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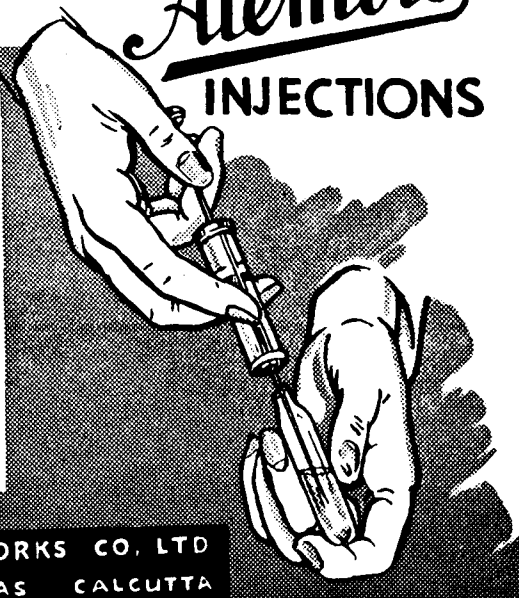
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Original Articles

TUBERCULOSIS OF THE LYMPHATIC GLANDS.

By

DR. N. S. NARASIMHAN, L.R.C.P. (Lond.), F.R.C.S. (England & Ireland)

Orthopaedic Surgeon, General Hospital, Madras.

Lymphadenitis may be acute and chronic and the Tuberculous variety forms 80 per cent of the cases and is mostly chronic.

It is very common in children and young persons due to poor food and bad surroundings.

PREDISPOSING CAUSES are various exanthemata, whooping cough, measles, pneumonia and enteric which lower the general resistance of the body and either predispose it to tuberculosis or light up quiescent tuberculous deposits. Tuberculosis of glands follows the chronic sepsis by streptococci, from carious teeth (septic process at the root of the teeth, decayed root-pulp), septic tonsils, chronic pharyngitis, adenoids, middle ear diseases impetigo and scalp lesions.

The lymphatic glands form one of the most important of the defence mechanism of the body. In children under one year of age the disease usually runs an acute course and with every succeeding year of life the general resistance is increased.

Coloured solutions when injected into the tissues are absorbed by the blood

vessels and not by the lymphatics. Insoluble particles are taken up by phagocytic cells and carried by them into lymphatics. "The history of the Tubercle Bacillus in its early stages in the body, is identical with that of solid particles. A normal physiological process is made use of for the absorption and arrest of the bacillus. The bacillus is carried into the lymphatics by the phagocytic cells and is deposited in the lymphoid tissue of the first lymphatic gland arrived at. Some of the bacilli may be destroyed in the process, others retain their vitality and multiply in the lymphoid tissue and give rise to a tuberculous focus in the gland. The toxins produced by the action of the bacilli in a gland, mix with the lymph stream and set up an intense lymphocytosis in the other glands through which the lymph passes. The toxin precedes the bacilli and renders the gland less pervious to them by narrowing the lymph sinuses and filling them with lymphocytes.

The bacilli may be carried to the gland by (1) the lymph stream, (2) by the blood stream (ten per cent). Lymph stream infection is common most, being about 90 per cent. A clinical distinction bet-

When the two groups is possible and essential.

Blood Infection:

1. Multiple scattered glands are affected.
2. Caseation begins at the centre, because the main blood vessel passes to the centre of the gland before it breaks up.
3. Operation is not indicated.

Lymph Infection:

1. The disease remains for a long time confined to one or two adjacent glands.
2. Caseation commences at the periphery of the gland since the lymph stream reaches the gland at that part.
3. Operative removal will be of use.

Glands in the neck, groin and axilla are usually infected with the human type of bacillus. Abdominal and Mesenteric types are infected with the bovine type. Tubercular infection occurs very commonly in the cervical and mediastinal glands, less commonly in the mesenteric glands, fairly common in the axillary glands and rare in the inguinal glands.

ANATOMICAL DISTRIBUTION OF THE LYMPH-GLANDS.

Drainage area.

Posterior-Auricular — Scalp, auditory meatus.
Parotid—Scalp, tympanum.
Sub-maxillary—Face, gums, teeth.
Pre-tracheal—Larynx, trachea, thyroid.
Occipital—Scalp.
Jugulo-Digastric—Tonsils, pharynx.
Deep cervical-Pharynx—Upper groups.
Sypra-clavicular—Neck, pectoral region.

Supraclavicular glands receive no afferent vessels from the mediastinal glands. Blood infections form ten per cent of the infection which are seen in

children under three years of age as recognised from the group of glands involved namely: lower deep cervical, pre-tracheal, posterior auricular and parotid with associated tuberculous lesions in the mediastinal lymph nodes and the ear.

In tuberculous otitis media, the parotid, upper deep cervical and pre-auricular lymphatic glands are usually enlarged.

PATHOLOGICAL CHANGES IN TUBERCULAR GLANDS.

A lymphatic gland is not an unilocular structure, but consists of several lobules. Most marked pathological changes are found in alveoli, near the periphery in infection by lymph stream; but in blood infections the medulla is the first portion of the gland to suffer. During an attack of lymphadenitis, the entire gland is swollen, but identical pathological changes do not take place in the whole gland nor in an equal degree in the different alveoli. *Areas of caseation are multiple and so small that no sign of softening or fluctuation can be found.* Such glands do not become completely confluent and it does not form a unilocular pus-sac, exhibiting signs of fluctuation. Frequently only a few alveoli suppurate, while the intervening portions of the gland are replaced by a dense proliferation of endothelial and connective tissue cells. *This accounts for the loss of elasticity and increased hardness of a pathological gland.*

Caseous material in the gland:

- (a) The caseous material may be quiescent within the capsule for several years before an extra capsular abscess forms.
- (b) Foci of caseation increase in size and threaten to involve the thickened capsule.
- (c) Peradenitis and thick adhesions to vessels and muscles and submaxillary glands form.
- (d) Adhesions may be very dense, where caseous material has totally eroded through the capsule.

(e) Ultimately the capsule gives way and an extra-capsular abscess forms. *It is only then that softening can be elicited.*

(f) Calcification, fibrosis, and areas of suppuration are found in different sectors in the same gland.

(g) A natural recovery should never be assumed if a gland is hard and palpable.

Different varieties of Pathological glands:

(1) Tubercular glands without alveolar caseation, are rare, but they show invasion with tubercle bacilli.

(2) Caseated glands may be of any size from a pea to a hen's egg. They feel firm, and solid; occasionally hard, and knotty, certainly not elastic or soft. The swelling waxes and wanes with the child's general condition, the state of naso-pharynx and the changes of the glands themselves.

Alternate attacks of swelling and periods of quiescence which correspond to the onset and recovery of successive attacks of peradenitis, are almost diagnostic of intracapsular necrosis and caseation.

Solid glands frequently contain pus although they are quiescent for over a year. Glands which have persisted for three months and have attained the size of a hazel nut show signs of caseation. *Shrinkage in the size of the gland will occur with any treatment as the peradenitis subsides.*

Abscess formation: This precludes a natural cure. This occurs in the following ways:

- (a) A small slowly developing abscess beneath the platysma in relation to a chronic gland.
- (b) A large group of glands with small superficial abscess.
- (c) An infiltrated mass in which the outline of the glands is lost in the surrounding inflammatory reaction.

(d) A reddish purple typical tuberculous abscess.

Sinus formation: After the chronic abscess has burst, it leaves behind a sinus leading down to an indefinite mass of cicatricial tissue to be surrounded with large glands in the depths.

SYMPTOMS: Tuberculous adenitis may be ushered in by acute symptoms during the course of some of the exanthemata and the outline of the glands is at first obscured by periglandular swelling. The latter gradually subsides leaving typical discrete chronic glands. *Slight improvement means that the infection is localised within the capsule.* When glands remain enlarged, necrosis has probably taken place in the alveoli during the original acute attack. It is common to find typical destructive lesions after a history of 3 to 4 weeks. *The more chronic type commences as small glands which gradually increase in size and number.* Sometimes there will be associated symptoms of ill health, slight anaemia, evening rise of temperature. In rare cases tuberculous glands are the starting point of a generalised miliary tuberculosis as is sometimes seen after operative interference.

DIFFERENTIAL DIAGNOSIS: This condition has to be diagnosed from:

(a) Lymphadenoma (Hodgkin's disease). Glands are soft, elastic, discrete, movable and large in size. These are the periods of pyrexia and spleen and liver become enlarged in all cases.

(b) Lymphosarcoma is a rapidly growing tumour, which is firm and painless in the beginning but soon increases in size, gets tender, softer and neighbouring glands become involved.

(c) Leucocythemia.

(d) Filarial Lymphadenitis.

(e) Cold Abscess from bones, spine.

(f) Secondary malignant glands.

A differential diagnosis is not always easy; very often biopsy results prove that

the diagnosis from lymphadenoma is difficult. *If in doubt, remove glands for biopsy.*

TREATMENT: Prophylaxis.

1. Remove the septic foci as carious teeth, decayed roots, adenoids, septic tonsils, and treat skin infections of the scalp etc.

2. Improve the child's general condition and wait for two to three months when the glands would decrease in size.

3. For mild cases, prolonged rest in the country and heliotherapy will be of great use.

Nature is a powerful healer, and deserves most, if not all, the credit paid to Iodine, Ichthyol and Mercurial ointments. Local applications and counter irritations are useless.

Pathological Tonsils: should be removed at the earliest possible moment, for when the disease is advanced in the glands, tonsilectomy is useless. It is very risky to dissect the glands when the tonsils are inflamed or harbour haemolytic streptococci.

Heliotherapy: Treatment in the open air, with exposure to the sun is always beneficial. Artificial light with the carbon arc or mercury vapour lamp improves a child's general condition, and small glands may disappear. Locally sunlight hastens nature's efforts at cure—it accelerates the breaking down of caseous glands, abscess formation and discharge of pus. There is a risk of suppuration if caseated glands are irradiated.

Irradiation for many months made no change in typically caseated glands. As the capsule is enormously thickened and there is no intimate vascular relation between a grossly pathological gland and the surrounding tissues, large sized glands will not be cured unless removed. An infiltrated swelling, which preclude all questions of radical treatment, is benefitted by heliotherapy. Cases with sinus may be benefitted with sunlight if no glands are palpable.

NON-OPERATIVE TREATMENT (conservative): Consists of good nutritious food; e.g., milk, egg, fruits (fresh), unmilled rice, dhals, butter, ghee, curds, ragi, etc. Cod liver oil and syrupus Ferri Iodide. Plenty of fresh air and sunlight for three to four years.

OPERATIVE PROCEDURES CONSIST OF:—

1. Incision of abscess; aspiration is not of much use.
2. Incision, evacuation and curettage.
3. Intracapsular, enucleation.
4. Radical excision (a) general and (b) individual groups.

CONTRAINDICATIONS FOR OPERATION:—

- (a) Blood borne cases—when there is haphazard distribution of glands in the neck, association with enlarged nodes in the axilla or groin.
- (b) In children under two years of age.
- (c) In senile and fibrous types of the disease.
- (d) In the stage of acute periadenitis.
- (e) In some cases where the disease is seen very early and when the glands are mobile and not caseated.

OPERATIVE RISKS: (1) Mortality after operation, (2) haemorrhage, (3) injury to thoracic duct, (4) injury to important nerves as spinal accessory and mandibular branch of the facial nerve, (5) wound suppuration (streptococcal) and (6) danger of generalised tuberculosis.

After twenty years follow up in cases under conservative treatment, it was noted that 30 per cent developed other forms of tuberculosis and 1 to 5 per cent developed tubercle of the lung. Recurrence of glands occur under the stimulus of any focus of infection even after many years. Results of curettage are good. *It is important to follow up all cases for two or six years.*

TUBERCULOUS AFFECTIONS OF THE GLANDS IN VARIOUS REGIONS.

AXILLARY REGION: Here the disease is due to extension from glands in the neck, lower deep cervical or from the tuberculous breast. It may also follow after wound of a finger and may be also a part of the generalised infection of lymphatic system. Suppuration is common. It is better always to operate early when localised. When the lymphadenitis is part of a generalised infective focus, treatment should be conservative and on general lines.

INGUINAL REGION: Here the tuberculous lymphadenitis is rare. Femoral or external iliac sets of glands are involved usually the latter. This results from a local area of the disease such as tubercular ulceration of vulva or perineal region, or tuberculosis of one of the joints of the lower extremity. Occasionally the infection is a blood borne one.

Differential diagnosis from the following conditions has to be done.

1. Acute Pyogenic lymphadenitis.
2. Inguinal and femoral hernia.
3. Venereal bubo.
4. Lympho granuloma inguinale.
5. Psoas abscess.
6. Hodgkin's disease.
7. Encysted hydrocele of perineal sac.
8. Primary or secondary malignant gland in the groin, tracheo-bronchial adenitis (mediastinum).

There is no other localisation of Tuberculosis which manifests so strong a tendency to spontaneous cure. It is primarily a disease of childhood; infection is by the Bovine strain of tubercle bacilli. But if it occurs in adults, it is chiefly of the human type. The tubercle bacilli penetrate the mucous membrane of the bronchiole and are carried to the nearest lymphatic gland where it may be imprisoned or escape into the blood stream

or pass through lungs, without being arrested until they are entrapped by the tracheo-bronchial glands where they light up a chronic infective process. This condition gives rise to the following combination of symptoms:—

- (a) Sallow complexion.
- (b) Undue fatigue.
- (c) Irritability and peevishness.
- (d) Anorexia and malnutrition.
- (e) Intermittent pyrexia.
- (f) Paroxysmal coughing.

Complication: Suppuration and pressure symptoms in all structures:—abscess may burst into trachea, pleura, large blood vessels, oesophagus, posterior mediastinum; there may be a sinus in the skin of axilla and suprasternal notch.

Physical signs in the chest are negative: There is no evidence by X-ray examination unless calcification has taken place; calcification means that the disease is well established or has healed.

Treatment: (a) If febrile, rest in bed.

(b) Heliotherapy for non-febrile cases.

MESENTERIC LYMPHADENITIS (Abdomen): The glands are infected either primarily without any lesion of the mucous membrane of the intestines or secondary to tubercular lesion of the bowel, or of lungs. Occurs in children between the ages of 7 and 11 years.

Anatomy of Lymph glands of the Abdomen:

(A) *Visceral*—Gastric, pyloric, splenic, hepatic, pancreatic, mesenteric, ilio-cæcal, colic and coeliac.

(B) *Parietal*—Iliac, lumbar, sacral, aortic, and anterior abdominal.

The commonest site of infected lymph nodes are at the ilio-cæcal angle, the petro-peritoneal spaces medial to cæcum, and ascending colon, and the lower part of the mesentery of the small intestine; occasionally a chain of glands following the course

THE GOVERNMENT SCHOOL OF INDIAN MEDICINE.

By

DR. B. SRINIVASACHARYA, B.A., L.M. & S., F.I.M.

The recent appointment of a special committee by the Government of Madras to examine the curriculum of studies and other affairs connected with the School of Indian Medicine, is a necessary and welcome step and it is expected that the Committee would seriously consider the reasonable doubts given expression to by disinterested votaries of Indigenous Systems of Medicine as well as of the Allopathic System now styled as the Scientific System both of whom have been complaining through the press and on public platforms that the medical education imparted in the Government School of Indian Medicine has brought into existence a hybrid system which far from encouraging the evolution of ancient systems of Indian Medicine is a real danger for the advancement of these systems and at the same time discrediting the Scientific system.

In the School of Indian Medicine a curriculum of studies has been followed, in which are included all Allopathic subjects, including the fundamental sciences, with a view to make it appear that the otherwise incomplete practice of Indian Medicine is self sufficient and up-to-date.

The School has been functioning for the past 15 years and a large number of practitioners of Indian Medicine, L.I.Ms. and A.L.I.Ms. are let out of the School with a Government hall mark that those possessing the diplomas granted by the School of Indian Medicine are proficient not only in Indigenous Systems of Medicine but also in all branches of Allopathic Scientific System. In addition, the Government were pleased to establish a Medical Register for the benefit of those practising the Indigenous System which they did, not by a Statute but by an administrative order and it is doubtful whether this administration act of the Government can have the force of law. Yet the practitioners of Indian Medicine belonging to "A" class, that is, those

possessing the diplomas, L. I. M., or A. L. I. M., are privileged to practise Medicine, Surgery and Midwifery and other branches of Allopathic Scientific Medicine in the same way as do the registered practitioners of Allopathic Scientific Medicine. Those belonging to "B" class of practitioners, i.e., all those practitioners practising Indigenous System of Medicine but who do not possess the L. I. M. or A. L. I. M. Diploma have to confine themselves to the practice of Indigenous Systems of Medicine only. But in reality there is no restriction to anybody not to practise the Allopathic Scientific Medicine. The effect of the registration of the practitioners belonging to the Indigenous Systems indiscriminately has been that a large majority of practitioners found in the Register are quacks recognised as registered practitioners by the Government. This is not all.

To enable the practitioners of Indian Medicine of class B to obtain registration under class A, a special course of two years has been instituted in the School of Indian Medicine. Within these two years, the whole of Western Medicine including the preliminary sciences such as Physics, Chemistry, Biology, Anatomy, Physiology are taught in addition to the professional subjects and a diploma A. L. I. M. (Associate Licentiate in Indian Medicine) is granted which entitles the holders thereof to practise Medicine, Surgery, Midwifery and other branches of Allopathy.

What the Medical Colleges find it difficult to teach in five or six years to students with the preliminary general educational qualification of not less than the Intermediate in Arts or Science, is claimed to be taught within two years to students with little or no preliminary education to enable them to follow the subjects of Western Medical Science. This gross incongruity, clearly indicates

the standard of Allopathic subjects followed in the School of Indian Medicine, which serves as an entrance into the established Allopathic medical profession, which is highly detrimental to the interests, efficiency and morale of the profession and the welfare of the public.

Whereas on one side a very valuable, long-felt salutary reform is carried out by the Government by abolition of a lower standard of medical education in Allopathy with a view to unification and maintenance of a single uniform standard, it is inconsistent with their policy to perpetuate the still lower standard of Allopathy in the Government School of Indian Medicine in the guise of Indian Medicine. At least as far as the branches of Western Medical Science are concerned, there should be only one single standard.

In defence of the present curriculum of the School, the Principal is reported to have stated as follows:—

"They (the students of the school) had not only received adequate instruction in Physics and Chemistry, but in Botany so vital to medicine, they had received instruction superior to that imparted even to-day in schools of foreign medicine. Indeed the training in general science given in that School excelled that received by an M.B. student".

—(The Indian Express, 1st April 1939)

How far the above claim can be substantiated, it is difficult to gauge unless an investigation is made of the methods and results of the examinations held in these subjects and unless also the students of the School are made to sit for the same examinations with those of the Medical Colleges.

The Principal is reported to have said further as follows:—

"This is a School of Indian Medicine, where we are the people who should lay down the standards—not the allopathic man who does not know anything about Indian Medicine"..... "From the commencement of the School of Indian Medicine, they had been having their own standards. Allopaths were not their masters."

The question is whether the standard of teaching and examinations in Medicine, Surgery, Midwifery, and other Allopathic

subjects in the School, is such as to satisfy the minimum essential standard to permit the practice of these branches of medicine with safety to the public and without detriment to other sections of the medical profession. The public and the profession have a right to be guided by a standard which guarantees public safety and not the convenience and advantage of a particular section of practitioners of Indian Medicine brought into existence in the Government School of Indian Medicine. Whether the standard now adopted in the Government School of Indian Medicine in the teaching of Allopathic subjects, is adequate or not can be determined on a consideration of the following points:—

1. Whether the preliminary education of students admitted into the School is enough to enable them to study the Allopathic subjects to a required standard,

2. Whether the staff and equipment of the School are adequate for the teaching of these subjects to the required standard,

3. What is the present standard? How is it determined?

4. And whether four years' course to teach the Indigenous Systems as well as Allopathic System of Medicine is sufficient?

Regarding the teaching of Indian Medicine in the School, the points requiring consideration are:

1. Whether the students admitted into the school possess the required knowledge of Sanskrit or Arabic etc., to follow the original text books in Ayurveda and Unani Systems?

2. Whether there are any text books in Siddha System, in spite of the Government having appointed a Siddha Text Book Committee for some years for the purpose at some expense?

3. Whether there are proper facilities to conduct research in Indian Systems of Medicine and whether the results if any, so far published are not misleading and tending to create confusion?

The Principal of the School appears to have realised the present anomalous position of the School when he writes in his annual report for 1937-38, on the working of the School, as follows:—

"Whether it is not high time to take steps to eliminate the double set of Institutions,..... and to provide for that single standard and that unified system under which they hoped that every future practitioner of India would be schooled and trained. So far as the purely allopathic education goes, the Government have already taken steps to achieve a single minimum standard by abolishing the allopathic medical schools of this Presidency and making increased provision for the minimum Collegiate standard of Allopathic education. The result of this is that considered from the standpoint of national medicine as a whole, there are still two standards, viz., the Collegiate standard of the Allopathic medical colleges and the school standard of the Indian Medical School. I submit that the next logical step to be implemented is to provide for the collegiate standard at the Indian Medical School and make for a single minimum standard of medical education....."

It is urgently necessary that the present double standard should be ended and that the prospects of the entrants to Indian Medical School or College (by whatever name the institution providing for collegiate standard is known) should be *at least* the same as those for the entrants to the purely Allopathic Colleges".

If the suggestion of the Principal is given effect to, it will again result in the uneconomic maintenance of two sets of institutions viz :

1. Allopathic colleges controlled by the Universities and the Medical Councils.
2. College of Indian Medicine with the same minimum standard of Collegiate education at least in Allopathic subjects, with an additional teaching of Indian Medicine of some standard, under the control of the Government and some other agency that may be created for the purpose.

This will again create a double set of institutions with some advantage in favour of the College of Indian Medicine in the eyes of the public and the Government. (Note the words '*at least*' in the last sentence of the above quotation). This difference will react on the status of the existing medical (Allopathic) colleges, unless provision is simultaneously made in

these colleges for the teaching of subjects of Indian Medicine.

Apart from the consideration of the standard of teaching of Allopathic subjects in the School of Indian Medicine, one should not lose sight of the standard of Indigenous Systems of medicine themselves. As expressed above the votaries of Indigenous Systems have been protesting against this standard. The teachers as well as the taught follow in actual practice a standard which will be attractive to the credulous public without minding in the least the evolution and advancement of Indigenous System of Medicine. The past history of the Government School of Indian Medicine and its present condition go to show that the long experience of 15 years has been as dangerous an experiment as it was costly and the fact that medical education and medical relief in whatever form have to be the concern of the Government and not of the votaries of different Systems of Medicines and consequently under the direct control of our oscillating politics, threatens the growth of scientific medicine in this country.

From the standpoint of national medicine as a whole and the safety of public, it is desirable that a system of medicine suitable to Indian conditions at the same time satisfying scientific standards should be chalked out. A few months ago Acharya Sir P. C. Ray in his address to the medical profession gathered in the Medical College, Calcutta, said:—

"I should say that the policy of passing off the Indigenous systems of medicine as Scientific systems of medicine after putting a veneer of modern sciences like Physiology and Anatomy on them does not seem to me to be the correct course. The policy should rather be to accept the Western Scientific System of Medicine as the nucleus round which the tested knowledge derived from Indigenous systems of medicine may be gathered. All our knowledge should be accumulated on scientific lines".

In a report of the deputation by the League of Nations (Health Organisation) as published in The Medical Practitioner, it was said:—

"European Medical Science is everywhere invading Asia, where it encounters what has

remained of the old medical lore of Hindu Medicine, the Arabian School, and the old Chinese Institutions, all of them based upon traditional empiricism. The importance of all these should not be under-estimated, and official medical science, over-confident of its own infallibility and of the inferiority of this ancient popular medicine, has made the mistake of scorning it. Yet many an old precept can be found which accords with our own views, even though put in a somewhat different form.....

The study of these ancient medical cultures and of their remaining vestiges would be of value. They should have a place in the training, so that the young doctor may have at least an elementary knowledge of these questions when he begins practising. Such knowledge is essential if he is to adapt himself to his social environment. Lastly, it would be desirable honestly to consider how far these old medical traditions can be reconciled with our own principles, instead of rejecting them in a body as useless and obsolete."

Lt. Col. K. G. Pandalai, I.M.S., in his address to the 14th All India Medical Conference at Madras said :

"Another problem in medical education in India, not less important than the removal of class distinctions in the Profession by abolishing the Licentiate's course, is the equally difficult one of approximating the large amount of clinical and therapeutic knowledge available in the Indigenous systems of medicine to the more modern systems which we call scientific and rational The question for the future will be whether it is possible to incorporate into the National Medical Service of India, all the advantages claimed by the different systems, now in vogue, and not to allow any medical practitioner to remain in ignorance of the practice of any system of the healing art, whatever its origin. I do not think it is impracticable to let our students of medicine to acquire a general knowledge of the various systems now prevailing in the country, as this is easily ensured by the provision of adequate teachers in existing medical colleges. As matters stand, the student of Ancient Indian Medicine is taught a great deal about modern medicine including the basic sciences while the student of Western medicine grows up in ignorance of the system which is extensively favoured by millions of his countrymen and which is most probably favoured by his own parents....."

The Medical Practitioner (April 1939) advocated the creation of special chairs in the existing medical colleges :

"Any amount of artificial propaganda by interested persons would not convince disinterested members of the public who knew anything of medical science that the products of this school could take the place of scientific trained

medical men for giving medical relief nor could they believe the reckless statements made in the lay press that the students of Government Indian School of Medicine received better training in Biology, Chemistry and Physics....."

The only way and at the same time the best way of encouraging Indigenous system is to create special chairs in the existing Medical Colleges for the teaching of Indigenous systems."

The same journal in February 1940 pleaded for a synthesis of all systems of medicine and said :

"The solution of the knotty question of Indigenous systems of medicine is a stupendous task and the attitude of the public and the Government is one of drift"

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."

Mr. C. V. Subramanya Shastri, an ex-Principal of Ayurvedic College, Tirupathi, condemned hybridisation of Ayurveda in a communication addressed to the Editor, The Hindu on 6.4.1940.

".....What is now wanted is not a hybridisation of Ayurveda with the Western systems of medicine, but only an opportunity for research, if necessary, on the lines on which the research in Western medicine has been and is still being made, with a view to bring the practice of Ayurveda into line with the theories already available."

"Coming to the School of Indian Medicine, those charges raise a doubt whether the school is intended for teaching Allopathic system or for Indian system The defects now pointed out . . . , only prove the fears expressed by me before the Usman Committee that both the Indian as well as the Western systems could ill go together and that the Indian systems to maintain their individuality should be pure and unalloyed. The present attempt to bring together the two irreconcilable systems—the Indian and the Western—only makes the Indian systems get dominated by the Allopathic system, At the same time it also makes it impossible for the students taking to the school to acquire within the limited period of four years, proficiency in either of the systems."

The Government School of Indian Medicine if it is really to advance the interests of Indian systems of medicine should be able to give only a proper and sufficiently subsidiary place to Allopathy, the study of the Indigenous systems itself being given the main place."

The following was my reply to Mr. Subrahmanya Sastri, which appeared in *The Hindu* on 13-4-1940.

".....The fragments of more or less mutilated books left to us and the dangerous bits of any degenerate forms of crude surgery and midwifery practised here and there even now in complete ignorance of Anatomy and Physiology and other Western sciences cannot be made the basis to bring the practice of Ayurveda, in these branches at least into line with the theories already available. For the practice of Surgery and Midwifery, a sound knowledge of Anatomy and Physiology and other Western sciences is absolutely essential. This fact has been indisputably admitted....."

That Ayurveda has got some underlying principles and theories, in addition to vast clinical and practical material, which are of such universal application in all varying conditions of time and clime as the truths of the Upanishads or the principles of Electricity or laws of Dynamics, may be accepted without hesitation. It has also to be admitted at the same time that Ayurveda to-day has to live, work and thrive in almost a universal background of well established modern progressive practical, world-wide system of Allopathy, which reacts to every progress or discovery in general science and adapts itself to the needs of the suffering humanity. It would be impossible to confine Ayurveda within the limits of a screened hot house and claim a separate existence for it for long. Medical systems cannot be treated as religious or philosophic systems which may exist side by side. Medicine is not merely a matter of faith, but of practical application and utility. A suffering patient cannot become the subject for a system or dogma. He naturally appreciates and follows the well known dictum of Charaka: "That alone is proper treatment which brings about health, and he alone is the best physician who liberates one from diseases," although the followers of one system or the other may ignore it in their zeal to support their own system.

The Ayurvedic system has to find a place and harmonise itself in the existing condition of things in the world. When the principles of Bacteriology and those of Vitaminology and Endocrinology and the modes of treatment based on these principles can be reconciled and co-ordinated with one another and exist side by side with other methods of treatment by drugs, X-rays etc., why should it be considered impossible for Ayurveda to keep its place and co-operate with the Western system, and the attempt to bring together the two irreconcilable (?) Systems—Indian and Western, be considered detrimental to the former?

For the present and for some time to come, it would be desirable to keep the research aspect of Indian Medicine separate from any scheme to encourage the different Indigenous systems of

Medicine as they are found to-day. It is from the living knowledge of the remnants of Indigenous practice of medicine still available and not from the extant text-books alone, that material for any research in Indian Medicine should be gathered. If this important material, conservative and orthodox though it be, is allowed to dwindle or perish, it will be a difficult task to revive Indian Medicine in its practical details. It will be the aim of future research to investigate and determine the exact field of medicine in which Ayurvedic principles and methods are complementary to others and become applicable in preference to them."

A consideration of the foregoing suggestions and criticisms made from all points of view, leads to the following conclusions:—

1. Abolition of the present School Standard of education in the Government School of Indian Medicine.

2. Conversion of the School and the attached Hospital to a Post Graduate Institution of Indian Medicine for teaching and research, to which only fully qualified practitioners will be admitted and suitable diplomas may be granted to them after a successful course of studies in Indian Medicine.

The attached hospital may be retained to serve the above purpose of the Institute; and as treatment of cases requiring regular Allopathic treatment especially in Surgery, Midwifery, Ophthalmology, etc., may be easily and conveniently carried out in other well equipped Allopathic Hospitals, such cases may be transferred to them. Admission to the hospital of Indian Medicine may be confined to cases requiring treatment on the lines of Indian System of Medicine, which will mostly consist of medical cases with a certain proportion of 'borderland' ones. The number of beds and the staff and equipment of the hospital of Indian Medicine may be thus limited to the requirements of the above cases. An arrangement made on the above lines will lead to economy and efficiency.

On the other hand, the proposal of converting the present School into a College, which means restriction of

admission to Intermediates with a knowledge of Sanskrit, Arabic, etc., will lead to the maintenance of three Colleges of Medicine in Madras, teaching the same subjects of Western Medicine to the same Collegiate standard. This will be uneconomical and superfluous. Further, the teaching of subjects of Indian Medicine in the proposed College of Indian Medicine, along with Allopathic subjects will lead to overcrowding of the curriculum, unless the course of studies is extended by 2 or 3 years. The same objection viz., overcrowding of the curriculum, holds good against the introduction of the teaching of Indian Medicine in the Allopathic Colleges.

If it is found possible to introduce the teaching of Indian Medicine in the existing Medical Colleges, without detriment to any of the subjects now taught, there will be no need for a College of Indian Medicine as an additional teaching Institution.

3. The term 'Registered Medical Practitioner' should be used to designate only those registered according to the Madras Medical Registration Act. The use of this designation by any other class of medical practitioners will be illegal. The passing off of practitioners of all sorts of qualifications as 'Registered Medical Practitioners' should be prohibited.

NOTICE.

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Abstracts.

NOTES ON SULFANILAMIDE THERAPY.

BY

ROBERT D. BARNARD, M.D.
CHICAGO, ILL.

The extension of sulfanilamide therapy to ophthalmologic practice followed immediately upon the demonstration of the efficacy of this drug in the treatment of systemic streptococcus infections. Sufficient time has now elapsed since the introduction of the drug to allow us to say that it can be considered one of the most valuable remedial agents of all time. It is natural that any drug with the manifold indications of sulfanilamide will be used very widely; that it will be misused; and that there will be a certain number of bad reactions, and even deaths, directly attributable to its use. The same can be said of acetylsalicylic acid, or digitalis, for that matter.

In spite of its widespread use, and a tremendous amount of well-controlled scientific work (and all that I have to say about it applies to the other sulphonated aromatic amides which are being used alternatively for it), we are still in the dark as to its mode of action. It is only inferentially that it may be concluded that the role of sulfanilamide is to facilitate phagocytosis by the polymorphonuclear leukocytes. Yet the inference is so clear in my mind that I have made it a rather universal rule not to give sulfanilamide unless conditions are present in the body for overcoming the infection by the agencies implied in leucocytic phagocytosis. It has been my experience that if this rule is followed, reactions will be minimized, and that the scope of this very valuable material will be considerably widened.

For phagocytosis to be the natural means of defense, the infection must be one by positively chemotactic organisms (the so-called pus producers). In this case the immunologic processes of the body call for an enhanced production of leukocytes to engulf the organisms by phagocytosis. From what will be apparent

by what is said, I believe that sulfanilamide does not stimulate the bone marrow to produce more leukocytes, but merely modifies the micro organism so that it may be assimilated. In this connection, I was informed by Miss Frankel, the technologist at the South Shore Hospital, that she had encountered considerable difficulty in typing of pneumococcus in the sputum of patients with lobar pneumonia and who had been given sulfanilamid before the typing was attempted because the organisms had apparently lost their capsules, a small vestige only remaining. It is on the basis of the reaction of the capsule when the pneumococcus is treated with its specific antiserum that the typing is done. It is notable that it has been in infections by the positively chemotactic organisms (streptococci, pneumococci, meningococci and gonococci) that the best clinical results have been obtained.

It should likewise be mentioned that in infections with the negatively chemotactic organisms (those that repel polymorphonuclear leukocytes and which clinically are attended by a relative or absolute leukopenia) there have been few reports of efficacious treatment by sulfanilamide. Such infections are those caused by the typhoidcolon group of bacilli, the hemophilus, and whatever is the infectious agent that is responsible for the "influenzas." In fact, many of the untoward reactions observed with sulfanilamide have been during the course of its administration in these infections. In the recent "influenza" epidemic (winter, 1939) many physicians have remarked the untoward prostration and slowness of recovery that appeared to distinguish this epidemic from those of past winters. It may or may not be coincidental that a large amount of sulfanilamide was used on a great number of patients this year for the "flu."

There is some experimental evidence to indicate the dangers of sulfanilamide administration to those with infections by negatively chemotactic organisms, or to those with infections by positively chemotactic organisms in which the body has failed to respond to the stimulus of the infection by leukocytosis. There is little utility for the administration of sulfanilamid, even though the organisms present are those regarded as being amenable to sulfanilamide therapy, if a leukocytosis does not accompany the infection. It is better in these cases to wait for, or attempt to induce, a polymorphonuclear increase (by foreign protein therapy or liver therapy) than to give the sulfonamide while the patient is exhibiting even a slight leukopenia.

This rule is, as I have remarked, simply an inference and an impression from the administration of sulfanilamide to over a thousand patients at the Cook County Hospital; but it is rational when we consider the fact that sulfanilamide seems to have a depressing effect on myelopoiesis (and this applies to the production of all blood cells originating in the bone marrow; the granulocytes, erythrocytes, and thrombocytes) when associated with infection. It must be remembered that sulfanilamide has been given to desperately ill patients, and that many of the reactions, while subsequent to the exhibition of the drug, can hardly be attributed to it. It is hard to enumerate the cases that would have exhibited reactions or idiosyncracies were they not very ill at the same time. That the concurrent illness has much to do with the untoward reactions that have been noted is vouched for by the fact that there is a tremendous amount of sulfanilamide dispensed and consumed without medical supervision, especially since it is now generally known by the laity that the material may be effective in gonorrhea. Yet it is usually in hospitalized cases that the reactions seems to occur, never in ambulatory patients. The best explanation would seem to be that it is the severely ill people who are hospitalized, and that the illness is the main cause of the reaction, the sulfanilamide being merely the straw that breaks the camel's back.

This same line of thought may be taken in the discussion of the commonest untoward occurrence during the administration of sulfanilamide, the cyanosis. This appeared rather frequently when the material was first used; more recently it is so infrequent that I have been unsuccessful in inducing cyanosis even by pushing the drug to heroic dosage in an attempt to secure the condition for experimental study. I am at loss to explain the almost complete disappearance of sulfanilamide cyanosis from our wards, except on the possibility that the material now used has been more purified than the earlier sample, turned out while the manufacturers were developing their methods, might have been. Many patients now develop a pallor while the drug is being given, but true cyanosis, such as was formerly the rule, now seldom appears even though the dosage is much large at the present time than at the time when the drug was first introduced.

Many of the taboos as to sulfur-containing foods, laid down at the time when cyanosis was a prominent symptom of sulfanilamide administration, are now ignored—the drug itself contains sulfur in its molecule. And when cyanosis does occur it cannot be construed as a contraindication to the continuance of the drug, particularly when it occurs alone, without any clinical or laboratory evidence of diminution in the oxygen-combining power of the blood. The latter would be implied by the appearance of sulfhemoglobinemia or methemoglobinemia, but these latter conditions are exceptional and in my experience occur only under circumstances where there would be an inactivation of the hemoglobin even if no sulfanilamide were given, as, for instance, in pneumococcus and Friedlander bacillus pneumonias, where the patient is very ill. I have seen true methemoglobinemia in such cases in which sulfanilamide has been given, but cannot honestly attribute the denaturation of the blood pigment to the latter, since it was also seen before the use of the drug in this type of infection. It is true that any case of marked cyanosis (except those which are due to frank cardiac decompensation, where the venous

character of the capillary blood is known to be responsible) should have the benefit of a blood study for oxygen-combining power and a spectroscopic examination for modified hemoglobin—tests for which even the smaller hospital laboratories are now equipped—but in most cases the darkly colored blood which is withdrawn from the patient who has been getting sulfanilamide will be found to have a normal oxygen combining power proportionate to its hemoglobin content. The dark color can be demonstrated to be due to a staining of the corpuscular stroma, and not to an alteration in the color of the hemoglobin. For instance, if the blood be shaken with toluene, the latter will extract the corpuscular lipoids, which will be a dark brown (normally white). I have attempted to isolate this pigment, and so far can say that it is a phenol derivative which is in no way related to altered hemoglobin. Its presence does not contraindicate the continuation of the therapy on theoretic grounds, and this assumption is borne out by clinical experience.

With regard to dosage, there has been much discussion as to whether large or small doses should be used. The advocates of the smaller dosages, at least initially, would find justification for their arguments in the fact that sensitivity to the drug will manifest itself with these small doses before too much damage could be done in one having an idiosyncrasy. I well remember a patient of mine, a man of 64, who was hospitalized for a severe cryptogenic fever of two weeks' duration, and who developed a rubelliform rash, extensive purpura, and a severe hyperchromatic anemia along with a hemorrhagic stomatitis after just 3 grams of sulfanilamide. Preceding the administration of the sulfanilamide he had had a leucopenia, and, knowing what I know now, I would not have given the drug, just on the implications of the white count alone. The erythrocyte count fell to one million in two days after the single day of administration. Massive doses of parenteral liver and vitamin C were given, with ultimate recovery, but I shudder to think what might have occurred had I continued the administration.

And it is true that relatively small doses may accomplish wonders in many cases. The first patient on whom I used Prontosil, which was at that time the only sulfanilamide clinically available, was in 1930 on a young woman with a purulent iritis of one month's duration, who was getting worse. She received five grains of the dye one evening, and the next morning was markedly improved. Her total dosage of five five-grain ampoules, one every other day, resulted in a complete cure. Today we would call such a dosage ridiculously inadequate. Still, where there is time for trial, I see no objection to the attempt at therapy being made with small doses.

On the other hand, I have given as high as eight grams of sulfanilamide per day for periods of forty days to average size patients without any untoward effects, though I have always followed up the blood picture in these patients. In none of the large dosage group was it found necessary to discontinue the administration.

Ideally, a determination of the sulfanilamide concentration of the blood of patients on this form of therapy, with a view of adjusting the dosage so as to keep this concentration at some definite level, might be aimed for in hospital practice, but since more and more of those patients who are getting sulfanilamide are ambulatory, this ideal will not be approached for some time. Until it is, I would like to state that, by the avoidance of the use of the drug in patients who do not exhibit an increased leucocyte count, I have not in the past year had any other reaction except the lassitude that one can anticipate whenever the drug is given in clinically effective amounts. The success which has been my experience in connection with the material I attribute to its use solely in infections by positively chemotactic organisms, and in which the patient shows evidence of a response to this chemotaxis by an elevated polymorphonuclear leucocyte count.

(*The Eye, Ear, Nose and Throat Monthly*
February, 1940).

MADRAS MEDICAL COUNCIL

REVIEW OF PROCEEDINGS

April 1940. Session

BY

DR. V. RAMA KAMATH,

Member, Madras Medical Council.

The meeting of the Madras Medical Council held on 15th April 1940 was the last meeting of the old Council. After the confirmation of the minutes of the last meeting the Council recorded the Government Orders relating to the tenure of office of old members and the life of the old Council, etc.

The readers might remember my having reported in these columns last January (while reviewing the proceedings of the October 1939 session of the Council) that Dr. N. Venkataswami Chetti moved and Dr. U. Krishna Rao seconded the following resolution:

"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 five 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."

The following is the Government Order on the above resolution:

"In Memorandum No. 36,375-3-D. 1., P. H., dated the 29th September 1939, a draft of certain rules to regulate the holding of First Elections under clauses (c) to (f) or sub-section (1) of section 5 of the Madras Medical Registration Act, 1914 (Madras Act IV of 1914) as amended by Madras Act XVI of 1928, was published for general information. The Government considered the suggestions which have been received with respect to the Draft Rules but see no sufficient grounds to accept them. The draft rules will now be confirmed and the appended notification published in the Fort. St. George Gazette.

(ii) The rules for first elections as recently amended and published as an annexure to the Government Order under reference will be duly incorporated in the next edition of the Madras Medical Registration Manual."

The recent elections proved that the apprehension of the two graduate members of the Council was not justifiable as the new Council has six graduates and six licentiates and three nominated members with foreign qualifications. The old Council including the ex-officio President contained 15 members and the new Council has sixteen members including the ex-officio President. Of the sixteen members the independent medical profession has been lucky to have nine members, two of them are honoraries in the City hospital, one a Surgeon, and another a Physician. As in politics, there cannot be parties in the medical profession for and against the Government and the principle of nomination is not to secure

representation to the Government but for certain interests. Fortunately for the profession whatever might be the motive or principles that guided the candidates who sought elections and the Government who nominated the three members, the net result has been a very compatible, harmonious mixture which I sincerely hope will serve as a panacea for all ills from which the profession has been suffering. It has been my experience and must be so with my old colleagues all of whom excepting Dr. R. J. Dyson and Dr. Miss. Ida Scudder are not now in the new Council that Major General N. M. Wilson, who is to be the President of the new Council never made the old Council feel that he was the head of the Medical Department and as such should protect the interests of the official medical profession as against the independent medical profession. I should publicly express my gratitude to him for making my path very easy while I moved five resolutions at the last meeting all of which were anti-official if I may use such a term in spite of the fact that I often annoy him by arguing my case longer than he feels necessary for he never shows a tendency to be against anything good for the entire profession. So, if the newly constituted democratic Madras Medical Council will not achieve all that is necessary for the harmonious growth and evolution of the medical profession in this Province, all blame will be on the heads of the Indian members of the Council whether they be official for the time being or the independent medical practitioners. All the same the Council cannot hope to do much unless the members of the medical profession take keen interest in the proceedings of the Medical Council and in other matters that concern the life and prosperity of the entire profession.

The following Government Order was placed before the Council:

MEDICAL REGISTER.

"In exercise of the powers conferred by clause (v) of sub-section (1) of section 24 of the Madras Medical Registration Act, 1914 (Madras Act IV of 1914), His Excellency the Governor of Madras is hereby pleased to make the following amendments to the rules published with Public Department Notification No. 673, dated the 15th December 1914 at pages 1719 to 1725 of Part I of

the Fort St. George Gazette, dated the 22nd December 1914 as subsequently amended:—

AMENDMENTS.

In the said rules under the heading "V-Rule under section 24 (1) (v) for the compilation and publication of the Medical Register and connected matters:—

(1) In rule 1, all the words beginning with 'it shall be divided into three parts' shall be omitted;

(2) In rule, for the words 'month of January' the words 'month of February' shall be substituted; and

(3) In rule 4, the words 'each part of' and the words 'in that part' in the two places where they occur shall be omitted."

While recording the above G. O., the following resolution was moved by Dr. V. Rama Kamath and seconded by Dr. T. S. Tirumurti and passed unanimously.

"While recording the Government Order on the amendment, the Council requests the Government to direct the Government Press to co-operate with the Registrar in publishing the register, corrected up to the 31st December of the year preceding, in the month of January as per the old rule."

It is reported that the Registrar brought to the notice of the President his inability to publish the Register corrected up to 31st December of the year preceding in the month of January as per old rule. I cannot conceive what prevented the Registrar to place this matter before the Council at the proper time instead of taking protection of the President. The President could not possibly deny to help a situation and that at a time when it could perhaps not be remedied otherwise. The readers might remember that before 1934 the Medical Register was not published in time i.e., in the month of January and in certain years the publication was delayed even for over one year. This chronic ailment did cost the Council over Rs. 5,000/- in the shape of defalcation. The ailment persistently continued during the term of office of a full-time Registrar whose services were dispensed with. During the tenure of office of Major-General Sir Frank P. Connor, he felt rather nervous to have a full-time Registrar from outside his office and at his suggestion, the Council appointed a part-time Registrar, one of the

then senior superintendents of the office of the Surgeon-General, the late Mr. Pinto. During the tenure of office of this part-time Registrar, it was possible for him to publish the Register within the time fixed by the Medical Registration Act. He requested the Council to give him additional help of an attender who could also assist him in office as a clerk. This was sanctioned on the express condition that the Registrar should not ask for additional help of a temporary clerk during the period the Register was compiled. After the untimely death of Mr. Pinto, his successor was also a part time Registrar, one of the Superintendents of the S. G's Office. During the regime of this temporary Registrar, the Register was compiled in time. As there was some technical objection to employ Government servants for part-time work, the Council appointed a full-time Registrar last year and it was expected at the time that the work of the Council would get along very satisfactorily. The Medical Register is a very important document and if the Registrar could not cope up with the work, the remedy was to request the Government to give additional help to the Government Press but not apply to the Government to condone the delay by the authority of a Government Order which instead of rectifying matters made an irregularity regular.

In the matter of reciprocity with other provincial Medical Councils, the Government communicated the following order to the Council:—

"The President, Madras Medical Council, is requested to place before the new Council the proposal for the levy of a fee of Rs. 5/- to meet the incidental charges in connection with the reciprocal registration by the Madras Medical Council of persons registered by other Provincial Medical Councils which charges a fee for such registration, and to communicate its views in the matter to the Government in due course."

DISCIPLINARY CASES.

As this was the last meeting of the old Council, the Council decided to appoint a Special Committee under Section 17 of the Madras Medical Registration Act, to go through the pending disciplinary cases and appointed Drs. V. Rama Kamath,

T. Satakopan and U. Krishna Rao as members of the Committee. The Committee after a preliminary meeting sat once again on 17th June 1940 and went through all the ten cases.

Complaint against Lt.-Col. S. C. Alagappan, I. M. S., Surgeon, First District: Dr. U. D. Gopal Rao, L.M.P., medical practitioner, Madras, made a complaint to the Council alleging that the Surgeon, First District, gave a second opinion on the certificate issued by him to a Government Telegraphist without summoning Dr. Rao to be present at the office of the Surgeon on the day the latter examined the patient and that the Surgeon gave some advice to the patient which Dr. Rao alleged as unprofessional.

The Registrar did not place the complaint before the President as is usually done and obtain a preliminary explanation from the practitioner complained against as per the rules governing such cases but placed the matter before the Council direct asking the Council's opinion whether the complaint might be treated as 'information' and whether further action might be taken in the matter. The complaint was defective as the complainant did not make a declaration as required by the rules. The Registrar sent back the complaint to Dr. Gopal Rao for its rectification before the same was placed before the Special Committee.

The Committee after hearing Dr. Gopal Rao, his patient Mr. A. Satagopa Chetti and the pleader for Lt.-Col. Alagappan, gave the verdict that the charges against Lt.-Col. Alagappan were not proved.

As the Registrar did not conduct a preliminary inquiry in this case and did not obtain Lt.-Col. Alagappan's explanation as he did in all other complaints following and as the explanation given by Lt.-Col. Alagappan and his pleader who appeared for him before the Committee were not published by the Registrar, I refrain from publishing the same.

Complaint against Dr. P. Varadarajulu, L.M.P.:—Dr. T. Narasinga Rao, L. M. P., private practitioner, Hindupur,

complained against Dr. P. Varadarajulu Naidu, Sub-Assistant Surgeon in charge of Government Hospital, Hindupur, alleging that Dr. Naidu violated the Code of Medical Ethics by treating a patient already under the treatment of the complainant. He added that Dr. Naidu did not even reply to his letter which he sent to him through a messenger informing him about the case. Dr. Naidu in his preliminary explanation said that at the time he visited the patient Dr. Naidu did not know that the patient was under the treatment of Dr. Rao and soon after he learned from Dr. Rao that the patient was under the treatment of Dr. Rao, he declined to treat the patient and advised the patient to go back to Rao. But Dr. Rao refused to take back the patient. The Committee after hearing both the parties came to the conclusion that no case had been made out against Dr. P. V. Varadarajulu Naidu. But before giving the verdict, the Committee advised Dr. Naidu that he would have avoided all trouble if he sent a courteous reply to a fellow practitioner.

Information against Dr. D. S. Asirvatham Nadar, L.M.P.: Information was received by the Registrar that Dr. Asirvatham Nadar circulated hand bills at Vaniyambadi and round about the place in Tamil, the English translation of which is given here below :

"Wanted for the A. I. I. D. & B. C., Ltd., Vaniyambadi Branch, a reliable and wealthy Agent who can deposit not less than Rs. 250. Applications for the Agent's post should be addressed to the address mentioned below :

For the A. I. I. D. & B. C., Ltd.,

Dr. D. S. ASIRVATHAM,

Director, Honorary Magistrate,
Chief Medical Officer,

Dr. D. S. Asirvatham's Nursing Home,
Principal, Dental College and
College of Physicians and Surgeons,

Vaniyambadi, } Vaniyambadi.
3rd June 1939. }

It was reported that Dr. Nadar had assumed imaginary titles such as D. D. S., D.M.D., M.D. (D), M.S. (D).

The practitioner was summoned to appear before the Committee. He sent a

lengthy statement but did not appear before the Committee.

The committee found Dr. Asirvatham Nadar guilty under sub-rule (2) of Rule No. 11 of the Rules for Inquiry and directed the Registrar to erase his name from the Medical Register. The charge under the Indian Medical Degrees Act was dropped.

Information against Drs. S. David Pillay, K. S. Thiagarajan and S. Srinivasachari: Information was received by the Registrar that the above three practitioners had lent their names as the members of a Board of Councillors amongst others of an institution styled as Madras Medical and Technical College run in Pudukottah State and that the prospectus of this College with the names of the Board of Councillors was distributed to the public. As such advertisement amounts to the violation of sections 5 and 6 of the Warning Notice, the three practitioners were charged for such violation. When asked to give preliminary explanation, Drs. Thiagarajan and Srinivasachari stated that their names were included without their knowledge. But Dr. David Pillai said he knew the fact but after having come to know that his conduct violated the Code of Medical Ethics, he asked the Principal of the College to remove his name from the prospectus. When all the three were summoned to appear before the Committee, only Dr. Thiagarajan appeared. After hearing Dr. Thiagarajan, the Committee found him guilty and he was warned. This verdict holds good for the other two absentee practitioners.

Complaint against Dr. K. Satyanarayana Rao, L.M.P.: One Bayyavarapu Appanna complained alleging amongst other things that Dr. Satyanarayana and his father K. Narasimha Rao operated upon him for Hydrocele-Elephantiasis-scrotum (complainant's own words) and "that the operation and after treatment was done in a reckless and negligent manner. . . . etc."

As no preliminary explanation was demanded by the Registrar before he placed

this complaint before the Council and as the statement submitted at a later stage by the practitioner, was not published, I could not mention more about the case. The complainant mentioned in his complaint that the case was in the hands of the police. The committee learnt at the time of the hearing of the case that both the father and son were undergoing trial regarding this case before a magistrate and therefore decided not to proceed with the case till the criminal complaint was decided.

Information against Dr. B. K. Narasimhachari, L.M.P. of Paramakudi: Copies of hand bills printed in Tamil were received by the Registrar published by the above practitioner informing the public that all kinds of disease were treated by him and that the author of hand bills had authority to issue all kinds of certificates, etc.

Preliminary explanation having been demanded by the Registrar, the practitioner stated that he was ignorant of the Code of Medical Ethics and expressed regret for having distributed the hand bills. The practitioner was summoned to appear before the committee but he reported ill. Consequently the case was adjourned.

Complaint against Dr. R. Narasimhachari, M.B.B.S.: One M. Krishna Pillay of Kumbakonam made the following complaint against the practitioner :

"I appeared on 7th October 1939 at about 8 a. m., before Dr. R. Narasimhachari M.B.B.S., Honorary Assistant Medical Officer, Government Hospital, Kumbakonam, at his consulting room for the purpose of getting a medical certificate to enable me to obtain my driving licence. At outset, I agreed to pay the doctor Rs. 2 for the certificate. This is the usual fee for the certificate concerned and this fact can be ascertained from others in Kumbakonam, who are also authorized to issue such certificates. I was duly examined. Then Dr. R. Narasimhachari took his fee and said that I was suffering from tuberculosis and that he would disqualify for the licence unless I paid something more. This demand of his was supported by him on the plea that he has to give a portion of it to the doctors in the Government Hospital. I being poor and getting only acting chances of driving, could not afford it and requested him to give me a certificate for the original fee agreed upon. But the doctor

was very adamant and would not even hear of payment that evening, since according to him, money would not be forthcoming when opportunity was lost. He then wrote up a certificate then and there which is herewith enclosed and started immediately for the hospital. I do not know English and on showing the certificate to some of my friends, I learnt that I had been disqualified on the plea of tuberculosis. I was at a loss to know how I could manage for my living particularly so, as the doctor had taken my licence number and threatened to report me to the District Superintendent of Police which would prevent me from obtaining a fit certificate from anybody else. I however decided to request Dr. R. Narasimhachari again for a fit certificate. I went to him again on 8th October 1939, i.e., the next day, and entreated him for the second certificate. After much pleading the doctor agreed, and wanted back the certificate given to me on 7th October 1939. But I had set plans and feigned to the doctor that the certificate was torn up excepting the Court Fee Stamp, by one of my friends on account of the nature of the certificate. The doctor wanted me to procure him at least the bits torn off. But this, I said, was washed out by the rains on the 7th evening. The doctor was suspicious and refused to give me the certificate notwithstanding my realistic lies. The next day again, that is on 9th October 1939 I renewed my attempt on the doctor for a certificate. I begged it of him. Then the doctor received another Rs. 2 with much imploring and gave me a fitness certificate, and deleting the mention of tuberculosis and saying that I was fit. This time he did not examine. The latter certificate I have sent to the District Superintendent of Police, Tanjore, for obtaining my licence and the document can be verified from the office. I am enclosing herewith a copy of that certificate. I am sure I am not suffering from any disease and I am prepared to appear before any medical officer for examination if so ordered.

It is highly regrettable that a member of the noble medical profession to take to such illegal objectionable methods of extracting money from illiterates. I would not have been sorry if the doctor had plainly told me that his fees for the certificate was Rs. 10/- or anything he liked without adopting such clever ruses to get more money than what was originally agreed upon. I humbly pray that the Council be pleased to enquire into the matter and help us, the ignorants, from being cheated by misuse of the powers given to the doctor."

The 2nd certificate was obtained from the District Superintendent of Police, Tanjore, and the practitioner was asked to explain his conduct in the preliminary enquiry and the practitioner made the following written statement :

"In obedience to your letter, dated 11th March 1940, I beg to submit the following as my explanation :—

It is true that I gave the two certificates. What I found on examination on 7th October 1939, I embodied in the first certificate. The complainant paid me the usual and fixed fee of Rs. 2/- and left my office. But on the next day he came again and entreated me to give another certificate which I promptly refused. He brought recommendations, even then I refused. Then he became a regular pest on me and with tears in his eyes begged me to save him, and moved solely by his entreaties, I gave the second certificate on 9th October 1939.

I did not then know that it was a trap to catch me unawares. I believed the man when he swore that he tore the first certificate away and allowed the pieces to be washed off by rains. I believed him when he literally prostrated himself before me and begged that I would be saving his life by my giving another certificate. He pleaded that he was very poor and had no other means of livelihood. He promised to undergo treatment for his condition and took a prescription from me. I am young in the profession, being only about two years since I set up practice and I fell into the trap, cleverly contrived by the complainant with the help and connivance, and I am constrained to believe, of another in the profession, having grudge against me.

I emphatically deny the imputations made against me by the complainant. I did not demand any fee higher than that fixed. I did not say that the complainant was suffering from Tuberculosis. I never stated that I would disqualify him and sought to obtain more money. It is false to say that I wanted the same to share it with others in the hospital. The further allegation I had taken the complainant's licence number is another audacious falsehood.

No monetary consideration whatever weighed with me when I gave him the certificate he asked for. It was merely on account of pity on his condition and nothing else. I am placed above want; born of a rich family and being of affluent circumstances, I am not in the habit of extracting fees, much less by adopting illegal means. My private practice and my work as honorary officer in the Government Hospital, till now, has been though "I say it", without blemish. I crave, therefore, the indulgence of the Council. I solemnly give this assurance that I will not give cause to any such complaint hereafter, as I will not swerve from the right path of duty. I feel heavily for what has happened.

I may, however, be permitted to point out that the complainant has not moved in the matter with best justices. He has adopted dubious methods, to entrap me, and taken nearly five months to give a shape to the complaint; not to speak of the cleavage that should have been brought in this condition of his body.

With a reiteration of my assurance that I will be more cautious in the future, I pray for a dismissal of the complaint."

The practitioner who was summoned before the Committee pleaded guilty and requested the Committee to take a lenient view of his conduct.

The Committee gave a severe warning to the practitioner.

Information against Dr. P. R. Rama Ayyar, L.M.P.: The Registrar received three leaflets printed in English and Tamil dated 15-6-1936 from Paramakudi on 15-3-1940. The leaflets contained information that the practitioner had opened a hospital in a particular locality where treatment would be given to all kinds of diseases and that further the practitioner had authority to issue all kinds of certificates. It was also said in the leaflets that the visiting fee during the day was Re. 1 and at night Rs. 2.

The practitioner when asked to explain submitted that he circulated this leaflet for the benefit of the people as there was only one Government dispensary which was insufficient to meet the growing needs of the place. He said he was ignorant of the warning notice and added that he circulated the leaflet three years ago and that he did not since circulate them nor would he do so in the future and prayed to be excused. The Committee summoned the practitioner to appear before them but as he did not obey the summons, he was found guilty under sub-rule (2) of Rule 11 of the Rules framed under Madras Medical Registration Act relating to Inquiry in disciplinary cases, the Committee directed the Registrar to erase the name of the practitioner from the Register for a period of one year.

It is a pity that the practitioner did not obey the summons of the Committee nor did he explain his inability to be present before the Committee. In cases where Registered practitioners are charged for having advertised even the General Medical Council usually does not have recourse to the extreme step of erasing the name of a Registered Medical Practitioner from the Register and gives a severe warning. To my knowledge the same thing is done even by the Provincial

Councils in India, the publication of the verdict of the Bombay Medical Council in the correspondence columns of the current issue of The Medical Practitioner is an instance in point. The fact that the circulation of the leaflets by the practitioner in this case was done nearly four years ago ought to lessen the rigour of justice.

It is really very unfortunate that a section of the medical profession seems to have no clear ideas of the responsibilities and functions of the Medical Council and much less know how to defend themselves when charged for infamous conduct in professional respect and at times fall a victim to technicalities. The practitioners should realise that the Medical Council though it has disciplinary control over registered practitioners, is a body consisting of only medical men, a large majority of whom are now elected by the practitioners themselves and nobody in the Council is anxious to expose the weakness of the practitioners but the Council has to maintain the prestige and status of the noble profession and weed out from it ignoble elements if they are proved to be such without a shadow of doubt. When they were charged for misconduct, they should avail themselves of all opportunities of defence and when they feel they have no justice, they have a right to appeal to the Government which they should do within three months from the date of the verdict of the Council.

Information against Dr. Sanjeeva Shenoy: The Government by an order reported to the Council that the practitioner being a drug addict had abused the privilege conferred by Madras Manufacturers Drugs Rules 1932 by possessing for his own use fairly large quantities of Morphia Hydrochlor and sent a copy of the proceedings conducted by the Excise Department against him requesting the Council to take such action against the practitioner as the Council deemed fit.

The practitioner was summoned to appear before the Committee but as the articles of charge and other connected papers were not supplied to the practitioner by the Registrar, the Committee

directed the Registrar to supply the same to the practitioner and postponed the case.

RESOLUTIONS.

The following resolutions given notice of by Dr. V. Rama Kamath were passed unanimously :—

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 expression as "L. M. Ps. 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. In order to maintain a standard relating to the Code of Medical Ethics, the Madras Medical Council requests the Government and local bodies to report to the Surgeon-General through the proper channels all *bona fide* cases of infamous conduct in a professional respect brought to their notice against official medical officers or non-official practitioners under their control such as subsidized practitioners, etc., before any action is taken against them; and that the Surgeon-General be requested to bring such cases as he thinks fit before the Medical Council.

3. Government are requested to direct local bodies not to deny the rights and privileges conferred on subsidized practitioners, who are on the Madras Medical Register, by virtue of their registration.

4. Resolved to inform the Madras Public Service Commission through Government that it is derogatory and against the spirit of the Madras Medical Registration Act to make invidious distinction between official and non-official registered practitioners in regard to physical fitness certificates demanded by the Commission from 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 or any equivalent eye qualification 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 Medical 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 that 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 Government Order on the subject. There-

fore, the Surgeon-General with the Government of Madras is requested to take notice of the conduct of the officers concerned so that that Government Order on the subject is strictly adhered to."

Resolutions No. 1 and 5 were passed as they appeared in original and 2, 3, and 4 underwent slight modification in the working.

Dr. T. S. Tirumurti took special permission of the Council to move the following resolutions as the notice of the resolutions was not sent to the Registrar within the prescribed time:

1. "That the Registrar be authorized to arrange alphabetically the names of the registered medical practitioners district war and publish the same as the electoral roll for the purpose of elections to the local Medical Council as well as the Medical Council of India".

2. "That the Registrar be authorized to change the addresses of all Government servants according to the latest Civil Medical List as this is an authoritative publication of Government".

3. "That the Registrar be authorized to delete the names of the registered practitioners whose ballot papers have been returned from the Dead Letter Officer with a remark that the addressee is 'deceased'".

4. "That the Registrar be authorized to make a list of all the registered medical practitioners whose ballot papers have been returned as 'addressee not traceable' and to refer such cases to the Revenue authorities or to the District Medical Officer for giving the correct addresses in order that the Madras Medical Register may be brought up-to-date, as the Register is in the nature of a public document".

Resolution 1 underwent slight changes from the original; 2, 3 and 4 remained as they were and all the four were passed unanimously.

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MEDICAL PROFESSION, PLEASE WAKE UP.

The Scientific Medical Profession in India being treated as a department of the Government has not been growing to its legitimate height as in other civilized countries and it is not strange that India will continue to be a death trap of diseases unless the members of the profession realise their responsibilities both to themselves as well as to the members of the public who are virtually their masters. Professional work with its prosperity is being cornered by a few whether it be in Government service or private service with the result that the rank and file in both services have little or no physical or material vitality to assert itself and command even a humble contented life to enable its members to maintain body and soul together. When the National Congress came into power in the seven out of eleven provinces, the members of the medical profession were in rapture that good days were dawning and in the Madras and Bombay Presidencies the joy of the profession knew no bounds as the Congress Governments in these two major provinces entrusted the Medical Portfolios to two independent medical practitioners. But within a few months of the Congress regime, it was felt by the medical profession that instead of a permanent Government Officer ruling it, another temporary Government Official had taken the role of a ruler under the garb of a popular Minister though it has to be said to the credit of the Madras Minister that the fundamental principles of his reforms are sound. But

he had not the insight to carry the reforms through without injuring the prestige of the members of the profession who were obsessed with a feeling of being let down in the eyes of the public ever since the Madras Minister expressed though unguardedly, that the living wage of a member of the profession was somewhere near Rs. 30 a month. Whereas in Bombay, the Minister by a special legislative measure brought everybody practising indigenous systems of medicine to the level of the members of the Scientific medical profession. Both the Ministers till they got into the respective cabinet, were members of the independent medical profession. They knew that the profession was helpless as against the Government for want of united organisation. They were quite conscious that a strong democratic union in the medical profession was an impossibility in India due to its heterogeneous growth which began with the advent of British Rule. Yet both of them minded politics more than the interests of the scientific medical profession and did not attempt to loosen the grip of the Government on the profession with the result that whether it be in cities, towns and villages the members of the medical profession, official and non-official, are completely at the mercy of the public and are dictated to instead of being heard. Cut throat and at times dishonest competition has consequently taken such a deep root shattering the hopes of the medical men ever growing a harmonious fraternity. Such a state of affairs has been cutting both ways, the medical profession and the public, the former being crippled not being

allowed to grow on scientific lines with the consequential result that the latter not having the benefit of scientific treatment.

All the same we must say that the scientific medical profession did not take advantage of the popular Government by conducting agitation on sound lines so as to force the ministers not to be led away by political considerations. There is a feeling in the public that the medical profession is another trade union and that its members mind their own prosperity and not the sufferings of the people. This impression could be removed only by the contact of the medical practitioners with the masses and making them feel that while they, the practitioners, exercise their profession, they are not unmindful of the sufferings of their patients. This the practitioners should demonstrate by example by bringing into existence public utility medical services even at some sacrifice with the sole purpose of giving publicity to the spirit of service inherent in the medical profession. It is usually said that the Government Medical Institutions are not popular but we actually see that year after year the numbers treated both in the out-patient as well as in the in-patient departments are going up by leaps and bounds and patients are found on the verandah and the floor for want of accommodation. How can the overcrowding of the Government Medical Institutions be reconciled with the popular saying that these institutions are unpopular though both the statements are too true to be disbelieved. The direct effect of such an irreconcilable popularity has been seriously telling upon the prosperity of the members of the medical profession especially the general practitioners. Consequently the general practitioners have begun to question if honorary medical service is conducive to the prosperity of the medical profession as a whole. The medical profession as well as the public

has not realised as yet that the artificial popularity of the Government Medical Institutions as judged by the number of patients treated, is solely responsible for the harsh criticisms against the honorary medical service and the faulty Hospital Administration and not extension of Honorary Medical Relief Scheme is at the bottom of all irreconcilable reckonings. So unless the Hospital Administration undergoes a rational change making the institutions available for only the necessitous poor, the rich being admitted under exceptional circumstances and being made to pay prohibitive rates, the Government Medical Institutions will continue to be as unpopular as they have been and the medical profession will continue to drift to much more dire circumstances. Such a state of affairs will tell seriously on the morale of the noble profession as well as of those who seek admission into the hospitals who can afford treatment in their own houses. The only way to put an end to this vicious circle is for the profession to wake up and press their views unreservedly and selflessly by taking into its confidence the public and thus create public opinion in favour of reforms to be advocated in Hospital Administration. Unless this is done effectively, the medical profession cannot evolve and cannot take its rightful place in medical relief.

As in politics, it has not been possible for the medical profession to organise itself into one solid all-India organisation nor will it be possible for it to rise up to this level for a century more if not for ever. The Government whether it be semi-bureaucratic, democratic or the unadulterated bureaucratic, have been moulding their policy of Medical Administration in such a way that what is happening about politics in India is reflected in the medical profession and we do not feel the necessity of pointing out the actors in the medical profession resembling the Congress, the Muslim

League, the Minority communities and the Princes. All the same we have faith in the medical profession, official as well as independent, that given the right lead, the deadlock can be broken at no distant date. To achieve this, the profession need not trouble the British Parliament, the Secretary of State, the Viceroy or even the Governors of the Provinces. If the profession minds its legitimate duties to itself and the public and educates the public dispelling from its mind that the medical profession is a trade union but is a service which does not recognise castes and even nationalities, there is every hope to win independence for the profession. A question is likely to be asked regarding the 'touch me not service', the I.M.S. Our answer is 'Leave this service alone'. They are in hopeless minority. They may cling to a few reserved appointments but this cannot affect the independent profession as a whole even if a few at the top covet to get into the shoes of I.M.S. Even then this service or any other service cannot rule the independent medical profession if they are united.

Every few years the Government feel or perhaps are compelled to feel that what they did and have been doing regarding the Honorary Medical Relief, has defects. As such defects are seen by one person whether he be the popular Minister or the bureaucratic Surgeon-General and as both of them so far never took the whole profession into their confidence in matters concerning the medical profession as a whole, the scheme has been ever changing with no beneficial effect. As expressed in The Medical Practitioner in the News and Comments Columns last month, only two medical associations in the City seem to have been confidentially consulted by the Madras Government relating to the working of Honorary Medical Relief Scheme which affects the entire medical profession. Why this enquiry

be confidential can only be answered by the Government. But we should apprise the members of the medical profession in the City of Madras who are not the members of the only two Associations consulted by the Government to bestir themselves and join their moffusil brethren and find out ways and means to express their views on Honorary Medical Relief Scheme not forgetting the larger interests of medical relief. The only way to pool the views of the profession is to organise medical conferences of groups of districts in close proximity and discuss the problems affecting the profession threadbare and come to decisions not minding vested or individual interests. After having done this successfully, representatives should be selected from each district and a conference of the representatives should meet in Madras and the Surgeon-General in his capacity as the President of the Madras Medical Council should be requested to preside over this conference. The President of the Medical Council in the person of Major-General N. M. Wilson has been able to forget his official position while conducting the proceedings of the Madras Medical Council. Why should he not be able to do the same when the representatives of entire profession request him to guide the profession about the problems of medical relief? As we are aware that the number of practitioners who are not the members of any existing associations is much larger than those who are members of one association or other, we advisedly suggest conferences of the entire profession and not of particular Associations so that the views expressed at the conferences are more democratic and representative than otherwise. We place our services and the columns of The Medical Practitioner unreservedly at the disposal of the members of the scientific medical profession requesting them to wake up.

News and Comments.

Hybrid System Should End: We invite the attention of the readers to an Article appearing elsewhere in the current issue of *The Medical Practitioner* under the caption, "The Government School of Indian Medicine". The author is a graduate in art and medicine and is also a votary of the Ayurvedic System of Medicine. He must have spent some time in the Government School of Indian Medicine before he was conferred the Fellowship Diploma of Indian Medicine. We are also informed that he was an examiner for the School for a number of years. So he must have had exceptional opportunities of knowing all about the School. Being a double graduate of the Madras University and having a good knowledge of Sanskrit he must also be in a position to have a comparative knowledge of the virtues of both the Allopathic and Indigenous Systems of Medicine. Consequently his views are worth the consideration of the medical profession. We are glad that we received this contribution from the author at an opportune time when a Committee recently appointed by the Government of Madras to go into the curriculum of studies etc., of the School of Indian Medicine is deliberating. We have no idea of the actual scope of the enquiry by the Committee but we can hope from its personnel that the interests of Scientific Medicine will be safe. The Chairman of the Committee is Sir Mohammad Usman belonging to a well-known family of hereditary Unani physicians. Rao Bahadur Dr. M. R. Guruswami Mudaliyar one of its members is a retired Government Medical Officer who spent major portion of his service as a teacher of medicine, therapeutics and pharmacology and is known for his unbiased views on indigenous medicines which he did not hesitate to prescribe when he was convinced that the disease from which his patient was suffering had indications for the use of indigenous drugs or preparations. Dr. Mudaliyar's connections with the Madras University will also be a valuable asset to the Committee. Rao Bahadur Dr. S. K. Pillai another retired Government Medical Officer was serving the Government in the moffusil for practically

the whole period of his service excepting the last period when he was the Personal Assistant to the Surgeon-General. So he had exceptional opportunities of knowing the mass conception of indigenous systems of medicine and as the Personal Assistant of the Head of the Medical Department, he must have gathered various other view points of the indigenous systems. The third member in the Committee is Dr. M. A. Nair who is enjoying the rare privilege of practising his speciality in the treatment of eye diseases as an Honorary Ophthalmic Surgeon of the Government Royapuram Hospital and the Government Hospital of Indian Medicine. It is not known if he has recourse to indigenous system in the treatment of eye diseases at the hospital of Indian Medicine. If he practises Allopathic Ophthalmology in the Hospital of Indian Medicine, he will be able to give the benefit of his advice whether such practice will not be detrimental both to the patients as well as to the Scientific System of Medicine practised by him in the other hospital. Basing on the views of Dr. Nair the Committee will, it is hoped, be able to judge if the treatment of eye diseases in the Government Hospital of Indian Medicine is a sound proposition both from the point of financial economy as well as the scientific evolution of Medicine.

Mr. K. Balasubramanyam Aiyar, another member of the Committee is the worthy son of the late Sir V. Krishnaswami Aiyar who was the only and the very first Indian philanthropist who conceived the idea of encouraging not only Ayurveda but also the knowledge of Sanskrit language and literature by endowing large sums from his earnings as the then leading Advocate. The late Sir V. Krishnaswami Aiyar must have been against getting artificial popularity for his Ayurvedic Hospital and his son Mr. Balasubramanyam Aiyar has been scrupulously following the footsteps of his father in this direction in spite of what is going along in the Government School of Indian Medicine. Almost all who have nothing to do with the Government School of Indian Medicine have been condemning the evolution of indigenous systems on

artificial line of hybridisation. Acharya, Sir P. C. Ray than whom we could not find a more ardent lover of India and things Indian, rightly proclaimed to his audience recently at the Calcutta Medical College:

"I should say that the policy of passing off the Indigenous Systems of Medicine as Scientific Systems of Medicine after putting a veneer of modern sciences like Physiology and Anatomy on them, does not seem to me to be the correct course. The policy should rather be to accept the Western Scientific System of Medicine as the nucleus round which the tested knowledge derived from Indigenous systems of medicine may be gathered. All our knowledge should be accumulated on scientific lines."

Basing upon the opinions gathered by him from eminent persons, Dr. Srinivasa-charya sums up the ways and methods of encouraging and evolving Indigenous Systems of Medicine in his Article, which deserve the consideration of the Committee appointed by the Government relating to Indian Medical School. Before closing we feel we should reiterate our suggestion to the members of the Scientific Medical Profession that they should express their unbiased views on this vital subject and not sit quiet gazing apathetically at what is going around them.

Role of General Practitioner In Cancer Control: During these days of Specialised Medicine, there is a real danger of the general practitioner being wiped out from the field of medicine especially in India where the craze for specialists for anything and everything has assumed the gravity of a fanciful danger. Under the caption "Cancer Control—Early Is The Word", the Managing Director, American Society for the Control of Cancer contributes a short article to *The Journal of Medicine* (March 1940 Number) which article has been quoted by us here below:

"Cancer is a curious foe. Second only to heart trouble as a killer and most feared of all causes of death, cancer is in its early stages one of the most curable of serious diseases. Its definite diagnosis requires the services of a highly trained pathologist, but early symptoms which may mean the disease is present are easily recognized by any alert individual. Once cancer is diagnosed the preferred treatment is by a group of specialists and yet the key man in the whole picture of cancer control is the general

practitioner to whom patients come for periodic examinations or for advice about apparently harmless conditions. While late cancer causes considerable suffering, in the early stages it is nearly always painless.

It is fitting that this paradoxical disease should be fought by an army, not chiefly of men but of women, an army not of destruction but of education, and its war should be a war to save life. Four years ago a small group of physicians, research workers, and club women launched the Women's Field Army of the American Society for the Control of Cancer. Its goal was to reduce cancer mortality and to arouse the interest of men and women everywhere in this disease and the methods and facilities available in their communities for treating and controlling it. Between one-third and one-half of those who now die could and should be saved by early diagnosis and prompt treatment, declared the American Society for the Control of Cancer.

The growth of the Women's Field Army has been rapid. Divisions are now underway in forty-six states, cancer information centers—local units of the army—have been established in more than half the counties of the country. Cancer control is receiving more attention than ever before.

A beginning has been made, but only a beginning in this peacetime war. Approximately 1,50,000 men, women and children were destroyed by cancer in 1939. The needs in the field are great: more clinics, more funds for research, more facilities for indigent patients, above all, more education for the general public.

Working under the supervision of physicians and other experts, women are the leaders and organizers of the fight against cancer. However, the most paradoxical thing about this complex disease is that we cannot leave its control to leaders, to research workers, or medical men. We must all do our bit.

The Field Army suggests three measures that each one may adopt and so play a part in cancer control:

1. Have a comprehensive physical examination once a year, however well one feels; Women over thirty-five years of age should have what the American Society calls the B. P. Examination, covering the breast and pelvic areas, semi-annually.

2. Memorize the cancer danger signals, early and usually painless symptoms that may mean the disease is present and should always mean a visit to a physician. They are: any persistent lump or thickening, particularly in the breast; any irregular bleeding or discharge from any body opening; any persistent and unexplained indigestion; any sore that does not heal normally, especially about the tongue, mouth or lips; any sudden change in the form or rate of growth of a mole or wart.

3. Enlist in the Women's Field Army in April, set aside by Special Act of Congress as Cancer Control Month, and so help the army carry on its work of education to save lives.

Educate, Save, Enlist. These are the imperatives of the war against this disease. One more word should be emphasized. It occurs in this editorial many times. The word is *Early*,—and *Early is the Watch word in Cancer Control.*

We trust the general practitioners more than the cancer specialists realise their responsibility in combating Cancer or any other social disease like Tuberculosis. For, as in Cancer so also in any such disease, playing havoc on society "Early Is The Word" which determines the fate of the patient. So to be able to realise the importance of the word "Early" the general practitioner has to be the specialist in the "Early Diagnosis" of diseases.

Arogyavaram Sanatorium: The medical profession in South India if not throughout India will share with pride the all round enthusiasm that prevailed at the Arogyavaram Sanatorium, Madanapalle on 19-7-40 when the leading Christian missions in South India in co-operation with the other minor missions celebrated the Silver Jubilee of the Tuberculosis Sanatorium started first on October 24th 1912 by the Arcot Mission at Madanapalle town as a subsidiary activity of the women hospital under the charge of Dr. Louisa H. Hart and later developed as the united activity of eight missions in South India. On the 19th July 1915, His Excellency the Governor of Madras, the late Lord Pentland opened the Sanatorium in a locality four miles from the Madanapalle town which is about 2,500 ft., above the sea level which till then was a forest and since converted into 'a place where health is given by God in answer to prayers' which literally means in Sanskrit 'Arogyavaram'. The Sanatorium as opened in 1915 July 19th had accommodation for 109 beds spread on a land measuring about 100 acres and on 19th July 1940 the Sanatorium has accommodation for over 250 beds and owns 300 acres of land commanding up-to-date treatment for Tuberculosis in no way inferior to the best of the Sanatoria in the West or the

East and is now a teaching institution for conferring T.D.D. Diploma, thanks to the untiring efforts of Major-General N. M. Wilson, Surgeon-General with the Government of Madras who was able to persuade the Government to inaugurate the T.D.D. Diploma the first of its kind in India. It was in fitness of things that Mr. G. T. Boag, the Chief Adviser to His Excellency the Governor of Madras was requested to associate himself with the festivities of the Silver Jubilee of an institution which has been to a large extent depending upon the bounties of the Madras Government. Rev. B. Rottchaefer, Chairman of the Committee of management of the Sanatorium presided on the occasion. He is the oldest missionary now in the Committee who has been the chief architect in the construction of the buildings of various designs from the hut of a menial worker to the imposing structures, such as of operation theatre, laboratory etc., not to mention the hygienic open air cottages designed to suit the convenience and sentiments of the Indians coming from various provinces in India including the Native States. One such structure which accommodated two useful purposes, a Recreation Hall and a Library was opened by Mr. Boag. The former is named after Dr. and Mrs. Frimodt Moller and the latter after an American philanthropic lady, Miss Dodd who has been endowing large sums of money to build and maintain mission hospitals in South India. In fact the Arcot Mission first started the Sanatorium at Punganur, a village 13 miles from Madanapalle, depending entirely on Miss Dodd's help. Rev. Rottchaefer began his address by saying, "According to your faith be it unto you is fully exemplified in the fight against tuberculosis by the Protest Mission of South India. Ours is an ever increasing faith. Twenty-five years and more have witnessed an ever increasing accomplishment". He closed his speech as he began and said, "We shall not forget the faith upon which this Institution was founded. We shall not fail to enlarge our faith and to ascribe unto Him, who dwelt among men, the Glory also to relieve human suffering and pain". In between the beginning and the end of

his speech Rev. Rottchaefer narrated the events with regard to accommodation and other matters during the period of 25 years of the life of the Sanatorium which in 1915 presented a value of 60,000 and in 1940 represents an outlay of 5,000,000 with an annual expenditure of about Rs. 20,000 twenty-five years ago, now nearly Rs. 1,70,000. All these activities were possible, as all those who worked in the Institution and outside for the Institution did so to glorify God and not man and took no pride in their achievements. Any institution run by any Government, public bodies or private individuals could not have such a brilliant record of work as one saw at Arogyavaram on the 19th July 1940. After a certain stage of development which resulted out of divine spirit of service, there comes usually and unconsciously a stage where man asserts himself and we trust that those in the staff of the Institution from the humblest to the highest and who were all trained under the direct care of a devout medical missionary and as devout his life partner, Dr. and Mrs. Frimodt Moller, would continue to remember that the 25 years of progress at the Sanatorium though depended upon human labour and human talent, would not have attracted the public to the extent it did, if the labour and talent had not divine inspiration. We trust that the Glory of God which pervaded in the address of Rev. Rottchaefer and of Dr. Moller while they narrated the history of the Arogyavaram Sanatorium and which the suffering patients have been witnessing and experiencing, will be always kept in view in future years and when the Golden Jubilee is celebrated, the Glory of God will be in evidence in greater abundance proportionate to the bulk of work for fifty years.

Though the Sanatorium is under the control of Christian Missionaries, it is a wonderful phenomena that neither the non-Christian patients nor visitors at Arogyavaram, ever feel that they are in the midst of the activities of a foreign religion though they, the patients at every step of progress and the visitors at every new step they take, experience the vision,

"According to your faith be it unto you". Major-General N. M. Wilson, the Surgeon-General with the Government of Madras while expressing his appreciation of the work done, concluded his speech by saying, "The whole fabric of the work done here is ideal, and those who have unremittingly, down the years, carried out Dr. Frimodt-Moller's inspiration, and who have made facts out of schemes, must feel the truth of that saying: 'The best must always succeed.' It is said that one judges another by his own standard and therefore General Wilson's ideals of service must be as high as he found them at Arogyavaram. Dr. Frimodt Moller might have, at the most, half a dozen medical men under him to do service at the Sanatorium whereas General Wilson has under his control over 1,000 medical men in Government and Local Board Service and as the Ex-Officio President of the Madras Medical Council, he can command influence over the entire profession in the Presidency. We fondly hope that General Wilson's ideals of Service given expression to by him at Arogyavaram will permeate far and wide especially in the institutions which are called charitable. Mr. G. T. Boag, the Chief Adviser to the Governor of Madras drew a contrast between the great work of healing that was going on in the Sanatorium and the destruction that was taking place in other parts of Christendom in the West and hoped that the truths of Christian civilisation as widened at Arogyavaram would finally prevail. The basic principles of all regions are just the same. It is the materialistic imperialism displayed as Fascism, Nazism and Communism by individuals and group of individuals that is the cause of destruction of civilisation and the profession must be proud that the art of healing is devoid of destructive potentialities as is evidenced in the West where the ever growing science is being freely used for the work of destruction. We ardently hope and pray that the tenets of Christian faith in co-operation and co-relation with the teachings of other great religions in the East more than the science of destruction of the aggressors, will soon bring peace to the world.

Correspondence, Reports, Etc.

PROCEEDINGS OF THE MEETING OF THE WORKING COMMITTEE HELD AT THE HEAD OFFICE, MADRAS

On 30th June 1940, at 2 P.M.

PRESENT.

DR. V. RAMA KAMATH, *President*;
DR. M. R. BHAT, *General-Secretary*;
DR. K. GOVINDAN, *Treasurer* and DR.
C. KUNJUNNI NAIR, *Joint-Secretary*,
Madras South.

The following resolutions were passed:—

1. The Working Committee authorises the President to publish the report in the next issue of The Medical Practitioner in relation to the Resolution No 5 of the Provincial Committee dated 27th December 1939 keeping in view the opinions expressed by the members during the discussions on the resolution.

2. The Working Committee desires to convey its appreciation of the team spirit exhibited by the successful candidates at the recent Provincial Medical Council Elections under the leadership of Dr. V. Rama Kamath and offers its felicitations.

3. As there is only one member dissenting to the amendments to the Memorandum and Rules of the Association passed by the Provincial Committee at Tirupati on 27th December 1939 which were a subject of a referendum to the General Body, circulated through the Official Organ of the Association, The Medical Practitioner (January 1940 issue) the Working Committee adopts the amendments which will come into effect from 1st July 1940.

4. The Working Committee requests the General Secretary to edit the Memorandum and Rules of the Association as amended by the Provincial Committee at Tirupati meeting on 27th December 1939 and publish the same as early as possible and the Treasurer is requested to keep at the disposal of the General-Secretary necessary amount for the purpose.

5. Resolved to convene a conference in December 1940 in a suitable place in Malabar to be settled by the Working Committee in consultation with Dr. C. Kunjunni Nair, Joint Secretary, Madras South, and authorises the General-Secretary to proceed with the arrangements in consultation with the District Branch Secretaries in the region.

6. The Working Committee authorises the Treasurer to collect Re. 1/- from each member of the Association towards conference expenditure.

7. Though it is mentioned in the Memorandum and Rules that the District Branches are to report about the election of the Secretary-Treasurer and Joint Secretary-Treasurer by the 10th of December every year the Working Committee requests the District Branches to hold elections to these two offices before the end of November and report to the General-Secretary the result of the elections on or before the 31st October of the year and in case the General-Secretary is not supplied with the information, the General-Secretary is requested to take such steps as he feels necessary so that such District Branches may be able to elect office-bearers on or before December as mentioned in the Memorandum and Rules of the Association.

8. (a) The Working Committee regrets to bring to the kind notice of the Government that the District Boards which deputed subsidized practitioners for Public Health training, have not engaged them for that work immediately after their training was over and therefore requests the Government to instruct the District Boards to make necessary provision in their budgets before deputing the Rural Medical Practitioners for Public Health training.

(b) The Working Committee requests the Government to direct the District Boards to sanction Rs. 2/ per month for contingent charges in connection with the Public Health Work.

(c) The General-Secretary is requested to supply the information as to how many subsidized rural medical practitioners who have been trained in Public Health Work have not been deputed for that work by the District Boards.

9. As anticipated by the President the subject of extension of Rural Medical Relief on co-operative basis is said to be in circulation amongst subsidized rural medical practitioners as could be seen from the Memorandum R. C. No. 321 S. U. P.-40 D dated 14th June 1940 of the District Medical Officer, Tanjore, addressed to the Rural Practitioners. The Working Committee, therefore, requests the President to send a circular to all the individual members of the Association instructing them not to commit themselves to any opinion individually as the subject is of such importance and so complicated that the Provincial Committee alone would be able to answer to the Memorandum suitably if necessary in consultation with the authorities concerned; the President may also kindly send a draft reply to be forwarded by the individual practitioners to the respective District Medical Officers so that there may be uniformity in the replies given.

10. The Working Committee requests the President to bring to the kind notice of the Government that three subsidized dispensaries in Malabar District (1) Koduvayur, (2) Tiruvellur and (3) Vadana-palle are not equipped with dispensary servants as per G. O. No. 3510 P. H., dated 4th October 1938 though the average attendance in these dispensaries is above 50 for the last two years.

11. It is reported to the Working Committee that at the instance of a newly elected member to the District Board for the special Mohammadan Constituency of Kollengode *firka*, the Malabar District Board is likely to decide shifting of the Subsidized Dispensary at Kodivayur to

another place, Pudunagaram, in the same village though the latter place was not approved by the District Medical Officer, Malabar, about two years ago when he was requested to effect this transfer. The Committee, therefore, requests the President to inform the District Medical Officer, Malabar that the existing place where the dispensary is located is in a most suitable and central place serving the needs of all communities.

12. The Working Committee regrets to note the press report of the proceedings of a meeting of the Krishna District Branch reported in The Hindu dated 18.7.1940 regarding the misleading and defamatory resolution of "nonconfidence" in the President of the Association on the ground he is not a rural medical practitioner and resolves to point out to the District Branch that the President is a member of the Association as provided in the Memorandum and Rules of the Association and he is the legally elected President as per the Memorandum and Rules of the Association and calls on the Krishna District Branch to rescind the said resolution and make suitable apology and publish the rescission and apology in all the Madras dailies. The Working Committee also regrets for the non-compliance of the Secretary-Treasurer of the said District Branch to the repeated requests of the General-Secretary to provide the General-Secretary a copy of the proceedings of the said meeting of the District Branch and calls upon the said Secretary-Treasurer to explain his conduct in not complying with the request of the General-Secretary. In case the District Branch fails to carry out the above resolution, the President is requested to take necessary action against the members of the Association who were present at the meeting when the "no confidence" motion was passed. The General-Secretary is requested to write to Sri A. V. Subba Rao of Kondapalli whose name appears in The Hindu as having presided over this meeting asking him to supply a true copy of the proceedings of the said meeting and the names of the members of the P. S. R. M. Ps.' Association who attended the meeting.

13. Resolved that the Secretary-Treasurers of all District Branches should communicate to the Central Office proceedings of every meeting of the District Branches soon after they are held.

14. Resolved to pass the expenditure of Rs. 14.8 incurred by the General Secretary for the purpose of running his office, relating to stationery, printing, and stamps etc., for the period of eleven months from 1st February 1939 to 31st December 1939 as shown in his letter to the Treasurer dated 4th January 1940, (Ref: 2/40) in addition to the expenditure of Rs. 4.5 out of the previous sanctioned amount of Rs. 20. The Working Committee points out to the General-Secretary the necessity of strictly adhering to the Rule 14(e) of the Association in future. The Treasurer is informed that he ought to have brought to the notice of the Working Committee the letter of the General-Secretary addressed to him and referred to in the resolution at the proper time. The Treasurer is requested to bring this expenditure to the notice of the Central Office soon after the funds are available.

15. As a large majority of the members of the Association have not as yet paid their annual subscription to the Association, the Working Committee requests the President to adopt V. P. system for collecting the subscription by first intimating to the members that if they do not remit the subscription by the end of July 1940 direct to the Central Office, the July issue of The Medical Practitioner will be sent to them V. P. P. to recover the dues. The Working Committee also requests the President to advance sufficient amount to be incurred for the purpose to be adjusted later out of the amount realised by the V. P. P. system.

N.B.—The report mentioned in the first resolution of the Working Committee, relating to the starting of a central general store for the benefit of members, cottage hospitals etc., will be published in the August issue of the Journal.

V. RAMA KAMATH.

GOVERNMENT OF MADRAS.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

(PUBLIC HEALTH)

G. O. No. 1821, 1st May 1940.

Stores—Medical—Supply to rural dispensaries and regular medical institutions under the control of local bodies—Measures to avoid delays—Instructions—Issued.

READ—the following papers :—

From Sri V. Ramakamath, dated 23rd February 1939, No. Mp. 93/178.

From the Principal, Indian Medical School, dated 12th May 1939, No. Nil.

From the Surgeon-General, dated 5th July 1939, No. 4965-A/39.

Order—No. 1821, P. H., dated 1st May 1940.

Complaints have been made of delays in the supply of medical stores to rural dispensaries and regular medical institutions under the control of local bodies, and the inconvenience caused thereby. In order to avoid such delays, the Government are pleased to issue the instructions in the appendix to this order. Presidents of local boards and executive authorities of municipalities are requested to follow the instructions strictly in future.

(By order of His Excellency the Governor)

R. V. KRISHNA AYYAR,
Secretary to Government.

APPENDIX.

I. Procedure to be followed for the supply of medicines obtainable from the Medical Store Depot, Madras.

(1) Medical officers in charge of local fund and municipal medical institutions and rural medical practitioners should, before the 15th February of each year, submit to the presidents of the local boards and executive authorities of municipalities concerned the annual indents for medicines, etc., required for the succeeding official year, in the prescribed forms. Rural medical practitioners should prepare the indents so that the value of medicines indented for, including freight charges, may not exceed Rs. 360. Local fund and municipal medical officers should prepare indents up to the value usually allowed for the institutions in their charge. The presidents of local boards and executive authorities of municipalities should verify the entries regarding budget allotment in respect of regular local fund and municipal medical institutions, and forward the indents to the District Medical Officer or the Principal,

Indian Medical School, as the case may be, not later than the 15th March. The District Medical Officer or the Principal, Indian Medical School, as the case may be, should return the indents after scrutiny, to the president or the executive authority concerned, not later than the 15th April. Presidents of local boards and executive authorities of municipal councils should immediately arrange for the pre-payment of the cost and then forward the indents with the treasury chalan, not later than the 1st June to the Medical Store Depot, Madras, for compliance.

(2) All medicines required should be obtained through annual indents. Supplemental indents should be exceptional and should be accompanied by an explanation showing why the medicines specified therein were not included in the annual indent.

(3) If supplies are required very urgently, they may be demanded by telegram, provided a covering indent in quadruplicate is submitted to the Medical Store Depot, Madras, by post the same day.

(4) If for special reasons, any articles not authorized for the institution, but available at the Medical Store Depot, Madras, according to the priced vocabulary, are required, the necessity for each of those articles should be clearly explained.

(5) Articles not included in the priced vocabulary of Medical Stores should not be indented for.

(6) Particular attention should be paid to note 1 printed at the foot of page 1 of both the annual and supplemental indent forms.

(7) Figures of quantities should be filled in round numbers and when possible in multiples of the quantity contained in the standard stock size of container. This allows articles to be issued in original containers, which diminishes risks of error and allows complaints to be traced to their source. It also tends to economy and accurate supply.

(8) Indents should be prepared in the Medical Stores Depot form. The heads of budget accounts to which the charges are debitable should be fully quoted on the first page of each of the four copies of the indent. The demand pertaining to each section of the priced vocabulary must start on a fresh page of the indent book, i.e., articles belonging to different sections of the priced vocabulary should not be entered on the same page.

II. Procedure to be followed for the supply of medicines not obtainable from the Medical Store Depot, Madras.

(1) Presidents of local boards and executive authorities of municipalities should invite tenders before the 15th December of each year from all approved pharmacies for the supply during the succeeding year, of medicines of Indian origin, and other medicines not obtainable from the Medical Store Depot, Madras, to

all institutions of Indian Medicine under their control.

(2) A committee of medical practitioners and medical officers should be constituted to advise on the qualities of the samples submitted by the tenders and also on the rates quoted by them. Orders on the accepted tenders should be passed by the middle of February. Rural medical practitioners should then prepare indents for the value of Rs. 360 for each rural dispensary, including freight charges. Local fund and municipal medical officers should prepare indents up to the value usually allowed for the institutions under their charge and submit copies of the indent simultaneously to the president or the executive authority concerned and the Principal, Indian Medical School, not later than the 15th April. After scrutiny, the Principal, Indian Medical School, should return the indents to the president or the executive authority as the case may be, not later than the 15th May. Immediately on receipt of the indents, the presidents of local boards and executive authorities of municipalities should forward the indents to the accepted tenderers for compliance.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

G. O. No. 2462, 6th June 1940.

Medical Institutions—Rural (subsidized)—Appointment of Government stipendiaries as medical practitioners in preference to others—Instructions issued.

Order—No. 2462, P. H., dated 6th June 1940.

Presidents of local boards are informed that when appointing medical practitioners to rural dispensaries subsidized by the Government preference should be given first to applicants who were in receipt of Government stipends and then to those stipended by the local boards.

(By order of His Excellency the Governor)

R. V. KRISHNA AYYAR,
Secretary to Government.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

G. O. No. 2776, 24th June 1940.

Medical institutions—Rural medical practitioners appointed in short vacancies—Claims for appointment in subsequent vacancies—Instructions issued.

READ—the following paper :—

From the Principal, Indian Medical School, No. 6439-1/P.L. 2/40, dated 27th March 1940.

Order—No. 2776, P. H., dated 24th June 1940.

It has been brought to the notice of Government that medical practitioners appointed to be

in charge of rural dispensaries in short vacancies, are sometimes not reappointed in subsequent vacancies and new persons are selected for appointment in those vacancies. The Government consider that once a medical practitioner is selected to be in charge of a rural dispensary in a short vacancy, he should be given an opportunity to serve as rural medical practitioner in subsequent vacancies and that his claims for reappointment should not be overlooked without adequate reasons as otherwise there will be no inducement to medical practitioners to be in charge of rural dispensaries in short vacancies.

(By order of His Excellency the Governor)

R. V. KRISHNA AYYAR,
Secretary to Government.

EDUCATION AND PUBLIC HEALTH DEPARTMENT.

G. O. No. 2828, 28th June 1940.

Medical Institutions—Rural (subsidized)—Agreements entered into with medical practitioners not to be allowed to lapse for the purpose of effecting transfers—Instructions issued.

READ—the following paper :—

From the Surgeon-General, dated 16th February 1940, No. 20258-8-His./38.

Order—No. 2828, P.H., dated 28th June 1940.

It has been brought to the notice of Government that a rural medical practitioner was appointed by the President of a district board to act as a sub-assistant surgeon in a regular dispensary when the agreement executed by him was about to expire, that no steps were taken to renew the agreement in time and that when the acting appointment as sub-assistant surgeon ceased, the medical practitioner was posted to another rural dispensary. This in effect amounted to a transfer of the medical practitioner in contravention of clause 8 of the agreement executed by him. When this irregularity was pointed out to the President, district board, it was contended by the latter that as there was no subsisting agreement at the time of the reposting of the medical practitioner, such reposting was a fresh appointment and that it should not be treated as a transfer.

The Government desire to impress upon the presidents of district boards that rural medical practitioners should not be transferred from one dispensary to another on such pretexts as that above mentioned and that the agreement entered into with them should not be allowed to lapse for the purpose of effecting their transfers without obtaining Government sanction. Their attention is in this connexion invited to paragraph 1 (1) of G. O. No. 3510, P.H., dated 4th October 1938.

(By order of His Excellency the Governor)

R. V. KRISHNA AYYAR,
Secretary to Government.

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EDUCATION AND PUBLIC HEALTH DEPARTMENT.

G. O. No. 2860, 29th June 1940.

Medical Institutions—Rural—Medical practitioners—Grant of permission to visit neighbouring villages for rendering medical aid—Orders passed.

READ—the following papers :—

From the President, District Board, South Kanara, dated 28th November 1939, No. 12871-A-4/39.

From the Surgeon-General, dated 23rd April 1940, R. No. 4925-H.

Order—No. 2860, P.H., dated 29th June 1940.

The President, District Board, South Kanara, is informed that the main object of the rural medical relief scheme is to encourage, by subsidy, private practitioners to settle in rural areas and cater to the medical needs of as many villages as possible. There is therefore no objection to rural medical practitioners being permitted to visit neighbouring villages to render medical aid, and run private clinics in those villages on

specified days in a week in the afternoon without detriment to their work in the rural dispensary, subject to the conditions laid down in clause (1) of the agreement prescribed for them.

(By order of His Excellency the Governor)

R. V. KRISHNA AYYAR,
Secretary to Government.

WARNING NOTICE.

Dr. V. L. Hingorani, L. C. P. S. is administered a warning by the Executive Committee of the Bombay Medical Council for contravening the provisions of clause (a) of rule 6 of the Warning Notice relating to advertising in the matter of printing his letter heads. He is also warned to so regulate his conduct hereafter as to conform strictly to the provisions of the Code of Medical Ethics, this being the second occasion when he is administered a warning.

Office of the Bombay Medical Council,
No. 19, New Marine Lines, Bombay,
15th April 1940.

A. P. PARIKH,
Registrar,
Bombay Medical Council.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of June 1940.

RECEIPTS.	Rs. A. P.	CHARGES.	Rs. A. P.
Cash balance (on 1-6-'40) ...	4 5 11	Postage ...	2 2 0
Subscription from members ...	29 0 0	Telegram ...	0 9 0
Advance from the President to meet the office expense ...	9 0 0	Pay to Clerk for May '40 ...	15 0 0
		Amount credited to The Medical Practitioner from subscription paid by members ...	10 12 0
		Printing charges ...	4 4 0
		Stationery ...	3 4 0
			35 15 0
		Cash Balance : Rs. A. P.	
		With Savings Bank 4 3 7	
		With the Office 2 3 4	
			6 6 11
Total ...	42 5 11	Total ...	42 5 11

V. RAMA KAMATH,
President.

K. GOVINDAN,
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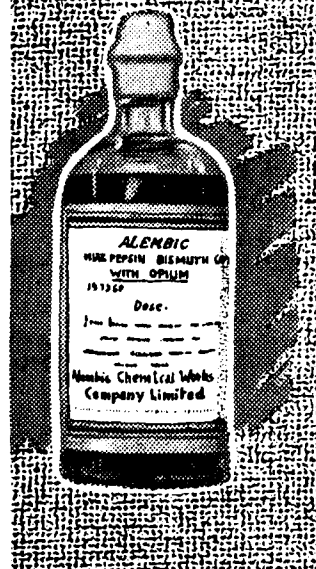
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