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EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

SCIENTIFIC SECTION.

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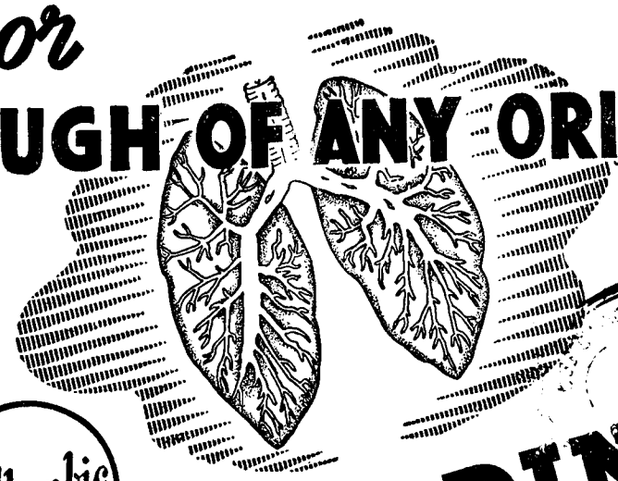

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Original Articles

RURAL OBSTETRICS IN INDIA

BY

RAO SAHIB S. M. THRASI, M.B. & C.M.,

Consulting Obstetrician and Gynaecologist, King George Hospital, Vizagapatam.

Many an observer has remarked on the high obstetric mortality—maternal, foetal, and neonatal—in this country. Even in our maternity institutions with expert staff for ready attendance, the mortality generally compares unfavourably with the West. Various factors contribute to this. A review of records of these institutions will show that their mortality rate is materially affected by cases admitted too late, often severely infected or moribund, from outside—suburbs and villages around. A prominent factor undoubtedly therefore is lack of efficient obstetric help in rural areas. The primitive conditions of life and lack of transport facilities in our villages are heavy handicaps in our Rural obstetrics. Many villages have still no medical officer nor one within reach, inspite of the introduction of Subsidised Rural Medical Service, a drop in the ocean in its present limited extent, in a country abounding in villages. Many have not even a trained midwife. Where there are such, from the limited scope of their training, they can only manage normal labour. Even in this they are often slipshod, rarely troubling to maintain their efficiency once they pass out. Where there are Rural Practitioners, few are obstetric post-graduates and no consultant advice is available to them in villages. Besides, due to poverty or prejudice against male attendance at labour, they are with few exceptions, rarely if ever engaged before hand or called in time, but generally late, often too late in delayed or obstructed labour needing urgent delivery and perhaps already mishandled and grossly infected by barber dhai or some incompetent midwife. They have also often to manage single handed, without help for anaesthesia or midwife to assist. Patients are often on the floor amidst lumbur in small dark, dusty, stuffy rooms perhaps next to latrines, cesspools or cowdung heaps and remote from living rooms from a not uncommon superstition in the orthodox class that parturients are untouchable. Their genitals may be found smeared with oil (to soften them?) or swollen from long impaction or perhaps inflamed and blistered from being made to sit on hot ashes (to stimulate uterus?) by barber dhai. Poverty, underfeeding, chronic ill-health and anaemia from Malaria, Ankylostomiasis, etc. due to bad sanitation in our villages, lower the vitality and resistance of patients. Ignorance, prejudice, social restrictions, superstitions, insanitary habits, all results of mass illiteracy prevailing in our villages are further drawbacks in our rural obstetrics. Use of dirty rags for diapers

159644

and cold dressing against instructions, not uncommon in villages from ignorance or poverty, often lead to sepsis or tetanus.

There are few opportunities for antenatal work either. When the medical profession itself came to realise the importance of antenatal care only within recent years, it is no surprise that our illiterate ignorant villagers know not its value, and rarely seek advice in pregnancy, till serious complications occur, and then too perhaps only after their favourite country treatment fails, leaving little chance of doing much good. Most villages too have no antenatal centres to demonstrate its value and popularise it among the villagers. Due to general poverty remuneration is often poor in obstetric cases for the extra care, time and trouble they need. Obstetric practice is therefore generally less remunerative though more taxing on one's time and patience. All these unfavourable conditions are apt to damp the Rural Practitioner's interest in obstetrics thereby affecting his efficiency in it to the detriment of his patients. Wrong procedures in difficult labour, brute force in instrumental and manual operative manipulations, from faulty judgment or inexperience are often resorted to, and are responsible for many fatalities both in Rural and Urban (Institutional) obstetrics. This is perhaps partly due to scant attention they pay as students to obstetrics and also perhaps to the too academical nature of teaching the subject. All these factors have a close bearing on our obstetric mortality both Rural and Urban but especially Rural. Until these factors are remedied and our rural obstetric service improved little improvement can be expected in our obstetric mortality. Some of these factors such as general illiteracy and poverty and their grave results are difficult to remedy against the heavy odds of present conditions. The others however ought to be remediable by co-operative concerted efforts of atleast public bodies like District, Local and Panchayat Boards, Medical Educational Bodies etc. From a consideration of these draw backs remedial measures indicated should be (1) Extension of Subsidised Rural Medical and Midwife Service, and antenatal centres into villages having none yet. This is for public bodies and our unemployed medical graduates to consider. Our colleges every year or half year turn out a number of medical graduates. District and Local Boards can subsidise as many as they can for their unprovided villages. With no prospect of Government Service in these days, others may well think of settling in independent practice in other such villages, where they would be much better off with cheaper and less complex living, rather than crowd, as they commonly do, in cities and towns where costlier living and the cut throat competition and unconventional methods of practice creeping in with the overcrowding, are bound to make their life a hard struggle.

(2) Improvement in village sanitation, transport facilities, roads etc. deserve serious attention of the public bodies concerned.

(3) Improvement in the general standard of midwives including their training in anæsthesia, periodical inspection of their work and efficiency-bar tests.

(4) Compulsory post-graduate training for Susidised Rural Medical Service and for employment in urban maternity institutions. These two (3) and (4) fall within the province of public and medical educational bodies.

(5) Provision of consultants to rural practitioners. This is for public bodies to consider.

(6) Special stress on the practical aspect of obstetrics in teaching.

(7) Steps to make students pay better attention to the subject. These last two (6) and (7) are for consideration of medical educational bodies.

Few will still contest the need for measures (1) and (2) unless it be the public bodies concerned on grounds of financial difficulties. But still they can do what little or as much as they can in this direction within their means if they apply their mind to it, with a will. There may however be differences of opinion on the need, advisability or practicability of the other measures. Some explanation therefore will not be out of place.

(3) *Raising Midwives' Standard*: Midwives generally see patients first. It is essential they should be able to recognize abnormalities to get timely help and also be able to help at anæsthesia in villages where anæsthetists are not easily available. Dr. Schudder in her pamphlet on V. V. F some years ago, stated that in her Vellore Mission Hospital Indian Nurses and Midwives were trained as anæsthetists and successfully helped as such at most operations. It should not be difficult to train our midwives too in the use of the Junker's inhaler if properly taught. Refresher courses, periodical inspections of their work, and efficiency bar tests, appear necessary in their case. At present, for want of these, they often become slack. Many of them, even after years of service, cannot count pulse or read a thermometer correctly, nor diagnose position and presentation by palpation, nor auscultate foetal heart. They often pay scant attention to asepsis, make unnecessary vaginal examinations, make no attempt to save the perineum, being sadly deficient in its technique, are too impatient to wait for placental separation, often forcibly expressing the placenta causing p. p. h. or tie the cord carelessly often leaving it open undressed. These are not imaginary statements but observed facts. As our Indian midwives are mostly drawn at present from uncultured classes rather deficient in their sense of responsibility or duty, some sort of check seems necessary to keep them alert in maintaining their efficiency.

(4) *Post-graduate Obstetric Training*: This should be a necessary equipment for rural practitioners and for employment in maternity institutions. For lack of it many lives are sacrificed from mismanagement of difficult labour especially in villages, where obstetric calls are mostly emergencies requiring urgent operative treatment. Incorrect procedures and unjustifiable force are often resorted to in such cases by inexperienced young practitioners resulting in serious injuries or death of patients. This can largely be avoided with post-graduate training.

(5) *Consultants*: In most districts there are experienced retired hands. Many of these may be willing to be honorary touring consultants and also inspect midwives' work in their districts in a missionary spirit without special remuneration on bare travelling expenses. It is for the public bodies to try and see if it is not practicable to secure their services.

(6) *Stress on practical aspect in teaching*: Most students at their final examination are particularly deficient in mechanism of labour, and instrumental and manual operative technique, so essential in village emergency. obstetric work. A good grinding in these in "conversazione" type tutorial classes, with demonstrations on the dummy, at which students are made to practise and study mechanism and technique, and their difficulties and doubts cleared, should go a long way to remedy these defects. Special stress should also be laid on the practical aspect in teaching the subject. Not that it is neglected at present, but only special emphasis on it is suggested.

(7) *Better attention by students to the subject*: Weekly or fortnightly oral class-examinations, carrying marks counting towards fitness for final examination in addition to mere percentage of class attendance as at present, and more stress on the practical aspect in the final examination, should make students pay better attention to the subject. The oral examinations will also enable the teacher to know if students pay enough attention to the subject or not. Medicine as an art, unlike other arts, is so intimately related to life and death that some stricter conditions and tests are desirable in it than in other arts.

Let us hope that the All India and Provincial Medical Associations and Conferences will take up this question of Rural Obstetrics in real earnest, discuss it in all its aspects and devise some ways and means and take practical steps, along with public bodies to seriously tackle this problem. Mere resolutions will lead nowhere.

MADRAS MEDICAL COUNCIL.

Review of Proceedings.

October 1941 Session.

BY

DR. V. RAMA KAMATH,
Member, Madras Medical Council.

The Madras Medical Council met on 20-10-'41 at 11 a.m. in the office of the Surgeon-General with the Government of Madras. Major-General H. Stott presided.

DISCIPLINARY CASES.

As usual I shall follow the order of placing before the readers the disciplinary cases as the members of the profession have to be concerned with the decisions of the council relating to the medical ethics more than anything else.

Alleged Perjury: Sri V. Ayyapu Reddi, Thamalamanchipatnam, Cuddapah District, was alleged to be guilty of perjury and misappropriation of properties entrusted to him by the Cuddapah District Board. The alleged perjury was in relation to the evidence given by the practitioner before the Sessions Judge, Cuddapah, in a case when eight accused were tried on a charge of rioting and murder. The practitioner gave evidence that one of the chief accused was treated by him on 6-2-'41 on the very day the said accused along with others committed the offence at Santakudlur. The Sessions Judge observed in the course of his judgement. "D. W. 1 has no register of patients or other such documents to support his evidence and only says that the date was noted in his pocket diary.....in the case of D. W. 1 his discomfort was so marked that it convinced me that he was not telling the truth."

The President District Board, Cuddapah, made a complaint to the police that on 25-11-'40, the same practitioner had absconded from duty—that the surgical instruments and furniture entrusted to him were missing. It was also said that many items of missing articles were condemned and that the practitioner was due some money by the District Board towards his subsidy. The Inspector of Police who was entrusted with the inquiry reported to the Superintendent of Police through the Deputy Superintendent that it would be a wild goose chase to go after the practitioner and that the President District Board might be informed that departmental action may be taken against the practitioner. The District Medical Officer reported to the council against the practitioner requesting the council to take disciplinary action against the practitioner.

After some discussion the council passed the following resolution:

"That in the case of Sri Ayyapu Reddi, the council defers further action until the legal proceedings against him are completed."

Dr. A. Seshagiri Rao's Petition: Dr. A. Seshagiri Rao of Masulipatam whose name was erased from the register in November 1938, submitted a petition to the council mentioning amongst other things that as he had materially suffered for nearly three years on account of his name being erased from the medical register, his name might be restored especially so as the practitioner wished to join emergency war service and could not do so as his name was not in the Register.

The following resolution was passed by council on the petition:

"The practitioner is directed to appear personally before the Council at its next meeting for the consideration of his application for being restored to the register. If he does not appear his application will not be considered again."

Dr. S. Sanjeeva Shenoy of Tandarampatti, S. Arcot District, who infringed, the Excise Rules (case appears in the June) 1941 issues of The Medical Practitioners and who did not produce certificates of his

subsequent conduct as decided by the council on 7-11-'40, was reported to the council by the Registrar for his not having carried out the decision of the Council. The Council directed the Registrar to send to Dr. Shenoy a reminder by registered post asking him to submit explanation within a month from the date of the said letter. The Council therefore deferred action.

Unwarranted Apprehension: In the June 1941 issue of the Medical Practitioner, while reviewing the proceedings of the Council (October 1941 Session), under the caption, 'An Omibus Allegation' mention was made of a letter from the Registrar, Bombay Medical Council, suggesting disciplinary action against all registered practitioners whose names appeared in an advertisement published in a Bombay newspaper. Amongst the names that appeared were those of the then Surgeon General with the Government of Madras, Principals, Madras and Stanley Medical Colleges, District Medical Officers, etc. A few months later when investigation was being conducted about the information, an anonymous information was received by the Registrar of the local Council enclosing a cutting from the prospectus of the Andhra Pharmaceutical Works Ltd. in which were found names of registered practitioners. The Madras Medical Council then passed the following resolution unanimously:

"The Council directs the Registrar, Madras Medical Council, to inform the Registrar, Bombay Medical Council, that the Madras Medical Council is of opinion that the association of the names of registered medical practitioners with a chemical industry or any industry or trade cannot itself constitute a breach of the Code of Medical Ethics unless infamous conduct in a professional respect is proved.

In regard to the particular advertisement of the Madras Chemical Industry, Limited, in the 'Bombay Samachar', the Council learns after enquiry that the Madras Chemical Industry published the said advertisement without the knowledge and consent oi the practitioners concerned who have since notified their protests and displeasure to the said firm."

The Managing Director of the Andhra Pharmaceutical Works who received a copy of the first part of the above resolution seems to have entertained apprehensions relating to the publications of any matter in regards to the Company as required by law and addressed a letter to the Registrar requesting him to elucidate the implications of the above quoted resolution of the Council. There was absolutely no necessity of further elucidation, yet the Council passed the following resolution:

"The Council has no objection to such publication as is consistent with Medical Ethics and meets the obligations of Company Law."

AMENDMENTS TO THE EXISTING MEDICAL ACT.

The Government Memorandum No. 27876/40-6G dated 4th September 1941 relating to the Amendments and the decision of the Council on each proposed amendment is published below *seriatim:*

N.B.—*G. P. stands for Government's proposal; C. D. stands for Council's decision.*

G. P. Section 5 (1) (*a*) *and* (*b*) *of the Act.* These provide for the election of a member to the Madras Medical Council by the Academic Council of each of the Madras and Andhra Universities from among the members of the Faculty of Medicine of the respective universities. The Madras Medical Council suggests that the member in each case should be elected by the Senate instead of by the Academic Council. This would bring the arrangement on a line with the analogous provision in the Indian Medical Council Act, 1933. The amendment required for the purpose is the substitution of the word "Senate" for the words "Academic Council" occurring in each of the clauses (*a*) and (*b*) of sub-section (*1*) of section 5.

C. D. Resolved to accept amendment proposed to section 5 (1) (*a*) and (*b*) of the Act and that the following be added to it:—

The rules relating to the procedure for election of the University representative to the Madras Medical Council may also be amended to be placed on a par with the procedure laid down for election of University representative to the Indian Medical Council (as per Resolution No. 32 (*a*) of the minutes of the Council meeting, dated 7th October 1940.

G. P. Section 8 of the Act:—Persons elected to the Council by the staffs of each of the three Medical Colleges under clauses (*c*), to (*e*) of sub-section (1) of section 5 are entitled to be members for the full term of five years prescribed by section 7. The proposal is that a person

so elected should vacate his membership when he ceases to be a member of the staff of the college which returned him to the Council. The amendment suggested is the addition of a clause to section 8 as follows:—

(8) In case he was elected under clauses (*c*), (*d*) or (*e*) of sub-section (1) of section 5, also on his ceasing to be a member of the staff of the Medical College concerned." Refer to item No. 15 in the minutes of the meeting held on 7th October 1940.)

C. D. Section 8 of the Act is approved with the following addition; but shall continue to be a member till the vacancy is filled up or on the expiry of three months which ever is earlier."

G. P. Section 14 (1) of the Act. The main income of the Council is deviced from the fee which it levies for registration of medical practitioners. This fee is now Rs. 15 for each person who applies for registration under the Act. The income is hardly sufficient for the expenses of the Council and the Government have had to supplement it by grants. With a view to improve the Council's finances, the Government suggested in 1939 an enhancement of the existing registration fee. The Council is not in favour of an increase as the fee levied by certain other provinces is Rs. 15 only and an enhancement would probably induce medical practitioners to to seek registration in other provinces and thereafter to obtain free registration in this Province under the reciprocal arrangement enbodied in section 14 (3) of the Act. Such cases are likely to be almost negligible. Further it is now proposed to provide for a fee of Rs. 5 for registration in this Province—paragraph 6 below—and this will have to be paid in future even where reciprocal arrangement exists in respect of primary registration. It is therefore proposed to raise the fee for primary registration from Rs. 15 to Rs. 20. (Refer to item No. 14 in the minutes of the meeting held on 7th October.)

C. D. The Council is of opinion that the registration fee should not be raised from Rs. 15 to Rs. 20.

G. P. Section 14 (2) of the Act. Again, as a measure of securing a small additional income to the Council, it is proposed to provide for a fee of Rs. 5 for any application for a change in the name of a practitioner as entered in the medical register. (Refer to item No. 17 in the minutes of the meeting held on 7th October 1940.)

C. D. The Council approves the suggestion for an amendment to section 14 (2) of the Act.

G. P. Section 14 (3) of the Act provides for the registration of practitioners on a basis of reciprocity as between the Provinces in British India. The Council says that most Provinces levy a fee of Rs. 5 for registration of practitioners who have already registered in other provinces. It is proposed to add a proviso to section 14 (3) to enable the Council to levy a fee of Rs. 5 for registration in this Province for meeting incidental expenses, ommitting at the same time all references in section 14 (3) to registration of additional qualifications on a reciprocal basis. (Refer to item No. 13 in the minutes of the meetings held on 7th October 1940.)

C. D. The Council agrees to Government's proposal to amend section 14 (3) of the Act.

G. P. Section 17 (1) empowers the Madras Medical Council to entrust enquiries under section 13 or section 16 and says that "The decision of the Committee shall be deemed to be the decision of the Council." The exact implication of the Sentence quoted is not clear. In any event it is not desirable that the powers of the Council and of a Committee of it should be co-extensive as regards final disposal of questions which should be decided by the Council. It is proposed that the sentence referred to above may be deleted and the following sentence substituted:—

When an enquiry is held by a Committee it shall make a report to the Council which shall pass orders under section 13 or under section 16, as the case may be.

C. D. The Council accepts the Government's proposal to amend section 17 (1) of the Act.

Executive Committee for the Council: The Medical Council meets only twice a year and consequently there is lot of in the execution of the work of the Council and as the Council has no power to delegate its authority to the President or to a Committee, the Madras Medical Council suggested to the Government on 9th April, 1939, to amend the Medical Act to provide for an Executive Committee. The Government ordered that the proposal might be placed before the newly constituted Council. The new Council at its very first meeting appointed a Committee consisting of Drs. R. J. Dyson, V. Rama Kamath and Rao Bahadur S. Ramakrishnam. This Committee's report was placed before the Council at its last meeting and the Council approved the same with a few modifications relating to the procedure to be adopted by the Executive Committee. The Committee is to consist of three members of the Council to be elected every year with power to co-opt any other member. The Chairman of the Committee shall be the President, in his absence the Vice-President. The Council may delegate to the Committee any of its powers. The Committee has power to appoint the Registrar temporarily.

The above Committee was entrusted also to frame rules relating Sec. 16 (4) of the Act which provides for the volutionary deletion of the name of a registered practitioner from the Medical Register. The following report submitted by the Committee was approved by the Council only one modification being made in para 6 of the report. The Council replaced the words 'any other Medical Council on whose Register the practitioner has been or is registered,' by the words 'all the Medical Councils in India'.

1. Every application by a registered medical practitioner for the removal of his name at his own request from the Register shall be accompanied by a Statutory Declaration, made by the applicant, that he is not aware of any proceedings, or of any reason for the institution of any proceedings which might result in establishing cause for the erasure of his name from the Register without his consent, or for depriving him without his consent of any qualification or licence entitling him to be registered.

2. Every such applicant shall, in the first instance, be referred by the Registrar, to the Medical Authorities who granted the applicant his qualification or qualifications, in order to ascertain whther there is any valid objection to such removal.

3. The Registrar shall bring the application before the next meeting of the Executive Committee, who shall consider the application and any objection thereto and report to the Council.

4. The Council shall, if they think fit, by formal Resolution, put by the President from the Chair, direct the Registrar to remove the name of such applicant from the Register.

5. The Registrar shall, upon the removal of the applicant's name from the Register, send notice of such removal to the applicant by a letter addressed to his registered or last known address.

6. When the name of any registered medical practitioner has been removed from the Register under this section the Registrar shall notify such removal to any other Medical Council on whose Register the Practitioner has been or is registered and the Registrar of such a Council will be requested on receiving this notification to remove forthwith the name from his Register.

7. The Registrar may restore to the Register, subject to the provision of sections 13 and 14 of the Act, the name of a medical practitioner which has been removed by him under the provisions of this section.

GOVERNMENT ORDERS.

The readers may remember that the following resolution was moved by Dr. V. Rama Kamath and was approved by the Council at the March 1941:

"The Madras Medical Council desires to point out to the Government that it is detrimental to the interests of the Medical Profession and the public to fix the maximum age-limit of 35 years for candidates appearing for the T.T.D. diploma, newly instituted by the Madras Government that the maximum age restriction may be done away with."

The Government Memorandum on the above subject No. 19770-2-D-2 dated 20th June '41, was placed before the Council and the Council passed the following resolution while recording the memorandum:

"While recording this Government Order this Council requests Government that with reference to applications of such of those individuals who have been working in an honorary capacity in Tuberculosis Clinics in the Presidency, the age-limit may not be strictly enforced."

The Council at its meeting held on 17th April 1939 passed the following resolution:

"The Madras Medical Council recommends to Government that medical missionaries who came from non-reciprocating countries but who possess a suitable qualification or degree be admitted to the register of the Madras Medical Council for such time as they continue to work with their

medical missions, and do not carry on private practice for personal gain."

"This Council further requests the Government to so modify the Madras Medical Registration Act as to enable this conditional registration."

The Government have accordingly published a Bill to amend the Act to suit the sense of the above resolution.

MISCELLANEOUS ITEMS.

All India Medical Register: The Government of India forwarded to the Government of Madras the following resolutions passed by the Medical Council of India:

I. (*a*) Provision should be made for the maintenance of an All-India Medical Register by the Medical Council of India.

(*b*) This register should include the following two groups:—

(i) All persons who hold quaiifications borne on the Schedule to the Indian Medical Council Act, 1933.

(ii) All persons who are practising the Modern Scientific System of Medicine in British India on the date the register comes into force and possess qualifications granted on or before the 31st December 1941 by Examining Bodies in British India (other than the Universities and whose names are on the registers maintained by the Provincial Medical Councils on that date.)"

The local Government informed the Central Government that they had abolished the Medical School education and had at present one uniform standard of University medical education. In regard to the common All-India Register, the Madras Government said that they would gather the opinion of the Surgeon-General and the Madras Medical Council and forward the same. Accordingly the subject matter of the All-India Medical Register was placed before the Medical Council at the last session and the following resolution was passed:

"The Council agrees to have an All-India Medical Register in case the names of all practitioners in the said register are arranged in an alphabetical order and all those registered practitioners on the register are entitled not only to vote but also to stand for election to the Medical Council of India."

A and B Class Practitioners Registered by the Central Board of Indian Medicine: Dr. G. V. Hanumantha Rao, Secretary, Guntur District Branch of the Indian Medical Association, brought to the notice of the Council through the Registrar that the Practitioners of the indigenous systems of medicine were styling themselves as Registered Practitioners deliberately with a view to be passed as the practitioners belonging to the Allopathic System, who are on the Madras Medical Register and that the public were likely to be confused. He suggested that this matter should be brought to the notice of the Government and that the Madras Medical Council should propose to the Government the desirability of appointing a Committee to go through the qualifications of the B class practitioners found in the Register belonging to the Central Board of Indian Medicine. The Council passed the following the resolution:

"This Council requests the Government that in view of the misunderstanding confusion and deception caused among the public by the use of the term, "Registered Medical Practitioner" both by the practitioners of the Modern Scientific System of Medicine and the Ayurvedic and other systems of medical practitioners, to direct that practitioners of Indian Medicine, whether A or B class be permitted to use the terms Licensed Ayurvedic, Siddha or Unani practitioners," only, while term Registered Medical Practitioners be strictly confined to those who have registered under the Madras Medical Registration Act."

Council Accepts Government's Decision and Throws Out Government's suggestion: In the Review of the proceedings of the March Session of the Council, it was said that one Dr. S. Asirvatham Nadar whose name was erased by the Council for the alleged breach of Medical Ethics and was restored on appeal to the Government. The Government in their decisions suggested to the Council that the practitioner might be re-tried as it was the opinion of the Government that the offence of the distribution of hand bills said to have been distributed by the practitioner was not proved. The readers might remember my comments on the decision of the Government. In brief, I said that the Government ought to have remanded for re-trial instead of allowing the appeal. The Council appointed a Committee at the March 1941 Session consisting of Drs. Gurumurthi, C. R. Krishnaswami and V. Krishna Menon. It is not clear from the proceedings for what purpose the Committee was appointed. The Committee cannot have power to review the decisions of the Government. Yet the Committee decided that purpose would be served if the practitioner was re-tried as the person who supplied the information refused to a declaration and the Council accepted the committee's decision. The Committee seems to have forgotten that Dr. Asirvatham was tried on an information and that no declaration is required while information is supplied. Even when a person who makes a complaint with a declaration does not appear before the Council to prove his case by anybody, the Council has to prove the case the Registrar taking the place of the complainant and in the case of information neither a declaration from the person who supplies the information nor his presence is necessary. The Government pointed out that the authorship of the hand bills was not proved. The authorship might have been elicited from the printer of the hand bills. This procedure was certainly more commendable than the shirking of responsibility of a re-trial as suggested by the Council. There is a feeling outside the Council that the Council usually takes a lenient view of disciplinary cases and there is a general feeling throughout India that Medical Ethics is flouted inspite of the presence of Statutory Medical Councils. In the circumstances the decision arrived at by the Council in not retrying the practitioner as suggested by the Government is likely to justify what is loosely talked about out of the Medical Councils.

Indian Medical Degrees Act 1916—Madras Amendment to the Act No. 20 of 1940: It was mentioned by me while reviewing the proceedings of the March 1941 Session of the Council that the new section 6-A would be applicable to those who possess foreign qualifications not recognised by the Provincial Governments and that it might be objectionable for a practitioner to own M. D. (Berlin) or M.D. (Vienna) as these qualifications are not recognised by the Provincial Governments. It was mentioned that this matter was referred to a Committee, consisting of Drs. P. Gurumurthi, V. Krishna Menon and C. R. Krishnasami. This committee submitted its report in which it is said that the titles such as M. D. (Berlin), etc., do not come within the meaning of Section 6-A. .

All the same the committee suggested to the Council to address the Government to permit the practitioners to use foreign qualifications not recognised by the Provincial Governments. The Council accepted the report.

In matters like the above the opinion of the Council should be of a definite nature and not equivocal.

Dr. P. Gurumurthi's resolutions not approved by the Committee: Dr. Gurumurthi gave notice of 6 resolutions at the March 1941 Session and withdrew 2. The other 4 were not approved by the committee of which he was himself one of the three members. It is said that Dr. Gurumurthi could not attend the meeting of the committee. The resolutions appears on page 292 of The Medical Practitioner (Vol. XII, No. 10).

Irregularities in the Madras Medical Register: Due to mismanagement in the office of the Registrar for some years before 1930, there was systematic fraud to screen lot of irregularities which cropped up both in the manuscript register as well as in printed registers, and they have been reprinted in the printed registers ever since. The following were the irregularities:

(1) Practitioners having two registration certificate numbers;

(2) More than one practitioner having the same registration number.

(3) Erasing of names and substitutig them by other names in the manuscript register.

(4) Want of significance of initials in the manuscript register.

(5) Names not found in the manuscript register but found in the printed register.

(6) 'O' being used as a registration number.

In addition to the above irregularities there are at present over for names in the printed register whose addresses are not known. There are also some practitioners who give evidence of their having paid the fees demanded for registration but who are not registered.

At the March 1941 Session, the Council appointed a committee consisting of Drs. Rao Bahadur S. Rama Krishna, C. R. Krishnaswami and V. Rama Kamath to rectify the above irregularities. The Committee requested Dr. V. Rama Kamath to draw a report suggesting ways to remedy the irregularities. Such a report was submitted. The Committee approved the report and forwarded the same to the Council. The Council accepted the recommendations made in the report and entrusted the Registrar and Vice-President Dr. C. R. Krishnaswami to carry out the corrections. Personally I feel that the Council has no power to saddle the Vice-President with the executive duties especially so, when the President is in office.

Maintenance Grant by the Government: The above Committee was entrusted by the Council at the March 1941 Session to find out ways and means to balance the budget. Dr. V. Rama Kamath submitted a report to the Committee. The report did not approve the suggestion of the Government to increase the fee for registration by Rs. 5. The report suggested that punishment by fines may be instituted in Disciplinary Cases as is done in Great Britain and concluded by mentioning that the Government should balance the budget by annual grants. The Council accepted the unanimous proposal of the Committee to balance the budget by Government Grants.

RESOLUTIONS.

Dr. V. Krishna Menon moved the following resolutions:

I. "This Council resolves that the minutes (or proceedings) of the Madras Medical Council shall be printed annually in separate volumes and made available for sale."

Seconded by Dr. M. V. Krishna Rao. *Carried.*

II. (*a*) "This Council resolves that the Medical Council shall appoint annually at the end of the last meeting of the year, a Penal Case Committee for the succeeding year consisting of four members of the Council, in addition to the President who shall be the Chairman, and of such four members, two shall represent the Moffussil."

This resolution was withdrawn by the mover:

II. (*b*) "And further the following shall be substituted for the latter part of rule 4 (1) beginning with "The Council may then" and ending with "The Committee shall report to the Council":—

"The Committee shall deal with and dispose of all penal cases referred to the Medical Council under sections 13 and 16 of the Act and the Committee shall meet on such date previous to every session of the Council as will allow for the issue of notices of inquiry in those cases to which the Committee are of opinion that the Council should hold an enquiry."

This resolution was withdrawn by the mover.

Dr. V. Govindan Nayar moved the following resolutions:

I. "This Council resolves that in future proper arrangements be made for recording in full the proceedings of the Council."

This resolution was withdrawn by the mover.

II. "This Council resolves that copies of the detailed proceedings of the Council be made available to the Medical Press of India."

This resolution was withdrawn by the mover.

III. "This Council resolves that the proceedings of the Council constituted itself as a court under section 17 (1) of the Madras Medical Registration Act, 1914, should also be recorded in the minutes of the Council."

Dr. M. V. Krishna Rao proposed that the above be amended as follows:

"This Council resolves that the proceedings of the Council constituted itself as a court under section 17 (1) of the Madras Medical Registration Act, 1914, should also be recorded as a supplement to the ordinary minutes and supplied to all members of the Council."

This was accepted by the mover and carried.

Dr. V. Rama Kamath moved the following resolution:

"The Madras Medical Council requests the Government that cases of in famous conduct in a professional respect relating to registered practitioners under the employ or control of the Government and Local Bodies should be brought to the notice of the Madras Medical Council for necessary action."

This was seconded by Dr. P. S. Srinivasan.

After discussion the above resolution was amended as follows and carried.

I. "The Madras Medical Council requests the Government that cases of proved in famous conduct in a professional respect relating to registered practitioners under the employ or control of the Government or Local Bodies should be brought to the notice of the Madras Medical Council by Government for necessary action, apart from any action that Government or the Local Body itself may decide upon in the matter instituted."

II. "The Madras Medical Council respectfully points out to the Government that the decision of the Government that physical fitness certificates in the case of candidates for employment in certain branches of the public service should be given by Medical Officers in Government service and that existing orders of the Government under which applicants for employment in Government service having defective vision should produce special certificates regarding eyesight from eye-specialists in the employ of Government, are against the spirit of the Madras Medical Registration Act and that therefore no invidious distinction should be made between Government-paid-registered practitioner and independent private pratitioners in the matter of issuing certificates of whatever nature."

Seconded by Dr. P. S. Srinivasan and supported by Dr. M. V. Krishna Rao.

Carried.

III. "The Madras Medical Council is of opinion that the Licensed Medical Practitioner Diploma known by the short title L. M. P. does not convey the idea that the medical practitioner owning this title, is a diploma-holder in medicine and surgery that the new diploma D. M. & S. conferred by the Government on those who passed out of the medical schools, indicates the real significance of the course of studies which students in the medical had to undergo and that consequently the practitioners holding the diploma of Licensed Medical Practitioner will be looked down in the estimation of the public. The Council therefore requests the Government that their order relating to D. M. & S. diploma be given retrospective effect in the way they did in regard to L. M. P. diploma conferring the same on all who passed out of medical schools undergoing two and three years' course of studies though the L. M. P. diploma was introduced after the course of studies in the medical schools was increased to four years.

The Council considers further that the new D. M. & S. diploma will give rise to cleavage in the medical profession to prevent which the Government were recently pleased to amend the Medical Registration Act, 1914, a reform which has democratised the medical profession to a great extent. Such a cleavage, the Council desires to point out to the Government is not justifiable and uncalled for when it is known that the Government have abolished the medical schools and the conferment of the new diploma will cease after a couple of years and with it the diploma itself."

This was seconded by Dr. V. Krishna Menon and supported by Dr. (Miss) J. Findlay.

Carried.

As usual I have reviewed only such items of the proceedings which are of interest to the members of the medical profession. These items form the bulk of the proceedings. The minor items concerning office, etc., have been omitted.

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.

Abstracts.

PROBLEMS IN INSULIN THERAPY.

FRANK N. ALLAN, M.D.,

Department of Internal Medicine, The Lahey Clinic, Boston, Massachusetis.

Twenty years ago Dr. Fred. Banting, an obscure young physician, conceived a plan to solve a physiologic problem which had baffled scientists for several decades. This winter Sir Frederick Banting, world famous from the successful outcome which brought help to humanity, lost his life in the service of his country.

Banting's discovery of insulin received prompt recognition from physiologists and physicians throughout the world and its merits were appreciated by the general public as well as by sufferers from diabetes. As everyone knows, he was awarded the Nobel prize and given other important distinctions. He was promoted to the chair of medical research in his alma-mater and given an annuity by the Canadian Government. Additional honors came with the years. The research institute which bears his name was erected at the University of Toronto ten years ago giving him additional scope for useful service. In 1934 he was knighted by the king. Now his life has come to its close in the midst of important activities. It is fitting that a discussion of insulin at this time should begin with a tribute to the man who gave it to us. The practice of every physician who deals with diabetic patients has been influenced by the work of Dr. Banting. All of us owe him a debt of gratitude.

PHYSIOLOGY.

The discovery of insulin was followed by intensive laboratory research and clinical study represented by an enormous number of publications. A monograph published two years ago (Jensen) dealing only with the chemical and physiological properties of insulin cited 624 references. Clinical papers seem countless. Among the many physiological researches of varying importance I wish to direct attention to three studies which have a direct bearing on the treatment of diabetes.

I. *The Glucose Equivalent of insulin.* When insulin was first used, it was commonly understood that each unit of insulin would provide for the metabolism of two grams of glucose. This rule applies only in a limited range and it is often widely misleading. Experiments on diabetic dogs showed that the amount of glucose utilized by each unit of insulin (the glucose equivalent) might reach twenty grams depending on the size of the dose used. As the dose is inreased, the total effect is increased of course, but the work done by each unit is less. This rule first demonstrated in diabetes induced by pancreatectomy, has now been shown by Young to apply in the experimental diabetes produced by administration of pituitary extract. It was furthermore shown that the glucose equivalent would vary with the amount of glucose provided by the diet. When the dosage of insulin was kept constant and the carbohydrate in the diet increased, each unit of insulin provided for utilization of a larger amount of glucose. Those not aware of this rule have sometimes concluded from insufficient evidence that a high carbohydrate diet would permanently promote production of more insulin from a weakened pancreas. It has been demonstrated that sugar does indeed stimulate production of insulin from the normal pancreas. It might temporarily stimulate a weakened pancreas but at the cost of later damage. Disregard of these facts regarding the pharmacological action of insulin has led to error in theoretical discussions of diabetic metabolism and has also led to injudicious adjustment of insulin dosage in the treatment of diabetes. One must keep in mind the fact that the work done by each unit of insulin varies greatly.

The variation depends on the size of the dose, the amount of glucose provided by the diet and doubtless on many other factors as well. It is essential to observe the individual response and govern treatment accordingly.

II. *The effect of insulin on the structure of the Pancreatic Islands.* Uncontrolled diabetes causes histologic evidence of damage to the islands of Langerhans in the pancreatic remnant of dogs submitted to subtotal pancreatectomy, Microscopic examination of tissue taken from the remaining stump of pancreas shows distinct degenerative changes. A section taken after treatment with insulin shows return to normal appearance. This fact was demonstrated independently by Copp and Barclay and by Bowie more than fifteen years ago. Similar observations were reported last year by Lukens and Dohan in dealing with diabetes produced in cats by partial resection of the pancreas and administration of pituitary extract.

III. *The Effect of Insulin on the Function of Pancreatic Islands.* It has long been thought largely as a result of indirect evidence that overwork would decrease the capacity of the islands to produce insulin and that rest would permit increase in that capacity providing irreversible changes had not occurred. The trend towards increased feeding of carbohydrate has caused less attention to be given this well known teaching of Frederick M. Allen. New support for the idea has now come from two observations. The production of experimental pituitary diabetes in dogs can be prevented by simultaneous administration of insulin, by fasting and by a diet low in carbohydrate and high in fat (Haist, Campbell and Best) Pituitary diabetes in cats can be cured by administration of insulin if the treatment is given at the right time (Lukens and Dohan).

Objectives of Diagnosis and Treatment. Differences of opinion regarding the optimal diet for diabetic patients have always existed. Proponents of different methods support their ideas with great zeal. In the light of the facts outlined above my own aims are first, that potential diabetes may be kept from developing into frank diabetes by a diet low in carbohydrate and high enough fat to provide adequate calories and second, that cases in which diabetes has just begun may be restored in some measure by treatment with insulin in addition to such a diet. It should be of great importance to discover even mild diabetes as early as possible and of equal importance to investigate cases of transient glycosuria which may represent protential diabetes. The clinical diagnosis of diabetes is made when there has been a breakdown in metabolism corresponding to congestive heart failure in the diagnosis of cardiac disease; constant glycosuria and hyperglycemia correspond to edema and ascites. The diagnosis of heart disease is commonly made long before failure occurs; there is need for corresponding discovery of diabetes before it has become "decompensated." From the standpoint of prevention especial attention should be given to those who have a family history of diabetes and to patients who have gallbladder disease and obesity.

DIFFICULTIES IN INSULIN THERAPY.

The effectiveness of insulin in controlling diabetes was quickly recognized in 1922 and as soon as it was made available it was employed in every part of the world. Yet there is reason to believe that insulin is still not used as widely nor as adequately as needed. Circumstances which have in the past retarded adoption of treatment must still interfere with satisfatcory use of insulin. It is important to see what these difficulties are. It must be admitted that treatment with insulin is not as simple as treatment with ordinary medication. Difficulties are met with in the routine handling of all cases and certain exceptional difficulties are encountered in a few cases. The latter are naturally now more common because of the greater number of cases treated.

Multiple Injections. The employment of insulin in the beginning was limited by the need for administration by multiple daily injections. It is a nuisance to all

and a burden to many. The need for regulation of the diet in conjunction with insulin therapy was another disappointment. Yet patients can be persuaded to accept the treatment when needed and experience with both diet and injection makes the regimen become more simple.

The introduction of protamine insulin has diminished the need for so many injections. Most mild cases can now manage with a single dose daily. However cases of moderate or severe degree almost always need regular insulin in addition to protamine insulin. It is our practice to use both when more than forty units are required in one day. It is difficult to stimulate artificially the production of insulin from the normal pancreas which automatically produces it as needed. It may be that newer modifications of insulin such as globin or histone insulin may help.

Insulin Reactions. Hypoglycemic reactions from overdosage have always been feared but have actually caused few serious results in spite of the careless manner in which insulin has so often been used. Apart from actual neglect their occurrence may be due to the following causes—failure to balance the dosage of insulin with the diet to permit the insulin to exert its optimal effect, lack of laboratory control of the adjustment of dosage, failure to scale down the dosage prescribed for juvenile cases, dependence on rules for dosage which have only limited application, and the use of protamine insulin when regular insulin should be preferred. All these difficulties should be avoided if the inauguration of insulin treatment in each case is considered an individual problem. It must be emphasized that no rule regarding insulin dosage can be applied in all cases.

Most children over twelve years and some under this age require as much insulin as adults but on the average, children from six to twelve years need approximately one-half the adult dosage, children six and under, one-quarter the adult dosage or less. Thus ten units for a child of five may correspond to a dosage of forty units for an adult. These figures can serve as a basis on which to begin treatment with later adjustments to be made according to the response.

Two common rules proposed to guide insulin treatment need critical consideration. To give one unit of insulin for every two grams of glucose to be metabolized may lead to extreme overdosage particularly when insulin is given along with intravenous injections of glucose. As explained above each unit may have an effect much greater than this. It is safer to give not more than ten units for each fifty grams of glucose injected intravenously.

To give twenty units for every test of the urine reported "red" or "four plus" and none when the test is "blue" or sugar free may also be unsatisfactory. Twenty units given because of a red test at night may lead to hypoglycemic reaction if a large amount of insulin has already been given earlier in the day and in particular if protamine insulin has been used; on the other hand a blue test in the morning would lead to omission of the breakfast dose according to this rule, when it is actually needed to prevent return of glycosuria. The dosage required at any time depends not on the color of the Benedict's test nor even on the level of the blood sugar but more on the amount of insulin already at work in the body. One can be bold in increasing the dosage of insulin in the early part of the day, but towards evening one must be cautious.

Insulin Allergy. Allergy to insulin is not uncommon but fortunately it is usually mild and temporary. The usual manifestation is a local irritation at the site of the injection which appears in the second week of treatment and disappears spontaneously in the next month. It is often not brought to the attention of the physician and the patient may endure the discomfort without complaint. Less commonly there is an intolerable painful swelling and in a few rare cases, there is a generalized reaction manifested by urticaria, circulatory, and abdominal symptoms.

Sometimes a change in the preparation of insulin employed is all that is needed. Now that the solution of insulin crystals is on the market this in the logical kind of insulin to use. However some patients are sensitive to all kinds of insulin including crystal insulin. Then one has to face a difficult problem. One may attempt desensitization by injection of graded doses of insulin beginning with dilute solution. Injection of graded doses of histamine has also been employed and administration of histaminase is a new procedure now on trial. By any of the present means of treatment the results are uncertain. The patient may be obliged to tolerate the discomfort of local reaction until he becomes desensitized spontaneously or if his diabetes is mild enough one may adjust the diet to control it without insulin.

Visual Changes. Blurring of vision is a common complaint when insulin treatment is begun and in some cases this may be alarming. It is a temporary disturbance which subsides in one to three weeks so that there is no occasion for anxiety. When organic changes in the lens and retina can be excluded, the visual change can be attributed to a change of refraction because of effects on the lens of the rapid change in the concentration of sugar in the body fluids. It is well to mention the possibility of temporary visual impairment to any new patient. He should also be advised to defer purchase of new glasses for a month.

Insulin Resistance. One of our patients has required from 300 to 1600 units of insulin daily for over two years. The situation seemed hopeless for a time. The tremendous dosage and changes in the requirement made treatment unusually difficult. Acidosis occurred frequently when insufficient insulin was given. However the patient was kept alive and regained health sufficiently to return to work. In recent months the amount of insulin needed has gradually declined and there now seems to be prospect of return to his former status.

The ordinary case of severe diabetes seldom requires more than 60 to 100 units of insulin. Refractory cases requiring larger doses of insulin for maintenance are fortunately rare. However an increasing number is being encountered. The gratest dosage of insulin on record was employed in the case of Wiener in which for sixteen months hundreds of units of insulin were given daily including 2000 units for several weeks and on one day over 3200.

Any diabetic patient may require much more insulin than usual when the diabetes is complicated by acidosis, infection, or gangrene, but one does not expect to use more than 100 units in twenty-four hours for more than the first day or two. If 200 units has to be given after the third day one must suspect that there is something else wrong. The function of the pancreas and the action of insulin may be modified by disorders of other endocrine glands, by changes in the liver, and lesions in the central nervous system. There may be interference with insulin action because of allergy and other physical and chemical disturbances. There has been speculation in regard to the possibility of the presence of an anti-insulin or lack of an insulin complement. There are many unsolved problems raised by the occurrence of cases of diabetes resistant to insulin. Their study should help to throw more light on metabolism. From the practical standpoint it is important to know that such cases exist so that one may be prepared to use insulin in the dosage needed no matter how large the dose may be, in order to save life.

Conclusion. In considering all the problems and difficulties which may arise in insulin treatment one can readily see that none should actually interfere with successful control of diabetes. Attention to the details of individual behaviour and patience in making necessary adjustments ensure safety and preservation of health.

The Journal of Medicine,
October 1941.

FUNCTIONAL DISORDERS in WOMEN

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ALEMBIC CHEMICAL WORKS COMPANY, LIMITED, BARODA.

THE Medical Practitioner

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THE INDIAN MEDICAL ASSOCIATION AND THE INDIAN MEDICAL PROFESSION.

Hyderabad, the capital of His Exalted Highness, the Nizam was the venue to demonstrate the activities of the Indian Medical Association under whose auspices the 18th All-India Medical Conference was held last December for three days commencing from the 26th of that month. Under the leadership of Major M. G. Naidu as the Chairman of the Reception Committee, the members of the medical profession in Hyderabad served as the hosts. Major Naidu was the fittest person to occupy the Chair in the Reception Committee as he is to our knowledge, the first as such, the oldest member of the Indian Medical Association in the Nizam's State, older than Lt. Col. Shastry who is said to be the President of the local Branch of the Indian Medical Asscciation. The position occupied by Major Naidu as the Chief of the hosts was natural, though he had to say out of modesty that the honour was thrust upon him. Lt.-Col. Shastry was only a bird of passage compared with Major Naidu who built the nest for himself in Hyderabad and knew his habitation and its surroundings much more than Lt.-Col. Shastry on active Military Service, who cannot have nests of his own till at least the period of war. The Indian Medical Association had the benefit of the guidance of the leaders of the type of Major Naidu, Chairman of the Reception Committee and Dr. K. S. Ray, the President of the Indian Medical Association, whose work as the General Hon. Secretary ever since its inception, has found recognition by his being elected as the President for two consecutive terms, an honour which would not have been bestowed on anybody unless for his rare gift of constructive leadership. Major Naidu is one of the few old veterans in the Indian medical profession, who from the very beginning of the existence of the Indian Medical Association was able to see opportunities of service to the medical profession and the public by the All-India organization of medical men, which fact he rightly stressed in his address. He condemned the critics among the ranks in the medical profession whom Major Naidu described as, 'Sceptics and Scoffers' and 'for the benefit of the unbelievers', he quoted a passage 'from Newman' which he did with the hope that it will 'break down their apathy and make them workers in the field of active co operation for the benefit of mankind. Relating to the activities of the Indian Medical Association Major Naidu said:

"It would be sheer ingratitude, however, if we did not appreciate the earnest efforts of the Indian Medical Association in getting the work and worth of Indian medical men and women recognised by the authorities, or failed to congratulate them on their success even if partial, in fighting the prejudice and perversity of vested interests."

Major Naidu's estimate of the work turned out by the leaders in the Indian Medical Association as quoted above speaks for itself. He seems to have little or no interest for the ranks in the profession. He is angry with "those with poor qualifications" who have settled in cities like Hyderabad. He dubs the latter class in the profession as "the inefficient doctor who scores a success over his betters and exercises more wit than knowledge in his work. "Of such" Major said, "there is a large number in every city, and Hyderabad is no exception. This unhappy competition leads to undesirable methods of practice such as indirect advertisements, touting, mopping up of cases belonging to others and many other breaches of discipline and ethics All the

while, the country-side is starving for medical aid even of a second rate quality."

The absence of any plan or any programme to lift the humble folk in the medical profession to the level occupied by Major Naidu and others like him who alone should practise in cities according to the future plan of the activities of the Indian Medical Association, should convince disinterested critics that Major Naidu is not concerned with the rank and file in the profession who have been assigned by him a place 'in the country-side.' At the same time in another part of his address he assumes the role of one who is very much interested in rural medical aid and rural hygiene 'which,' he says, 'are so inextricably mixed with those of economics that it is difficult to speak confidently their solutiou.' We wonder how a person of the age and experience of Major Naidu could forget a large number of medical men in India, who have "poor qualifications" and yet who have been able to do solid work of the type which Major Naidu demands from medical men like himself. His memory could not fail him that one amongst them was honoured and elected as the President of the Association. There is another humble medical man who was able to convert a village into a town by attracting the people of the villages towns and cities of India on account of his professional skill and reputation and who is now the guest of His Exalted Higness, the Nizam, doing propaganda in the Nizam's State for preventing blindness. As regards Major Naidu's condemnation of the medical men with 'poor qualifications' as being responsible for indiscipline and breaches in the code of medical ethics, we would ask Major Naidu to send for the report of two meetings on Medical Ethics, held in Bombay on 30-1-'41 and 7-4-'41 by the Bombay Medical Union. In a city which is the biggest and the nearest to Hyderabad, the President of the oldest Medical Union in India made a very sorry tale of those possessing the highest qualifications in regard to breaches in the code of medical ethics. We wish Major Naidu would realise that it is not always possible to give the dog a bad name and hang the same. The present state of the medical profession in India and the future of the Indian medical profession demand from leaders in the position of the Major Naidu a more liberable and unprovoking estimate of medical men whom Major Naidu describes as men of 'poor qualifications'. It should not be made to appear either directly or by implications that "the fighting the prejudice and perversity of vested interests" is for the purpose of transferring power and authority from those possessing a foreign white skin to those possessing a brown skin and medical qualifications higher than the 'poor qualifications' referred to by Major Naidu.

Dr. K. S. Ray, the President, reiterated the stock expressions relating to "various problems which fall on our profession-grave problems with which are linked inseparably the health and prosperity of our nation". He also confessed that these problems had been before the yearly All-India Conferences organized by the Indian Medical Association for 18 years and in a way expressed the helplessness of the Association for want of "proper response from the authorities in whose hands action lies". Yet consistent with the phraseology now adopted in communicating to the public the war news Dr. Ray said, "much has been achieved during the last eighteen years that we had been holding these conferences but a good deal more has to be secured. Days are changed and are rapidly changing, and no power and no vested interest can lightly treat the voice of an organized body as ours," "yet", says the President, 'the curious position is that hundreds of qualified medical men are going about without employment and are hardly able to make a bare living'. Where than does the cause of this deplorable situation lie? We cannot be convinced as Dr. RAY seems to be that the cause lies entirely on the authorities. Nor can it lie on the medical profession which consists of the rank and file in very large numbers, who though they form the largest bulk cannot on account of their humble position speak for themselves as the leaders do. The latter are holding the strings of the All-India Medical Association, who while speaking for the profession have done very little for the humbler folk who have been the main sinews of the Association. Far from sympathising

with their lot they are described as the black sheep. All concerned forget that the sheep serves as food to those who condemn them. We wish there were signs of a change in the angle of vision in the leaders in the Indian Medical Association, who should view things with a broader outlook and be more sympathetic to the rank and file in the profession. We hope the President would turn his eyes inwards towards the working activities of the Association and see that the term 'vested interests' are out of the scope of the activities of the Association which even with the existing apathy of the authorities should find out ways and means to have a bare living to the members of the profession. Dr. Ray gave out a long list of the activities of the Association fron 1929 till 1941, from the Presidential chair at Vizagapatam and he repeated a few of them at Hyderabad. But we fail to see if any one activity was likely to improve the lot of the general practitioner. If the Association concentrates all its activities towards the lot of the members of the profession to enable them to have a bare living and does nothing more till this is achieved to an extent likely to be felt by them, the Association will have stronger sinews with higher morale to fight out the 'vested interests' out side the Association. Medical Education, Indian Drug Industry, Medical Research, Post Graduate Training, Quackery, Unemployment Among Medical Men etc., were amongst the special subjects discussed by Dr. Ray in his Presidential address. He reiterated the pious hopes without giving a lead as is usually done by leaders in All-India gatherings year after year. Regarding medical education his address to his audience was not dissimilar to the address to the jury by a judge. Though in words such addresses are of a non committal nature, an intelligent jury could know the mind of the judge. The President while summing up his address relating to Medical Education says:

"Conditions in different provinces differ and while there is a strong body inclined to the view that the medical education should be uniform and equal almost to the college standard there is also the opposite view that lower standard is necessary particularly in the *interest of the rural areas*, and that the effect of abolition of medical school education may mean a heavy fall in the number of qualified practitioners in rural areas. There is, however, unanimity in the view that the students should have a higher type of preliminary education and the present standard of education in medical schools is unsatisfactory and must be improved."

If one can read between the lines Dr. Ray is for perpetuating two standard of Medical Education at two different levels which will keep in perpetuity the divide and rule policy. This apart, lower standard of medical education is certainly inconsistent with the ideals of village reconstruction about which Dr. Ray pleaded vehemently in his address so also did Major Naidu. The other subject which affects the scientific medical profession is quackery. The present tendency seems to be to recognise quacks rather than condemn them. The popular Congress Government which has to mind votes and which was in the saddle for a short time did actually encourage quackery by registering them in separate registers. In the Madras Presidency their number has reached to 30,000 and in Bombay and other provinces it is steadily multiplying and the successive Presidents of the Indian Medical Association are silent about this increase. Politics as practised by the politicians is not true politics which is a science of good Government and the politics in India is likely to increase quackery. The policy of those who wish to rule cannot be always conducive to scientific advancement of medicine though it may help scientific advancement for destruction which role science is made to play now by the all-world politicians. The leaders in the noble medical profession should keep their heads above the politics of the Government of the people. They shouldfearlessly fight for politics which conveys the idea of good Government for the welfare of the people. Viewed in this light the address of the President at Hyderabad was not above the level of the routine addresses that came from the Presidential chair year after year. The Medical Profession should aim at quality and not quantity. Dr. Ray from what we know of him is a shrewd and intelligent medical man and is as scientific in his outlook. Perhaps he has more faith in quantity than in quality relating to the evolution of the Indian Medical Association.

MAYOR CORRECTS OFFICIAL DEFAULT.

There is discontent throughout India that the country is not satisfactorily protected against an impendiug invasion by the enemy. We cannot take the role of a political cretic. But in regard to war measures relating to military medical service and medical aid during the air raids on civil population, we have to say that there has been culpable lack of imagination. These two years during the period of war we have been suggesting in these columns ways and means to stimulate recruitment for emergency war service and we did also point out to the authorities how best medical relief to civil population during air-raids, could be commandeered with the help and co operation of the members of iudependent medical profession. For this purpose we hinted that a meeting of the doctors in the City of Madras might be summoned by those who are in charge of A.R.P. work so as to enable the medical practitioners to have their say in the matter. Though our suggestion had not the desired effect in Madras, we are consoled that in Calcutta a meeting of the medical men was recently summoned and was addressed by the Minister in charge of Medical Port Folio, and the Surgeon-General. The Mayor of Madras is reported to have conceived the idea that without the co-operation of non-official doctors A R.P. work cannot be complete; and we understand that the Mayor will soon convene a meeting of the medical practitioners in the City. We trust the practitioners in the City will respond to the Mayor's invitation in large numbers and bring credit to themselves showing a lead to the doctors outside Madras.

We pointed out in these columns a couple of months ago that it was a very fortunate circumstance that Madras has one qualified doctor roughly for every thousand of its population and the A. R. P. medical relief work could be spread evenly throughout the roads in the City and there would be a doctor for each mile length of road. It is well known that the people as a rule do not like the idea of going to hospitals if they could help it and prefer to go to private practitioners. We mean no disrespect to the official medical practitioners. They are the creatures of administrative rules and regulations which are wound up and securely tied with the red tape. If during adversity the official and non-official medical men work in harmony which they are bound to do, this temperorary adversity will strengthen the bonds of friendship and cordiality amongst medical men and out of evil will come good. We should say that the work of medical relief during air raids is not less onerous or even less risky than that on the battle field and the Government and public should realise that medical men especially such of those who are exposed to danger should be compensated on the same scale as their brethren in active war service. It is too much to expect honorary service when life is in danger as those who have to risk their lives, have their responsibilities to their wives and children in case of death or disability. Even Government medical officers while doing A R. P. work should be assured protection against risk of lives. If as referred to above officials and non-officials work hand in hand in perfect harmony, the morale of the public will not be affected and with it there will be little or no panic. We earnestly hope that the Mayor will not stop with the convening of the meeting of doctors in the City but will pursue his endeavours till what he has at heart is achieved. If this is done, is mayoralty will ever be remembered for having achieved a task which those in authority failed to do—we may as well say could not do.

A NEW APPOINTMENT.

The designations given to the officers in the Medical Department do not indicate the actual nature of work turned out by them. For example there are for all practical purposes three cadres, the Sub-Assistant Surgeon, the Assistant Surgeon and the Civil Surgeon called also by the name District Surgeon. The officers belonging to the first two cadres invariably hold charge of independent stations and do professional work independently yet they are known as sub assistants and assistants. The idea seems to be a complex of subordination though a particular office may do independent work.

Consistent with the nomenclature in the Medical Department the name Surgeon-General was given to the Head of the Medical Department. Such an office or even a department never existed in the British Isles when the Medical Department was first created in India nor does it exist even now. It looks as if the name was borrowed from America but curiously enough the Surgeon General in America is one who is in charge of Public Health Department. We have no idea from where the imaginative American got this novel name for a Public Health Officer. The Surgeon-General in India has been a member of the Indian Medical Service. Thirty years ago and earlier the immediate assistant to the Surgeon-General was also from the I. M. S. and was called the Personal Assistant to the Surgeon-General. The latter post was Indianised and, a senior Civil Surgeon took the place of the I. M. S. officer. The duties of the Surgeon-General are published in a Government book called the Civil Medical Code. In the same publication could be seen the duties of all medical officers in the Civil Medical Department. But no where we could see the duties of the Personal Assistant. Virtually a convention seems to have been established which has the force of a Government Order even perhaps of a Statute, empowering the Personal Assistant to do all the duties of the Surgeon-General though the name Personal Assistant does not convey any idea that this officer can act for the Surgeon-General in administrative responsibilities. The Personal Assistant acts for the Surgeon-General only when the latter officer is on his chair and when he vacates this chair due to illness or exigencies of service, the same Personal Assistant can not act for him. It is a queer position indeed but it does exist perhaps due to the fact that the Surgeon-General has more than twenty *ex-officio* responsibilities and the Personal Assistant has to be *defacto* Surgeon-General. It was said that when Major-General Megaw was the Surgeon-General with the Government of Madras, he felt that there should be some reality in the responsibilities of the Surgeon-General and he suggested the need of a Deputy Surgeon-General in the place of Personal Assistant. This idea did not bear fruit perhaps due to the complex of subordination. It is said that soon after Major-General Stott took charge of office as Surgeon-General he felt the urgent need of more assistance and a new appointment has been created with the designation, Assistant to Personal-Assistant to the Surgeon-General with tne Government of Madras. Whether he is directly responsible to the Surgeon-General is not known but as he is in the category of Assistant-Surgeon it looks as if he is an assistant to the Personal-Assistant. Perhaps it may not be unlikely that the new Assistant wll have a Sub-Assistant as time goes on. We have said in these columns many a time that the Surgeon-General should have relief. Assistants cannot relieve him only a deputy can. The Personal Assistant was originally an I. M. S. officer and till three years ago a senior Civil Surgeon was in this place. But now it is the lot of the Medical Department to have a junior Civil-Surgeon. The office of the Surgeon-General is not ment only for quill-driving. It has to form and dictate policies to the Government not only relating to administration but also relating to medical education and it is regrettable indeed that the Surgeon-General is to get only the help of an Assistant to an Assistant. It can not be said that there were not even a few in the Medical Department who could serve as efficient deputies to the Surgeon-General. If war was in the way, the Government could have chosen one such deputy temporarily as an experimental measure from amongst the retired Civil Surgeons whose service as an administrator and educationist were recognised by the Government War should stimulate imagination and should not cultivate complexes. We have been saying that war should be made use of as a corrective and repeat our view once again.

Correspondence, Reports, Etc.

THE 18th ALL-INDIA MEDICAL CONFERENCE 1941, HYDERABAD.

WELCOME ADDRESS

BY

MAJOR M. G. NAIDU,

Chairman, Reception Committee.

(EXTRACTS).

Major M. G. Naidu, Chairman Reception Committee, mentioned at the outset that he had to take the place of Lt.-Col. Sastry, the President of the local Branch of the Indian Medical Association who had left on active military service and he said that his task was rendered less onerous and more pleasant on account of the support of the Nizam's Government to the Conference and the generous help of the members of the profession in Hyderabad.

Major Naidu referred to the apathy of the Governments of India relating to Medical Profession and Indian Industries and said :

"The belated and misconceived attempt to appeal to the patriotism and sense of self-preservation of the Indian medical man, after a studied and systematic course of purging him of his patriotism and demanding him of his self-respect, is regarded as an insult to his intelligence and a gross attempt to take advantage of his weakness. Patriotism which means love of freedom and one's country was and still is, a crime punishable with imprisonment. Now that there is a sudden call for its cultivation, it is argued, there is a definite want of response."

He exhorted "The Indian Medical Association" and said :

"It would be shear ingratitude, however, if we did not appreciate the earnest efforts of the Indian Medical Association in getting the work and worth of Indian Medical men and women recognised by the authorities, or failed to congratuate them on their success even if partial, in fighting the prejudice and perversity of vested interests."

He referred to the callousness of such of the members of the Medical profession who did not realise the benefits of yearly conference and said :

"Doubts exist in certain quarters, sometimes frankly and even brutully expressed and sometimes shown in a furtive non-commital way, as to the utility of holding such conference year after year and passing resolutions more honoured in the breach thau the observance. I regret to state that some of the sceptics and scoffers are to be found in the ranks of our own profession. For the benefit of the unbelievers I shall quote a passage from Newman :

"Such gatherings would to many persons appear at first sight simply preposterous. Above all subjects of study, Science is conveyed, is progated, by books, or by private teaching; experiments and investigations are conducted in silence : discoveries are made in solitude. What have philosophers to do with festive celebrities, and panegyrical solemnities with mathematical and physical truth ? Yet on a closer attention to the subject, it is found that not even scientific thought can dispense with the suggestions, the instruction, the stimulus, the sympathy, the intercourse with mankind on a large scale, which such meetings secure. A fine time of year is chosen when days are long, skies are bright the earth smiles, and all nature rejoices; a city or town is taken by turns, of ancient name or modern opulence, here building are spacious and hospitality bearty. The novalty of place and circumstances, the excitement of strange, of the refreshment of well-known faces, the majesty of rank or of genius, the amiable charities of men pleased both with themselves and with each other; the elevated board, the not ungraceful hilarity, the evening circle; the brilliant lecture, the discussions or collisions or guesses of great men one with another, the naratives of scientific processes, of hopes, disappointments, conflicts and successes, the splendid eulogistic orations ; these and the like constituents of the annual celebration, are considered to do something real and substantial for the advance of knowledge which can be done in no other way. Of course they can but be occasional ..... but I can well believe in their utility. They isssue in the promotion of a certain living and, as it were bodily, communication of knowledge one to another, of a general interchange of ideas, and comparison and adjustment of science with science, of an enlargement of mind, intellectual and social, of an ardent love of the particular study which may be chosen its each individual, and a noble devotion to by interests."

Major Naidu then made a survey of the achievements so far made in the Nizam's State in the realms of Surgery, Medicine and Public Health.

Rural Medical Aid and Rural Hygiene were also the topics in the address of Major Naidu. He said that experiments for Rural re-construction were being conducted in Hyderabad State but such experimental measures did not touch even the fringe of the problem and medical men could not be denied their share in this work. He advocated the need of Medical Planning Committee consisting of representatives of service men, private practitioners and even medical students.

In regard to Medical Education he said the developments in Hyderabad was not only interesting but romantic. He gave a brief history of the stage of medical education in Hyderabad and said that the Osmania University had taken charge of medical training with Urdu as a medium of instruction ; though the experiment was a bold and costly one he said that the results were proving worthy of the great endeavour. He then referred to the changes of alterations in medical curriculum in Germany and America and quoted the following changes suggested at the Congress of National Union of Students in Cambridge :

(*a*) "A general course of biology should be introduced as a preliminary to the preclinical subjects. The Americans call it an orientation course, and its object is to give a picture of life in many different forms, rather than a detailed knowledge of a few types.

(*b*) Closer integration of anatomy, physiology, and bio-chemistry, which so far as possible, should be regarded as one subject.

(*c*) A more realistic clinical curriculum with more stress on minor ailments and less on major surgery, which for most practitioners is less important and a sounder grounding in general psychology.

(*d*) More preventive medicine. This involves a new conception of medicine, a conception of disease as being due to biological and sociological causes. It involves an enquiry into the social and economic environment as part of every diagnosis. It involves a greater knowledge of social agencies—*e.g.*, of rehabilitation, insurance, compensation."

Major Naidu placed his view before the Conference of the internal reforms that should be advocated by the Medical Associations in India. He said :

"Once before, I pleaded that before we attempt to remove the mote from the eyes of the Government or the public we must clear the beam in our own. The time has come for Associations like yours to rectify several abuses that have crept into the practice of our profession. It is not necessary to wash our linen in public; but, as the public is intimately concerned with and immensely interested in our work, I shall briefly refer to one or two of our failings which are sometimes exaggerated into dis-demeanours. We must put our own house in order if we are to expect others to do likewise. There is, as you are aware, a tendency amongst medical men to gravitate to the cities; even those with poor qualifications. The rush of the latter may mean either a large number of poor in the cities who in the absence of Government medical aid require their services, or the inefficient doctor who scores a success over his betters and exercises more wit than knowledge in his work. Of such there is a large number in every city, and Hyderabad is no exception. This unhappy competition leads to undesirable methods of practice such as indirect advertisements, touting, mopping up of cases belonging to others and many other breaches of discipline and ethics. All the while the country-side is starving for medical aid even of a second rate quality."

Indigenous Systems of Medicine was the next subject dealt with by Major Naidu. He said :

"It must he confessed that an unbiased observation of their methods and their results reveals that their systems of therapeutics is worth further and closer examination. Apart from being mostly swadeshi, their medicines and cheaper than ours and can always be obtained anywhere—war or no war. I am aware that some of our Allopathy have taken up a *non-passumus* attitude, but they may find it worth while to reconsider the matter. If we seek progress we must be prepared to learn and to borrow."

Even Homeopathy received sympathetic attention from Major Naidu.

In conclusion Major Naidu thanked His Exalted Highness the Nizam for his gracious message to the Conference, and to his Government for their kind sympathy and help in various directions, and he expressed his gratitude to His Excellency, the Nawab Saheb of Chhatari, for his having inaugurated the Conference and to all members of the Nizam's Government, including the authorities of the Osmania University for the help rendered by them to the Reception Committees.

PRESIDENTIAL ADDRESS

BY

K. S. RAY, M.A., B.Sc., M.B., Ch.B. (Edin.), M.L.C. (Bengal).

(EXTRACTS).

The President thanked "The Indian Medical Association" for the honour in electing him for the second time as its President. He began his address with with the discussion of various problems confronting the medical profession. He said that though much problems were discussed year after year at the annual conferences they were worth reiteration with increased pressure till there was a response from the authorities:

"Much has been achieved during the last 18 years that we had been holding these conferences but a good deal more has to be secured. Days are changed and are rapidly changing, and no power and no vested interest can lightly treat the voice of an organised body as ours."

He then referred to the all round apathy and said:

"We see round us a moribund populace, a spectacle of millions suffering from preventible disease and succumbing without proper medical aid or any medical aid, we naturally pause and ask where does the wrong lie, who is at fault and what is the remedy? I will not bore you with statistics, but the fact is that we have not even one doctor for ten thousand population. Yet the curious position is that hundreds of qualified medical men are going about without employment and hardly able to make a bare living. Where then does the cause of this deplorable situation lie?"

He blamed the authorities for lack of sufficient interest stating to public health and medical aid and said:

"A broader and more realistic view of things is what is needed. Disinclination to utilize the resources which exists in the host of private practitioners, is another regrettable feature of the official-mind. This water-tight barrier and want of co-operation between the official and non-official medical men must be removed. There are however, signs of a change in the angle of vision; and if this augers the introduction of a braoder and more sympathetic policy, it is all the more necessary that we, the great body of medical practitioners represented in this Association of ours, should be more alert and not miss this opportunity. We must direct our best efforts to consolidate our organisation and make it as broad-based as possible with branches in every district and sub-district. We should not merely indulge in carping criticism of what the authorities are doing or wherein they are remiss, but as experts with full knowledge of the various types of local conditions, we have to place before the Government and the public constructive suggestions; and if we do so, our opinion cannot fail to carry full weight. Over eighty per cent of our people live in rural areas, in wretched huts and have an average earning of less than two annas a day. Not more than 10 per cent of them are able to read or write even in their own mother tongue. To leave this problem of medical relief for these people to unaided private practitioners is nothing short of denying them any relief whatsoever. Yet such is the unfortunate position today. Private practitioners like all human beings, must live, and they have to resort to places where there are some people who can pay. No wonder then, that they crowd to the towns. The only way of providing medical aid to the villager is for the State to make out a comprehensive plan of the country, how the people are distributed in it, what are the diseases which are endemic in different areas, what are the methods of preventing them and of giving medical aid in case of illness, and then utilise the immense resources in the shape of medical practitioners, who could be induced with State aid to set up in the different areas and whose services would be available to the furthest limit of this vast country preparing schemes for the prevention and cure of diseases. Some scheme of health insurance might be introduced in towns and selected villages, with panels of qualified medical men, in the lines recommended by the League of Nations in 1927. Most countries have adopted this scheme, modifying it as required by local circumstances. But India has been lagging behind."

The role of doctor was then described by Dr. Ray in the following words:

"The doctor is no longer the mere therapist that he used to be. He has become the adviser of the educator—mental hygiene, which keeps individuals socially adjusted and which is the chief weapon in the prevention of crime. The doctor has today become the scientific and psychological adviser to the court; the administration of law would be impossible without him. The physicians has also become the adviser of the statesman. The chief cause of disease is poverty with all its consequences-slums, malnutrition, alcoholism, crime, etc. The solution of the problem is not only medical but political as well. The physician who is in close touch with the people, knows their want and difficulties, sees the evil effects of poverty on the individual and the society and has an important task to fulfil. It is for the State to employ such resources in the service of the public."

Medical Education was the next subject dealt with by the President. He concluded this topic by saying:

"Conditions in different provinces differ and while there is a strong body inclined to the view that the medical education should be uniform and equal almost to the college standard; there is also the opposite view that a lower standard is necessary particularly in the interests of the rural areas, and that the effect of abolition of medical school education may mean a heavy fall in the number of qualified practitioners in rural areas. There is however, unanimity in the view that the students should have a higher type of preliminary educations and the present standard of education in schools is unsatisfactory and must be improved."

The Attitude of the I.M.A. to the War and Recruitment to Emergency War Service was then talked out by the President. He said that the Association issued pamphlets relating to Air Raids and appealed to the profession to co-operate with the Government in war efforts. But the response from the Government was lip deep. He summarised the demands made by the Indian Medical Association to stimulate recruitment to war service. They are:

(*a*) "The Civil side of both the I.M.S. and I.M.D. constituting the "War Reserve" should be abolished and officers be recalled to the Army and vacancies filled by selection after open advertisements. These appointments should be made on a temporary basis for the duration of the War so as to enable the officers returning from War Service to apply for and compete for these posts on equal terms.

(*b*) That no distinction shall be allowed to continued as between the Indian and European members of the I.M.S. and I.M.D.

(*c*) That the policy governing the changes proposed should be under the directions of a Central and Provincial Boards on which the I.M.A. should be adequately represented so as to facilitate recruitment.

(*d*) That holders of Emergency Commission should be given preference for holding permanent posts in the I.M. S. and I.M.D. and a few others."

Indigenous Drug Industry was another subject in the Presidential address and Dr. Ray requested the Government to see that when the war ceases adequate measures were taken to save these new industries in the face of post-war competition.

Need of an Indian-Pharmacopoeia and of qualified pharmacists and compounders was then stressed by Dr. Ray.

Relating to *Medical Research* in India the President said,

"It is indeed a sad commentary on our medical scientists that while many of India's sons have won world-wide fame in the domain of pure science, very few have succeeded in making similiar contributions in the realm of medicine. For one thing, our medical men have few opportunities for sustained research. The Government have an organisation called the Indian Research Fund Association, but the terms under which its grants are made lead to so much official control that the worker is seldom a free agent.....If red-tapism continues to hamper the activities of the Research Fund Association, we must appeal to our philanthropic rich to do their duty to the country by encouraging research by their private charities. It is not that India lacks talent; but with the right organisation, I am convinced, results of the highest value could be obtained."

Post-Graduate Training was the next subject appearing in the address. Dr. Ray said that the Indian Universities generally neglected such training. He suggested that if the resources of Universites were not adequate one or two particular branches of medicine if not all might be taken by neighbouring universities and a start made in this direction.

Nursing Profession attracted the attention of the President who deplored the paucity of qualified nurses in India and suggested that the universities might institute a course for granting diplomas or degrees in Nursing.

In regard to *Non-employment among Medical Men*, Dr. Ray opened that this subject would be solved more satisfactorily if the Indian Medical Association organised itself. He advocated the Panel System and Health Insurance Schemes. He deplored the existing practice of appointing needy young practitioners as Honorary Medical Officers in State Hospitals which he said was nothing but exploitation.

The problems of *Quackery* was also talked out by Dr. Ray. He said that the number of quacks in villages could decrease if some scheme of Health Insurance was introduced. He concluded this subject by saying

"In the course of this address as also in my last I have emphasised more than once the want of any plans and programme for solving the medical and public health problems of our country. The Indian Medical Associations has not attempted up till now any comprehensive palns in the matter, although it has suggested many measures and criticised proposed plans and policies. It is obvious that any comprehensive scheme must start with the collection of data which can only be undertaken by the State, and which is not possible for a body like the Indian Medical Association, without State help. I can assure the Government that should such help be forthcoming the Indian Medical Association would not be found wanting in rendering every assistance."

The President concluded his address with the following warning:

"There are poople who dream of a rosy future emerging from the ruins of the war and statesmen, industrialists and economists are letting their imagination a free play to reconstruct the world of their own fancy in which they believe man will have shaken off the shakles which he has forged on himself through prejudices and conventions of the outworn traditions. But practicals must not rest content with dreams of the future. Even on the termination of the war, the country and the profession will be faced with new problems in the course of reconstruction of the world. It is not possible to envirage at the present moment how the problems will present themselves, and how the reconstruction would be nobody can say. But on the other hand it may be more difficult ....."

RESOLUTIONS PASSED BY THE CONFERENCE.

A resolution moved by Dr. Jivraj Mehta of Bombay stated that, until the civil side of the I. M. S. was entirely done away with and the racial distinctions between Indian and British members thereof as embodied in the Government of India resolution of March 1937 and the distinctions which existed at present between the different groups that constituted the I. M. D. were removed and until the licenciates were also granted commissions in the I. M. S., the Government would find it extremely difficult to persuade the members of the independent medical profession to volunteer to any appreciable extent to join the Army Medical Service. The resolution also expressed the opinion that the I. M. S. and I. M. D. as at present constituted had failed to supply the needs of the Indian Army during the war and that the civil side of the I. M. S. has totally failed in its "alleged object of being a war reserve".

By another resolution, the Conference drew the attention of the Government and the public to the steadily deteriorating physique of the nation caused, amongst other things, by malnutrition and adulteration of food and demanded a Nutrition Commission to study the subject in all its bearings and made certain recommendations in this connection.

The Conference endorsed the views expressed by some members of the medical profession regarding the diet of "C" class prisoners generally and particularly in Central Provinces jails and urged the Government to investigate into the matter and provide milk for "C" class prisoners.

The Conference by a resolution moved by Dr. R. A. Amesur of Karachi deplored the complete lack of preparedness of the country to meet air attacks so far as the medical side was concerned and viewed with apprehension the effects that rapid evacuation without properly planned sanitary and medical arrangements would cause and called upon all local bodies to take measures, in consultation with the members of the medical profession to meet the threat and meet the probable outbreak of epedemic diseases. The resolution also urged all medical organisations in the country to co-operate with the local bodies in this connection.

The Conference by another resolution urged the Central and Provincial Governments to give effect to a comprehensive scheme for making India self-sufficient in drugs and help the industry by providing during the war facilities for getting raw chemical materials and machinery not available in India by issue of priority certificates after the war and by providing tariff protection and buying for Government Medical Stores drugs of standard qualities from the indigenous manufacturing firms only. The Conference also urged the Government to adopt the recommendations of the Drugs Enquiry Committee of the Government of India (1929-30).

The Conference protested against the practice resorted to by the Central and Provincial Governments of recalling to the higher posts in the Civil Medical Department of retired men as this blocked the promotion of junior men to those higher posts to which they may have risen, if such retired men had not been re-appointed during the period of the war.

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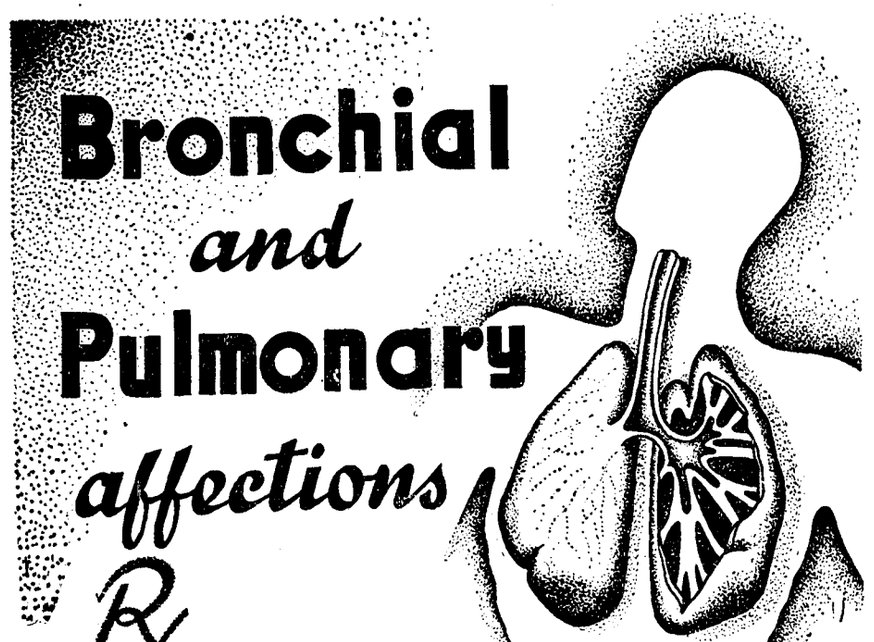

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The Recruitment of Medical men for Military Service.

TO THE EDITOR,

The great dearth of medical men for war service is manifested by the unusual advertisements appearing in the lay press inviting medical men for military services. It may appear paradoxical that when we have thousands of medical men who are eager to get employed, the military department feels that they cannot get sufficient hands to man their services. In India we have several thousands of qualified medical men—people who have been registered as qualified to discharge all the responsible duties of the medical profession. As an example, I might point out that in the two major provinces of Bengal and Madras there are over 11,000 and 6,000 medical men who have registered as qualified men in the statutory Medical registers of those two provinces. Similarly, there are thousands of Registered Medical Practitioners in the provinces of Bombay, Assam, the Punjab, the United Provinces, Behar and Orissa and even in Hyderabad. Why then is this great dearth felt by the military department is a question which requires probing into. As far as I could see it is the reluctance of the military medical department to recognise the qualifications possesed by a certain class of medical practitioners whose qualifications are recognised by the Provincial Statutory Medical Councils in India and who have been practising Medicine, Surgery and Midwifery and holding posts under the Provincial Governments. The Military Department knows that there are medical qualifications of various standards in the British Isles and yet no invidious distinctions are made between higher and lower medical qualifications while recruiting medical men for war-service in Great Britain. Why not follow the same procedure in India? It is really sad that when educated Indians are recruited as commissioned Military officers for regular Army Service the same Indians who have undergone four now, five years course of medical studies in recognised medical schools are denied the same rank in Army Medical Service.

Critical times demand emergent measures. This has been shown by the department in other directions, but not in the recruitment of medical men. In an emergency, as the present when the department felt the shortage of the nursing staff, fresh girls are taken for the Auxillary Nursing Force with such a low general educational qualification as the eighth standard or the III Form, given training for three months or so and taken as nurses in the Military Department with a salary of Rs. 175/- and, treated as first class officers for all practical purposes while medical practitioners with much higher standard of general education and who have undergone four to five years' course of medical studies are to get the low salary of Rs. 75 with an allowance of Rs. 125 a month. Is there any wonder then that the very large number of medical men in India do not come forward for a service which denies them position, emoluments and the status of nurses who have to work under them? In an unusual emergency as the present one, which has faced our country, the military department requires a large number of medical men. If the Government is not prepared to extend the privilege of granting qualified medical men the King's Commission, at least as an emergency measure, they will not have to blame anybody for the extreme shortage of medical men for war service. It is a case of "water, water everywhere not a drop to drink." I earnestly appeal to the Government and the other military authorities to act wisely in an emergency, and grant Commission to all qualified men whose names are borne in the provincial medical registers. Let them not waver till the last moment when all and sundry may have to be recruited. The anxiety of the Government relating to the shortage of medical men for war service could be imagined when it is known that medical examinations are being held earlier than the specified time, for such of the final year medical students who undertake to enter war service soon after passing. There would not have been a need for this questionable procedure if existing Medical Licentiates were recruited as Commissioned officers. I know somewhat the pulse of the medical profession. I know thousands of them will certainly volunteer for war service if they are given encouragement by recruiting them with proper status and emoluments. Educated qualified men consider it beneath dignity to work along side people with low general and professional qualifications, such as the A. N. F. I can assure the Government that the response from the medical profession will be spontaneous and generous if the Government will only be pleased to grant Commission to all qualified and registered practitioners. Why not tap this granary when there is shortage of grain.

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EDITED BY

Dr. V. Rama Kamath,

Member, Madras Medical Council.

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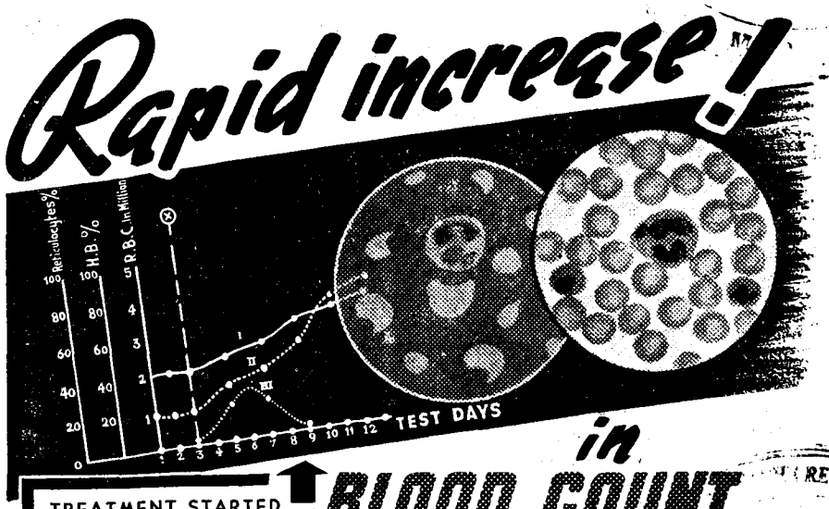

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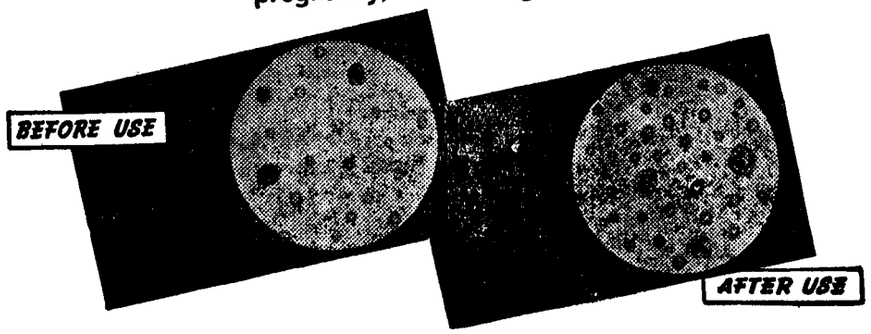

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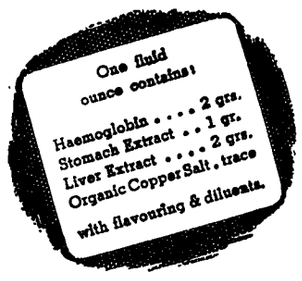

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Original Articles

THE PROGRESS OF THE TUBERCULOSIS ASSOCIATION'S CAMPAIGN AGAINST TUBERCULOSIS IN INDIA.

By

LIEUT.-GENERAL G. G. JOLLY, C.I.E., K.H.P., I.M.S.

The Tuberculosis Association of India was inaugurated in February 1939, so that a period of one year and nine months is available for review.

The Need for Contacts. First of all it was necessary to establish contacts, contacts with Provincial and State Committees, the forerunners of the local associations, with Government officials and with Presidents and Chairmen of urban and rural Local Authorities already interested in or who might become interested in the tuberculosis problem, with tuberculosis workers in the various institutions dealing with the disease throughout the country and it was necessary to inspect these institutions.

Her Excellency the President, from the life-long interest in Tuberculosis, which she had acquired through her distinguished Father's association with the famous Papworth Colony, was in a position to speak with authority on the subject and the personal contacts she had established through her "Appeal" with all prominently interested in the problem in India were of inestimable value.

The Chairman and some of the members of the Central Committee were able to meet a number of officials and non-officials dealing with tuberculosis and to inspect institutions on their periodic visits to Provinces and States, but were not in a position to make systematic tours for the purpose.

Medical Commissioner's Tours. The detailed work in this connection therefore fell to Dr. Frimodt-Moller, the Medical Commissioner of the Association, whose long experience of the disease in India had equipped him singularly well for the purpose and who only needed a survey of persons and institutions dealing with the disease to be in a position to advise his Committee on the present situation in the several Provinces and States and as to the possibilities of development. Based on his advice an interim "policy" has been drawn up and adopted, to which I shall refer in more detail later.

In his travels the Medical Commissioner has visited all the Provinces of India, including the Centrally Administered Areas, and also fifteen Indian States. He has met and talked with 56 local tuberculosis committees or groups and has given 43 addresses to medical men or the public. He has visited in all III institutions old and new in the country.

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Visits appreciated. It will readily be appreciated that while it has been necessary to establish these contacts and to carry out quick surveys of the state of development in different parts of India in order the 'Centre' may have a conspectus of the position, this work has also been of help to the Provinces and States and to the local Associations there. Indeed it is becoming abundantly clear that a visit from the Medical Commissioner is eagerly looked forward to, and I myself have deeply appreciated the warm welcome that has been extended to me by local Associations and tuberculosis workers wherever I have been and their keen desire to discuss local schemes and to hear what is happening elsewhere.

In the process of formation of the local Associations and in the development of their programme of work these "contacts" have been of particular value, especially those established by our President.

Affiliated Associations. I shall now give you the "affiliation" position. We have at the present time thirteen Provincial and eleven State Associations affiliated to the Centre. This family of twenty-four is by no means final however and we expect additions shortly, for Associations are in process of formation in Bihar Province and in the States of Indore, Bikaner, Hyderabad, Mewar, Jaipur and Mysore.

Tuberculosis Institutions. The position in regard to new institutions for tuberculous persons is also striking. Since our Association came into being new sanatoria have been completed and opened at Amritsar and Quetta, eight are under construction of Baroda, Anantagiri (Deccan), Indore, Nagercoil, Bombay, Bangalore, Kapurthala and Kasauli respectively, while eleven others are under consideration. New Clinics have been constructed at Budge-Budge and New Delhi one is being built at Balsan, while twenty-five others are planned. Five Tuberculosis Hospitals also are under consideration.

I feel sure you will agree that this indicates a live interest in the problem in many, though by no means all parts of India. In particular you will notice the lack of Care and After-Care Committees and of Settlements.

Central Institutions. The need for central institutions became apparent early. I do not like very much the term "model" as applied to these for this year's model is apt to be superseded by next year's one, but it expresses the correct meaning in the sense that the Centre should give an example to the rest. Furthermore, institutions are needed at the Centre for training purposes, for investigation and for the development of new technique. The Centre should be complete but, so far, we have only gone the length of completing our Clinic in New Delhi, which, is to be opened by Her Excellency the President on the 20th of this month, and of beginning on our Sanatorium at Kasauli, a project which has been rendered possible with the financial co-operation of the Government of India and of the Punjab and, we hope, of some of the State, by a liberal action on the part of the Pasteur Institute of India who are leasing us their estate on nominal terms, and by a generous gift from an individual donor. These two institutions will, it is hoped, be linked up in time with sufficient bed accommodation for advanced cases, with a settlement and with an adequate follow-up and care and after-care organisation, all of which should be available for the purposes I have mentioned.

Training. One of the greater needs is the training of doctors and tuberculosis visitors. The maintenance of proper standards of training of under-graduates in Medicine is in the hands of the Medical Council of India, and your committee have not so far found occasion to make any recommendations to that body. In the matter of post-graduate training we have continued the policy of the King George Anti-Tuberculosis Fund and have organised and helped to finance short courses for medical practitioners. These of course are not intended for specialists but rather to meet the requirements of general practitioners who wish to do more for the tuberculous patients in their practice and particularly for such as are prepared to co-operate in tuberculosis scheme based on dispensary clinics for the poor. Short post-graduate courses of this type have been held at Madras and Calcutta and two more will be held at Bombay and Calcutta next January.

Madras has been the pioneer in organising a full 9 months curriculum of study leading to a Diploma in Tuberculous Diseases and our Medical Commissioner took part in the first course this Summer. Apart from this, the Association has assisted a few doctors to obtain clinical training at suitable institutions. This is admittedly only a beginning, but the beginning is the most difficult bit and progress should now be more rapid.

The problem of the Tuberculosis Visitor is not an easy one. Nursing is still a backward profession in India. Demand greatly exceeds supply; costs are relatively high, particularly for trained health visitors, a product which has been somewhat 'forced' in this country, whereas in others it has sprouted as a highly specialised branch of an already well-developed profession. It looks therefore as if, for many years to come, our Tuberculosis Visitors, if we are to have them in anything like an adequate number, will have to be drawn from a less highly trained and therefore less costly class than the fully qualified health visitor. I should be glad to have the views of delegates on this important question.

Publicity and Propaganda. As an Association we inherited a good deal of publicity material from our predecessor and we continue to use much of that, with fresh or revised editions where necessary. There is also some useful material with the Indian Red Cross, a society with which we are in close liaison. A really good tuberculosis film for India has yet to be produced and, for this purpose, it may be advisable to appoint a special committee who should, I feel, for the most part at all events, be actual tuberculosis workers. The first technical medical film ever to be produced was on tuberculosis. If I remember rightly, it was called "The Story of John McNeil" and was produced some thirty odd years ago by Dr. Halliday Sutherland —a well-known author who was also a tuberculosis specialist. The film was a great success.

So far the Central Association has not yet produced a journal, but I hope this will come soon. Most of you will be familiar with the pioneer one of the Bengal Association to which we have sent a good deal of material, but it is desirable that we should have a central periodical on the subject.

Surveys. Tuberculosis surveys bulk largely in the programme of an anti-tuberculosis campaign in India. Only by carefully prepared and conducted surveys and re-surveys carried out upon an agreed plan, so that the findings in different parts of the country can be compared with one another and with the findings in other countries, can we obtain sufficient and sufficiently exact information upon which to plan our work in detail and to assess its value. This has been recognised by the Indian Research Fund Association who brought out, a year or two ago, a most useful booklet of instructions on the subject. This has been under revision by a small technical committee on which members of our Association are well represented, and the new pamphlet will be published very shortly. In the meantime, this important subject is on the agenda of the Conference. During the current year our Association have been assisting, by a grant given through the Indian Research Fund Association, a survey investigation into tuberculosis at Saidapet, Madras, conducted along lines approved by us. Three other surveys are in progress; one into tuberculosis among industrial workers, under Dr. Ukil; one into infection among medical students in Lahore by Major Taylor and a third in Vayalpad, Chittoor District, by the staff of the Arogyavaram Sanatorium. In each of these cases the survey is correctly based on a well-developed institution.

Although we are not in a position to finance other such surveys and indeed will probably be unable to repeat our grant to Saidapet, I would like to state that we are anxious to keep in touch with all surveys proposed by local Associations and to emphasise how important it is that these should not be hastily started on different

lines from those recommended by the Indian Research Fund Association, or without the necessary institutional background.

Policy. The affiliated associations as well as Local Governments and Municipal and District Authorities naturally look to the Central Association for guidance as to policy. This is not an easy subject to generalise upon. Tuberculosis has been more or less successfully controlled in various countries by methods most of which are well-known. In the absence however of a specific preventive such as Jenner's lymph for small-pox or of a reasonably satisfactory therapy such as quinine and its synthetic substitutes in malaria, the control of tuberculosis depends upon the combined application of a number of methods, most of them costly, so that financial considerations are frequently the limiting factor. This is markedly so in India and the Central Committee of the Association, bearing this in mind and realising that it is futile to advise authorities to equip themselves at once with an adequate number of clinics, hospitals, sanatoria and so on, have adopted a policy which is recommended for trial, not as the ideal policy but as one that is practicable in the present stage of development, that brings the general practitioners prominently into the picture and which can lead us to and is compatible with a steady, if slow, development of institutional treatment which is the best that most areas in India can reasonably look forward to. Copies of the brochure describing this policy which we have decided to call "Organised Home Treatment" will be made available to all delegates and I hope that there will be a full discussion on the subject.

Classification. I have not much more to say. A uniform system of classification of the disease for use in India was considered by the last Conference to be necessary, and the report of the Committee then appointed will be considered at the present Conference. While recommending the adoption of the usual three stages with the sub-divisions A, B and C, the report makes, a number of helpful suggestions and proposes the adoption of a standard procedure, the specification of which in a clear and readily accessible form will be of great value.

Environment. The relation of environment to tuberculosis is one of such fundamental importance that it must form a main consideration in our programme. So far the Association has been able to do little about it, has now appeared in the agenda of our Conference; we have two papers on the subject and there will be opportunity for free discussion in which I hope our delegates from Local Authorities will participate.

I have attempted to give you a brief picture of the present stage in the campaign against tuberculosis in India from the point of view of the Central Association. There are other view points and I look forward to hearing them from the members of this Conference in what I trust will be a general discussion. We welcome any constructive suggestions or criticisms.

DISCUSSION.

The necessity of increased co-operation of *Public Health Departments* and tuberculosis workers was stressed. There was a tendency to regard the Tuberculosis Associations as foreign bodies not directly connected with the health work in the Province of State, and this hindered the work. The improvement of housing conditions, the raising of living standards, and possibly, the introduction of legislation to deal with certain tuberculosis problems, could not be done by tuberculosis workers alone.

Legislation, specially notification of cases of tuberculosis, with a view to check the spread of infection, was raised by several speakers, but some thought that the present stage of the campaign was too early for legislation, as it would lead to the hiding of the disease.

The work of the Central Association and its place to the campaign was discussed by a number of speakers. In tuberculosis surveys, the help of the Central Association would be very valuable in planning and advising, and analysing the results, and in providing a statistician for survey work, in suggesting and even allotting research to avoid duplication of effort specially when funds were limited as at present. One speaker thought the work of the Central Association should be more advertised, and others wanted more propaganda help from the Centre.

The training of tuberculosis workers both doctors and health visitors was discussed by several other speakers, and also tuberculosis instruction for medical students, and information was supplied as to what was being done in Madras, Bengal and elsewhere.

The Place of private practitioners in the tuberculosis compaign was discussed by several speakers. The important place general practitioners had in the campaign was well brought out in discussion, but if they were to be able to co-operate, they must have some training; therefore several suggestions were made for lectures to be arranged by the Central Association, the Provincial and State Associations, and by local institutions: another suggestion was a Handbook on dealing with tuberculous patients to be intended of general practitioners. Organized home treatment, which was a policy of the Association, depended for its success on the private practitioner in co-operation with the tuberculosis clinic, but the co-operation of private practitioners would be very difficult to obtain if the clinic doctors had private practice. For this same reason, also, the staffiing of clinics with honorary doctors was an unwise policy. It should be made possible for private practitioners to get increased facilities for X-ray and laboratory examination for their patients, although where such facilities did already exist they were not always taken advantage of.

Other matters raised in discussion were: the question of what to do with soldiers discharged from the Army as tuberculous; the need of after-care establishments; a suggestion for mobile tuberculosis clinics, instead of fixed clinics in some places; the provision of some form of isolation for the poor in organized home treatment; and heliotherapy.

The Medical Commissioner, referring to a remark of a speaker, said that the arrangement of the present Conference had been the outcome of the last year's Conference, certain subjects having been selected for special attention, as suggested. The policy of organized home treatment was not wrong, provided it was carried out in the right way. This did mean some training of the private practitioner, and it did mean that the staff of all the larger clinics should not have private practice. He also mentioned the difficulties of some of the legislation proposed by several speakers, the difficulties of getting newspaper propaganda; but difficulties were not going to stop the campaign.

In reply to the discussion, *General Jolly* said that he was grateful for the idea of a central, more or less permanent survey which could co-ordinate results of surveys in different parts of India: the Centre could not interfere too much with local and provincial associations, but they were anxious to have as much co-ordination as possible. As regards free examination of sputum, recommendations had already been made to Government; many free facilities already existed, and other Governments were dealing with the problem. Referring to collaboration of private practitioners, this collaboration itself needed a good deal of organization. The question of discharging tuberculous soldiers from the Army, and its danger to healthy recruiting centres was mentioned. It would be a great advance if the Army would accept the principle of not discharging open cases. The Tuberculosis Association would be glad to assist the Army as much as possible. The discussion of the morning had disclosed the enormous amount of work to be done, and all must do what they could in each locality.

In closing the morning session of the Conference, Lady Linlithgow said:

That she wished to refer to only two subjects—first the co-operation of public bodies in the tuberculosis campaign must be stressed on every possible occasion; secondly, there was an appalling ignorance of the lay mind specially with regard to the fear of infection spreading from institutions like sanatoria to the neighbourhood, and it was hoped that more knowledge would in time be acquired in these matters by those at present ignorant.

TUBERCULOSIS SURVEY

BY

DR. R. B. LAL, M.B. B.S., D.P.H., D.T.M. & H.; D.B.,

Professor of Epidemiology and Vital Statistics, All-India Institute of Hygiene and Public Health, Calcutta.

A really good physician treats the patient rather than the disease. This dictum applies equally to the public health administrator, only, the unit in this case, is the community instead of the individual. The physician cannot be content with the mere diagnosis of the disease. If he is to treat the patient he must know *him* and all the circumstances relating to him. It is only then that he will be able to devise the best means of treatment peculiarly suited to the individual in his charge.

If we apply the same considerations to communities, we at once appreciate the objects and scope of health surveys. Here it is a question of gathering knowledge about the community and of all the circumstances which have a bearing on its health, efficiency, morbidity and mortality. Unfortunately, we in India, are too often apt to take a narrow view of things and restrict our attention to sickness and deaths, ignoring the mass of people who are not yet sick. These people, in fact, constitute the reservoir which furnishes the sick. Then there are circumstances, both favourable and unfavourable, which determine or aid the transfer of persons from the health to the sick group and *vice versa* and also from the sick to the dead. Could a physician or a surgeon afford to concentrate his attention on the diseased part of the body and ignore the rest with any chance of success? If he did so he might end by saying that the operation was succcessful but the patient was dead.

To pursue our simile further, just as this broader outlook is all the more necessary in the case of chronic illnesses, so also a more comprehensive survey is called for in the case of endemic or so-called social diseases. Besides, in acute diseases the time element would not permit of an investigation on a wider basis. Tuberculosis is a typically social disease. In the dissemination of this disease, social factors play as important, if not more important, a role as the biological factors. While unlike many tropical and other diseases, which, chiefly for biological reasons, are restricted to certain regions, tuberculosis follows man wherever he might live, both the type of disease and its distribution in different communities and in different sections of the same community show remarkable variations. These community differences have been ably discussed by Lyle Cummins in his little book called 'Primitive Tuberculosis'. But the point I wished to make was that although it would be rash to say that only social and not biological factors were concerned in these variations, there is little doubt that it is chiefly, the former that determine these variations and their trends. An excellent discussion of this subject will be found in a recent publications of the National Association for the Prevention of Tuberculosis by Dr. P. D'Arcy Hart and Prof. Play Wright. Since the differences in incidence, types of disease and sections of the community chiefly affected, as also the trends and rates of change of these variations constitute the main tuberculosis problems, the discovery of the social causes underlying them assumes major importance.

Tuberculosis survey, is therefore, an investigation into the social and other factors determining the peculiar distributions of the disease in the community and their trends as also of the potential forces which aid or combat dissemination of the disease and determine the types.

It is largely on the basis of the results of a survey so defined that the anti-tuberculosis campaign best suited to the community can be devised in a rational manner. You may perhaps feel that I have unnecessarily laboured the point regarding the need of tuberculosis survey. Most workers are already alive to the

desirability of carrying out these surveys, but the question is how best to carry them out. The answer to this question is easily given.

Tuberculosis Surveys should be carried out in the way fully described in the Survey Committee's Report. I do not propose to refer to any practical details, because I believe the main points are set out in the report in as comprehensive and as concise a manner as one would wish to do. However, I may say here a word or two in explanation of the general principles and the general scheme adopted in the report.

There are two methods of approach in pursuing the objects of a tuberculosis survey, *viz*:

(1) to proceed with a qualitative estimation of all the factors to which the community is subjected and which are known to influence the incidence of the disease, and its types, its peculiar distributions, trends and rates of change and

(2) to determine precisely the results of the operation of these factors, namely, the incidence the types of disease, etc., etc., in the community and to infer back from these data, the causes which are known to operate to bring about these results. Having gained this knowledge it may be verified by suitable investigations. Thus, for instance, it was recently found in New York that tuberculosis death rate was not only high but had been persistently high in coloured adult males, as compared with coloured females in the corresponding age-groups while in adolescence the position was reverse This leads to the consideration of certain *a priori* causal factors namely, the particularly unfavourable housing and working conditions of the coloured labour. Attention having been drawn to these facts, their verification or otherwise could then be proceeded with.

The above example illustrates that the second method of approach which is partly inductive and partly deductive, economises time and money and taking all circumstances into consideration it is the one considered suitable for practical purposes and has been adopted in the Survey Committee's Report.

In following this matter, however, one should not confine his attention to the incidence of sickness and mortality from tuberculosis but should take into consideration the whole range of host-parasite relationship of which sickness and death are only specific phases. The relationship of the tubercle bacillus and man extends over a wide range from primary focal infection, which unless very massive or occurring in primitive tribes is of a benign type, through the various types of non-productive lesions to extensive systemic dissemination including tissue breakdown and excretion of bacilli. It also includes the negative relationship, namely cases in which either no infection has taken place or the lesions have retrogressed and completely or incompletely healed. Besides these relationships associated with changes in tissue there are other and perhaps more fundamental changes which are to be included in the term host-parasite relationship namely, sensitivity and resistence. When these various phases of host-parasite relationship have been related to different sections of the population, the stage is set for a consideration of the *a priori* causes of such happenings and subsequent investigation of the issues thus formulated. The Types I and II surveys described in the Survey Committee's Report are aimed towards this end. I hope this discussion will help to clarify the reasons why we are keen to see Types I and II surveys being carried out along sound lines. It is hoped that such investigations will not only provide useful experience which could be employed for the improvement of the technique of surveys but also furnish data the scrutiny of which will give us leads for further investigation and control of the disease in a rational way.

Some of the general principles of practical importance in connection with planning and execution of tuberculosis survey have been discussed in the Special Tuberculosis Number of Indian Medical Gazette (October, 1940). Perhaps a mention of a few salient points may not be out of place here.

In the first place it is manifestly necessary to define exactly the immediate objects of the survey. Much effort has I am afraid, been wasted in undertaking surveys with vague and ill-defined objectives. In defining the objectives one has to be guided by two practical consideration, *viz*:

(1) that the funds and other facilities available will permit of institution of the enquiry in a satisfactory manner, and

(2) that the knowledge likely to be obtained as a result of the enquiry, would be directly useful in institution of anti-tuberculosis compaign.

Unfortunately, it often happens, that either no thought is given to planning of the enquiry or too grandiose ideas are entertained at the time of planning the survey with the result that in the end, one is lost in a maze of enormous undigested data. 'Plato', as Macaulay says 'aimed at the stars and missed, lesser men aim at objects on earth and hit'.

Another pitfall to which many field investigations succumb is lack of appreciation of the fact that a proper technique and experience pay as well in planning surveys and conducting them as in planning and erecting buildings or in making diagnosis of disease. Eminence in clinical medicine has too often been assumed as sufficient and adequate qualification for planning surveys with, I am afraid, sometimes disappointing results. Those proposing to undertake surveys particularly if they are of any size will save much money and time and obtain more satisfactory results if they either acquired the necessary technical knowledge and experience themselves or consulted one possessing both for purposes of planning the surveys and interpreting the resultant data.

Apart from the problems of sampling which is as important as they are intricate one of the practical questions which faces every investigator is what data to collect, how to collect, for how long and to what degree of accuracy and finally how exactly to proceed about it. The Survey Committee's Report has attempted replies to these and other similar questions for surveys undertaken for limited objects. In any case there are a few simple general principles which must be adhered to in drawing up schedules of the enquiry *viz*;

(1) the objective defined in the beginning should be constantly kept in mind and in including or excluding any particular item the question as to whether it will elect information which will serve the objective directly should be satisfactorily answered. There is very often a tendency to include items which are either not strictly relevant to the enquiry or whose answers are not likely to be obtained in a satisfactory manner,

(2) one must remember that Dame Nature will truthfully answer questions when they are actually put and not when they are only meant to be put. This truism is, often forgotton in drawing up schedules and in interpreting results. Slightest confusion in one's mind as to the questions he wishes to be answered defeats the purpose of the enquiry and results in waste of money and time with any achievement. Here clear vision and experience count as much as they do in the case of a successful advocate with this difference that while the advocate's questions are often-times tendentious, they should be free from such blemishes in the case of the students of nature,

(3) another matter which special attention should be paid is to make sure that the collected mass of data can be properly analysed. One is inclined to postpone facing the problem of analysis as long as possible because the interest in the early stages of the enquiry is centred entirely on the content and method of collecting data. This delay may be fatal because without a proper previously conceived method the task of analysing heaps of information may become well high impossible—at any rate a good deal of data may be found either unanalysable or incomplete in many important respects. The remedy lies in deciding upon the methods of analysis of data before planning and undertaking collection,

(4) another matter to which attention may be drawn is the need of defining the units of observation, the classes to which they are to be assigned and the exact definition of each class. Perhaps an example will explain my point. If it is desired to give description of a rodent, one must define the species under discussion. It will not do to mix up mice, black rats and brown rats if it is desired to obtain average weight of some type of rat. That type of species must be clearly defined and observations must be restricted to a representative sample of that species only. Similarly the units of measurement of weight should be decided upon and class intervals should be distinctly stated so that they are mutually exclusive, and

(5) any possibility of confusion regarding individual units should be avoided. This is usually done by a simple device *viz*: individual serial numbers. However, one must exclude all possibilities of giving duplicate numbers to different individuals or more than one number to the same individual.

I do not wish to bore you with any further details and I will end up by mentioning one important principle viz: that accuracy of observation and record is essential for any scientific investigation. Tendency to overload workers with multifarious duties which is so frequently seen, shows lack of appreciation of this fundamental principle.

Abstracts.

SURGICAL TREATMENT OF BURNS.*

BY

VINTON E. SILER, M.D.,
Cincinnati, Ohio.

That burns occur frequently and constitute one of the most serious problems in medical practice is accepted by all of us. The treatment of a burn has varied in many respects from time to time and a review of the methods cannot be discussed here. In the literature one is impressed by recent added knowledge in handling such cases through the efforts of the surgeons and the physiologists.

Burns constitute a degree of injury to the skin and underlying tissue which we recognize as being first, second or third degree in extent. There is more to the picture than mere cutaneous destruction and the physiological phase must be emphasized. In any burn the vascular bed of the area has been seriously affected. Blalock and other observers have definitely shown that in such an injury there is marked increased capillary permeability bringing about not only loss of blood plasma, of plasma proteins and electrolytes on the burned surface, but also into the surrounding tissue. This loss, in turn, causes a diminished blood volume, decreased minute cardiac output, vasoconstriction, circulatory stagnation, tissue anoxia and, in severe untreated cases, circulatory failure and collapse. If this picture is of sufficient magnitude so-called "thermal shock" will follow immediately. It is not improbable that if it were possible to prevent the loss of blood plasma, of plasma proteins and electrolytes by any method, whether by internal or external medications or by mechanical or chemical means, so-called "thermal shock" could not only be alleviated but could practically be prevented.

The injury sustained by a burn is an open wound and is comparable to traumatic open wounds. Most burns are contaminated because they are exposed to the air, to people hovering over them, allowing bacteria from the uncovered nose and throat to fall upon them and not infrequently they are grossly infected with bacteriologically active home remedies. During the past ten years the surgeons have proven that infected wounds, treated early, can heal primarily if properly cleansed and debrided. In brief, we advocate essentially this: that a wound resulting from a burn can be converted from a potentially infected wound into a surgically clean one by the same surgical principles, enabling healing per primum or at least minimizing the infection. Prevention of infection is probably the most important single factor in the treatment of burns. Many observers, particularly Aldrich, have proven beyond question of doubt that so-called "toxemia" and the clinical course is not only dependent upon the degree of infection, but also upon the type of organism found in the infected wound.

These relatively recent physiologico-pathological concepts which have been set forth are responsible for the presentation of a method advocated by Koch and Mason and modified by us. It can rightfully be called "Surgical Compression Treatment of Burns." Briefly, this procedure is outlined in the following manner.

A burned case is an emergency and must be seen immediately upon entry into the hospital. All nurses and doctors should wear caps and masks when handling such a patient. A rapid general examination will establish the presence or absence of "thermal shock." Pain should be alleviated by administration of morphine to adults and codeine to children. We believe that surgical cleansing and debridement can best be done only in the operating room and under general anesthesia. Ideally, the patient is placed on the table upon a sterile sheet and in position to facilitate best cleansing. General anesthesia is administered. The surgeons, having been gowned and gloved in the usual fashion after scrubbing for ten

* Read at a meeting of The Academy of Medicine of Cincinnati, April 15, 1941.

minutes, drape the involved region with sterile towels and sheets. The wound is gently washed with white soap and water for ten minutes. The soap is irrigated from off the area, using physiological saline solution. Gross debridement is carried out during this procedure. The surgical team changes gown and gloves after which the area is redraped. A more minute debridement is done and, using a clean scrubbing table, the wounds are gently washed a second time with white soap and water. Irrigation is carried out using physiological saline. The wound is covered with sterile fine mesh single-thickness vaseline gauze strips on top of which are placed flat gauze dressings, followed with fluffed sponges. Pressure is exerted with a brain roll. Firm compression is obtained not only upon the wound itself but also upon the surrounding tissue by applying large sterile sea-sponges. These are held into position with sterile muslin rolls. The dressing is made a complete surgical one by means of adhesive tape which maintains the pressure and aids immobilization of the involved part. In some instances light plaster casts have been applied. This dressing is allowed to remain untouched for from eight to fourteen days. In the case of first and second degree burns the wounds should be completely healed when the dressings are removed while in the case of third degree burns, the wounds may allow the application of a split thickness graft as advocated by Blair and Brown. If there is mild infection of the granulating wound postage stamp Thiersch grafts may be easily applied. In rare instances the wounds must receive pre-grafting care.

In a series of more than one hundred cases treated at the Cincinnati General Hospital and the Children's Hospital we have proven to ourselves beyond question of doubt that one can convert a potentially infected burned wound into a surgically clean one.

We have good reasons to believe that surgical compression dressings will prevent so-called "thermal shock." It should be clear in the minds of all that since severely burned cases lose large amounts of blood plasma, hemoconcentration occurs. Concomitantly, the loss of plasma proteins and electrolytes aid in mobilization of the blood plasma at the site of injury as is shown by the edema at that point. Therefore, whole blood transfusion or administration of parenteral fluids is contraindicated since the former gives rise to further hemoconcentration and the latter increases local edema which means loss of more plasma, plasma proteins and electrolytes. Blood plasma should be administered to control this abnormal physiology. Our clinical research reveals that surgical compression dressing aid materially in preventing this physiologico-pathological syndrome.

Splinting of involved extremities in the position of function either by sterile aluminum splints or by plaster casts aids greatly in wound healing and also in the prevention of not infrequent serious contractures.

Plastic repair must not be minimized and wounds larger than a quarter in size should be grafted as soon as possible. The application of split thickness grafts or of small postage stamp Thiersch grafts is a matter of personal opinion. Skin replacement is the important feature.

As soon as the surgical compression dressing has been applied and the patient is in his bed, his general condition becomes the concern of those attending him.

Other than the clinical and laboratory observations made, there is little else to do except see that nursing care is adequate. Certainly, one great advantage this method has over other forms of treatment is the fact that no further local treatment is necessary. We have insisted on charting temperature, pulse and respirations every half hour for the first four post-anesthetic hours and every four hours thereafter. During the first twenty-four hour post-operative period the blood pressure should be observed frequently. It is important that the fluid intake and output of these patients be recorded in daily periods. A daily urine analysis should be reported until the patient is past the danger zone. It is very important that the amount of fluid intake is within reasonable limits. Where one has facilities for capillary hematocrit, specific gravity and plasma protein determination, the control of fluid therapy

should be much more accurate than by mere clinical impressions. Also, the indications for whole blood or blood plasma transfusion are shown by these observations. Using the surgical compression method of treatment we have found, particularly in the case of children, as well as in adults, that these patients rapidly assume their own water balance by oral fluid intake and that parenteral administration is only required in the more severe cases. These patients are given high protein diets as soon as possible and it has been our experience that solid food is fully enjoyed by the second or third day in most cases.

Morphine sedation should be used where pain is intense; however, as soon as possible codeine should be substituted. We believe that the use of coedine in the case of children is much safer than morphine.

In keeping with recent advances of vitamin therapy in wound healing and also in infection we have given a vitamin B complex with ascorbic acid in capsule form. At this time we are unable to draw any conclusions as to whether or not this medication is beneficial in burned patients.

From a purely scientific standpoint is it desirable to have daily white and red blood cell counts, hemoglobin, plasma protein, blood chloride, non-protein nitrogen or urea nitrogen determination and a carbon dioxide content of plasma. If one suspects liver damage in the case of severe burns an icteric index and blood cholesterol should be obtained.

From a practical standpoint such examinations would not only be expensive, but are not always available. Much can be learned from examination of a daily urine, red and white blood cell counts, a hemoglobin determination and the clinical course of the patient.

One great feature this method has over other forms of treatment, particularly the tannic-acid silver nitrate method, is that after the initial dressing these patients are easily able to move or be moved in bed. This certainly inhibits the onset of upper respiratory tract infection and pneumonitis which sometimes become serious complications. In the case of children we have been impressed by the fact that they not infrequently stand up in their cribs by the third or fourth day, but play with their toys and seem to enjoy themselves. They have displayed more contentment with compression dressings than those treated otherwise. These facts have not only been observed by the attending doctors but also have vividly impressed the nurses in charge of them.

CONCLUSIONS.

1. A method of treating burns has been advocated which will reverse the physiological pathology presented by such cases.

2. This method advocated by Koch and Mason and modified by us, we believe, has more advantages than other methods of treatment. Briefly enumerating, these are:

(*a*) Infection is entirely prevented or minimized and hence toxemia and the febrile clinical course usually seen are inhibited.

(*b*) With sterile compression dressings it is believed that "thermal shock" and the complex blood concentration syndrome are prevented.

(*c*) With the immobilized surgical compression dressing the involved area heals primarily in the case of first and second degree burns, and in the case of third degree burns, the granulating tissue by virtue of its cleanliness allows for plastic repair much sooner than any other known method of treatment. In any case, hospitalization is minimized.

(*d*) There are certain definite advantages from a nursing standpoint using this form of treatment. Some of these are: ease in handling the patient, general-well being of the patient, unrestrained activity which prevents complications such as pneumonia, a definite saving of dressings and hospital linens, and probably one of the most desirable features is the fact that children who are burned do not suffer psychotic changes which usually come from long periods of multiple daily moist dressings.

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MEDICAL ETHICS.

The President of the Bombay Medical Union for the year 1940—'41, Dr. A. Bacha delivered two lectures on Medical Ethics to the members of the Union at the special request of the two Joint Secretaries of the Union. The first lecture was delivered on 30-1-'41 and the second on 7-4-'41. The Union passed unanimously a resolution at the second meeting to the effect that the President's Address and discussions which followed be summarised, printed, published and circulated amongst the members of the medical profession with a request to them to send their opinions to the Union. We learn that the Indian Medical Association has also taken up the subject of Medical Ethics and is gathering the opinion of its various branches and a report from this association is awaited.

After The Medical Practitioner came into existence in 1929, we had occasions to come in contact with a large number of members of the medical profession of all grades in private practice and in government service practising in the two major provinces, Bombay and Calcutta, and casually we used to meet a few of the practitioners from the two minor provinces, the Punjab and the U.P., and every one of them complained seriously that the affairs of the profession relating to Medical Ethics was at a very low level in India. The European members of the profession who are mainly the members of Indian Military Service in civil employ though they themselves did not much suffer on account of perverse Medical Ethics, have also been complaining that Medical Ethics was a dead letter in India. There are some amongst the latter group and as many amongst Indian private practitioners in Madras who have lost faith in the local Medical Council which had to sit in judgment so far on the conduct of at least two registered practitioners belonging to the I. M. S. and some belonging to the rank and file amongst the registered practitioners and let them off much to the disappointment of the complainants who are amongst those who have lost faith in the Council. In Bombay an ex-President of the Bombay Medical Union complained bitterly at the Bombay Medical Union meeting on 7-4-'41 that the Executive Committees of the medical councils were often unnecessarily imperious in their attitude towards the practitioners complained against and punished them without giving an opportunity to which they were entitled to submit the defence of their supposed infamous conduct.

From the above facts it may be surmised that the medical profession

159644

in India has not so far been able to establish honourable traditions worthy of the noble profession and the affairs have drifted to such an extent that a large section in the profession has lost faith in itself and there is a group which has lost faith even in the statutory bodies established to wield discipline in the profession. The Indian Medical profession was described in all its nakedness by the President of the Bombay Medical Union and its members at the two meetings of the Union referred to above. The President of the Union categorically gave a list of abuses relating to Medical Ethics in Bombay. He said that practitioners possessing high qualifications canvassed directly or indirectly for patients out of greed for money. As an example, he mentioned that it was very common to find portraits of medical luminaries in lay newspapers with a biographical sketch of their professional skill and attainments, that even the technique of surgical operations performed by some practitioners found a place in newspapers and that undue publicity was given in lay press of social functions in regard to the opening or even of closing of the nursing homes. His next attack was on consultants who charged low fees and attracted the patients of general practitioners. Dr. Bacha gave out instances when consultants deprived the general practitioner of his patients that were introduced to the consultants by the general practitioners. He deplored the prevailing habit in many practitioners of following the principle of low fees and large practice. Touting by hired agents or through grateful patients, was also a subject of attack The evil of fee splitting which led to a sort of partnership between particular consultants and general practitioners was another item of condemnation. The President pointed out that there was a tendency in Bombay for finding excuses by general practitioners of unnecessary consultations or even operations. Hospital abuses were also the subject which the President considered were largely responsible for unhealthy competition with disastrous results.

During the course of discussion that followed all the speakers endorsed what the President said and some commented on the degrading methods employed by a large number of Insurance doctors, which while bringing more prosperity to the medical examiners were likely to add to the risks of the companies. What is happening in Bombay cannot surprise the members of the profession in other provinces. But we were astounded to read a statement made by a member of the Bombay Medical Union, an ex-President of the Union to boot, that the practitioners possessing the L. C. P. S. diploma were brought to existence for the purpose of giving medical relief to the village folk and as such they should not practise in the city of Bombay. It is rather difficult to understand what this veteran had in his mind while referring to the L. C. P. S. practitioners in the way he did. Neither he nor any member of the Union, who preceded or followed the veteran stated that these practitioners were worse sinners in Bombay than those possessing the higher or highest qualifications, Indian or foreign or both. The leaders who wish to lead the medical profession should know that the medical licentiates outnumber other qualified and registered practitioners in this country and more than anything else that these practitioners who are not recognised as such by the Bombay Medical Union, are the actual feeders of the consultants who form the bulk amongst the members of the Bombay Medical Union. Self-preservation being the first cannon of any existence it behoves the

leaders of Bombay to take the licentiates with them in their own interest and not so much in the interest of the licentiates without whose co-operation Medical Ethics is bound to remain at the lowest level it is now in Bombay in spite of the fact that the conservative section of the Bombay Medical Union is said to be not associating with the licentiates and there are amongst them at least a few who have no faith in Ethics or are having a standard of their own relating to Ethics. The President of the Bombay Medical Union says :

"The practice of our profession and the teaching Institutions and Hospitals are now entirely in the hands of the independent Indian medical men and we have no longer to depend upon Army Surgeons as was formerly the case. If I were asked my honest opinion with regard to the education and professional abilities of Indians, I would not have the slightest hesitation in saying that we are equal to the members of the profession in any other civilised country. Of course, I confess that we havn't enough educational and research institutions and most of us are practically devoted to private practice only ; still, individually, we have as much capacity for practising Medinine and Surgery as any in the world. If anything, we have got a greater reputation for being very careful and svmpathetic to the patients. But if I were asked a similar question with regard to the correct practice and observance of Medical Ethics by most of our professional practitioners, I will have to confess with great sorrow and regret that most of us have not reached the same level as we have in the practice of our profession. Instead of matter improving, I am afraid the things are going from bad to worse. There is no proper organization ; there is no unity and there is no respect for each other. The whole profession is disorganized and in a state of confusion and one does just what he likes to get hold of as many patients as possible....."

Mere confessions will not serve to set right the ills in the profession ; on the other hand, these will lower the members of the profession in the eyes of the public to an unredeemable extent.

Corrupt practices in the hospitals have been mainly responsible for the deterioration of private practice outside these institutions and attempts for survivorship by those outside the hospitals has been the chief cause for the state of affairs now seen in the medical profession. In some cities especially in Bombay and Calcutta, all the important hospitals are now staffed largely by private practitioners possessing high qualifications both Indian and foreign, and in all provinces Indianization of medical services is on the increase. To the same extent the Indian Medical Profession has degenerated in its morale as could be seen from the discussion at the two meetings of the Bombay Medical Union. The President of the Union who said at the very outset of his speech,

"It was Hippocrates who by the way derived most of his knowledge and experience from Physicians of Oriental countries and it is his oath which is still respected and taken by the present generation of medical men, who in his time laid down certain ethical principles of professional conduct."

has to come down from the pedestal in which the "Physicians of oriental countries stood during the days of Hippocrates" and had to say at the concluding part of his address :

"It is here that our foreign colleagues score over us. They charge a very high standard of fees, give definite appointments to each and every patient and devote a reasonable time in examining their patients. Naturally they make a better impression on the patients than our over-worked Indian Colleagues."

Statutory medical councils, Government orders and even the Criminal courts cannot be expected to set right the morals in society more so in the medical profession which is most pliable. A saint in the medical fraternity may not be known while a devil in the same fraternity may go undected and may even look like a saint.

What the profession should first attempt to do is to organise and unite. The President of the Bombay Medical Union did stress on this maxim though the Union which he leads is living a life of isolation without casting its lot with the All-India Medical Union. The Union may have its reasons, good and justifiable to remain isolated but the needs of the profession demand a wider outlook for common good. Let the Bombay Medical Union at least for the sake of Medical Ethics give up its creed of isolation and the unjustifiable attitude towards the Medical Licentiates and in the meanwhile follow the sound advice that example is much better than precept, which advice came from the mouth of one of its members during the discussion on Ethics.

There is no doubt that the profession has learnt to its cost that dishonesty, unhealthy competition and disloyalty to the noble instincts of the profession do not pay in the long run though these did bring prosperity to a few. If the code of Medical Ethics was disobeyed, this was done out of love for money and degradation due to violation of Ethics seems to have generalized to such an extent that dishonest methods do not pay. *Necessity* which is the mother of invention first thought that dishonesty would pay ; now the same *necessity* found out that this commodity does not pay. The profession took several years of research to know the true and inherent qualities of the profession and we trust the result of the research will be soon demonstrated by the All-India leaders in the profession by example and not by precept.

News and Comments.

Transactions of The Second Tuberculosis Workers' Conference : We express our gratitude to The Tuberculosis Association of India whose Secretary was kind enough to supply us a copy of the transactions of the second Tuberculosis Workers' Conference held in New Delhi under the auspicies of The Tuberculosis Association of India. Nearly one hundred delegates from various parts of India representing almost all the provinces and Indian States attended the conference. Amongst the delegates there were physicians, surgeons, pathologists, medical men representing preventive medicine, a few lay men interested in the compaign against tuberculosis, in fact it was a gathering representing all interests in regard to the compaign against tuberculosis in all its aspects and the conference was opened by Her Excellency the Marchioness of Linlithgow who has been the devoted and selfless worker in the field for preventing and curing tuberculosis, a disease which has been responsible for the largest number of deaths and a source of misery for all classes of people living in all climates, be it in cities, towns and villages. The importance of the role of the general practitioner in the campaign against tuberculosis has been acknowledged and must be acknowledged by the most eminent workers in tuberculosis, whether they be professional specialists or the lay members of society taking keen interest in tuberculosis work. To the same extent we have to say with regret that the general practitioner has not been so far conscious of his responsibility to himself and to the public due to many causes, some due to his callousness and some due to circumstances beyond his control. The Medical Practitioner has been attempting to collect and place before its readers all materials which it could gather relating to tuberculosis. The task of approaching tuberculosis specialists and persuading them to give the benefit of their experience to those who cannot take the role of specialists is rather a difficult one. These specialist are busy persons and they can spare very little time to sit down and write for others. Even if they can scrape up a few leisure moments they have special journals for the propagation of their views. The Tuberculosis Association of India has been doing splendid work in all directions and a couple of years ago we approached the Association through its Medical Commissioner to supply us all available News and Publi.

cations relating to the activities of the Association and the Associafion responded to our request. At the Second Conference of the Tuberculosis Workers arranged by the Tuberculosis Association, eminent and recognised specialists in Tuberculosis read papers on important subjects concerning this disease and we thought that the readers of The Medical Practitioner will be highly benefited to go through the proceedings of the conference and for this purpose we have reprinted two addresses one by General G. G. Jolly, Director-General, Indian Medical Service who is also the Chairman of the Executive Committee of the Tuberculosis Association of India and another by Dr. R. B. Lal, Professor of Epidemiology and Vital Statistics, All India Institute of Hygiene and Public Health, Calcutta. The former address is, on, "The Progress of the Tuberculosis Association's Campaign against Tuberculosis in India," the latter is relating to "Tuberculosis Survey". These will be followed by other addresses delivered by other workers. The readers will realise that in India we cannot get more authentic as well as educative information about Tuberculosis than what we intend supplying to them as reprints from the proceedings of the Conference of Tuberculosis Workers who assembled in Delhi under the inspiration and guidance of Her Excellency the Marchioness of Linlithgow and under the immediate supervision of the Director of Indian Medical Service, the Chief Adviser to the Government of India on all matters concerning the Medical Department which controls also to a large measure the destinies of the entire medical profession in India. We trust the readers will go through these addresses intelligently and circulate The Medical Practitioner amongst their friends. This propaganda will be in the mutual interests of the medical profession and the public.

General Stott and the Medical Profession : The South Kanara District Medical Association took advantage of the official visit of Major-General Stott, the Surgeon-General, to the South Kanara District on 17-2-1942 and arranged a social to meet the distinguished guest, report of which appears in the Correspondence Columns. The President of the Association Dr. K. R. Kini who till recently was its Secretary ever since its inception twelve years ago, welcomed the Chief Guest in the course of his address and let down a few items of the affairs of the medical profession, which served as an angle to catch the views of the Head of the Medical Department, who is also the Head of the Medical Profession, in his capacity as the nominated President of the Madras Medical Council. Usually the depth of mind of the officials in this country is unfathomable and one has to use unsuccessfully a number of baits to catch the views of these officials. The baits used by Dr. Kini for this purpose fell on very shallow waters and did not go far deep to attract that which does not frequent the shallow waters, nor was it possible for Dr. Kini to reject what he caught, and no other member of the Association seems to have taken advantage of the usual formality at the end of a social function and expressed that what the President was able to get was not what the profession would have liked to have or deserves to have. All the same the members of the independent medical profession in the South Kanara District and outside should be thankful to Dr. Kini for getting an idea of the views of the Surgeon-General who is at present virtually the mouthpiece of the Government as well as the head relating to matters, medical. The queries in regard to Emergency War Service were such that the Surgeon-General could easily answer them by repeating the substance contained in the several communiques published by the Government. The questions put ought to have been more searching. Perhaps this was not possible as the atmosphere so far prevailing in India during the British regime is one of mercenary service and the medical profession is made to count service in terms of money. Patriotic service by medical men is out of consideration and will continue to be so as long as those controlling the destinies of the medical profession are devoid of the necessary qualifications to infuse patriotism in the profession. That the success of a nation as agressors and democrats, does not depend upon the numerical strength of a nation is being amply proved and felt. Almost every day we hear from the War-Lords of the Allies that four-fifth of the world population is on the side of democracies. But so far this numerical strength has not been able to demonstrate the strength of its numbers. To find out the cause of this strange and truthful irony, an Indian need not keep thinking as he feels or rather made to feel every day that patriotism cannot have any value in India. Dr. Kini must know his district much more than the Head of the Medical Department. There was no need for him to feel shy to express how the profession should be approached to save or at least give succour to the innocent unprotected 400 millions of civil population in India, the bright spot of the British Empire, which is every moment threatened with destruction by the War-Lords of a nation which can boast of only 80 millions of population. South Kanara is a very intelligent District so also its doctors. Dr. Kini was too modest when he complained that the geographical situation of his district was such that its people are not in a position to know what was actually going on in the metropolis. The Surgeon-General said that the place as well as the occasion was not suitable to discuss the affairs referred to in Dr. Kini's address and he suggested that he would be quite pleased to meet any representative of the Association at Madras to have a talk on all matters in detail. It is acknowledged by many on the battlefield as well as in the civil area which is as bad or perhaps worse place for destruction than the former that the rule of red tape has been the cause of set-backs and serious attempts are made to burn the red tape. But the office of the Surgeon-General is very particular that anybody approaching that office should scrupulously follow the rule of the red tape and an unwary visitor is snubbed and if he happens to be one belonging to the Medical Department, he feels his folly in making a pilgrimage to the office of the Surgeon-General. The present feeling both in the official and non-official medical circles seems to be to avoid interviews though such interviews are invited by the Heads of other Government Departments including the Advisers to His Excellency the Governor. Major-General Stott could not perhaps conceive that at a social function at least, he should make his brethern in the profession feel that in spite of his official position he was one amongst them. This is the corrective demanded by the War and unless the Britisher in office or outside office corrects himself, the war is not likely to come to end soon or will be delayed indefinitely.

To the complaint made by the President of the South Kanara Association against the present policy of the Government of recalling retired medical officers in every cadre of civil medical service, the Surgeon-General's reply that it was a wise step to keep the appointments open to those who might return from war was likely to amuse a few and baffle many. The Government were neither consistent in their policy in this direction nor did they show any regard for the welfare of the civil population while filling temporary vacancies in the cadre of Assistant Surgeons and juniors just fresh from the medical colleges are posted for doing independent duty in big stations where senior practitioners are available to serve either as stipendiaries or honararies. Dr. Kini ought to have pointed this out to the Surgeon-General as his district was not free from the grave error committed by the Government. It was likely that the Surgeon-General would have listened to Dr. Kini if he put the argument the other way and pointed out to the Surgeon-General that in case young graduates are provided with temporary posts in the Civil Department, to the same extent this policy would retard recruitment to the military medical service. We would repeat what we said in these columns two months ago that there would have been some justification if professorial appointments were offered to the retired Civil Surgeons who held these posts instead of appointing young Assistant Surgeons superseding many seniors above them as was done recently in the case of a professorial appointment in the Madras Medical College. The Government have to depend upon their Advisers for selecting proper persons for particular posts and it looks as if the Government has more than

one official Adviser to guide them in regard to their policy concerning the Medical Department. This is perhaps the cause of the inconsistent policy referred to above. The profession is made to understand that the Medical Department exists as a citadel to a few and a wild unprotected area to the rest in that Department.

The reply of the Surgeon-General in regard to subsidized rural practitioners was rather encouraging. The profession will watch tangible proof of General Stott's sympathies towards the rural practitioners to whom Dr. Kini styled as a fourth class medical men in the Government Medical Service. We are glad that the South Kanara District Medical Association demonstrated through its President that in spite of the existence of an association of their own, the rural practitioners can depend upon the co-ordinating help of the District Medical Association. We trust the spirit of such co-ordination will prevail in other districts as well.

The reply given by the Surgeon-General who is also the President of the Madras Medical Council to the 'vexed question relating to the procedure of obtaining second opinion from the Government Medical Officers on the certificates issued by private practitioners, is as falacious as it is unethical. The sponsers of the modern scientific system of medicine should follow the ethical standards obtaining in the country from where the scientific system formerly mis-named, the Allopathic system was introduced in this country. May we ask the Surgeon-General whether in the British Isles there are Presidency Surgeons, District Medical Officers, Assistant Surgeons, Sub-Assistant Surgeons from whom only those in Government Service should obtain medical certificates and whether the certificates issued by private practitioners have no value? Does he know that the work of the Medical Board relating to medical certificates to be produced by Government Medical Officers during their sojourn in Great Britain is done by two independent registered medical practitioners practising in that country, who are neither Presidency Surgeons nor Civil Surgeons? The specious argument put forth by the Surgeon General, comparing the Government with a limited or unlimited company employing labour cannot hold water but will serve only as a white wash to cover the black spots in the Medical Administration of this country, which far from elevating the scientific medical profession to a level obtaining in the country of the birth of the rulers is pulled down to demonstrate the power of vested interests.

We wonder if the Surgeon-General was invited by Dr. Kini to pay a visit to a local medical stores run by a large number of independent medical practitioners of the South Kanara District for the benefit of their patients. The concern seems to be an emporium of all the requisites necessary for the practice of scientific system of medicine. It is certainly a reasonable and modest suggestion that the Government should encourage such concerns which while helping indigenous enterprises, could supply the urgent needs of the medical institutions at a cost much cheaper than what the Government would have to pay in case they indent for the urgent requirements of the Medical Institutions from outside the district especially during these troublesome days. We wish other District Medical Asscoiations follow, what the South Kanara District Medical Association did in attempting to popularise the Medical Department with the sole idea of bringing about cordial harmony between the official and non-official sections in the Medical Profession.

Government Divides The Profession: The readers might remember the news appearing in these columns last December that a deputation representing the medical profession in the Madras Medical Council waited on Mr. T. Austin, Adviser to the Government, in charge of medical port-folio, and put before him, the views gathered by them from various medical associations in the Madras Presidency relating to the D. M. & S. diploma basing upon which a memorandum was submitted by the deputationist to the Government. The memorandum was

published in the December 1942 issue of The Medical Practitioner. It was pointed out in the memorandum that the Madras Medical Council passed a resolution on the same subject. The concensus of opinion including that of the Medical Council as conveyed by the deputation to the Government, was that the Government order relating to the D. M. & S. Diploma should be given retrospective effect so that all those who passed out of the Government recognised medical schools should be permitted to have the benefit of the diploma. It was mentioned last December in the News Comments columns that a few days after the deputation waited on the Adviser, a rumour was afloat in a Government Hospital from a responsible source, that the Government would not grant the request of the deputationists. It was confirmed by another source in an administrative office of the Government and the informant seems even to have gone to the extent of saying that it was preposterous to go against the wishes of two medical officers who were definitely against the recommendation of the deputationists. From the trend of questions and answers during the course of conversation between the Adviser and the deputationists, it was felt at the time that the deputationists met all the arguments satisfactorily. Though we were in possession of the confirmation of the rumour before The Medical Practitioner came cut of the press last month, we thought it was not graceful to comment on rumours more than necessary. After we learnt that the deputationists have since been informed that the Governmnet could not find their way to give their order on the D. M. & S. diploma retrospective effect, we feel justified to let the readers know about the confirmation by an administrative officer, of the rumour which started from a hospital. It is regrettable that an affair which vitally concerns the medical profession was decided by the Government who based their decision not on the opinions conveyed to them by the entire profession interested in the matter and which section of the profession is likely to be affected by the ill-conceived order of the Government. The Government seem to have minded the prestige of their individual officers who whether they be Europeans or Indians are birds of passage of a particular department of the Government. The British Government of which the local Government is a link is now fighting for democracy as against autocracy. Individual officers of the Government in whatever high position especially those in the Medical Department are not in a position to conceive the effects of Government Orders which are moulded on the opinions of individuals. The area of the territory of influence of medical men is certainly larger than that of ambitious politicians who have to go far and wide to spread their influence which a medical man is in a position to weild from his chair. We wonder whether the Government Medical Officer who was the first source of the rumour and the other who confirmed the rumour before the Government decision reached the deputationists, were conscious of their individual influence over the members of the medical profession at least to the extent of making them believe the rumour. If they were, their conduct is blameworthy. If they were not, they are not worthy of the position they hold.

Apart from all considerations in regard to the medical licentiates whom the Government have denied a privilege on the advice of their officers, may we ask the Government a plain question, "Does the D. M. & S. diploma confer on its recipients any additional status to enable them to enjoy better prospects than those now restricted to the other licentiates either in Government service or in private practice?" The Government answer cannot but be in the negative. Our next question to the Government is, "What is the gain or advantage to the Government in conferring a high sounding diploma on a few medical licentiates?" The answer to this question will come out spontaneously from persons who do not like the methods of British Rule. They will exclaim in one voice, "The new diploma will divide the profession the more, consistent with the British policy, in India which is to divide and rule." Whatever politicians have been saying or doing against the British Government we have been entertaining the hope that the salvation of India

depends upon the Britishers moving hand in hand with the Indians with equality of status. We expected war will make this task easier but alas! even in a trifling matter of the nature under reference where the Government has nothing to lose, a further division in the medical profession is made which in a way would be detrimental to war efforts relating to recruitment to emergency medical service. Though the largest section in the medical profession will materially suffer by the ill-fated division effected by the Government, the profession may be consoled to a certain extent if the Government recognise the D. M. & S. diploma holders to the same extent the medical graduates are recognised at least for the purposes of war. Such a step is likely to relieve the anxiety of the Defence Department in regard to medical personnel in the army. If this suggestion does not catch the eyes or the ears of the Government, the prevailing feeling of distrust against the Government is likely to be on the increase. Let wisdom dawn to clear the clouds of distrust which is a worse enemy than Germany or Japan.

Will The Madras Government Follow The Lead of The Bengal Ministry? Three months ago we brought to the notice of the Government of Madras the necessity of taking the independent medical profession into their confidence in regard to medical relief to the civil population during war-raids by the enemies. We did it before Japan declared war. There was no response from the Government. After the declaration of war by Japan, when due to the horrors of invasion of Malaya and Burma the unfortunate evacuees were rushing to the ports on the Indian shores, the Mayor of Madras thought it was desirable to institute a "Safety Committee" which has since been known as "The Mayor's City Safety Committee". Early in the month of February the Mayor's Committee conceived the idea of co-ordinating to this committee, a sub-committee of the members of the medical profession. Though the idea was a splendid one, neither the medical men nor the laymen who took part in the formation of the latter sub-committee realised the responsibilities of medical men during the present emergency nor the responsibility of the lay public and the Government towards medical men with the result that it was decided to have first aid posts only in the consulting rooms of the private practitioners to give first aid during air-raids. It was thought at the time that these posts would serve a moral purpose of preventing panic. The example of free service rendered by a few practitioners in George Town some years ago when the Police had recourse to Lathi Charge Rule against the Congress activities was quoted for the purpose. It was a pity that while this example was quoted the destructive nature of air-raids was not conceived and it was decided that such of the private doctors who were willing to take up First Aid Posts in the 'Mayor's City Safety Committee' should be provided with necessary equipment from the funds of the 'Mayor's Committee'. It now transpires that 40 first aid posts are proposed to be started immediately and the cost of equipping these is considered to be Rs. 1,000 at the rate of Rs. 25 for each and that the Government should be asked to supply this amount. This is an eye was not worthy of the medical profession. It is also reported that it is the intention of the 'Mayor's Committee' to centralise the activities of all non-official committees such as the Ooru Kapu Sanghams, in the Mayor's City Safety Committee. To this extent the responsibilities of the medical men in the Medical Sub-Committee are increased to a great extent. The central and the only policy of any safety committee official or non-official, is the welfare of the civil population which is more risky in a country like India, than the actual battlefield where all possible precautions are taken for the safety of the combatants who are in addition provided with modern weapons and can look after their individual safety. Nowhere war is fought or could be fought depending upon the charitable disposition of the people. Even provision has been made in the laws of the countries to confiscate private properties during war emergency. It is so in India. So the Government cannot stint all reasonable expenditure to save the lives of the

unprotected civil population. The Government have power to conscript any profession during emergency. It was done in Burma to secure the services of the medical profession though the effect or restult of such conscription is not to be known till the end of the war. There is very poor response in India for recruitment in Emergency Military Service. There are rumours that the Central Government is planning to have recourse to conscription of doctors. The responsibility of the medical profession is such that they have to render service even without being conscripted. It therefore, behoves them to demand from the Government what they want to serve the people satisfactorily. The Government especially those under the control of Advisers are now on their test and the test should be forced on them as speedily as possible and nobody could do this more effectively than the representative statutory bodies such as the Municipalities and Local Boards. These are not days for pious resolutions and long speeches. The country is in need of action, intensive and prompt. The public feel that their safety is in danger one way or other. Let them make themselves felt by those in authority. The Government properties moveable or immoveable are the properties of the people and the people have every right to force the Government to spend for them lavishly when they are in danger. The doctors in Bengal have forced their resolute demands on the Government. They refused in a body to have anything to do with the Government unless what they demanded was given. Fortunately during this emergency Bengal has been lucky to have a National Government though not of the type existing in free countries. The Minister in charge of Medical Port Folio recently summoned a meeting of the medical profession in Calcutta, which was addressed by him and the Surgeon-General. The result of the appeal to the profession seems to be very good and under the leadership of Dr. B.C. Roy, the President of the Indian Medical Council, the profession placed before the Bengal Government certain proposals in regard to the protection of civil population during war-raids and all of them seem to have been approved by the Government. They are:—

1. All Honorary Medical Officers in the staff of the hospitals should be paid during the war emergency on the same scale as their brethren in stipendary service.

2. Special emergency hospitals should be started to meet the demands of air-raids to coordinate with the existing State or Private Hospitals. There should be two visiting surgeons for each hospital on a monthly salary of Rs. 300/- or very near this amount and a resident medical officer on Rs. 250/- assisted by two junior officers on a less pay.

3. First Aid Posts to be established in suitable places and the doctors in charge of these posts to be paid at least Rs. 150/- on full term basis or less if they do part time work.

Our information in regard to the actual amounts of pay to the doctors the Bengal Scheme is based on second hand information. It is subject to correction. Our object in commenting on this subject is to place before the readers and the authorities the spirit and principle behind the Bengal Scheme which appears to be ideal. It is regretted that advantage was not taken of the Bengal Scheme by the medical men who attended the meeting of the citizens summoned at the Ripon Buildings by the Mayor on 25-2-'42. The Mayor must have been requested to place the Bengal Scheme of medical relief before the Government and the Mayor ought to press the inauguration of such a scheme in this province. All those in authority who are paid by the Government to exercise authority are encircled by red tapes as the spider is with cobwebs. They cannot get out of them without the help of the brooms which are the only weapons in the hands of Indians at present.

Private Practice By Government Officers: On the information received by us from the members of the independent medical profession in the City as well as in the moffusil, that some of the Government Medical Officers have been violating the G. O. relating to the privilege of private practice which according to the said G. O. is restricted only to consultation practice. We referred this information to the Surgeon-General with the Government of Madras as the infringement of the G.O. was reported to be on a large scale. We thought at the time we received the information that it was likely the G. O. passed

by the predecessors of the present Government must have been since annulled or at least modified as was the case of many such orders relating to the Medical Department. For, we could hardly believe that the Government medical officers, a large number of whom in the position of civil-surgeons, holding teaching appointments, were setting at naught an order of the Government and while teaching the students the healing art, would take the role of teachers of indiscipline to say the least. We have received a communication from the Personal Assistant to the Surgeon-General to the effect that no action could be taken on a complaint of a general nature and if specific cases are brought to the notice of the Surgeon-General suitable action would be taken. Our reference to the Surgeon-General did not demand action but only information whether the G. O. relating to the restriction of consultation practice was modified or cancelled. This reference has not been answered but on reading the whole reply, we could assume that the G. O. remains unaltered. We suggest to our readers who have complaints against the Government Medical Officers to write to the Surgeon-General mentioning true facts, without any reserve or exaggeration, and before doing so get ready unimpeachable evidence preferably documentary. What is wanted in India to-day is courage to expose all that is wicked, fearless of consequences. This is the only way to cultivate and demonstrate sound morale without which nothing could be attempted and nothing gained.

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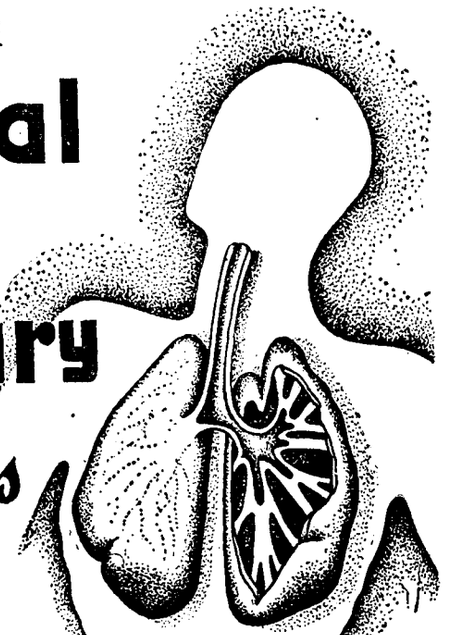

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Correspondence, Reports, Etc.

WELCOME

TO

The Surgeon-General with the Government of Madras

BY

THE SOUTH KANARA DISTRICT MEDICAL ASSOCIATION.

The South Kanara District Medical Association was At Home to Major-General H. Stott, Surgeon-General with the Government of Madras on 17th February 1942 in one of the Halls of the Kanara High School, Mangalore., Dr.K.R.Kini, the President of the Association in the course of his Welcome Address briefly gave an account of the past history of the Association for a period of 12 years when the private practitioners of the district and the officials belonging to the Medical Department conducted the activities of the Association in a spirit of cordial comradeship. He mentioned that one of the members of the Association Dr. K. M. Nayak had recently made a gift of ninety medical books on various subjects as a nucleus for starting a library for the benefit of the members of the Association. The President thanked the Government for having permitted the use of the hospital buildings in the town for conducting the clinical meetings and incidently said that unlike the majority of the Association in the Province, the South Kanara District Medical Association had a healthy convention of having as its President, a non-official medical man and that in spite of this fact successive District Medical Officers helped the Association in all possible ways. It was also announced by Dr. Kini that the Association had taken up research relating to Infantile Biliary Cirrhosis which caused a large number of deaths of children in the Kanara District.

Dr. Kini then placed before the guest some of the affairs relating to the official and non-official medical profession which deserved the earnest attention of the Government. At the very outset the President thought it necessary to tell the Head of the Medical Department in the Province the views gathered by him from the members of the profession in the South Kanara District. He said that the members of the independent medical profession did not seem to have been attracted by the several communiques so far published by the authorities announcing several attractions and they demanded that all military medical officers in the civil department should be sent to their legitimate field of activities. They felt it was humiliating to serve as an Assistant-Surgeon having once served as commissioned officer in the army even if they were to be fortunate to return safe from war. Dr. Kini mentioned that many practitioners who commanded good practice apprehended that they were likely to lose their practice and it would be rather difficult for them to re-establish their popularity after they returned from war. He informed the Surgeon-General about a rumour that the authorities would have recourse to conscription of medical men in the near future. Dr. Kini believed that if the Government took the independent medical profession into their confidence through the representative Medical Associations, there would be a good response from the profession to meet any emergency.

Dr. Kini deprecated the present policy of the Government in recalling retired officers to the detriment of those in service. The temporary vacancies ought to have been more advantageous filled in by recruiting members of the independent medical profession. He hinted that the Government must have taken advantage of honorary service in staffing the hospitals. He warned the Surgeon-General in very mild language that the present crisis

could only be handled efficiently with the help and co-operation of private practitioners.

Subsidized rural medical service was also referred to in the address by Dr. Kini who said "Though there is an organisation of theirs headed by that fearless champion of the cause of independent profession, Dr. V. Rama Kamath yet, I feel that this Association should place its views before you on behalf of its members." Dr. Kini was of opinion that the subsidized practitioners should not be treated as subordinates and that there was no need of executing bonds of service.

The President brought to the notice of the chief guest the humiliation to which members of the independent medical profession were put to, on account of the procedure now adopted by the Government in demanding second opinion from Government medical officers on the certificates issued by private practitioners to Government servants. He asked a plain question whether the Surgeon-General who was also the President of the Medical Council did consider it fair to allow the baneful practice of demanding a second opinion. Before concluding Dr. Kini suggested to the Surgeon-General the desirability of placing orders with local firms in regard to supply of hospital requirements not available in the Medical Stores Depot. He said that such a policy in addition to supplying urgent demands of medical institution would also be a sound financial proposition. He repeated his request to the guest to trust the independent medical profession, as with mutual faith between officials and non-officials more efficient and useful service could be made available.

Surgeon-General's Reply.

"It is with the greatest appreciation that I have to thank you for your kindness in arranging this meeting of the South Kanara District Medical Association here to-night, and so giving me the pleasure of meeting so many of the leading doctors of this far way district of the province. I have read with much interest the history of your Medical Association which has already carried on its fine work for the past 12 years, as a common meeting place for all medical men of the Independent Profession and of the Service. Your regular clinical meetings addressed by specialists in individual subjects must be of the greatest benefit in the exchange of professional ideas and of the latest scientific diagnosis and treatment. Such studies unite every member and every branch of our great profession by spreading the latest knowledge directed to the healing of our patients. It is gratifying that you circulate medical journals amongst your members and that you have already through the generosity of Dr. K. M. Nayak laid the foundation of a medical library and further that your Association has realised the great importance of professional research by instituting an enquiry on that most important of subjects "Infantile Biliary Cirrhosis." Such a research outlook means that your Association is standing for active progress. Your endeavour to add to the store of medical knowledge is very worthy. I am glad to note that you note that the relationship between the Independent Profession and the service members and between graduates, licentiates and all other doctors as always being most cordial. This is readily understandable in so successful an Association, for the tendency in any Medical Association is to bind doctors together in their common aim of alleviating distress. It is gratifying to note that your Association finds the use of the Government Hospitals helpful for your activities, both for clinical meetings and in obtaining clinical material. I feel sure that the District Medical Officer will always do his best to help in every way so beneficient an Association as yours.

"In your speech, Mr. President, you have raised some important questions affecting the Medical Profession. I feel this is hardly the place to go into these points in detail and especially as your district is so far from Madras. I will endeavour to indicate most briefly some comments of the points you mention and I shall be only too pleased if any of you would like to see me when you have greater leisure concerning these or any other problems you would like to discuss.

As you rightly say, the main topic of the day is to secure a greater number of medical graduate and licentiate recruits from Madras. Madras, indeed, has played a very worthy part in so far contributing over 500 doctors to military duty and I am glad to say the very large bulk of these have been derived, as they should be derived, from the Independent Medical Profession, including members who were holding honorary appointments in district and other hospitals. This response has shown that the magnificient spirit of service, which is always characteristic of the Medical Profession, still exists. But the Indian Army is rapidly and very considerably enlarged and is bravely defending the shores of India on all fronts, Egypt, Palestine, Iraq, Iran, the North West Frontier, Burma and elsewhere. These fine troops who are undertaking the active defence of India, deserve the best medical and surgical aid that the Profession can give them. As the Army is so rapidly increasing, a large number of additional doctors are required. The Independent Medical Profession has been largely consulted and terms, many of which they the Profession itself have advised, have been introduced which are, without doubt, not ungenerous and indeed most attractive. Indeed they are far more generous than when I first entered service over 33 years ago. Every one of you is well aware of the present conditions but may I point out apart from the financial and material advantages, those great moral, mental, physical and educational advantages which intercourse with a large variety of other officers of all services and of many castes, creeds and races provides. With these advantages and with the wider professional outlook on many varieties of medical, surgical, public health, administrative and speciality problems that I.M.S. Emergency Commissioned Officers obtain, will make these military doctors of great value in carrying on their work when they return to Civil Independent Profession or to Government Service.

"I hope each one of you will do his best to point out these great advantages to all young doctors and enable them to understand these advantages and to fill the gaps and to volunteer their help in the great cause for which all men who love freedom are sacrificing so much.

"You ask whether medical officers in civil employ who are liable for military duty have all been detailed. As regards the Indian Medical Service, every one of those who are liable for military call (that is 26) has already been recalled. Only those I. M. S. not returnable to military (*i.e.*, 6) have not been and cannot be recalled, with 3 administrative and jail officers. His Excellency the Governor, as a further contribution to the war efforts in which His Excelldncy has always played so outstanding and noble a part, has permitted his personal Surgeon to proceed to military duty and has thereby incurred the personal inconvenience which must have thereby arisen, as a further contribution from His Excellency to the War. Of the Provincial Medical Service, though all are liable for military duty, only those so far who have volunteered for Specialist or for ordinary appointments have so far been called, but in the P.M.S. there are now only a few men under 40 years of age. Amongst the Sub-Assistant Surgeons, though all are liable to military duty, every one of those under 40 years of age has been deputed. The Independent Profession, many of them belonging to the honorary staff, as I have already said, have rightly furnished the vast number of volunteers and this, of course, is as it should be, for the Independent Profession is the great reserve of doctors for military employ. You will have noticed amongst the conditions, a gratuity has been offered to emergency commissioned officers the object of which was to help to enable them to restart in practice.

"The policy of re-employing those efficient and suitable retired men who desire to continue working and are medically fit, is without doubt, wise one, so that the younger men may not be absorbed into Government and other posts (which after all are only of a temporary nature) so that junior doctors instead of taking temporary civil appointments will have the advantage of a few years of military duty and thus will be qualified, on their return, for per-

manent Civil Medical appointments in Government and Local Body services, or with their gratuity and with the money they have saved, they will have a substantial help in re-establishing themselves in practice. It is hoped that many more medical volunteers will come forward to take up the great opportunities that await them.

"I will now refer to the fine example set by the Madras Medical Relief Unit for Rangoon. During the first Rangoon air bombings many casualties were caused by the public not remaining within buildings. An appeal from His Excellency the Governor of Burma, was responded to by the volunteer party known as the Rangoon Relief Unit which consisted of no less than 48 American, European, Indian and Anglo-Indian doctors, nurses, medical students, ward orderlies who left the comforts of their home not only for military duty or for oveseas or active service, but to proceed to actively bombed area. They did this because they knew the urgent need for their help in that area.

"You rightly anticipate, Mr. President, that the part the Independent Profession will take in Civil Medical Defence is a most important one. Indeed it is, and their help in the formation of First Aid Posts and Parties and other A.R.P. duties can be with every confidence, relied upon both here in South Kanara, as elsewhere throughout the Presidency.

"I specially appreciate your remarks concerning the Rural Medical System. The success of the rural system is of the greatest importance. I have the real and deep personal sympathy with the Rural Practitioners who are in the very forefront of the fight for popularising the scientific system of medicine amongst the uneducated in the face of many great difficulties.

"As regards medical certificates, every employer of labour has the right to lay down the conditions of service in his employ. Many employers, for instance, provide doctors to attend their employees. It would perhaps be hardly fair that Govrnment who is a large employer of labour, should not have the right all other employers have and thus the right to require medical certificates from those doctors. Government provides for its own employees when Government so desire.

"As regards medicine, any firm manufacturing or importing such should take the greatest care that the analytical standard of contents is maintained in the correct proportion or shown by repeated routine analysis.

"You will have noticed a large increase in Air Raid precautions taken along the sea coast towns. This is not perhaps in anticipation that any attack will be made in the near future. These measures are however precautionary so that should the occasion arise, the public may have been instructed how to act best to the common good. There is no need for panic. I feel sure in addition to the precautionary measures undertaken, the great importance of those outstanding virtues of personal discipline and courage will continue to be shown by the Medical Profession of the Madras Presidency as has always been shown by the Madras Doctors and doctors throughout the world in times of emergency so that all aid may be rendered to those who are distressed.

May I once again thank you, Mr. President, and each member of this large and representative audience for having come here to meet me and have come from long distances. Often it must have been at much personal inconvenience and must have involved the loss of much valuable personal time. I am very sensible of your kindness which I sincerely appreciate and which has given me the greatest personal pleasure.

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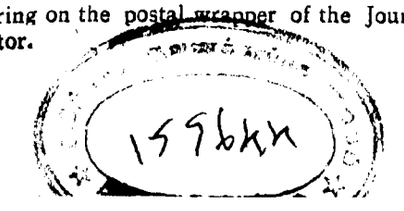

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Cash balance as on 1-1-'42 ...	392 2 11	Postage ...	32 8 6
Subscription from members:		Amount credited to The Medical Practitioner ...	118 0 0
For 1942 353 8 0		Printing Charges ...	15 12 7
Part payment received from members 11 0 0	364 8 0	Stationery ...	1 1 6
		Pay to clerk for the month of December, 1941 ...	15 0 0
		Contribution to the Reserve Fund for the month ...	29 8 0
		Cash balance:	
		With Savings Bank 533 10 7	
		With Office 11 1 9	
			544 12 4
Total ...	756 10 11	Total ..	756 10 11

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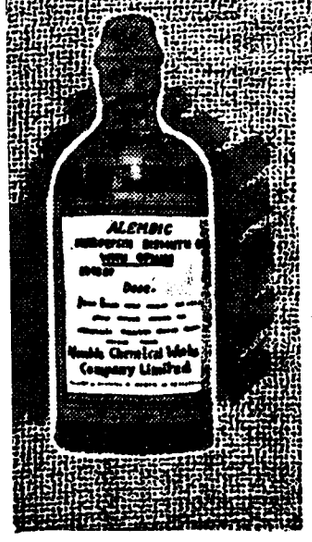

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