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THE
Medical Practitioner

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Vol. XII] APRIL, 1941 [No. 7

Original Articles

SOME RECENT ADVANCES IN MEDICINE

BY

LT. COL. G. R. MCROBERT, M.D., F.R.C.P., I.M.S.

Professor of Medicine, Madras Medical College,

Superintendent & Physician, Government General Hospital, Madras.

(*Under the auspices of the Provincial Subsidized Rural Medical Practitioners' Association, the Subsidized Rural Medical Practitioners working under the Local Bodies in the Madras Presidency met in Conference at the Madras Medical College from 14-4-1941 to 18-4-1941 both days inclusive. Col. H. Stott, O. B. E., K. H. S., M. D., F. R. C. P., I. M. S., opened the Conference on 14-4-1941. On 15-4-'41 the Scientific Section was inaugurated by Lt. Col. G. R. McRobert, M. D., F. R. C. P., I. M. S., who gave a discourse on "Some Recent Advances in Medicine". This was followed by the other Professors of the Madras Medical College on their special subjects every evening from 4-30 to 8 p. m. As the interesting lectures are likely to be of benefit to the readers of The Medical Practitioner, a gist of them is given in these columns in indirect narration. Members of the Medical Profession both official and non-official were invited to attend the Scientific Section and there was fairly a good response.—Editor.*)

Dr. V. Rama Kamath, President of the Association while introducing Lt. Col. McRobert to the audience said that the rural practitioners were very lucky indeed that an eminent member of the profession in the person of Col. McRobert should, in spite of his heavy responsible work, had consented not only to inaugurate the Scientific Section but also to give them a talk on "Some Recent Advances in Medicine". Dr. Kamath added that Col. McRobert was a fountain of knowledge and had always a desire in him to give the benefit of his ripe knowledge and experience to those who needed them. Dr. Kamath informed the audience that Col. McRobert was the first Professor of the Madras Medical College whom he approached with a request to address the rural practitioners and he was so pleased and as much relieved that Col. McRobert readily consented and was in their midst. Dr. Kamath incidentally mentioned that it would be painful news for the rural practitioners to hear that the City practitioners both officials and non-officials had not been evincing any interest to attend lectures delivered by the staff of the Medical Colleges and the Principal of the Medical College was disappointed twice in his attempt to hold post-graduate training classes for the benefit of the junior practitioners. He hoped that the occasion of the Rural Medical Practition-

...rs' Conference would be a happy augury and that in future the members of the medical profession would be encouraged to attend scientific lectures arranged in the teaching institutions and that the lectures to be delivered that day by Col. McRobert, Dr. P. V. Cherian, Professor of Ear, Nose and Throat Surgery, and Dr. K. Koman Nayar, Professor of Ophthalmology, Madras Medical College, would serve as an earnest to establish earnestness in all concerned.

Col. McRobert at the outset thanked Dr. Kamath for giving him an opportunity to be in the midst of rural practitioners. He said that he could not possibly say "No" to a request that came from three sources, Editor, The Medical Practitioner, Ex-Vice-President, Madras Medical Council and the President, Provincial Subsidized Rural Medical Practitioners' Association. He then began his discourse which was listened to with great attention.

Col. McRobert, first stressed the necessity of a physician knowing his responsibilities to *preventive medicine*. He said, even in the matter of notification of infectious diseases the members of the profession were very much lacking in their sense of responsibility and duty. As an example, he mentioned enteric fever, which was constantly present in the city of Madras as an epidemic and which could be controlled to a great extent if those who came in contact with enteric cases reported to the health authorities whose duty it was to investigate infection and to prevent the spread of the disease. The source of infection of enteric fever was through the water supply, food and milk and therefore the disease could be very effectively prevented if the source of infection was known. The only thing a householder had to do in those cases was to drink boiled water and boiled milk and the next preventive measure was the anti-typhoid inoculation. By advocating inoculation and by pointing out the method of the spread of the disease to their patients a good deal of public health work could be done by medical practitioners towards preventing enteric fever.

By way of emphasizing how practitioners, well meaning but ill-equipped with up-to date knowledge of preventive medicine could waste money without producing any benefit, Col. McRobert made some remarks about diphtheria prevention. He pointed out that the administration of T. A. F. and A. P. T. in the middle of an epidemic could not be in any way effective in preventing its spread as these prophylactics took several months to produce immunity in the person inoculated. If diphtheria were spreading through a household, the only preventive measure of real value was the administration of 1,000 units of anti-diphtheritic serum to each contact, especially to young children. It was pointed out however that the immunity conferred was short lived and that serum sensitiveness would result so that the method had certain disadvantages. In cases of suspected diphtheria the practitioner should give serum by the intramuscular route even before the result of the swab was known.

Relating to B. Coli infections Col. McRobert said the best way to combat the infection was by using combined alkali and sulphanilamide therapy. Mandelic acid had a limited field of usefulness in patients who could not tolerate sulphanilamides.

The next subject about which he talked was relating to the carelessness on the part of the practitioners in regard to injections. Col. McRobert said it was a painful sight to see the haphazard way in which the sterilisation of the syringe and the needle was at times done by some practitioners. They usually took a small piece of cotton and dipped the same in methylated spirit and merely rubbed the needle with this cotton and it was no wonder that in such cases induration and abscesses started at the site of injection especially so when the injection was intramuscular and the substance used was quinine. He impressed on the audience the necessity of remembering the postulates of Pasteur and of Lister, the former should convince them of the presence of bacteria and the latter about safe methods to be employed in the destruction of bacteria. For sterilisation of the syringe and

the needle Col. McRobert said that it was wise and safe to depend upon hot oil sterilization.

The lecturer then talked about the *treatment of enteric fever*. He said that there was a lot of ignorance relating to the diet of the patients in typhoid fever. Usually the practitioners forgot that enteric fever was an exhausting illness and the patient was depleted to such an extent that in case he was not properly taken care of during the course of illness, he would take a lot of time to resume his profession if he was an earning adult. So Col. McRobert said that it was desirable that the patient should have enough quantity of food given to him in an easily digestable form, the food given should be sufficient to supply 2,000 calories of heat for the system and should contain vitamins A.B.C. and D. He informed the audience that in the medical unit under his care in the Madras Government General Hospital the patient suffering from enteric fever got sufficient dose of cod liver oil, marmite, (vitamin B. complex) and vitamin C. The lecturer added that there was no reason why carbohydrate diet should not be given to enteric cases especially in the first, and the fourth weeks, so also albumen water and custard. Regarding specific treatment he said there was nothing to depend upon excepting antityphoid serum which to be useful must be given within four days of the manifestation of fever. If given later, it would serve only academic interest, sulphanilamides had their share in the treatment of typhoid fever especially in complications when the lung was attacked with pneumonia or the urine of the patient was infected.

Hydrotherapy in the treatment of enteric cases, was the next line of treatment which Col. McRobert said was used with great success in combating toxæmia in typhoid cases. Plenty of water should be administered to the patient by mouth and in case the patient was not in a position to take fluid by mouth, the most effective method of sending in the fluid into the system was through the rectum by slow drip method day and night. Normal saline was used with great advantage for the purpose. A soft narrow rubber tube should be used and the practitioner should satisfy himself that only drops flow and not a stream from out of the tube. He advocated the use of at least 6 pints of saline a day by this method. He informed the audience that many cases which were given up for lost on account of toxæmia in enteric fever had been saved in his wards by having recourse to rectal saline by drip method. In cases of diarrhoea he advised the use of kaolin preferably collossal kaolin. The drip method and kaolin by mouth had two distinct advantages. One was supplying the body necessary fluid and the other was the adsorption of toxins by kaolin.

Col. McRobert then talked about *bacillus coli infection*. He warned the practitioners that in the infection of the urinary system, the practitioners should make themselves sure that there was no obstruction for the free flow of urine from the kidneys to the ureters, from ureters to the bladder, from bladder to the urethra. Apart from the direct infection of the bacillus coli in the urinary system itself, he said, that due to ulceration of the intestines especially in cases of dysentery etc., coli infection started in the urinary system through the blood stream. The best way to combat B. Coli infections was by using combined alkali and sulphanilamide therapy. Mandelic acid has a limited field of usefulness in patients who could not tolerate sulphanilamides.

Treatment of anæmias was the next subject of the lecture by Col. McRobert. He said that anæmia due to the deficiency in blood which prevented its oxygen-carrying function was most common in India. The deterioration of the red blood cells in the blood was the cause of this anæmia and the oxygen-carrying element in the blood cell was hæmoglobin. The red blood corpuscles were manufactured in the bone marrow and in order to change their primitive form they want hæmopoetine, a compound of two factors, the extrinsic or the food factor and the intrinsic or the internal secretion of stomach. The food factor was obtained from the food the patient ate and the intrinsic factor was

from the internal secretion of stomach. In the food factor vitamin B was an important feature.

Macrocytic, *e. g.*, large cell anæmias were rarer than those due to deficiency of hæmoglobin, 90 per cent of anæmias were due to want of iron. They may also be due to a small extent to want of manganese and copper.

In *ankylostomiasis*, patient might lose as much as 90 per cent of hæmoglobin. To have recourse to treatment by liver extract was absolutely useless in case of anæmias due to want of iron in the blood. Iron preparations had to be depended upon mainly for the treatment of anæmias due to want of hæmoglobin in the blood and the most elegant B. P. preparation for supplying iron to the system was ferri et ammonium citras which should be given in doses of 90 grains per day for an adult. Ferri sulp. was also mentioned as a reliable iron preparation so also ferrosolate pills, a speciality of Glaxo laboratories. The treatment with iron was cheap and the patient could certainly get 100 per cent of hæmoglobin by spending annas 4 or very near this amount. The lecturer pointed out cases of anæmia not amenable to iron where food factor was the important cause and the best way to treat such cases was by administration of marmite. Liver extracts were useful only in cases of large cell anæmias. In the treatment of ankylostomiasis it was not safe to administer an anthelmintic when hæmoglobin content in blood was 10 p. c. or very near to it. Before administering an anthelmintic, the lecturer warned the practitioners to raise the hæmoglobin content to at least 30 p.c. The safest anthelmintic advised by Col. McRobert was tetrochorethylene in 4 c.c. dose *i.e.*, a teaspoonful to be given in 2 oz. of saturated solution of mag. sulph. The drug had slight intoxicating effect which usually went off without any harmful effect on the patient.

He warned the practitioners against *indiscreet use of harmones* as a therapeutic measure especially for increasing the vitality of man or a woman. Many of these harmones if prescribed indiscriminately did more harm to the patient than good. In the opinion of the lecturer thyroid was the only safe and useful drug for endocrine therapy by mouth.

Inducing *diuresis* by means of *digitalis* preparations and preparations of *mercury* was the next subject about which the lecturer talked to the rural medical practitioners. In his opinion digoxin was a useful and a reliable preparation of digitalis and Mersalyl, a preparation of B. D. H. was a good substitute for Salyrgan. He brought to the notice of the audience of the indiscreet use of Salyrgan which was usually administered to promote diuresis in heart cases being used for a patient who had a fainting fit evidently under the wrong impression that this mercury preparation was a cardiac tonic.

He then mentioned about *venesection* in some forms of heart failure and was of opinion that this useful method of instantaneously relieving an over-loaded heart was not used as often as it should be in such cases and he advocated the use of venesection in acute heart failure especially in the presence of engorgement of portal system. Before closing he said a few words about blood transfusion and its value in surgical operations. He said, if ever a patient was undergoing a serious surgical operation, transfusion of a pint of blood as a preliminary measure would benefit the patient and prevent dangers of shock and sudden death. He advised the practitioners to educate the lay public to come forward as donors for the purpose of blood transfusion as loss of blood up to a pint from a healthy individual was of no consequence at all and far from doing any harm to the donor, such a loss would stimulate the bone marrow and help the donor to have a better supply of blood after he gives his own blood for the purpose of blood transfusion.

Col. McRobert was adequately thanked by Dr. Kamath for his valuable advice relating to the treatment of several diseases mentioned in the course of his lecture and appealed to Col. McRobert to be of help not only to the rural practitioners but to the entire profession whenever help was needed by them.

SOME COMMON DISEASES OF EAR, NOSE AND THROAT.

BY

DR. P. V. CHERIAN, M.B., F.R.C.S., D.L.O.,

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and

Ear, Nose and Throat Surgeon, Government General Hospital, Madras.

On 15th April 1941 soon after Lt. Col. McRobert finished his discourse Dr. P. V. Cherian, M.B., F.R.C.S., D.L.O., Professor of Ear, Nose and Throat Surgery, Madras Medical College, was introduced to the rural medical practitioners by Dr. Kamath, President of the P. S. R. M. Ps' Association. While introducing Dr. Cherian, Dr. Kamath said that he was not an artificial specialist as many young practitioners styled themselves these days. He was a general practitioner to begin with and after having served in the Government General Hospital, Madras, for some years in the Surgical Wards, qualified himself as a specialist which position he now held in eminence. Dr. Kamath added that the lecturer must have been known to them by his name and his reputation and that day, the rural practitioners had an opportunity of not only seeing him in person but also in hearing his learned discourse on "Common Diseases of Ear, Nose and Throat".

Dr. Cherian thanked Dr. Kamath and the Association for giving him an opporunity to meet them. He appreciated the idea of giving opportunities to junior practitioners to have the benefit of hearing their seniors relating to their special subjects.

In regard to the subject of his discourse on diseases of the nose he first mentioned about the common diseases of the nose. He began with *Epistaxis* in which he said in a large number of cases the bleeding took place at the anterior and lower part of the septum where there was anastamogis of capillary blood vessels and this spot was known as the "bleeding spot". Usually the bleeding stopped after pressure on the nostrils. Swabbing the bleeding spot with hydrogen peroxide controlled the bleeding in some cases. Application of ice and injection of Haemoplastin and administration of calcium salts by mouth or through the intravenous route might be had recourse to also. The surest method was to cauterise the "bleeding spot" using heat when it was just fading as such heat helped coagulation.

Hæmatoma in the anterior part of the septum was usually caused by a blow on the nose. It looked smooth, red, rounded and was a fluctuating swelling. They might be in one or both nostrils and obstruct breathing. They might be mistaken for a polypoid growth or gumma. In case of hæmatoma if it was pressed with a probe, the swelling at the touched spot looked pale. Gumma appeared as a broad based thickening and did not attract any attention till it was ulcerated. Treatment of hæmatoma was simple and consisted in making a large incision evacuating its contents and plugging tight with gauze. The lecturer advised that care should be taken to avoid perforation of the septum when there were hæmatomas on both sides.

Deflection of Septum was the next subject of the discourse. The lecturer said that the deflection produced obstruction to breathing and gave rise to post-nasal catarrh ending in para-nasal complications and deafness. Surgical treatment consisted in the submucous resection of the septum which was the field of the specialist. He also said that cauterisation of the deflected septum would also relieve the patients if the deflection was due to hyperplasia of soft parts.

Common Cold was the next subject of the talk by Dr. Cherian. He said that the causal factors of cold were as difficult for detection as was the treat-

ment. The internal treatment for common cold being familiar to all practitioners the lecturer dealt with local treatment only. He advocated warm saline douches and stressed the need of advising the patients not to blow through the nostrils violently soon after the douche as the liquid was likely to enter the nasal sinuses, causing their infection. In acute cases inhalation of steam from hot water to which was added a few drops of tinct. benzoin co., gave great relief (a drachm to a pint). In troublesome cases the lecturer advised cauterization of nasal mucous membrane if thickened. Regarding vaccine therapy he believed more in commercial vaccines and not autovaccines.

Polypi was the next subject in the course of the discourse by Dr. Cherian. He said polypi were pedunculated oedematous growths hanging from the turbinal area and pushing themselves against the septum. They originated from ethmoidal air cells due to chronic rhinitis. They grew downwards from the turbinates in the direction of least resistance. They were usually pale grey. The lecturer pointed out to the practitioners that hypertrophy of the interior or mid-turbinated bone might look like a polypus and care should be taken in differentiating this condition from polypus. The polypi are usually multiple and move freely, and when not inflamed were pale grey, and if a practitioner had a good view of a polypus he could always make it out by its characteristic colour. One or two practitioners wished to know about the treatment of polypus but the lecturer rightly said that operative treatment was beyond the scope of the discourse for the day.

Dr. Cherian next mentioned about *foreign bodies* in the nose which trouble was of very common occurrence in children. The child was generally his or her own victim and at times the victim of the play-mate. Many a time the lecturer said, children felt afraid to convey the news of the accident to their parents and in such cases the foreign body got impacted and gave rise to inflammation, resulting in suppuration. An unilateral purulent discharge from the nostril of a child, was almost always due to a foreign body in the nose, whereas in an adult such a condition was suggestive of pus in the antrum. He warned the practitioners to be very gentle while attempting to remove foreign bodies from the nose and should never bruise the nasal mucous membrane as the bruising of the inner surface of the nose was likely to give rise to disastrous results at times causing severe bleeding or severe infection likely to end in meningitis with attendant complications.

Asthma of nasal origin was the next subject dealt by the lecturer. He mentioned that there were sensitive spots in the nose brought about by inherited or acquired sensitive nervous system, stimulation of which by an attack of cold, a mere smell or change of climate brought about an attack of asthma. These spots were either in the anterior and inferior part of the inferior or mid-turbinal. These spots could be made out by the mere touch of a probe and if such patients squeezed their eyes, at the same time they would water. This phenomena would serve as a tip for diagnosing asthma of nasal origin. The lecturer said that the treatment in such cases of asthma was the cauterization of the sensitive spots.

Infection of para nasal sinuses was the next item of the discourse. These sinuses were the antrum, the frontal and and sphenoidal sinuses and the ethmoidal cells. The infection of sinuses was mainly due to infection in the nose due to constant attacks of cold, foreign bodies in the nose, in influenza and other respiratory diseases where the nose was involved. Some cases of maxillary sinusitis were due to bad teeth. When the frontal or sphenoidal sinuses were infected there might be eye symptoms and headaches. Headache worse in the morning, was usually due to frontal sinusitis and occipatal headache worse in the evening was due to infection of sphenoidal antrum. Treatment consisted in keeping the nose clean of the discharge by the nasal douch containing boric acid or inhalation of hot steam from a hot water kettle to which tinct. benzoin co., was added

(a drachm to a pint). If palliative treatment had not the desired effect, the lecturer advised radical operative measures.

Dr. Cherian then diverted his talk and began speaking about the *common diseases of the throat.* He said that tonsils when healthy served as a protection to prevent respiratory diseases but when diseased they were the source of infection to the entire system. He then mentioned the tonsils might get inflamed acutely in three different ways. The first was acute parenchymatous tonsillitis when the whole tonsil got inflamed. The second variety of infection was follicular tonsillitis when the lacunæ in the tonsil were chiefly affected. They get distended with inflammatory products which were seen as white points. The lecturer then referred to Vincents' angina, a variety of tonsillitis in which ulcerated patches looked like those of diphtheria. In diphtheria the membrane could not be easily removed and when removed, the tonsillar surface bled which was not the case in pseudo-diphtheria. He also mentioned that ulceration of tonsils due to syphilis and cancer were common. He briefly narrated the indications for treatment for each variety of tonsillar infection. He advocated salicylate mixture for ordinary tonsillitis and said that fractional doses of calomel (1/8 to 1/16 gr.) had marvellous effect in controlling the inflammation of the tonsils. Locally medicated gargles such as Condy's and throat paints were advised by the lecturer. In cases of chronically ulcerated tonsils or tonsils causing obstruction to breathing, the lecturer advised their removal. If the lymphatic glands behind the angle of the lower jaw were indurated, the lecturer said it was always an indication for the removal of tonsils. In Vincent's angina painting of tonsils with methyleneblue was specially mentioned. Antisyphilitic treatment was to be followed for syphilitic ulceration of the tonsils. He advised the practitioner to make an early diagnosis of cancer of the tonsils as with radium and deep X-ray therapy, the chances of relief were great.

Before closing his talk relating to the diseases of throat Dr. Cherian mentioned about naso-pharyngeal fibroma, a fixed growth springing from the baste of the skull. It was highly vascular and gave rise to epistaxis and had to be diagnosed from naso-antral polypus hanging from the edge of posterior nares. It grows during the period of adolescence and shrank during adult life and might assume local malignancy. The treatment was to excise as much as possible and to have recourse to radium treatment.

Diseases of the larynx was the next subject dealt by the lecturer. For acute laryngitis he advised hot fomentations to the throat and hot steam inhalation (10 to 20 drops of acid carbolic being added to a pint of water). The lecturer said that repeated attacks of laryngitis were precursors of cancer.

Tubercular laryngitis was usually secondary to lung infection and a terminal complication. He said that malignant and benign growths could be found in the larynx. Amongst the benign papilloma of the vocal cords was most common. The voice in these cases was painless but hoarse and the treatment was very unsatisfactory. Deep X-ray was usually tried with the varied results. Malignant growth especially cancer might be intrinsic *i.e.*, confined to vocal cords extrinsic in the body of the larynx. In the former case the lymphatics being closed the chances of recovery after removal of the growth were very great whereas in the intrinsic variety there was no relief. He advised the practitioners on the necessity of early diagnosis.

Diseases of the ear was the last topic in the discourse. Dr. Cherian said that *wax in the ear* was a normal secretion which was naturally removed by the movements of lower jaw. If it accumulated more than necessary it became hard and at times firmly impacted. To remove such wax the lecturer advised the necessity of first making it soft by instilling warm alkaline drops three times a day (soda bicarb 30 grs., Glycerine 1 dr. and aqua 1 oz.) or by filling the meatus with hydrogen peroxide and then gently syringing out the wax after two or three days. He then mentioned about *Keratosis Obturans*, a condi-

tion where wax and dirt accumulated in the ear in the form of hard mass attendant with much pain in the ear. The lecturer advocated the use of hydrogen peroxide and alcohol drops in equal parts for a few days and the gentle removal of the hard mass by syringing. After removal boric acid and alcohol drops were advised (acid boric grs. 10, aqua dist. drs. 2, rectified spirit drs. 2). *Furnuncle of the meatus* was next mentioned. The lecturer said that it was a very painful disease usually met with in children and elders suffering from diabetes. Dry heat to the ear and application ichthyol and glycerine (10 p.c.) were advised. As the trouble was due to staphylococcal infection a course of stock staphylococcal vaccine was also advised. *Middle ear disease* in children was the next subject of the discourse. The lecturer said that pus in the middle ear was almost always due to direct infection of the tympanum from naso-pharynx. After an acute attack of pain attendant with high fever, the tympanum bursted and pus was found in the middle ear. There were two ways of cleaning the ear, one was by dry method, the other by the wet. In the dry method the ear was cleaned with sterile cotton swabs. Boric Acid was insufflated into the ear or boric acid to which is added 10 grs. iodum dissolved in rectified spirit. In the wet method the ear is gently irrigated or syringed with warm boric lotion (1 dr. to a pint). Then glycerine carbolic 5% ear drops (warm) were instilled into the ear. Hydrogen peroxide was also used for cleaning. Dr. Cherian said that there was no harm in syringing the ear if it was done gently. Later when the pus was scanty, the lecturer advised instillation of ear drops containing boric acid grs. 10, hydrogen peroxide ½ oz. alcohol ½ oz. or the same drops without hydrogen peroxide. Zinc ionization was also mentioned as one of the methods of treatment. Within two weeks the discharge from the ear should stop or else operative treatment might be necessary later. The lecturer then traced the cause of neglected cases of middle ear disease which eventually terminated in Mastoiditis and mastoid abscess. Dr. Cherian advised the practitioners to note three points before deciding to operate in *Mastoiditis*:— (1) tenderness at the tip of the mastoid, and (2) tenderness along the posterior border of the mastoid and (3) tenderness on the antrum itself. *Deafness* was the last subject talked of by the lecturer. He said deafness was due to two main causes, one due to middle ear disease when conducting apparatus was interfered with; the other cause was due to the disease of the nervous system when the auditory nerve centre which had to transmit sound to the brain was damaged. He explained how to use the tuning fork to find out whether the deafness was of one origin or the other. In middle ear disease the vibrations of the tuning fork reached the nerve centre through the bones of the skull but in the disease of the nerve centre itself, the bone conduction was very much delayed or there was no conduction at all.

Dr. Kamath expressed the gratitude of the Association to Dr. Cherian for the interesting discourse which he said would be of immense help to them and serve to refresh their knowledge relating to 'Common Diseases of Ear, Nose and Throat.' Dr. Kamath apprised the rural-medical practitioners about their responsibilities in the early diagnosis of diseases, such as cancer in the throat and middle ear disease before these diseases reached a stage when operative treatment by the Specialist was of little or no avail. The success of a specialist depended upon the general practitioner and if both co-operated, not only the villages but also urban areas would be much healthier and happier to live.

NOTICE.

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

SOME RECENT ADVANCES IN OPHTHALMOLOGY.

BY

RAO BAHADUR DR. K. KOMAN NAYAR, L.R.C.P. & S., D.O.M.S., (LONDON),

Professor of Ophthalmology, Madras Medical College

and

Superintendent, Government Ophthalmic Hospital, Madras.

On 15-4-41 at 6-30 P. M. soon after Dr. P. V. Cherian finished his talk, Rao Bahadur Dr. Koman Nayar gave a discourse on "Some Recent Advances in Ophthalmology". Dr. Rama Kamath introduced the lecturer to the rural practitioners and said that Dr. Koman Nayar was the first Indian who held the combined post as Professor of Ophthalmology, Madras Medical College and Superintendent, Government Ophthalmic Hospital and he highly deserved this responsible position as a specialist. He added that Dr. Koman Nayar was perhaps the only officer belonging to the Madras Medical Service who began his career as a specialist from the lowest rung, as an Assistant Surgeon in the Government Ophthalmic Hospital. Then he ascended the second higher rung as the Resident Medical Officer. From there he was promoted to the rank of the Asst. Superintendent of the Ophthalmic Hospital. He then acted several times as the Superintendent of the same hospital and was now virtually the Chief of the Hospital. Dr. Kamath mentioned that the rural practitioners were most fortunate to have the opportunity of not only seeing Dr. Nayar but also hearing him, and be benefited a good deal in refreshing their knowledge in the treatment of eye diseases.

Dr. Koman Nayar before he began his discourse thanked Dr. Kamath for the references made by him about his official and professional career and expressed his pleasure to be in the midst of Rural Medical Practitioners who had been doing good service to the village folk.

The first topic of the discourse was relating to *detachment of retina*, a disease which till recently did not receive any definite satisfactory treatment. The lecturer mentioned about the aetiology of the condition and said that detachment took place when the pressure over the retina by vitreous was diminished either due to its escape during operation or by the shrinking of vitreous due to inflammatory cause such as irido-cyclitis or irido-choroiditis and there was accumulation of serous fluid between the retina and the choroid. The same phenomena took place in high myopia. The old treatment consisted in the use of purgatives and diaphoretics such as pilocarpine combined with a firm bandage on the eyes to make the eyes motionless and the patient was made to lie down for several weeks with the head immobile. Such a treatment was very tedious to the patients with little or no hopes of relief. Recent advances in the treatment of detachment of retina depended upon causing adhesion between the separated retina and choroid after draining away the serous fluid in between the two structures. This was brought about by cauterising the sclera (with diathermy) and bringing about adhesive choroiditis or by puncturing the sclera with a trephine, letting out the serous fluid and by bringing about adhesive choroiditis by touching the choroid with caustic potash and neutralising the excess with acetic acid. Electrolysis could also be had recourse to for starting the irritative inflammation to cause adhesion. It was rather difficult to locate the hole in the retina which is the cause of the detachment with the help of ophthalmoscope. If the operation was done satisfactorily nearly 50% success could be hoped for in early cases. Excepting the scotoma corresponding to the spots of adhesions there was no other inconvenience to the patient and if the macular region was unaffected the patient could hope for straight vision.

The lecturer then described the operation of *corneal grafting* in patients whose corneae were opaque. As the cornea was avascular the operation was fraught with difficulties. The hole usually was made with a trephine where the new cornea had to be grafted. The hole should not be smaller—may even be a little bigger—than the size of the healthy cornea which was to be grafted as allowance should be made for the swelling of the graft soon after it was placed into the hole. Sutures are passed over the graft to keep it in place. He advised that the sutures should be removed on the 4th day of the operation.

Sulphanilamides in ophthalmic practice was the next subject of the talk. The lecturer said that in gonorrhoeal ophthalmia, the sulphanilamides were very effective especially in cases of adults in whom gonorrhoeal ophthalmia most often took a serious turn. Chemosis which was a sign of the approaching destruction of the cornea was remarkably controlled under sulphanilamide treatment. It was also an effective remedy in orbital cellulitis; so also in acute cases of trachoma. He was doubtful about the effect of sulphanilamides in chronic cases. He was of opinion that in acute granular lids there were other infections which the sulphanilamides controlled. Generally his experience was that the sulphanilamides were of use in corneal complications more than those of the lids unless the complications in the lids were of an infective nature.

The lecturer then mentioned about *contact glass* which had of two curvatures, a spherical corneal portion surrounded by a flatter peripheral scleral rim. The scleral rim rested upon the sclera and the corneal part in front of the cornea separated by waterly fluid having a refractive quality of the aqueous humour which altered the refraction of light by the cornea. The contact glass was useful to patients having conical cornea, irregular astigmatism or very high refractive errors. He mentioned also about *telescopic spectacles* devised for high myopes and those with defective vision who if they wore one lens of very high power had distortion of images. *Prismatic glasses* were also mentioned which were used in cases of people who, lying in bed, could read books placed flat on their chest. The lecturer told the practitioners that he gave names and descriptions of these different lenses as a matter of curiosity. For, these glasses were rarely used in India on account of their prohibitive prices.

Anaesthesia in ophthalmic practice was one of the subject of the discourse. For surface anæsthesia cocaine (2 to 4 p c. solution) was mentioned as the best and in case of facial nerve block and ciliary nerve block novocaine solution 2 p.c. was most satisfactory in the opinion of the lecturer. Dr. Koman Nayar advocated facial and ciliary nerve block in operations as these prevented voluntary movement of the eye muscles and the operations could be done without any untoward happenings. He warned the practitioners that before bandaging the eye after operation care should be taken that both lids were brought together; if any difficulty was felt by the patient on account of the paralysis of lid muscles due to facial nerve block, the lids should be brought together by manipulation, they should be held in position with plaster or even be stitched temporarily.

The lecturer warned the rural practitioners to be very careful in *diagnosing early cases of glaucoma* which at times was wrongly diagnosed as a case of early cataract by the mere appearance of the pupil which being a bit grey was mistaken for a hazy lens. Lot of harm was done by such a mistake. For, Dr. Nayar said that if a case of chronic glaucoma was not diagnosed early, nothing could be done to the patient at a later stage when he would lose all sight. In the same way the lecturer said *follicular conjunctivitis* was wrongly diagnosed as trachoma by the mere appearance of follicles in the lower lids which when a bit inflammed due to secondary infection was mistaken for granular lids. Follicles are rarely seen if at all in the upper lids. If strong caustic medicines were used in the case of follicular conjunctivitis, serious complications of the cornea would arise and the eyes made worse out of mere ignorance.

Dr. Nayar then mentioned about *chronic conjunctivitis* when the conjunctiva looked red and velvety and the patients kept rubbing the lids in the evening, especially the presbyopes. Such a condition was usually due to refraction error in the eyes and the best thing to do was to correct the vision with suitable glasses and instill Z. B. drops for a few days. Before concluding his discourse Dr. Koman Nayar exhorted the rural practitioners that they could do a lot in preventing blindness to a large extent by the proper treatment of eyes when they were affected by venereal infection, deficiency diseases such as keratomalacia and common diseases like corneal ulcers and trachoma. Dr. Nayar said that eye speciality could be very well practised in rural areas, for, unlike general surgery there was no need for even a trained assistant or anæsthetist to do eye operations almost all of which could be done under local anæsthesia.

Dr. Kamath thanked the learned lecturer on behalf of the Association and said that Dr. Koman Nayar did not only talk about "Recent Advances in Ophthalmology" but encouraged the rural practitioners to take to eye speciality. He admired the spirit of the lecturer; for though a specialist of eminence he did not feel jealous of others entering his field but on the other hand encouraged even the rural practitioners to practise eye surgery as a speciality. Dr. Kamath incidentally mentioned that there was a tendency in some to style themselves as eye specialists the moment they did a few cataract operations. He warned the practitioner not to risk operations on patients unless and until they worked under eminent specialists and knew all about the eyes. All the same Dr. Kamath said that without being an eye specialist of the type and rank of the lecturer, the rural practitioner had opportunities of preventing blindness with the help of his knowledge as a general practitioner.

Abstracts.

THE PROVINCIAL SUBSIDISED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

IX ANNUAL CONFERENCE

OPENED BY

COL. H. STOTT, O.B.E., K.H.S., M.D., F.R.C.P., I.M.S.,

Surgeon-General with the Government of Madras,

On 14th April 1941, at the Madras Medical College.

ELECTION OF THE PRESIDENT.

Soon after the guests and the members of the Association assembled in the Conference Hall, Dr. V. Rama Kamath was formally elected President of the Association. The General Secretary Dr. M. R. Bhat welcomed Col. H. Stott and other guests.

WELCOME ADDRESS

BY

DR. M. R. BHAT,

General Secretary.

Col. Stott and Gentlemen,

I am really in an anomalous position when I have to welcome you in the capital of the Presidency where the Rural Practitioner as the name implies has no concern. The real person who is technically in a position to welcome those present here is the Principal, Madras Medical College, who has been very kind and generous to house us in the premises of the College. The only consideration which must have weighed with him in allowing our Association to hold the Conference, seems to be that we, the subsidized practitioners belong to the medical fraternity to which the Principal and all the rest of you have the honour to belong. This benevolent disposition on the part of the Principal, Medical College, has practically demonstrated that you, eminent men recognise us and our humble work in the villages and we are encouraged to depend upon your help and sympathies. The anomaly of the reception to you by our Association is still the more when it is known that almost all the Professors of the Madras Medical College, have magnanimously consented to treat us with the benefit of their ripe experience in treating human diseases—general and special, medical and surgical in fact, diseases of every denomination. So virtually for all practical purposes you are our hosts to supply us the food of medical science. All the same, Gentlemen, I welcome you most heartily and thankfully on behalf of the Provincial Subsidized Rural Medical Practitioners' Association whose members are entrusted with the work of the medical profession in the rural areas. Though these members are most humble, the nature of work performed by them carries with it stupendous responsibilities relating to village reconstruction, a problem which has been attracting the attention of all known authorities, yet, Sir, I beg to be excused if I were to say that to the same extent practically the affairs of the villages are the last concern excepting for the purpose of using them as a plank for political purposes.

We have read Sir, in the columns of the official journal of our Association, The Medical Practitioner, with great pleasure and with as much hopes about your official career both in this province at the early period and later till you assumed the onerous responsibilities as the Head of the Medical Department of this Presidency. It was to see you in person and hear your advice that the Executive of our Association readily consented to give effect to the suggestion made by the President of the Association to change the venue of the Conference from a village in Malabar District to the capital of the Presidency. This Conference must have met in the village of Kodavayur during the last Christmas holidays. But Major-General N. M. Wilson, your predecessor, expressed his inability to go to the village as he was busy with official work preparatory to his retirement. The President advised the Working Committee of the Association that the Association would be well advised if theConference was opened by you,Sir, the worthy successor of General Wilson who had left indelible marks of his sympathies to the lot of the Subsidized Practitioners as did Major-General Sir Frank Connor, the predecessor of General Wilson. In fact Sir, if the Provincial Subsidized Rural Medical Practitioners' Association is alive to-day and has been doing some work, it is due to the encouragement given to it by Major-General Sir Frank Connor who showed his sympathies practically by opening the Conference of Rural Practitioners in the year 1937 in Madras at Y.M.C.A. Auditorium on 10-7-37. That day Sir Frank Connor concluded his address by saying :

> **"Thousands and thousands of young men were working hard like coolies in other countries, in labour camps and elsewhere, for the sake of their countries and turning marshy lands into cultivable ones. With that sort of spirit you must go ahead. When you do such work in India, this country would be happier and the rural medical practitioners would have a fair share in the picture."**

Dr. V. Rama Kamath who presided over the Conference the same day apprised us seriously that *as long as the Medical Profession was under the control of any political Government* and *not under the control of the profession itself, you must be prepared for any future exigency and should establish our usefulness and popularity always remembering, "I am my brother's keeper."*

True to the warning given to us by our President, in September 1938, the Congress Government sent round a memorandum to all of us asking us if we were willing to work without the help of the Government subsidy or on half subsidy receiving from the District Board supply of medicines only. This threat served us as a blessing in disguise and consistent with the history of national movements in this country and elsewhere this adverse news made our Association stronger and thanks to the agitation conducted in the columns of The Medical Practitioner, our official organ, the Government were forced to give up the ideas adumbrated in that fateful memorandum. We are sure Sir, you must have by now had at least an inkling of the Subsidized Rural Medical Relief Scheme and must have known that the fundamental idea of the scheme was to encourage qualified practitioners to settle in villages to afford the benefit of scientific medicine to the village folk. For this purpose the practitioner is given a special subsidy of Rs. 500 (L. M. Ps.) to Rs. 600 (graduates). The principle and spirit of the Scheme being to encourage qualified practitioners to settle in villages, transfer of practitioners from one village to another being incompatible with the fundamentals of this Scheme, provision was made in the agreement to be executed by the Practitioners that the local bodies under whom the practitioners have to work should not effect transfers at all. In the early days though the agreement contained a clause that the agreement was to be renewed every year the authorities made it possible for the practitioners to continue serving in the same village without any disturbance. But unfortunately the tides in the politics of this province went against the very fundamentals of the Scheme and the fate of the rural practitioners depended entirely on political currents and the conditions of the agreement were flouted and later even the terms of the original agreement have ever been changing to suit not the welfare of the villagers but to appease the ambitions of the politicians or their henchmen. I do not wish to tire you Sir, and our other guests with the stories of our grievances but I will not be doing my duty to my brethren and more

to the villagers if I do not reiterate our standing prayer to the Government that no time should be lost in the interests of all concerned to bring the entire scheme under the control of the Government. Your predecessor, Sir, Major-General Wilson, did console us when he had opportunities of addressing the branches of our Association in several districts that the Government had been considering the desirability of bringing the scheme under their direct control. General Wilson went a step further and told us that he had recommended to the Government that the smaller hospitals and dispensaries in the mofussil might be put in charge of Subsidized Practitioners who had merit and experience to their credit. Later, when recently Government thought it desirable that the labourer should be paid his hire and have been considering the desirability of paying the honoraries and recruiting hands for regular Government service, we heard Sir, that General Wilson was in favour of giving preference to the subsidized practitioners.

The memorandum No. 5304-4 E. dated 19-3-41 issued by you Sir, to all of us through the respective District Medical Officers clearly indicates that you are following the policy of your predecessor, General Wilson relating to Subsidized Rural Medical Relief Scheme and what is more—we could see that you are as sympathetic towards us as much as General Wilson and your statement given expression to at one of the social functions organised by the Licentiates Association to honour you and General Wilson to the effect that you considered that the Surgeon-General was not merely the head of the Government Medical Department but was the protector of all services and you asked yourself the question that if the Surgeon-General was not going to protect the practitioners, who else was going to do so.

We are very hopeful that the destinies of not only of the village practitioners but of all practitioners of every denomination will be safe in your hands, and the traditions to be laid down by you and already laid down by your last two predecessors in office will be so truly and firmly laid that your successors will have to follow them and bring this unfortunate country to the level of other progressive countries in regard to medical relief not only in the Government hospitals but also outside the hospitals.

I will not be true to me and to our Association if I do not give expression to the heartfelt gratitude of us all to our revered President, Dr. Kamath under whose guidance we have been steering clear of the hardships and vicissitudes though time has not come to say we are safe. We rely upon him entirely and I will not be far wrong if I say that the entire profession has been relying upon him as was indicated by his success at the last medical council elections when he was able to be returned to the Council as a representative of the entire medical profession which he did carrying on his shoulders 5 more with him from different parts of this vast Presidency. Though he does not look old, those who have been seeing him at his residence always on bed know that in spite of his indifferent health he has been working hard for the uplift of the entire profession. He has been very often telling us that it is his ambition to build the profession from the bottom, he meant from the rural medical practitioners upwards and for such service God has spared him. It looks to be very true or else how can we expect to be in this building and in your midst?

Sir, I now conclude my address and thank you for having consented to be with us this day in the midst of your multifarious duties at a time when the destructive Hitler menace seems to be very near our doors. Equally thankful are we to all the other guests who found time to honour us and encourage us by their presence. I would now request you Sir, to declare the Conference open and give us your blessing for the successful session of the Conference.

COL. STOTT'S ADDRESS.

Col. H. Stott, Surgeon-General with the Government of Madras, before he formally opened the Annual Conference of the Provincial Subsidized Rural Medical Practitioners thanked Dr. V. Rama Kamath, President, Rural Medical Practitioners' Association for giving him an opportunity to learn more about the hopes and aspirations of the rural practitioners. He said that the Association was lucky in procuring the services of Dr. Kamath who was not only energetic but was full of enthusiasm. The rural practitioners, without doubt, were in the forefront of the fight against pain and sickness.

His first advice to them was to 'avoid politics.' 'Politicians would only let them down, and no good results would be obtained by associating with them.

Rural medical practitioners had to depend on private practice to supplement their subsidy, and if they turned politicians, or active sympathisers of any party, that would only affect their income. The followers of the party would expect to be treated free, and the opponents might refuse to be treated by them. There was also risk of their being harassed by those who wielded power in local bodies. Taking all these things into account, it was clear that if they belonged to any political party it would place them in jeopardy. So in their own interests, they should avoid politicians, and devote themselves to their profession.

It was also necessary that they should support their association. If they transferred their loyalty to the association from those whom they believed would support them, but who would only let them down, and made it strong, it would help them in many ways. The fees paid to a doctor in India were low and even the low fee was at times difficult to get from his patients. In England, he said, it was regarded as a matter of honour to pay the doctor.

Proceeding Col. Stott urged the need for their active help to win the war, if they were to progress in a democratic form. There were many ways in which they could help. They should educate the public with regard to the justice of the allied cause. He regretted that the question of recruitment of medical men to army appointments had not been taken seriously enough by Licentiates', and Rural Practitioners' Associations. There were great opportunities, and he was sorry to say that advantage had not been taken of them in Madras. He appealed to medical men to come forward for training for appointments in the army, and benefit by the broad education and wide experience they would have. As regards the danger, he would assure them that there was far more danger in staying in some of the heavily infected and malarial parts of the country, than in a highly protected community like the army. In conclusion he appealed to practitioners to contribute their share to the Governor's War Fund.

MAJOR-GENERAL N. M. WILSON'S PORTRAIT UNVEILED.

Before the ceremony of the opening of the Annual Conference of the Provincial Subsidized Rural Medical Practitioners' Association came to an end, Dr. V. Rama Kamath, the President of the Association while requesting Col. H. Stott, the Surgeon-General, to unveil the portrait of Major-General N. M. Wilson, the ex-Surgeon-General with the Government of Madras, said that it was originally the desire of a few old boys of the Royapuram Medical School, now the Stanley Medical College to make a gift of the portrait of General Wilson to the Stanley Hospital. Later these old boys had to change their mind due to circumstances beyond their control and they thought the Stanley Medical College was better suited to have the portrait of General Wilson in some prominent place where the students of the College had opportunities of seeing the picture of a person who had done much in rearing the College from the stage of its infancy to one of adolescence and nurtured it so efficiently that there was every chance of that institution growing to the height of another similar teaching institution in Madras over a century old. That was not all, observed Dr. Kamath General Wilson was the first Surgeon General in the province who actively organised the corps of St. John of Jeruselam and raised its strength from a number below one hundred to a couple of

thousand or perhaps more. The usefulness of this army for serving the injured and the sick could now be imagined when the war clouds of destruction were seen in the horizon. The fact that a division of St. John's Ambulance Corps was inaugurated in the Stanley Medical College by General Wilson was yet another factor which weighed with the donors to have a picture of his in the Stanley Medical College to serve as an example to the young medicoes to follow and to emulate General Wilson. It was a happy coincidence, said Dr. Kamath, that the portrait was to be unveiled by Col.H. Stott, a good friend of General Wilson and one who had done splendid work to organise St. John Ambulance work wherever he was before he came to Madras. Dr. Kamath then narrated the circumstances which led to the unveiling of the portrait of General Wilson that day. He said that as one of the old boys of the Royapuram Medical School he requested the Association to permit him to have the unveiling ceremony that day as the same had to be postponed for various reasons—chief amongst them being the speedy construction work that was then going in the Stanley Medical College. The Provincial Committee of the Rural Medical Practitioners' Association did not only give him the permission but also forced him to permit the Provincial Subsidized Rural Medical Practitioners' Association to show its regard to the retired Surgeon-General who was not only a sincere sympathiser of the rural practitioners but actually put his sympathies into action. Dr. Kamath observed that though it was an occasion when he was expected to say all about General Wilson and his career as the Head of the Medical-Department he did not wish to reiterate what all appeared in The Medical Practitioner as all who had assembled before him were the readers of that journal. "Suffice it to say," said Dr. Kamath, that General Wilson was one of those bureaucrats who had a democratic heart and one who respected the rule of the red tape very sparingly and did more than he talked. He appealed to Col. H. Stott to follow the policy of his predecessor while administrating the Medical Department in the Madras Presidency.

Col. H. Stott then formally unveiled the portrait and informed the rural practitioners that he would convey to General Wilson the news about the pleasant function.

PRESIDENTIAL ADDRESS

BY

DR. V. RAMA KAMATH.

15—4—1941.

Brethren,

We are having the Ninth Conference in the capital of the Presidency at a time when every one of us feel that the world war is very near the doors of India and when our minds are full to find ways and methods to put down Hitlerism. The yearly Conference of your Association which was decided to be held in Tirupathi, Chittoor District in December 1939 was converted into a meeting of the Provincial Committee as this body which has full authority to decide about the affairs of the Association thought at the time that no good purpose would be served by having a Conference that year when the political atmosphere as reflected by the world war was such that the then Government who were indecisive to continue in power had had troubles of their own and could bestow very little thought on the resolutions passed by the Conference at Samalkot in April 1939 and without knowing the fate of those resolutions the Association would not be justified to take stock of past events between the authorities controlling the Rural Medical Relief Scheme on one side and the Association on the other. The Provincial Committee therefore decided to set their house in order so that the affairs of the Association could be effectively controlled by that body. Consequently, suitable amendments to the constitution of the Association were made by the Provincial Committee at Tirupathi and the Provincial Committee was made the final arbiter in regard to affairs of the Association. All the same, this Committee was made subordinate to the collective will of all the members of the Association, provision being made in the constitution that a referendum should be made to all the members of the Association in all matters relating to any

changes in the rules and bylaws of the Association. Consequently it may now be said that the Association is an ultra-democratic body. The Provincial Committee has since found it necessary that there should be additional amendments to the constitution of the Association and the General-Secretary has undertaken to place before the Provincial Committee necessary amendments to make the lives of the Executive more tolerant and less vulnerable to outside unhealthy influence. These amendments will be placed before the Conference for being discussed and basing upon the decisions arrived at by the Conference, a referendum will be made to all the members of the Association, and the majority decision will be carried out by the Provincial Committee and duly intimated to all the members through the official journal.

VENUE OF THE CONFERENCE.

The Provincial Committee decided that the Annual Conference should be held in Kodavayur, Malabar District, last December but due to circumstances beyond the control of the Executive of the Association, the Conference was postponed and venue was changed from Kodavayur to Madras. It was truly said by your General Secretary yesterday in the course of his welcome address that the destinies of the medical profession depend entirely on political Government and not on the profession and the present Government now on the saddle is an emergency Government whose tenure of office depends entirely on the political conditions in the country. All the same, the executive of your Association thought and rightly so that the Association was likely to gain at least, nothing to lose if the Conference was held in Madras, the seat of the Government and associated its activities with the Head of the Medical Department, who being new to this province might be apprised of the affairs of the Association; and I should say from what all transpired yesterday in the hall when Col. H. Stott kindly inaugurated the proceedings of your Conference that you were wise to have the Conference in Madras.

PAST AND FUTURE OF THE ASSOCIATION.

I could tell you from what I hear and see that Col. H. Stott is a man of business and does his business after careful study of the same. Your association through your General Secretary did place before the Surgeon-General last evening a comprehensive summary of the past history of Subsidized Rural Medical Relief Scheme which he aptly said depended entirely on the political tides and currents and not on the welfare either of the villagers or of the practitioners to whom the welfare work is entrusted. He also said that the scheme had been undergoing drastic changes all of which were detrimental to the spirit and principles of the scheme as originally contemplated by the framers of the scheme. Your sufferings and your vicissitudes have been such that the elders amongst you whom I could call the pioneers to carry scientific medicine to the doors of the village folk are being compelled to change your lives of independence to one of dependence and the younger amongst you are distressed to such an extent that all of them are anxiously awaiting any opportunity to enter regular service. The circumstances which have been forcing you all to change your outlook from one of service and sacrifice to that of subordination and drift, are entirely due to the system of Government in India especially in this Province where paid medical service gets along much more happily than the independent private practitioners and in your case you have all the disadvantages of independence and many more disadvantages of dependence. For though your more fortunate brethren in service have to depend on their immediate superiors about their conduct, all of them can be sure of their daily bread enough to keep their body and soul alive while a pittance of Rs. 41 and odd a month given to you as subsidy and not as pay has turned you down mute and dumb. The Rural Medical Relief Scheme empowers you to claim remuneration from those whose income is Rs. 30 or more for a month but as a matter of fact if you claim and demand your remuneration, your life is made

miserable and cock and bull stories are invented against you by those who could afford to pay you and I may not be far wrong if I say that the poor to whom you are expected to serve gratis pay you and those who can afford to pay you, make use of the ignorant credulent village folk to get petitions and mahajars against you. The Surgeon-General gave you very sound advice last evening and pointed out to you that you should eschew politics of whatever denomination whether pertaining to the locality or to the entire province. He told you that politics had parties and those whom you favoured would not pay you for your services and those with him you did not take sides, were likely to be your enemies. I am sure you must have taken this advice with mixed feelings. For, there are many amongst you who cannot demand your legitimate fees for services rendered in spite of your not taking any part in politics. Your only sin seems to be in such cases that the patients whom you treated were politicians. Though you are independent and are bound by the terms of agreement there have been instances when at least some of you had to take the part of the lamb *in the wolf and the lamb drama* that was played against you by some rich and influential men in the villages who were either members of the local bodies, or of the provincial legislative bodies or supporters of such members. In regular service there are departmental rules and regulations which give sufficient protection to the members thereof but you have no such protection. You are governed by the conditions of your agreement and even the conditions of that agreement have been undergoing drastic changes when it was found that such conditions protected you against the inroads of the politicians. For example, transfer of subsidized practitioners being incompatible with the spirit and the principles of the Subsidized Rural Medical Scheme which originally contemplated the permanent settlement of a practitioner in a village, did not find a place in the terms of the agreement which originally existed and the Congress Government found it necessary to incorporate a condition to enable the Government to transfer the subsidized practitioners from one place to another. Though it is mentioned as an eye-wash that recourse will be had to effect transfers in exceptional cases, such exceptions have now become the rule and any unwanted practitioner in a village who demanded his legitimate fee from an influential politician or his henchman could now be easily transferred from one village to another with little or no difficulty. It is the duty of the Government to protect such practitioners instead of having recourse to transfer even when the professional record of the practitioner was quite satisfactory. From my personal experience I could safely say that the only protector the subsidized rural medical practitioners could depend upon, is the Surgeon-General with the Government of Madras, but unfortunately for the rural practitioners, and I could even say to the entire medical profession in this province, the Surgeon-General has over 30 demi-official responsibilities in addition to his legitimate duties as the head of the medical department and he naturally finds little or no time to go through the files of the subsidized rural medical practitioners who are virtually at the mercy of the clerks in the office of the Surgeon-General.

After your Association was rejuvenated in 1937 by Major-General Sir Frank Connor, the then Surgeon-General, some of you realised for the first time that in case your grievances were intelligently explained to the Surgeon-General not through petitions or memorials but by word of mouth, you had always justice. During the regime of Major-General N. M. Wilson, it was practically demonstrated to you by him that the safest way to protect you was not through the red-tape rule but by heart-to-heart understanding of facts. He did tell you more than once when he had opportunities of coming in contact with you that the only salvation for running the Rural Medical Relief Scheme to the benefit of the village folk was to bring the entire control of the Scheme under the Government. I therefore take this opportunity of appealing to the Government on your behalf not to lose any more time in deciding to transfer the control of the Scheme directly under the Government. Time is now very opportune and the fact that the Government have created a new appointment of a Dy. Secretary to be in charge of the Rural Medical Scheme along with other subjects should make the Government not hesitate to transfer the control of the scheme. I should also say that the Surgeon-General should be given suitable help so as to enable him to be in personal touch with the Rural Medical Relief Scheme and of such important subjects especially during these anxious days when in addition to his official and demi-official duties he has to be busy to control war efforts relating to the safety of the public.

Col. Stott told you yesterday that all of you have very great responsibilities in the villages which are as great, if not, greater than those of administrators and research workers. I trust this advice given publicly by the chief adviser to the Government will be heard by all those in power who have anything to do with you. You have a frame-work placed before you so intelligently by the Surgeon-General and you should certainly find your way much easier to frame suitable resolutions to be placed before the Government so as to make the Subsidized Rural Medical Relief Scheme really useful and at the same time make your lives more tolerant in the villages.

Before closing I feel I should remind you all of the contents of a memorandum circulated amongst you through the District Medical Officers by the Personal Assistant to the Surgeon-General and which ran thus:

"Copy of No. Ref. 21469-3-H dated 20-12-40 of the Surgeon-General to all D.M.Os."

"Ref:—This office memo Ref. 21469-1-H dated 9-12-40, re: Revision of Rural Medical Relief Scheme."

"Please ascertain and report from the rural medical practitioners in your district whether (1) they are willing to strengthen their status by being classed as Government servants with a right to practise, and (2) whether they are willing to accept war service in time of emergency up to the age of 40."

"Copy to Rural Medical Practitioners (Allopathic) for report as early as possible. The reference may be treated as urgent."

The Provincial Committee was summoned by me in December last to consider the above Circular. You were advised to give the following reply:

"In reply to the Circular No. 21469-3-H dated 20-12-40 sent to me through the District Medical Officer, I am led to think as per the Memo from the Surgeon-General's office No. 21469-1-H dated 9-12-40 to the District Medical Officers that the Circular is relating to the revision of the Subsidized Rural Medical Relief Scheme and I beg to state as follows:—

"I regret I am unable to understand the implications of the first clause in the Circular. If it means the transfer of the entire control of the Subsidized Rural Medical Relief Scheme to the Government, I whole-heartedly and gratefully accept that part of the Circular."

"The second clause in the Circular, I respectfully submit cannot have anything to do with the revision of the Subsidized Rural Medical Relief Scheme and its acceptance should be left to the opinion of individual practitioners"

In the case of Medical Licentiates who desired to take up war service the following clause was added:—

"The second clause in the circular, though it cannot have anything to do with the revision of the Subsidized Rural Medical Relief Scheme, I am prepared to take up Emergency War Service if I am immediately recruited in the cadre of Civil Sub-Assistant Surgeons, my service as Subsidized Practitioner being counted for the purpose of service and I am paid the same scale of pay and allowances as paid to the Civil Sub-Assistant Surgeons now on War Service."

and in the case of Graduates Subsidized Practitioners, the following clause was added:—

"I am prepared to take up War Service in the rank of the Commissioned Officers in case after my return from War Service my application for Government Service is preferred to the other applications from candidates who have not rendered War Service."

Soon after some of you sent me copies of the Personal Assistant's circular, I saw the then Surgeon-General, Major-General Wilson, to have a definite understanding of the contents of the circular and he expressed to me his view that the emergency war service was quite a different subject from the Revision of Rural Medical Relief Scheme and the Subsidized Practitioners were at liberty to give their views on the 1st item of the

circular without tacking it on to war service. Basing on this advice, the Provincial Committee drafted the reply to the circular. We have yet to know what had happened to the circular and the replies sent by you all in answer to the circular. I made an attempt to know if there were any proceedings of the Surgeon-General or any order of the Government on this subject and failed in my attempt. After hearing the Surgeon-General and his concern towards the Rural Medical Relief Scheme, I still hope to be able to communicate to you either the proceedings of the Surgeon-General or order of the Government if passed, relating to the circulars.

WAR AND YOUR RESPONSIBILITIES.

Col. Stott referred in his address to you last evening about this subject and I feel confused to guide you as to what you should do in regard to emergency war service. I am not in a position to say more than what is contained in your replies to the Surgeon-General's Circular referred to above. Yet let us try and find out a solution.

Regarding your humble contribution to His Excellency's war fund, the Provincial Committee did advise each of you to voluntarily pay Re. 1 a month from your subsidy and to make the procedure of collection easy, the Provincial Committee suggested that the Treasury Officers might be authorised by individual Subsidized Practitioners to deduct Re. 1 from his monthly subsidy and send it to the War Fnnd each month for Ambulance purposes. In addition to this I have information that many of you did make voluntarily contributions even before the date of the meeting of the Provincial Committee which advised you to make voluntary contributions. Many of you even paid more than what you would have paid as per the advice of the Provincial Committee. I also know that a few of you served in the war committees and if my information is correct, a Rural Medical Practitioner in Salem District in co-operation with the Sub-Registrar of the place collected a pretty large amount for the Governor's War Fund.

REFRESHER COURSES.

When the Provincial Committee decided to act on my suggestion to have the Conference in Madras, I thought of giving you the full benefit of your stay in this city especially so as the Conference was to be held in the Madras Medical College. I approached almost all the Professors of the College and requested them to address you on their special subjects and I am most happy to inform you that all those whom I was able to approach readily consented and consequently I was able to add a new feature to the activities of your Conference in arranging lectures in the evenings. The first would be delivered this evening by Col. G. R. McRobert, Superintendent, General Hospital and Professor of Medicine, Madras Medical College, who was so kind to take the lead to help you and he will also inaugurate the scientific section to-day at 4-30. I take this opportunity of expressing my gratitude to all the Professors, many of whom though conspicuous by their absence last evening will be with you to-day and tomorrow or even a few days more if you are willing to stay. In this connection I wish to make a suggestion to the Government that wherever post-graduate training classes are held in the teaching institutions in Madras or Vizagapatam, the Subsidized Practitioners might be permitted to attend the classes free of any charge. I may add that in England, Panel Doctors who receive decent remuneration for their services are given post-graduate training at the cost of the authorities running the Panel System of Medical Relief and in addition paid all incidental charges for travelling, boarding and lodging while working in the hospitals. Is it too much for me to suggest that the same consideration may be shown to Subsidized Practitioner whose lot is certainly much more humble than those of Panel Doctors in British Isles?

I had no time nor the energy to prepare a bigger address with more details and I request you to excuse me if you find my guidance below your mark or expectation. All the same I assure you that whatever decisions you arrive at during the course of your deliberations will have my best

and earnest attention including the schemes proposed by the Provincial Committee relating to death and disability fund, starting of village hospitals and a central store in Madras to supply your needs in the villages.

LOYALTY TO THE ASSOCIATION.

Before I conclude my speech, I feel I should remind you of the valuable advice given to you by Col. Stott, the Surgeon-General, yesterday that you should be loyal not only to your profession, but also to your Association and the welfare of your Association as well as the Profession depends entirely on your organised efforts through your Association and not through any outside agency of whatever sort. I hope that this advice will reach a few official and non-official medical men who, I am painfully surprised have been trying to break your Association by all possible means fair and foul for reasons best known to themselves and I expect they will take a note of the advice given to you by the Surgeon-General. At the same time you should individually make every effort to enrol such of those comrades of yours who have been hesitating to join the Association. Ignorantly or perhaps innocently some of the non-members of your Association hold the view that whatever your Association is likely to achieve they will also get the benefit of the same. This is indeed a most selfish argument put forth by them and you will be doing good service to yourself and to your Association by bringing your doubting comrades into your fold.

RESOLUTIONS PASSED BY THE CONFERENCE.

I. Read the report of the General Secretary of the Association for the period ending 31-3-41 and the report of the Treasurer and the Balance Sheet for the period ending 31st December 1940.

Resolved that the report of the General Secretary and Treasurer with the Balance Sheet be adopted.

II. The following amendments to the Memorandum and rules of the Association were adopted unanimously:—

(1) Delete' 'Rs. 5 only' and substitute 'Rs. 6 only' in clause (5) c.

(2) In clause 10 (a) add after the words "from amongst the members of the Working Committee" occurring in the second sentence "after its formation."

(3) Delete para 1 of clause 12 and substitute the following:—

"The President shall preside over the Conferences which may be held annually in each of the following five regional areas and a Provincial Conference be held in Madras only as and when the Provincial Committee decides to that effect."

(4) Delete clause 14 (f) and substitute the following:—

"Out of the yearly membership fee of Rs. 6 (Rupees Six only) collected from each member of the Association Rs. 2 should go towards the funds of the official organ "The Medical Practitioner" and as. 8 shall be credited to reserve fund of the Association and the balance of Rs. 3-8-0 should go towards the Provincial Fund inclusive of expenditures towards the Provincial Conferences."

(5) Delete clause 14 (g) and substitute the following:—

"The District Branches shall not claim any contribution from the Provincial Fund but each District Branch shall have a fund of its own."

(6) Delete clause 14 (h) and substitute the following:—

"The actual travelling allowances of the members of the Provincial and Working Committees shall be paid from the Provincial funds for attendance at the meetings of the said Committees."

(7) In clause 15 (e) after the words "General Secretary" add "and the Treasurer," and in the place of the word "power" after 'shall have', add "a permanent advance of Rs. 5 each," and in the place of the word "to" before the word "incurring" substitute the word "for."

(8) In the existing rules under the numbers 15 and 16 substitute clauses 15,16 as appearing hereunder and change the subsequent numbers suitably.

Clause No. 15.

In the event of any District Branch failing to elect its office-bearer and representative of the District Branch concerned, to the Provincial Committee the Working Committee after notifying to the members of the particular District Branch shall nominate a suitable member of that particular District Branch to act as Secretary-Treasurer and member of the Provincial Committee for the period deemed necessary by the Working Committee. The said nominated Secretary-Treasurer shall select his Joint Secretary-Treasurer from amongst the members of the District Branch after receiving his consent and notify his name to the Working Committee for approval. In case any District Branch fails to elect a Joint-Secretary-Treasurer, the Secretary-Treasurer elected by the District Branch

shall similarly select the Joint-Secretary-Treasurer and submit his name to the Working Committee for approval.

Clause No. 16.

No-Confidence Motions.

(*a*) No-confidence motion in the Provincial Executive shall be passed by the Provincial Committee at a meeting specially convened for the purpose. Such meetings shall be convened by the General Secretary of the Association on the written requisition of not less than two third of the members of the Provincial Committee specifying the object of the meeting. The General-Secretary shall issue notice of the Special meeting eight clear days before the date of such meeting and the motion shall be valid provided that not less than ⅔ of the members in the Provincial Committee be present and vote for the motion and such motion shall come into effect immediately after its adoption by the Provincial Committee and the President and other office-bearers shall cease to function immediately after the election of a new President.

(*b*) The Provincial Committee at this Special meeting, in the event of an adverse vote against the Executive shall immediately proceed to elect a new President who shall announce the names of the members of the new Working Committee not later than 15 days from the date of the dissolution of the old Executive Committee. In the interval the new President shall act as directed by the Provincial Committee at the said meeting. Every member of the Provincial Committee shall be eligible for re-election to any office in the Executive to be re-formed.

(*c*) No-confidence motion in the Secretary-Treasurer shall be considered at a special meeting of the particular District Branch provided the Secretary-Treasurer issues a notice to all the members of the branch 8 clear days before the date of the meeting and 2/3rds of the members of the branch sent to the Secretary-Treasurer requisition in writing giving the object of the meeting and that at the said meeting ¾th of the number of members of the District Branch vote on the motion. The Proceedings of such meeting shall be duly communicated to the President with the names of the members for and against the motion for scrutiny and final orders. The Orders of the President thereon shall be binding on all concerned.

(*d*) Resolved that the above amendments to the Memorandum and Rules of the Association be adopted and shall come into effect a month after a referendum is made to the General Body by the Working Committee for which purpose the Working Committee shall make a referendum to the General Body of the Association by publishing the same in its official organ "The Medical Practitioner" and shall fix one calendar month to receive and consider the replies that may be received. The Working Committee shall then announce the result of the referendum and the date of the amendments coming into effect.

III. Read the letter from Dr. N. Rama Rao member, from Kistna District dated 17-1-41 relating to the non-confidence motion passed against Dr. V. Rama Kamath, President, of the Association by the Kistna District Branch on 15-5-40.

Resolved to empower Dr. N. Rama Rao to get a statement of apology from such of the members of the Kistna District Branch who attended the meeting when the non-confidence motion was passed by the District Branch on 15-5-40 in the form of a letter written in the same terms as was done by Dr. N. Rama Rao and send the same to the President of the Association within a month from the date of this resolution.

IV. Read the draft reports by the General Secretary on the schemes about 1. DEATH AND DISABILITY FUND, 2. Central Stores, and 3. Guest House.

Resolved that the President be entrusted to put before the next Annual Conference of the Association these schemes, and in the meanwhile all the members of the Association be requested to send their views to the President relating to the Scheme.

V. This Conference has carefully considered all its previous resolutions and those of the Provincial Committee on the subject of transfer of control over the Rural Medical Practitioners to the Government and respectfully requests the Government to find their way to effect transfer of control as requested.

VI. The Conference respectfully points out to the Government that as there is a well organised Provincial Association of Rural Medical Practitioners in the Province with its branches in all the districts and with a Provincial Committee consisting of elected representatives from each District and an Executive Committee, and requests the Government that in all matters relating to the Subsidized Rural Medical Relief Scheme the Association may be consulted before any decision is arrived relating to the Scheme.

VII. Whereas the Surgeon-General with the Government of Madras while reviewing the confidential reports of the District Medical Officers on the work done by Rural Medical Practitioners during the last two years, was of opinion that the work of some practitioners was inefficient and warned the practitioners to work more enthusiastically and whereas basing upon the above referred proceedings of the Surgeon-General, some of the Presidents of District Boards have taken undue advantage of the said proceedings and threatened the practitioners with termination of their services as per the terms of the agreement executed by them, this Conference brings to the kind notice of the Government that the fixing the minimum average daily attendance at 30 for each and every dispensary is arbitrary and is a great hardship on the practitioners if the efficiency of their work is to be judged on the standard of average daily attendance only as the Rural Dispensaries are situated in the villages with a varying population from 1,000 to 6,000 and with as varying environments,

and the Conference requests the Government to be good enough to review the reports of the District Medical Officers taking into consideration the population of the village where the dispensary is situated, development of communications in and around the village and health consciousness of the villagers.

VIII. The Conference is of opinion that the dispensaries which have a daily average attendance of less than 20 for three consecutive years may be shifted to suitable centres with large population and the practitioner be given a better chance to serve a larger number of necessitous poor.

IX. The Conference has noted with great concern the rapid and fabulous rise in the prices of drugs and appliances on account of war and requests the Government to advise the Local Boards to sanction increased Budget grants for supplying medicines proportionate to rise in prices.

X. As the Government Medical Store Depot is not in a position to supply the demands of the Rural Medical Practitioners in their annual indents this Conference requests the Government to be pleased to relax the rules of procedure to be adopted by the local board in the matter of local purchase and supply so that the efficiency of the Rural Dispensaries may not suffer to the detriment of the necessitous poor.

XI. As the recent Government Order that casual leave for 12 days and leave of absence for 18 days to be availed by the subsidized practitioners as and when earned, is a hardship, the practitioners not being able to avail the leave as and when necessary for them to the maximum limit of 15 days at a time, this Conference requests the Government to permit the practitioners to avail public holidays exclusive of the leave of 30 days now allowed to them.

XII. (*a*) This Conference resolves to request the Madras Medical Council to recommend to the Government to grant permission to the existing Licensed Medical Practitioners to add the words "D. M. & S." (Diploma in Medicine and Surgery) as otherwise it creates a small and new class of medical practitioners if the new diploma is confined to those who have undergone a course of study for five years.

(*b*) The Conference resolves to represent to the Government to give their Order relating to the D.M. & S. diploma retrospective effect so that all the registered practitioners who passed out from the Government recognised Medical Schools may use the new Diploma.

XIII. The Conference respectfully brings to the notice of the Government that it is detrimental to the interests of the modern scientific medicine and of the indigenous system that subsidized dispensaries belonging to the indigenous systems if medicines and drugs belonging to the Allopathic system are supplied to the subsidized dispensaries belonging to the indigenous systems and requests the Government to confine the supply of drugs and medicines of the indigenous systems only to the dispensaries belonging to the latter systems.

XIV. The Conference is of opinion that the practitioners belonging to the indigenous systems of medicine if registered by the Central Board of Indian Medicine should be made to add a suffix after the term 'registered practitioner' to denote that such practitioners are registered by the Central Board of Medicine.

XV. This Conference requests the Government that for the purpose of considering the affairs of the Subsidized Rural Medical Relief Scheme the Government may be pleased not to make any difference between those subsidized by the Government and those subsidized by Local Boards specially because that many of the subsidized practitioners who began their lives on Government Subsidy have been transferred from the Government subsidized dispensaries to those subsidized by the local bodies.

XVI. As the Subsidized Rural Medical Practitioners have to depend entirely on private practice for their maintenance and as there have been many instances reported to the Association by the practitioners that in some districts the Government and Local Fund Medical Officers take up cases for treatment within the reasonable area of the activities of the subsidized Practitioners, the Conference requests the Government to prohibit their Medical Officers and those under the Local Fund Service from undertaking to treat patients residing in the villages which are the legitimate fields of practice of Subsidized Practitioners unless the services of such officers are requisitioned by the respective rural practitioners.

XVII. The Conference requests the Government that when a Subsidized practitioner applies for any plot of land in the village where the Rural Dispensary is situated on *Darcast assignment* that plot of land may be given to the subsidized practitioner in preference to other applicants.

XVIII. (*a*) This Conference strongly advises all the subsidized rural medical practitioners to apply for emergency war service and for this purpose requests the Government to waive the age-limit for recruitment.

(*b*) This Conference requests the Government that for the temporary vacancies which have occurred or may occur in future during the duration of war in the Civil Medical Department, the subsidized rural medical practitioners may be preferred.

(*c*) This Conference requests the Director-General, Indian Medical Service, to recommend to the military authorities to give to all the new recruits to the I. M. D. Department the rank of Subedar.

XIX. (1) The Conference expresses its heartfelt gratitude to Dr. V. Rama Kamath for having kindly consented to take up the Presidentship for one more year and assures him the continuous loyalty and support to his leadership

from the members of the Association to enable him to ameliorate the condition of the Rural Medical Practitioners.

(2) The Conference expresses its high sense of gratitude to Col. H. Stott, O.B.E., K.H.S., I.M.S., the Surgeon-General with the Government of Madras, for having kindly opened the Conference with a message of sound advice.

(3) The Conference thanks the Principal, Madras Medical College, for kindly permitting the holding of the Conference in the premises of the College and Dr. A. S. Mannady Nayar, Professor of Bio-Chemistry for specially looking after the details of the arrangement of the Conference.

(4) The Conference expresses its gratitude to the Professors of the Madras Medical College, who delivered interesting and educative lectures at the Conference on subjects of their special study, and the Conference fervently hopes that the Professors will always be pleased to give the benefit of their ripe experience to the rural practitioners whenever they are in need of them.

(5) The Conference thanks Col. H. Stott, O.B.E., K.H.S., I.M.S., Surgeon-General with the Government of Madras, for kindly unveiling the portrait of Major-General N. M. Wilson, ex-Surgeon-General with the Government of Madras, who was not only sympathetic to the Subsidized Practitioners but also did what he could to ameliorate their lot.

(6) The Conference thanks the management of P. P. Chetty Raghava Chetty Charities for having placed "Ramanuja Koodam" at the disposal of the Subsidized Rural Medical Practitioners' Association for accommodating the members of the Association who attended the Conference.

XX. The Conference authorises the President to prepare a memorandum on the subject-matter of the resolutions that require the consideration of the Government and submit the same to the Government at an early date.

XXI. The Conference requests the President to communicate other resolutions to the respective authorities and persons concerned.

Referendum to the Members of the Provincial Subsidized Rural Medical Practitioners' Association.

As decided by the Ninth Annual Conference of the P. S. R. M. Ps' Association, and at the direction of the Working Committee of the said Association, the undersigned is hereby making a Referendum to all the Members of the aforesaid Association with a request that any Member who does not agree with the resolution No. II passed by the Ninth Annual Conference and appearing on pages 273 & 274 of this issue of The Medical Practitioner relating to the Memorandum and Rules of the P.S.R.M.Ps' Association, should send his objection to any particular amendment or amendments in writing to the Central Office, No. 147, Purasawalkam High Road, Vepery, Madras, within a month from the date of the publication of the April 1941 issue of The Medical Practitioner. The result of the Referendum will be announced in the May 1941 issue of The Medical Practitioner.

Madras,
Dated, 7-5-1941.

V. RAMA KAMATH,
President,
P. S. R. M. Ps' Association.

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RURAL MEDICAL PRACTICE.

A perusal of the proceedings of the IX Annual Conference of the Subsidized Rural Medical Practitioners working under the Local Bodies in the Madras Presidency would convince the readers how the politicians who formed the successive Governments in the major Province of Madras have been making use of the members of the medical profession for their own purposes with little or no regard for the fundamental principles underlying the Subsidized Rural Medical Relief Scheme. The preamble of the Scheme as contained in G. O. No. 1522 P. H. dated 22-10-1924 runs as follows :—

".. ...Government strongly feel that some amelioration of the masses is urgently called for, and that for want of unlimited funds at their disposal, encouragement of private practitioners (allopathic) to settle down in villages for practice by the grant of money subsidies and supply of medicines from public funds, as being the cheapest and at the same time the best from many points of view, and thus to divert to the villages the large number of unemployed medical men who now congregate in towns for private practice, as also tend to solve the problem of unemployment to a material extent."

From the above preamble it is seen that 'the amelioration of the masses' is to be entrusted to the practitioners belonging to the allopathic system and not to the practitioners of any other system; but the very Government under the Panagal Ministry during whose regime the Subsidized Rural Medical Relief Scheme was brought into existence, within two years after the passing of the Order on the Subidized Rural Medical Relief Scheme, did not feel it repugnant to employ the practitioners belonging to the indigenous systems of medicine and as a corollary to the recognition of indigenous systems introduced registration of the practitioners of the latter system not by a statute but by an administrative Order. The result of such recognition has in effect cut the very root of the Rural Medical Relief Scheme and more quacks and charlatans are now let loose on the villagers under the very authority of Government to prevent whose inroads in the villages, the Rural Medical Relief Scheme was said to have been introduced by the then Government under the leadership of the late Raja of Panagal. The rest of the principles underlying the preamble have been completely flouted by the successive Governments including the Congress Government and it was no exaggeration when the General Secretary said in his Welcome Address that the Scheme had been undergoing drastic changes all of which were detrimental to the spirit and principles of the Scheme as orginally comtemplated. Equally well founded were the remarks of the President of the Provincial Subsidized Rural Medical Practitioners' Association who said in his address :

"Your sufferings and your vicissitudes have been such that the elders amongst you whom I could call the pioneers to carry scientific medicine to the doors of the village folk are being compelled to change your lives of independence to one of dependence and the younger amongst you are distressed to such an extent that all of them are anxiously awaiting any opportunity to enter regular service. The circumstances which have been forcing you all to change your outlook from one of service and sacrifice to that of subordination and drift, are entirely due to the system of Governments in India especially in this Province where paid medical service gets

along much more happily than the independent private practitioners and in your case you have all the disadvantages of independence and many more disadvantages of dependence. For, though your more fortunate brethren in service have to depend on their immediate superiors about their conduct, all of them can be sure of their daily bread enough to keep their body and soul alive while a pittance of Rs. 41 and odd a month given to you as subsidy and not as pay has turned you down mute and dumb."

It is indeed a strange yet most happy irony that to the extent the demi-popular and ultra-popular Governments of this Province were breaking their orders year after year to the same extent the successive bureaucratic Surgeon-Generals have been realising that politics played a great part in the affairs of the Subsidized Rural Medical Relief Scheme and have been advising the rural practitioners to eschew politics. It is a good omen that Major-General H. Stott, the new Surgeon-General who succeeded Major General Wilson, a couple of months ago seems to have, within a very short time, come to know the dangers of politics to the rural medical practitioners as could be seen from his address to the rural practitioners on 14th April 1941 when he opened their Annual Conference. General Stott warned the practitioners :

" Politicians would only let you down, and no good results would be obtained by associating with them. Rural medical practitioners had to depend on private practice to supplement their subsidy, and if they turned politicians, or active sympathisers of any party, that would only affect their income. The followers of the party would expect to be treated free and the opponents might refuse to be treated by them. There was also risk of their being harassed by those who wielded power in local bodies. Taking all these things into account, it is clear that if they belonged to any political party it would place them in jeopardy. So in your own interests, you should avoid politicians, and devote yourselves to your profession."

Dr. Kamath, the President of the Association, did apprise the rural practitioners, soon after he was elected to this office in 1937 to the effect that so long the Medical Profession was under the control of any political Government and not under the control of the profession itself, the rural practitioners should be prepared for any exigency and should establish their usefulness and popularity always remembering " I am my brother's keeper "

Quite consistent to his valuable advice General Stott exhorted the rural practitioners:

" It was also necessary that they should support their association. If they transferred their loyalties to the association from those whom they believed would support them, but who would only let them down, and made it strong, it would help them in many ways."

It looks as if those who are in a position to advise the rural practitioners anticipated each other's advice ever since the Provincial Subsidized Rural Medical Practitioners' Association was rejuvenated in the year 1937 just a few days before the Congress Government assumed the reins of the Madras Government. Major-General Sir Frank Connor who opened the Conference in 1937 fully realising the signs of times advised the practitioners to follow the example of '*thousands and thousands of young men*' who were *working hard like coolies in other countries in labour camps and elsewhere for the sake of their countries and turning marshy lands into cultivable ones*'. There was patriotic wisdom and solace in his words which he gave expression to without injuring anybody's feelings allegorically and as aptly. Sir Frank Connor's successor, General Wilson, whose administration was one of action and not of words, did what he could by advising the Government that the entire control of the Subsidized Rural Medical Relief Scheme should be transferred to the Government. He did not believe in petitions and memorials. He demonstrated his policy in the files that were placed before him by his office. He had a high sense of prestige and to

the same extent he did not allow prestige to over-rule justice and with it expediency. He was ever ready to listen to the grievances of the subsidized practitioners and did not mind the rules of the red tape. General Stott, the worthy successor of General Wilson, has been able to know within a very short time where the troubles of the rural practitioners lay and as an astute physician which he is, did prescribe the remedy which while being rational, was neither costly nor difficult to procure. We only wish the Executive of the Rural Medical Practitioners' Association broadcast General Stott's wholesome remedy that the practitioners should depend upon their Association and be loyal to it and to the profession to which they belonged. We fervently hope that the value of the remedy prescribed by the Surgeon-General will be appreciated by all in authority not excluding those in the office of the Surgeon-General. Effect of a remedy however wholesome will be felt and should be made to be felt by adopting as wholesome methods in its administration if necessary not minding the name of druggist's shop where the remedy is obtained so long the ingredients of the remedy were found to be pure. This is what a practical physician would expect and it will not be too much for us to reiterate that General Wilson though a surgeon, administered remedies as a cutting physician even without mentioning his recipes for; perhaps surgeons realised expediency at times more than the healing physicians whose knowledge of the art was so full that at times they faltered to find out the best amongst the remedies.

We trust, such of the rural medical practitioners who are not members of the Association will make up their minds to enroll themselves as members so that their Association may be literally be able to speak in one voice for all now working in the villages. Self-help is the best help to get which one has only to depend upon himself and not outsiders and by being a member of the Association the rural practitioner will help himself and strengthen an organisation whose members depend upon self-help. To be of help to himself a practitioner has to be self-sufficient in his professional and worldly knowledge. Both he will have by being a member of the Association. From the perusal of the resolutions passed at the last Conference, it would be evident that the Conference had turned out quite good and useful work.

We have been often mentioning in these columns that the welfare of the people is the only index of good Government and nobody could do the welfare work more satisfactorily than the members of the medical profession, and the welfare work should begin in villages, as India is a country of villages and depended entirely on its agricultural population for its nation-building activities. This is the reason why The Medical Practitioner is concentrating its activities in building up village practice on good and solid foundations built in the villages with the help of the village soil. As the lay public got all that they wanted from the villages so also the members of the medical profession have to depend upon village practice for their prosperity. The rural practitioners are the first link in the golden chain of the medical profession and if this link is sound, it can link on to it many more and make the chain look as valuable as gold. So, rural medical practice should be the concern of every patriotic Indian medical practitioner. This was amply demonstrated by Col. G. R. McRobert and other Professors of the Madras Medical College, who were kind enough to address the conference day after day during the period when the Conference was in session.

News and Comments.

Emergency War Service: No activity of whatever nature can go on without its being associated with a medical man. The World War started by Hitler for world domination for which purpose he has been applying the scientific intelligence of German nation for destruction not only of the war combatants on the field but of the civil population with the sole purpose of cowing down the morale of the people, has been demanding a supply of medical men from all quarters. The battle field which began with Poland in the West has practically extended to all the boundaries of Europe excepting Spain and Portugal and Soviet Russia which is having its share of the war gifts without blood-shed and it is ever ready to pounce on small countries when they resist its ambition for dominating over them. The entry of Russia into the war field seems to be a matter of time whereas the other two countries are being threatened with invasion by Hitler at any moment. From Europe the battle has been spreading to Africa on the borders of Mediterranean sea otherwise known as the Middle East of the world and has reached Iraq. In the far East, Japan is the ally of Hitler and the Japanese are as ambitious as the Germans, to be virtually the rulers of Asia; and India being in Asia, the shining jewel in the British Empire, is attracting the eyes of the enemies of the Allies. India has not as yet experienced the horrors of war in regard to destruction of human beings and before the war reaches India which God forbid, it must be the duty of all human beings to help the Crown by all possible ways, for, by helping the Crown, India will be helping herself and her 400 millions. We have little or no control over the political destinies of India and any effort towards this end is beyond the scope of The Medical Practitioner. But it is our duty to apprise the members of the medical profession who alone have the inborn qualities of standing the horrors of destruction relating to the war by virtue of their being the votaries of the healing art which knows no enemies even on the battle field and which art does not stand in need of any special training to enter the battle field at any moment. It must also be said that the risks of war are very much less to the doctors in the army than to the actual combatants in the war field. Under these circumstances the Heads of the Medical Department and even the Governments in India are disappointed why medical men especially the licentiate section of it are not volunteering for Emergency War Service as in other countries. In our own way though not through these columns, we did explain to General Wilson, the Surgeon-General with the Government of Madras, who has just retired and did suggest ways and means by which War Service could be made popular and attractive at least for the purpose of recruiting medical licentiates for War service. We should also say that General Wilson was quite in accord with our suggestion and for aught we know, he must have conveyed our suggestion to the proper quarters as the lot of licentiates was improved a bit though not to the extent desired for by them.

A recent Government Communique published in the Press, a copy of which is also in our possession, says that the Defence Department is in need of medical men and to attract medical men to War Service, the Madras Government along with the other Provincial Governments, have modified service rules making it possible for the probationers already in the Civil Medical Department to be confirmed soon after their return from war, the period of military service being counted towards probation, pay and promotion and in case of permanent medical officers, the War Service will count for Civil pension. It is also said in the communique that the period spent on field service will count double for probation and increment of pay and also for accumulation of leave under Civil Rules if any taken while on Military duty being deducted. In regard to qualified doctors who are not employed in the Civil Department and who have taken up war service, substantive vacancies in the Provincial cadres of Sub-Assistant Surgeons and Civil Assistant Surgeons will not, except in special circumstances be filled during the period of the War. Candidates selected for the Military Department will first be appointed to the Provincial cadres and then be deputed for duty in the Defence Department. Candidates with good war service will be preferred in the matter of selection in officiating vacancies, and confirmation in the Civil Department will be made in the order in which they proceed for duty in the Defence Department. It is also mentioned in the communique that Service rules relating to the Madras Medical Service and Medical Subordinate service, have been amended implimenting the above decisions. The Military Department has also suspended permanent recruitment to Military Service during the War period so as to be able to absorb the private doctors who have volunteered for Emergency War Service into regular Military Service after the termination of the War. So far so good.

We are of opinion that the existence of the paid Civil Service of a type which does not exist in any other country, has been the cause for the private doctors to hesitate to take up Emergency War Service especially in case of medical men who are earning their daily bread. Service in a Government Hospital of whatever nature is considered to be more paying even as honoraries and as the Government have amended the Service rules to suit war emergency, there seems to be more hesitation than there would have been otherwise. We do not think there was any necessity for making War Service attractive in British Isles and elsewhere in the active war zones by offering civil appointments as is done in India. We have information that even retired officers belonging to I.M.S. are working in honorary capacity in A.R.P. work, in the British Isles. How we wish the same patriotic feeling is made to prevail in India by the powers that be.

Medical licentiates in India are treated as an entity in itself. For the purpose of Government Service they always hold a subordinate position but as private doctors they have been holding their own and they have shown their capacity not inferior to any other class of medical men whom the Government either for Civil or Military purposes recognise as a class superior to the medical licentiates. The disparity regarding the pay and status between the medical licentiates and other class of qualified doctors is such that many of them in the former class, who, as private practitioners, manage to make an honest living prefer to be where they are. If there can be patriotism in India the medical licentiates own it to the extent others do and if War demands more patriotism it must be consistent to the price offered for the same. Cannot the medical licentiates be valued for the purpose of Military service half as much as other qualified doctors who start with Rs. 450 pay per mensem and with the status of a commissioned officer as compared with Rs. 75 per month paid to the medical licentiates who are started with the status of only of a Jemadar? We wish the Governments, Civil or Military be imaginative at least to be able to conceive that there are persons who though they do not command an income earned by their chief advisers are anxious that His Majesty, the King Emperor, should come victorious so as to be able to put down Hitlerism once for all. Such persons can only be in a position to advise young men to take up Emergency War Service, they cannot do anything more. They have to put down their heads when those whom they advise turn round and ask some reasonable questions in terms expressed by us relating to the glaring disparity of the pay offered for Military service to the medical licentiates. There have been occasions when well-meaning elders in the medical profession felt humiliated for being misunderstood by those in office who hesitated to clear any doubts relating to the communique or any departmental orders relating to War which required elucidation. Such attitude is against the very principles of democracy to protect which His Majesty's Government have been forced to take the sword against those who are attempting to wreck democracies. If those in the Government Departments are not able to know who is who and who is what that approach them in these troublesome days it will be a safe war measure if they are shunted to positions where they can drive their quill without having the necessity of seeing or talking to anybody. It is wrong to make it appear

that Emergency War Service is a gift in the hands of a few who may be in office for the time being. The practitioners in whatever position should be made to feel that it is a patriotic responsibility on their part which responsibility they should be made to take up for its own sake as members belonging to a noble profession. We read and we hear with greed that in the British Isles it is not the Government Department who control recruitment of qualified doctors to Emergency War Service but the British Medical Association and there is no such spirit of a donor and a donee in that free country ; the young and the old in the medical profession have girdled up their loins and have taken up positions to serve their country and their King befitting their age and they have no necessity of thinking and adjusting their positions in terms of medical licentiates, graduates, members or fellows of any known bodies conferring such qualifications. All these are considered equals for the purpose of recruitment to Military or any service and these qualifications are recognised with age, experience and merit only for the purpose of division of labour. It will be a dream to conceive about affairs relating to the medical profession as obtaining in the British Isles or elsewhere nor is it expedient to think of these, during the war period where quick action to put an end to Hitlerism should be the only consideration. There is no medical association in India of the power and influence of the British Medical Association. Though there are two medical associations of an all-India importance, both have little or no control over the entire medical profession as such for the mere reason of the differences shown between the India-made-medical licentiates and all other qualified doctors. The existence of such differences should not stand in the way of anybody much less the Governments to speed war efforts. During the period of War it is not possible to brush aside the policy of the Governments in India as they now exist nor the mentality of persons who form the Governments. There is at least one medical association in the Madras Presidency which out of mere necessity cannot afford to speak in terms of qualification while considering their lot. The strength of the Association is a little over 350 not an insignificant number compared with the other existing associations. Far from asserting independence this association has been always depending upon the good-will and sympathy of individual members of the profession, official, non-official or groups of the members of the profession belonging to any association. All the members of this Association did publicly demonstrate their willingness to serve in the war. They demanded or rather suggested to the Military authorities to give them the rank of Subedar to the medical licentiates; of course, the graduates amongst them are getting the commissioned rank without asking for the same. We appeal to all authorities who have anything to do with the War efforts to consider favourably this suggestion which will bring into the war field a large number of qualified medical men who while being as good as any other qualified doctors for war purposes, will not cost proportionately more than the commissioned officers taking into consideration war expediency and with it war finance.

D. M. & S. Diploma : As soon as we came to know that the Madras Government passed orders on the recommendation of the then Surgeon-General, Major-General N. M. Wilson to confer the new Diploma D. M. & S. on those who passed out from the Government recognised medical schools after the introduction of 5 years' course of studies, we made a representation to the Government through these columns pointing out to the Government the necessity of giving their order a retrospective effect so that the new Diploma could be made use of by all the existing licensed medical practitioners who passed from the Government recognised medical schools. At the same time we carried this news to all the existing medical associations, a large majority of which in the Districts as well as the branches of the two All-India Medical Associations in the city have, we learn, forwarded resolutions unanimously passed either by the associations or by their executive committees requesting the

Government as we did to give their order retrospective effect. In the meanwhile we understand from the newspaper reports that the representatives of some of the provincial branches of the All India Medical Licentiates Association met in deputation Col., now Major-General H. Stott, Surgeon-General with the Government of Madras on 21st April 1941 and presented the memorandum of the Association. We have no idea of the contents of the memorandum but judging by the talk between the Surgeon-General and the deputationists as reported in the Press, we should say that neither the pleadings of those who put the case of Licentiates' Association nor the reply of the Surgeon-General was satisfactory.

The first spokesman said that amongst other things the entire medical profession in the province was unanimous in its view that the new D. M. & S. diploma should have a retrospective effect. Then he gave out the strength of the Association represented by him. The three that followed the first speaker supported him. The fourth expressed that the D. M. & S. Diploma should be conferred on all irrespective of the period of the course they had to undergo. The fifth deputationist instanced that the course of L. R. C. P. and M. R. C. S. diploma in England was originally for 4 years and now 5 years. The Surgeon-General in reply seems to have said,

> "……that however much he might sympathise with them there were administrative difficulties which he could not overcome. The five-year licentiates agitated for a new diploma and led a deputation headed by Dr. Dinkar Rao to the previous Surgeon-General, who also consulted some of the older L. M. Ps. for their opinion. It was only on the strength of the representation of this deputation and the assurance that there would be no opposition by the older L. M. Ps. that the new diploma was conferred. There was no use discussing a settled and agreed fact."

Finally when one amongst the deputationists intervened and said that he was not aware so far of any older L. M. Ps. having been consulted, the Surgeon-General asked the deputationist if it was their wish to withdraw the new diploma in case the D. M. & S. Diploma could not be given to existing licentiates. The deputationists appealed to the sentiments of the Surgeon-General and did not attempt to get from him the nature of the administrative difficulties pointed out by him. All concerned would have been consoled to learn if the administrative difficulties which the Surgeon-General could not overcome, related to the conferring of equality of status between the D. M. & S. Diploma-holders and the medical graduates for the purpose of recruitment in the Civil Medical Department.

As mentioned above the resolutions passed by a large number of Medical Associations in the Province are now under the consideration of the Government and just at that stage the representatives of the All-India Medical Licentiates' Association were not well advised to approach the Surgeon-General when the appeals from several associations were under the consideration of the Government. The members of the legal profession would say that it was illegal to get an opinion in a case when the matter was before a judicial body which the Government are in this case, the matter being *sub-judice*. We are not aware if the deputationist brought this fact to the notice of the Surgeon-General. If they did, we are sure Major-General Stott who has a great regard for official constitution, would not have sat in judgment over an issue brought into existence by the Government and which affects the largest section of the practitioners now in the Madras Medical Register and which issue is before the consideration of the Government. The deputationists meant well in their hasty zeal and enthusiasm to rush to the Surgeon-General but unfortunately have given room for prejudicing the decision of the Government.

There is universal faith and admiration in India for British sense of justice. We have presented the case relating to the D. M. & S. Diploma to the kind consideration of the Government through these columns last February giving a brief history of the licentiates and why the L. M. P. Diploma does not convey the idea for which it was meant. We have

also said that the term Licentiate in Medicine and Surgery with the abbreviation L. M. & S. would have suited well to indicate the course of studies undergone by the medical licentiates by which name and not as Licentiated Medical Practitioner they are known in spite of the L. M. P. Diploma. We also said that as the Government were pleased to institute a new Diploma and as this Diploma correctly indicates the nature of course which the medical licentiates underwent, the Government might be magnanimous to give their order retrospective effect as they did several years ago when the L. M. P. Diploma was instituted by them. The new Diploma affects the harmonious growth of the medical profession in this province and the Government have nothing to lose by conferring it to all the medical licentiates; on the other hand, the Government will earn the gratitude of the entire medical profession, the representatives of which from the City as well as from the moffusil have appealed to the Government for giving retrospective effect.

The Tuberculosis Association of India: The Annual Meeting of the Tuberculosis Association of India was held at the Viceroy's House, New Delhi, on 25—3—'41 under the presidency of the Marchioness of Linlithgow, the President of the Association. At the outset she made a reference to the death of Sir Pendrill Jones who had been connected with the Papworth Institute from its very inception. Her Excellency then expressed her delight at the record of work turned out by the Association. She specially referred to the establishment of a Central Anti-tuberculosis Clinic in Delhi and to the decision of the Government of India to approve the scheme put forth by the Association to have a Sanatorium at Kasauli which would serve as a training centre for tuberculosis specialists. She appealed to all the provinces to give their liberal support to the Kasauli Scheme. She conveyed the glad news that the Bengal Branch of the Association was able to start a Sanatorium at Peshok in the Darjeeling district, the nucleus for financing having come from a rich donor and the Bengal Government had undertaken to build and equip the sanatorium. She congratulated the Bombay Branch which gave a liberal grant to the Salvation Army towards the cost of building a tuberculosis hospital at Anand. Before closing her address she brought to the notice of the Association the ignorance of a municipality in a well-known hill station where according to the report made to her by Dr. Frimodt-Mollar the municipality ran a clinic with the help of a doctor who got his training in tuberculosis work from a health-visitor who was not a qualified doctor and the same municipality employed a tuberculosis specialist in a hospital managed under it, who had only one month's training in tuberculosis. She appealed to all public bodies to be very careful in selecting a properly trained specialist to treat tuberculosis patients and in her opinion any specialist trained at a special hospital for less than six months was not suitable to be in charge of tuberculosis work.

Lt. General G. G. Jolly presented the annual report and gave an account of the developments of 12 Provincial branches of the Association and said that the Association was under a deep debt of gratitude to Lady Linlithgow the benefit of whose ripe experience and driving force the Association would have for one year more.

Sir Cameron Badenoch, the Hon. Treasurer gave an account of the financial position of the Association which was highly satisfactory.

After the elections to Committees of the Association Sir Sri Ram thanked Her Excellency Lady Linlithgow for her work in the cause of suffering humanity.

We join the members of the Association in not only appreciating the splendid work of Lady Linlithgow but for whose driving influence the anti-tuberculosis campaign in India would have been only in paper. She has not only been instrumental in starting several institutions for the treatment of the tuberculosis patients but has also made India self-sufficient to train specialists in tuberculosis and we should express the pride of the Madras Presidency which was the first province to institute T.D.D. course which was entirely due to the strenuous work in this direction by Major-General N. M. Wilson who throughout his regime as the Surgeon-General with the Government of Madras talked and dreamt of tuberculosis and worked hard to realise his dreams. Relating to the remarks of Her Excellency about the tuberculosis clinic and the tuberculosis specialist under a municipality in an important hill station, she would have done well if she mentioned the name of the hill station. It would have served as a more effective preventive measure, as usually, medical institutions under the local bodies are under the control of Provincial Governments who administer their control through the Head of the Medical Departments.

Strictures on Medical Certificates: We saw in the columns of our contemporary, The Mail, a report of the proceedings of the Annual Meeting of the Employers' Association of South India when Mr. H. S. Town, the Chairman of the Association while reviewing important questions relating to Labour and Employers mentioned about the proposed legislation of Sickness Insurance and made severe strictures against medical practitioners for granting medical certificates indiscriminately to the workers and The Mail while commenting on the proceedings of the Annual Meeting of the Employers' Association said,

> "Most of the larger employers deal generously with their employees in the matter of sickness and other leave, but as Mr. Town points out, the unreliability of medical certificates granted by certain unscrupulous practitioners makes impracticable any general system of medical insurance. He quoted cases where healthy men have been granted medical certificates, and in one case, the same man was given two certificates for different complaints, while still at work, hale and hearty. We have had a similar experience as a result of a similar test. Such practices should, as Mr. Town remarked, receive the very careful attention of the Government. More, they should come under the immediate consideration of the Medical Council, which should take action forthwith against the guilty. Mr. Town understands that it would be completely useless to make any attempt to take action against such doctors, but surely the Medical Council, anxious for reciprocity with countries where high standards of conduct are enforced, would be prepared to act. We should like to bear its views on this point"

Mr. Town referred that one of the employees working under one of the members of the Employers' Federation "was hale and hearty at work" yet could get two certificates from two different Licensed Medical Practitioners to the effect that the employee was suffering from dysentery. If it is the intention of Mr. Town to raise the professional honesty and integrity of the members of the medical profession in this Presidency, he should come forward and narrate in the columns of the Madras Mail the circumstances which compelled the Employer to send his employees to two licensed practitioners when, as mentioned by Mr. Town, the employee "was hale and hearty at work." It will appear to a casual reader who might have read Mr. Town's criticisms on medical certificates that the employer under reference wanted to test the honesty of two practitioners for which purpose he must have specially deputed an employee to go to the two practitioners and must have managed through this employee to tell the two doctors that the employee was suffering from dysentery and wanted a certificate. Usually when a patient goes to a practitioner and mentions about the name of a common disease such as dysentery, the practitioner does not feel the necessity of examining the patient and treats him for the complaint mentioned by the patient aud if the patient demands a certificate, grants it making mention of the same disease mentioned by the patient. In the particular case quoted by Mr. Town the same thing must have happened. If our presumption is corrrect, we cannot commend the ingenuity of the method employed to test the honesty of two practitioners. Mr. Town was not at all justified to make a general statement that it "would be completely useless to take action against these doctors" basing it on the questionable method employed to detect the honesty of the two practitioners which amounts to trapping of evidence.

We assure Mr. Town and other employers that the Madras Medical Council which is presided over by the Surgeon-General with the Government of Madras

is a statutory body which has powers more than those possessed by the Government in dealing with unscrupulous practitioners, private or Government paid, and the Council will deal with such practitioners and maintain the prestige of the noble profession irrespective of the suggestion made by the Editor of The Mail that the Medical Council, "anxious for reciprocity with countries where high standards of conduct are enforced would be prepared to act." Black sheep are found in every country, India including Madras Presidency is not wanting in the conception of high standards of character. Let the employers know if they do not know it already that the affairs of the medical profession are controlled by the Government and not by the profession as obtaining in other civilized countries and the Government and not the medical profession as such is responsible for what all they see and hear of the medical profession as all practitioners while they were students were taught everything within the walls of the Government buildings under the authority of the Government and by Government medical officers. The proper places for the practitioners to imbibe noble traits of character are the teaching institutions and the proper time is when the practitioners are students. Let not unscrupulous practitioners come in the way of the employers for instituting necessary legislation for sick insurance. The labourers in Madras seem to know the existence of the Madras Medical Council, though not its powers and functions. Recently a complaint was received by the Registrar, Madras Medical Council and the Surgeon-General with the Government of Madras, copies of which were communicated to the members of the Madras Medical Council, wherein allegations were made against the management of a mill in Madras for not looking after the sick labourers. It has been our lot to practise medicine in the labour area, in the Madras city and many cases did come to our notice where patients in the 2nd or 3rd week of typhoid fever and patients suffering from pneumonia and such serious diseases were asked to appear before the mill doctor for the purpose of getting sick leave and we had to certify their inability to go to the mill and did prevent many mishaps in a few instances by reporting the condition of the patients to the managers of the mill. In the same way the employers would do justice to themselves and also to their employees in case the former report to the Madras Medical Council the conduct of the practitioners who are unscrupulous in giving false certificates instead of making statements of the nature made by Mr. Town and bring the Indian Medical Profession and the Medical Council to disrepute on imaginary grounds.

T. D. D. Course: We learn, that in the notification published under the authority of the Surgeon General relating to the admission of the next batch of candidates for the T. D. D. Course, age restriction of 35 years has been mentioned. We cannot feel tired in reiterating that the medical profession is made to feel that it exists only for the Medical Department as such. The T. D. D. diploma is an administrative act of the Government of Madras so also the running of the course which is entrusted to Surgeon-General as everything else relating to the medical profession. Fortunately for the profession these few years the successive Surgeon-Generals have been showing their concern to the non-official medical profession as well and the new Surgeon-General did publicly declare his interest in the members of the independent medical profession and they cannot forget his statement that if the Surgeon-General did not protect them who else could do so. There is now an opportunity amongst many others for Major-General H. Stott to put his desire into action. He possesses the highest possible medical qualifications that could be aspired for in Great Britain some of which he must have obtained after his 35th year. He knows more than anybody else that in the British Isles and anywhere else no age restriction exists preventing any member of medical profession to aspire for any qualification —special or general. India is the only country in the British Empire, if not, in the whole world where caste, age and other varieties of restrictions exist all of which have been hampering the growth

of scientific medicine and we earnestly appeal to Major-General Stott to come to the aid of the medical profession in this unfortunate province where invidious distinctions of all sorts have come to stay. At the request of a large number of practitioners Dr. V. Rama Kamath, Member, Madras Medical Council, gave notice of a resolution at the March Session of the Madras Medical Council (which appeared in these columns last month) requesting the Government to do away with the age restriction for T. D. D. course and we learn that the resolution was unanimously passed by the Council. Major-General Stott is the President of the Medical Council. He has the unanimous support of the Council and we trust he will find his way as the chief adviser of the Government to throw open T. D. D. course to all qualified practitioners without age restriction.

I.M.S. & I.M.D. Expansion Schemes: As we were going to the press we heard that the Superintendents and Civil Surgeons of all Civil Hospitals in this and other provinces had been asked by the respective Governments to examine all the sub-Assistant Surgeons below the age of 50 working under them regarding their fitness or otherwise for Military service and read also in newspapers that the Government of India might summon a conference of the representatives of provincial medical departments and certain leading medical men in India to devise measures to stimulate recruitment.

In a way, war has been serving as a corrective and everybody in authority and power have now to reckon their past mistakes and till they are rectified war is not likely to come to an end. For reasons mentioned elsewhere in these columns while dealing with the same subject offering of the posts, Civil or Military, to the prospective Military candidates is not likely to improve matters. Money spent for conferences and propaganda to stimulate recruitment to Military Service will be a waste. The only way to popularise Military Service in a country which is not free, is to pay the temporary recruits substantially more than those in permanent Military Service.

The idea of the provincial Governments to send all the Sub-Assistant Surgeons serving under them below the age of 50 may not meet the situation as efficiently as it would if fresh recruits are entertained, not to mention about the dislocation of medical relief to civil population which will be in danger if India were to be the battlefield. Even otherwise on financial grounds it is not an economical proposition to recruit Civil Medical Subordinates nearing the age between 40 and 50 for Military Service. They will have to be paid their grade pay which will be above Rs. 150 a month on an average plus Rs. 50 military allowance. These careworn subordinates will be far below the level of efficiency of the young and energetic recruits between the ages of 25 and 35. If medical licentiates are offered the rank of Subedars, it is very likely that the required number of recruits will be available as and when wanted.

Statement of Receipts and Charges of the Madras Provincial Subsidized Rural Medical Practitioners' Association for the month of March 1941.

RECEIPTS.	Rs.	A.	P.	CHARGES.		Rs.	A.	P.
Cash balance as on 1-3-'41 ...	310	0	9	Postage ...		17	13	6
Subscription from members ...	105	4	0	Stationery ...		5	2	1
Subscription from members towards Provincial Conference.	19	0	0	Pay to Clerk for February 1941 ...		14	8	0
Entrance fee from a new member ...	0	4	0	Amount credited to The Medical Practitioner from subscriptions paid by members ...		42	0	0
						79	7	7
Postage recovered from members for sending the Circular No. R.M.P.M. 50/139 ...	0	12	0	Cash Balance:	Rs. A. P.			
				With Savings Bank	... 315 13 7			
				With Office	... 39 15 7			
						355	13	2
Total ...	435	4	9	Total ...		435	4	9

V. RAMA KAMATH, *President.* K. GOVINDAN, *Treasurer.*

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Original Articles

CLINICAL SIGNIFICANCE OF BIO-CHEMISTRY

By

DR. A. S. MANNADY NAYAR, M.B.B.S., Ph.D.,

Professor of Bio-chemistry, Madras Medical College.

This article and the following three are the continuation of a series of subjects of the discourses given by the Professors of Madras Medical College to the Subsidized Rural Medical Practitioners at the Madras Medical College where the rural practitioners met in conference from 14-4-1941 to 17-4-1941. The Conference was presided over by Dr. V. Rama Kamath, President, the Provincial Subsidized Rural Medical Practitioners' Association. The previous three lectures were published in the April issue of The Medical Practitioner.

On 16-4-'41 at 4-30 p.m. Dr. A. S. Mannady Nayar, Professor of Bio-chemistry, Madras Medical College, gave a discourse on, 'Clinical Significance of Bio-chemistry'. While introducing Dr. Mannady Nayar to the rural practitioners Dr. Kamath, the President, said that Dr. Nayar after qualifying himself for Ph.D. Degree of the Edinburgh University, was appointed as the first permanent Indian Professor of Bio-chemistry, Madras Medical College. Dr. Kamath observed that the role of Bio-chemistry in medicine had been recognised to such an extent that almost all diseases might be traced either to the deficiency or excess of some chemical salt or other and Dr. Nayar would tell the practitioners about the necessity of a general practitioner studying bio-chemistry to be able to diagnose and treat diseases on rational lines.

Dr. Mannady Nayar began his discourse explaining to the rural practitioners that both the physiological as well as pathological functions depended to a large extent upon chemical reactions and stressed the need of the study of bio-chemistry by all general practitioners. He then discussed about *the presence of sugar* in urine which he said did not always mean diabetes mellitus. There was a condition called renal glycosuria and in his opinion a good number of patients especially those from the west coast belonged to that category. He observed that in renal glycosuria the blood sugar was within normal limits 80 to 120 m.g.

per 100 c.c. of blood. He advocated Benedict's solution for testing the urine for sugar in preference to Fehling's as the latter was reduced by glycuronic acid, uric acid and creatinine. Dr. Nayar then talked about glucose tolerance test with the help of diagrams and case reports in his possession. While fasting, in a healthy individual the blood sugar ranged from 80 m.g. to 120 m.g. per 100 c.c. and when the patient was given 50 g of glucose, the sugar went up to 140 m g. or 160 in $\frac{3}{4}$ or one hour, and reached the normal level in 2 hours. Sugar was stored in the liver as glycogen and also in fact, the lecturer said that sugar was found everywhere in the body except in the brain. When the sugar was 160 m g. in 100 c c of blood, it stimulated internal secretion of the pancreas and combustion of sugar. No sugar was found usually in the urine when blood sugar did not go above 160 to 180 m.g. per 100 c.c. of blood. But the renal threshold varied with individuals. A person might safely take 100 to 200 g of sugar a day without causing glycosuria; but here again there were variations due to many other factors The lecturer then discussed about the influence of endocrine glands on the sugar metabolism. When thyroid gland was active, the sugar tolerance was decreased The anterior pituitary had an antagonistic effect on the cells of the islands of Langerhans in the pancreas and the over activity of the anterior lobe of the pituitary gland raised the blood sugar. Dr. Nayar with the help of case reports impressed on the practitioners the danger of treating cases of renal glycosuria as diabetes mellitus, for if these cases were put on diabetic diet and treated with insulin, the general condition of the patient deteriorated and he turned out to be an actual diabetic patient. Unnecessary starvation would bring about presence of acetone bodies in the urine. Nervous strain and less of physical work usually brought on diabetes mellitus. Chronic headache and fainting fits or giddiness four or five hours after food indicated blood sugar below 70 *i.e*, hypoglycaemia. Infection of the gall-bladder or any organic disease that interfered with the functions of the liver was likely to raise the blood sugar.

Indications of the presence of albumin in the urine was the next subject of the discourse. The lecturer observed that mere presence of albumin in the urine did not mean kidney disease. A person might have only $\frac{1}{4}$ of his kidney substance healthy and might be able to work and live without any trouble. The lecturer then mentioned about the tests to find out normal functions of the kidneys, their relative insufficiency and absolute insufficiency. For testing the normal function of the kidney there were two simple tests, one, the dilution test; the other, the concentration test. The patient was made to drink 1500 c.c. of water after first passing urine and kept in bed. He was asked to pass urine every half hour for the next 4 hours, each specimen being examined for volume and specific gravity. If the function of the kidneys was normal, the patient passed 1500 c. c. of urine or a little more within 4 hours and the specific gravity fell to 1002 or less. In the concentration test ordinary dry food was given to the patient but the amount of fluid was limited to 500 c. c. for 24 hours; urine was passed every two hours, specimens collected separately and tested for volume and specific gravity. The total urine passed for the day should not exceed 750 c. c. and the specific gravity should be at least 1026 or above. In cases of renal insufficiency the volume of urine in the dilution test would be much diminished and in the concentration test the volume and specific gravity will be more. The lecturer said that the test could not be satisfactory unless the patient co-operated with the doctor.

Dr. Nayar then explained *the technique of blood urea clearance* test to estimate the function of the kidneys. Bladder was emptied completely at a noted time and 300 c.c. of water was given by mouth and bladder was emptied again one hour and two hours after. One sample of blood was collected during the interval. Urea was estimated in the sample of blood and two urine specimens. Blood urea clearance was calculated by the formula $\frac{U}{B} \times \sqrt{V}$ or $\frac{U}{B} \times V$ according to the quantity of urine per hour was below

120 c.c. or over 120 c.c. respectively. The first was called Standard Clearance and the second Maximum Clearance. The average normal of Standard Clearance was 54 c c. and Maximum Clearance was 75 c.c. The clearance of a particular case was compared with those average Standards and the clearance percentage of those average Standards was then found. Normally the percentages would be above 75 per cent. If below 75 per cent, the kidneys were showing insufficiency. When the percentage went below 30%, accumulation of urea, non-protection nitrogen, etc., took place in the blood. When the percentage was below 20%, the kidney insufficiency was severe, and when below 50%, uraemia was imminent.

Analysis of stomach contents was the next subject dealt with by the lecturer. For this purpose the stomach should be first emptied. He showed the practitioners fine rubber tubing used these days for the purpose, which did not hurt the patient or cause any irritation as was the case when a stout rubber stomach tube was used. After emptying the stomach the patient was given oatmeal congy and stomach contents were examined every 1/4 hour for 2 hours. Presence of 40 to 60 c.c. of hydrochloric acid was normal. Above 60, it was abnormal and below 40 subnormal. Hyperacidity did not always mean gastric or duodenal ulcer.

The lecturer then mentioned how *blood calcium and phosphorus estimation* helped in the diagnosis of rickets which disease could be prevented by the administration of vitamin D. He then cited a case of polycythaemia vera in which administration of vitamin C improved the clinical condition of the patient remarkably and the effect of vitamin C on blood was being investigated.

Before closing his discourse Dr. Nayar suggested that the equipment of a modest Bio-chemistry Laboratory which would cost only Rs. 500 or thereabout was a necessary desideratum in the medical institutions in the villages where the rural practitioners cannot have the assistance of laboratory methods for diagnosis of diseases. He said that though the capital expenditure of Rs. 500 might look a bit large the illness could be prevented to an extent which, if not prevented, would cost several times more than Rs. 500.

Proceeding he observed that a training of about 3 months in the bio-chemistry laboratory attached to Medical Colleges would be ample to enable the village practitioners to have recourse to common bio-chemistry tests about which he talked to the Rural Practitioners.

Dr. Kamath thanked Dr. Mannady Nayar on behalf of the Association and said that the hall where the Conference met belonged to the Bio-chemistry Department, Madras Medical College and Dr. Nayar afforded all the facilities required for the holding of the Conference. Consequently the lecturer should be thanked doubly. It was very kind of Dr. Nayar, said Dr. Kamath, to have encouraged the rural practitioners to be self-sufficient even in regard to diagnosis and Dr. Kamath wished that the authorities over the Rural Medical Relief Scheme would note the suggestion of Dr. Nayar.

ACUTE ABDOMEN

By

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and
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On 16th April 1941 at 6 p.m. soon after Dr. A. S. Mannady Nayar finished his address on "Clinical Significance of Biochemistry", Dr. N. Mangesh Rao gave a discourse on "Acute Abdomen" and before he did so, he was introduced to the rural practitioners by Dr. Kamath who said that Dr. Mangesh Rao was a rising Surgeon and his talk on a most important surgical affection, would be very useful to the practitioners. Acute abdomen, observed Dr. Kamath, must be as common in the villages as in the towns and cities and the responsibilities of the rural practitioners were all the more as without the help of a consultant they should not only come to early diagnosis of acute abdomen but should be able to transport the patients suffering from acute abdomen to the nearest hospital for operative treatment and in a condition when operation was not risky or was not made risky for want of proper care and attention bestowed to the patients. Proceeding Dr. Kamath observed that the advice and guidance which the rural practitioners would have from an experienced Surgeon doing good work in one of the biggest general hospitals in the world would be of great help to them.

Dr. Mangesh Rao began his discourse by thanking the President of the P. S. R. M. Ps'. Association who gave him an opportunity of meeting the rural practitioners.

Dr. Mangesh Rao at the outset explained the necessity of early diagnosis of cases of acute abdomen as successful surgical treatment depended entirely as to how the cases were handled at the early stage. He observed that it should be the duty of every practitioner who had come across a case of acute abdomen to send the patient with a written history speedily to a nearest hospital where surgical aid was available. While taking the history, age was an important factor as certain affections had special proclivity for certain periods of life. After obtaining the history, the practitioner should make a thorough *inspection* of the patient and his attention should be directed to the patient's *respiration*. He would find in a case of acute abdomen, the breathing was of thoracic type, the abdomen being immobile. Distension of the abdomen was the next sign to be observed which would be rather difficult in a patient with a fatty abdomen. The next sign to be noted was visible peristalsis which would be marked in obstructions of the lower gut, ladder pattern in obstruction of lower part of small gut and festoon type in obstruction of lower part of large gut if the obstruction was chronic. If obstruction was acute and high up *i.e.*, in the small intestines, there was no ladder pattern peristalsis but there would be persistent vomiting. In a case of acute appendicitis the patient would draw up his begs and keep them flexed. If a patient suffered from simple colic, he would be seen rolling in his bed while in a case of acute abdomen, he would lie quiet and anxious. Proceeding Dr. Rao said that the next item of examination was palpation and examination of all external abdominal openings—the inguinal, the femoral, the gluteal, obturator, to find out if there was any strangulation. Then the practitioner should palpate the abdomen and find out the nature of rigidity whether it was reflex rigidity or board-like rigidity; the former was found in cases of inflammation of a viscus underneath the area palpated and the latter in cases of peritonitis or perforation. If a swelling was felt in the abdomen and if it moved with respiration, it was connected with viscera attached to the diaphragm *e. g.*, gall bladder, liver, spleen and kidney.

The lecturer then mentioned about the use of stethoscope on the abdomen. In simple obstruction lot of noise would be heard whereas in peritonitis no sounds could be heard. He then explained how a test-enema would be useful to confirm if the obstruction in the intestines was complete. The lecturer said that immediately after obstruction or strangulation of gut, the part below emptied itself by peristalsis below the obstruction or strangulation. In such a case if turpentine and soap enema was given, a little fæces or fæces coloured liquid might be passed but this was due to partial peristalsis below the gut which was obstructed or strangulated. Flatus would not be passed in these cases and if passed at the time the turpentine and soap water was given as an enema, it might be said that there was no obstruction or strangulation. The importance of rectal examination was then pointed out by the lecturer as by that means pelvic appendicitis could be diagnosed.

Dr. Rao warned practitioners against the practice of giving purgatives and laxatives in abdominal colics.

He also warned the practitioners against the use of morphia till the case was diagnosed definitely and if at all used, it should be during the stage of taking the patient to a neighbouring hospital, to relieve pain and shock of journey. The lecturer said that in all cases of acute abdomen no food should be given by mouth and the patient's strength should be maintained by rectal saline and glucose by drip method and that the patient should be kept in Fowler's position.

Dr. Mangesh Rao then recapitulated all conditions which gave rise to pain in the abdomen. He said that he was referring only to pain due to non-traumatic causes. He first mentioned about simple abdominal colic due to indigestion and then about biliary colic in which a mass was usually felt at the costal arch under 9th costal cartilage; there was also reflex pain in the right shoulder. Proceeding, the lecturer referred to renal colic which at times looked like the pain in acute abdomen attendant with vomiting but could be differentiated by the presence of dysuria which usually accompanied renal colic. At the same time he apprised the practitioners of a condition in acute abdomen which sometimes was diagnosed as renal colic while an inflamed appendix lay on the ureter. He reminded the practitioners of an important tip in these cases about which he mentioned in his talk at an earlier stage and that was that in all abdominal colics when the peritoneum was not involved, the patient would be seen rolling in his bed, whereas if there was peritonitis, the patient would be lying down quietly in his bed. The lecturer then told the practitioners, of abdominal colic especially in women due to recurrent hydro-nephrosis, and in those patients the practitioners could always elicit a history of repeated attacks of pain and passing of urine in large quantities and constant pain in lumbar area. He then talked about intestinal pain due to obstruction and strangulation. The obstruction might be high up and in the mid-bowel in which case vomiting was a very prominent symptom attendant with dehydration and the shock was very severe. The obstruction was usually in the upper part of jejunum—internal strangulation in the duodeno-jejunal fossa where there was a tendency for a kink. The lecturer said that when the obstruction was in midbowel, there was distension and vomiting but less shock. The obstruction might be due to chronic adhesions from previous inflammation or to tubercular ulcers. The obstruction could be made out by X-rays by finding gas and fluids levels in the gut. He then mentioned about hypertropic pylorus in infants which could be made out by visible peristalsis, projectile vomiting attendant with inanition. He advocated early operation in these cases.

Intussusception was the next subject of the discourse. These cases, the lecturer said, were usually met with in children whose diet was suddenly changed. These children would cry and look pale during attacks of colics when a sausage-like tumour might be palpable. Between the attacks they might be quiet. The stools might look healthy to begin with and later assumed the dysenteric type but there was no flatus passed. Examination by rectum was very useful in those cases for arriving at diagnosis.

The lecturer made the rural practitioners remember that in old people intestinal obstruction was usually of larger gut and in the young it was of the small gut. In regard to distension of the abdomen due to obstruction in the large gut, the lecturer said that in volvulus the distention was barrel shaped and if the obstruction was due to cancerous growths or other growths, it was festoon-shaped. Impaction of foreign bodies in the gut was mentioned by the lecturer as one of the causes of obstructions; a mass of round worms near the ilio-caecal valve was referred to as also one of the causes of obstruction; so also gall-stones in elderly women. Acute dilation of stomach and paralytic ilius were also mentioned as amongst the causes to produce distress in the abdomen.

Before closing his discourse the lecturer mentioned about the conditions in women which were likely to give rise to acute abdomen such as torsion of the fallopian tubes due to ovarian tumour, rupture of an ectopic gestation and torsion of subserous fibroid. In such cases, apart from other methods used for diagnosis a P. V. should be made and examination per rectum should also be made to find out whether there was fullness in Douglas's pouch or not.

Dr. Kamath thanked the lecturer on behalf of the Rural Medical Practitioners' Association and advised the practitioners to remember all the tips and points mentioned by the lecturer to diagnose cases of acute abdomen. As the success of operation in acute abdomen (as in all surgical diseases) depended upon early diagnosis, Dr. Kamath said that the general practitioners had a great part to play in surgery and yet it was rather a distressing feature that in these days the general practitioners were entirely forgotten both by the patients and the surgeons with the result, that the general practitioners showed little or no zeal in the treatment of surgical diseases. Whatever be the state of affairs in urban areas, in rural areas, the practitioners could ill afford not to know how to handle any disease much less in the domain of surgery, for, in case they failed to make an early diagnosis the popularity of surgeons was at stake. So in the individual's interest, if not, in the interest of the profession, specialists of the eminence of Dr. Mangesh Rao should come forward to teach the rural practitioners what they, the specialists, knew and it was really a very good augury, observed Dr. Kamath, that a large number of professors of the Madras Medical College were kind enough to show their concern towards the Rural Practitioners and Dr. Kamath hoped that it should not be difficult for the Teaching Institutions to be always open to all Practitioners alike in the near future.

NOTICE.

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

SOME ASPECTS OF ENDOCRINES

BY

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and

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On 17th April 1941 at 4 P. M. Dr. K. Venkatachalam addressed the Rural Medical Practitioners on "Some Aspects of Endocrines." The lecturer was introduced to the practitioners by Dr. Kamath and while doing so, Dr. Kamath said that he was a quiet research worker, who had his training under Brevet-Col. R. N. Chopra. Dr. Venkatachalam had been conducting research, being connected with Pharmacological Department of the Madras Medical College. He was making a special study of endocrinology, a subject in which the general practitioners should take lively interest, for, with the proper knowledge of this subject a practitioner should grow a very useful physician and at the same time would be in a position to prevent abdominal operations especially relating to gynaecology. Dr. Kamath observed that endocrinologists all over the world had been making rapid strides especially relating to the organs of female generative system. Dr. Kamath stressed the need of introducing the study of endocrinology as one of the subjects in the medical colleges. Dr. Venkatachallam was silently working in that direction and the rural practitioners would be highly benefited by hearing attentively the discourse on "Some Aspects of Endocrines".

Dr. Venkatachalam said, "The prerequisites, that are essential for ensuring for the organism the capacity to react favourably to its surroundings (*i.e.*, the well-being of the tissue) and thus sustain itself and help the continuity of the species which after all is the aim of the organism, are:—

(*i*) Efficient transformation and assimilation of ingested food-stuffs into materials essential for the building up of protoplasm, (*ii*) storing of excess of assimilated material for growth and energy purposes as and when needed, (*iii*) transportation of nutrient materials to different parts of the body in proportion varying in quantity and quality as the demands of the various parts of the organism vary from time to time, (*iv*) a contrivance for burning up and elimination of the waste products of the body and (*v*) the availability of a method which will help in the release of energy from stored up materials quick enough to meet emergent situation.

Without capacity to react favourably to its surroundiags the organism, deteriorates in quality and thus far, is incapacitated in propagating the species in its original form; if the incapacity exceeds a limit, death occurs. For, death itself is defined as absolute incapacity of a tissue to react to its surroundings.

The various factors mentioned as essential for the well-being of the tissue may be grouped into:—

(*a*) an assimilatory system and (*b*) a dissimilatory system. The assimilatory system deals mainly with the various processes involved in the abstraction of the essential ingredients necessary for the well-being of the organism from the food-stuffs ingested and storing of extra quantities thus abstracted for purposes of energy-release in times of emergency.

The dissimilatory system on the other hand, is chiefly concerned with the spending of energy and material that has been abstracted and stored. It is common knowledge that, when a man with very good appetite is partaking of savoury dishes, if his mental composure is disturbed by a sudden cry in the street due to a nasty car accident resulting in the death of an individual, his appetite disappears and in extreme cases the disgust produced

by the accident may even make him sick. The disappearance of his appetite and the sequelae are due to the sudden mental strain he was subjected to. It is known that mental strain, worry, anxiety, fear and anger help dissimilatory processes which put a stop to assimilatory processes. Thus it is clear that dissimilatory processes are antagonistic in nature to assimilatory processes. One can neither assimilate nor store essentials of life when he is worried or anxious. It is said in New York that "when the stocks go down, Diabetes goes up". Diabetes is a disease where storage of glycogen becomes impossible and glycogen gets released into the circulation as glucose and eliminated through the kidneys without being utilised by the tissues. When one is free from anxiety and nervous strain, his assimilation and storage of nourishment becomes more satisfactory. That is why it is said "When you sleep, you dine". To make individuals free from the strain associated with their avocations in life, it has been providentially arranged that the processes concerned with storage and discharge of energy are entrusted to a physiological system which is free from volition and knowledge and known as the involuntary nervous system. This system appears to possess an uncanny discriminating capacity to determine the requirements of the various parts of the organism at different times and to make adequate adjustments. Thus it is said to be charged with:—(*i*) the duty of the efficient circulation of the chemicals needed by the tissues in quantities and qualities as circumstances require, (*ii*) controlling the capacity of the bronchial tree to take in air for oxydising the waste products of metabolism, (*iii*) the determination of the amount of blood which the digestive organs will require when active assimilation is going on and the extent to which the blood must be depleted from the great blood-lakes, (the splanchnics, the liver, the spleen etc.,) and carried to parts of the body which require more blood, (*iv*) helping the individual to overcome an emergent situation and to prevent his bleeding from the blood lakes, if by chance he should get wounded in meeting the emergencies, (*v*) regulation of the amount of evaporation that must take place from the biggest organ of the body, the skin, to help the maintenance of the temperature at the desired level and (*vi*) many more duties of this nature essential for efficient survival. This important system, though involuntary, is very often affected detrimentally by the strains of life that individuals are subjected to in modern life. As a general rule, the pancreas, the para-thyroids, the supra-renal cortex and the gonads which work in association with assimilation and storage processes become less active whereas the anterior pituitary, supra-renal medulla and the thyroids concerned with the release of stored up energy become overactive with the result that high blood-pressure and diabetes have become more the rule than the exception in the individuals who earn their livelihood more by their brains than by their biceps.

And yet the glands of the dissimilatory group need not be considered as ones of an undesirable nature. They also have their very useful functions to perform. The thyroid, actually determines how much of oxygen the tissues should utilise and a few milligrammes of thyroid secretion may be all that stands between an individual and his sanity. The supra-renals determine whether you are going to win or lose in a bad struggle either with a foe or an infection. The anterior pituitary decides, besides controlling the other endocrines, whether the structure of your body is to be tall and well-formed to be capable of putting up a fight, or short and ill-formed destined to lose in a fight. The posterior pituitary is the gland that keeps up the tone of all the involuntary muscles and is the one responsible for one's periodic habits of sleep and wakefulness and for inducing at regular intervals menses in women and contraction of the uterus when child-birth is due. Recently, Sir Henry Dale has proved definitely that almost all the glands of the internal secretion bring about their respective effects by inducing chemical changes in the system. This is proved beyond doubt in the case of the involuntary nervous system with which are associated the various glands previously mentioned. As the glands of the internal secretion change the chemistry of the blood, chemical substances and food-materials are expected to change the chemistry of the glands of internal secretion.

Inorganic iodine has been known to affect thyroid secretion. Vitamins A. B. C. & D. are considered to act through their influence on the supra-renal cortex which is said to be "The gland of energy and the life gland of the body". Vitamin E is said to act through the anterior pituitary which is not only the master gland of the endocrine system but also is the body-builder and along with thyroid, gonad and the supra-renal cortex, provides nourishment for the maintenance of the intellectual calibre of the individual.

Health depends on the integrity of the glands of internal secretion; susceptibility or otherwise to a disease depends on the incompetence or otherwise of the endocrines of the individual to withstand infection; victory or defeat in a fight and recovery or death in an infection depends on the capacity of and the promptness with which the endocrines can release energy to meet the situation. Even our intellectual ability seems to be nourished and sustained by endocrines.

From the above it is clear that the endocrines form the basic system determining the health and disease of individuals. Our present knowledge on the endocrines are only fragmentary and even this fragmentary knowledge has given us a fair insight into the subject. So, it is needless to say that further elaborate study of the subject is needed to derive all the benefits that could be achieved through the endocrines."

The lecture was closed with a summary of the various changes occurring in the female generative system during pre-menstrual, menstrual, post-menstrual and mid-menstrual periods and the lecturer could not go into the details of the secretion and action of all the endocrine glands for want of time.

LOCAL AND SPINAL ANÆSTHESIA

BY

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and

Anæsthetist, Government General Hospital, Madras.

On 17th April 1941 at 5 p.m., Dr. P. V. Francis gave a talk to the rural practitioners on "Local and Spinal Anaesthesia". Dr. Kamath introduced the learned lecturer to the audience and while doing so, said that the rural practitioners were very lucky indeed to have the benefit of hearing Dr. Francis who was an ideal anaesthetist not only on account of his professional attainments but also by his temperament. Dr. Kamath observed that Dr. Francis was always composed and never got puzzled to meet any situation. The success of operation depended to a very great extent on the anaesthetist so also the popularity of surgery for, it was on the anaesthetist as well as the surgeon the life of the patient wholly depended.

Dr. Francis before beginning his discourse expressed his pleasure to be in the midst of practitioners doing good service in the villages. As almost all the operations in surgery could be done by local and spinal anaesthesia and as the rural practitioner could not afford to have another doctor in the same village to administer chloroform, he would tell them something about local anaesthesia including regional anaesthesia and low spinal anaesthesia. Dr. Francis said that he would not advise the rural practitioners to have recourse to high spinal anaesthesia as at times it led to dangerous consequences.

The lecturer advised the practitioners to keep the patients to be operated upon in a semi stupor condition even in case of local or spinal anaesthesia as the patient was not likely to be frightened with his new surroundings during the operation. Morphia or omnopon might be given for the purpose hyodermically; Any preparations belonging to barbituric group or potassium bromide might also be given. Mere skin infiltration was not enough if the area to be operated upon was below the skin and over touching deeper tissues. In the latter case he advised injection of the nerve trunk which supplies smaller branches to the part to be operated or deep into the area surrounding the nerve trunk. The drug of choice for local anaesthesia was novocaine but as this was a German preparation and not easily available due to war conditions, names of other preparations more or less of the same chemical composition and of equal efficiency were mentioned by the lecturer which were available in the market. The lecturer gave out their names—ethocaine, planocaine, procaine, scurocaine, neocaine, syncaine and kerocaine.

The drug used for infiltration anaesthesia should not be toxic if absorbed and novocaine or equivalent preparations could be safely used up to 1 gram at a time which was contained in 100 c.c. of 1% solution or 200 c c. of 1/2% solution. For regional anaesthesia 2% solution must be used and the total quantity used should not exceed 50 c.c. The lecturer advocated mixing of 4 drops of solution adrenaline (1 in 1000) to an ounce of novocaine solution just before it was used, as adrenaline prevented spreading of the solution to a larger area to be operated upon by constricting the capillary blood vessels and controls also bleeding to some extent. It also prolonged the duration of anaesthesia.

The lecturer observed that those who wished to have recourse to local and regional anaesthesia should have good knowledge of neurology.

He warned the practitioners against accidents usually due to sending the novocaine solution into a vein. If the novocaine solution got into a vein, the patient became pale and unconscious showing signs and symptoms of heart or respiratory failure. There was also danger if more than 1 gram of novocaine was used. The treatment advised for novocaine poisoning was as that employed for cardiac or respiratory failure.

One of the practitioners requested the lecturer to let him know the procedure adopted for doing abdominal operations with the help of local anæsthesia. The lecturer answered by saying that both the recti muscles should first be infiltrated and when the peritoneum was reached, an area which should be 3 inches more all round than the area to be occupied by the operation should be infiltrated; then 100 c.c. of pantocaine solution 1 in 1,500 should be thrown into the peritoneal cavity which after a five minutes time should be mopped off. He also advised his hearers that at least 5 to 7 minutes should elapse after infiltration before the operation was actually started. He also advised the practitioner not to have recourse to local anæsthesia in septic cases as there was danger of spreading the septic infection. He added that local anæsthesia should not be used in cases of children.

The lecturer next addressed the practitioners about spinal anæsthesia and told them once again that they should not attempt to have recourse to high spinal anæsthesia. He said that for spinal anæsthesia the spinal canal must be reached between 2nd and 3rd lumbar vertebrae or between 3rd and 4th. At the 2nd sacral vertebra the dural sac ended. The nerve roots supplying upper abdominal structures were at the 5th dorsal vertebra, and those supplying the appendicular area were at 9th dorsal. Those supplying the inguinal and scrotal area were at the 12th dorsal. A solution introduced into the lumbar area could be made to reach all these areas by adjusting the position of the patient. The lecturer then described the technique for the spinal anæsthesia. He said the strength of novocaine in the solution was 7½%; in glucose solution 5%. Glucose was added to give the solution a certain amount of viscosity. The lecturer advised the practitioners to take care that the injected fluid was in the theca. As there was generally a fall of blood pressure as a result of spinal anæsthesia, ephedrine should be given before the spine was punctured. In cases of local spinal disease, spinal anæsthesia should be avoided and also in case of children. The dose of the novocaine solution ranged from 1 c c. to 2 c.c. and the solution should be diluted with cerebro-spinal fluid before the same was injected. He stressed the need to be scrupulously careful relating to asepsis, in spinal anæsthesia as infection in the spinal canal might bring on meningitis. He also said that spinal fluid that got back into the injecting syringe should not be blood-stained. Before closing the discourse Dr. Francis briefly referred to *evipan sodium anæsthesia*. He said that the dose of the drug should not exceed 1 gram *i.e.*, 15 grs. in 10 c. c. of water and the injection should be done slowly at a rate not less than 15 seconds for injecting 1 c.c. The total solution injected at a time should not be over 5 c.c. Later if deep anæsthesia was indicated, another 5 c. c. might be given. If anæsthesia was required after giving this maximum dose, recourse should be had to general anæsthesia. The lecturer observed that under evipan anæsthesia there was always a tendency for the drooping-down of the lower jaw and for shallow respiration. Therefore the lecturer advised the practitioner to support the jaw of the patient while under anæsthesia and also to watch the respiration. He warned the practitioners not to use morphia for patients before or after the injection of evipan anæsthesia as it would depress the respiration.

Dr. Kamath thanked Dr. Francis for having spared his precious time to address the rural practitioners that evening. He advised the practitioners to remember more the dangers of anæsthesia of whatever variety and not so much the benefits. For, any untoward happening in the course of anæsthesia would bring them discredit which could not be counterbalanced by all the good actions of the practitioners towards their patients.

With this lecture, the Scientific section of the IX Annual Conference of the Provincial Subsidized Rural Medical Practitioners' Association was closed.

Abstracts.

RURAL MEDICAL RELIEF.

By

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Lieutenant-General, I.M.S., Director-General, Indian Medical Service.

This article is the substance of the opening address at the Women's Medical Conference held in New Delhi on the 16th December, 1940.

The subject on which I have been asked to address you is 'Rural Medical Relief.' The title sets one reflecting on the scope of the subject. India is predominantly rural; about 90 per cent of her population live in villages and the problem of medical relief to some 350 millions of rural dwellers out of India's total population of 400 millions is essentially the problem of medical relief in India as a whole.

The tahsil headquarters hospital, though usually built in a town, is intended to serve the tahsil; the district headquarters hospital, sited as it is in an urban area, nevertheless serves the rural population more than it does the urban, while the large central teaching hospitals of a province which are located in the great cities, far from being restricted to urban residents, cater extensively for rural dwellers who are attracted by the fame of the hospital and its specialists or referred thereto by practitioners in the rural areas. The proportion of rural to urban patients admitted to the Irwin Hospital, New Delhi, is 3 rural to 2 urban. In the Mayo Hospital, Lahore, the percentage of cases from the rural areas is 66.

I would stress this point because there is sometimes a tendency to split medical relief into urban and rural as if they were entirely separate systems, and it is necessary to realise that this is both illogical and impracticable unless economic laws are to be disregarded and an unduly costly and cumbersome system established. Medical relief to any given population requires to be organised in a chain, or rather a series of chains, whose links are located in the various centres of population, large and small, urban and rural, one end of each chain being the general practitioner, the unit, whether in village or town, in immediate contact with the family, while the other end terminates in the central hospital with its exceptional facilities for diagnosis and treatment and its team of specialists.

It is therefore with a realization that the whole range of medical relief in a sub-continent is included in the title of my address that I approach the subject this morning. At the same time, I assume that I am expected to emphasize those aspects of medical relief that are of especial value to the rural dweller and in particular to deal with medical relief agencies sited in the rural areas themselves which comprise the village practitioners and the smaller dispensaries.

There is a dangerous tendency in India to take what appear to be short cuts in medical health work, and to attempt to build from above downwards instead of from below up. These propensities are illustrated by vain endeavours to dispense with the costly foundations of environmental hygiene, such as good water supplies and waste disposal system, and to engage expensive inspecting officers before the rank and file exist for them to inspect.

In the case of medical relief the tendency has been to provide elaborate institutions and specialists at the large centres, contrasting with the most primitive arrangements and practitioners in the villages. The reasons for this are understandable. They are: the small number of qualified medical men, the natural disinclination of these to

settle in the villages where life is rough, and material reward scanty, and the insistent demand in the towns for better and yet better facilities for medical treatment, supported by the attraction of good fees. Possibly the development that has taken place was inevitable; perhaps it is necessary to fill the towns with medical men before they can overflow to the villages—I don't know.

Of this however I am certain; a sound system as a rural medical relief can only be built upon the foundation of an adequate number of medical practitioners settled in the rural areas. There is no short cut to success here; provincial, district, tahsil hospitals, however well developed, cannot take the place of the general practitioner. Even rural dispensaries, lavishly distributed as they are in the Punjab, cannot play the part that can only be filled by general practitioners. There is indeed no alternative to the general practitioners' service in the rural areas, whether it is developed as a State service, on a private basis or on the subsidized system. All my experience in the public health and medical services of India has but served to drive home this truth.

In the well-organised village of the future the rural medical practitioner will be able to make a comfortable home and to achieve a reasonable standard of living. Life in the village of the present day however, except in a few favoured spots, is pretty grim and the necessary monetary compensation to lure the young doctor away from the amenities of town life is seldom forthcoming unaided. This is why a number of provinces have tried a system of subsidies with notable success in Madras where there are some 500 subsidized practitioners settled in the rural areas. In the Punjab I devised a modification of the subsidized practitioner system linked with the co operative movement. Wherever a co-operative society existed, its members, by paying an extra few annas a month, subject to a total minimum collection of Rs. 50 per mensem, could obtain free medical attendance from a doctor approved by the society, whose remuneration and costs were met in part by the society from these ad hoc subscriptions and partly by a subsidy from Government. The subsidy is given for specific functions to be performed by the practitioner, including attendance on 'entitled' government servants and medical relief to genuine paupers. Additional duties imposed on the subsidized practitioner would, under this system, be paid for separately. These in the future might include school medical work, vaccination and inoculation and the reporting of vital statistics and epidemic diseases. Such duties should not be imposed at the outset of the scheme or they may easily wreck it. There is a real danger of the 'jack of all trades' who is 'master of none'. Success or failure will depend upon whether the practitioner is a good family doctor inspiring confidence in his diagnosis and treatment and not upon his capability as a sanitary inspector. Duties other than medical relief should not therefore be given in the first instance, or until the practitioner has won for himself a position of trust. On the co-operative medical benefit society side the doctor appointed would be their servant subject to their reasonable rules, and his emoluments would in considerable measure depend upon his popularity with actual and potential society members, since the more people subscribed the higher would be his remuneration.

This system enables government to 'place' medical practitioners in the rural areas at the small cost of Rs. 600 each per annum; it brings modern medical relief within reach of the villagers at a cost that is not beyond their means, and it guarantees a doctor, settling in a large village or village group, a minimum income of Rs. 100/- per mensem to cover his living and professional expenses, an income on which he will not starve and which, if he makes good in his area, he should have little difficulty in doubling before long. It will be appreciated that four annas a month paid by 400 householders with an average family of five gives the doctor a 'panel' of 2,000 and an income over and above his government subsidy of Rs. 100 per month and what he may get in fees from well-to-do persons

outside the co-operative society. Naturally the 'medical' benefits received from this small contribution cannot be great but what is needed is a beginning that is financially possible for government, villagers and doctors, that establishes the principle of payment for services received and that holds out prospects of development into an eventual state-aided and controlled system of medical insurance, beneficial to public and practitioner alike.

This scheme, which I have only outlined here, is on trial in the Punjab and its progress is being watched with great interest. If it succeeds, the problem of medical relief in the rural areas of India is in my opinion solved. If it fails, the failure will put the clock back and be a serious reverse for modern scientific medicine in this country. I am convinced that it can succeed. Modifications and adjustments may require to be made to meet local conditions, but the principles on which the scheme is based I believe to be fundamentally and entirely sound.

I come now to the rural dispensary, by which I mean a small permanent self-contained building arranged as an out-patient clinic with, usually a few beds for emergency cases. Besides the doctor, there are generally a compounder and about two menials, all of whom are housed on the premises. The dispensary costs from Rs 5,000 to Rs. 10,000 to construct and usually about Rs. 2,500 per annum to maintain. Upon such a rudimentary medical institution, in rural areas devoid of private practitioners from 30,000 to several hundred thousand persons may have to depend for medical relief by modern methods.

Clearly the rural dispensary doctor is an unsatisfactory terminal link to the chain of rural medical relief. Where there is nothing beyond him one would expect him to be completely overwhelmed by demands for urgent casualty treatment alone. Any suggestion that he should take on public health work in addition to medical relief appears merely ludicrous. To demand from him preventive work in an epidemic seems to necessitate a breach of humanity in the neglect of the sick and helpless for the sake of the healthy.

This is all true in a measure. Where, under such circumstances, a dispensary doctor is efficient, upright, impartial and disinterested, four qualities not easy to obtain together in the conditions of rural dispensary work, he quickly achieves renown and becomes a medical pilgrimage centre famed throughout the district and embarrassed by his popularity. What more often happens is that, if he is reasonably efficient, the villagers nearest his dispensary monopolize his services to the exclusion of the more distant who are obliged to rely upon the vaid and hakim. If, on the other hand, the rural dispensary doctor is below average in efficiency, the chances are that he will become discouraged by the hopelessness of his task, turn lazy, seldom stir from the village in which his dispensary is situated and join the ranks of those public servants who do as little as possible for their pay. This is the explanation of the paradox that in the midst of dire necessity the dispensary sometimes stands half empty. The fault lies with the system rather than with the individual.

What then is the correct role of the rural dispensary in the chain of medical relief? I submit that it is to help in the settling of general practitioners in the rural areas and, when they are so established, to act as a 'cottage hospital', serving the area and collaborating with the practitioners in its vicinity. It should in fact be the link between the general practitioners in contact with the families and the district hospitals. With this conception of its role in mind it becomes clear that this institution should not be saddled with public health duties. As already noted the general practitioners settled in the villages will in time take on a good deal of this work, but it would be wrong for the rural dispensary doctor to do so. If he is functioning well, he certainly has no time for anything but medical relief. Moreover his assumption of public health duties may postpone the taking up of this work by general practitioners and will certainly delay the development of his dispensary into a cottage hospital. His functions should be clinical and, as soon as there is a sufficient group of general practitioners settled in his vicinity, he should get busy developing the indoor side of his hospital. The rural dispensary, re-oriented as a cottage hospital serving a village group, will as in other countries, act as a hospital depot, or, to use an apt military term, as a casualty clearing station, taking such cases from general practitioners as cannot be treated at home and passing on to the large hospitals those who require special facilities for diagnosis or treatment.

It remains to elaborate the statement, that the rural dipensary should help in the settling of general practitioners in villages. In the Punjab, collateral with the subsidized practitioner scheme there has been developed a system by which the rural dispensary doctor pays regular weekly visits to two or three key villages suitable for the establishment of subsidized practitioners. He holds an out-door clinic there and sees such serious sick cases as time permits in their homes. When he has worked up a connection and the villagers have begun to appreciate his visits, he suggests that they form a medical benefit society, subscribe the minimum Rs. 50 a month qualifying for the Government subsidy, and obtain a resident subsidised practitioner. It is hoped in this way to build up around each rural dispensary a small group of subsidized practitioners in touch with and feeding it just as the dispensary, developed into a cottage hospital, will itself feed the larger hospitals.

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THE SCHOOL OF INDIAN MEDICINE.

We are glad that the Madras Government were pleased to publish the report of the Committee appointed by them a year ago to suggest whether the curriculum of studies, methods of teaching and examination followed in the school of Indian Medicine should be improved or altered. The Committee have recommended the continuance of the existing curriculum with a few changes. The Committee before making their recommendations reviewed the events that led to the origin and working of the school. It is mentioned in the report that towards the end of 1921 the Government of Madras (with the Rajah of Panagal as Chief Minister) appointed a committee under the Chairmanship of Mr. (now Sir) Mahomed Usman to report on the question of the recognition of the Indian Systems of Medicine in vogue in this Presidency.

The old Usman Committee expressed their view that, "*every scheme of study of Indian Medicine whether Ayurveda, Siddha or Unani should make adequate provision for the teaching of essentials of whatever is valuable in the Western Medicine.*" Accepting the recommendation of the Committee, the Government established the School of Indian Medicine in 1925 "*to give such instruction to its students as would enable them to become practitioners of Indian Systems of Medicine with a good working knowledge of the Western System*". The Secretary of the old Usman Committee was made the Principal of the School and continues as such.

The new committee appointed by the present Government was presided over by Sir Mohamed Usman and this committee did not find it necessary to examine anybody else excepting the Principal of the school. It is said in the report that Dr. Srinivasamurthi pleaded before the committee "for the raising of the general educational qualification of the students from the S.S.L.C. to the Intermediate standard and consequently for converting the school into a college". The committee observe in their report that, "it has been the practice to admit into the school students who have not completed the S. S. L. C. course with the result that such students find it difficult to follow the subjects of Western Medicine which are taught in English". They also found that Ayurveda was taught in Tamil and Telugu and the knowledge of the students in Tamil was too low for them to understand Siddha

system which was written in advanced Tamil '*Slokas*'. It is also hinted that the students in the Unani System had not good knowledge of Urdu in which language the original books on Unani System have been translated from the Arabic language. As the authoritative texts in Ayurveda, Siddha and Unani Systems are in Sanskrit, Tamil and Urdu respectively, the committee opined that the practitioners of these three systems could not be competent to study the Indian Systems nor could they be efficient in their profession. The committee have the authority of the Principal and the four lecturers who have been teaching the three Systems of Indian Medicine in the School for basing their opinion relating to the languages in which the subjects are to be taught in the school. It is now evident that the practitioners that passed out of the school from 1925 could not have working knowledge of the Indian Systems much less of the Western System.

Though the committee did produce indisputable evidence relating to the incompetence of the students to study the Indian and Western Systems of Medicine they did not take the trouble to point out to the Government whether it was justifiable to run a school by the Government with features of heterogeneity savouring hybridism. It cannot be said that the members of the committee could not conceive the dangers of a hybrid. It looks as if they were overcautious not to overstep the conditions of the terms of reference: Or is it a compromise for the safety of the school? Science is an uncompromising mistress and has to be respected as such for the welfare of the public. She cannot talk but she acts and what is not approved by her, if acted upon, will be to the detriment of the public. So others who have to speak for science, cannot mince matters but should strengthen the hands of the Government to rid things which are unscientific. In this spirit we shall point out the errors in the findings of the new Usman Committee.

Having pointed out the necessity of sufficient knowledge in Sanskrit, Tamil and Urdu for the study of the three Indigenous Systems of Medicine, the committee should have pointed out to the Government whether the Indigenous Systems and the Western System of Medicine could be taught in the school within a period of 4 years even taking for granted that the Indigenous Systems could be made a nucleus around which the Western Scientific Medicine is to be made to stand for satisfying the qualms of ultra patriotism. Where is the need and justification for the public to be treated by the practitioners of the school of Indian Medicine for surgical diseases, for obstetric emergencies, for diseases of Eye, Ear, Nose and Throat with imperfect knowledge of physiology. anatomy and pathology and little or no knowledge in prescientific subjects such as physics, chemistry and biochemistry etc., when the Government have established well-equipped hospitals within the city and in the moffusil staffed by officers who have undergone 5 years course of medical studies and who possess additional high qualifications in special subjects? Even in private practice, is there a dearth of well-qualified doctors to justify the training of practitioners on unscientific lines? The new Usman Committee have approved the findings of the old Usman Committee and have conceded that the Indigenous systems themselves are inadequate to meet the demands of medical relief to the public and the essentials of whatever valuable in the Western Medicine should also to be taught to the students of Indigenous Systems. The Government have now to decide which of the two courses

would be rational, the one suggested by the new Usman Committee to impart knowledge to the students of the school in Indigenous and Western Systems within 4 years or to run the school of Indian Medicine as a training centre to the qualified practitioners of Scientific system of medicine who after a course of studies for over 5 years will be in a position to pick out of Indigenous Systems, the essentials after scientific tests. In this connection we would quote the statement made by Acharya P. C Ray when he made a speech on the Founder's day of the Calcutta Medical College on 20 2 40. Acharya Ray said amongst other things:—

"We must now look forward and judge where we stand in the present world, which is based on scientific civilisation. Although I have referred to Ayurveda, 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."

Before closing we wish to inform the Government if they do not know it themselves that the School of Indian Medicine far from serving as a centre for encouraging the Indigenous systems is now an asylum for the incomplete S. S. L C. students who for want of any employment are naturally rushing into this Government institution. Some of the alumni of the School after the publication of the Government Order on the last administration report of the school and the report of the new Usman Committee are conducting a campaign of vilification against the Government and all those who criticise the working of the school. They are adopting the methods of the politicians and a few of them from the city are touring from place to place being naturally bewildered that the disinterested public are now in a position to understand and justify the remark of the Government that it was doubtful whether the designation 'Indian Medical School' now gives a correct impression of the nature of the Institution. We are sure that the present non-political Government would not be carried away by the statements made by a few alumni of the School of Indian Medicine and endorsed by a prominent nationalistic lay newspaper that the practitioners who have passed from the school are very popular especially in the villages. It will be correct to say that some of L.I.Ms. are a menace to public safety in the villages. They dabble with the practice of Allopathic system and make it appear to the credulous villagers that they are far superior to the practitioners of Western system of medicine as they were taught both systems whereas the former know only one system which the L.I.Ms. style as *alien*—this word is used to arouse false ideas of patriotism in the villagers. Apart from anything else, the Government should consider the waste of public funds in running parallel institutions, whether it be in the city or in the villages where patients are treated by having recourse to Allopathic system of medicine, one class of institution under the real name while the other under the pseudo name of Indigenous Systems. The Government know that the cost of medicines now supplied to the Institutions of Indian Medicine is as much as of those supplied in pucca Allopathic institutions. While calculating the cost the Government would do well to make allowance for the waste of drugs and medicine by those who cannot have a working knowledge of both the Indian and Western Systems of medicines as proved by the findings of the new Usman Committee.

News and Comments.

Lt-General Jolly and R. M. Ps: The March 1941 number of Indian Medical Gazette contains an article by Lt-General G. G. Jolly, Director General, Indian Medical Service. This is a substance of the opening address delivered at Women's Medical Conference, held in New Delhi on 16th Dec. 1940. We are most happy that General Jolly, the chief Adviser to the Government of India shares with many of the ideas expressed in The Medical Practitioner relating to the role of the general practitioners both in the urban as well as in rural areas. What impresses us the most is the conception of General Jolly for establishing cottage hospitals in the villages to serve as a link connecting village practice to the city medical teaching institutions; a prologue to this scene was enacted by the Madras Provincial Rural Medical Practitioners' Association at the Madras Medical College last month and it is hoped that in the near future the Association of the rural practitioners of the Madras Presidency, will stage the actual drama which General Jolly has in view by starting cottage hospitals in the villages about which the Executive of the Association have been contemplating for over two years. It is hoped that the Madras Government to whom we shall submit a copy of General Jolly's article will consider the necessity of encouraging the Rural Practitioners' Association to establish cottage hospitals in convenient centres in the villages to serve as a connecting link to the Head Quarters Hospitals.

We wish the local Government will be pleased to peruse the remarks of General Jolly in regard to the part to be played by Subsidized Rural Medical Practitioners relating to official Public Health measures. General Jolly observes that any suggestion that the rural practitioner *"should take on public health work in addition to medical relief appears merely ludicrous. To demand from him preventive work in an epidemic seems to necessitate a breach of humanity in the neglect of the sick and helpless for the sake* of the health. In the opinion of General Jolly, the success or failure of rural medical relief scheme *"will depend upon whether the practitioner is a good family doctor inspiring confidence in his diagnosis and treatment and not upon his capacity as a sanitary inspector."* True to the saying that distance lends enchantment to the view, the Madras Provincial Subsidized Rural Medical Relief Scheme is looked upon as a "notable success" not only by General Jolly but many others in distant provinces. There cannot be denying the fact that the principles and spirit underlying the scheme at the time of its inauguration, were good but the actual working of it under the local bodies is so much deteriorated that the Scheme is drifting towards indentured service which depends upon entirely on the whims and caprices of those responsible for the running of the scheme. There is now a tendency in the Madras Scheme to make the Subsidized practitioners pucca sanitary inspectors to do the public health work only but not for the matter of getting the wages of the sanitary inspectors. The subsidized practitioners are compelled to serve as subordinates of the Public Health Department much against their will. The seniors amongst them who have fairly established themselves as popular practitioners cannot afford to leave the villages where they were allured to settle over a decade ago. They now groan under the additional yoke of Public Health Department. Everybody including the rich expect the subsidized practitioners to serve them free and the Government expects them to do the sanitary inspector's work on a monthly subsidy of Rs. 15/- even without the help of a peon to do menial work. This is the picture we see of the Rural Medical Relief Scheme at close quarters, which looks as a notable success to General Jolly. We have no idea of the co-operative movement in the Punjab. They say the co-operative department of the Punjab is a model in some respects and there were occasions when officers of the Madras co-operative department, were deputed to study co-operative movement in the Punjab. In the same way though the Madras Rural Medical Relief Scheme is a notable success perhaps from the perusal of administration reports, none so far, has come to see the actual working of the Madras

Scheme. The watch-word of co-operative movement is "one for all and all for one" but there have been instances in the Madras co operative movement where the watch-word was "one for one and all for one" with the result that recently, the Madras Government found it necessary to amend the co operative law prohibiting so-called honorary co-operators to be directors of co-operative institutions where the relatives of the directors were employed. The Congress Government decided to work out the Punjab scheme of co-operative Health units in some selected villages, on co-operative basis. From our experience of co operative movement in this Presidency we pointed to the Government the undesirability of running rural medical relief on co-operative lines. The subsidized practitioners also disfavoured the idea; so did the medical profession in general and thanks to the sagacity of the Congress Government who gave up the new idea which had no popular support from the medical profession. General Jolly was the Head of the Medical Department in the Punjab before he was promoted as the Director-General, Indian Medical Service. He seems to be the founder of the co-operative Health Units in the Punjab and he is hopeful of good results relating to his scheme to such an extent that eventually he expects the Health Units will take the place of panel practice obtaining in the British isles. If the popular Governments in India are run on the British ideals where ministers dictate policies and do not interfere with the working of the departments under them, medical relief schemes of the type which General Jolly has in view may be workable with benefit both to the public as well as the medical profession. Rural Medical Relief Scheme is a big. problem. The Madras Rural Medical Relief Scheme with all its defects is considered to be worth the attention of others to follow. General Jolly calls the Madras Scheme notable and whatever be the actual working experience of the Punjab Scheme, it has to be said that there are potential good virtues in the Punjab Scheme as described by its founder in his article under reference. We suggest to the Madras Government that a senior subsidized practitioner belonging to the Madras Scheme may be deputed to go to Punjab for studying the scheme on the spot and report about the Scheme to the Government. Considering the large expenditure which the Government have been incurring by deputing their high salaried officers to study the working of some departments in India and even outside India, a small expenditure which the Madras Government may have to incur for sending one of their subsidized practitioners to Punjab, will be nothing taking into consideration the magnitude and utility of an ideal rural medical relief scheme which while inculcating sound and scientific methods of medical relief is likely to infuse in the villages the ideals of self-help.

L. I. Ms Blow Hot And Cold: The recent Government Order on the last administration report on the working of the School of Indian Medicine and the publication of the report of the Committee appointed by the Government to go into the curriculum of studies in the school and suggest alteration or modification have upset some of the old boys of the schools, who are now active running from one place to another after the inauguration of a campaign of vilification at a conference held in Madras on 12-5-'41, which was opened by the Deputy President of the Madras Legislative Council. The conference had a chairman of reception committee and also a president. The chairman, reception committee, complained against "a number of allopathic medical associations all over the presidency presided over generally by the District Medical Officers" who, the chairman said, "strongly advised the Government to close the School of Indian Medicine, convert it into an institution where Indian Medical Systems only should be taught or convert it into a research institution like the School of Tropical Medicine." He made a revelation that before the School of Indian Medicine was started there were 10,000 quacks for every ten learned practitioners of the Indian System. He added that most rural practitioners were those trained in the School of Indian Medicine and

the villagers preferred the L. I. Ms. He said that the "present move" of allopathic practitioners was "to manufacture unfavourable opinion against A and B class registered practitioners. He declared that A and B class practitioners were "the real votaries of the medical science of the land" and were entitled to be styled as Registered Practitioners and those belonging to the Western Scientific Medicine should be called "Allopathic Registered Practitioners" to identify the former from the latter. In conclusion, he advised the Government to close the Stanley Medical College which was a waste and added that the money saved by closing that college should be utilised to convert the School of Indian Medicine into a College.

The Deputy President of the Legislative Council while declaring the conference open, endorsed the views of his host and said that the present Government were treating the School of Indian Medicine in a step-motherly way and advised the L. I. M. practitioners to be united.

The President of the Conference said that the very existence of the L. I. Ms. was threatened though they had dedicated themselves for a noble cause and their school and hospital were growing rapidly "inspite of the obstacles which a jealous and official pampered class" of medical men had been creating. He was shocked that the "the Government of the Advisers" condemned the school in the most ungenerous terms inspite of the excellent reports furnished by the public and the authorities of the school. Then he appealed "the Advisers of the Government in whom, he said, he had confidence to ignore all the mischievous propaganda of the vested interests and warned the Government not to increase the estrangement of the people.

Then the conference is said to have passed a number of resolutions protesting against the proposal of the allopathic practitioners' Associations to abolish the only school which turned out qualified practitioners of the Indian Systems of Medicine, inviting the attention of the Government to take disciplinary action against the District Medical Officers who presided over the protest meetings referred in the addresses of the reception committee chariman and president of the conference. A committee was appointed to study the new Usman Committee's report and the conference authorised the Executive of the Association to wait on deputation on the Adviser to the Government and tour the presidency for canvassing support to the school as it existed.

We wish our readers to note the vacillating campaign of the L. I. Ms. who, seeing the cat outside the bag, are puzzled and bewildered. They are having necessary support of persons and papers who wish to make a capital of any agitation as they know excitements more than cool deliberations is the order of the day. Medical conferences of all-Indian importance and even provincial medical conferences which concern themselves in the promulgation of established and tested scientific facts, do not attract the columns of some newspapers to the extent the questionable and mud-slinging campaigns do. All sorts of vile language is used by a few L. I. Ms. in their attempts to get public support for an institution which cannot be owned either by the genuine practitioners of Indian Systems or by the practitioners of the Scientific Systems of Medicine.

Thanks to the elaborate report of the conference appearing in a leading newspaper, which drew the attention of its readers to the vicillating statements. The conference was as unreal as it was artificial. What was the need for using the dignified word conference for a meeting of a few L. I. Ms. who are resident in the city. Where is the need of a reception committee for a meeting of the members of the city L. I. M. Association who were the hosts as well as the guests. Was it only to receive two honoured guests, one belonging to the scientific system of medicine and the other, the Deputy President of the Legislative Council both of whom must have felt humiliated more than honoured. For, one could very well imagine the feelings of the ex-Principal, Stanley Medical College who started and nurtured the infant college, when a reference was made by all who spoke at the

conference to the effect that the Stanley Medical College was a waste and must be closed to make room for the L. I. M. College. The humiliation of the Deputy President of the Legislative Council was of another type. He, a recent convert to the Congress faith, cannot but have the subconscious feeling that the School of Indian Medicine, a political hybrid product of the party whose credentials he used to begin his career in the political arena and which school was not favoured by the Congress Government and which institution now gave him an opportunity to condemn the present Government for obvious reasons. The Government did not so far have occasion to treat the school in a 'step motherly' way as complained of by this gentleman. We ask this gentleman a plain question which we did not hesitate to ask the late Hon. Raja of Panagal when he was the Minister, whether he would like to be treated at the Hospital attached to the School of Indian Medicine if he suffered from any surgical disease (which God forbid) including those of the eye, ear, nose and throat, subjects belonging to the Western Scientific System, included in the School curriculum by the old Usman Committee whose continuance has also been recommended by the new Usman Committee? Can the same gentleman put his hand over his chest and tell us that the lives of women folk are as much safe in the maternity wards of the Hospital attached to the School of Indian Medicine as they would be in Government Hospital for women and children in Egmore, the Raja Sir Ramaswami Mudaliar lying-in hospital, George Town, the Victoria Caste and Gosha Hospital, Triplicane, not to mention the two lying-in hospitals run by the missionaries in the North and South Madras? We know the late founder of the Swadeshi School had faith only in the scientific system of medicine. We also know that even when he was on his death bed, he preferred to be treated by the Allopathic Practitioners whom the Conference condemned because the latter are voicing the truth that the fostering of a school which does harm both to the Indian and Western Systems, is not only a danger to the public but is a wasteful financial drain. For, the Allopaths ask whether the Government is justified to waste public funds to maintain maternity wards, surgical wards including those for the treatment of special diseases when there are well equipped maternity, general and special hospitals in the City. Regarding the usefulness of the school to supply practitioners to treat the village folk it is preposterous to say that "the villager preferred the L. I. M. which preference was rather distasteful to the Allopathic practitioners." Nor is the statement made by the so-called chairman of the reception committee that "most of the rural practitioners were those trained in this (Indian Systems) school" could be believed unless he meant the non-subsidized rural medical practitioners. For, the school has so far manufactured only about 500 practitioners and there are about 700 subsidized dispensaries of all denominations of which a little over 500 are staffed by the practitioners belonging to the allopathic system. We may also say without fear of contradiction that almost all the L. I. Ms. including those in subsidized dispensaries live more on allopathic practice. The chairman, reception committee asserts that before the school was established there were ten "learned practitioners" he means the practitioner belonging to the Indian System—to 10,000 of quacks. We wonder where he procured this statistics. It must be infered from his statistics that after the Government introduced a medical register for the practitioners of Indian Systems incorporating two classes of practitioners, one belonging to L. I. M. class styled as 'A' class and the other certified as qualified practitioners by the Revenue Department of the Government styled as 'B' class. Evidently the number of quacks have decreased to be called as such as a large number of them over 20,000 in the Presidency are now in the 'B' class of the Register maintained by the Central Board of Indian Medicine which is a co-ordinating agency set up by the Justice Party Government for the encouragement of Indigenous Systems and with it perhaps to strengthen the party. The president of the conference adds to the encomiums of his comrade relating to his Alma Mater and

at the same time condemned the Allopaths as a "jealous and official pampered class" and the Advisers to His Excellency the Governor as "most ungenerous" in condemning the school. Neither in the G.O. relating to the last administration report of the school nor anywhere else the Government did condemn the school. The bare fact that in their opinion the School has ceased to give a correct impression of the nature of the institution has caused disappointment and bewilderment in the L. I. Ms. When the school dabbles with allopathy how could it be called the School of Indian Medicine must be beyond the comprehension of all sane people. The president who had lost faith in the Advisers and the Government constituted by them, is now touring the various places trying to canvass support for his Alma-Mater and columns after columns appear in a leading newspaper wherein the Government are condemned by those who live on so called public agitation. That the agitator feels guilty of what he has been doing for his own safety could be judged by the fact that after blowing hot against the Government he climbs down and says:

> "The advisers to the present Government are experienced Civil Servants who are able to know the pulse of the public. We have confidence in them, and so we appeal to them to ignore all this mischievous propaganda of the vested interests and not to betray the wishes of the public by any shortsighted policy which will only tend to increase the estrangement of the people."

He holds out a threat also to the Government in the last sentence of his appeal to the Advisers. We are forced to criticize the boisterous activities of some of the alumni of the School of Indian Medicine as the practitioners of the scientific system cannot afford to use the platform or the lay press in the way the alumni of the School have been utilising. Evidently they do not feel the necessity of blowing their own trumpets nor is there a need for it; for, science, though dumb, speaks for them by the actual results achieved in alleviating human suffering. All the same we suggest to all the Medical Associations run by the scientific practitioners to do quiet work and express their unbiassed opinions on the Usman Committees basing their arguments on facts and figures and not on imaginary grounds. There is what is called public opinion which no Government can afford not to mind. Public opinion does not always mean agitation in the press and on public platforms. The best thing to do to create public opinion is to submit memoranda to the Government on the reports of the Usman Committees by all the existing associations and responsible medical practitioners belonging to Scientific system of medicine direct to the Government and not necessarily to the lay press. As the members belonging to the Scientific system of medicine are not likely to rush on public platform or to the lay press to answer the criticisms against them, we had to deal with this subject at length.

An Example: Quite in accordance with the suggestion made in these column that the practitioners of Scientific System of Medicine should express their views in a quiet yet dignified way in regard to the Usman Committee reports, old and new (because the latter depends entirely on the former and has little or no changes) Dr. G. V. Hanumantha Rao, Secretary, Guntur District Branch of the Indian Medical Association has led the way to his brethren by submitting his views direct to the Government of Madras and we trust others will follow him. Extracts of Dr. Rao's letter appear in the correspondence columns. While the members of the Scientific Medicine are likely to agree with the majority of the views of Dr Rao, some will certainly object to the grouping of L. I. Ms with other qualified practitioners in the Madras Medical Registers. The right method to recognise practitioners of all systems who had no training on scientific lines would be to bring into existence a Licensing-Body consisting of suitable persons representing every system of medicine and bring all such practitioners under the control of the Licensing Body. Such a body exists in Siam and Portuguese India and some years ago when the Justice Ministry was contemplating to constitute the Central Board of Indian Medicine our suggestion to have a Licensing-Body did not attract the attention of the then Government as well as of the members of the medical profession with the result that in this Presidency there are over 20,000 practitioners registered by the

Board of whom only 800 or very near this number are the products of the School of Indian Medicine who now claim the rest as their own for the purpose of agitation against "Step-motherly" Government of "ungenerous Advisers." For our own part the A. & B class of practitioners of Indian Medicine should thank their stars if the present Government give these practitioners recognised by the Central Board of Indian Medicine the place they actually deserve.

A Domestic Quarrel: The readers of The Medical Practitioner might remember over Comments on the News relating to the formation of the South Indian Branch of the Indian Medical Association under the caption, "Cart Before The Horse" appearing in the May issue of The Medical Practitioner. Amongst other things we said that the Andhra Branch of the Indian Medical Association which came into existence earlier than the first preliminary meeting held for the constitution of the South Indian Branch did send a protest to the Executive of the mother Association that the branches south of Madras should not be permitted to use the name South Indian Provincial Branch as such a name was likely to convey an idea to outsiders that Andhra Provincial Branch is included in the South Indian Branch as the Andhra Districts are in South India. At the time we saw 'the cart before the horse' we had occasion to meet one of those who had the strings of the picture of the South Indian Branch and when we questioned about the gallop speed with which the picture was moving, he ejaculated by saying that the cradling ceremony had the pernal approbation of the gentlemen in the Executive of the mother Association and a formal sanction was only a matter of time if the time did not already pass. What this gentleman expected did take place and the executive committee of the Andhra Provincial Branch who met at Bezwada on 26-4-41 protested against the decision of the Central Council of the Indian Medical Association and have communicated their protest to that body. The Indian Medical Association is just reaching its adolescence and at this stage the mother should be stern yet reasonably kind to the wants and grievances of growing children who always have a tendency to revolt a consistent yet undesirable proclivity—consistent because of the surcharging political atmosphere and undesirable because the spirit of revolt will retard the growth of the adolescent children. The new President of the Association was installed on Andhra soil and in Andhra atmosphere last December and should know that the Andhra acts on what he says. He has no faith on a war of nerves. We wonder if the President who had been the General Secretary of the mother Association ever since its birth, and who must know the affairs of the Association more than his predecessors did, had time to see the "Cart Before The Horse". We wish he sees the cart before the horse runs away either out of despair or restiveness.

Will Madras Government Copy? It is a strange coincidence which serves to prove the signs of the times that when the Madras Government appointed a committee last May relating to the suitability or otherwise of the existing curriculum of studies in the School of Indian Medicine, the Government of the Punjab should have thought it necessary exactly in the same month to appoint a committee to suggest measures to regulate the practice and education of Homoepathic System of Medicine. The Associated Press of India published on 15th May 1941 that the above committee made a reference to the Punjab Medical Council and the latter council is said to be of opinion that "the system of Scientific medicine as recognised by the Medical Council of India should alone receive State recognition and that the possession of a knowledge required for such registration should be the basis to the practice of any other system of medicine which an individual practitioner may choose to practise. This attitude, the Council points out, does not exclude practice of the Indigenous systems of medicine or any other systems possessing wide recognition including homoeopathy. The fundamental position insisted on, however, is that for the relief as well as prevention of disease, adequate knowledge of different subjects of the medical

curriculum, recognised by the Medical Council is essential. The practice of any other system based upon such scientific knowledge, in the opinion of the Council, will protect the public against quackery and charlatanism."

The Medical Council of India cannot at present function in the way suggested by the Punjab Council and Dr. Hanumantha Rao in his communication to the Madras Government. This council is empowered to deal with the standard of university medical education and nothing more. All the same the principle enunciated by the Punjab Medical Council relating to recognition of any system of medicine by the Governments is to be respected by all concerned in the interest of the welfare of the public. What is happening in the Madras Presidency relating to the Indian System of Medicine is repeated in the Punjab relating to Homoeopathic System of Medicine as it is very likely that the Punjab Legislative Assembly has a large number of members who had the help of the homoeopaths during their electioneering campaign as the members of the Legislative Assembly in Madras had the support of the quacks and charlatans who have been able to be recognised as registered medical practitioners by the Madras Government to the detriment of the safety of the public especially in the villages. The Punjab Ministry seems to be most modern in its conception of democracy which does not show signs of drifting into mobocracy inspite of the fact that for the political salvation of India it is the Punjab that suffered most even in relation to the loss of lives in the fateful and cruel tragedy of Jallianwala Bagh. If the Panagal Ministry in 1921 followed the lead now given by the Punjab Ministry in relation to not only democracy but also the recognition of existing systems of medicines outside the purview of science, the state of affairs in Madras would have been more tolerable whether relating to systems of Government or systems of medicine. Even at this stage of unscientific evolution of the Government School of Indian Medicine to which it is drifted by the false ideals of the politicians in this unfortunate province, there is an opportune moment for the present Government to rectify matters on the lines suggested in the policy of the Punjab Government and we have stated elsewhere all this could be done. We hope the Madras Government will copy the Punjab Government.

Supersessions Again? It is rumoured that an assistant surgeon in the grade of a demonstrator in a particular subject, who acted as such in the Andhra Medical College from 1928 and transferred to Madras Medical College in July 1934 as such, was transformed recently to officiate as a professor of the subject, on account of, it is said, exigencies of service. He is now to be appointed as a pucca professor superseding three officers who have been holding the permanent positions of Assistant professors in the particular subject from the years 1916, 1927, and 1925 respectively. The pay of the demonstrator is Rs. 350, or somewhere thereabout, whereas the pay which his three seniors have been getting ranges from Rs. 430 to Rs. 725. It is also said that the Syndicate of the Madras University has been approached to condone the necessary educational qualification fixed by the Madras University in case of this junior officer so as to enable him to be the professor of the subject in the Madras Medical College. Recently, when a vacancy occurred in a professorial appointment in the Stanley Medical College when a suggestion was made to the proper authority to fill up the temporary vacancy by transferring a senior from the Andhra Medical College, it was argued at the time that Peter should not be robbed to pay Paul. All the same a recent notification in the newspapers has established the fact that Andhra Medical College has been actually robbed of the very senior to replace the very junior who was pointed out as such, and who is now returned to the Madras Medical College in the place of a senior I.M.S. officer, overlooking the claims of another very senior who is still made to act as a lecturer whereas the junior assistant surgeon who was transferred as a professor in the Stanley Medical College is to act as the professor in the Madras Medical College, whereas the existing senior is to continue as a

lecturer, though the proficiency of the latter has been unquestionably established to be styled as professor. It looks as if persons and not the seniority, merit or qualification is the criterion, to effect promotions. As there is no special teaching cadre in the Madras Medical Service which supplies teaching staff to all three Medical Colleges under the control of the Surgeon-General and as even transfers can be effected nay must be effected from one teaching institution to the other on a 5 years plan, it is not known how the rumoured supersessions pass unnoticed by the Surgeon General. During the regime of the so called popular Governments such supersessions could not possibly be prevented as popular Governments have to depend upon the leaders of the party which constitutes the Government and who might at times be interested in persons and not in principles. The Secretariat is the only authority, which has to be depended upon for justice and fair play and the present Government which is ultra Secretariat as against ultra democratic, is expected to mind justice and fair play which bring contentment in service. They are expected also to know that a contented service is an asset to a good Government. Under the circumstances, we trust that the rumours commented on by us will end as such and not turn out to be facts. While commenting on the subject, we cannot possibly forget the exigencies of war and we wish to point out to the Government, that they would have served war efforts more efficiently in case, wherever possible they filled in temporary vacancies either in teaching institutions or elsewhere, by appointing for such vacancies temporarily honorary medical officers who have to their credit sufficient experience and qualifications for the post. If this was done, there would have been in the Madras Medical Service, more officers to be spared for emergency military duty. To mention one such instance, the temporary professorial vacancy that occurred in the Stanley Medical College might have been admirably filled in by a senior honorary surgeon, whose merit as a surgeon is recognised as such by the medical profession and ought not to have been ignored by the Government. If that was done, there would not have been a necessity for a chess play to effect rumoured supersessions.

Civil Assistant Surgeons for War Service: We learn that the turn of Civil Assistant Surgeons has come to be recruited for war service and all of them under the age of 40, have been served with a notice, drawing their attention to Rule 15 (6) (iii) of the Madras Medical Service special rules issued in G. O. No. 2232 P. S. dated 22-11-37 which renders the members of the Madras Medical Service liable for duty, civil or military including field service beyond Madras Province. They are asked whether they are willing or not to do war service. If the Service rules demand military duty including field service, where is the need to consult them and why should conscription be limited to only those below 40 when the service rules demand military duty from all in the Madras Medical Service. It is a pity that the Government though with the best of intentions, make military service unpopular. What is the idea to restrict compulsion only to those under 40? Can there be much difference in vitality between assistant surgeons of the age 40 and 45 and 45 and 50 or even 55? It is probable that there may be officers in the Madras Medical Service nearer 55 who are more sturdy than some under 40. And after all there will be only about 30 or very near this number of civil Assistant Surgeons under 40 excluding the temporary Assistant Surgeons who are now being recruited in the Madras Medical Service. The latter ought to have prepared for Emergency Commission if they wished for it. Compulsion even in an indirect way will not meet the situation satisfactorily. There cannot be any doubt that military duty during war time cannot be as attractive as the civil duty. It is also a natural psychological phenomenon that as per the present Madras Medical Service Rules if all in this service are warned for military duty, the scare will not be felt so much and there will be a larger number available for war service immediately. To meet the needs of civil population the Government will do well to grant extension of Service to such of those who are likely to retire soon and recall if necessary those who have just retired, in case they do not get equally qualified private practitioners of sufficient age and experience to be put in charge of civil medical work. Those who are compelled to do military duty and who have no heart for it being accustomed to a particular mode of living, are not the right sort of persons on the war field. In the case of the civil assistant surgeons who are now warned for militray service the best way of creating in them a desire for military service even against their natural and inherent instincts is to give them the rank of commissioned officers beginning with that of a Captain to that of Lt-Colonel according to their period of service in the Civil Department. Such a course is likely to stimulate war recruitment not only in the case of the medical officers of the civil department in the Government but also in the case of private practitioners. We feel it our duty to bring to the notice of the Governments throughout India that there is a feeling amongst the members of the medical profession both official and non-official that consistent with the policy of the Government relating to war reserve of officers belonging to the I. M. S., that all such officers should be immediately called to do their legitimate duty in the military department without any exception. It will not be out of place for us to bring to the notice of all concerned that civil sub-assistant surgeons who possess high foreign qualifications, such as M.R.C.P., F.R.C.S., etc., who, we are informed, are forced to enter war service as ordinary I. M. D. officers, a state of affairs which should not only be condemned but also to be put a stop to, not so much in the interest of the humble medical subordinates, but in the interest of the prestige of the institutions in the British Isles and elsewhere which confer such high qualifications. We have mentioned some of the most glaring drawbacks in the present policy of medical administration in this country which materially obstruct recruitment to war service.

Correspondence, Reports, Etc.

SCHOOL OF INDIAN MEDICINE.

Extracts of the Communication submitted by Dr. G. V. Hanumantha Rao, Secretary, Guntur District Branch of the Indian Medical Association.

Dr. Hanumantha Rao complains at the outset, that the old Usman Committee, appointed by the Government in 1921, to go into the question of recognition of the Indigenous systems of medicine, did not consist of experts competent enough to go into the subject and that the Panagal Ministry in their anxiety to revive the indigenous systems were blind to the most essential requirement that any system of medicine should be scientific and must be practised by medical men well equipped in medical science. Dr. Rao was of opinion that if the committee consisted of scientific men, they would have surely recommended that the indigenous systems of medicine could be encouraged only by instituting post-graduate training in these systems for the benefit of practitioners belonging to the scientific system of medicine.

He pointed out that even before the School of Indian Medicine came into existence, there was an agitation to the effect that the scientific system of medicine should have one uniform standard, and therefore the L. M. P. course should be abolished. He scoffed at the idea, how the students trained in the School of Indian Medicine could have a working knowledge of Western system of Medicine when it was known that incomplete S. S. L. C. students were admitted into the School and both the Western and Eastern systems of Medicine were said to be taught to the students within four years. He submitted that it was an audacious claim on the part of the L. I. Ms that they practised what was best in both the Western and Indian systems of medicine. He added that the school did greatest injury even to the L. I. Ms on account of the indifferent training given to them.

He observed that the success of the Indigenous systems depended entirely on

the mode of preparation of medicines and the purity of the drugs contained therein; and the L. I. Ms have little or no working knowledge of the preparation of the indigenous medicines and they entirely depend upon mass production of the medicines manufactured by firms of questionable reputation. He brought to the notice of the Government that Ayurvedic physicians who ran private Ayurvedic schools entirely on Indigenous lines, led an agitation sometime ago to abolish the School of Indian Medicine as the students trained therein knew little or nothing of these systems. He referred to the oft quoted term of the L. I. Ms that "Science knows no frontiers" and that the L. I. Ms should be allowed to choose what was best in the Indian and Western Systems of medicine. Dr. Rao said that this claim was preposterous on the part of the L. I. Ms and it was only those who are real scholars in their own systems that could find out what was best in both.

He then referred to the statement usually made by the L. I. Ms and others interested in them, that the number of quacks has numerically and substantially dwindled after the starting of the school. Dr. Rao was of opinion that the existing quacks are now recognised as 'B' class practitioners by the Central Board of Indian Medicine and in fact the term, 'Registered Medical Practitioner,' had lost its significance, as the public has no means to know the indications of this term.

Relating to the cry of the L. I. Ms to raise their School into a College, the training should be given for not less than eight years and that to the students who have passed the Intermediate examination.

The charge made by the L. I. Ms against the District Medical Officers for presiding over the District Medical Association meetings where resolutions were passed relating to the unsatisfactory affair in the School of Indian Medicine, Dr. Rao said that the District Medical Officers were the best judges as they were entrusted by the Government to inspect institutions of both the Indigenous and Western systems of medicine.

He submitted that it was desirable in public interest that the practitioners of the indigenous systems of Medicine should style themselves as Registered physicians of Indian Medicine and the term 'Registered Medical Practitioner' should be used only by those who are in the Madras Medical register. In conclusion, he suggested to the Government that the medical administration of all the systems of Medicine should be brought under the control of the Surgeon-General with the Government of Madras and that the Central Board of Indian Medicine should be abolished, and that the names of the qualified practitioners in Indian Medicine should be published as a supplement to the Madras Medical Register. He appealed to the Government to consult the medical Council of India before they passed orders on the Usman Committee's report.

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