gurumurthi, P. Chalapathi, C. Suryanarayana-murthy, Y. Suryanarayana Rao, M. Rangayya, T. Kanaka Raju, M. V. Krishna Rao.

9. Resolved to request the Government to amend the G. O. regarding the limiting of the practice of salaried Government Doctors to consulting practice only as defined in the G. O., but to enforce the letter and the spirit of the original G. O. and exhort the Salaried Officers and the general practitioners to co-operate in respecting the provisions of the G. O. and thus help to eliminate unhealthy rivalry and overlapping between the two sections.

10. This Conference places on record its deep sense of sorrow for the premature demise of Major Ebdon.

11. Resolved to request the Andhra University to inaugurate a practical scheme of publishing standard books in Telugu on the basic sciences necessary for medical studies (a) Anatomy, (b) Physiology, (c) Biochemistry, (d) Hygiene, (e) Pathology, (f) Bacteriology, (g) Pharmacology, (h) Physics, (i) Chemistry, (j) Biology, (k) Nursing.

12. Resolved to draw the attention of the Government regarding the teaching of pupil nurses in Telugu and other Provincial languages and urges that immediate steps be taken in view of the complete vernacularization of the S.S.L.C.

13. While the medical profession in general in India is agitating the services being made Indian, the Conference urges on the Government that no non-British Indian should be appointed as Honoraries in State Hospitals.

14. Resolved to request the Government of Madras to allocate more of the Central Research Association funds at the Calcutta Tropical School of Medicine towards research at Vizagapatam Medical College in Pharmacology and Indigenous drugs and institute a chair in Pharmacology research at Vizagapatam.

THE KRISHNA DISTRICT MEDICAL ASSOCIATION, MASULIPATAM.

The following are among the resolutions which were unanimously accepted by the members :—

1. We are of opinion that out of the 7 seats allotted to the General Constituency of Registered Practitioners of the Allopathic System on the Madras Medical Council, not less than 3 seats shall be assigned to the Practitioners practising in the Andhra Districts. This convention should be worked up until the Act is amended suitably.

2. We are of opinion that the Madras Medical Council Act should be amended at an early date so as to provide for 9 seats for the General Constituency, reserving not less than 4 seats for the Andhra Practitioners.

3. We resolve that in the ensuing election to the Madras Medical Council the following candidates should be supported and elected by the Andhra Practitioners, namely Dr. P. Gurumurthy, L.M.P., of Rajahmundry, Dr. Y. Suryanarayana Rao, L.M.P., Tanuku, Dr. C. Ramakrishna, L.M. & S., of Ongole and Dr. Samuel of Kurnool.

4. As regards the Indian Medical Council Act we are of opinion that it should be amended in the following particulars:—

(i) to provide for a majority of elected members,

(ii) to provide an All-India Register; and

(iii) to include in the Register names of all persons now borne on the Provincial Medical Registers.

(iv) to provide for three seats for the Madras Presidency to represent the General Constituency of Registered Medical Graduates and to assign one of them to the Andhra Area of the Madras Presidency.

5. We are of opinion that the following candidate may be supported for the one seat of the General constituency in the ensuing election to the All-India Medical Council, namely Dr. T. S. Tirumurthy, Principal, Stanley Medical College, Royapuram, Madras. Since Dr. T. S. Tirumurthy has replied in the following manner promising to abide by the views of our Branch, namely: (1) The same candidate should not stand for re-election as the term of five years is sufficiently long and as it is desirable that other willing and deserving members should be given a fair chance to represent the Constituency in the Medical Council of India.

(ii) That from the Andhra area and from the Non-Andhra area one Representative who is popular, willing and deserving should be elected alternately in future, so long as there is provision only for one representative for the whole Presidency.

(iii) That it is desirable to make Statutory provision for the separate representation of the Andhra Graduates in the General Constituency; no formal resolution was moved regarding this understanding.

The Andhra Provincial Branch was formally established and Lt. Col. Shastry was elected to do all preliminary work. There was a sumptuous Lunch, Lt. Col. Shastry being the host.

Dr. V. Govindan Nair spoke suggesting that all the members may enlist themselves as members of the Reception Committee for the next All-India Medical Conference which will be held at Vizagapatam.

A very interesting entertainment of Bharata Natyam from 6-30 to 9 p.m. performed by a boy of 14 years named Vedantam Jagannadha Shastry of Bhagavatula Kuchipudi was much appreciated by the large gathering of Doctors and Citizens.

M. V. SUBBA RAO,
Secretary.

The Madras Provincial Subsidized Rural Medical Practitioners' Association.

COIMBATORE DISTRICT BRANCH.

A meeting of the above branch was held on 30-3-1940 at 9 A.M. in the premises of the Coimbatore District Medical Association Buildings. Dr. V. Rama Kamath presided., Capt. E. S. Gopalan, Secretary, Coimbatore District Medical Association was present at the meeting.

At the outset the President appealed to the members present that it is desirable in the interests of the Association that any one amongst them who honestly believes that he could whip up his comrades to be active, should come forward to take up the work of the Secretary-Treasurer so that he might be elected unanimously.

Dr. N. S. Mukunda Rao offered his services and was unanimously elected as Secretary-Treasurer for the current official year and Dr. G. J. Dawson was also unanimously elected as Joint Secretary-Treasurer.

The following resolutions were passed unanimously:—

1. Resolved that there should be a meeting of the District Branch of the Association at least once in a quarter.

2. Resolved that each member of the District Branch should pay to the Branch Re. 1 to meet the trainage of the Secretary-Treasurer for attending the Provincial Committee meetings.

3. Resolved that in case any member of the Association is in trouble, he should immediately report about it to the Secretary-Treasurer and send a copy of the report to the Central Office for necessary advice and action. He should not under any circumstance take action himself, but in case an urgent report is demanded from the aggrieved practitioner by the authorities he may submit the report direct to the authorities and at the same time send a copy and further particulars to the Central Office.

4. Read letter from Dr. K. V. Hari Rao dated 23rd March 1940 addressed to the Secretary-Treasurer informing him that he had entered L. F. Service and that he might be permitted to resign his office as Joint Secretary-Treasurer of the Branch.

Resolved to inform Dr. K. V. Hari Rao, that the question of his resignation as Joint Secretary-Treasurer does not arise as a new Secretary-Treasurer & Joint Secretary-Treasurer for the year has been elected by the District Branch. It was further resolved to request Dr. K. V. Hari Rao to continue to be member of the Association.

5. Resolved that Dr. P. Sivasami Aiyar who was a member of the Association and who has since entered L. F. Service may also be requested to continue his membership of the Association.

6. Resolved to appoint a Committee consisting of Drs. S. Ramanathan, N. S. Mukunda Rao and G. J. Dawson to audit the accounts of the Association up till the date of handing over charge by the old Secretary-Treasurer to the newly elected Secretary-Treasurer and a copy of the same report be submitted to Central Office for record.

7. Resolved that no Subsidized Rural Medical Practitioner, subsidized by Government or District Board should consent to get himself trained at his cost for Public Health work as there is a specific G. O. asking local bodies to train the former free of any cost, while the latter at the cost of the local bodies.

8. Resolved to thank Dr. V. Rama Kamath, President, P. S. R. M. Ps Association, Madras for having gone over from Madras to Coimbatore for presiding over the meeting.

9. Resolved that Capt. E. S. Gopalan, Secretary District Medical Association be

thanked for kindly placing at the disposal of the Association the premises of the District Medical Association for holding the meeting and also for his having kindly attended the meeting.

10. Resolved to thank Dr. G. J. Dawson outgoing Secretary-Treasurer for the zeal and enthusiasm shown by him in working for the Association from the time of its inauguration.

The Special Committee appointed to audit the accounts of the Branch met and after going through receipts and expenditure found that there was a deficit of Rs. 23-14-0. Out of this amount Rs. 11-9-0 were to be paid to Dr. Dawson, Rs. 3-5-0 to Dr. S. Ramanathan and Rs. 9-0-0 to Dr. K. V. Hari Rao.

It is hoped that the subsidized practitioners in the District would make up this deficit by dividing the sum equally amongst them so that there may be a clean account for the current official year.

TANJORE DISTRICT BRANCH.

A meeting of the above branch was held on 31-3-1940 at 2 P. M. under the presidency of Dr. V. Rama Kamath.

The following resolutions were passed unanimously.

1. Resolved that Re. 1 to be paid as contribution to the District Branch by each member of the District Branch to meet any extra expenditure.

2. Resolved that as Dr. K. Govindan is a member of the Working Committee of the Mother Association, he should continue to be the Secretary-Treasurer for this official year and Dr. K. A. Annamalai Pillai to be the Joint Secretary-Treasurer for this official year for this District Branch.

3. Resolved that the meeting of the District Branch must be summoned by the Secretary Treasurer at least once in every quarter in any convenient place in the District.

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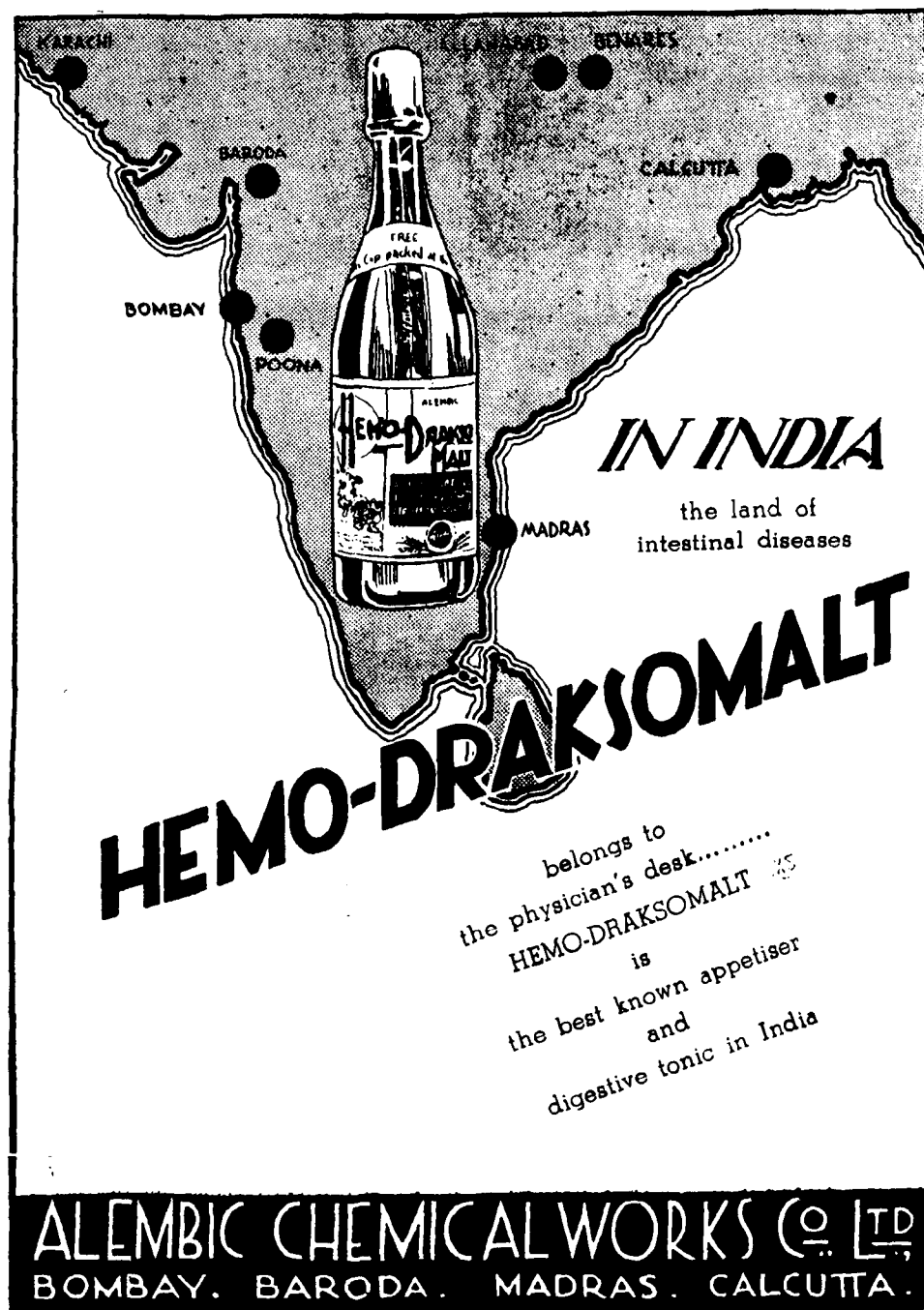
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Review.
ANNUAL REPORT
OF
THE UNION MISSION TUBERCULOSIS SANATORIUM
AROGYAVARAM.
1938-'39.

The report of the work turned out at the Arogyavaram Sanatorium is a valuable document which while placing before the public and the profession the services rendered at the Sanatorium to the patients suffering from Tuberculosis should encourage those interested in combating the scourge that their efforts in this direction are bound to bear good fruits if the campaign is conducted on the lines suggested in the pages of the report under different heads. We had the good fortune of visiting this institution and it struck us that the simplicity of the buildings laid on an extensive airy plateau, having the best advantages of the nature's gifts, a salubrious atmosphere and a plentiful supply of sunlight and wholesome water, added to the grandeur of this famous sanatorium. The spirit of service and the disciplined team work which renders this service, is as attractive as it is lofty and worthy of emulation by those serving in State institutions where service is only a duty and generally not a responsibility. The fact that those serving in missionary institutions are paid workers of the mission though the grade of pay is much less than that obtaining in State medical institutions with no privilege of additional income by private practice makes, this service more selfless. India where Tuberculosis has taken a deep root having infected over 60 per cent of the population, should have many more institutions of the type of the Arogyavaram Sanatorium then only that beneficent Lady, Marchioness Linlithgow will be able to realise that her selfless and noble efforts to make India a free country at least in regard to Tuberculosis are not dreams but a reality. We congratulate Dr. P. V. Benjamin an Indian who is now acting for his Guru, Dr. C. Frimodt-Moller whose services have been lent to the Tuberculosis Association of India as its Medical Commissioner. We trust that Dr. Benjamin would deserve the confidence reposed in him by his Guru and maintain the very high traditions of Arogyavaram Sanatorium left behind him though temporarily by that wonderful worker Dr. Frimodt Moller who by his devoted work as a missionary has been able to attract patients to the institution from all parts of India and elsewhere. We wish the institution a perennial life of usefulness and send our good wishes to Dr. Benjamin and his colleagues.

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RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance on 1-2-'40 ...	205 4 2	Postage ...	8 4 6
Subscription from members including V. P. charges ...	118 3 0	Pay to Clerks for January '40 ...	15 0 0
Entrance fees from seven new members ...	1 12 0	Amount credited to The Medical Practitioner from the subscription paid by members ...	66 3 0
Advance from the President to meet office expense ...	98 2 0	Advance refunded to the President ...	98 2 0
Part payment made by Dr. Doraiswamy, Secretary-Treasurer, Coimbatore District towards the amount advanced to him ...	9 0 0	Quota paid to District Branches:—	
Amount paid by Secretary-Treasurer, Coimbatore District Branch towards the expenses incurred by the Association for the inauguration of the Coimbatore District Branch on 22-12-'38 ...	9 6 3	Rs. A. P.	
		Arcot North ...	6 0 0
		Arcot South ...	8 0 0
		Chittoor ...	9 0 0
		Coimbatore ...	22 0 0
		Godavari East ...	10 0 0
		Godavari West ...	13 0 0
		Kistna ...	3 0 0
		Madura ...	3 4 0
		Nellore ...	3 0 0
		Ramnad ...	3 0 0
		Tanjore ...	6 0 0
		Trichinopoly ...	6 0 0
		Amount contributed to Chittoor District Branch to meet the expenses for the Provincial and Working Committee meetings held at Tirupati during December last ...	60 0 0
		Amount advanced to Dr. Doraiswami, Secretary-Treasurer, Chittoor to meet the expenses of the Tirupati meeting. ...	38 2 0
		Cash Balance:—	
		Rs. A. P.	
		With Savings Bank ...	4 3 7
		With Office ...	59 8 4
			63 11 11
Total ...	441 11 5	Total ...	441 11 5

159636

V. RAMA KAMATH,
President.

K. GOVINDAN,
Treasurer.

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