

Indian Medical Journal.

Journal of the All-India Medical Licentiates' Association with which the Agra Medical Club Journal is incorporated

Vol. 40 No. 7
July 15, 1946

Editorial and Publishing Office
32, Sullivans Garden St., Mylapore, Madras

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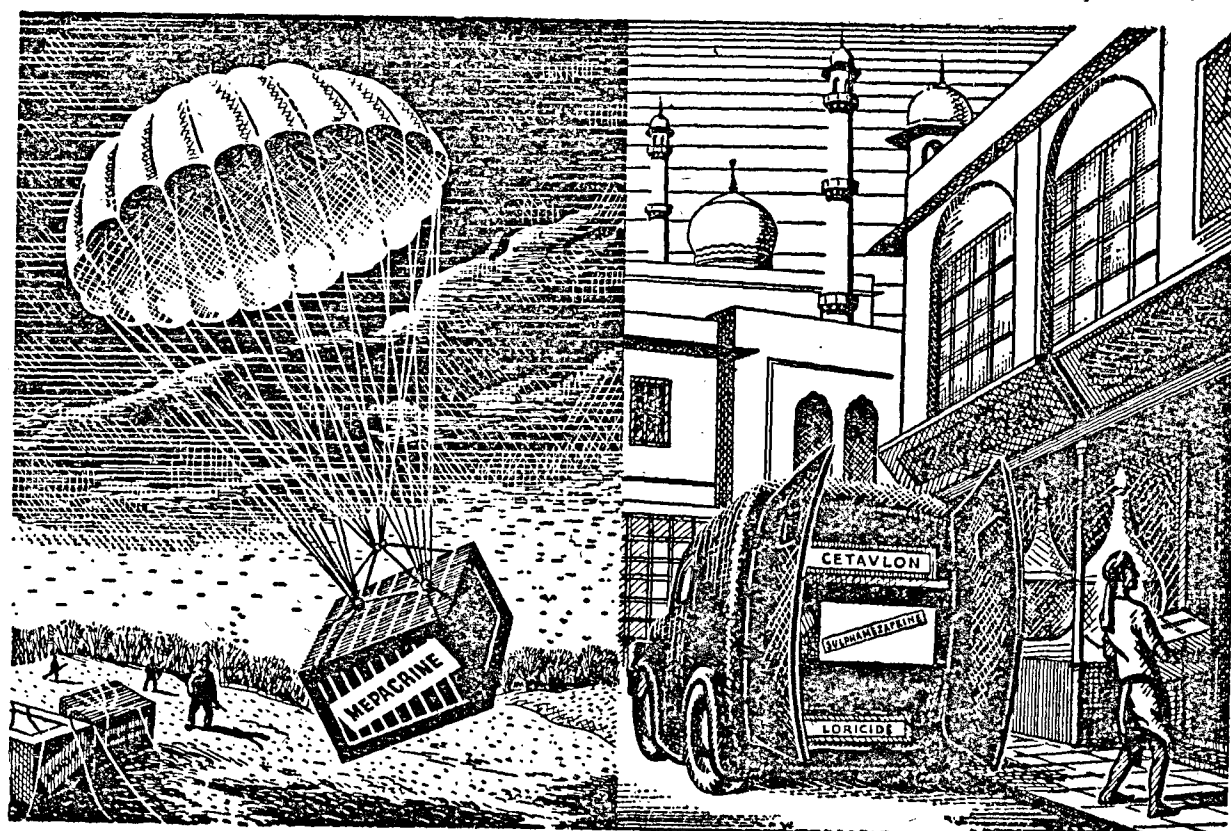
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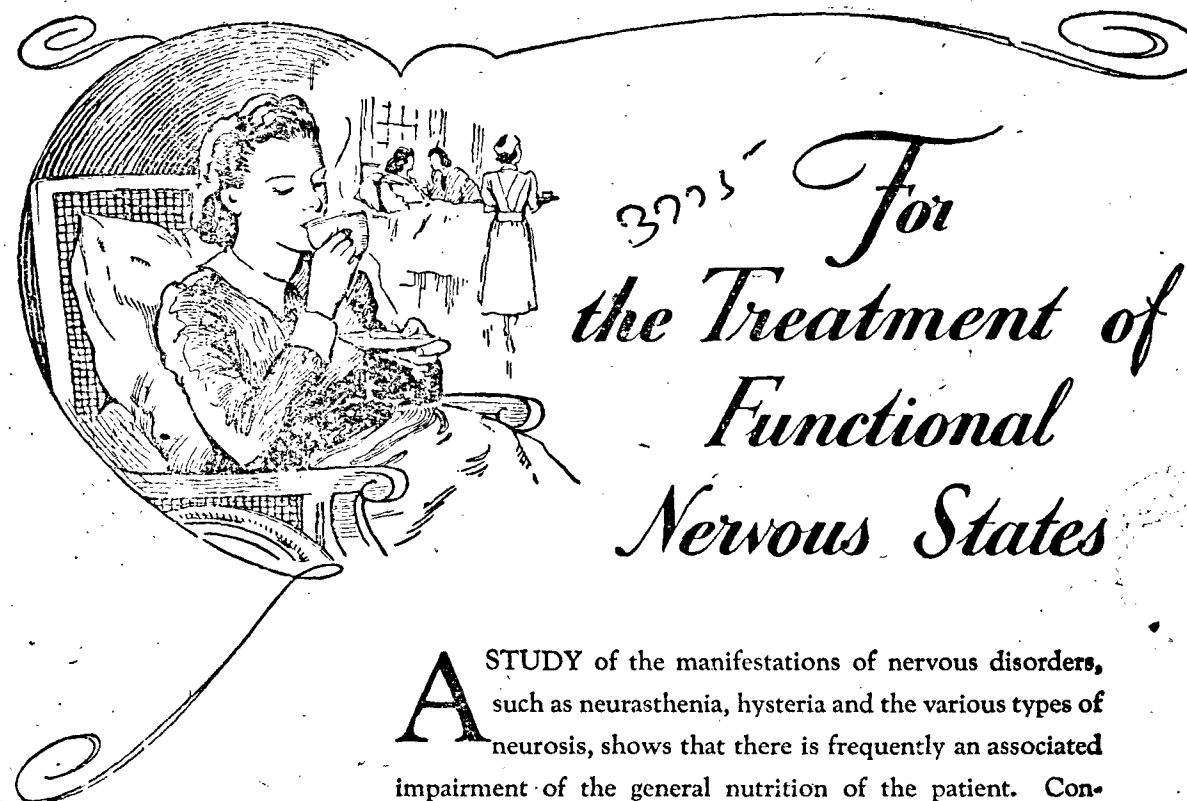
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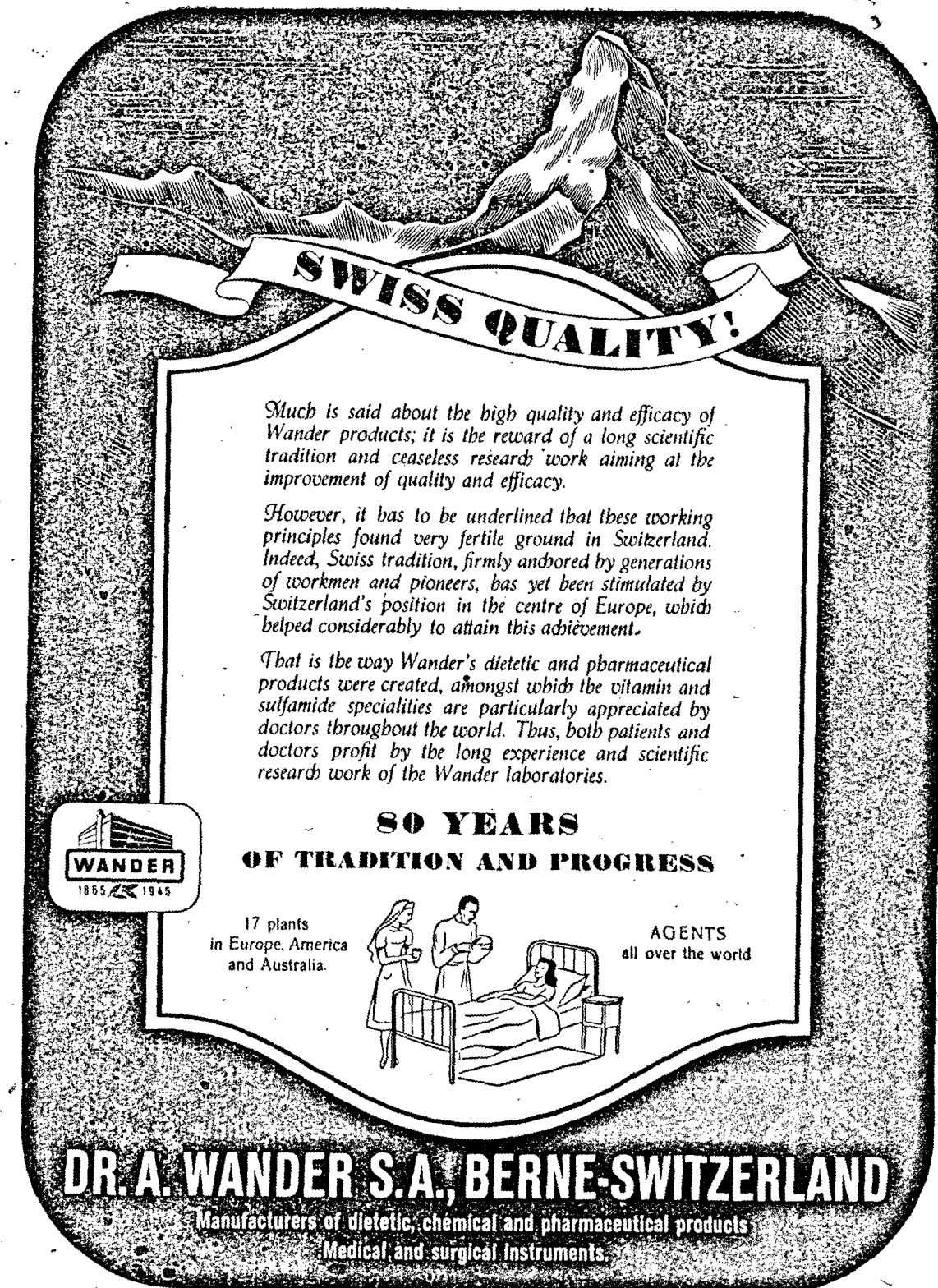
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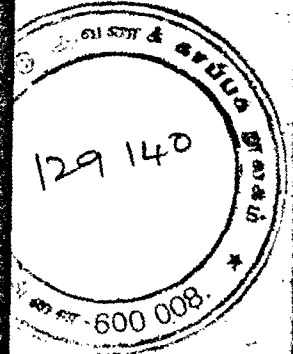
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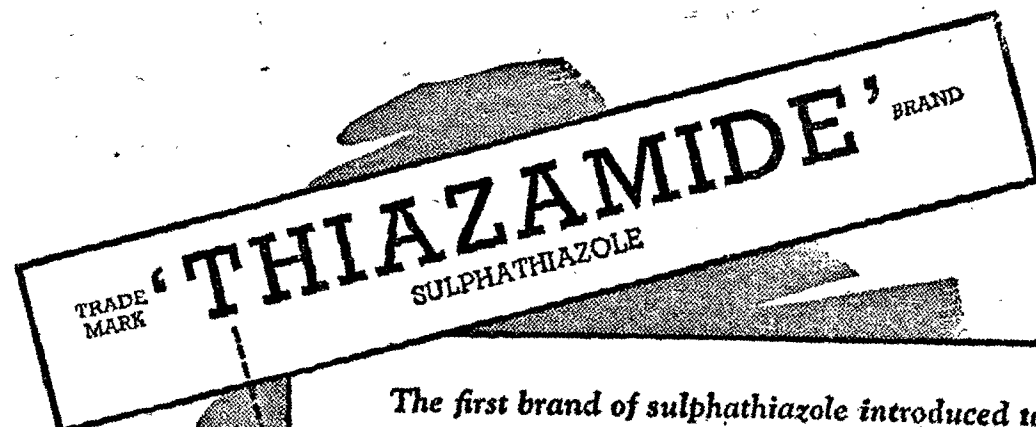
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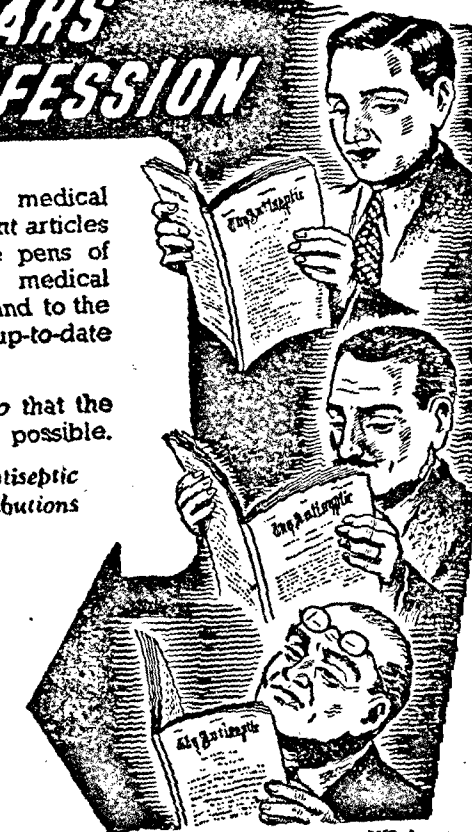
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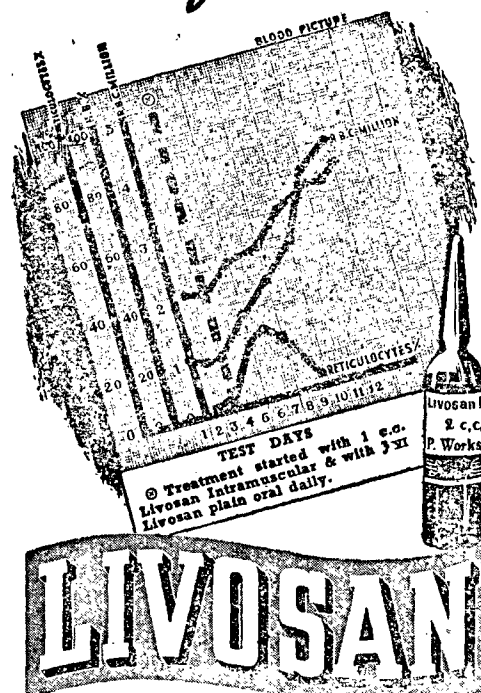
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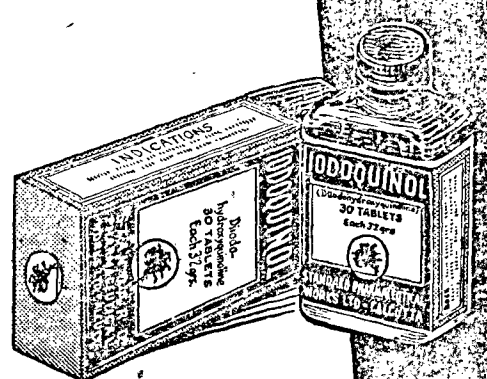
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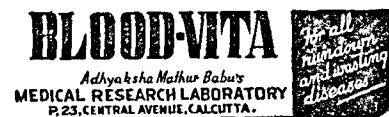


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Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras : July 15, 1946. No. 7

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All-India Medical Licentiates' Association

34th CONFERENCE

- ★ Will be held at Poona on 19th, 20th and 21st October 1946.
- ★ A Special feature will be Symposium on "Nutrition in India".
- ★ A Medical and Scientific Exhibition is also being arranged.

More details re: reception of delegates, their accommodation and programme of the Conference will be announced duly in this column.

V. G. PARANJPE,
General Secretary

Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras, July 15, 1946 No. 7.

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Members are requested to quote their roll numbers when intimating their change of address to the Managing Editor or when remitting their subscription to the Treasurer.

OUR MONTHLY SURVEY.

Strange Perversity: Our readers are aware that the conference of Provincial Administrative Medical Officers held during November, 1945 recommended the abolition of Sub-ordinate Medical Service and with it the designation of Sub-Asst-Surgeon, and a scale of pay of Rs. 150—15—450 for the Licentiates and Rs. 250—15—450 for the Graduates. We, of course, could not endorse the recommended scale, as even this difference in the initial scale of pay is untenable and unjustifiable. Be that as it may, we now understand that the Punjab Government accepted the recommendation in respect of the Graduates' Scale of pay while turning down what was recommended for the Licentiates. This is indeed an act of strange perversity, and cannot be explained away easily by the Punjab Minister of Health. Obviously he has been wrongly advised. His act is an insult to the officers of the Punjab Subordinate Medical Service. These officers have been doing their work splendidly and are responsible for the popularity of the largest number of hospitals in that province. The Punjab Provincial Branch must pursue this matter seriously and see that the prestige of the Licentiates in service is upheld. If their pay is not improved immediately or within a reasonable time, we would even suggest a whole-sale resignation. Unless such drastic action is taken, we have no chance of success under the existing circumstances.

Release of I.A.M.C. Officers: It is but natural that when the war is over these officers are released gradually. But what surprises us is the reason addu-

ced for the release. It is said that they are released because the civil authorities are badly in need of their service. But when these released officers report themselves to the Provincial Administrative Medical Officers, they are told they have no jobs to offer them and they are not responsible for the statements made by the military authorities. In cases where the officers held temporary appointments before joining the Army, even these are denied to them after their release. We have received a good number of letters from the released I.A.M.C. officers indicating their spirit of frustration, dejection and disappointment. There seems to be a whole-sale betrayal of the interest of these officers. The Government of India owes a duty to these officers in seeing that they are settled in life in suitable jobs, and should not shirk this issue on the plea that such action rightly belongs to the Provincial Governments and that they could not interfere in their decisions. We feel strongly that this matter should not be treated in this manner which practically amounts to evasion of responsibility. At the same time we would appeal to the released military medical officers not to wait in hope that the Government will find them suitable jobs, but to make arrangements for starting their own private practice. Chances of earning and real service to the people are infinitely greater in private practice than in service.

A Medical College For Licentiates: General Hance in his reply to the Association's farewell address in last march mentioned that the Government of India are making arrangements for the establishment of a medical college in Calcutta solely for the purpose of providing opportunities for the licentiate officers and ex-officers of the I.A.M.C. to qualify for M.B.B.S. as per the regulations laid down by the Indian Medical Council. We have not heard so far what progress has been made in this direction. The establishment of this college must be expedited. We understand that already 200 applications have been received for admission into the Madras Medical College where there is a provision for only about 20 or 25 seats. In view of this position, we urge upon the Government of India to speed up their proposals to a successful issue.

An Unwanted Cadre: The Governor of the United Provinces announced in a G.O. dated 7th April, 1942 that recruitment to Provincial Medical Service (U.P.) would be stopped with a view to provide for the released I.M.D. and I.A.M.C. Officers. That is one of the reasons which induced the licentiate leaders of this province to help the authorities in the recruitment to I.A.M.C. But what the Government has now done is entirely different. They have created an unwanted cadre, styled it as P.M.S. II, and fixed a salary of Rs. 120—200. It is in this cadre the war-retained medical officers will be given jobs. Except that the post in this cadre is gazetted, it is no better than the existing P.S.M.S. cadre. The Government of Madras have taken all the released I.A.M.C. officers who had a lien on the Subordinate Medical Service into the Provincial Medical Service as Assistant Surgeons, and there is no reason why the U.P. Government should not do like-wise. The U.P. Provincial Branch of the A.I.M.L.A. has protested against this breach of faith and the institution of an

unwanted cadre—a fifth wheel in the coach. We hope the U.P. Government would do justice to the licentiate by abolishing altogether the subordinate medical service and have only one service open for all registered medical practitioners, if need be by competitive examination. Meanwhile the released I. A. M. C. officers who are provided with jobs should be provided only in the Provincial Service, as is done in Madras.

ADDRESSES AND ARTICLES

Observations on Bhore Committee's Report

RAI SAHEB DR. MANOHARLAL KAPUR

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The Health Survey and Development Committee was appointed by the Government of India in October 1943 to make a broad survey of the present position in regard to health conditions and health organisations in British India. The Committee observed that this important survey could not be undertaken:

"The necessity for the presentation of a report as early as possible had been repeatedly emphasized and any detailed examination of medical institutions, health conditions and the various health services open to the public, which would have postulated close and extended investigations, was therefore impracticable."

The Committee has however made sweeping recommendations for future developments without surveying the present situation in regard to health organisations in British India and based the recommendations on the report of its five advisory committees.

The Committee, through questionnaires, has consulted many heads of medical departments in various provinces, Principals of Medical Colleges, various medical associations in the country and a number of individual medical men and social workers in the provinces, but did not study the detailed working of a provincial headquarter hospital, a hospital attached to a teaching institution, a district headquarter's and a taluk headquarter's hospitals, and dispensaries situated in a town above 10,000 population, 5,000 population or population less than 5,000 in each province, nor the Committee studied the statistics of hospitals and dispensaries of various provinces relating to any definite period with a view to find out the number of outdoor and indoor patients treated at such institutions, the surgical and medical work done at important hospitals and dispensaries, the staff employed in such institutions and their budget allotment to show how much money was allotted yearly to each institution of various categories for the pay of the staff and for the purchase of medicines and instruments. The Committee would have given useful information to the public if through their personal enquiries on the spot, they would have studied how the real work in such institutions is being carried on apart from the information available from the annual reports of hospitals and the conditions under which the staff has to work and live in these institutions.

Medical Licentiatees who are responsible for looking to the medical needs of 100% rural population, i.e. 90% of the total population in India and 3% of urban population out of the remaining 10% of population in the country are not only not satisfied but are convinced that their services are not being fully utilized in the interest of the suffering humanity while constant efforts are being made to condemn them in the eyes of the public, by giving them humiliating pay and rank, and depriving them of proper equipment and facilities badly needed in the discharge of their important duties.

If the Provincial Governments are not coming forward to better the prospects of these hospitals and dispensaries and their staff now, how can we believe that there will be a miraculous change in the attitude of the authorities, when basic doctors with four years medical education and one year internship, will replace the existing medical licentiatees of equal training with 1 to 30 years internship in the profession.

During the last 100 years, we have not produced more than a dozen doctors in each province at a time, who have won the confidence of the people as competent surgeons and physicians and it cannot be believed that under the same policy, we will be able to produce a larger and larger number of experts to attract 2500 inpatients a day, at a district headquarter's hospital, as proposed by the Committee, when at present out of 60 beds at such institutions, hardly 45 are full on an average in a year. If the scheme will be given effect to, most of the district headquarter's hospitals will cover a bigger area than the towns where hospitals will be situated.

I am sure if the Committee would have studied all these facts, its recommendations would have been absolutely different from what they are today, which are only based on high ideals without keeping in mind the economic position of the country and the faith of the people on the working of present medical institutions. It would have been better if the Committee would have seriously studied the curriculum of medical colleges and schools and tried to find out the fundamental difference between the studies in these institutions. This Committee must have been then convinced that the main subjects of medical study, including the text books, are the same and the medical school students have to prepare for their examinations according to their text books, where no page is earmarked for medical graduate students only.

The Committee now envisages to produce as many as 233630 doctors in the country by opening more medical colleges and expects to absorb all the output of such institutions in their services. How far this new scheme will be helpful to the public, as, today, the people of this country prefer to consult private practitioners, if available on all medical needs other than surgical, than service people in hospitals and dispensaries, and there is no likelihood of change in their policy in the near future until there is a miraculous change in the efficiency of our institutions, which one cannot expect so soon in the near future. With the increase in the number of doctors in the country, without any positive hopes of their absorption into the services on honourable remuneration, there will be high competition and I am sure, the wages of the basic doctors of the future will be further

reduced than are today for medical licentiatees, until we are in a position to compel the provincial authorities not to offer less than the fixed salary, which we cannot do today, nor is dreamt of in future.

If the pay for a qualified medical man is not fixed now, how will the people of India take the proposed basic doctor of the future having four years medical education and one year internship on different lines from the medical licentiatees of today having attended four years medical education and put in more than 20 or 30 years experience in the profession.

Self-Supporting institutions: Those who have got the practical experience of actual working of our hospitals and dispensaries believe that it is unwise to throw the whole burden of expense of hospitals and dispensaries on the State, rather they are convinced that the bright future of any institution depends on how far it can be run on a self-supporting basis.

In my own opinion, all specialist institutions, all institutions at district headquarters, can be run on their own income, medical institutions in taluk and tehsil hospitals and others in rural areas, must be 50% and 25% self-supporting.

If these institutions are unable to contribute this quota out of their income, it can be rightly said that they are not serving the public but the personalities which are running the show. An experiment may be made in this direction and will be successful provided popular doctors are selected without regard to high sounding qualifications.

Before opening more medical colleges, we must try to admit more students in the existing medical colleges by introducing the double shift system in such institutions. Thus we will be able to save a large sum of money which can be rightly used on some other useful campaign.

Even before increasing the present number of doctors to double its strength, we must consult Provincial Governments and confirm if they are prepared to meet the proposed enhanced expenditure in hospitals. If so, well and good; otherwise the fact may be conveyed to the public that a majority of doctors from the medical institutions shall have to stick to private practice.

In the interest of the country and its finances, it will be still useful to explore how many percentage of the public are inclined to Ayurvedic and Unani treatment.

At present we have got 47,000 medical men in India out of whom it is said about 13,000 are in services, and we envisage now to produce 223,650 doctors in our new scheme within the next 25 years.

Increase in Beds: It is a good idea, but we must not forget that out of the existing beds available is district and taluk headquarter hospitals, some of them remain unoccupied. At present on an average, we have got about 60 beds at each district headquarter hospital and not more than 25 at each taluk hospital.

The Committee now envisages to provide 2500 beds at each district headquarter's hospital and 650 beds at each taluk hospital.

Patients to these institutions are attracted not because beds are available there but because of the

popularity of these institutions and it is often seen that if one hospital with 50 beds is overcrowded today having more than 300 patients lying in verandhas and under shadow of trees, on the transfer of this medical officer, the same institution does not attract more than 15 patients a day. Such popular figures are very rare in all provinces.

Therefore it is highly risky to embark on proposals which may outwardly look very attractive to the public but may be a source of embarrassment to the institution which has to maintain the staff according to the beds of the institution. I can safely say that at present our important institutions are not very popular and hardly able to keep up the present beds even full and that also, only if they gain more popularity than today. The statement gathered from the Annual Reports of Hospitals and Dispensaries for the year 1940 in the Punjab, appended at the end this note will speak for itself.

If the actual working of hospitals and dispensaries are closely studied by a Committee consisting of one member of the Central Assembly, one I.M.S. officer, one medical graduate and one medical licentiate, visiting at least all district headquarters, half of the taluk hospitals, the same number of dispensaries as district and taluk hospitals in one Province, we will be able to come to some conclusion as how to proceed in expanding our doctors, beds and hospitals.

Hospitals:—The Health Survey and Development Committee has recommended the following number of hospitals and dispensaries, excluding the existing ones, for the eleven Provinces of India.

	No. of dispensaries with 4 beds each	No. of 30 Beds hospitals	No. of 200 Beds hospitals	No. of 500 Beds hospitals
End of first six year	2293	639	216	nil
End of ten year period	3905	1990	216	139

The idea is grand but we have no faith in its success until the humiliating conditions in the existing hospitals and dispensaries are corrected. Example is better than precept.

90% dispensaries in our country today are only provided with Rs. 250 Rs. 400 per annum for medicines and instruments. It can be well imagined how with this scanty sum they can supply medicines etc. to innumerable patients, visiting these institutions and how on earth can they buy appliances which may help them in diagnosis etc.

Therefore, is it wise to demand, first of all, to equip the existing dispensaries and provide them with medicines etc. which may be sufficient for the number of patients that flock round these institutions, before thinking of opening new ones?

The people in rural areas believe that the medicines supplied to their dispensaries for one year are hardly sufficient for one month and the doctor in charge has to satisfy his patients more through tact than through the supply of proper drugs. The people in urban area believe that hospitals are meant to supply proper drugs to rich patients, who are the private patients of the doctor in charge or of the dispensers, while the poor have to go back satisfied with stock mixture containing inadequate drugs, by spending their whole morning and perhaps a large number with a decision not to pay a return visit,

This is the actual position of hospitals and dispensaries today when we are aiming to increase the number of such hospitals to an amazing figure. How far the Provincial Governments would meet this expense, when they could not provide sufficient drugs to existing dispensaries and adequate pay to the existing medical personnel is open to doubt. The pay of the Medical Licentiates is kept low because of their large number in Services. If the Provincial Governments could not utilize them properly by granting them adequate pay, position and equipment it is advisable to close down $\frac{1}{4}$ of the existing institutions and thus enable the rest to run decently rather than to suggest expansion, fifty-times of the present one.

Professional Education: The Committee envisages to produce a basic doctor in future, a medical graduate with four years medical education, and one year internship.

Thank God, by proposing this, the Committee has given a full opportunity to the medical licentiates of India who have attended four years medical education and have put in, in some cases, one year internship and in other cases experience in the profession ranging from 1 to 30 years, to ask this Committee if medical licentiates come up to its standard. If so, is it in the interest of the country to continue to treat them in a step-motherly way? It is really gratifying to note that Sir Joseph Bhoré's Committee has not approved the present syllabus of Medical Colleges and has accepted four years medical education; in other words, it can be rightly said that in future all medical colleges will teach the same course, as in medical schools today but will be called medical colleges and not medical schools.

Nurses: We require a large number of nurses at each hospital and dispensary in the interest of our best working but more male nurses must be trained for male wards.

Clerks: Doctor-in-charge must be relieved of all clerical responsibilities and should only be asked to do professional work—hospital stores, including medicines and instruments, must be supervised by clerks under the Doctor.

Hospitals and Dispensaries: These must be in ideal locality, having their own garden and dairy.

Women Doctors: The Committee envisages to have 50% women doctors out of the total strength of doctors in Services. This is impracticable as maternity needs alone cannot be equal to total medical and surgical needs of the people in the country. We have yet to know if women doctors are anxious to take up medicine or will they like to stick to it even after qualifying. The present experience shows otherwise. Women doctors should be produced as are required for the maternity and gynecological needs of the country and not 5% of the total strength of doctors.

Post-graduate Education: It should be conducted in special hospitals under the charge of popular doctors, and certainly not merely with a view to grant diplomas in certain specialties.

Our past experience is that more than 50 percent specialists of our country, who are to day in possession of special higher qualifications of foreign coun-

tries or India, are not practising in their specialties—why so

Profession separated from Executive The Civil Surgeon in the district is considered to be the specialist in all branches of medicine. People therefore in trouble wish to approach him. 90 percent of people in India, who are living in rural areas, cannot approach him due to his headquarters being far away from their residence; cannot approach him as ordinarily he charges four-times his usual fees, already prohibitive. If asked to go into the interior 8 percent of the people who live in urban areas other than the district headquarters also find it beyond their financial position to engage him for any patient; some living at a district headquarter call him as a consultant but as the doctor in charge of the case does not like this idea, they have even to give up calling him for the second and third time. Others who wish to consult him as a surgeon find him either absent from his headquarters on tour to inspect hospitals and dispensaries in the district or find him engaged in his office work, jail work or other executive work and people really wonder if such an officer, whose mind is upset due to hundred and one duties attached to his office, can really be of any service to them even if he cares to operate hurriedly on his patients but not available to them once they are out from the operation theatre.

Health organisations for Delhi Province:—

It is certainly advisable to try this new scheme of medical expansion, now proposed by the Bhoré Committee, in Delhi and proceed by setting up one institution on old basis manned by popular surgeons and physicians only and the other under the new scheme with 2500 beds, 268 medical officers and 1398 non-medical staff!

An *ad hoc* Committee as proposed by Sir Joseph Bhoré's Committee should be set up immediately with one member of the Central Assembly, one I.M.S. officer, a medical graduate and a medical licentiate to go thoroughly into the question of revising the pay of medical officers of all grades in the department as on this foundation lies the future of the profession. A similar Committee will be useful for thoroughly studying the working of existing hospitals and dispensaries in the country and to make comments in the light of the searching examination of medical institutions on the recommendation of the Health Survey and Development Committee.

Nobody can deny that a medical licentiate, if given special training in any special subject for a particular period under the control of a competent surgeon or physician, will prove equally efficient in the discharge of their duties. If so can anybody believe it is in the interest of the public to treat medical licentiates so shabbily and not to utilize them to the full?

The All-India Medical Licentiates' Association followed the policy of compelling the Provincial Governments to close down all medical schools, as it felt justice is being denied to the licentiates, and not for any other reason.

Government must decide now to undo the wrong done to the medical licentiates by allowing them the same status and position as are enjoyed by the medi-

cal graduates in this country on the basis of a competitive examination for entering into the Services.

If, however, justice will not be done to them by giving them the rightful place in the profession, medical services in India will be a failure. The Committee suggests to dispense with the services of I. M. S. officers from the Civil Medical Services in this country, perhaps forgetting that 90 per cent of general and special surgeons in India today belong to this class and if they will not be available, the public shall have no other recourse but to consult *Vaid*s and *Hakim*s till they die slowly, rather than to be treated in hospitals, with no competent and popular surgeon, to die immediately. Let us produce surgeons to replace them before finally taking action on this policy, which is surely suicidal.

In the interest of our country and profession, I propose,

(a) That the existing hospitals and dispensaries must be provincialised and controlled by the Government.

(b) All the doctors i. e., medical graduates and licentiates be designated as medical officers.

(c) They should be recruited on ten years contract with a starting pay of Rs. 150/-p. m. for medical licentiates and Rs. 200/-p. m. for medical graduates with Rs. 10/-p. m. as yearly increment for medical licentiates and graduates. 75 per cent of this number should be discharged from services with a gratuity of Rs. 5,000/- for medical graduates and Rs. 4000/- for medical licentiates after ten years service, the remaining 25 per cent selected on merit alone, be retained in Service for another ten years on contract at Rs. 300-15-450 per mensem. The policy of giving them low pay is that they must try to be more popular and successful and depend more on their private practice than pay.

No one should be given extension after 20 years contract service until selected as specialists and teachers—after the lapse of second term, they should receive gratuity of Rs. 10,000/-both for medical graduates and licentiates.

(d) Specialists and Teachers should be selected from among those who have put in 20 years contract service or from the open market of the same standing. Merit alone should be the criterion for selection of specialists. They should receive reasonable remuneration and be engaged on contract system for seven years.

(e) Beds already provided in existing district and tehsil or taluk headquarter's hospitals should be increased to four times, at all other hospitals to three times the present strength, and the other staff increased accordingly.

(f) Travelling dispensary for each tehsil or taluk, in an ambulance car, should be provided.

(g) Health Department should be separated from Medical Department in Districts and there should be separate medical officers for both duties but at the centre in each Province, the head of the Health Department should have three assistants—one for medical, the second for health and the third for administration. The headquarters of the administrative staff should be at the centre and there should be one

administrative officer for six districts who should remain out on tour for 3 months at a stretch and then 3 months at the headquarters. There should be no administrative officers in the districts.

(h) Medical officers of less than 5 years service should work as assistants at district and tehsil headquarter's hospitals between 5 and 10 years service, they should be in charge of all hospitals and dispensaries other than district and taluk.

Medical officers with 10 to 15 years service should be in charge of tehsil or taluk hospitals and between 15 to 20 years of district hospitals and taluk hospitals.

(i) All specialists should be posted at a district headquarter's hospital, two specialists of different subjects in each district, in other words specialists of six different subjects should be placed in three neighbouring districts.

(j) Private practitioners should be encouraged to start their own nursing homes, preferably on co-operative basis.

(k) All private practitioners throughout India should be utilized for health purposes on a part-time basis i. e. one or two hours each, a day for vaccination and other inoculation purpose. They should be entitled to charge a nominal fixed fee for each vaccination or inoculation, say -/8/- from all excepting those who are very poor. They should issue receipts for such fees. Vaccines and serum should be supplied by the Government free of any charge. There should be no remuneration from the Government for their special service. Areas in the towns should be fixed for each private practitioner and the people of that area must come to the doctor in charge of that area for vaccination and inoculation purposes only.

(l) All Government servants should be relieved of medico-legal work, where private practitioner of standing are available, who should be called for such examination in the hospital in turn and allotted beds there to treat these patients till they are cured. If surgical interference is necessary, the Government doctor in charge of the department will treat this case in so far as operation is concerned and advice is necessary for him after treatment in collaboration with the private practitioner in charge of the case.

(m) All specialists institutions and District Headquarter's hospitals should be run on self-supporting basis. Tehsils or Taluk Headquarter's hospitals and other hospitals and dispensaries should be 50 per cent and 25 per cent self-supporting respectively.

(n) Surgical fees for operations should never be more than Rs. 32 in case of selected operations and Rs. 8 in case of minor operations at all hospitals and dispensaries in India for all grades of medical men out of which $\frac{1}{4}$ th of the operation fee should go to the operator. There should be no fee for minor operations such as abscess or boil, tooth extraction or extraction of foreign body and from the poor for selected or other operations.

(o) An enquiry Committee as suggested before be set up immediately to study the actual working of hospitals and dispensaries from 1938 to 1940 and to fix the wages of medical men in the light of their actual capacity for work.

APPENDIX 'A'

Statement of the working of hospitals and dispensaries, gathered from the Annual Reports of Hospitals and Dispensaries in the Punjab for the year 1940.

District	Hospital	Beds available	Total treated	Daily Average	Expenditure Rs.
HISSAR	Hissar G	32	667	3620	8,650
	Bhiwani G	32	691	36'00	10,815
	Tohana L	44	542	26'30	5,281
ROATAK	Rohtak G	26	527	21'72	12,301
	Beri L	36	2,044	52'74	8,010
	Jhajjar L	10	427	15'00	4,458
	Kalanaur L	4	586	0'75	3,112
GURGAON	Gurgaon CH G	44	930	24'64	19,399
	Taoru L	4	1,573	42'45	4,090
KARNAL	Karnal CH G & L	99	3,398	102'94	18,891
	Shahbad L	19	2,826	109'44	4,649
	Bapauli L	4	1,097	30'75	3,391
AMBALA	Ambala CHG	59	893	30'58	18,115
	Rupar G	24	646	23'58	11,502
KANGARA	Dharamsala CH G	18	224	8'81	17,737
	Barsar L	7	831	34'49	5,373
	R. E. L.	8	394	21'03	3,094
	Nagrota L	4	228	1'30	865
	Palampur G	14	152	8'86	7,186
	Kulu G	28	222	6'63	8,771
HOSHIAR-PUR	Hoshiarpur CH G	46	863	31'12	15,789
	Tanda L	6	1,117	37'13	5,122
	Mukerian L	62	1,903	113'38	7,414
JULLUNDUR	Jullundur CH G	140	1,904	84'34	31,034
	Banga L	150	1,432	68'20	5,856
LUDHIANA	Ludhiana G	40	1,806	39'65	22,668
	Jagron G	23	1,807	59'49	7,144
	Malauda L	23	2,302	64'18	4,371
FEROZEPUR	Ferozepur CH G	46	734	26'48	20,731
	Mukat Sar L	12	1,245	52'93	8,532
	Moga L	786	3,651	141'80	26,288
	Mandot L	2	549	31'16	4,155
	Jalabad L	16	843	40'27	3,554
	Mault L	4	460	21'36	5,229
	Feroz Shah L	10	413	24'04	3,646
	Kot Issa Khan L	4	648	21'67	4,818
LAHORE	Mayo Hospital G	486	9,575	442'95	6,94,082
	Kasur G	36	824	30'90	12,659
	Infections Hospital Lahore G	65	646	35'23	23,833
AMRITSAR	Civil Hospital ASS G	310	8,574	276'09	1,72,650
GURDASPUR	Civil Hospital G	54	961	30'60	13,536
	Batala G	26	1,009	32'65	6,871
	Kahnawan L	24	655	13'21	3,691
	Gorala	4	613	14'12	3,926
SIALKOT	Civil Hospital G	56	1,228	53'63	29,771
	Narowal G	42	685	22'35	7,369
	Dasaka L	26	2,000	150'40	12,661
	Talwandi L				4,182
GUJRAN-WALA	Civil Hospital C				15,842
SHEIKHU-PURA	Civil Hospital C				12,461
GUJRAT	Civil Hospital C				15,673
	Mandi Bahaud-din L				7,924
SARGOIHIA	Civil Hospital C				15,421
	Bahlwal L				5,266
	Sillian Wall L				4,289
	Mitha Tiwana I				2,812
	Jaura Kallan L				2,613
JHELM	Civil Hospital G				15,253
RAWAL-PINDI	Civil Hospital C				13,195
	Gujar Khan G				11,566

District	Hospital	Beds available	Total treated	Daily Average	Expenditure Rs.
CAMPBELL-PUR	Civil Hospital G	36	682	32'43	12,734
	Hazro G	28	626	21'46	6,466
	Bahatar L	4	255	1'82	2,818
MIANWALI	Civil Hospital G	40	754	26'15	19,438
	Isa Khel G	26	537	14'64	5,715
	Daudkhal L	55	1,050	33'57	4,084
MONTGO-MERY	Civil Hospital G	52	1,031	30'17	11,151
	Chichawatni L	35	1,776	53'09	6,823
	Haveli L	6	1,194	48'61	4,693
	Arrafwalla L	16	1,775	44'74	6,409
JHANG	Civil Hospital G	56	1,392	49'82	14,231
	Shorkot G	20	608	17'52	9,936
	Chinot L	20	685	19'52	10,732
	Ahmadpur L	8	612	17'50	4,708
LYALLPUR	Civil Hospital G	56	1,621	67'36	25,208
	Gojra G	106	8,248	346'17	32,734
MULTAN	Civil Hospital G	85	1,142	52'14	24,101
	Khanewal G	14	626	19'92	9,017
	Mailsi L	18	790	20'26	10,864
	Lodhran L	32	1,139	52'19	8,032
	Kharor Jakku L	10	1,461	17'53	7,435
MUZAFFAR-GARH	Civil Hospital G	51	933	33'65	14,136
	Leiha L	19	977	32'62	11,066
	Alipur	8	705	24'51	17,902
	Kot Adu L	40	991	40'42	4,454
DERA GHAZI KHAN	Civil Hospital G	28	1,305	41'63	1,197
	Jampur L	26	1,550	70'11	7,634
	Rajhan	16	506	22'32	5,140

Note.—G stands for Graduate in charge of the Hospital.
L stands for Medical licentiates in charge of the Hospital.

Out of 28 district headquarters hospitals, five hospitals maintained beds in full, 23 hospitals could not utilise the bed accommodation available in full.

Average number of beds available at district headquarters in the Punjab today is 60. Sir Joseph Bohore Committee Report envisages 2,500 beds at a district headquarter, at Taluk Hospitals or secondary unit hospitals of tomorrow, the beds available today are about 25, the Committee now recommends 650.

At present there are in average four medical officers at each district headquarter's hospital, the Committee now suggests 268 medical officers, similarly there are today two medical officers at each taluk or secondary unit hospital, the Committee now recommends 139 medical officers. The number of other staff at District Headquarters's hospital and taluk Hospital today is about 20 and 12 respectively, while that now recommended by the Committee is 1398 and 358 respectively. Where to accommodate Medical Officers and staff, how to pay them or engage them are the points perhaps not considered by the Committee. Medical licentiates due to their large number in Services, are getting low pay and are always cursing the day when they entered services, how will the medical officers of tomorrow, 40 times more in services than today, will pass their time?

If we study this statement seriously, we find that 20 per cent medical officers of Graduate Class were able to maintain the beds available at their hospitals in full, while more than 75 per cent medical officers of medical licentiates class have not only engaged their beds in full but had to put more than double number of beds to accommodate their patients.

APPENDIX B

Copy of para 20 of the Annual Report of Hospitals and Dispensaries in the Punjab for the year 1940.

The following medical officers performed the following selected operations:—

	Number of operations.
A Medical Graduate	2,870
"	979
"	558
"	4,497
A Licentiate	1,543
"	2,138

A Licentiate	No. of operations.
...	2,108
...	2,007
...	1,968
...	1,679
...	1,468
...	1,116
...	1,029

The above statement shows that only four medical graduates had been mentioned as Surgeons for the year 1940 while nine medical licentiates were declared as Surgeons in the same period. The Government and the Public should judge if it is in the interest of the public not to utilize the services of the medical licentiates to the full by placing all facilities for them for the smooth working of their hospitals and allowing an encouraging pay and position in the Services.

(8)

Presbyopia or old Age Sight.

BY

Dr. R. S. AGARWAL,
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Presbyopia is the name given to the loss of power to use the eyes at the near point, without the aid of glasses, which usually occurs after the age of forty.

The text-books teach that this change is a normal one; but it is a noteworthy fact that many other eye troubles often appear at this age or develop a little later. Many cases of glaucoma start about this time, and so do many cases of cataract and inflammation of the interior of the eye. Patients with presbyopia are very likely to have conjunctivitis. They are also subject to congestion and hemorrhages of the interior of the eye. One patient developed a lot of muscular trouble and a marked degree of double vision at the time he became presbyopic, and suffered three nervous breakdowns in quick succession. He was operated on for the muscular condition, and took prism exercises, but obtained very little relief. In another case a patient began to suffer, at the time she became unable to read without glasses, from a contraction of the muscles of the face, congestion of the conjunctiva and continual headaches. The strain was so great that she had to keep her eyes partly closed, and glasses did nothing to relieve her discomfort. Up to the time when her presbyopia appeared she had had none of these troubles.

The accepted explanation for the loss of near vision with advancing years is that it is due to the hardening of the lens, but it is quite impossible to reconcile the facts with this theory; for not only does presbyopia occur much below the age of forty and even in childhood, but it is often delayed beyond the age of fifty, and sometimes does not occur at all. There are also cases in which near vision is restored after having been lost. We are told that presbyopia comes early in the hypermetropic (farsighted) eye, and late in the myopic (nearsighted) eye; that premature hardening of the lens add weakness of the ciliary muscle (supposed to control the accommodation) may cause it to appear in youth; and that the swelling of the lens in incipient cataract many account for the restoration of near vision after it has been lost; but there are still many cases to which these explanations cannot be made to apply.

It is true that hypermetropia does hasten and myopia prevent or postpone the advent of presbyopia, and as myopia may exist in only one eye, without the patient's being aware of it, he may think that his vision is normal both for the near-point and the distance. There are cases, however, in which the vision has remained absolutely normal in both eyes long after the presbyopic age, and a considerable number of these have been brought to my attention. One of them, a man of sixty-five, examined in a moderate light indoors, was found to have a vision of 20/10. In other words he could see twice as far as the normal eye is expected to see. He also read diamond type at less than six inches, and at other distances, to more than eighteen inches. In reply to a query as to how he came to possess visual powers so unusual at his age or indeed, at any age, he said that when he was about forty he began to experience difficulty, at times, in reading. He consulted an optician who advised glasses. He could not believe, however, that glasses were necessary, because at times he could read perfectly without them. The matter interested him so much that he began to observe facts, a thing that people seldom do. He noted, first that when he tried hard to see either at the near-point or at the distance, his vision invariably became worse, and the harder he tried the worse it became. Evidently something was wrong with this method of using the eyes. Then he tried looking at things without effort, without trying to see them. He also tried resting his eyes by closing them for five minutes or longer, or by looking away from the page that he wished to read, or the distant object he wished to see. These practices always improved his sight, and by keeping them up he not only regained normal vision but retained it for twenty-five years.

"Doctor," he said, in concluding his story, "when my eyes are at rest and comfortable, my vision is always good and I forget all about them. When they do not feel comfortable I never see so well, and then I always proceed to rest then until they feel alright again."

The fact is that presbyopia is due to a strain. It is a strain similar to the one that produces hypermetropia, but differs from it in the fact that it affects chiefly vision at the near-point. This can be demonstrated with the retinoscope. When a person with presbyopia tries to read, the retinoscope will show that he has hypermetropia, but when he looks at a distant object the retinoscope will show either that his eyes are normal, or that the hypermetropia is less. Simultaneous retinoscopy is difficult in the case of a reading patient, for not only is the pupil small, but in order to find the shadow it is necessary for the patient to look in one general direction all the time, and this is not easy. It is also difficult to hold a glass at one side of the eye for the measurement of the refraction in such a way that the observer can look through it while the patient does not. With a sufficient zeal for the truth, however, these difficulties can be overcome.

The strain which produces presbyopia is accompanied by a strain, more or less pronounced, of all the other nerves of the body. Hence the many distressing symptoms from which presbyopic patients suffer. Glasses, by neutralising the effect of the

imperfect action of the muscles, may enable the patient to read; but they cannot relieve any of these strains. On the contrary they usually make them worse, and it is a matter of common experience that the vision declines rapidly after the patient begins to wear them. When people put on glasses because they cannot read fine print they often find that in a couple of weeks they cannot do without them, read the close print that was perfectly plain to them before. Occasionally the eye resists the artificial conditions imposed upon them by glasses to an astonishing degree, as in the case of a woman of seventy who had worn glasses for twenty years, in spite of the fact that they tired her eyes and blurred her vision, but was still able to read diamond type without them. This however is very unusual. As a rule the eyes go from bad to worse, and, if the patient lives long enough, he is almost certain to develop some serious disease which ends so frequently in blindness that nearly half of our blind population at the present time is believed to be over fifty or sixty years of age. Persons with presbyopia who are satisfied with the relief given to them by glasses should bear this fact in mind.

Presbyopia is cured just as any other error of refraction is cured by rest. But there is a great difference in the way patients respond to this treatment. Some are cured very quickly, even in as short a time as fifteen minutes; others are very slow and need the use of glasses but as a rule relief is obtained within a reasonable time.

While it is sometimes very difficult to cure presbyopia, it is, fortunately, very easy to prevent it. Oliver Wendell Holmes told us how to do it in "The Autocrat of the Breakfast Table," and it is astonishing not only that no attention whatever should have been paid to his advice, but that we should have been warned against the very course which was found so beneficial in the case he records.

He says, "There is now living in New York State, an old gentleman who, perceiving his sight to fail, immediately took to exercising it on the finest print, and in this way fairly bullied Nature out of her foolish habit of taking liberties at the age of forty-five or thereabouts. And now this old gentleman performs the most extraordinary feats with his pen, showing that his eyes must be a pair microscope. I should be afraid to say how much he writes in the compass of a half-day, whether the Psalms or the Gospels, or the Psalms and the Gospels, I won't be positive."

Persons whose sight is beginning to fail at the near-point, or who are approaching the presbyopic age, should imitate the example of this remarkable old gentleman. Get a specimen of diamond type, and read it every day in an artificial light, bringing it closer and closer to the eye till it can be read at six inches or less. Or get a specimen of type reduced by photography until it is much smaller than diamond type, and do the same. You will thus escape, not only the necessity of wearing glasses for reading and near work, but all of those eye troubles which now so often darken the later years of life.

The cure of presbyopia, as of any other error of refraction, is rest, and many presbyopic patients are able to obtain this rest simply by closing the eyes.

They are kept closed until the patient feels relieved, which may be in a few minutes, half an hour, or longer. Then some fine print is regarded for a few seconds. By alternately resting the eyes and looking at fine print many patients quickly become able to read it at eighteen inches, and by continued practice they are able to reduce the distance until it can be read at six inches in a dim light. At first the letters are seen only in flashes. Then they are seen continuously. When this method fails sun treatment and palming may be tried, combined with the use of the memory, imagination and swing. Imagination of a thin white line in between the lines of print is usually very helpful.

Many presbyopic and hypermetropic persons are benefited by the following method:

The patients are taught to practise central fixation on the letters of the shellen test card in such a way that they see a small part of each letter blacker or more distinct than the rest of the letter. The practice is done then on the smaller letters at ten or twenty feet. After normal is obtained for distance, the eye training is continued for small letters at the reading distance. A dot (size of full stop) or comma is selected. The patient looks away from the dot until he can appreciate that the dot is less black or worse. He then regards a letter nearer the dot and notes that the dot is worse. The distance from the dot is gradually shortened, until by practice the patient can make the dot appear less black. The distance between the dot and the letter is reduced so much as the diameter of a small letter. He can now read the print. Then he is encouraged to practice holding the fine print closer to his eyes until he can read at four inches. Some patients are relieved in a few days. Permanent relief is never obtained without constant or daily practice reading diamond type without glasses at four or twenty inches. The efficiency of the eye is very much increased, and one reads more rapidly than with glasses and without pain or fatigue.

How Dr. Bates Cured Himself.—Dr. Bates was using glasses of plus three in his old age and was in search of some treatment for his presbyopia. He could read fine-print with his glasses at thirteen inches, but was unable to read fine-print either at twelve inches or at fourteen inches. The retinoscope showed that when he tried to see anything at the near-point without glasses, his eyes were focussed for the distance, and when he tried to see anything at the distance they were focussed for the near-point. He consulted various eye specialists but his language was to them like that of St. Paul to the Greeks, namely, foolishness. "Your lens is as hard as a stone," they said. "No one can do anything for you." Then Dr. Bates went to a nerve specialist who said to Dr. Bates that he had come to the conclusion that there was only one man who could cure him, and that was Dr. William H. Bates of New York.

"Why do you say that?" Dr. Bates asked.

"Because he is the only man who seems to know anything about it," he answered.

Thus Dr. Bates was thrown upon his own resources. One day, while looking at a picture of the Rock of Gibraltar which hung on the wall, he noted some black spots on its face. He imagined that these spots were

the openings of the caves, and that there were people in these caves moving about. When he did this his eyes were focussed for the reading distance. Then he looked at the same picture at the reading distance, still imagining that the spots were caves with people in them. The retinoscope showed that he had accommodated, and he was able to read the lettering beside the picture. He had, in fact, been temporarily cured by the use of his imagination. Later he found that when he imagined the letters black he was able to see them black, and when he saw them black he was able to distinguish their form. His progress after this was not what could be called rapid. In six months time he could hardly read the newspaper, but in a year he could read the newspaper without glasses quite comfortably from four inches to eighteen inches. This experience was extremely valuable to Dr. Bates. Fortunately for the patients it had seldom taken Dr. Bates as long to cure other people as it did to cure himself. In some cases a complete and permanent cure was effected in a few minutes. One patient had completed his forty-second year; at times in the night he noted that his vision remained dim for about half an hour and then became quite clear. While writing he felt pain in the right eye. He hated spectacles as they had caused deterioration in the eye-sight of some of his friends who used glasses.

The examination of his eyes revealed that the vision of each eye for distance was 20/10, and he could read photo print at twelve inches with each eye separately. I said to him, "Your eyes are quite alright but you should read photo print two or more times daily especially in artificial light. If the print is not clear in the artificial light, read diamond type or glance at the white lines in between the lines of print. This will prevent and cure all the complaints and you will not need glasses in your life time." He then put the following questions:

Q—Why am I not able to read clearly at times at night?

A—Because the focussing of the eye is not correct at that time due to strain. At the beginning of the study palm and read fine print or photo print.

Q—Why do I get pain in the right eye and not in the left eye while writing?

A—There are two eyes and both function separately but the images of both the eyes are fused together by the mind. The right eye tries to see the back letters or words already written and loses central fixation while the left eye does not. The remedy is to train the eye to shift with the movement of the pen, and not to try to read the black letters or words while writing.

Q—Is intense light useful for reading?

A—The light may be intense or not but it should not be glaring light and cause reflection. For example, if you read in the sun, the eyes are soon tired and the vision becomes dim; because the glare reflected from the paper causes strain; but you can read quite comfortably in the shaded light of the sun. Similarly, if you read under strong electric light falling directly on the paper, it will cause reflection of the glare and eye strain. The arrangement of the light should be such that it does not fall directly on the paper.

Q—Can I use dark glasses in the bright sun?

2

A—The bright sun cannot trouble you if you frequently blink and keep the upper lids down; but if you cannot control the wrong habit of opening the eyes widely in the sun, then mild shaded dark glasses as Crooks B may be used.

A man had difficulty in reading in the artificial light, and consulted an eye specialist who prescribed glasses for him for near work. The doctor assured him that he might be able to discard the glasses after sometime, and if he lived long enough he would have what is called "second sight."

There is not much harm if the correct glasses are used only when it is absolutely necessary. If the wrong glasses are prescribed or if the glasses do not fit well, the patient usually suffers from headache or his eyes are soon tired. Patients who have myopia or near-sight sometimes obtain normal vision just by removing glasses and not wearing them again for reading.

This patient used the glasses for reading according to the instructions of the doctor but felt tiresome after reading for an hour or so. After sometime headache also developed. Then he consulted another eye specialist who prescribed bi-focals. His vision and headache became worse and worse and had to change his glasses quite frequently according to the instructions of the doctors.

I tested his vision on the Snellen test card and it was recorded as 10/20 with each eye. He could hardly read No. 1 Fundamentals without glasses, and No. 8 with glasses. To relieve his headache and tiredness I asked him to practice the long swing before a window. As he swayed from side to side the window bars appeared to him to be moving in the opposite direction. Then I placed him before a long mirror. He stood with his right foot out about a foot further than the left. I told him to look at the tip of his shoe as he swayed forward, and to look in the mirror at the top of his head as he swayed backward. After practising long swing for about ten minutes he felt good relief.

The next procedure was to practice palming. While palming he was seeing floating clouds of gray instead of black. To improve palming I directed him to look at the Snellen test card letters at about five feet distance with central fixation. He could easily note that the part of the letter or the letter regarded appeared very black. Then he was instructed to palm again while holding the memory of the black. As he was able to keep the memory of the black, it was all quite dark before his eyes while palming.

After palming he read No. 4 of the Fundamental card but complained that the letters were gray and the letters of the rest of the Fundamental card appeared blurred and mixed. I reminded him that the type was printer's ink which he had noted in the letters of the Snellen test card. He replied that he knew they were black and printed with printer's ink, but that they looked gray.

"If you know they are black, you can imagine also that they are black. Can you do that?" I asked.

"Yes", he said, "I can imagine that they are black"; and then he proceeded to read them.

In a week's time he could easily read the fine print with the memory of black both in day light and artificial light. Such quick cures are rare but some improvement has always been obtained in all cases. To such cases lower power of glasses are prescribed to use them only in necessity, and the instructions of reading fine print with or without glasses are given.

The Treatment Of Cholera And Acute Gastro-Enteritis*

BY

CAPT. D. C. GUPTA, I.A.M.C.

Twenty five cases of Cholera Gastro-Enteritis were admitted to 13 INDIAN MALARIA FORWARD TREATMENT UNIT, Myingyan, Burma between 16 and 25 August '45. They comprised young and old of different nationalities, i.e., Indians, East Africans and Europeans in various stages of the disease. All of them had been working on the Irrawaddy docks or on a chaung tributary of the Irrawaddy before reporting sick and were with one exception supposed to have been inoculated against cholera within the last 3 months. The Units involved in this out-break were two Pioneer Companies, one Bridge Building Company of E.A. En Bn and I.W.T Company who were all working on the dock. It is most likely that the men were drinking water indiscriminately from all sources with no regard for its sterilisation and thereby contracted the infection.

May I say a few words about the cases themselves and the line of treatment followed? I have thought it desirable to classify them according to their severity and will give you some idea about their symptomatology in a tabular form.

SIGNS AND SYMPTOMS

Signs and Symptoms	Cases with no appreciable dehydration I	Cases with Moderate dehydration II	Cases with severe dehydration. III
1. Onset	Sudden	Sudden	Sudden
2. General condition on admission.	Fairly good hydration not apparent.	Moderately dehydrated	Marked dehydration with cold clammy perspiration all over the body, skin shrivelled, eyes sunken, cheeks shallow, voice low and husky, Cyanosis. ++
3. Vomit and Stool.	Watery but no faecal matter in stool	++ Rice watery	+++ Rice watery
4. Pulse.	80 to 90 p.m. volume and tension good	100 120 p.m. weak and feeble.	Hardly-perceptible
5. Cramps.	Not present.	++ in lower extremities	Very severe in the lower limbs and lumbar region. The patients were actually seen tossing in their beds.

*Extracts from a Paper read by the author at a clinical meeting in 13 Indian Malaria Forward Treatment Unit on 30-8-45

6. Suppression of urine.	Not present.	Not present.	Present.
7. Response to treatment.	Rapid and satisfactory.	Satisfactory.	Slow but highly satisfactory.
8. C.S.R. Stools report	Negative for commabacillus.	+ in one case.	+ in eight cases.
9. Culture. Field Lab.	Cholera vibrio isolated in one case.	Cholera vibrio. not isolated	Cholera vibrio. isolated in 4 cases.

TOTAL CASES: 4 6 15

Diagnosis in all cases was based on clinical findings but stools were sent to the Clinical Side Room for microscopic examination and for culture to the Field Laboratory. In 9 cases the report from the clinical side room was "Comma Bacillus seen" while the Field Laboratory isolated the cholera vibrio in 5 cases. The point of interest is that in some cases clinical side room report was negative and the culture result was positive but in other the positive reports from clinical side room were not confirmed by the Field laboratory. The reason for these variable results is probably the lapse of time after the collection of specimens till the examination in the Field Laboratory, which was fifty eight miles away. In some cases, I think, the specimens could not possibly have been examined in the Field Laboratory in less than 48 hours after their collection and this lapse of time may be quite enough to destroy the cholera vibrio.

Now a few words about the line of treatment adopted in different cases.

Group No. I. was treated with sulphaquanidine and plenty of fluids, chiefly in the form of weak permanganate solution, hot tea etc. They responded very within 6 to 12 hours.

Group No. II. was treated on similar lines to group No. I with the addition of isotonic glucose saline intravenously. These cases started showing well improvement after 12 to 24 hours.

Group No. III. was treated on similar lines to group No. II with the addition of adrenalin chloride intravenously to combat collapse, which was a common feature in group III. Most of these cases responded rapidly within 12 to 24 hours after the commencement of treatment. Three cases were exceptions. They showed slight improvement which lasted for short time and then the condition again became worse and more intensive treatment had to be adopted. Such relapses occurred 3 or 4 times in each of these 3 cases. But fortunately all of them recovered.

Remarks on Treatment

I. Sulphaquanidine was started with 7 gms. and subsequently continued with 3½ gms. every 4 hours until the stools became normal. It was observed in two cases that as soon as they took sulphaquanidine they either vomited or showed a tendency to vomit and the result was that I had to discontinue sulphaquanidine and put them on Kaolin bolus 25 per cent ad lib. The results were satisfactory.

II. Isotonic glucose saline was not considered necessary in Group No. I. Group No. II required about 12 to 18 pints and in Group No. III it was considered necessary to administer 20 to 30 pints a day intra-

venously for two days; but in two cases it had to be continued for more than 90 hours. Glucose saline was administered rapidly at the very outset i.e., 2 pints in ½ hour and then continued by drip method. It was observed that patients with suppression of urine started passing urine after they had 10 to 15 pints of saline.

III. Adrenalin chloride was given intravenously in 3 cases out of Group No. III four times in 24 hours for combating collapse.

IV. Sodium bicarbonate solution 3 per cent in one pint of isotonic glucose saline was given intravenously to one of the cases in Group No. III, who showed evidence of acidosis, indicated by rapid and deep breathing, great restlessness, mental confusion and acid urine, in spite of sodium bicarbonate taken orally. As there was no ready made sterile sodium bicarbonate solution available for intravenous administration in the medical stores, I had to give a locally prepared solution. I did not observe any ill effects after the intra-venous administration of 1 pint of this 3 percent sodium bicarbonate solution. It was however thought advisable to discontinue intravenous administration and give the sodium bicarbonate solution orally in massive doses at frequent intervals and this eventually proved effective.

The patient got over the acidosis although rather slowly.

Complications: The only complications observed were.

- (1) acidosis
- (2) reactionary hyper-pyrexia, which lasted from 12 to 24 hours. Blood slides were negative for malaria parasites.

General Remarks.

More severe cases occurred in the earlier part of the out-break. The reasons for the diminution in the severity with the lapse of time may be that:

(a) the micro-organisms became less virulent as a result of production of phage in the intestines;

(b) that the people became so much cholera minded that they rushed to hospital for even slight gastro intestinal disturbances. I think that this is the only right thing to do on such occasions. It would not be out of place to point out that the disease in East African patients appeared much more severe than amongst the Indians.

As regards death rate amongst my cases, there was only one fatal case i.e., a case mortality of 4%. This man came to hospital very late and died within few hours of his arrival.

I would like to bring to your notice the large quantity of isotonic saline used in some of these cases, as much as ninety to one hundred pints were administered to each of the three very severe cases without any ill effects, in fact with obvious benefit. No evidence of pulmonary oedema was noticed.

I am convinced that the mortality rate in cholera can be reduced to the minimum provided that the patient reaches hospital before it is too late to do any thing for him and that immediate and intensive treat-

ment is instituted without any delay. Patients must be watched very carefully for any evidence of relapse.

I express my grateful thanks to Lt.-Col. F. W. Snedden I.A.M.C. for helping me in preparing this paper and according me the necessary permission to forward it for publication.

Crime-Its Relation with Climate, Age etc., and a Short Note on The Psychology of Crime.

By

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My observation on the subject is limited and I have not been able to pay as much attention to it as this vast subject deserves. I do not claim any originality, but I present it with the expectation that this may form a nucleus for a thorough study of the subject in its fullest details by those interested in it.

Col. Waddell writes: "Indian experience generally supports the modern school of criminal anthropologists in regarding the criminal as a degenerate. Certainly prisons all the world over contain a considerable proportion of persons under punishment who are little better than half-witted. The great majority of violent criminals and murderers in India are 'criminals by passion', fairly well-meaning and generally law-abiding men, who, stung into sudden madness by some insult or wrong, real or fancied, to themselves or families, take justice or retaliation into their own hand and so find themselves in the clutches of the law. A large number are criminal through natural stupidity and want of self-control, rather than inherent wickedness."

In the opinion of criminologists, all criminals are feeble-minded. The main cause of crime is corruption of mind and corruption begets weakness. Scholars like Parretto, Lombroso and Parmelle think that absence of intellectual faculty and power of discrimination, generally marked in the criminals, is due to mental weakness. Hilli says that such people fall under the category of 'born-criminals'. To quote him, he writes, "The gist of the whole situation concerning 'born-criminals' is that they are individuals who definitely belong to scientific categories of mental defect and mental aberration". It has however been observed that environment, illiteracy and some abnormal development of mental faculty lead them to the habit of committing crimes. In the majority of cases these people commit crime due more to stupidity or at the instigation of others. It may not be that they do so, because they desire to commit a crime or always after deliberate consideration or it may be possible that some defective development of cerebral hemisphere is responsible for such commitment. Besides these, there is another class of people who present a peculiar physical hardness or mental invulnerability. Physically hard are those on whose mind or action it is by no means possible to bring aversion by corporal punishment however severe it may be. Such people are not generally sympathetic towards others.

There are others who are incorrigible to sound advice, reproach or even threat of punishment and these are the people who belong to the mentally invulnerable class. This class is bound to have the weakness so commonly seen in the criminals. No reaction can be brought about or noticed in these people whether you laugh them to scorn, insult or put them to indignity. But it will be a mistake to take it for granted that people with physical or mental invulnerability must naturally be criminals. As already stated, they, by displaying these symptoms, will present or show the mental weakness so common to the criminals.

From a psychological point of view, it is interesting to study the classification of criminals. Here also the authors differ. To me, Essafanbun appears to be more accurate and he places them in six classes. (1) Chance criminal, (2) Criminals of passion, (3) Criminals of opportunity, (4) Deliberate criminals, (5) Habitual criminals, (6) Professional criminals. The terms are self-explanatory, free from repetitions and can be amplified.

In presenting the statistics, I must admit that for simplicity of purpose, I have intentionally omitted most ordinary crimes e. g. cheating, bribery, pick-pocketing etc., which in my opinion appear to have little relation with my particular subject. The period included in the statements that follow, extends from January 1942 to December 1945.

Table No. 1 shows the age of the criminals according to the official records and the number and percentages of crimes committed within the specified age limits.

TABLE 1

Age Below 20	21 to 35	36 to 50	51 to 65	Above 65	Total crimes
17	164	49	28	3	261
6.5%	62.8%	18.8%	10.8%	1.1%	

It appears that the largest number of crimes, in this series, were committed by people between the age 21 to 35.

TABLE 2

Total number of crimes in relation to height of criminals.			
Below 5'	5' to 5'-6"	Above 5'-6"	Total
7	229	25	261

Contrary to the common belief that short people are more likely to be criminals, it is noted that the largest number of crimes were committed by people of medium stature.

TABLE 3

Maximum temperature and percentage of relative humidity.

I have divided the years in three periods—November to February, March to June and July to October, according to the climatic conditions of Silcher. Relative humidity has been shown below the lines and maximum temperature above.

	Nov. to Feb.	March to June	July to Oct.
1942	83.9 F 93	88.4 F 88	91.4 F 94
1943	86.7 F 86	89.2 F 85	90.9 F 89
1944	83.9 F 87	88.9 F 89	90.6 F 89
1945	82.6 F 86	89.8 F 91	89.9 F 93

TABLE 4

Total number of crimes and percentages during the above periods.

	Nov. to Feb.	March to June	July to Oct.
1942	24	6	15
1943	18	22	33
1944	22	27	11
1945	17	20	46
Total	81	75	105
%	31.04%	28.78%	40.22%

Acknowledgment.—My thanks are due to the authors for the references made in this article. I am grateful to Major P. H. Cummins, M.B., B. Ch., I.M.S. and to Dr. R. M. Deb, M.B., Civil Surgeons, for permission to use Jail records and to publish this paper. Thanks must also be expressed to the Director, Regional Meteorological Centre, Calcutta for kindly supplying the statement of temperature and humidity for the period of the report.

Perspiration

BY

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Perspiration is a vague term meaning secretion of the sweat glands. To facilitate description of the disorders of secretion, it has been classified into four conditions as under:

1. ANIDROSIS.

Definition:

The term denotes diminution or complete absence of sweat secretion.

Etiology:

- Hypothyroidism (Myxoedema)
- Senile degeneration of skin.
- Scaly skin diseases e. g., Psoriasis.
- Heat stroke.
- Poisoning by drugs like arsenic.
- Ichthyosis congenita-congenital in origin-affects babies only who are premature and stillborn.

Varieties:

- Xerodermia.
- Ichthyosis.
- Ichthyosis Hystrix.
- Hyperkeratosis.

Pathology:—On histological examination, marked increase in thickness of horny layer of skin is noticed which is irregular and originates directly from the mucous layer as the granular layer is absent. Sweat glands, though quite normal in appearance, cease to function and hence the dryness of the skin. Whether such changes are allied to one another or the causative factor is common is not yet definitely established.

The overgrowth of the horny layer is, however, believed to be an attempt on the part of nature to compensate for protection usually supplied by the oily secretions.

CLINICAL PICTURE:

- Xerodermia:**
 - Skin rough and dry-brawny scales over the surface.
 - Hairs dry and lustreless, occasionally stunted and brittle-downing on the scale.
 - Prominent hair follicles.
 - Small horny layers on exterior surface-flexor side little or no change.
 - Palms and soles usually lined more than normal.
- Ichthyosis:**
 - Body covered with large fish-like adherent scales which are thin, transparent or colourless, thick and dark in colour (so called alligator skin.)
 - Trunk and extensor surface mostly involved-scalp and face little change.
 - Subject to bacterial inflammation owing to altered protective mechanism.
- Ichthyosis Hystrix:**

Develops in localised sheets, lines and bands-closely related to linear naevi.
- Hyperkeratosis:**
 - Abnormal dryness of the skin.
 - Overgrowth of the horny layer.

Prognosis:

Temporary relief but no radical cure-usually persists throughout life.

Diagnosis:

The criteria for diagnosis are:

- Dry skin.
- Onset of the disease in early life
- Persistence of the disease.
- fine or coarse scaling with the absence of inflammation.

Treatment:

- Frequent warm baths.
- Application of oily preparations e. g. equal parts of Glycerinum amyli and adeps lanae hydresus to 2 per cent salicylic acid.
- Thyroid extract—gr. $\frac{1}{2}$ tablet twice daily.
- Avoid using soaps too vigorously.

2. HYPERIDROSIS.

Definition:

Excessive sweats or perspiration due to the over-activity of the sweat glands.

Varieties:

- Generalised: common in adults (elderly)
- Localised: common in younger peoples.

Etiology:

- Secondary to primary conditions e. g.,
 - Pulmonary Tuberculosis.
 - Obesity.
 - Chronic alcoholism.
 - Hyperthyroidism.
 - Septicaemia.
 - Toxaemia.
 - Nodular Leprosy
 - Rickets. (especially at head.)
 - Rheumatic fever (acid sweats.)

- Paratyphoid.
- Amoebic Hepatitis.
- Liver abscess.
- Malaria.
- Black water fever.
- Undulant fever.
- Relapsing fever.
- Lowered neuro-muscular tone.
- Excitement.
- Cropulency.
- Stimulant drinks and foods.
- Neurotic persons
- After introduction of foreign proteins intravenously like T.A.B. vaccine, sera etc., to induce pyrexia.
- Blood transfusion.

Symptoms:

- Generalised: Excessive secretion all over body on least exertion and excitement. The drenching night-sweats, a late symptom of phthisis, may be as taken a typical example requiring frequent changes of clothings even in cold weather.
- Localised: (i) Excessive sweating in certain regions of the body viz., palms and soles, axillae and ano-genital area. (ii) May persist for a long time. (iii) Most marked in later half of second and third decade of life.

Complications:

- Pruritus.
- Dermatitis.
- Miliaria Rubra.
- Cheirpompholyx or Dyshidriosis.

Prognosis:

Localised cases generally respond well to treatment whereas generalised ones tend to persist.

Treatment:

- Generalised: (A) General.
 - General tonic.
 - Frequent warm baths to keep the skin clean and dry.
 - Rectification of dietetic errors and habits causing the condition.
 - Mixture of:

Pot. Bromide	gr.	7
Sodii. Bicarb	gr.	10
Sodii. Bromide	gr.	5
Liq. arsenicalis	m.	2
Tr. Belladonna	m.	10
Aqua anethi	oz.	1
- Dab the skin with 1 percent tannic acid sol. in 50 percent alcohol.
- Dust the skin with talc powder containing 3 percent salicylic acid.
- Application of weak solution of aluminium chloride or vinegar diluted in water.

(B) NIGHT SWEATS:

- Free exposure to air.
- Light clothings to be worn.
- Thorough sponging with a solution containing equal parts of saturated solution of alum in rectified spirit and aqua destillata before going to bed.
- Subsequent dusting with equal parts of zinc oxide and talcum powder.

(v) In case of persistent "sleep sweating" a glass of milk and biscuit just before retiring to bed. A similar feed to be kept ready for taking when the patient wakes up during night.

(vi) Mixture of:

Atropine Sulph.	gr.	1
Morphine Sulph.	gr.	1
Tr. Belladonna.	dr.	1
Acid sulph. Aromat	dr.	2
Aqua Mentha Pip.	oz.	2

8 drops in water thrice daily after food.

(vii) Pill:

Zinc Oxide	gr.	2
Agaricin	gr.	$\frac{1}{2}$
Ext. Belladonna Siccum	gr.	$\frac{1}{4}$

One pill at bed-time.

(viii) at bed time daily.

Acetyl-choline B. D. H. '05 grams in $\frac{1}{2}$ C.C. I. M. daily for 3 days.

(ix) Doryl or Moryl or Pacyl.—one tablet thrice daily after food.

3. BROMIDROSIS.

Definition:-

It is characterised by excessive perspiration mixed with the sebaceous secretion and subsequent decomposition on clothing giving rise to pungent and offensive odour. Some say that decomposition with staphylococcal growth in alkaline sweat impart the disagreeable odour. In fact, it is a localised variety of hyperidrosis.

Treatment:-

1. Daily washing of the parts affected with formalin solution.
2. Frequent washing and changing of socks when worn—socks to be soaked in saturated solution of boracic acid before using it again.
3. Affected parts to be washed twice daily with soap and warm water to which condy's fluid is added.
4. Painting of glucose or glycerine over the parts to induce acid reaction, hence no decomposition.
5. Dust the affected area with:
 - (a) Pulv. Acid Salicylic. (B.P.C.)
 - (b) Dermatol. (Bayer.)
6. Paint the parts twice daily with any of the following:
 - (1) 1 percent formal in lotion.
 - (2) 5 percent chronic acid.
 - (3) Linimentum Belladonna.
 - (4) Glycerine.
 - (5) 25 percent sol. of aluminium chloride.
 - (6) Ung. acid salicylic.
7. Apply any of the following:
 - (a) Tannic acid as spray.
 - (b) Diachylon Plaster.
 - (c) R. Betanaphthol 5.
Glycerine 10.
Alcohol, (90%) 100.
8. To dust over the area:
 - (a) R. Bismuth Subgallat 10 parts by wt.
Zinc Oxide 1 " "
Acid Boric 1 " "
Talc. 8 " "

or (b) R.

Acid Salicylic.	gr.	20
Zinc Oxide.	gr.	10
Acid Boric.	dr.	4
Pulv. Amyli.	dr.	2
Talc. ad	oz.	10

9. In most severe cases, application of 10 or 12 doses each of sabour and pastille X-rays—given in group of 4 doses at weekly intervals with gap of one or two months in between.

4. CHROMIDROSIS.

In this condition, the sweat is occasionally coloured chiefly due to bacterial activity.

Etiology:-

1. Dye.
2. Lepothrix: Red and yellow (chiefly in pubis and armpits.
Blue due to B. Pyocyneus or Indican.

Treatment:

As above.

References:

1. Price's Medicine 5th Ed. 1937. page. 1394-95.
2. Sear's Vademecum of treatment 2nd Ed. 1939. page 255.
3. Dunlop's Medical treatment. 2nd Ed. 1943 page 140.
4. Dhar's Medical Treatment. March 1939. page 118.
5. Savill's system of Clinical Medicine. 11th Ed. 1939. page 796.
6. Majumdar's Bed-side Medicine. 4th Ed. 1938. page 350.
7. Majumdar's modern Pharmacology and Therapeutic guide. 5th Ed. 1937. Page 472, 463, 526.

LETTERS TO THE EDITOR

Why Not 'Strike' Work

I have been a member of your Association for the last two years, and have been continuously studying the *Indian Medical Journal* during this period. I do appreciate the efforts and enthusiasm which you have been showing for the cause of the licentiates of this country, and am so thankful to you for the same.

But there is one mis-hap, recently occurred, for which I feel myself duty-bound to inform you, and get your instructions and advice in the matter.

You are fully aware of the fact that the A.M.O.s. of all the British-Indian-Provinces met at New-Delhi in Nov: 1945 and recommended unanimously that no graduate or licentiate should be started on less than Rs. 250 and Rs. 150 per mensem respectively. But do you know what has happened here in the Punjab? According to the revised scales of pay the graduates have been given the recommended start of Rs. 250 p. m. while licentiates have been offered Rs. 80 p. m. instead of Rs. 150 p. m. as decided by all A.M. Os. at New Delhi. How should we proceed in the matter? It is really painful to serve on this degrading and mean start. Even a matriculate clerk of today is drawing more or less Rs. 100 p. m. and we, who are to look after the health and life of millions, are being offered such a demeaning start. Is this the fruit of our four years hard and laborious studies after passing the Intermediate Science Examination? You have rightly advised us in the columns of your Journal that the licentiates in service, or who desire to join it, should not run after it, and should enter private

practice. But will it be fruitful? I do not think so. Because it will not be a combined force against the evil. Some may leave today and some tomorrow. And it is more difficult for a person to sacrifice separately than when he is joined by all of his comrades. Have you not noticed the subordinates of various departments going on strikes which usually end in fruitful results. So what I suggest is that we should organise ourselves in a single unit and all of us should give in resignations on one particular date; and should continue the strike till our grievances are met with. But this procedure is only possible if you advise the authorities of the Provincial Branch to lead the licentiates of the province in the matter and to take keen interest. I will be highly obliged if you spare space for this note of mine and inform me of the plan you intend to advice.

Thanking you

29-5-46

A LICENTIATE.

(Serving in the Punjab Subordinate Medical Service)

Delegates to the Next Conference.

In view of the great injustice done to the Licentiates who did not wait for the new change of 3-4-'43 but volunteered for the Army at the beck and call of the D. G., I. M. S. and were fools, as they proved later on to be, enough to believe in his propaganda appeals, I request all the local branches to try to send one delegate, from each district or town branch, out of such released S. M. S. licentiates to the Annual Conference to be held at Poona in October, '46. This will give the A. I. M. L. A. opportunity to have at first hand the different woeful stories and then to think of taking some action on it and to bring further pressure to bear on the Government to grant K. C. even posthumously and allow the rank of at least Captain to be retained in the civil. If they come in as good a number as possible, they would be able certainly by their strange stories to convince some of the A.I.M.L.A. Executives that it is not really due to their worthlessness, as some of the latter sincerely seem to believe with the Indian Medical Directorate, but that it is really due to the dislike of some of the I. M. S. for the new change that certain unfortunate licentiates who happened to be under such I. M. S. Officers that they were not recommended and selected. I have gathered the sense of the Association Executives and some still need to be convinced of the genuineness of the cause of this unhappy lot of S. M. S. licentiates.

16-5-46.

'ONE INTERESTED'.

Popular Ministries and Licentiates.

With the installation of the popular Congress Ministry, people have quite reasonably began to entertain hopes that their legitimate demands will be surely attended to, to their satisfaction. Hence the following appeal, I think, will be in time.

It is no doubt a big step in the right direction that soon after taking charge of the portfolio our Hon. Minister of the Medical Department has announced that the present Darbhanga Medical School will be very shortly transformed into a Medical College,

thereby doing away with the dual system of medical education in Bihar. This will certainly bring harmony amongst the medical men by putting an end to the existing ill feeling amongst them.

If the Government want to provide adequate medical aid for the masses of the province or if they want to act according to the scheme chalked out by the Bhore Committee with the so called highly qualified doctors—then the Government have to wait for nearly fifty years which the two provincial Medical colleges will take to produce the required number of doctors for the purpose. This means that people will have to suffer till then.

It is curious why the existence of the licentiate doctors, who constitute the majority amongst the medical men, both in service and private practice, has totally escaped the notice of the present popular Government.

No one can deny that the L. M. P.'s are the backbone of the whole medical organisation in India; this will be quite evident if they cease to work for a day only.

Again it is these much neglected doctors who venture to settle down in the remotest villages, who mix with the village folk, who give medical aid to the suffering millions in the villages of India at a great sacrifice, who during the outbreak of epidemics run on cycles or walk the distance on foot through the muddy impassable roads in the villages, carrying in their bags prophylactic vaccines and disinfectants and appear in the remotest and inaccessible corners of the province and try their level best to save the suffering population from the disastrous ravages of the epidemics.

In service, whether at the sadar hospitals or village dispensaries, they have to do lots of things and have to labour hard, although they are very poorly paid.

It is a great pity that despite all these facts, these downtrodden doctors have been kept in such an air-tight compartment that they can never peep through it even for the next higher position, however wide their knowledge and abilities may be. In the medical department they are treated as "veritable untouchables". As regards their ability I only quote below what Lt. General J. B. Hance, Director General, I.M.S., spoke:—

"It has been my privilege to be associated with Licentiates, who, but for the limitations imposed upon them by their qualification could have risen to almost any height in their profession, had they not found in their path a hurdle of three years extra study which few of them were in a position either domestically or financially to undertake. These men possess a store of professional wisdom and experience such that no doctor associated with them could fail to learn their clinical and therapeutical accumen and judgment."

From the above mentioned admitted facts it is quite clear that the licentiates are in no way inferior to the so called higher grade of medical men intellectually and that they can ably manage any work that may be entrusted to them.

Then why this invidious distinction? Why this nepotism? Why should not the licentiates

be allowed to rise to the top by dint of their sheer ability, when people in every branch are allowed to do so.

These are the long drawn out injustices done to the licentiates. We have been begging and begging but in vain. Our draw-back is that we are soft hearted, that we are always accustomed to sympathise and relieve human ailments and that we cannot act in a manner which would embarrass the people. People take advantage of this gentle quality of ours and now we have become painfully conscious of it. Everything has a limit.

So it is our earnest desire that the present popular Ministry will enquire into our long standing grievances, give a patient hearing to the leaders of our class, who will be meeting them very soon and try sincerely to ameliorate them as far as they are legitimate.

A BIHAR LICENTIAATE.

The use of Iodides in Anuria Complicating Cholera.

I was treating a case of Cholera with all possible recoupment treatment. I could not produce any diuresis with all remedies known to me save and except cupping.

While a student, I read the use of Iodides as diuretics. But nowhere I have found any body attempting it for the same. Finding no other measures, I ventured to push Sodium Iodide I. V. I waited for half-an-hour to watch its effects.

Within 15 minutes rigour came in and it was soon followed by a rise of temperature. I returned home remaining anxious whole of the night. Next morning I came to know that the patient was alright. She had diuresis within two hours of the injection. She was given simple diuretic mixture. Next day I was told that the running of the nose had set in and there was much secretion of bronchial mucosa or in other words the symptoms of iodism had appeared. I added Tr. Belladonna to the mixture to diminish secretions.

Thus the patient made an uneventful recovery.

I would like to ask my friends if they have used the drug in such cases. According to R. Ghose's *Materia Medica* the Iodides act as diuretics possibly by diminishing reabsorption from the tubules, I further ask why it is not used as diuretic? What is the harm if used as such? Can anybody explain?

BANKIN CH, SEN.

Tiluri, Bankina.

NEWS AND NOTES

Conditions of admission for the Licentiates into the M.B. B.S. Course of the Calcutta University

(1) A licentiate who passed the Matriculation or an equivalent Examination may be admitted to the condensed M.B. course without passing the I Sc. Examination which is considered to be preliminary qualification for admission into M.B. course, in case of a non-licentiate candidate.

(2) A Licentiate when admitted to the course is required to undergo training in Physiology, Anatomy and Pharmacology for

6 months and two years' training in all other clinical subjects for making him eligible to appear at the Degree Examination.

(3) A Licentiate who is Commissioned Officers at the I.A.M.C. or a Naval Medical Officer (who has passed the Examination after undergoing an extensive training at the Army Training Centre, Poona) has been granted a remission of 6 months in his period of clinical studies of 2 years.

(4) A Licentiate Officer who possesses D.M.S. (Madras) involving medical studies for 5 years has been granted this remission of 6 months in his training in clinical subject as well as the additions of 6 months.

(5) A copy of the curriculum of studies for the condensed M.B. course is given below.

(6) Every Licentiate admitted to the condensed M.B. course in this College will have to pay the tuition fee at the rate of Rs. 500 per annum, payable at two 6 monthly instalments, besides the usual admission fee of Rs. 25.

(7) The session for the condensed M.B. course is to commence once a year and the next session is likely to commence by the middle of October 1946.

Syllabus for the Condensed M.B. Course Calcutta University

1.—Pre-Clinical :

A. Physiology—

(i) Systematic lectures	...	...	25
(ii) Practical classes			
Physiological Chemistry	...	...	30
Experimental Physiology	...	...	30
Histology	...	...	20

B. Anatomy—

Systematic lectures on embryology, nervous system and special senses	...	...	25
Practical demonstration on dissected parts	...	...	50
Tutorial in Osteology will be held in addition	:	:	40

C. Pharmacology—

Systematic lectures	...	...	12
Practical classes	...	...	20

Lectures and classes for Licentiates admitted to pre-clinical part of this course will be held quite separately from the lectures and classes of the regular M.B. course.

2.—Clinical :

A. Systematic lectures—

(1) To be attended separately from regular M.B. students—			
Medicine	...	...	25
Surgery	...	...	25
Pathology and Bacteriology	...	...	40
Midwifery	...	...	20

The course of systematic lectures in these subjects will require to be condensed. These lectures will, therefore, be held separately from the lectures for regular M.B. students. Besides attendance at these special separate lectures, the students, if they so choose, may attend general systematic lectures along with regular students.

In addition to systematic lectures in Pathology the following instruction will also be compulsory:—

Practical classes in Pathology and Parasitology	...	...	25
Clinical Pathology—Practical classes and demonstrations	...	...	12
Museum demonstration	...	...	12

Students will also be required to attend Pathological post mortems:

(ii) To be attended with regular M.B. students—

Hygiene and Public Health...	30 lectures or demonstrations
Forensic Medicine	...
Applied Pharmacology and Therapeutic	20 lectures or demonstrations
Mental diseases	...
Ophthalmology	15
Ear, Nose and Throat	10

During the period of 24 months set apart for clinical subjects there will be sufficient time for the licentiates to attend the full regular syllabus of lectures in the above subjects and Licentiates will, therefore, attend the full course in these subjects with the regular M.B. students.

B. Hospital Work—

1st Clinical Year—

Medical Clinics	...	4 months	Each 3 hours a day.
Surgical Clinics	...	4 months	
Eye Clinics	...	2 months	
Midwifery and Gynaecology Clinics	...	2 months	

During this period the students will be divided into 3 batches—one batch will go to the Medical Clinic for 4 months, one batch to Surgical Clinic for 4 months and one batch to the Midwifery and Eye Clinics (2 months in each). With 100 students entering the clinical period there will, therefore, be 33 students in each batch. Eight students will be allotted to each Surgeon and Physician. They will be expected to do their case taking like regular M.B. students and for this purpose they will be allotted some separate beds in the Wards. If these do not prove to be sufficient they will be allowed to write up cases already allotted to the regular students but quite separately from the matter. They will attend clinics with the regular students 4 days weekly but on two days weekly they will be taken separately by the Professors and Clinical Tutors. They will be allowed to witness and conduct as many labour cases as can be allotted to them without interfering with the requirements of the regular M.B. students.

2nd Clinical Year—

Medical Out-door Department	...	2 months	Each 3 hours a day.
Surgical Out-door Department	...	2 months	
Special Department	...	2 months	

During the last 6 months of the Clinical Course, the students will not be tied down to any particular clinic or department. During the period they may be required to work in the special departments of the Hospital like Venereal Disease Department, Skin or Tuberculosis or Children's Disease Department. Those students who get a remission of six months according to the University Regulations will not be required to do this part of the work.

During the Clinical period special tutorial demonstrations will be given on minor surgery and bandaging, anaesthetics operative surgery, applied anatomy, medico-legal post mortems etc.

With reference to G.S. letter No. 1522 dated the 23rd March 1946, Director of All India Institute of Hygiene, Calcutta writes to state that the information that the D. P. H. and Hy Course has been suspended is incorrect. The course is open to medical licentiates of recognised institutions as usual. Only candidates possessing M.B. or L. & M.S. qualifications are eligible for admission to the D.P.H. Course and the rule is not relaxed in any case. Persons with approved war service are exempted from payment of the tuition fee.

Abstract of the important decisions of the Bengal Council of Medical Registration at their meeting held on the 12th February 1946.

(1) The qualifications of M.B., B.S., and L.M. & S. of Hyderabad were recommended to Government for recognition for registration on reciprocal basis of similar recognition by the Hyderabad Council of M.B., L.M.F. of this province.

(2) The following resolutions moved by Dr. Mukherjee were carried:—

(i) In view of the acceptance of the unanimous recommendations of the special Committee on Medical School education by the Government of Bengal and the decision to convert the Dacca and Campbell Medical Schools into colleges affiliated to the University this Council resolves that the other Medical schools recognised by this Council be also raised to the college standard by the year 1950 at the latest, after which no school be allowed to admit students for the training of Medical Licentiates.

(ii) That the compartment system of maintaining the Register of the Medical Council, viz., the Annual Medical List be replaced by publishing the List with titles of Registered practitioners irrespective of their qualifications as had been the practice before.

(iii) That the Government of Bengal be urged upon to undertake the amendments of the Bengal Medical Act as per various recommendations of this Council as they are more free now to take up normal work with the cessation of hostilities.

Congress Medical Mission. (Malaya):

The following are the names of the members of the Congress Medical Mission who have left for Malaya.

1. Dr. M. R. Cholkar (Director).
2. Dr. B. N. Basu (Deputy Director)
3. Dr. K. H. Theodore.
4. Dr. Jyotirmoy Mazumdar.
5. Dr. Subodh Ranjan Chakravorty.
6. Dr. Debendra Chandra Sinha.
7. Dr. Satyendra Chakravorty.
8. Dr. K. N. Datar.
9. Dr. A. D. Narde.
10. Dr. C. S. Sastri.
11. Dr. Chittaranjan Desai
12. Sree Sital Chandra Samanta.
13. Sree Ganadas Banerjee.
14. Sree Amal Chandra Sanyal.
15. Sree Jivananda Bhattacharyya.
16. Sree Hirendra Nath Datta.
17. Sree Rabindra Kr. Banerjee.

Following is a Memorandum submitted by the Punjab Branch of the A. I. M. L. A. to The Inspector General of Civil Hospitals, Punjab, Lahore.

We have been deputed by the Executive Committee of the Punjab Branch of the All India Medical Licentiates' Association to enter a strong protest against gross injustice done to the Sub-Assistant Surgeons by the Punjab Government in the matter of pay as recently revised by them and make the following representation:—

That the Sub Assistant Surgeons as a class have been instrumental in popularising the scientific system of Medicine and in alleviating human suffering in the remotest corners of the country. It is this class which has to bear the brunt whenever there is a breakout of any epidemic.

That the members of this class have to serve mostly in out of the way places where even adequate educational facilities are not existent, let alone the ordinary amenities of life.

That this class has to put in most strenuous work practically without any holiday.

That during the recent war this class wholeheartedly co-operated with the Government in their war effort and sent over 300 doctors on active service from this province alone, besides, supplying hundred others for recruitment work and for civil medical duties in military hospitals.

That the Soutter Mission composed of distinguished medical men from the United Kingdom, that visited this country in 1942, recognised the standard of education of Medical Licentiates as almost equivalent to that of the Graduates and recommended that in the Army Medical Department Medical Licentiates be treated on equal footing with the Graduates. The Government accepted their recommendation and granted King's Commission to the Licentiates.

That in the Army a large majority of Medical Licentiates held the rank of captain carrying with it a salary of Rs. 500 per month and those with special qualifications were raised to the rank of Major and received as much as Rs. 800 per mensem.

That in whatever capacity these Licentiates Commissioned Officers were ordered to serve, they discharged their duties with credit and won praises from superior officers.

That the efficient manner in which the Medical Licentiates have discharged their responsible duties in the Army has established beyond doubt the fact that given equal opportunities they are, in no way, inferior to the Medical Graduates and they can hold their own in any position they are placed.

That it was in realisation of this fact that the Administrative Medical Officers and Directors of Public Health from all over India at their meeting held at Delhi in November last unanimously recommended that the Subordinate Medical Service be abolished altogether and that Medical Licentiate be placed on a scale of pay not less than Rs. 150 to Rs. 450.

Sir, in view of the facts mentioned above and the promises held out to them by the Government, from time to time, during the recent war, this class entertained high hopes that the Government would raise the status of Medical Licentiates by bringing it up to the level of Graduates and for the matter of that increase their emoluments. But to the frustration of their hopes and to their utter disappointment the Government have not only ignored the recommendation of the administrative heads, but have given the Sub-Assistant Surgeons the lower-most scale of pay even amongst the subordinate services in the province, vide comparative table given below:—

Name of service	Preliminary qualification prescribed	Period of Technical training	Scale
Naib Tahsildar	Matriculation	One year	125—300
Tahsildar	do	do	270—450
Teachers in Schools	B.A.	do	90—300
in Colleges	M.A.	do	150—350
Agricultural Assistants	Matriculation	4 years	100—300
Overseers	do	2 years	90—275
Zilladars	do	6 months	90—235
Stenographers	do	"	100—250
Veterinary Assistant Surgeons	do	4 years	100—300
Forest Rangers	do	3 years	80—250
Sub-Asst: Surgeons (L.S.M.F.)	F.Sc.	4 years	80—200
Sub-Asst: Surgeons (L.M.S. or M.S.M.F.)	do	5 years	80—200

A comparison of the course of training prescribed for Medical Licentiates with those for other subordinate services makes this step-motherly treatment meted out to the Sub-Assistant Surgeons still more flagrant. As the above table shows the prescribed preliminary qualification for all services, except the medical, is the Matriculation examination, while in the case of the Medical service it is the Intermediate Science. Further the period of technical training in the case of Sub Assistant Surgeons exceeds that of all other services and is actually much longer than most of them. For instance, an overseer has to put in two years, while a Ziladar and a Stenographer hardly six months.

Sir, we are at a loss to understand what considerations have weighed with the Government in meting out such a shabby and contemptuous treatment to this class. Is it because the Government and the High Court of Judicature have deemed fit to entrust them with the heavy responsibility and onerous duty of medico-legal work or is it because in their hands are placed the lives of human beings? The duties and responsibilities of a Sub-Assistant Surgeon being similar to those of an Assistant Surgeon, the justice demanded that the status and emoluments of the former should have been on a level with those of the latter. This inequity can brook no further delay when it has been done away with in the Army.

The argument that a Sub-Assistant Surgeon can supplement his pay by private practice does not hold water in the face of the fact that a large majority of Sub-Assistant Surgeons have to serve in villages where poverty is proverbial; while those few who serve in the towns can hardly stand competition from well-established private practitioners. Moreover why has not the same argument been applied in the case of Assistant Surgeons who have been granted the same scale of pay as that of the other provincial services?

Sir, we beg to submit that as mentioned above our class strongly resents the contemptuous treatment meted out to it in this matter and earnestly requests you to convey the feelings of our class to the Government. We feel that nothing less than a scale of pay from Rs. 200 to Rs. 550 would satisfy our aspirations. May we hope that you will be pleased to recommend the same for acceptance by the Government and also recommend the acceptance of our demand for the abolition of the Subordinate Medical Service. It is in the Government's own interest to raise the status of the Medical Licentiates, for it is largely on them that the Punjab Government rely for the success of their schemes for the post-war expansion of medical relief in the rural area.

Sir, another matter of great urgency which we want to place before you and for which we solicit your help is in regard to the facilities given to those demobilised Licentiate Commissioned Officers of the I.A.M.C. who wish to obtain the M.B.B.S. degree. The concessions announced, welcome though they are, are hedged in by certain conditions which almost nullify them. By these conditions a Medical Licentiate is required not only to undergo a course of studies in all the pre-clinical subjects but in some of these he has also to take the examination. We beg to submit that this amounts to a mere repetition of what they have already studied at the medical school. To study them again would not be of any material advantage to the students. On the other hand it would prevent them devoting full attention to the clinical subjects. We therefore urge that this conditions not be imposed.

As for the period of training, we are of the opinion that it should be further reduced from 18 to 12 months, for, besides a course of intensive training which these Licentiate Officers have undergone at the Army Medical Training Centre Poona, they have acquired a great deal of clinical experience in Military Hospitals by holding independent charge of various sections. What is

really needed by them is a refresher course in clinical subjects only for which one year is, in our view, quite sufficient. Furthermore, in view of the fact that the gratuity that has been granted to them is much lower than that granted to the graduates, we urge that this course should be imparted to them at Government expense.

We thank you, for the opportunity you have given us for placing our case before you and we hope you will be pleased to take a sympathetic view of it and strongly recommend to the Government for the redress of our grievances.

Lahore:

Dated the 4th April 1946.

1. Sd. Mathradas Rao Bahadur,
President.
2. " Chhabildas,
Working President.
3. " Kishor Chand,
Member Exc. Committee.
4. " Ghulam Mustafa,
Member Exc. Committee.
5. " Sadiq Ali Bukhary,
Secretary.

the members of the deputation of the Punjab Branch of the All-India Medical Licentiates' Association.

Copy of letter dated Feb. 26 1947, from the Deputy Secretary to the Government U. P. to the Provincial Secretary A. I. M. L. A., U. P.

With reference to your letter No. 363, dated September 28, 1945, I am directed to say that necessary amendment has been made to the Drug Control Order, 1945 (Vide Government of India notification No. I. D. A. (I)/A/44, dated January 19, 1946 so as to except registered medical practitioners from taking out licence for purchase of drugs. As regards your other requests the Provincial Drugs Advisory Committee is not likely to continue for long, and the Governor considers that it is not necessary to nominate a representative of your Association to this Committee now. This disposes off Standing Committee resolution no. 9.

2. Orders will be issued separately regarding resolutions Nos. 11 and 16.

Bengal Provincial Conference

(Continued from page 184).

I request our mother Association to press hard upon the government to include our names in the Indian Medical Register, with the help of the President of our conference and others of our profession as the transformation of schools and colleges have been agreed to by the authorities. I request our worthy President to let me know the future of our Association as no more Licentiates will be created by the Government. I request the authorities of private medical schools to raise funds and transform them to colleges.

It is good news that Government has at the joint appeal of A.I.M.L.A. and I.M.A. agreed to grant permit for $\frac{1}{2}$ lb. of quinine to Registered Medical Practitioners per month who own dispensaries for their patients, though it is very difficult to secure permit from the staff who issues them. Government should see that quinine permit is granted to Registered Doctors without any harassment. I also request the Government to issue quinine tablets to post offices for sales in remote villages. I have also another appeal to make to the Government and that is this. The Government is exploiting the medical men by making appointment in hospitals on honorary basis. This should be stopped forthwith or in the alter-

native provisions should be made to give handsome allowance to such staff in fairness to them.

I am of opinion that sale of dangerous drugs as sulpha groups to laymen is most objectionable. The allopathic system of medicines should not be handled by those advocating other systems of medicines or by quacks. It should be stopped by the government.

I am very glad to see that we were asked to help the Government in the last epidemic. I can assure the Government that in case of need our association will always be placed at the disposal of the needy. The prevention of an epidemic can only be solved by the co-operation of local Doctors

Before I conclude I must thank the Salkia Anglo Sanskrit School authorities from the bottom of my heart on behalf of the Reception Committee for kindly allowing us to use the whole building for our conference.

Annual report on the working of the Bengal Provincial Branch of the All-India Medical Licentiates' Association 1945, by Dr. B. Chaudhuri, Provincial Secretary, Bengal.

WORTHY PRESIDENT, DEAR BROTHERS AND SISTERS,

It is again my proud privilege to-day to place before you the annual report on the working of the Bengal Provincial Organisation of the All-India Medical Licentiates' Association for the year 1945.

Since the successful 11th Session of our Provincial Conference held in January, 1945, under the auspices of the Budge Branch and presided over by Dr. A. D. Mukharji, two meetings of the Provincial Standing Committee were held, one at Dacca and another at Calcutta, to consider and decide various important issues affecting our countrymen and the Medical Profession in general and the Medical Licentiates in particular.

It is pleasing to record that Bengal had the honour to invite and successfully hold the 33rd Session of our All-India Conference in Calcutta in March, 1945. Calcutta Branch together with most other branches of the Province rose equal to the occasion, left no stone unturned to make the Conference a success and thereby maintained the fair name of our beloved Provincial Organisation. We are also grateful to the delegates of the All-India Conference coming from different provinces for their high appreciation of our humble work and their election of Dr. A. N. Roy, our ex-Provincial Secretary, as the General Secretary of the All-India Association.

It is also my pleasant duty to mention about the District Medical Conference held successfully by the Chittagong Branch in February 1945. Your Provincial Secretary had the opportunity to be present in that function which was well attended by the Licentiates from all corners of that big District.

We could not make much headway in starting new branches. Only one branch viz., Munshiganj has been started during the year under review and Jalpaiguri Branch has been revived under its able President, Dr. S. C. Bhowmik and Secretary, Dr. J. N. Moitra. Now we have altogether thirtyseven branches throughout the province and there is not a single district without a branch of our Association.

Our membership strength in Bengal was 1538 on 20-3-45, we have recruited 231 new members and 138 members have given up membership during the year. So our present strength is one thousand six hundred and thirtyone members only.

We have sent memorials and representations to the Government for introduction of the condensed M. B. course in the Calcutta Medical College, upgrading the Medical Schools of the province into Colleges without delay, abolition of the S.A.S. ranks, introduction of one civil Medical Service for the graduates and licentiates, improvement in the service conditions of the Railway, District Board and Union Board Medical Officers, issuing of free drug control licenses and Quinine to the registered medical practitioners for the best interest of the suffering public and on other important matters.

It is gratifying to observe that the doors of the Calcutta Medical College has been thrown open to the Licentiates for the condensed M. B. course as has already been done by the Carmichael Medical College. I may also quote here for your information

the reply which I have recently received from the Deputy Secretary, Medical and Health Department of the Government of Bengal which is as follows:

(1) "Under the existing terms of service in Bengal there is no bar to meritorious Sub-Assistant Surgeons being promoted to the rank of Assistant Surgeon and that, in fact, such promotions are made from time to time.

(2) So long as the basic medical qualifications of the Licentiates are lower than those of Graduates the rank of Sub-Assistant Surgeon cannot in reason, be abolished; but that, steps are being taken as part of Post War Reconstruction in Bengal to abolish Medical Schools and to replace them by Colleges and to provide post-graduate training to licentiates so as to enable them to improve their prospects and qualifications.

(3) The exceptional circumstances under which the military recruited licentiates to commissioned ranks cannot be argued as a justification for not distinguishing between persons of higher and lower medical qualifications in a peace-time Civil Medical Service."

We hope that the Government of Bengal will expedite the conversion of medical schools into Colleges. We also hope that the Black Act of 1933 (The Indian (?) Medical Council Act denouncing the Indian Medical Licentiates), for the abolition of which our branches are protesting every year, will be given a decent burial in the near future and in its place will appear the new and real Indian Medical Council Act which will acknowledge the legitimate claims of the medical licentiates. Incidentally, you will be astonished to learn that in these days of onward march one Dr. Biswanath of Lahore moved a resolution sometime ago in the Punjab State Medical Faculty to reduce the medical licentiates' course of study to 3½ years and to perpetuate it obviously with the sinister intention of maintaining a perpetual class of underdogs to serve the interests of persons like him. We of Bengal strongly protested against this derogatory move and we hope that it has been set at rest for good.

Rs. 78 have been contributed by various branches to Dr. Ahi Bhushan Mukharji Memorial Fund during the session and Rs. 140 to the newly started Dr. Satkari Ganguly Memorial Fund. We hope that those branches which have not yet contributed to the Funds will do so during the 12th Session of our Provincial Conference and will bring the Memorials to fruition. Altogether 831 letters including circulars have been issued and 363 letters have been received by the office of the Provincial Secretary during the year under review.

Friends, before I close, I must appreciate and respectfully acknowledge the valuable suggestions which I have received from many of you and which have helped me in carrying out the work of this responsible office. I am very much thankful to Dr. A. D. Mukharji, our President, Dr. A. N. Roy, General Secretary, all branch secretaries and members of the Provincial Standing Committee for ungrudgingly extending their co-operation to me.

My lapses and shortcomings have been many. Various other most exacting duties have taxed away much of my time and I could not sincerely devote the hours necessary for the Association work. So, in the fitness of things, I seriously requested the constituent branches not to elect me again as the Provincial Secretary. But the branches commanded me otherwise and I cannot but obey the command. I fervently hope that I shall receive the same amount of, nay, more, co-operation from you all. I should also urge upon you for your serious consideration about appointing a whole-time clerk for the office of the Bengal Provincial Secretary without whom it is very difficult to carry on with the voluminous and arduous work properly.

BRANCH ACTIVITIES.

Calcutta—Held twelve meetings. Recruited 72 new members. Took active part in checking small pox and cholera epidemics in Calcutta and rendered medical aid to the injured on the occasion of police firing in November 1945. Made representation to the Government for opening the condensed M. B. Course in the Calcutta Medical College. Met the Director of Public Health, Bengal with a deputation for releasing quinine to the registered Medical practitioners. Helped much towards the success of the last All-India Conference.

2. Howrah—Held 10 meetings. Recruited 19 new members. Actively participated in the All-India Conference. Though rather a small branch its enthusiastic members have taken the responsibility of holding the Provincial Conference.

3. Mymensingh—Held 10 meetings. Recruited 45 new members. Made representations for proper distribution of Quinine. Actively co-operated with the authorities for checking Cholera, Small-pox and Malaria epidemics.

4. Budge Budge:—Successfully held the 11th Session of our Provincial Conference. Held 12 meetings.

5. Nadia:—Held 12 meetings. Contributed Rs. 100 to the Satkari Ganguly Memorial Fund. Moved Higher Authorities to modify the defective measure of distributions of Quinine and Mepacrine.

6. Chittagong:—Successfully held a District Conference. Recruited 40 new members. By its efforts Quinine and Mepacrine were distributed to every Medical practitioner of the district.

7. Narayanganj:—Held 7 meetings. Members did relief work during the epidemics. Recruited some new members.

Want of space at my disposal prevents me from mentioning the activities of all other branches in details. Each of the following branches also held several meetings, recruited new members and performed other duties during the year under review; Burdwan, 24 Paraganas, Barisal, Kishoreganj, Tanjail, Khulna, Pabna, Bankura, Noakhali, Dacca, Berhampore, Feni, Rajshahi, Munshiganj and Jalpaiguri.

STATEMENT OF ACCOUNTS

Central Fund

Receipts:	Rs.	a.	p.
Subscriptions paid by members	106	0	0
Received from the Mother Association	182	12	0
Due from the Mother Association for C. Bills	96	15	6
Total	385	11	6

Payments:	Rs.	a.	p.
Postage and Telegrams	92	7	6
Miscellaneous	65	6	0
M. O. to Treasurer	106	0	0
M. O. Commission	1	14	0
Part-time Clerk	120	0	0
Total	385	11	6

Provincial Fund

Receipts:	Rs.	a.	p.
B. F. from previous year	322	3	0
Subscription from Budge Budge Branch	6	0	0
Do. Jalpaiguri	10	0	0
Interest accrued from S. B. a/c	4	6	0
Total	342	9	0

Payments:	Rs.	a.	p.
Paper and Printing cost of Annual Report for 1943-44	40	0	0
Collection charge for Jalpaiguri Branch cheque	0	6	0
Balance in Bank	302	3	0
Total	342	9	0

Ahi Bhusan Memorial Fund

Receipts:	Rs.	a.	p.
B. F. from Previous year	423	12	0
Received from Hooghly Branch	10	0	0
" " Pabna	13	0	0
" " Ranpur	10	0	0
" " Feni	20	0	0
" " Nadia	5	0	0
" " Budge-Budge 2nd instalment	20	0	0
Bank interest accrued	7	1	0
Total	508	13	0

Less collection charge for Pabna Branch cheque	0	4	0
Total in Bank	508	9	0

Satkari Memorial Fund

Receipts:	Rs.	a.	p.
Received from Budge—			
Budge Branch	25	0	0
" " Nadia	100	0	0
" " Pabna	10	0	0
" " Bardwan Branch	5	0	0
Bank interest accrued	1	0	0
Total in Bank	141	0	0

Dr. A. D. Mukharji, President-elect, delivered his address as follows:—

Sister and Brother delegates, ladies and gentlemen.—

Medical Education: I have in course of my various presidential addresses in All-India or Provincial Conferences stressed on the futility of maintaining two types of education for the production of two kinds of doctors to minister to the health necessities of our people. I am glad that this view is shared by a large body of medical men and women and also by the members of the public. Perhaps you remember that last year when we met in conference, I told you that the Government of Bengal have appointed a Special Enquiry Committee to go through the whole question of medical school education and I was appointed a member of the said Committee. You must have seen a summary of the recommendations of this Committee which has unanimously recommended the abolition of the medical schools and their replacement by colleges. It is gratifying that acting on the recommendations of this Committee, the Government of Bengal have ordered the conversion of the Dacca Medical School from July, 1946 and the Campbell Medical School from July, 1947 into University Colleges. I am sure, as per the recommendations of this Committee, the Medical Schools at Jalpaiguri, Chittagong and Burdwan will also be converted in colleges by the year 1950, if not earlier. Attempts are being made to convert the National Medical Institute of Calcutta into a college, either individually or by amalgamating with the Calcutta Medical School. My information is that the authorities of the two institutions are exploring avenues for union to fall in line with the Government medical institutions. Nothing has so far been heard about the other non-official school at Bankura. I believe, the Association under whose auspices we have met to-day, has legitimate grounds for gratification for getting its voice effectively heard at last by Government for the introduction of reforms in medical education on most modern lines. I am sure within the next few years, there will be nothing like a medical school not only in this province but also in other portions of India. The benefits of this reform would be enjoyed by our people in getting better medical aid all over the country.

Medical Services: With the introduction of the two types of doctors two kinds of Provincial Medical Services were maintained by the Government keeping the two compartments entirely separate and water-tight. The terms of the subordinate services starting from Rs. 60/- to Rs. 155 are, to my mind, incompatible with the modern struggle-some existence which the members of this service have to maintain. Of course the conditions caused by the War have given the members a temporary lift to Rs. 100 only from Rs. 60. This even does not come to the modest expectations of any public servant called upon to discharge his duties honestly and creditably. I would urge a thorough overhauling of the system of services under the Government by the introduction of one provincial medical service portals of which would be thrown open to all the qualified medical men and women of the country, and only those who can show their competence should find place in the same.

With the cessation of hostilities the question of absorption of those members of the subordinate medical service of Bengal who were compelled to join the War by virtue of the bond they executed or who volunteered themselves is causing considerable amount of consternation as neither the Central nor the Provincial Government, have so far announced their policy towards these members of the service, on their demobilisation from the military. Most of them have enjoyed the much coveted commissioned ranks and many are in the enjoyment of specialist-posts and if they are to fall back in the same old subordinate position of Sub-Assistant Surgeons to which the Army gave goodbye in the year 1941, would be a complication of a very serious nature and discontent that is brewing in the minds of these members regarding the unstable future of theirs, would be a definite handicap to the continuance of the goodwill towards the powers that be. I would urge that all those who had been enjoying the commissions should be promoted to the Assistant Surgeons' grade on demobilisation, particularly when this would not entail any financial loss to the Government but what is needed is a great change of heart of the powers that be to lift these men up from the position to which they were relegated all through their life due to the vicious system of compartmentalism in these services.

I think it will not be out of place to mention that the Government of India acknowledged the claims of these members of the profession during the earlier phases of the War and in 1941 issued the following communique: "The old name of Sub-Assistant Surgeon was originally given to hospital assistants who at the time required far less in the way of educational and other qualifi-

cations than the medical licentiates who serve as Sub-Assistant Surgeons in the I.M.D. to-day. The present day Sub-Assistant Surgeon is a well educated and qualified man and it is felt that there is no reason to retain the title which suggests that he holds the same subordinate status as his original predecessor." Thus the Government of India admitted the claims of our members for a better deal at a time when probably such recognition was of utmost sequence to the needs of the Army. I believe that this recognition should not be given the go-by as soon as these men get away from their present onerous obligations and relegated to the cold shape of neglect which had been the unfortunate fate of our brethren in service.

Regarding those who belonged to the former I.M.D. but promoted to the I.A.M.C. during the World War No. 2 and thus made history, have rendered an excellent account of themselves, working shoulder to shoulder with other groups of the profession in various theatres of War, must be taken care of under any scheme of post-war rehabilitation and settlement. It is unfortunate that although plans for demobilisation have long been settled and men are being demobilised, till this day Government have made no announcement regarding the future of the I.A.M.C., whether this service is going to be perpetuated or given a farewell as the game of war is over with the revival of old I.M.S., and I.M.D. It will be a lamentable state of affairs if that is done and the I.A.M.C., not made a permanent feature of the Indian Army. This will go down in the history of the medical profession in India and also on the administration of the Military Department as a standing mark of unworthy exploitation if due notice is not taken of the growing feeling of frustration in the minds of a large section of medical men who were or are still in this corps. I urge upon the Government of India to make this service a permanent one and absorb in its permanent cadre at least those of its members who have rendered a good account of themselves. Let not the same conditions that developed after the World War No. 1 be repeated after World War No. II.

In this connection I am much constrained to make a reference about those members of the old I.M.D., who unfortunately became prisoners of war in Europe, Middle East, and Far East due to no fault of theirs. On release they have not yet been given the commission which their brethren who did not meet with the ordeal of being prisoners had been enjoying since April 1943. I think their cases also merit special and due consideration.

Turning to the several medical services of the province I have already said that there should be only one service and till that condition is ensured, I would urge upon the appointment of the demobilised commissioned officers in independent charge of Sub-divisional and Sadar hospitals and to some teaching posts in the existing medical schools in this province.

With the provincialisation of the Sadar and Sub-divisional hospitals in Bengal, conditions were expected to be better in them but I have had a different story from many a sources. The new scheme has deprived a number of Sub-Assistant Surgeons holding charge of Sadar hospitals which have been recently made over to newly appointed Assistant Surgeons, although these Sub-Assistant Surgeons are of considerable experience and have been held in high esteem by the members of the public in those stations. Not only this but in some cases the quarters which they had been occupying and are entitled to have, are being taken away from them and made over to the newly appointed Assistant Surgeons much to the disadvantages of the former as in the maffassil it is almost impossible to get habitation in the neighbourhood of the hospitals. The Government should have taken these difficulties into consideration and should have posted officers, if at all, where necessary, after making proper arrangements for their lodging without up-setting the arrangements that were in vogue.

There are a number of other knotty questions relating to those of our brethren in the Government service, and, I believe, these will be discussed during this conference and specific recommendations sent over to the proper quarters for redress such as promotion to the Assistant Surgeon cadre and to the selection grade and availability of selected posts to them and grant of study leave facilities.

Along with the conditions of the Government service, those under which our brethren have to work under the various State Railways cannot escape our notice. These friends have from time to time put up a very strong case for better deal and had the unanimous support of the administrative medical officers of various Railways in India who recommended a thorough overhauling of the Railway Medical Services all over the country and the introduction of better nomenclature and emoluments to their medical officers. I am told that the Central Government did not allow

these reforms in the Railway Medical Services to be given effect to as a piecemeal reform as they thought, perhaps, during the post-war regime, the other medical services will also have to be looked after and there should be some coordination between them. I do not grudge this opinion of theirs but what I feel is that there is a limit to the patience of these members of the profession who have rightly or wrongly placed their services under these concerns and it is legitimate and fair for them to get some decision arrived at by the powers that be without any further loss of time. A contented service would surely be an asset to any administration and the sooner this is realised the better for all concerned.

I cannot pass this occasion without making a reference to unfortunate brethren of ours who are doing yeoman and national service by rendering succour to a large body of our people in the rural areas under adverse circumstances employed by the District Boards and the Union Boards. The pittance which they ranging between Rs. 20 and 50 can hardly keep one's body and soul together in these days of inflation and abnormal conditions, not to speak of enjoying any amenity of life or looking to the normal needs of their relations and dependants. These local self-governing institutions are run by representatives of the people. I wonder how they can except that these employees of theirs would be able to render real service to the afflicted countrymen suffering themselves from a keen sense of privation of their normal needs for bare existence. There is a talk of these services being taken over by the Government. I think these local bodies however sincere and well-meaning they might have been, have not succeeded in meeting the needs of the people of the country as a whole in extending medical aid due to the lack of funds at their disposal and for want of proper planning on the score of improving the health of the people. I would, therefore, suggest that a trial should be given to the Government to undertake the responsibility of providing medical relief under their care and supervisory.

Medical Relief: I feel that the obligations of the State towards the health of the people of the country are better realised and there is introduced a well planned public health and medical service to take charge of the health of the nation as a whole so far as the curative and preventive aspect of diseases are concerned. The existing arrangement of having a few so called dispensaries as the outcome of charity of local bodies or philanthropic persons can hardly be said to be satisfactory. I consider it the inherent obligation of the State to provide for the education, medical relief and sanitary measures, as well as, basic food for the people as a whole for whom the State as supposed to exist. The State must not exist for its display of power in the administration of only the "Law and Order" much of which have been felt through years of suffering without any improvement whatsoever in the conditions of the people in general. But to provide for this a comprehensive and well planned scheme dividing the country into several units according to population and in charge of trained medical personnel is called for. No part of the country or any portion of the population should be deprived of getting the modern scientific medical aid under the State programme by mobilising the services of all the members of the profession on a payment basis. Along with this, the economic condition of the people must also be raised by better forms of agriculture and marketing facilities, irrigation, communication mass education on national regeneration lines to lift them up from the rut in which they have been pressed under due to sheer neglect of all these years of so called civilised administration of the country. The rate of spending anna one per capita on public health as per 1941 report of Government is too meagre to cope with the situation.

To ensure these conditions the whole outlook of the Government has got to be changed, may revolutionised, which, I do not think is possible unless the true and self-sacrificing representatives of the people of the land are placed in charge of the administration of the country because I feel and feel very strongly that they only can usher in a changed outlook for the suffering mankind from all spheres of life and cause a re-orientation of the entire social fabric of the nation. For this the country would need a large number of medical men than what exists now and I believe the recommendations of the Public Health Planning Committee of the Government of India which are likely to come out very soon would be taken due care of by the Central and Provincial Governments and given effect to as these are of a far reaching character and envisage a programme for the genuine wellbeing of the masses of India as a whole. They have urged upon the provision of one Doctor for every 2,000 people as against one for about 4,500 as obtained now in Bengal. I am glad at least in the name of post-war reconstruction the Government as well as the members of the public has shaken off their timeworn

lethargy and at last stepped forward to undertake some reform in the existing public health administration of the country. Let us all hope that the labours of the Committee will not meet with the fate of such Committees of the past, and something definite is achieved in the near future to save the nation from utter ruin of their health by the Central Government as well as the Provincial Government that are soon expected to be constituted with representatives of the people. I have a misgiving about the administration of the medical and Public Health Department in Bengal which is tagged with the Local Self-Government Department. All the successive Ministers since 1920 till the application of Sec. 93 of Government of India Act in 1945 did more to develop the Local Self-Governing Bodies than these departments resulting in the miserable state of health of the people who were carried away like flies whenever any epidemic visited the province. Recently Government have re-organised various departments but the attention and care which Medical and Public Health branches needed have not been shown introducing these changes.

Medical Councils: You all know that the Medical Council of India have not as yet recognised our qualifications although the same receives the seal of recognition of the Provincial Medical Councils. The Medical Council of India in October, 1940 agreed to recognise the qualifications of licentiates till the year 1947 and recommended to the Government of India to bring about the abolition of the centres for the licentiates qualification by that time and were prepared to include the licentiates on the proposed All-India Medical Register. But although five long years have passed by, Government have not acted on these recommendations to amend the Medical Act. I think on the analogy of the Medical Act of Great Britain when it was introduced the recommendations of the Medical Council of India should even now be accepted and a time limit be allowed to the provinces to come up to the standard laid down by the Medical Council till when these qualifications should be recognised by the Medical Council of India. Unless that is done, I am afraid, the name Medical Council of India debarring two thirds of the qualified medical profession outside its scope would be a misnomer.

Coming to the question of Provincial Medical Councils I think time has come when it should have election to the Council by joint electorate in which all the registered medical practitioners would jointly participate as happens, to be the case in Madras. The Council should also have an elected President as in the case in the All-India Medical Council and in Madras.

The members of the profession should develop a keen sense in obeying the code of ethics which should be their ideal in their daily life.

Relations with the Indian Medical Association:

For some time past the question of the amalgamation of the Association, under whose auspices we have met today, and that of the Indian Medical Association is looming large with a certain section of the profession. I would like this conference to give a lead in the matter as I feel that time has come when we should not keep ourselves isolated from the rest of the profession by maintenance a separate communal entity, helping in the maintenance of two different All-India organisations for the profession. In provinces where medical schools have been replaced by colleges, problems particularly related to the licentiates are becoming less acute and time is fast approaching when this would disappear altogether. I consider that we must endeavour to present to the authorities, as well as, to the world a united medical profession as exists in other free countries to fight out the battle of the profession taken as a whole, shoulder to shoulder. I am sure that a body of this nature would be able to wrest out the ills due to the profession from not only the powers that be but also from the public at large. Let us demonstrate that we are fully alive to the necessity of joint action and we would be worthy of the profession if we can achieve unity of thought and action under a single organisation. Those of you that feel that our interest would not be safe by joining with other organisation, I can tell them that in these days of democratic determination of things all round, the voice of the licentiates who for outnumber others in the profession, will have to be paid due heed to, if, of course, we can make the same felt by our efforts, sacrifice and service. I have personally no misgivings on this issue and if we so desire we can swamp any organisation and shape it to come to our rescue. I would expect you have gathered in this conference to give your considered views on this question because the might help the Sub-Committee that has been appointed by the last All-India Conference at Calcutta in solving this problem.

Honorary Services: I have often condemned the practice of appointing the members of the profession, particularly the new

entrants to it to public hospitals and paying them nothing. This is a kind of exploitation which must be suppressed from all quarters. Like other professions the medical men have got to live and have other obligations to their people and must not be victims of the vicious system of continued exploitation any longer. The experience which we have gathered by the honorary system should be utilised and the whole policy by revised in the light of this experience and the system be substituted by paid service. Of course, I do not begrudge the employment of the senior members of the profession who have made their pile or can devote some portion of their time to give free service to public institutions to come forward and do the same but to ask a new comer to the profession or a struggling young doctor to undertake that is, to my mind, a member which must be condemned.

Public Activities: Whenever need our members have joined works of public utility to serve our people and have received encomiums from all for the humble services they have rendered. We are in an age which is passing through revolutionary changes and I would urge upon my fellow professionals to take things in their practical aspects and look ahead to plan the future so that they might take up their rightful places amongst the community at large whom they have the unique privilege to serve often under circumstances not very favourable. I would urge upon you all to organise yourselves to collaborate with all your best in making any scheme of post-war reform in public health and social matters successful. I am sure in the future evolution of things for the well being of the nation, the co-operation of the members of the profession can be safely assured. I have felt often that the members of the medical profession should take more interest in the activities of the legislature and other local bodies and enter them in large numbers so that they can contribute for the ensurance of better public health and medical reforms along with the other leaders of the society. I know of many members of the profession owing allegiance to the different political parties seeking election to the legislatures, but I must mention with some sense disappointment that so far as the province of Bengal is concerned, at least the popular political element viz. the Congress has not taken the issues of the medical profession in adopting them as its party nominees for the ensuing Legislative Assembly elections. I consider this as lamentable because I know of many medical men whose contributions for the political and social regeneration of the country are of no less magnitude than many of those who claim to be genuine political personages. To plan medical and public health reforms, I believe, opinion of the medical men, particularly, those amongst them who have done considerable medico-political work should not be brushed aside.

Ladies and gentlemen, I am sure by this time I have reached the limit of your endurance and therefore thanking you for the honour you have done me, again and again I leave you to the other items of our very interesting programme.

The Open Session commenced at 4 P. M. with Dr. A. D. Mukharji in the Chair. The following resolutions were passed unanimously:

1. This conference congratulates the Special Committee on Medical School Education appointed by the Government of Bengal in recommending the early introduction of unitary type of University Medical Education in Bengal and appreciates the decision of the Government Bengal in resolving to convert the Dacca and Campbell Medical Schools into colleges from the year 1946 and 1947 respectively.

This conference also urges upon the Government of Bengal to convert the remaining Government Medical Schools into colleges without further delay and to render financial assistance to the non-official medical schools to raise up their standard.

2. This conference urges upon the Government and all concerned to revise the existing practice of utilising the services of the members of the medical profession on honorary basis and to introduce a system of honorarium.

3. This conference views with concern the practice of appointing new entrants to the profession as House Officers on purely honorary basis and urges upon the Government and those who run public hospitals to introduce a system of paying a subsistence to these services for more efficient and devoted service.

4. While realising that the poor medical aid facilities and dietetics in general available to the masses of this country which has brought in serious consequences in the social fabric of the nation, this conference urges of the Government devising a practical scheme to provide for better medical aid on equitable basis and to ensure nutritive food for the masses and to utilise the

existing members of the civil and military services, temporary or emergency, on a planned basis under the aegis of the Government.

5. This conference urges upon the Government for the recognition and regrouping of the existing emergency Hospitals in the country and distribute them equitably all over the country according to the area and density of the population.

6. As in spite of the Indian Medical Degrees Act and the Bengal Medical Act the practice of quackery is on the increase this conference urges upon the Government to prohibit the use of the courtesy titles of "Doctor" by the unqualified persons and to rigidly enforce the provisions of the Poisons Act so that none but registered medical practitioners can use them.

7. The conference urges upon the Government to give effect to the provisions of the Drugs Act passed in 1940 and establish Testing Laboratories through which all products, Indian and foreign, must be certified before use by the public.

8. This conference feels that compartmentalism in civil medical services on grounds of class distinction is standing in the way of the growth of efficient medical service in the country and requests the Government of Bengal to do away with compartmentalism in civil medical service and introduce one uniform standard of service starting with minimum monthly salary of Rs. 200 with gradations irrespective of caste and creed and in order to improve the service conditions to introduce recruitment on merit through the Public Service Commission.

9. In view of the better organisation and working of high order with the introduction of the Indian Army Medical Corps doing away with the compartmentalism in the Military Medical Services, this conference urges upon the Government of India to make the Corps permanent and to admit medical licentiates, who have rendered meritorious service, in the Corps.

10. This conference requests the Calcutta University to reconsider the decision regarding the Condensed M.B. Course for medical licentiates and to limit the same to two years' course of study for the medical licentiates in general and to one and a half years' for those who have undergone training at the Army Medical Training Centre as per recommendation of the Medical Council of India and to keep the scheme in operation till the upgrading of all the medical schools to colleges is effected in the province.

11. While thanking the authorities of the Carmichael Medical College and the Calcutta Medical College for implementing the University regulation of Condensed M.B. Course and thus giving facilities to the medical licentiates for going in for the M.B. degree of the Calcutta University after undergoing the condensed course, this conference requests them to reduce the tuition fee which is considered prohibitory for advancement of knowledge and to fix it at par with that of their regular students. This conference further requests the authorities to eliminate the age-bar on the intending candidates for admission.

12. Resolved that a Sub-Committee be formed with the following gentlemen to look into the grievances of licentiates in various medical services and to move the authorities for the redress of the same:

1. Dr. A. D. Mukharji, 2. Dr. A. N. Roy, 3. Dr. B. Chaudhuri, Provincial President, General Secretary and Provincial Secretary respectively of the All-India Medical Licentiates' Association; 4. Dr. T. N. Bhattacharyya, 5. Dr. Emududdin Ahmed and 6. Dr. K. P. Sen.

Further resolved that the Sub-committee be requested to commence work as early as possible.

13. This conference requests the Amalgamation Sub-Committee formed at the last Calcutta Conference to expedite the work entrusted to them so that a definite decision can be arrived at the earliest opportunity.

14. This conference resolves to keep open the Ahi Bhusan Memorial upto 31st March, 1946 and requests the Provincial Secretary to try his level best in co-operation with the branch secretaries to realise the required amount.

15. This conference records with concern the sudden illness of Dr. Jibananda Mukherjee, Chairman, Reception Committee, and prays for his speedy recovery and restoration of health.

16. Resolved that the authorities of the A. H. S. School Salkia, Howrah, be thanked for allowing the school premises for holding the Conference.

17. Resolved that the conference places on record its thanks to Mr. Sailo Kumar Mukerjee, Chairman, Howrah Municipality, for assisting the conference in all possible ways.

18. This conference also places on record its appreciation of services rendered by the members of the Reception Committee and the volunteers for the success of the conference.

19. Resolved that the various manufacturing houses who have participated in the Scientific Exhibition in connection with

the conference be offered the thanks of the conference for the valued cooperation.

20. This conference thanks M/S Oriental Research and Chemical Laboratory Ltd., Bengal Chemical and Pharmaceutical Works Ltd., and Asia Drug Co. Ltd., for the Social Parties they organised in honour of the members of the conference.

Afterwards an interesting address by Dr. San Lal Roy was read out. Dr. A. N. Roy and Dr. J. Majumdar also spoke.

Dr. M. C. Chattarjee, on behalf of the Reception Committee, then thanked the President, delegates and visitors. At last with vote of thanks to the Reception Committee, volunteers and the President the Session closed at 6-30 P.M. which was followed by a tea party.

ALL-INDIA MEDICAL LICENTIATES' ASSOCIATION.

Report of the Bhoire Sub-Committee appointed by Resolution No. 10, of the Standing Committee A. I. M. L. A. held in Delhi on 4th & 5th March, 1946, the Sub-Committee met from 12th to 15th June, 1946 at 27, Dixon Lane, Calcutta.

Supplement but not to supplant—The Committee often stresses in the course of the report that the health services they propose are to supplement but not to supplant the existing ones. During the greater part of the short-term programme the country will be still served by the existing organisations and that the disparity of amenities in these two areas will result in discontent and resentment.

There is no reason why the present organisation should not be displaced by the new except it be that the Committee thought that it would be discourteous or dangerous to tread on other's corn. The present organisation, particularly the medical side of it, is so rotten that it deserves to be displaced by the new one. If it is not done at the very outset of the new organisation it will grow in mock derision of the other and stifle it by all possible means and on all opportune occasions. In fact our judgment indicates that unless the new displaces the old there is little chance of its success in the near or distant future.

Instead of starting fresh primary and secondary centres and units, the present dispensaries should be immediately raised to the level of primary units as outlined in the Bhoire Report in all respects, i.e., salaries of the medical and other staff, equipment, dispensary buildings etc. The present medical personnel should be immediately absorbed in the proposed scheme. A regrouping of the dispensaries may be made and new dispensaries should be started so as to see that every 20,000 population gets one primary unit and it covers an area of a radius of about 6 miles.

And any new primary unit proposed under the short term plan should only be started if the existing ones fall short.

We fully agree with the note of dissent by Dr. Viswanath and Dr. Butt and feel that if instead of improving the existing machinery a new experiment is made by starting new primary and secondary unit it will bring about new complications and further divisions in the profession.

We must definitely state that the salaries of the present M. O.s in-charge of dispensaries are wholly inadequate and they should be immediately revised as indicated above if the Government is really anxious for the successful working of the scheme in rural

areas. We, therefore, feel that this question should be definitely decided and for which our association should be duly consulted and given necessary representation in the All-India Committee referred to in Para 61 of the summary.

We have to point out that in improving the future primary units, i.e., the dispensaries, government should profit by past experience and see that these units are fully provided with necessary equipment and drugs essential for their proper working.

In considering promotions of medical officers, merit and experience should be the only criterion. Similarly the health of the area in charge of a particular M.O. should be the guide of his efficiency and merit. Regarding the question of admission to medical college the sons of medical men should be given preference, other qualifications being equal.

For the new recruitment to medical services as proposed in the scheme or otherwise the ratio of medical graduates to licentiates should be at least 1:2, for a period of the next ten years.

When we are talking today about the need of more medical men, the present idea of retrenching the posts of temporary officers in the civil medical services is not understandable and so we trust that all these temporary officers will be first absorbed, in due consideration of their services during the critical period.

We regret to note that the Government of India appointed a joint committee of the Central Advisory Boards of Health and Education to consider the problem of Blindness in India in which the A.I.M.L.A. was not given any representation though it is the medical licentiates who are doing pioneer work in blind relief work and so requests the government to give us representation in the All-India and Provincial Councils as suggested in the report, issued by the joint committee.

At this stage we also urge upon the Government to give us representation on the Central Advisory Board of Health and Education.

Basic Doctors :—

While fully agreeing with the views that there should be only one type of basic doctor for the future, we take strong exception to the suggestion of raising the existing licentiates to the level of basic doctor. We have to say that the present medical licentiates should be considered as "Basic Doctors" with the full implications of that term as they have undergone the same training of four years which is now proposed for the future "Basic Doctors" by the Bhore Committee.

We further feel that medical licentiates should be afforded full opportunities for post-graduate training and qualifications in India and abroad, so that our country may benefit by their past experience and practical work without undergoing the full university M.B.B.S. Course.

We feel that the medical licentiates who form the bulwork of medical relief in India should be given full opportunities for medical services, research as well as administration. We appreciate the remarks in the report "with the award of officer status in the I.A.M.C. to licentiates, the latter have taken their rightful place as fully qualified medical officers and discharged duties in every respect identical with those of graduates" and

urge upon the authorities to translate these remarks into action by giving suitable employment to demobilized I. A. M. C. licentiate officers in higher medical services. We further point out that graded and recognized specialist licentiate officers from the I.A.M.C. be recognized as such in future civil employments without the necessity of obtaining a routine diploma or degree.

We further fully agree with the note on employment of personnel demobilized by the Army by Dr. Viswanath, Dr. A. H. Butt, Lt.-Gen. J. B. Hance and Sir F. James (on P. 473. Vol. II).

We again reiterate our demand that the A.I.M.L.A. should be given full representation at the Centre and in the Provinces on all committees which will be set up under the post-war health schemes.

Indian Medical Council :—

We regret to note that the Committee has given no clear lead regarding the inclusion of the present medical licentiates in the purview of the I. M. C. Act and we urge upon the Government to amend the I. M. C. Act in such a way as to change the present preamble and substitute the original preamble which clearly stated that the Act was intended to establish a uniform minimum standard of medical education and to give full recognition to the medical licentiates regarding registration and representation without any restrictions or distinctions.

Adequacy of medical ancillary personnel :—

The health personnel required to complete the long term programme and the number now available is shown in the table on page 58 of the Report. But let it not be forgotten that the number immediately required, so far as medical personnel is concerned, is not more than 20,000 and this, in our view, can be made available for employment in the health services, provided reasonable remuneration is offered to them. Out of 47,500 medical men, not more than 13,000 are in salaried job at present. The vast majority have settled in practice because there has been no scope for them in State services. Nearly 50 per cent of the present available medical men could be mobilised to run the health services provided, as we have said, proper salary and reasonable prospects to rise to higher positions are given. The committee itself suggests that 25 percent of medical staff in the secondary and district units can be employed on a part-time salary basis. This is a welcome suggestion. We are quite confident that the practitioners would avail themselves of this offer, if there is not much red-tapism and official pin-pricks behind it. As for the long term requirements, establishment of a number of medical colleges, anew or by conversion of the existing medical schools, has been strongly recommended. But in this recommendation we find a strange omission, as each new medical college would at least take 5 years to bring out qualified doctors, provided the start is made immediately which of course is not likely; we expected, the committee would recommend the introduction of double shift system of teaching in the existing medical colleges. It has not said even a word about this method of meeting the present inadequacy of medical personnel. This method has got two definite advantages :—

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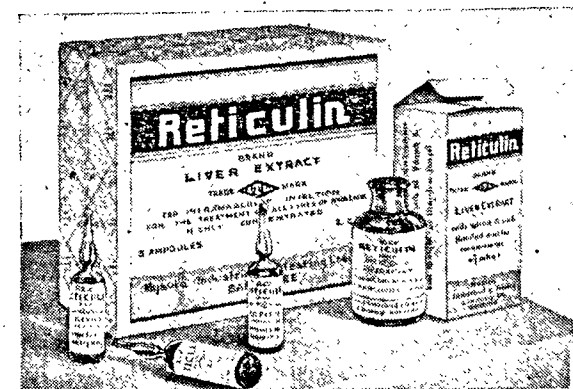
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BENGAL PROVINCIAL CONFERENCE, A.I.M.L.A.

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(2) Double the present number of students can be admitted.

Extra teaching staff would, however, be necessary. Although we welcome more colleges we are yet against too many as it virtually means an avoidable duplication of equipment and buildings and as the amount spent on this account can be usefully diverted to the other more urgent needs of health services.

Indigenous systems of medicine.—We feel that the Committee has failed to put up proper recommendations as to how far and how best the indigenous system of medicine could be synthesised and absorbed into the modern scientific system. It has suggested an Indian Pharmacopoeia inclusive of such indigenous drugs which have proved their value, empirically or scientifically. It has also suggested the institution of a Chair in History of Medicine in the proposed All-India Medical Institute. One of its functions would be to study the indigenous systems and drugs with a view to find out to what extent they can contribute to the sum total of medical knowledge. But these are not sufficient in our view. The Committee must have called upon the leaders of the indigenous system of medicine to give evidence as to the possibility of absorbing them into modern medicine on the basis of scientific acceptance. Unless medicine is taught within the perspective of our characteristic culture and civilisation, our people would not resort to it in such large numbers whom the comprehensive national health service contemplates to serve. Surely a suitable curriculum could be made out on the basis of proper standard of instruction and examination in the combined systems of medicine. There is, in our view, an imperative need for maintaining the historic continuity between the past and present medicine in our country while planning for the future. We have always consistently set our face against separate fostering of indigenous medicine. This is bound to result in a conflict at the end. It is better to avoid this while we are on the eve of considering changes in the organisation of medical teaching institutions and of medical relief. We do not at all accept the view of the Committee that the modern health practice gives no room for adjustments with the concepts of health and disease held by the indigenous systems of medicine.

(Sd.) M. L. Kapur,
A. D. Mukharji,
A. N. Roy,
V. D. Sathaye,
G. K. Kulkarni,

Members, Bhore Sub-Committee A.I.M.L.A.

ALL INDIA MEDICAL LICENTIATES' ASSOCIATION

Proceedings of the Ex-I.A.M.C. Officers' Conference held under the Auspices of the All-India Medical Licentiates' Association at 27, Dixon Lane, Calcutta on 15th and 16th June, 1946.

In view of the present discontent and dissatisfaction prevailing particularly amongst the rank and file of the demobilised licentiate army medical Officers about their future for which Government of India gave such high hopes and since nothing has come out

so far to allay their intense anxiety and concern, the President of the A.I.M.L.A. called for a conference of representatives of the Ex-I.A.M.C. officers from the different provinces in India on 15-6-46, at 27, Dixon Lane, Calcutta.

The following were present:—

R. S. Dr. M. L. Kapur, President A. I. M. L. A. presided.

1. Captain B. Bagchee—Bihar
2. Captain M. R. Vaze,—Poona-Bombay.
3. Lt. M. H. Vaidya—Nagpur—C.P.
4. Captain S. K. Roy—Bengal.
5. Captain F. I. S. Chishty—Punjab.
6. Dr. D. V. Venkappa—Madras.
7. Subedar Dr. Suba Bahadur Singh—U.P.
8. Captain D. K. Ramadwar, M.C.—Raipur.
9. Captain N. R. Mazumdar—Assam.
10. Dr. A. N. Roy, General

Secretary, A.I.M.L.A. } *Representatives*
11. Dr. V.D. Sathaye, Poona. } *of the A.I.M.L.A.*
12. Dr G. K. Kulkarni, C.P.

Resolutions passed in the meeting:—

1. This Conference resents and strongly protests against the continuance of the Sub-Assistant Surgeon's rank in spite of all the great sacrifice made and risks undertaken in the several theatres of the world War II by the licentiate army medical officers at a time of crisis and dire necessity of the Government and in spite of several pronouncements made by the administrative heads of the medical department of India and the Government of India Communique, the text of which is as follows—"The old name of sub-assistant surgeon was originally given to hospital assistants who at the time required far less in the way of educational and other qualifications than the medical licentiates who serve as sub-assistant surgeons in the Indian medical Department to-day. The present day sub-assistant surgeon is well educated and qualified man and is felt that there is no reason to retain the title which suggests that he holds the same subordinate status as his original predecessor".

1. This Conference therefore urges upon the government to abolish immediately the sub-assistant surgeon rank and subordinate medical service and bring into existence a unified civil medical service to allay the strong discontent and disaffection prevailing in the class.

2. This Conference trusts that the recommendations of the A.M.O.'s Conference with regard to the scale of pay for medical licentiates ranging from Rs. 150 to Rs. 450 will be given effect to as early as possible.

3. This Conference feels that when recruitment was in full swing during the period of the war and the Association entirely collaborated with the Government of India in supplying the necessary personnel, through its provincial representatives, it deems necessary and reasonable that similar representation should be given to appoint a medical licentiate as resettlement and post-war reconstruction officer in each province and at the Centre both civil and military to safeguard and support the interest of the medical licentiates of India.

4. This Conference is anxious to know the exact nature of the concessions offered to those licentiate I.A.M.C. officers who are desirous of undergoing the

M.B.B.S. and other postgraduate courses with regard to study leave, tuition fees, etc.

This Conference urges on the Government to give similar facilities to the licentiate I.A.M.C. officers as are being given to medical graduate for post-graduate courses abroad.

5. This Conference observes with great concern that release benefits *viz.*, release leave, victory leave, gratuity, etc. are denied to the I.A.M.C. officers before reversion to Civil Service and trusts that in future the rules regarding the above will be strictly adhered to and that those already released without release benefits should be given the benefits as announced from time to time in the different army instructions without further delay.

6. This Conference of Ex-I.A.M.C. officers consider it essential to bring to the notice of the Central and Provincial Governments that medical licentiates generously volunteered their services for the army at the sincere call of the All-India Medical Licentiates' Association with the full belief that it was their duty to serve the soldiers of India and thereby prove to the authorities, who now and then drew their attention to the fact that test of their professional abilities in military services would decide their future, that they are competent to undertake all responsible duties including administration, in the profession as best soldiers of the medical licentiates of India and hence trust that the Government will give full consideration to these resolutions of this conference and the memorandum submitted to Medical and Public Health Ministers at the Centre and Provinces by the President A.I.M.L.A. for their consideration to enable them to decide once for all their future in the profession and services.

7. Recent advertisements for services in civil and military and post graduate training for the medical graduates abroad give us a clear clue that the Government is forgetting soon the sincere and loyal services of the medical licentiates during the world War II and this has become possible because representatives of the former are represented in one form or the other at the Centre and Provinces to watch their interests.

This Conference, therefore, urges on the Government to appoint representatives of the medical licentiates at the Central and the Provincial Resettlement and Reconstruction Committees and any other committees that the Government may set up for health scheme of this country.

8. This Conference brings to the notice of Government the number of Conferences held with regard to recruitment campaign and the impetus given to the same for its success in this direction and urges the necessity of convening a similar conference to uphold the legitimate claims of these demobilised officers to allay their discontent and dissatisfaction which are growing intense day by day. Further resolved that the decision of the Government should be made known to the All-India Medical Licentiates' Association at the earliest opportunity to enable the Association to place the same before the Annual Conference for consideration by the Ex-I.A.M.C. Officers and the members of the A.I.M.L.A.

9. This Conference reiterates the resolution No. 2 passed in the Standing Committee meeting of the A.I.M.L.A. held on 4th and 5th March, 1946 in Delhi

as noted below and trusts the Government will take early steps to move in the matter.

I.A.M.C. and Demobilisation:—

This meeting records with concern that although demobilisation has long commenced the Government of India have not yet announced their policy regarding the permanency of I.A.M.C. *vis-a-vis* the position of Licentiates who have served the Army during the strenuous period of world War II, which lack of settled policy is borne out by the fact that a large number of demobilised licentiate officers of the I.A.M.C. are being relegated to their former ranks in I.M.D., and provincial subordinate medical services. This meeting urges upon the Government of India to announce the

- (i) permanency of I.A.M.C.
- (ii) abolition of I.M.D.
- (iii) eligibility of licentiates to permanent commission in I.A.M.C.
- (iv) absorption of I.M.D. officers transferred to I.A.M.C. (Special section) into the permanent I.A.M.C.
- (v) absorption of I.M.D. officers who held temporary commission in I.A.M.C. into permanent I.A.M.C.
- (vi) to direct Provincial Governments to provide the demobilised commissioned Licentiate officers with permanent posts in provincial medical service.
- (vii) to allow the temporary I.A.M.C. officers to retain the rank which they were enjoying at the time of demobilisation.

Government of India be further requested that the emergency Medical Officers in the special section of the I.A.M.C. be given the honorary rank of Captain on demobilisation, and that no differentiation should be made between them and the medical officers of the I.A.M.C. holding emergency commission, in the matter of resettling them in civil jobs.

10. This Conference requests the General Secretary, A.I.M.L.A. to move the provincial and district branch secretaries of the A.I.M.L.A. to arrange branch meetings in collaboration with Ex-I.A.M.C. officers with a view to give wide publicity to the proceedings of this Conference and the memorandum submitted to the Hon'ble Ministers of Health and get their views as to the action to be taken in future. This Conference impresses on the medical licentiates of India that success of all our efforts lies in our strength in the Association and requests one and all to become the members of the Association.

11. Further resolved that the General Secretary, A.I.M.L.A. be requested to forward the copy of the resolutions and the memorandum of the Association to H.E. The Commander-in-Chief of India, the Hon'ble member I/C, Health Department, Government of India, D.G., I.M.S. Director Medical Service, India, Hon'ble Ministers of health, Surgeon Generals, Inspector-General, D.P.H., of all provinces and States, Members, Standing Committee, A.I.M.L.A., Provincial and District Branch Secretaries, A.I.M.L.A. and members attending this Conference for their information and necessary action.

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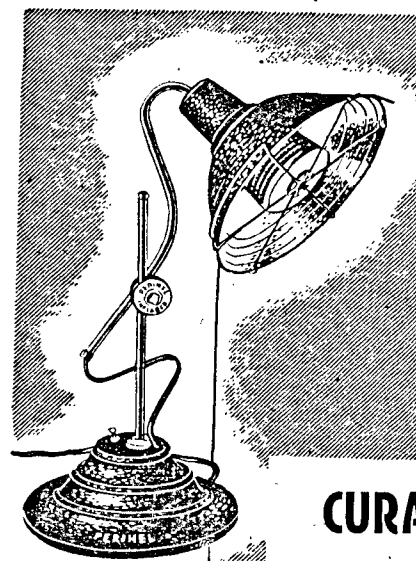
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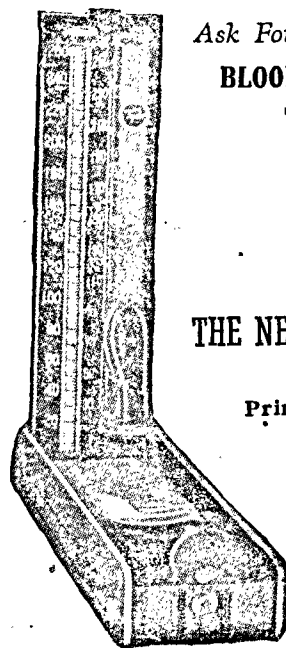
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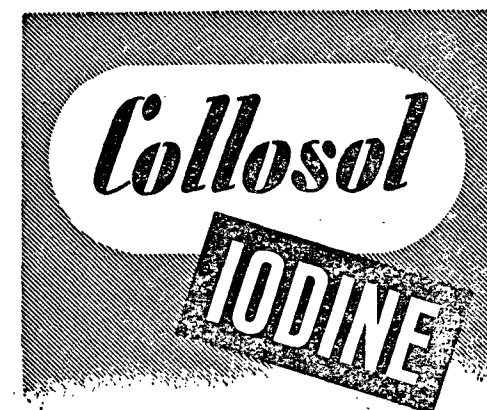


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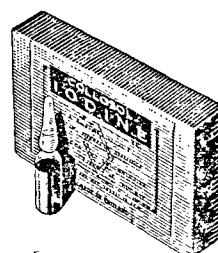
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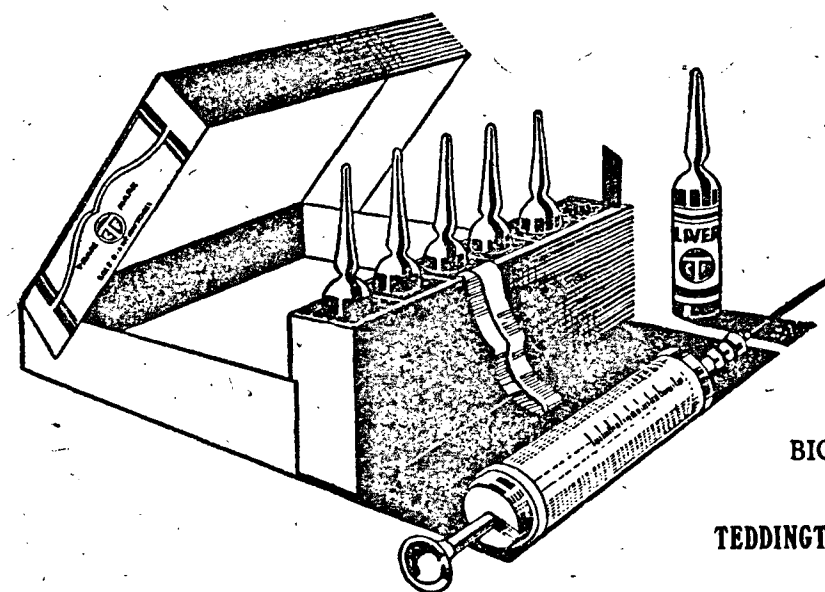
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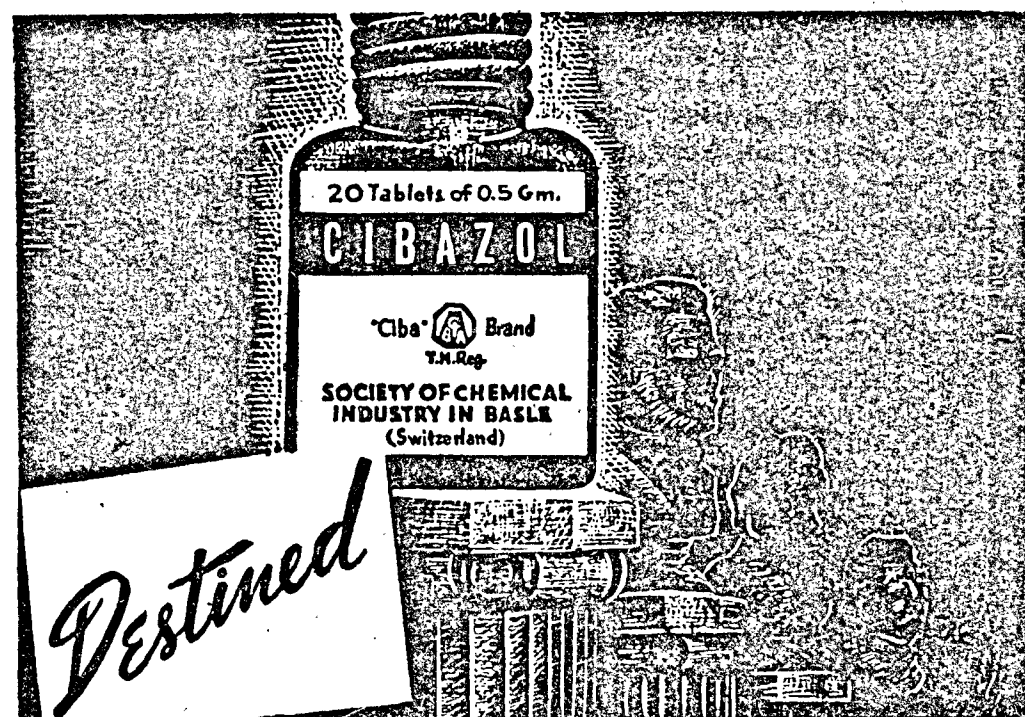
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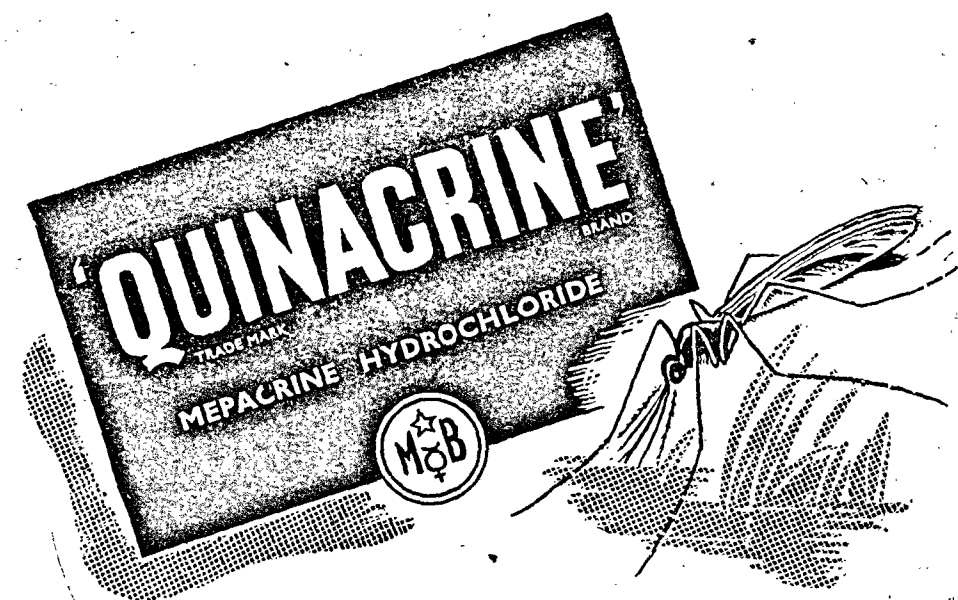
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Vol. 40, No. 8
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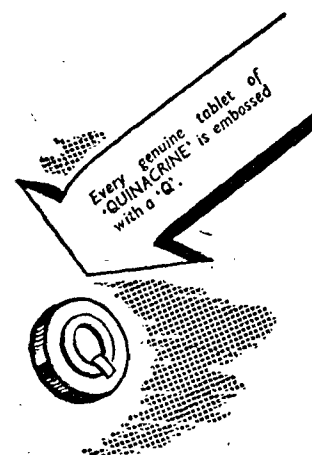
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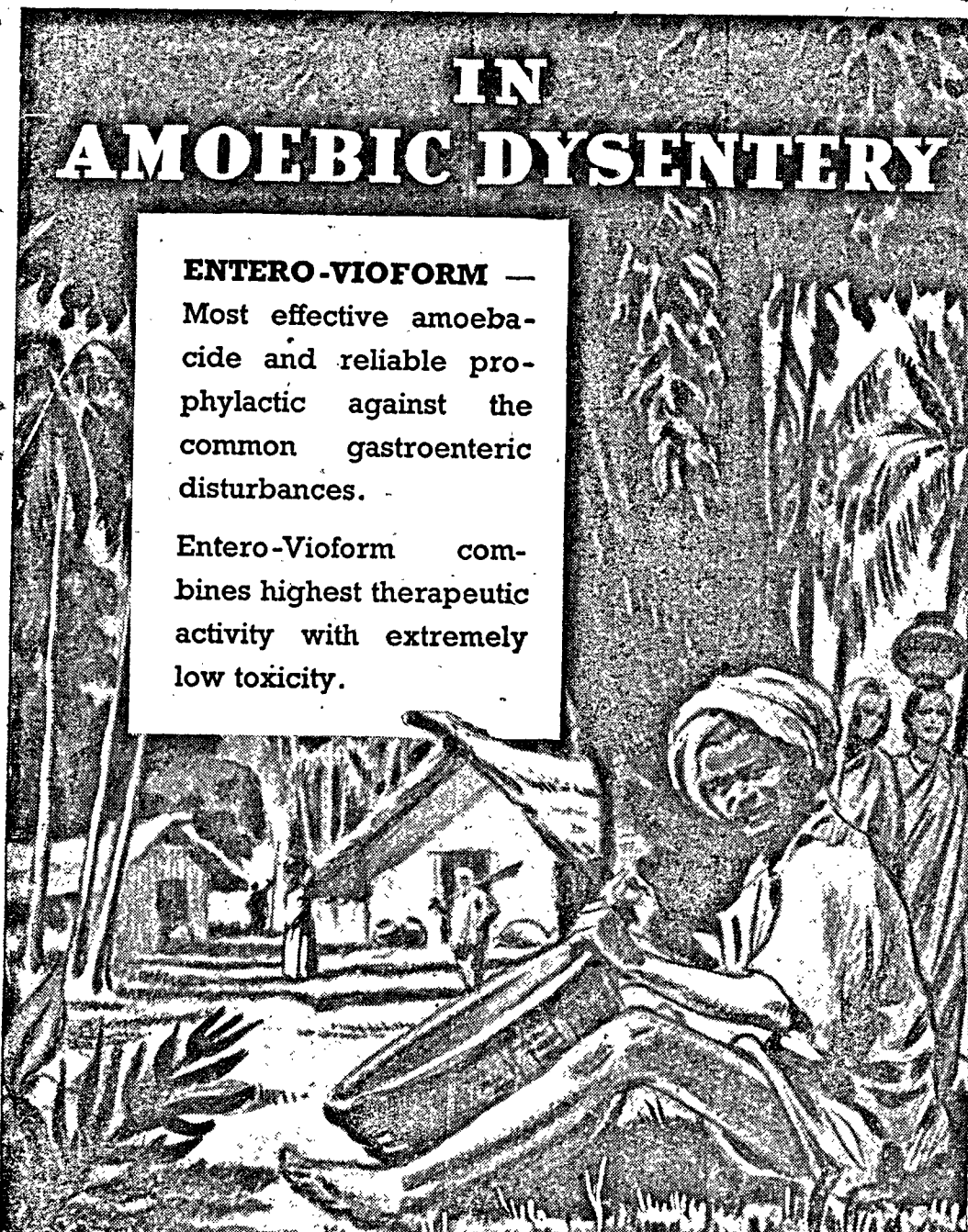


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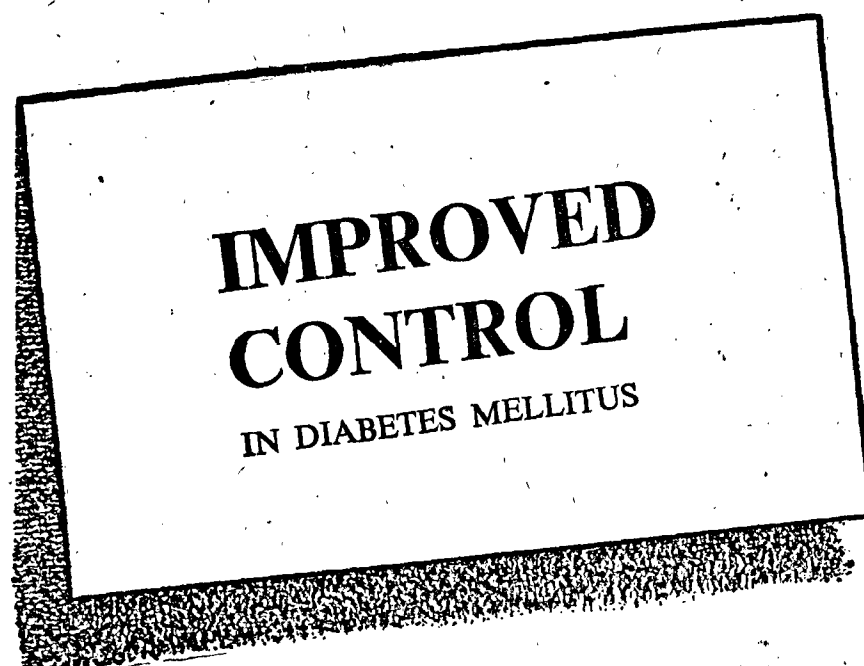


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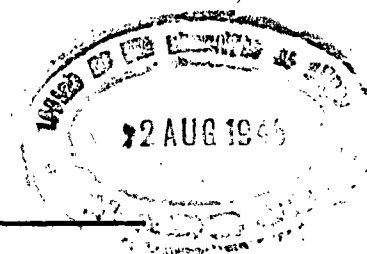
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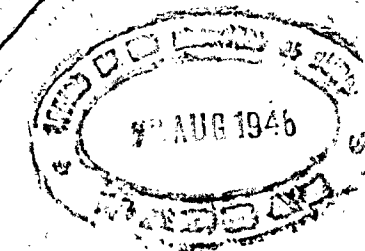
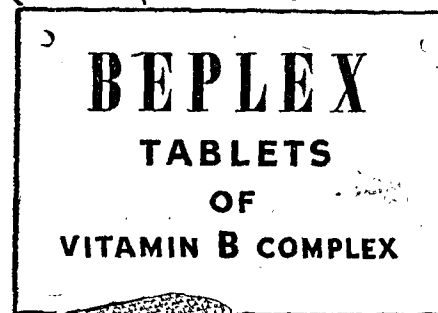
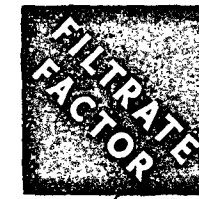
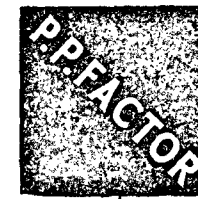
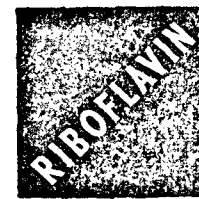
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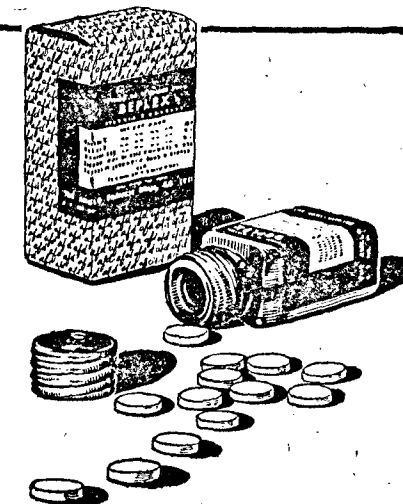
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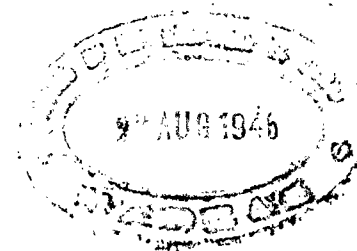
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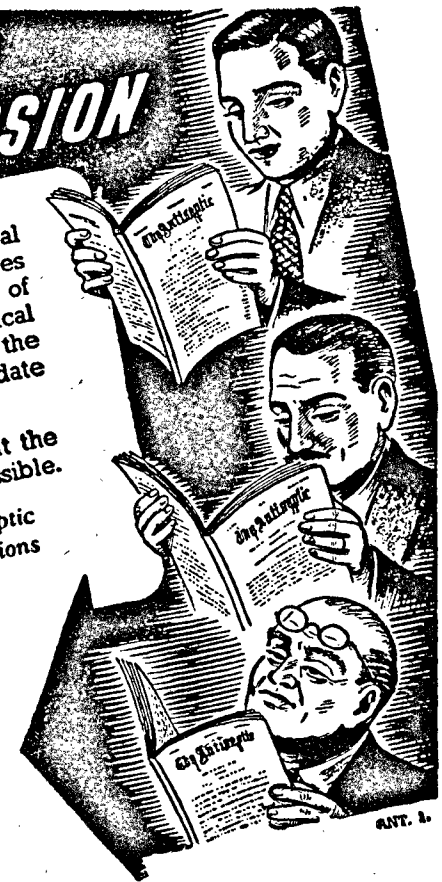
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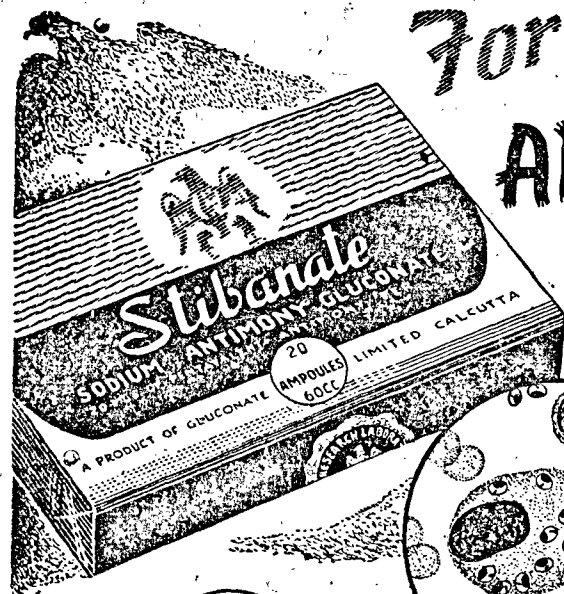
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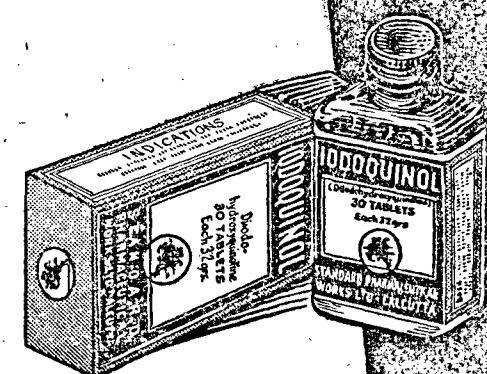
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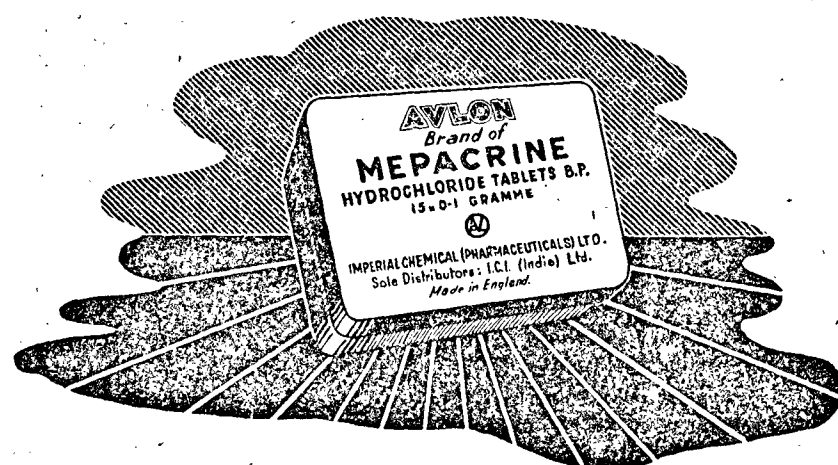
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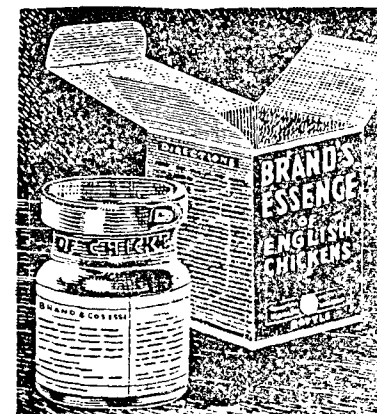
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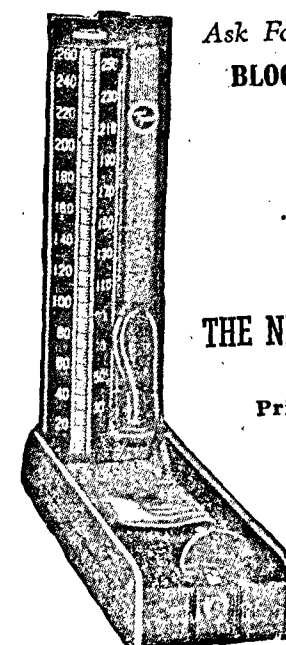
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Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras : August 15, 1946. No. 8

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All-India Medical Licentiates' Association

34th CONFERENCE

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V. G. PARANJPE,
General Secretary.

Indian Medical Journal

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Vol. 40. Madras, August 15, 1946 No. 8.

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OUR MONTHLY SURVEY.

Dr. B. M. Das Gupta.—We regret to record the death of Dr. B. M. Das Gupta, Director of the School of Tropical Medicine, Calcutta. He was occupying a pre-eminent position in the world of medical research and his contributions to tropical bacteriology have been considerable. In life, he was simple and unostentatious, beloved greatly by his co-workers and other friends. In his death, the licentiate class has lost its brightest jewel, the profession its best worker and the country its greatest medical scientist. We offer our condolences to the bereaved family.

Absurd and Provocative.—Dr. U. B. Narayan Rao of Bombay has done a great service by directing the attention of the authorities to the absurd and provocative regulation of the postal authorities during the postal strike that only medicines certified as essential by Assistant Surgeon could be transmitted by registered post. It is absurd because, by far the greater number of smaller mofussil stations have no assistant surgeons. How then could the people get the required certificate, unless they travel some distance, by train or bus, to get at an assistant surgeon? It is also provocative because, the postal authorities have no business to favour one set of registered medical practitioners as against another. When the licentiates are not prevented from issuing medical certificates or from giving evidence in medico-legal cases, by any provincial government, we wonder on what basis has the postal authorities made this stupid regulation, particularly during the time of emergency like the postal strike. It is on the whole a silly regulation.

News-print Scarcity.—The size of paper in which we print our Journal (demi-size) is not available, and we are supplied with other sizes which vary every month. The size of the journal would therefore vary every month according to the size supplied. We request our readers and advertisers to over-look this inconvenience as it is unavoidable at present.

B.Sc. in Nursing.—We are glad that the Madras and the Delhi Universities have introduced a course of B. Sc. in Nursing. It runs to four years with two examinations at the end of the second and fourth year of studies. This is indeed a welcome move and we sincerely hope that girls of respectable families would take advantage of this course and make the nursing profession popular, efficient and honourable. In Madras province, the training is given at the Christian Medical College at Vellore and 15 girls were admitted this year. We wonder why the Madras Government have not utilised the two medical colleges in the city of Madras for the purpose of coaching in B. Sc. Nursing. We do hope that they would open these courses in the city medical colleges next year at least. That would enable a larger number of girls to seek admission to the Nursing Degree. We also hope that other universities would start similar courses. In fact, each medical college should have also, as an annexe, a college of Nursing leading to B. Sc. in that subject.

Suitability for Medical Education.—The Christian Medical college at Vellore is the first institution in this country which has introduced this year proper psychological and other tests for ascertaining the suitability of the candidates for undergoing the arduous course of medical education. As a result of these tests, they have found that candidates who got first class in I. Sc. or B. Sc. are not necessarily suitable for medical education. We do hope that similar tests will be introduced with regard to the admission of students into the medical colleges, so that wastage of valuable human material may be avoided as far as possible, and misfits to the profession may be eliminated at the very beginning.

ADDRESSES AND ARTICLES

A note on the role of Vitamin B Complex in the causation of Leprosy.

By

Dr. A. K. ROY CHAUDHURY B. Sc. M. B. (Cal)
169, Bowbazar St., Calcutta.

Leprosy is a very peculiar disease in the fact that it seems not to obey Koch's famous postulates. Infection of leprosy cannot be explained in terms of *Leprosy Bacillus* alone. There must be some other additional predisposing cause, which changes the body tissue in such a way that on the top of which only the leprosy infection can be grafted. None of the factors of immunity, heredity, contagion geographical, geological, or climatic conditions, vector, age or sex as predisposing cause can answer for all the infec-

tions that occur. Error in the diet can act as a predisposing cause and in dietetic error there are two possibilities.

(i) either the food is carrying some chemical or bacterial poison or (ii) the food is deficient in some essential food elements.

Against the first possibility, it may be said that nobody upto the present day has been able to isolate any such chemical or bacterial poison in the food of lepers. Of course from time to time, leprologists of repute have held responsible some food or other as the predisposing cause but all in the long run were proved to be wrong e.g., Hutchinson's food theory or Oberdaeffler's colocasia theory.

The idea that the diet of lepers is deficient in some food essential, e.g., vitamin B, gains support in a detailed study of leprosy from various angles.

(1) It has been found in all lands where leprosy was in epidemic form at one time or other that the usual food (animal or vegetable) during that period was either not fresh, long kept-up, salted or rotten, and the disease died down with the improvement of fresh animal and vegetable food supply.

(2) There is a striking resemblance between the vitamin B deficiency diseases and leprosy. Both in the chronic Beri Beri and in neural leprosy, the clinical neurological picture suggests that the cause of the sensory, trophic and motor disturbance may well be founded in a polyneuritis which develop after long period of incubation, beginning peripherally and progressing proximally in a slow manner due to Vitamin B deficiency. Pellagra also shows a striking similarity to leprosy in the gastro-intestinal troubles and in the skin and nervous involvement. In this connection the outbreak of pellagra in leper asylum of Korea and India as observed by Willson and Lowe is worth noting.

(3) The distribution of leprosy in the map of the world is either similar or overlapping with areas specially susceptible to beri-beri, pellagra and such other vitamin B deficiency diseases.

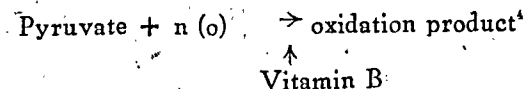
(4) A seasonal variation as observed by Lowe and Chatterji in the incidence of leprosy in Bengal also gives support to the possibility that this increase in the incidence coincides exactly with the period (March-October) when the Vitamin B containing food is on the decrease.

(5) It has been found that the Vitamin B excretion in the urine of lepers is either nil or far below normal.

(6) The food of the lepers as analysed by several leprologists were found to be lacking in Vitamin B and the findings of several leprologists in rat-leprosy suggest that increased susceptibility to rat-leprosy is definitely due to Vitamin B deficiency. It was also observed that the amount of Vitamin B in the diet has got much to do either to attenuate or aggravate the condition of experimental rat-leprosy.

(7) Good and promising therapeutic results in leprosy with Vitamin B treatment have been claimed by several prominent leprologists.

From the physiological standpoint we may say that vitamin B acts as a catalyst in the intermediate carbohydrate metabolism e. g.,



So without the requisite amount of vitamin B naturally the people with carbohydrate as their staple food suffer most, as in the case of people of the tropical countries. In the absence of requisite amount of Vitamin B the normal oxidative metabolism within the cells is inhibited resulting in characteristic functional disturbances of the nervous system and this nervous system (which otherwise was quite immune) falls an easy prey to the invading mycobacterium *laprae*.

In contradistinction to the carbohydrates, the fats have an economising effect with regard to Vitamin B, this property is common to all fatty substances and probably explain the therapeutic value of vegetable oils (*Chaulmoogra* and *Hydrocarpus* etc.) and fats employed in the treatment of leprosy.

It will be of interest to note in this connection:—

(a) that people of tropical countries with carbohydrate as the staple food and with a lack of Vitamin B intake due to (1) less intake (2) little or no capacity on the part of the human body to store Vitamin B

(3) low absorption of Vitamin B in tropical people due to chronic amoebiasis and gastro-enteritis suffer most. (b) That the children are said to be more susceptible to the leprosy infection, also suffer most due to the want of Vitamin B as with a growing body the need for this vitamin is at its highest.

(c) that rat-leprosy is a disease analogous to human leprosy almost in all respects excepting that rats never develop any nerve signs or symptoms. The same is true for rats suffering from purely Vitamin B deficiency. Though they develop all other symptoms analogous to man, yet they seldom develop polyneuritis.

From all that has been said above it would appear that in the complex aetiology of leprosy Vitamin B deficiency may play a very important role as a predisposing cause.

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Difficulties in Medico-legal work in the Punjab*

BY

DR. KHAN CHAND WOHA,

In-charge Cure Dispensary-Chichawatni (Punjab)

The doctors doing medico-legal work in the Punjab have to face a lot of difficulties. I would narrate a few of them which I have experienced during my service of about 24 years.

* A paper read before the Montgomery Branch of the A. I. M. L. A. on 26-8-45.

Malingering and Wrong History

Persons injured by blunt weapons, especially in the case of head injuries, will in most cases state that the weapon used was a sharp edged one. (1) A case came to the Chichawatni Dispensary sometime back with a contused wound on the head along with the fracture of the skull. He stated in his dying declaration that he got an injury with an axe. The police investigation proved that the weapon of injury was a lathi. So there was a difficulty for the Police in conducting the case. (2) A case came to me recently with whole of the head and face bandaged, stating that his tooth was fractured. On careful examination I found that there was no injury to the gums or the lips and the man had an artificial set of front-teeth, one of which was fractured deliberately and again put up.

(3) One of the most interesting instances of malingering I found was in a case who came to me on 25-4-45 named Ghulam Mohd. s/o Jamal Mussali of Patiala state. He was an expert in this art. He was brought to me on a charpai, his tongue was protruding with blood and saliva running out of the angle of the mouth as in the case of dead bodies. He had only one contusion mark on the back. His look created the impression that the man was dying. His pulse and respiration were almost normal and conjunctival reflex present. It appeared that he produced bleeding from his gums with pricks. It took some time before he could be brought to his senses. One of the important signs of malingering is that when eyes of the person are opened he rolls them upward, the conjunctival reflex being present.

Misleading Police Report

Some time back a case of wound on the head was brought to me from the neighbouring thana by the Police "for special reasons". It was also mentioned by the Police that according to their investigation the wound was caused by a sharp edged weapon. On examination it was found to be a contused wound and result was given accordingly.

Dissatisfied with my opinion the case was taken to the Civil Surgeon who I was informed was also of the same opinion. I came to know later on that the case was first taken to the Medical Officer in whose jurisdiction the thana was situated and the doctor was verbally asked about the weapon of the injury. He opined that it was caused by a blunt one. The case was therefore sent to me "for special reasons".

Interference by influential people

Some years back when I just took over charge of the dispensary, the very next day a batch of medico-legal cases came accompanied by some people who wanted to talk to me in private. I hated the idea of interference by other people. So I firmly told them that it was no business of theirs to come to the hospital when they were not themselves in need of medical aid. The people tried to show their authority but I was firm and told them to leave the hospital. Thus the whole matter ended peacefully and afterwards I had no difficulty. In some rural and outlying dispensaries the position is still worse. I know of a case where the doctor had to face a lot of difficulty

and trouble for the independence of his opinion and integrity of his character.

Artificial Injuries

A few years back I was attached to a Jail hospital. A prisoner was brought to me with a swelling of one of his ankles stating that the convict warder had struck him and also stretched the part producing a sprain. He was examined by myself along with my two other colleagues in the Jail but we could not come to the conclusion as to the exact cause. Similar swellings over the other parts of the body came to my notice. On investigation the cause of these swellings came to light. The ordinary ratti (Jacquetry) was rubbed with water and a threaded needle was soaked in this emulsion for some time. This needle was passed through the skin and the thread was kept inside. There was swelling and inflammation and in some cases suppuration depending upon the length of the time the thread was kept in.

Wilful attempt to Mislead the doctor

Recently there was a case in England where a doctor was prosecuted for giving a false certificate under Defence Regulation. In the course of evidence it was disclosed that three agent provocateurs consulted a medical practitioner at the instigation of the New Scotland Yard and after giving a false name in one case and false medical histories in all cases they obtained certificate to the effect that they were unfit for work. The three men were subsequently examined by the Police Surgeon but were found fit for the work. The medical practitioner was later arrested and proceedings brought against him under the Defence Regulation. It was admitted in the court by a Police witness from the C. I. D. that he had instructed the three Police agents to give the false information, to feign sickness and that he had also told them what to say. Finally all these facts were admitted by the legal representative of the Director of Public Prosecution. The charges against the doctor were dismissed and a cost of 10 guineas awarded against the prosecution. The Magistrate in the course of judgement observed that "the very basis of the relations between the doctor and patient was honesty. In his view the doctor has got reasonable cause to believe that these three certificates, which he had given in good faith because of the story which was told to him by the men. "Mutual confidence is the only possible basis between doctor and the patients and the history of the symptoms is so essential for accurate diagnosis that except in gross and advanced diseases or in the case of known malingerers, the doctor is bound to accept it as a part of his medical evidence. The difficulties in connection with medical certificates are great and the doctor usually grants a certificate only after the consideration of the patient's physical manifestations and a consideration of patient's temperament and work, and even the with best will of the world there will on occasions be differences of opinions as to whether a patient is or is not fit for work. But what is the hard pressed doctor to do when confronted with a patient who may after all be a police decoy acting under the instructions and whose stories are a tissue of lies from the beginning to end. The simulation of signs may not be difficult to those who have been carefully coached and so the unwary

doctor acting in good faith may become the victim of the Police.

Head Injuries

Hippocrates had said, "No head injury is too trivial to dispose off and too severe to despair from." The following cases will show the truth of the above statement. Head injuries present a great difficulty in diagnosis as to the amount of intracranial mischief present. Simple looking superficial wounds are sometimes accompanied by extensive fractures of the skull bones while patients who have had severe injuries recovered.

(1) On 15-5-45 two persons came to the dispensary having engaged in a fight. Both had superficial contused wounds on the head without any symptoms whatsoever referring to the intracranial complication. Both of them were examined and a result of "simple injuries" was given. The next day one of them (Rehmat Ali) developed vomiting, drowsiness and headache. Police was immediately informed to have his dying declaration recorded. He died on 19-5-45 Post Mortem examination showed fracture of the skull with extradural blood clot which caused compression and death.

(2) A person named Qadir Bux was brought to the dispensary on 17-2-44 early in the morning. He had an incised wound across the skull, cleanly and also injuring the meninges. This man remained in the hospital till 28-12-44. During his stay he developed hemiplegia from which he completely recovered. He was later sentenced to imprisonment but was let off on appeal. He is alive till this day.

(3) In 1939 a case was brought to Raiwind Dispensary with severe injuries to the skull and the brain. As there was no magistrate nearby the dying declaration was recorded by the doctor in the presence of the Police Officer and two other respectable gentlemen of the locality. In the High Court it was contended by the defence that a person who had such severe injuries of the skull and brain could not have been fit to give the dying declaration. The Civil Surgeon, Lahore was called by the High Court as a court witness and he was also of the above opinion. The High Court ordered that the criminal proceedings be started against all the signatories of the dying declaration including the doctors and the Police Officer. A trial was started and it was held after such injuries the persons could have been able to give his dying declaration and hence everybody was acquitted.

There has recently been great development in brain surgery. Dandy of Baltimore removed the right hemispheres of brain in cases of malignant glioma. The first case died 26 months after operation and was in a good mental condition. He wrote a perfectly sensible letter dictated after 5 weeks of operation. The second case ended in death from infection 10 days after the operation. The patient's mind worked quite normally for 2 days before pyrexia set in. Gardener of Cleveland removed the right hemisphere from a woman 31 years old with a malignant parietal glioma. A few hours after the operation she talked with friends but was incontinent for two weeks. She could go about without aid and could go up and down stairs and frequently went shopping. These cases show that even after the removal of the whole hemisphere the patient's mental conditions could remain sound.

In the literature, several instances are given where the patients developed the intracranial symptoms some days after injury. A case is cited in the Rose and Carless Surgery (1930 edition page 829) where a person with a fracture of the base of the skull was capable of doing his work for 10 days after the accident.

(4) A patient named Dost Mohd was brought to the dispensary on 18-5-45 with a compound fracture of the skull. His dying declaration was recorded. There was exten-

sive swelling of the head with ecchymosis and swelling of both the eye-lids. Gradually the swelling disappeared and patient went on improving. He later on got fever. Suddenly on 11th June he developed drowsiness and headache and slow pulse. He was transferred to the Civil Hospital, Montgomery on 12-6-45 where he died a couple of days later.

Fissured fractures give no symptoms and are often missed unless there is a wound deep to the bone and we can actually see the fissure.

From what has been said above it is clear that an ordinary wound of the skull may take serious turn and cause the death of the patient. The only way to guard against this is to keep the victim of the head injury under observation for some time and see their conditions. Modi in his Medical Jurisprudence is also of the same opinion. If an opinion as regards the nature of a particular injury cannot be formed at the time of examination, as in the case of extensive swelling of a limb when its fracture cannot be detected or in the case of a head injury where the symptoms are obscure, the injured persons might be kept under observations until a definite opinion can be formed and the police should be notified of this fact.

Kinds of weapon used

It is a common knowledge that in those places of the body where the bone is situated just under the skin or there is only a thin layer of tissue intervening, wounds caused by blunt weapons may appear like the incised one. The chief points to see are in the case of incised wounds that the edges are straight and clean cut. There is some ragging near the ends of the contused wounds while in the case of the incised one the edges are cleanly cut. In one case I saw an accidental wound caused by a string in the perineum which looked just like an incised wound.

A patient was brought to me some time back stating that she was struck by a phawra (an implement used for the collection of the cow dung from underneath of the cattle shed). It is made of wood and has a handle. The body of the wound looked like an incised one. One of the ends was however a little ragged. The bone underneath was fractured but not cut. It was declared to be contused wound.

Grievous hurt

Section 320 I.P.C. gives the details of what constitutes a "grievous injury." It consists of 8 clauses. The first 6 clauses, in my opinion, do not present any difficulty to the examining doctor. I will deal on only with the last 2 clauses.

7th clause. Fracture or dislocation of a bone or tooth.—In some cases the fracture of a bone is only partial and cannot be detected without the aid of an X-Ray. In all cases where one is in doubt facilities for the X-Ray may be sought. As regards the fracture or the dislocation of the tooth they are far from common in India. In most cases a tooth is removed and presented for examination. Injury to the lip and laceration of the gums should always be observed carefully.

8th Clause.—It reads "any hurt which endangers life or which causes the sufferer to be during the space of the 20 days in severe bodily pain or unable to follow his ordinary pursuits". Now let us analyse this.

The injury should endanger life. This means those injuries which are extensive and implicate important structures or organs so that they may prove fatal in the absence of the surgical aid. "For instance compound fracture of the skull a wound of large artery or rupture of some internal organ such as spleen should be considered dangerous to life. But the injuries which prove fatal remotely by inters current disease such as tetanus, erysipelas etc., should not be considered as dangerous". Modi.

"Which causes the sufferer to be during the space of 20 days in severe bodily pain or unable to follow his ordinary pursuits". In the I. P. C. it is mentioned: "The mere fact that a man has been in hospital for 20 days is not sufficient, it must be proved that during the time he was unable to follow his ordinary pursuits. Where a man was so much injured that he had to go to a hospital but left it perfectly cured on the 20th day, it was held that that day would count as one of the 20 days during which he was unable to follow his ordinary pursuits, and where the accused caused hurt to a woman who remained in a hospital for 17 days, out of which she was in danger for 3 days, it was held that he had caused grievous hurt. A disability for 20 days constitutes grievous hurt: if it continues for a smaller period, then the offence is hurt.

Reference

1. British Medical Journal 1943, December 4.
2. Medical Annual 1935, page 200.
3. Medical Annual 1935, pages 200 and 201.
4. Medical Jurisprudence by Modi 1943 page 239.
5. Indian Penal Code by Ratanlal Ranchbad Das and D. K. Thakore 1939 Edition page 280.

(9)

Hypermetropia

By

Dr. R. S. AGARWAL,

Eye Specialist, Delhi

Hypermetropia is the opposite of myopia. The optic axis is shortened instead of being elongated as in myopia. It is believed that hypermetropia is congenital and not acquired, though it is seen in many cases being acquired at ten, twenty, thirty or forty years of age and under different conditions of life. The majority of persons at the age of forty or over acquire hypermetropia. Some people can read the finest print in a bright light but they become hypermetropic as soon as the print is read in a dim light. This fact is usually experienced by persons approaching old age. It is often experienced by many that the sight is normal in the beginning of reading a print but after a short period the eyes develop hypermetropia. When the normal eye tries to read an unfamiliar language, hypermetropia is produced. Many persons acquire hypermetropia when they are under worries or physical discomforts. Eighty percent of eye troubles are caused by hypermetropia. Risley believed that hypermetropia caused headache, pain fatigue, and other symptoms to a greater degree than that myopia. In the middle age many serious eye troubles as glaucoma, cataract, diseases of the optic nerve and retina are caused by hypermetropia.

Hence, it is more necessary to relieve the symptoms of hypermetropia than those of myopia if for no other reasons than the fact that hypermetropia is more injurious to the eyes. Eye diseases are more readily cured in the early stages than when they become chronic or serious when the vision is slightly affected.

The cause of hypermetropia is a strain or an effort to see at the near point. By making an effort to see central fixation is lost, the letter or the word regarded does not appear more distinct than the others not directly regarded. The patient tries to see several letters or words at a time, consciously or unconsciously. It has been found that many people have the tendency to concentrate or stare. When a letter on the Snellen test card or on the book is regarded continuously, imperfect sight is produced. Trying to keep the eye immovable causes imperfect sight. The normal eye when it is at rest is always moving and sight becomes imperfect when an effort is made to keep the sight fixed on a letter. While writing when one tries to see the back letters which are already written, hypermetropic symptoms are produced. When ladies do some fine work of sewing and keep the sight fixed at a point, they often complain of headache and eye discomforts.

Treatment by glasses for hypermetropic eyes is insufficient to obtain the best vision, and relieve or cure pain, fatigue, dizziness, double vision or other nervous troubles. It is a fact that an effort to see increases hypermetropia but it is unfortunate that the physicians who found that a strain was bad did not try the opposite of strain—relaxation. Rest or relaxation when properly employed cures hypermetropia and relieves all the discomforts. The great difficulty is that all people are not able to rest their eyes properly and perfectly, yet many of them can be cured while others can be relieved of the disagreeable symptoms and the extent of hypermetropia can be either prevented or decreased. Cases who cannot be cured of hypermetropia and feel difficulty in their work may be helped by glasses along with the relaxation treatment. Hypermetropic patients are more readily cured than myopia.

The prevention and cure of hypermetropia is very simple. When one practises in the right way, a cure is always brought about. Hypermetropia is cured by rest or relaxation, and cannot be benefited by an effort. Practice of central fixation and palming relieves hypermetropia.

The best methods of preventing hypermetropia are reading fine print such as diamond type, piaming occasionally, and imagining stationary objects to be moving. The last one of these methods is not always easy to practise. Some cases are very obstinate without any known reason. They may try for days, without success, to imagine stationary objects to be moving. The cause of failure is usually due to concentration, staring, looking fixedly at a stationary objects, and efforts to try to see.

When success is not attained, hold the finger about six inches from the chin while looking at distant objects and move the head and eyes from side to side, taking care not to look directly at the finger. When this movement of the head and eyes is practised

easily, continuously the finger appears to move. This method is called the variable swing and most people have no trouble whatever in imagining the finger moving. The length of the movement of the finger is much wider than stationary objects regarded at ten, twenty, or forty feet or farther.

Practice with fine print is one of the best methods of relieving hypermetropia. The fine print is held first at the distance from the eyes at which the patient sees best and gradually brought closer until the patient can read it at six inches from his eyes. He should not look directly at the letters; he should look at the white spaces between the lines and imagine that this is a thin white line beneath each line of letters. Correct practice with fine print daily has cured many hypermetropic patients. A girl of 10, wearing glasses of 2.0 was cured in two days. A boy wearing plus six glasses was cured in a week's time.

Case Reports

The most difficult thing for a patient to do is to discard glasses immediately. When a patient comes to us, recommended by his physician or oculist, we have no difficulty in this respect, even though he had worn glasses for many years. But when a patient comes for treatment at the suggestion of a friend or someone who has been benefited by the Bate's Method, there is sometimes a doubt in the patient's mind as to whether it is a mistake or injurious for him to stop wearing his glasses immediately, after having worn them for a long time.

About a year ago a patient came to me. Headache, nausea, and continuous pain in the back of his neck made him irritable and nervous, and sometimes he was not a very agreeable person to keep company with; a neighbour told him about my clinic and how his children were cured of imperfect sight.

The patient felt quite comfortable at times with the glasses he wore and because they helped him to see better, he wore them almost constantly. He had worn plus glasses for more than five years and during that time he had changed them thrice. The last glasses he wore did not help him when he first put them on. The oculist informed him that he would have to wear them for a few weeks until he became accustomed to them. They were much stronger glasses than those he had worn previously and for that reason the oculist told him that his eyes would adjust themselves to the glasses in time. He felt alright with these glasses for a few hours every day but towards the end of almost every day headache, nausea, and discomfort became a regular occurrence. When he visited my office for the first time he did not know that the glasses he was wearing were the cause of his pain and discomfort. In fact he did not altogether believe that I was right in the diagnosis. Somehow I convinced him that he must put away his glasses if he wanted a cure.

On the first day I taught him to keep the upper lids down so that the eyes may remain half open, and to blink frequently. I noticed that he did not breathe regularly and advised him to do so. He made it a practice to blink as he inhaled and exhaled, so one thing reminded him to do the other. He looked into a mirror and noticed that his eyes moved slightly as he blinked, and the movement of the eyes gave him a

sense of relaxation which he did not have while wearing his glasses.

The second day he wanted very much to put on his glasses again because he woke up that morning with a terrible headache. He was almost sure that I was wrong about the whole thing. He telephoned to me and argued the matter with me. He was much surprised when I told him that he might have strained his eyes during sleep. How absurd this seemed to him, but I was right about this and I explained to him how he could be relieved of this strain.

I advised him not to sleep more than two hours at a time. He placed his alarm clock on a table beside his bed and set the alarm to ring two hours after he had fallen asleep. Being a light sleeper he did not wind up the alarm to ring more than a second or two. In this way he did not awaken anyone else in his household. If he had a dream during these two hours of sleep, he had a pad and pencil near him to write down what he could remember of his dream. He practised the long swing for five minutes or longer every night and morning in addition to other things. Every morning he enjoyed the sun and practised palming and read fine print card. In a week's time the patient became quite alright.

2. A man fifty years of age began to wear glasses of 1.0 from the age of forty for near work. He had the habit of looking through these glasses at a distance also when anybody came to see him and did not care to remove them while looking at the distant objects. He knew that the distant objects were seen hazy through these glasses. Gradually the sight began to deteriorate both for distance and near. Few black thread-like spots appeared before his eyes and their appearance was annoying to him. At the age of 48 he had consulted a doctor who had prescribed glasses of plus two for distance and plus 3.5 for reading. Though it is a general belief that hypermetropia is congenital and the normal eye does not become hypermetropic especially in old age but many such cases are noticed during the course of practice and are usually ignored as they went against the orthodox theory of hypermetropia.

His vision in each eye was 10/40 without glasses and 10/20 with glasses. He could not read any letter of the Fundamental card without glasses. While he was reading the reading test type with his glasses, he looked at distant objects several times without removing his glasses. He kept his head lowered so that his chin almost touched his chest and then tried to look through the margin of the glasses. This produced a strain which the patient did not believe at first was the cause of hypermetropia.

This patient was quite intelligent and reasonable. He was enthusiastic to know what were his mistakes which caused eye strain and hypermetropia, and how he could make his sight worse by increasing the strain and how he could relieve the strain to improve his eyesight.

I taught him to raise the chin and blink frequently while looking at distant objects. I encouraged him to do the long swing, not paying attention to stationary objects in the room. Occasionally I had to remind him to keep his chin up like a soldier and blink gently at each side movement. His vision improved

to 10/20 in less than a half hour's time. Having no sun shine on that day I asked him to face the strong electric light with the eyes closed.

Next day he brought his daughter twelve years of age. Her vision was tested and found to be normal. Her father said to her: "Can you tell that the largest letter on the test card is blacker than the very small letters." The child intelligently declared that the large letter was not blacker or clearer than the smaller letters. The father then asked his daughter how she explained that she could see the small letters better than large ones. She replied that the reason she saw small letters better than large ones was because there was not so much to see.

The patient then realized that his central fixation was not so good as hers. It was difficult for him to imagine the top of a letter best and the bottom worse or to imagine the bottom best and the top worse. He invariably saw both at the same time nearly equally well, while the daughter always saw one part of a letter at a time, the upper or lower, best. To improve his central fixation I placed two charts three feet apart at a distance of five feet from him. When he looked at the big C on the right hand chart, the C on the left hand chart was seen worse and the C regarded on the righthand chart was seen blacker and clearer than the other C. Next I shortened the distance in between the charts successively to two feet, one foot, and six inches, with a constant improvement in central fixation; and finally he became able to look at the bottom of the letter and see the top worse, or look at the top and see the bottom worse. With practice he became able to look at the smaller letters in the same way, and finally he became able to read the ten feet line at 10 feet.

This day we had sun shine and while the patient resented the strong light of the sun at first as the sun glass was used on his closed eyelids, he soon became accustomed to it and liked it, asking for more.

To improve the near vision the patient was advised to practise on the fine print card, and in a week's time he became able to read the fine print in good light. Glasses of 1.5 made the reading quite comfortable in the dimlight or in the artificial light. He practised palming for a few minutes now and then during the waking hours, and made it a routine to read the fine print with or without glasses.

NOTICE OF AMENDMENTS

(1) Amendment by Dr. V. D. Sathaye, 502, Narayan Peth, Poona.

After Rule No. 181 add new rule:—

Meeting of the Standing Committee:—A meeting of the Standing Committee will be called either on requisition by 15 members as per rule 182 or by the President in consultation with the General Secretary and with the consent of ten members of the Standing Committee.

Rule 150:—Substitute as follows:

He shall send every week the following to the Manager, Indian Medical Journal and the General Secretary:—(1) list of new members enrolled during the week. (2) List of defaulters during the week (3) change of addresses if any.

He shall also send to the respective provincial secretaries, the list of new members, list of defaulters, and change of addresses during the week, in their respective branches.

(2) Amendment by Dr. Khan Chand Wohra, Chichawatni, (Punjab.)

Rule No. 231, 2nd line, substitute "Inter Class" for "third class". Last two lines substitute "Rs. 2/- a day" per Re. 1/- a day.

3. Dr. K. P. Ghosh, Secy., Chittohong Branch writes:

I like to put this question in next Annual Conference at Poona.

(1) Central Head-quarter of our Association should be either in Delhi or in Calcutta and all the sections as Journal, Finance, Secretariat should be in one building.

(2) General Secretary should get a reasonable pay so that he can work efficiently.

(3) From the Association, Post Graduate courses should be arranged in connection with some big hospital, so that among us, those who are willing to have can get.

Fees and accommodation will be arranged by the candidates themselves.

Medical Licentiates Conference Chindwara District

Second Conference of the Medical Licentiates of the Chindwara District was held under the auspices of the All-India Medical Licentiates Association in the Panch-Valley-Indian-Institute Hall at Barkan on 25th and 26th May 1946. The Hall was decorated to choice and was full to its capacity. Nearly one hundred persons were present. The Medical Licentiates from other mining areas in the Province and in Central India were also present.

Chairman of the Reception Committee Dr. Banerji gave a hearty reception to all. The Secretary Dr. Tembhekar of the "Mining Area" Branch gave a short history of his Branch. Then was delivered the Presidential address by Dr. G. K. Kulkarni in his forcible and unmistakable terms.

Hon. Minister Dr. Hasan was then requested to give his inaugural address. The Hon. Minister assured the Medical Licentiates that he was fully aware of the injustice done to the Medical Licentiates and that he would do all what he could to remove the wrongs done to them.

Exhibition was then opened by Capt. A. E. Douglas the representative of Shaw Wallace & Co. The Stalls were very beautifully decorated. All the guests of honour, conspicuous amongst whom were Mrs. Hasan, Mrs. Kulkarni, Mrs. Bhate, Mrs. Tembhekar, Dr. Sen of Naweagon Sanatorium, Dr. S. V. Kale, Civil Surgeon, Chindawara were taken round by the President and then were entertained to a tea-party. Photo was also taken.

Scientific session was most lively and successful as all the Doctors took part and discussed many diseases. Dr. Sen of Naweagon gave lines of treatment of all those diseases according to Homoeopathy.

In the open session very many important resolutions affecting the Medical Profession were unanimously passed. Thanks-giving was a very difficult job for Dr. Bhate who said that he did not know whom to omit, because all had so sincerely co-operated with the Reception Committee. He made a special mention of Capt. A. E. Douglas, but for whose co-operation the Conference would not have been held at all. Mr. Puransingh Verma, Assistant Manager, for his active help and Mr. V. S. Asolkar, Head-master, Panch Valley School, who so beautifully managed the Boarding and Lodging of the delegates.

Tea was served by Messrs Midland Laboratory, Nagpur and the Conference came to a successful termination.

Presidential Address by Dr. G. K. Kulkarni

It gives me a great pleasure to find amongst us one of the popular Ministers and that too in the person of Hon. Dr. Hasan, about whom I must say as little as possible for fear of flattery. I know him since long and I can only say that we can safely look to him for all help and our interest is safe and well guarded now.

I do not want to detain you long by narrating the same old old woeful stories of the past which are all disappointing and disgusting. It has been amply proved that the Licentiate holders have been treated very shabbily by the authorities and in the Profession.

I shall be however failing in my duty if I were not to make my young friends realise that in the Medical Profession they are not "Doctors", they are Licentiate holders—Licence Holders. They hold licence in medicine and not in Bhan, Ganja, or Charas and therefore they are called Medical Licentiate holders. They are no better than other licence holders minus wealth. They are holding the position in the profession so low. Some of the graduates have made themselves bold to say that the Licentiate holders are no better than Compounders.

I am however happy to say and proud to point out that in spite of all such humiliating treatment by the vested interest which should be neglected with the contempt it deserves, the Licentiate holders have served the country and humanity in times of war, famine and epidemics and have won the laurels of the highest authorities—Civil and Military. In the last war the names of so many Licentiate holders have been mentioned in Despatches. Then what does it matter if few interested were to look down upon the Licentiate holders?

Unfortunately these few in combination with the Government are carrying the day. The All India Medical Licentiate Association has to face such a powerful combination and certainly it is a very hard job. But with our moral strength we have been able to knock out certain facilities—though they are so negligible. Fortunately now the days are fast changing and the minority cannot hold long.

I shall take only the most important points which deserve special consideration.

Medical Education.

We all know and I have also said just now that the Licentiate holders are considered by the vested interest no better than Compounders. It clearly means that these duly recognised Medical Schools are producing under the false name of "Licentiate holders" only Compounders. Why this vested interest does not make itself bold to charge and sue the Government for cheating the public for giving Compounders instead of Doctors to the Public? Since it has not been done so far it means this vested interest wants to perpetuate this class for its selfish interest. Ladies and Gentlemen, I assure you, it is a great hoax. Intelligence is not the monopoly of A or B. Merit must count. Those who are creating hindrances and the Government which are banging the doors against the Licentiate holders who may be attempting to get out of this stagnated and and water-tight compartments, are morally criminal. Fortunately now we in C.P. can breathe the sigh of relief since we are having a Medical College which will permanently do away the caste distinction in our province. Here I must say a few words more. The C. P. Government know quite well that medical aid has been and is being given to the remotest possible corner of the province through the Medical Licentiate holders whose maximum salary—may wages—is Rs. 125/- p.m. only. The Medical Licentiate holders cannot afford within such a meagre and beggarly pay to avail of the High School Education even to their sons or daughters, then what to talk of Medical Education. It must be admitted that a son of a medical man is more adaptable to the medical profession than a son of a goldsmith. It is the moral obligation of the Government therefore to afford all sorts of facilities and preferences to the sons or daughters of a medical man specially the Medical Licentiate holders while admitting students to this Medical College. This point has already been stressed in the Deputation which waited on the I. G. C. H., on 8th January 1946 and I once again like to remind the Government of the same. Medical Licentiate holders deserve no less preference in post-graduate courses in view of the low salary they are given. These post-graduate courses must enable the Licentiate holders to hold higher posts.

Medical Councils.

One of these is the Provincial one and the other is the Indian Medical Council. Regarding the Provincial Medical Council I have already moved a resolution asking for the amendment on the lines of the Madras Medical Council. The resolution has been unanimously adopted. We had no legislature and hence no further attempts could be made. Now we have it and to add to it we have the popular Ministry which I have no doubt will surely agree to my proposal. Hence I refrain from criticising the Provincial Medical Council Act which is too old and rusted to suit the present requirements.

Regarding Indian Medical Council Act I must say that it has become scandalously proverbial amongst the Medical Licentiate

holders who have been protesting against it since its very birth. One cannot resist saying that it was the master-piece of the autocracy of the British Medical Council. Acceptance of the position by the members of that Council was a great National disgrace and personal humiliation. National disgrace because the British Medical Council was to dictate and the Indian Medical Council was to act so far as reciprocity was concerned. Indian qualifications may not be recognised by a country but the qualifications granted by that country must be accepted by the Indian Medical Council because the British Medical Council had recognised it. Indian Medical Council dared not to refuse recognition. Personal humiliation because the members of this August body were some time or the other either Professors or Examiners of those who were duly declared to be competent to practice Medicine, Surgery and Midwifery. By the refusal of the recognition of such duly declared competent students by these members themselves means they themselves say when they sit in those judgment chairs that they were either incompetent to examine the students or they have falsely declared the students as competent. What a great hoax it is? The only honourable course for these big guns was and is even now to walk out from the Council in protest for such humiliation if not for their students—the Licentiate holders—at least for their own prestige. There are many anomalies in the Act. It says to fix minimum standard for higher qualification in medicine throughout India. If the Act wanted to standardise the higher education what about the standardisation of the lower qualification. Should every Province have any and every standard of education?

In short, the Indian Legislature swallowed the threat of non-recognition of the Indian Medical graduates by the Medical Council of Great Britain and the Indian Medical Council followed the dictates without giving a moment's thought to the National respect and honour. Is it not the Hitlerism of the British Medical Council and slavish mentality of the so-called leaders in a Medical Profession? The Indian Medical Council has sacrificed the interest of their own kith and kin to appease the foreigners. It is, however, never too late to mend and let these leaders realise their own mistakes and let their own young ones be duly recognised, come what may. I for one refuse to believe that the Licentiate holders' education as imparted today is in any way insufficient. My statement is borne out by facts and corroborated by reports and despatches of the highest Indian and British Officers.

The All India Medical Licentiate Association is advocating abolition of this class only out of sheer disgust for the inhuman treatment meted out to the Licentiate holders. One finds distinction everywhere. The Licentiate holder is not even allowed to join certain post-graduate courses; for example; D. P. H., D. T. M. Calcutta, but is asked to join L. T. M., D. P. H. Y., the curriculum of which is just the same as that of D. P. H., but the prospects to the possessor of D. P. H. and D. P. H. Y. are different. Can there be any greater injustice?

Another instance is that of Malaria Experts. Those Licentiate holders who have actually worked and worked too to the greatest satisfaction and won the laurel are superseded by the newly trained outsiders. Why? Government only can explain with due regard to sense of justice. If the Government would have been wise and sensible enough to remove such wrongs the All India Medical Licentiate Association would not have any reason to commit the suicide.

In this province as in others, the Government has decided to abolish the Schools and it is a very happy thing. I must, however, say that the fad for lengthy courses of studies has already started melting. Need of the country has to be looked to. This brings me to the Bhoré Committees' report. I can dare say that it is a fine wranglership and play of figures. Millions are dying by starvation and epidemics. They want something immediate. I cannot resist the temptation to point out certain things from the report. It advises to have primary centres, secondary centres and District Head quarter centres containing varying numbers of beds. When the whole country requires beds how these few beds can be sufficient? The question is not to arrange for beds so much as it is to remove the necessity for beds.

Bhoré Committees' report talks of milk, milk products, preservation of milk and research. I would like to ask anyone "but where is the milk?". How can we think of milk products, its preservation when all the milking animals are or are being slaughtered. Those who talk of such hollow sounding schemes must first advise the Government that slaughtering of milking animals should be made crime by law. I find no advice of such a kind anywhere in the report. In my opinion, therefore, the report is a criminal waste of money and time. Let the power that be, give the rural population actually something real—never mind

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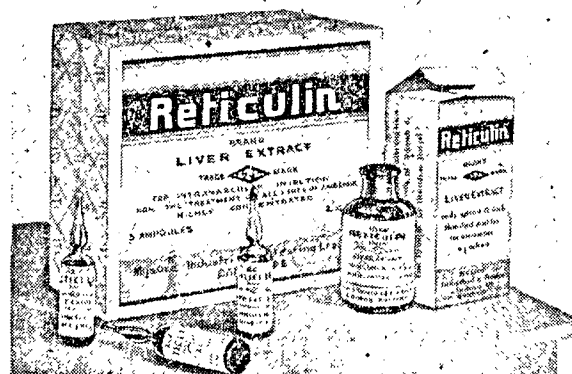
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ALBERT DAVID'S Milk Protein 'SIOLAN' is therefore worthy of a permanent place in your surgery.

We shall be proud to supply your regular requirements,

and remain, Dear Doctor,

Yours faithfully,

ALBERT DAVID LIMITED.

August, 1946]

ASSOCIATION NOTES

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how little it is. Only schemes and words are not going to save the millions dying from preventable diseases and malnutrition. We can proceed then with any scheme or plotting and planning. I am here reminded of one sentence published some time before in "Hindu" of Madras. It is this? "The recommendation of Lovett Committee furnishes a striking illustration of the art of contriving a method of reforms which will leave the matters exactly where they are". I believe none can disagree.

It is a matter of great regret that we appreciate the reports of the foreigners while we do not care to give a moment's consideration to the simplest plans placed before us by our own and world's greatest leader Mahatma Gandhi. How much time we are inclined to give to think what he means by "Village-uplift." The urban population requires improvement trust, best sanitation and excellent Medical aid. Is it that the rural population can safely do without them all? As I conceive "The Village Up-lift" means that the huts of the villagers should be properly grouped with due regard to drains, proper arrangement for drinking water should be made, and adequate medical aid should be provided.

I do not propose to deal in details the problem of pay. I would only say that it is cruel to offer such a meagre pay to the Licentiate who actually bears the brunt in the profession. This meagre salary—I would say wages—ruins the Licentiate as well as his sons and daughters who cannot be given any higher education. We are living in the Age in which cruelty to animals is considered to be a crime. Will the eyes of the authorities be opened?

Still more cruel and merciless treatment is given to released Licentiates from I. A. M. C. When their services were badly needed the help of the All India Medical Licentiates Association was sought. The help was wholeheartedly given by the Association and in every province the main and influential office bearers of the Association took up the work of the Civilian—Recruiting Officers. Many unwilling Licentiates were prevailed upon to join war service. What is their fate now? They are asked to return to their previous jobs, with no change whatsoever.

Disappointment and disgust for all these shabby treatment have surcharged the atmosphere with an idea of absolute non-cooperation with the power that be—not strike, a step beyond. I, however, request one and all who may have that idea to have patience. I would request them not to use the sharpest weapon because I don't know how far the power that will be affected but surely the suffering humanity—our own brothers and sisters will be hit very hard. I request them to remember that we are born for relieving the sufferings of the humanity and not to increase it. The I. A. M. C., people some of them actually have shed their blood on the battle field, have suffered very heavily at the hands of the enemy. The Licentiates have a glorious past and present. Please do not be disappointed and disgusted. Let us try again. We have now our own people in power. Let us hope—hope is life. They will understand us quickly and easily and will try to remove our sufferings. I am always optimistic and believe in trying. We shall try once over again, communicate all our grievances, personally if needed and if we fail then we shall see. Please don't be impatient. Rely and believe in our own brothers. We have now no reason to distrust. We are all one and let us as one relieve the sufferings of our brothers and sisters.

ASSOCIATION NOTES.

Jalpaiguri Branch.—Meeting of the Jalpaiguri Branch of the All-India Medical Licentiates' Association, held on 10-2-46, in the District Board meeting hall.

Resolution Passed.—"This meeting of the Jalpaiguri Branch of the All-India Medical Licentiates' Association expresses its deep sorrow at the sad death of Sir U. N. Brahmachari, Kt., M.A., M.D., Ph. D., a scientific luminary in the medical world and one of the best and renowned physicians in the medical profession of India, effect of whose fruitful research work, saved millions of lives in India and abroad."

Jalpaiguri.—Proceedings of the annual General Meeting held on 27th January, 1946.

1. 18 Members were present.
2. Dr. Saradindu Chatterjee was elected unanimously the chairman of the meeting.
3. It is resolved that the secretary's report with the account for the year 1945 be adopted unanimously.

4. List of the Annual Report.

No. of members at the beginning of the formation of the branch ... 4.
No. of members at the end of the year 1945 ... 51.

Meetings held in the season:—

General Meeting ... 3.
Ext. Com. Meeting ... 4.
Scientific Meeting ... 1.
Subject discussed in the scientific meeting—
Blood Transfusion by Lt. Col. S. Anna-swami, I.M.S.

STATEMENT SHOWING THE ACCOUNTS OF THE ALL INDIA MEDICAL LICENTIATES' ASSOCIATION, JALPAICURI BRANCH FOR THE YEAR, 1945, RECEIPT

	Rs.	As.	Ps.
Realised as subscription from members	159	0	0
Extra subscription realised	16	0	0
	175	0	0

EXPENDITURE

	Rs.	As.	Ps.
Remitted to the central office as subscription of the members of the Branch	122	0	0
M. O. Commission	1	6	0
Subscription fee	10	0	0
Entertainment Cost	28	3	3
Postage etc.	12	13	0
Stationeries	10	2	0
	184	8	3

5. Budget for the year 1946.**INCOME**

	Rs.	As.	Ps.
Subscription from the members 39×6/-	234	0	0
Student members 12×3/-	36	0	0
	270	0	0

EXPENDITURE

	Rs.	As.	Ps.
To be remitted to the Central Fund a/c subscription 39×4/-	156	0	0
Student members 12×2	24	0	0
Stationeries etc.	18	15	0
Postage	20	0	0
Propaganda Expenditure...	50	0	0
M. O. Commission	2	8	0
Entertainment Expenditure	25	0	0
Almirah	75	0	0
Peon	60	0	0
Provincial Fund	10	0	0
	441	7	0

Resolved that the budget for the year 1946, estimate of Rs. 270 income and Rs. 441-7-0 expenses is considered and adopted by the members present.

6. The following office bearers have been elected for the year 1946:

President ... Dr. S. C. Bhowmik.
Vice-president ... Dr. P. C. Saha.
Secretary ... Dr. J. N. Moitra.
Jt. Secretary (i) ... Dr. N. Ghosh.
(ii) ... Dr. Md. Solemen.

Treasurer—will be the Secretary.
Managing Committee will be composed by the following members:—

- (1) Dr. C. H. Gupta.
 - (2) Dr. S. Chatterjee.
 - (3) Dr. Ganesh Roy.
 - (4) Dr. S. N. Majumder.
- Elected unanimously.

7. It is resolved that the scientific monthly meeting will be held on the first Sunday of every month. It is also resolved that the secretary with consultation with the secretary, I. M. A. will inform the venue of the meeting to the members.

8. Resolved that the mother Association be requested to move to proper authorities concerned and the members of the Indian Medical Council to enforce the Indian Universities to give facilities to Licentiatees for undergoing training in the Post Graduate classes under the Universities in different Provinces. Proposed by Dr. S. C. Bhowmik and seconded by Dr. N. Ghosh.

9. Be it resolved that in view of the fact that the Licentiate Medical Practitioners of India joined the I.A.M.C. ungrudgingly at the call of A.I.M.L.A. endangering their valuable lives and even future prospects, in consideration of the facts that some Licentiatees after the joining I.A.M.C. have proved themselves as efficient as any graduates in the cadre and some of them have been received decorations from the military administration for their gallantry and valuable and efficient medical service in I.A.M.C. This Branch of A.I.M.L.A. do hereby earnestly requests the mother Association to move the Government of India and the authorities concerned to induce them to give permanent commission to Licentiate I.A.M.C. officers.

10. It is resolved that the General Secretary of the mother Association be requested to help this branch of the Association for the deficit budget so that the account of this branch may be balanced according to the branch secretary's note, submitted to the General Secretary on 22-9-45 ... proposed by Dr. S. B. Bhowmik and seconded by Dr. N. Ghosh ... Passed unanimously.

N. W. Ry. Branch (Lahore):—Minutes of the Annual General Meeting of the All-India Medical Licentiatees' Association, N. W. Railway Branch held at Lahore on 10th February 1946.

Fourteen Railway Medical Licentiatees representing various divisions of N. W. Railway were present and under the Chairmanship of Dr. M. N. Karmarkar, the following business was transacted:—

1. The minutes of the last meeting held on 29th July 1945, were read and confirmed.

2. Resolved unanimously that in view of the latest recommendations of the Administrative Medical Officers Conference held under the Chairmanship of Lt.-General J. B. Hance at New Delhi in November 1945 and with a view to adequately compensate for the non-provision of rent-free quarters and limited scope of private practice in Railway medical service, the Railway Administration be approached for the immediate enforcement of I.R.C.A. Resolution MD/122 of March 1944 with the following modifications.

(i) Substitution of the existing rank of Sub-Assistant Surgeon by that of Medical Officer grade II.

(ii) Scale of pay Rs. 185-15-350.

(iii) Promotion from grade II to grade I Medical Officers:—33½ per cent of the total number of grade I Medical Officers, posts be reserved for promotion from amongst the medical licentiatees of outstanding efficiency with over ten years professional experience and holding additional post-graduate qualifications.

(iv) Special posts, viz., House Surgeonship, 'X' Ray Antibiotic, Anaesthesia, Laboratory, etc., be very adequately compensated.

(v) Scale of fee for attendance on families of Railway employees:—

(a) Pay below Rs. 50 ... Free attendance.

(b) Pay Rs. 50 to Rs. 250 ... Rs. 2 per visit.

(c) Pay Rs. 251 and upwards ... Rs. 3 per visit.

(iv) Study Leave:—Ample provision be made under the rules to extend privileges of study leave to medical licentiatees desirous of post-graduate studies.

3. Resolved unanimously that the Railway Administration be requested that Railway Medical Licentiatees on demobilisation from I.A.M.C. be granted an improved status worthy of their Military rank. Their Military service be counted double towards pay and promotion, etc., and they should be provided ample facilities for graduation.

4. Resolved unanimously that a deputation consisting of Drs. S. S. Jettley, M. A. Rehman, D. D. Aggarwal and Capt. Mohinder Singh Plato, I.A.M.C. should wait upon Dr. N. Ahmed, Officer on Special Duty, Railway Board, with a view to discuss at length and convince him of the genuineness of the grievances of Railway medical licentiatees.

5. Resolved that S. Guruswami, M.L.A., (Central) be approached with a request to accept the partnership of the N.W. Railway Branch A.I.M.L.A.

6. The following were elected as office-bearers for the year 1946:—

1. President, Rai Bahadur Dr. Mathra Dass Pahwa.
2. Working President, Dr. M. N. Karmarkar.
3. Senior Vice-President, Dr. M. A. Rahman.
4. Junior Vice-President, Dr. Daya Ram.
5. Branch Secretary, Dr. S. S. Jettley.
6. Joint Secretary, Dr. Devi Dyal Aggarwal.
7. Treasurer, Dr. Hakim Rai.

Division	Divisional Secretary	Asst. Divl. Secretary
Lahore	Dr. Jaimal Singh	Dr. Mohd. Sharif Chowdry.
Ferozepore	Shadi Ram Sud	Dr. H. C. Jain.
Rawalpindi	Roshan Lal Soni	Kahan Chand Maini.
Delhi	Kundan Lal	Dr. Mohd. Ahmed
Multan	Harkishan Lal	Behari Lal
Karachi	Amar Nath Kapur	Devi Dyal Ahuja
Quetta	Mohd. Yusuf Toor	Roshan Lal Makol

7. Accounts relating to receipts and disbursements for the year 1945 were scrutinised and passed.

Bengal:—A meeting of the Provincial Standing Committee was held on 11-3-46 at 5-30 p.m. at 27, Dixon Lane Calcutta.

The following members were present.

1. Dr. A. D. Mukharji (in the Chair), 2. Dr. K. P. Sen, 3. Dr. R. N. De, 4. Dr. B. Lahary, Howrah, 5. Dr. T. N. Bhattacharjee, Pabna, 6. Dr. J. Majumdar, Cal. (could not remain as he had to go away due to some pressing engagement) Capt. S. L. Roy, ex-I.A.M.C., was present by invitation.

The following resolutions were passed.

1. Received the Provincial Secretary's letter intimating his inability to attend the meeting and noted contents.

2. In the absence of the minutes book the proceedings of the last meeting could not be confirmed.

3. Considered the proposal of electing a Joint Provincial Secretary and resolved that this meeting does not find any urgency for this office at present.

4. Resolutions passed by the last Howrah Conference were circulated to the branches and to the persons and authorities concerned in the various departments and results are awaited.

In pursuance of a resolution of the said conference a deputation consisting of nine persons headed by Dr. A. D. Mukharji, Provincial President, waited upon the Surgeon General to-day—a copy of the Memoranda was placed before the meeting and approved by the same.

5. The Reception Committee of the last All India Conference, Calcutta, has not yet closed the accounts and as such the same could not be placed before this meeting.

This meeting however requests the Reception Committee to close the accounts and place the same before the next meeting of the Provincial Standing Committee.

This meeting also requests the Reception Committee to donate Rs. 250 to the funds of the proposed Congress Medical Mission to Malaya, out of the funds of the Reception Committee immediately.

6. Read the letter of the Munshiganj Branch and papers connected therewith.

Resolved that as questions of observance of medical ethics by two professional men are involved in the issues the Branch Secretary or the aggrieved doctor be requested to refer the matter to the Registrar of the Bengal Council of Medical Registration for any action the Council might deem fit and proper.

With a vote of thanks to the Chair the meeting terminated.

Memorandum submitted by the deputationists on behalf of Bengal Provincial Branch of the All-India Medical Licentiatees' Association re: the service questions, on Monday, the 11th March, 1946, to the Surgeon-General, Bengal.

(1) Number of Sub-Assistant Surgeons to be promoted to Assistant Surgeon cadre be fixed at 12 per cent of the strength of Sub-Assistant Surgeons.

(2) Number fixed for promotion to the selection grade of Assistant Surgeons be strictly adhered to and whenever vacancies occur these should be filled up.

(3) The following posts which were held by Sub-Assistant Surgeons in the past have been by gradual processes taken away from them:

(a) Assistant to Police Surgeon, Calcutta.

(b) Deputy Superintendent, Voluntary Lock Hospital, Alipur.

(c) Teacher of Physiology and Pathology in Mofussil Medical Schools.

(d) Demonstrator of Materia Medica in Campbell Medical School.

(e) Anaesthetists in Campbell Hospital.

(f) Sadar Hospital Appointments.

The Deputation resents this and urges upon the following posts being made over to Sub-Assistant Surgeons:

(a) Additional Teacher of Clinical Surgery in Campbell Medical School and Hospital.

(b) Resident Surgeon and Physician in Campbell Hospital.

(c) Sadar Hospitals which were managed creditably by them all these years.

(d) Medical Officers Posts in Venereal Clinic of Government.

(e) Teachership of Physiology and Pathology in Mofussil Medical Schools.

(4) The rank of Sub-Assistant Surgeons be abolished and replaced by a single Provincial Medical Service throwing open its door to all qualified medical practitioners including Licentiatees but till such time this is not achieved the pay of Licentiatees in service be fixed in the grade of Rs. 200—500.

Sub-Assistant Surgeons attached to teaching work in Medical Schools and other appointments in jails and elsewhere which entails non-practice a special non-practising allowance ranging between Rs. 75 to Rs. 100 per month be sanctioned.

Radiologists be allowed to get 90 per cent of the fees as received by Pathologists.

Risk allowance be also admissible to S. A. S. Radiologists. House Rent allowance for all S. A. S. Rs. 30 for Mofussil and Rs. 50 for Calcutta and big towns.

(5) (a) Demobilised I. A. M. C. Commissioned Officers, belonging to B. M. S. (Lower) be all promoted to Assistant Surgeon's cadre.

(b) Any scheme of Government of Bengal for their future rehabilitation be announced.

(c) Whether period spent on War Service would be counted double for fixing pay.

(d) Whether rank held to be retained by these officers.

(e) Whether they would be allowed to retire on proportionate pension.

6. Sub-Assistant Surgeons selected for I.A.M.C. but not released by Government for active service should get special facilities in service and further study.

7. Sub-Assistant Surgeons should be granted study leave for 2½ years on full pay plus a gratuity to prosecute their studies for higher education.

(8) Subsistence allowance for House Officers in Medical School Hospitals be fixed at Rs. 75 at the least for Junior and Rs. 100 for Senior with free lodging.

(9) Surgeon General should not refuse interview to Sub-Assistant Surgeons seeking to see him with permission of their superior officers. Recently this practice is very much on the increase.

(10) Tenure of each post be fixed and transfers be not made before the period is over and in the middle of the year.

(11) Temporary Sub-Assistant Surgeons should be absorbed in the permanent service and those who would not be able to be absorbed because of advanced age and other factors be granted a gratuity of Rs. 1000 to enable them to settle up.

(12) Lady Doctors in Sadar Hospitals should be brought in a scale to be fixed at Rs. 200-500.

(13) Honorary Appointments to public Hospitals be thrown open to Licentiatees and deserving and experienced amongst them be provided with some of these posts.

(14) The posts of District Medical Store Keepers be thrown open to Medical Licentiatees.

(15) To safeguard the interest of Licentiatees serving the Government a post of a Special Liaison Officer from Licentiatees be created in Surgeon General's Office with a high basic pay ranging between Rs. 500-1000.

(16) In any Committee appointed by the Bengal Government re: the Rehabilitation of demobilised medical personnel or any other question affecting the profession representatives of this Association be provided with seats.

1. A. D. Mukharji, President, Provincial Branch A.I.M.L.A. 2. Dr. K. P. Sen, 3. Dr. T. N. Bhattacharjee, 4. Dr. J. N.

Sarkhel, 5. Dr. J. Majumdar, 6. Dr. A. Sen Gupta, 7. Dr. G. Ahmed, 8. Capt. S. L. Roy, I. A. M. C. 9. Dr. A. N. Roy, General Secretary, A.I.M.L.A.

Dr. Mukharji opened the discussion in which all members took part.

The Surgeon General patiently heard all the points and sympathised with the issues raised and promised to do his best to help the members of the services as much as he can. After which the deputationists dispersed.

Dacca Secretary's Report for the year 1945:—Eight meetings were held during the year including general, managing and clinical lectures. Besides considering various circulars and letters from the General and Provincial Secretaries, the following matters were also transacted.

1. Approached the Civil Surgeon for the redress of grievances of our fellow brethren on many occasions.

2. Given all possible assistance to the Licentiatees intending to join I. A. M. C.

3. Did relief works in collaboration with Dacca District Medical Relief Organising Committee.

4. Observed anti-medical Council day.

5. Met the Civil Surgeon and discussed with him about the condensed M. B. Course for the Licentiatees.

6. Attempts have been made for arranging Clinical Lectures in the Mitford Hospital open to all.

7. Waited in deputation on the Civil Surgeon on behalf of Hony. R. M. O's, (Mitford Hospital) 'Strike' and their grievances were all redressed.

8. We have reopened our Medical Club at Baboo Bazar (opposite to Mitford Hospital).

9. We had only 16 members in the District (six years back) and at present we have two more branches in Narayanjanj and Munshiganj Sub-Division and another branch is shortly going to be opened at Manikganj Sub-division and total numbers of members of this Branch exceeded 150 (One hundred and fifty).

Mymensingh 1. —A general meeting of the Branch held on 23-12-45 with D. B. Chowdhury in the Chair. Seven members were present.

1. Resolved—to request the authority concerned to show proper consideration and justice to the Medical Officers of I.N.A., in the post-war reconstruction of India.

2. 4 Delegates were selected for the Bengal Provincial Conference at Howrah.

3. A scientific paper on Anaemia of Pregnancy was presented by Dr. D. N. Chowdhury.

4. Resolved that Rs. 15 will be donated to Howrah Branch for the ensuing conference.

5. Resolved that resolution No. I, will be sent to All-India Conference.

Mymensingh 2. —A meeting of the Executive Committee was held on 29-1-46, to meet Dr. A. D. Mukherjee, the provincial president, with Dr. H. Bagchi in the Chair. All local members, Licentiate practitioners and local medical students were invited.

Dr. A. D. Mukherjee explained the service conditions of the licentiatees. He also dwelt at length on the present situation of the Licentiatees and pointed out their future programme. He urged the abolition of the dual system of medical education immediately, and asked this branch to urge upon the members of the Legislative Assembly and the public to exert pressure on the Bengal Government to convert the medical schools into Colleges without further delay and to abolish the Sub-Assistant Surgeons' Cadre. The local medical students were impressed by the talk and his advice to them was really valuable. He requested the students to devote their time to study so as to make themselves fit in every respect.

3. A meeting of the Executive Committee of this branch was held on 12-2-46, to condole the death of Rai Sahib Dr. N. K. Roy, Assistant Surgeon with Dr. B. Choudhury in the Chair.

Resolved that this meeting deeply condoles the sad demise of Rai Sahib Dr. N. K. Roy, Assistant Surgeon and late teacher of Anatomy, L. M. School, Mymensingh, and a member of A.I.M.L.A., and records its heartfelt sympathy with the members of the bereaved family. May his soul rest in peace.

Resolved that a copy of the above resolution be sent to Mrs. Roy, the wife of the departed. The resolution was read from the Chair, passed unanimously and after that, 2 minutes silence was observed.

4. A meeting of the local branch was held on scientific subjects on 15-3-46, with Dr. B. Chowdhury in the chair.

Dr. N. Chowdhury and Dr. L. Saha Chowdhury demonstrated plates of a case of "Thoracopagus with single Heart," Lt. D. C. Sen, I.A.M.C., read a paper on "Fever and its management", which was largely discussed and debated by Dr. N. Chakravarty, particularly about High Caloric diet in long

continued fever and about the difference in meaning of terms of Pyrexia and fever. Lt. Sen read a clinical note about Malarial Therapy as a treatment of Heart block. Dr. A. Talukdar read a paper on "Importance of Vitamins in Ocular Diseases". The meeting ended with vote of thanks to the chair and a light refreshment was served. 18 members and invitees were present.

Chittagong:—A meeting was held on 31st January to meet Dr. A. D. Mukherjee President, Bengal Province, on Thursday at 7.30 p.m., at our association room. 20 members were present. Dr. Mukherjee discussed the following points elaborately:—

1. Future of I.A.M.C., medical officers.
2. Amalgamation of our association with Indian Medical Association.
3. Unification of medical education with abolition of medical schools.
4. Condition of Subordinate Medical Officers in B. M. S. Service.
5. About Drugs Control Order.
6. Registration of medical licentiates in Indian Medical Council.

He also answered some questions from the members present. Meeting ended at 10 p.m., after vote of thanks to Dr. Mukherjee and slight refreshment.

24 Parganas:—A General Meeting was held on 31-3-46 at 5.30 P.M. at Dattapokore in the residence of Dr. Phani Datta, under the presidency of Dr. S. Sarkar. 15 Doctors were present.

1. Proceedings of the previous meeting held on 28-2-46 were read and confirmed.

2. Six new members were recruited and some money was realised for the Branch fund.

3. Resolved that Dr. Rajendra Nath Maschatak's place (Gobardanga) be selected as the next place of meeting in April '46.

4. The following resolutions were put forward by Dr. R. N. De and were carried unanimously:—

- (i) This meeting requests the authorities of the Calcutta Medical College and Carmichael Medical College to reduce the fees for the students of Condensed M. B. course and also requests the authorities of Calcutta University to withdraw the age bar at the time of admission for the Condensed M. B. Course.
- (ii) This meeting urges the India Government to make I.A.M.C. permanent and to admit the Licentiates in the permanent corps.

5. Interesting discussions on Mepacrine on Malaria (merits and demerits) were held by the doctors present and it was resolved that discussions on the treatment of cholera would be held in the next meeting.

II. A general meeting of the 24 Parganas Branch (Bengal) held on 28-2-46 at 5 P.M. at Dum Dum in the residence of Dr. K. K. Sen Gupta, under the presidency of Dr. S. Sarkar. 11 Doctors were present.

- (1) One minute's silence was observed condoling the death of Sir U. N. Brahmachari.
- (2) Proceedings of the previous meeting held on 25-12-45, were confirmed.
- (3) **Membership Campaign drive:**—Dr. P. B. Datta's place (Duttapokore) to be selected as next place of meeting in March '46 for having a drive for recruiting members.
- (4) **Branch Fund:**—Some money was realised on the spot of the meeting and it was resolved unanimously that an appeal to be sent to the existing members of the branch for the Branch Fund.
- (5) Resolved unanimously that the meeting strongly condemns the resolutions Nos. 2, 13 and 14 passed by the Standing Committee of the A.I.M.L.A. held in Delhi on 25-11-45 (Published in the I.M.J., Dec. '45).
- (6) Proceedings of the last Provincial Conference at Howrah were read out.

Nadla: (Bengal)—A monthly meeting was held on 24-2-46 at 7 P.M. in the house of Dr. K. R. Ray, Krishnagar. 75 Members were present.

1. The proceedings of the last meeting were read and confirmed.

2. The letters of the Bengal Provincial Secretary with the resolutions of the Howrah Provincial Conference and the copies of the Presidential address and Welcome Address etc., were placed on the table and discussed. The members of this branch much appreciated them.

3. Scientific discussions were made on Meningitis.

Budge-Budge:—Proceedings of the ordinary meeting held on 17-2-46 at 5 p. m. Dr. N. B. Sanker was voted to the Chair. Seven members were present.

1. This meeting, just at the outset, expresses a deep sense of sorrow at the death of Mr. H. S. De, father of Dr. (miss) S. De Secretary of the Association and conveys sympathy to the bereaved family.

2. Proceedings of the last meeting read and confirmed.

3. This Meeting gladly accepts the handing over of her charge by Dr. J. Bose, Jt. Hony. Secretary for two months during her stay outside for a change of climate and wishes a speedy recovery of her health and energy.

4. In view of the fact that there being a unanimous resolution in the last Provincial Conference held at Howrah to abolish the Honorary system of service, the local doctors belonging to this Association are requested not to accept any such job under any Government or semi Government Institution.

5. In connection with certain Honorary appointments of some of our local members in the Budge-Budge Hospital, the Jt. Honorary Secretary is authorised to carry on correspondence with the municipality and settle up the matter before the next meeting.

Bankura:—The Annual General Meeting was held on 7th February, 1946, in the premises of the Medical School at 9.30 A.M. 15 Members of the branch and 30 other licentiates from neighbouring districts were present.

a. Dr. R. N. Barat was unanimously elected President of the meeting.

b. The Annual Report for 1945 was read, considered and accepted.

"Annual Report for 1945"—The last Annual General Meeting was held on 4th January, 1945. Dr. R. N. Barat was President, Dr. N. Roy, Honorary Secretary and Treasurer and Dr. R. N. De, Joint Secretary.

The events in the period under review were:—

- (i) Number of members ... 56.
- (ii) Number of meetings ... 6 (General).
- (iii) Number of new members ... 5.
- (iv) Drs. R. De, N. Roy, R. Barat and S. Sengupta were delegates for 3rd conference at Calcutta.

c. The accounts for 1945 were audited and passed.

RECEIPTS

	Rs.	As.	Ps.
(1) Opening balance	389	13	0
(2) Subscriptions from members	47	12	0
Total	437	9	0

EXPENDITURE

	Rs.	As.	Ps.
(1) Postage	0	7	0
(2) Contributions:			
(a) Chairman, R.C.			
3rd conference	50	0	0
(b) A. B. Memorial Fund	10	0	0
(3) Salary (bearer)	28	0	0
(4) Miscellaneous	2	9	6
(5) Closing balance	346	8	6
Total	437	9	0

4. The estimated budget for 1946 was considered and accepted:

RECEIPTS

	Rs.	As.	Ps.
(1) Opening balance	346	8	6
(2) Subscriptions	45	0	0
(3) Bill collection from Assn.	35	0	0
(4) Miscellaneous	10	0	0
Total	436	8	6

EXPENDITURE

	Rs.	As.	Ps.
(1) Postage	15	0	0
(2) Contributions	40	0	0
(3) Salary (Bearer)	24	0	0
(4) Miscellaneous	10	0	0
(5) Closing balance	347	8	6
Total	436	8	6

5. The following were elected office bearers for 1946 and members of Executive Committee:

President:—Dr. R. N. Barat.

Vice-Presidents:—Drs. B. Ghosh and M. Ghatak.

Honorary Secretary and Treasurer:—Dr. N. Chatterji.

Members:—Drs. N. Roy, R. De, K. Das, S. Chakravarty, A. Banerji, N. Mukherji, S. Sengupta, A. Bose, Mr. A. Ghose, student.

They are empowered to co-opt two more members, in a meeting, if necessary.

6. This meeting thinks it a necessity to start a propaganda throughout the district to enlist all the licentiates (who are approximately 100) still outside the fold of the Association and urges the Association to help this branch with a financial help of Rs. 100/- and the Executive Committee of the branch is requested to draw out a detailed programme and to work out the programme in earliest possible time.

Karimganj:—A meeting was held on the 7th January 1946 at 5.30 P. M. at the premises of Dr. S. K. Das.

Dr. S. C. Paul was elected President.

1. Dr. J. L. Das read a paper on pregnancy anaemia. It was an illuminating discourse pregnant with facts. Dr. S. K. Dutt and Dr. B. De joined in the discussion that followed. Dr. J. K. Das gave a suitable reply to the points raised in course of the discussion.

2. No other paper was forthcoming.

3. In view of the fact that as a result of certain restrictions imposed on druggists for sale of certain drugs and foods, the general public are experiencing a good deal of inconvenience and the physicians are greatly handicapped in the matter of proper treatment of their patients, that this meeting is of opinion that such restrictions are no longer inform as the supply of these drugs and foods is now not restricted as before. This meeting further notes that such restrictions on sale are no longer in vogue in any other stations like Silchar, Sylhet, and Shillong. It is therefore, resolved that a deputation consisting of the following doctors should wait upon the S. D. O. and impress on him the necessity of immediate withdrawal of these restrictions. Dr. S. C. Paul, Dr. B. Dey, Dr. J. K. Das. Moved from the Chair and carried unanimously.

4. This Branch proposes the following names for the ensuing conference at Silchar:—1. Dr. G. S. Das of Gauhati as President, 2. Dr. Srihas Das of Shillong as President of scientific section, and 3. Hon'ble B. K. Das, Speaker, Assam Legislative Assembly as the inaugurator.

5. Resolved that each member should contribute Rs. 5/- for the ensuing conference at Silchar.

6. Dr. J. K. Das, be requested to send a paper on pregnancy anaemia to be read at the conference.

7. Dr. S. K. Das, be nominated as the delegate from this branch to the ensuing conference.

Silchar (Assam).—Minutes of a meeting of the branch held on the 30th March, 1946.

Major P. H. Cummins, M.B., Ch. B., I.M.S., Civil Surgeon, Cachar presided over the scientific section.

Dr. S. K. Datta read a very interesting paper on 'Conjunctivitis' which was appreciated by all present. Some of the doctors present took part in the discussion which followed. Incidentally it was mentioned that a large number of cases attend the out-door departments of all hospitals and dispensaries specially of the Surma Valley with ulcer of the cornea, chemosis and hypopyon in such an advance stage that most of them lose their eyes. Probably malnutrition plays a great part in high percentage of failure of response to treatment. The President remarked that venereal cause should not be lost sight of and he stressed on the necessity of establishing travelling eye hospitals. Dr. Sinha added that a separate eye department should find a place in the proposed State Hospital at Silchar.

This section closed with a vote of thanks to Major Cummins. Dr. M. R. Chakrabarty then took the Chair and the following resolutions were passed.

1. Minutes of the last meeting were read and confirmed.
2. Dr. S. K. Datta was elected as the Secretary of this branch in place of Dr. S. P. Nath, now Provincial Secretary.
3. Accounts of the Reception Committee of the Provincial Conference were placed before the House and were passed subject to audit.
4. Accounts of the branch upto date were checked and passed.

The meeting ended with a vote of thanks to the Chair, Dr. Datta entertained the members with tea.

Goalpara (Assam).—A meeting of the Medical Licentiates' of Goalpara was held on the 16th December 1945 at 5 p.m.

Dr. R. Ahmed took the chair. Dr. M. Ali stated about the previous meeting held in presence of Dr. L. K. Barua and Capt. A. Majumder some time back and the intention of the members to start a branch here.

(1) Thereafter, Dr. G. S. Das, Provincial Secretary, Assam Branch, elaborately explained to the members, the objects of the Association, and the progress it has made—the utility of joining the Association. He thanked the members for their eagerness to start a Branch at Goalpara.

(2) The following resolutions were passed unanimously:—
(i) Resolved that a Branch be started at Goalpara, the sub-divisional Head-quarters with the jurisdiction of the sub-division.

(ii) Resolved that the following office bearers be elected for the year 1946.

1. Dr. P. Ganguli—President, 2. Dr. Mehedi Ali—Secretary.

Members of the Executive Committee:—1. President, 2. Secretary, 3. Dr. Rohimuddin Ahmed, 4. Dr. B. L. Dutta, 5. Dr. Miss. N. Areng.

Members of the Standing Committee:—1. Dr. A. K. Das, 2. Dr. Rohimuddin Ahmed.

Dr. N. K. Das has been enlisted as a member of the Association in the meeting.

Dibrugarh:—A general meeting of Dibrugarh Branch of the A.I.M.L. Association was held on 29-12-45 with Dr. K. L. Ghose in the chair.

1. Minutes of the last meeting were read and confirmed.

2. Resolved that the monthly account ending 29-12-45 be passed for payment.

3. Resolved that Dr. J. N. Roy of Gauhati be elected as President for the next Provincial Conference (11th) to be held at Silchar.

4. Resolved that (i) Dr. K. L. Ghose and (ii) another member to be selected by the Secretary are elected as delegates from this branch.

5. With a vote of thanks the meeting ended.

Tezpur.—A meeting of the Licentiates of Tezpur, was held at the premises of Rai Shahib Dr. H. C. Das on 2-1-46 at 6.30 p.m. R. S. Dr. H. C. Das was proposed to the Chair. 13 members were present:—

At the request of the Chair, Dr. G. S. Das, our Provincial Secretary, spoke, on the utility of the Association and the great services our A.I.M.L.A., has rendered towards securing the equal status and other advantages and securing King's Commission in I.A.M.C., of our class. Also he dealt in a very lively manner, the medico-political developments that are being evolved in the body politics of future Medical and Public Health development of the country. He also requested fervently to join the Association and be in touch with recent and on coming progress of the Licentiates.

After his lecture, the following office bearers of this branch were elected unanimously and the following resolutions were passed.

1. Resolved that a branch be opened at Tezpur with the following office bearers.

(a) Office bearers.

(1) Rai Shahib Dr. H. C. Das, President.

(2) Dr. P. K. De, Branch Secretary, Tezpur Branch.

(b) Executive Committee—be formed of the following members.

(1) Dr. L. M. Choudhury.

(2) Dr. P. K. Sen Gupta. (Sub-Assistant Surgeon, Tezpur).

(3) Dr. K. Bose. (Deputy Superintendent, Mental Hospital, Tezpur.)

(4) Dr. S. Bhattacharjee. (District Medical Officer of Health, Darrang.)

(5) Dr. A. Halim. (Urban Health Officer.)

Four members will form the Quorum.

(c) Standing Committee be formed of the following members.

(1) Dr. L. M. Choudhury.

(2) Dr. P. K. De.

Juri Valley (Assam): Proceedings of the Annual General Meeting of the Branch, held at the Juri Valley, Central Laboratory on the 23rd December, 1945.

Dr. K. C. Ghosh of Rathna T. E. took the chair.

Col. C.S.P. Hamilton L.R.C.P., M.R.C.S., C.M.O. Juri Valley Medical Association was present as a chief guest in the meeting.

1. The Honorary Secretary gave a brief description of the activities of the branch, which was appreciated by all.

2. The following were elected office bearers for the year 1946.

President:—Dr. K. C. Ghosh, L.M.P., Ruthna T.E., P.O. Juri Sylhet.

Honorary Secretary:—Dr. S. C. Nag, L.M.F., Dhamai T.E. P. O. Juri, Sylhet.

3. Resolved that this branch suggests the names of Dr. G. S. Das to be the president of the main conference, Dr. S. P. Nath, President of the scientific section, Col. Taylor—inaugurator of the conference.

4. Resolved that every member should contribute Re. 1 to help the conference fund; and every member should try to contribute scientific papers as well.

5. Resolved that Dr. K. R. Bhattacharjee of Sonarupa Tea Estate, P. O. Dakshin-bhaṅ, (Sylhet) be elected as a delegate from this branch to the provincial conference.

6. Resolved that a Male Nursing Association of India should be formed in every province, and as well as a Female Nursing Association. The nucleus of this male nursing association should be drawn from nursing Sepoys of the I.A.M.C. and Sick Berth attendants of the R.I.N. A nominal roll of all demobilised trained male nurses, operating room Orderlies and laboratory attendants etc., should be called for from the army and naval authorities, and their men be given an opportunity to continue civil life as nurses. Those would immediately place the future of nursing in India on a much firmer footing. These demobilised medical Service Personnel should be encouraged to take a state nursing examination.

This branch earnestly requests the Association to find out ways and means to bring the above constructive resolution into effect.

7. The following case notes of professional interest were read and discussed.

(i) A few observations on the therapeutic value of M. & B. 693 including a case of icterus neonatorum by Dr. K. C. Ghosh.

(ii) Two case notes on the toxicity of M. & B. 693 by K. N. Das. A valuable lecture on Chloride deficiency was given by Col. Hamilton.

8. A contingent bill for Rs. 3-8-0 (Rupees three and annas eight only) for the year 1945 and an honorarium of Rs. 5-0-0 (Rupees five only) which should be paid to Sgt. G. C. Roy for the help he has rendered (in typing all association's letter and Circulars) to the Honorary Secretary, was scrutinised and passed.

Annual Report

May 1, on your behalf, express our joy at Col. Hamilton's presence in our midst, and we are extremely thankful to the Providence for his safe return from the War.

Our Branch was quite active during the year under report.

(1) We sent a delegate to the Provincial Conference at Gauhati to explain the position of licentiates in Tea-estate service. Result was, a special Committee was formed to enquire into this matter with the Provincial Secretary as convenor.

(2) We have 15 members in our list.

(3) Six meetings were held. Professional subjects were discussed in many of the meetings. Attendance in many meetings was poor, but this was due to distance. I do not find any reason why the Garden A.M.O.'S. should not be given proper conveyance to attend clinical meetings. I appeal, on your behalf, to the C. M. O. as well as to the managers of the Tea estates to give a favourable consideration to this question.

(4) The Last Provincial Conference recommended a scale of pay for the A.M.O.s., in the Tea-estate, viz., 150-10-300, but nothing has come out of it till now. (Dr. K. Das, Secretary.)

Badarpur.—Proceeding of the first meeting of the Badarpur Branch held on 15-2-46 Dr. P. R. Purkayastha took the chair.

The following resolutions were unanimously passed.

1. As the members are to face various difficulties to attend the Silchar and Karimganj Branch it is resolved that a branch be started at Badarpur.

2. Resolved that the Provincial Secretary be requested to get this branch affiliated at a very early date.

3. Resolved that the willing medical licentiates be enlisted as members of the Association.

4. Resolved that the following members be elected as Office bearers of the Badarpur Branch of the Assam Provincial Medical Licentiates' Association.

*1. *President*.—Dr. P. R. Purkayastha.

2. *Secretary and Treasurer*.—Dr. B. K. Ghosh.

3. *Joint Secretary*.—Dr. S. K. Roy.

Executive Members.—1. Dr. R. N. Banik. 2. Dr. I. B. Mazumder. 3. Dr. N. Haque. 4. Dr. A. U. Ahmed.

Jorhat: (Assam) Meeting held in B. B. Civil Hospital on Sunday the 20th January at 6 p.m. 6 members were present.

Dr. B. B. Sengupta was in the Chair.

1. Read the letter from Provincial Secretary dated Gauhati the 23rd December 1945 and resolved that Dr. Mafazal Hazarika will attend the Provincial Conference to be held at Silchar, failing which, Dr. B. B. Sengupta will attend the Conference.

2. This branch proposed the name of Dr. J. N. Roy to be the president of the Conference, Assam Branch and Dr. G. S. Das may be requested to continue as the Provincial Secretary.

3. List of subscribers towards the Provincial Conference.

	Rs.	A.	P.
1. Dr. B. B. Sengupta	...	10	0 0
2. Dr. A. Khasru	...	5	0 0
5. Dr. Hazarika	...	4	0 0
4. Dr. C. M. Paul	...	5	0 0
5. Dr. N. N. Bhattacharjee	...	5	0 0
6. Dr. S. K. Sen	...	4	0 0

4. It is proposed that a general meeting will be held in the 1st week of February preferably on Sunday at 3 p.m.

5. The office bearers of Jorhat branch for the year 1946 has been elected as follows:

1. Dr. B. B. Sengupta—*President*, Proposed by Dr. Hazarika, seconded by Dr. Bhattacharjee.

2. Dr. S. K. Sen—*Secretary*, Proposed by Dr. Bhattacharjee seconded by Dr. Paul.

3. Dr. M. N. Bhattacharjee—*Joint Secretary*, Proposed by Dr. S. K. Sen, seconded by Dr. A. Khasru.

4. The following have been the Committee members.

(a) *President*,

(b) *Secretary*,

(c) *Joint Secretary*,

(d) Dr. Khasru,

(e) Dr. Hazarika,

(f) Dr. Paul,

(g) Dr. Miss B. Zillie.

6. The accounts of the branch for Rs. 3-3-6 has been passed.

7. The annual report has been read and passed.

With a vote of thanks the meeting was closed.

(Sd.) B. B. SENGUPTA,

President.

Annual report for the year 1945. The work of Jorhat Branch has been continuing successfully during the year. 4 new members have been enlisted and one member re-enlisted. 2 of our members have just arrived after completing their war service in the I.A.M.C.

Receipt—Rs. 20-0-0. **Expenditure** Rs. 14-0-6. This Branch has completed its 14 years. There are 20 members in its register and there is a promise of 2 more members who will be enlisted soon. I congratulate all the office bearers and the members of this branch who have worked with interest for the cause of the association. There were some remarkable scientific discussions in all the meetings, one of which was held in Christian Mission Hospital, Jorhat, under the presidency of Dr. O. W. Hasselblad, M.D., Medical Officer. I request the members to continue their membership and to write scientific papers to discuss in the meetings and to express their professional experience through the Journal.

2. **Jorhat:** A meeting of the Branch was held in B. B. Civil Hospital at 6-30 p.m. on Sunday the 3rd February 1946.

8 members were present:—

Dr. B. Sengupta was in the chair.

The following resolutions were recommended for adoption by the ensuing Assam Provincial Conference.

1. As per recommendations of the Medical Education Committee of 1939 for raising the Berry white medical school into a medical college under the Calcutta University the Assam Government be moved to take measures to start the college session from 1947.

2. The Government be moved to abolish the designation of Sub-Assistant Surgeons and Assistant Surgeons which are unsuitable in many ways, and to replace by the designation of "Medical Officer" in Government service, in Railway Service and the Tea-garden Service.

3. The Government be moved to modify the regulations regarding issuing of license for opening a pharmacy by registered practitioners.

4. That the Government be moved to institute a survey of the medical arrangements in all registered Tea Estates and adopt strict measures for employment of registered practitioners as medical officers in pursuance of the Assam Medical Act.

5. The account of the branch for Rupee one and annas three only is passed

Bokaro-Ramgarh:—A meeting was held on 11-1-46 at Bokaro with the following members of the A.I.M.L.A.

1. Dr. A. C. Das, L.M.F.

2. Dr. T. Hussain, L.M.P.

3. Dr. F. Sen, L.M.F.

4. Dr. R. N. Roy, L.M.F.

5. Dr. B. Ghose, L.M.F., L.T.M.

It was proposed by Dr. R. N. Roy and seconded by Dr. A. C. Das that a local branch of the above association may be formed in this locality under the name of Bokaro-Ramgarh—branch of the A.I.M.L.A. and passed unanimously.

2. Proposed by Dr. R. N. Roy and seconded by Dr. T. Hussain that Dr. A. C. Das be elected as president of the newly formed branch for the year 1946.

3. Proposed by Dr. R. N. Roy and seconded by Dr. Sen that Dr. T. Hussain, be elected as Honorary Secretary of the branch.

4. Proposed by Dr. A. Das and seconded by Dr. P. Sen that Dr. R. N. Roy be Honorary Treasurer of the above branch.

5. All the three proposals are carried through unanimously.

6. It was proposed that the General Secretary, A.I.M.L.A. be approached for the recognition of the newly formed branch and for his direction for the running of the same on regular lines.

Guzarat:—Summary of the working of the Guzerat-Branch for the period 1-11-45 to 31-1-46.

Meetings. In all two managing committee meetings, and one clinical general meeting was held, and all meetings were well attended to by members.

Managing Committee Meeting on 25-12-45. This was the first meeting of the year 1945-46. The following business was conducted—

1. Proceedings of the last meeting held on 26-10-45, were read and confirmed.

2. The circular No. 8, dated 30-10-45, from the G. S. was read and it was resolved to file it.

3. Resolutions from the Provincial Secretary, which were read and discussed on 31-10-45, were finally approved of and the secretaries were authorised to send them to the proper authorities.

4. Dr. P. R. Trivedi, the Branch Secretary informed the committee regarding his last tour of Kathiawar and formation of branches of the Association at Wadhwan City, Wadhwan Camp Gondal and Viram-Gam and revival of the working of Junagadh Branch. He also informed the house that two members of the Raycat Branch, Drs. Rao Saheb Trivedi and Rao Saheb Antani were promoted to special selection grades of B.M.S. Officers. It was resolved that both these members be congratulated for their achievements.

5. The Honorary Secretaries placed the programme of working of the branch for the year 1945-46, for approval as under:—

a. To initiate membership campaign drive in right earnest.

b. To prepare a directory of all members of our class in and around 5 miles of Ahmedabad city and to establish contact with them.

c. In order to create more interest in clinical meetings well-known personalities from our profession be invited to speak

under the auspices of the Association, and the meeting be kept open to the entire profession of the city.

d. In order to establish further social contact amongst the members at least one or two outings be arranged where our members can spend few hours together and may have time to discuss various problems affecting the class at ease. All the above proposals were approved by the committee and the secretaries were authorised to take necessary steps in the direction.

Clinical meeting on 17-1-46. Dr. R. C. Dalal gave a very interesting lecture on "Anaesthesia" in general practice dealing with all aspects of the subject in detail and the various methods and drugs employed for the purpose. The subject was also discussed by the members and various questions were fully answered by the speaker.

Managing Committee Meeting on 31-1-46.

1. The proceedings of the last meeting on 25-12-45, were read and confirmed.

2. Letter from Lady Vidyaauri regarding donation towards Casket Presentation and Patriot unveiling ceremony in respect of over fifty years of public services of Dr. Joseph Benjamin, was placed before the meeting and since the person to be honoured being one of us the committee sanctioned a sum of Rs. 25 as quota of our branch towards the function. The function was under the auspices of fourteen different public bodies including Ahmedabad Medical Society and was presided over by Hon. G. V. Mavlankar, the President of the Central Assembly, and attended by prominent people of all castes, and public workers.

3. Regarding letters No. 59, 64, from the Pro-President it was decided that either the President or the Secretary of the Gujarat Branch should join the deputation to the Bombay Government as arranged by the Pro-President.

4. The Secretaries informed the committee that they had contacted nearly 75 members of our class during January '46 and had enlisted 34 new members and revived 4 members thus bringing the total number of members on 31-1-46 to 125. The Secretaries also brought to the notice of the committee that this enlistment involved considerable expenditure for conveyance etc. and requested them to approach the Pro-President for special grant for Propaganda and enlistment of new members. The Secretaries were authorised to communicate to the Pro-President and on hearing from him to submit the bills.

5. It was resolved that the summary of the working of the branch be regularly sent to the important office-bearers of the Association and to the Manager, Indian Medical Journal for publication.

6. Branch Secretaries' Bill of Rs. 22-5-6, from 1-11-45 to 21-1-46 was sanctioned.

All India Medical Licentiates' Association.—A copy of the proceedings of the opening of four new Branches in Kathiawar in December 1945.

Wadhwan Camp.—A meeting of the Licentiates of the place was held on 8-12-45, at the premises of the Civil Hospital. The following doctors were present:—

1. Dr. S. K. Shukla, 2. D. A. Jhala, 3. J. V. Mankad, 4. Mrs. S. Vighne, 5. Dr. K. T. Vora, 6. Dr. R. K. Shah, Dr. P. R. Trivedi from Ahmedabad addressed the meeting and it was resolved that a Branch of our Association be started. Dr. D. A. Jhala supported by Dr. Mankad proposed Dr. Shukla as President of the Branch for the year 1945-46. Dr. Shukla then proposed the list of Office-bearers for the year 1945-46, from the Chair. The list of the Office bearers is enclosed separately herewith. It was also resolved that Dr. Trivedi be requested to send the proceedings of the meeting to the authorities concerned. With a vote of thanks to the Chair and the Guest, the meeting terminated.

Wadhwan City.—Meeting of the Licentiates of the place was held on 9-12-45. The following doctors were present:—1. N. V. Raval, 2. R. A. Shukla, 3. K. H. Mathekia, 4. B. D. Dave, 5. P. P. Raval, 6. M. K. Shukla Dr. Trivedi addressed the meeting and it was resolved that a branch be started. Dr. M. K. Shukla supported by Dr. Dave proposed Dr. Raval as President for the year 1945-46. Dr. Raval then proposed a list of Office-bearers for the year 1945-46, from the Chair, which was accepted, and is separately enclosed herewith. Dr. Trivedi was requested to send the proceedings of the meeting to the authorities concerned. With a vote of thanks to the Chair and the Guest, the meeting terminated.

Gondal.—Meeting of the licentiates of the place was held on 15-12-45, when the following members were present:—

1. Dr. P. C. Parekh, 2. R. P. Kamdar, 3. S. G. Vyas, 4. K. J. Upadhyaya, 5. Dr. D. N. Patel, 6. S. M. Dawda, 7. R. K. Pandya, 8. K. J. Shah. Dr. P. R. Trivedi addressed the meeting and it was resolved that a branch should be formed. Drs. Kamdar & Vyas proposed Dr. P. C. Parekh as President of the Branch for the year 1945-46. Dr. P. C. Parekh then proposed the list of Office-bearers, herewith attached, from the Chair for the year 1945-46, which was unanimously passed. Dr. Trivedi was then requested to send the proceedings of the meeting to the authorities concerned. With a vote of thanks to the Chair and the Guest, the meeting terminated.

Viramgam.—A meeting of the licentiates of the place was held on 17-12-45. The meeting was addressed by Dr. P. R. Trivedi of Ahmedabad, and it was resolved to start a branch of our Association at Viramgam. The following members were present:—

1. Dr. N. K. Adeshara, 2. N. A. Pathak, 3. I. S. Parikh, 4. G. M. Parikh and 5. Dr. S. Singh. Dr. G. M. Parikh supported by Dr. Pathak proposed Dr. Adeshara as President of the Branch for the year 1945-46. Dr. Adeshara then proposed a list of Office-bearers, herewith attached from the Chair, for the year 1945-46, which was accepted unanimously by the house. Dr. P. R. Trivedi was then requested to send the proceedings of the branch to the authorities concerned, for information and further action. With a vote of thanks to the Chair and the Guest, the meeting terminated.

Annual Report of the Bombay Branch.—The period under report covers from January 1st 1945, upto date. The number of members in the branch is about 186. In the absence of definite information from the Head Office about refusal of V. P. Ps., by members, it is very difficult for us to know the exact number of members. The notes of meetings and socials are however being sent regularly to all licentiates in the city and it is hoped that in the coming year a completed list could be prepared and a fresh membership organisation drive carried with the co-operation of all the members. We would request every member to bring in his friend into the fold of the Association.

Nine General Body meetings were held during the period under review and as many managing committee meetings. Clerical dissensions on the important Medical Problems of the day were being held in almost all meetings wherein members present evercid great interest. It is earnestly requested that more members would attend these meetings and take part in the debates.

With a view to have more attendance in the meetings the monthly meetings were held in different localities of the city on different days of the week, but even then we are sorry to note that the response from members was very poor. We fervently appeal to all the members to attend these meetings and help us in our work by their mature experience.

The branch elected Dr. J. B. Desai as the President of the Calcutta Conference and Drs. A. D. Mastapar, V. K. Desai, L. K. Rao, and M. S. Sankholkar as the delegates. A condolence resolution was passed on the sad demise of Dr. J. B. Patel, one of its old members, Dr. A. V. Baliya, F.R.C.S., was congratulated on his election to the University senate.

Several important resolutions were passed in the various meetings, important amongst which are appeals to the Government of Bombay to (1) reduce the price of penicillin and make it available to all general practitioners (2) allow full quota of sugar to all dispensaries and that too of sort No. 1 (3) establish a composite Provincial medical service by the abolition of the S.M.S., (4) appoint a licentiate as an additional personal assistant to the Surgeon General (5) to promote S.M.S., officers in the Public Health Department to B.M.S., on the lines of the medical Departments. (6) have no discrimination between officers returning from war service and those who were prevented from going to war service on account of departmental needs.

The I.M.C., day was observed as usual on the 20th September, 1945.

Drs. A. D. Patel and M. S. Sankholkar were elected to the Provincial Standing Committee.

The managing committee offers its grateful thanks to the various members who helped them in the discharge of their duties.

C. P. Provincial Branch:—At the desire of R. S. Dr. M. L. Kapur the President of the A.I.M.L.A. who was keen to meet the members of this Association, a meeting of the C. P. and Berar Provincial Standing Committee was convened on Sunday the 17th February 1946. At the Congress-Nagar office of Dr. G. R. Kulkarni the Provincial President, Nagpur Dr. Kulkarni Presided. R. S. Dr. M. L. Kapur was also present.

R. S. Dr. Kapur was requested to address the members and in his brief, lucid and forceful speech, he laid stress on the unity of the members on a programme, for expansion of membership and co-ordination with the public. He also advised that approach must be made to the high Government authorities, as often as possible to redress their grievances and they must be impressed with the utility, experience, and the enormous services the licentiates have rendered in war, in peace, and in epidemic periods, not only in India, but also even outside.

He suggested opening of Nursing-Homes and medical stores on co-operative basis wherever the number of the licentiates permitted.

On question of amalgamation he narrated all about what took place in Amritsar meeting. He also stated that the A.M.O's. conference recommended the scale of the licentiates, starting from Rs. 150 with the designation as M.O's. He advised that the licentiates should not accept a remuneration of Rs. 150 p. m.

The following resolutions were passed:—

1. The mother association be requested to allow at least 25 per cent of the Provincial income to the Provincial Branches to meet the propaganda work as well as the other expenses of the Standing Committee. Proper accounts of such sums should be kept by the Secretary and were to be periodically audited.

2. The committee suggests the following ways for Propaganda:—

i. Vigorous, continuous, and widely spread appeals through the medium of newspapers and periodicals.

ii. To approach every individual non-member with an appeal for enrollment.

iii. Intimating every branch secretary the name of the licentiate who is not on roll from his district or area. The branch secretary will further be requested to exert his personal influence on the gentlemen who are not members and persuade them to become one.

iv. The Provincial office-bearers to visit personally at fixed intervals at their own convenience, places where old branches have ceased to function, with a view to re-organise them, or open new branches. This will also bring the office-bearers in contact with the members and give an opportunity for exchange of views on matters of common interest.

v. To appoint paid organiser to visit places, collect information, persistently endeavour to explain the aims and advantages of the association and remind the office-bearers and members of their duty to work for expansion of the organisation by inclusion of every licentiate as member.

3. The provincial Government be requested to revise the scale of the A.M.O's. and fix the pay of the licentiates from Rs. 150 to Rs. 450.

4. The committee resolves to reject the proposed amalgamation as totally prejudicial to licentiates' interests.

5. Government be requested to retain all the licentiates of the I. A. M. C. permanently in civil or military department.

6. The committee also requests that in their own interest and in the interest of the profession the discharged licentiates should not accept the jobs for less than Rs. 150.

Dr. R. S. Agarwal writes:—

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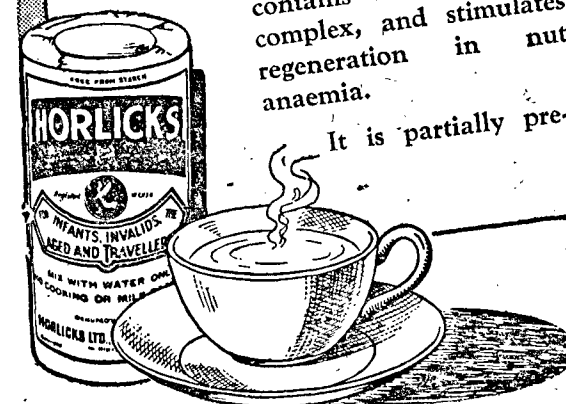
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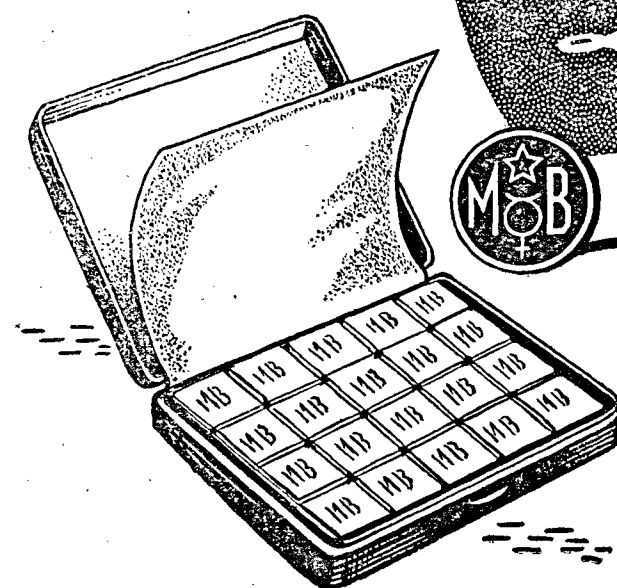
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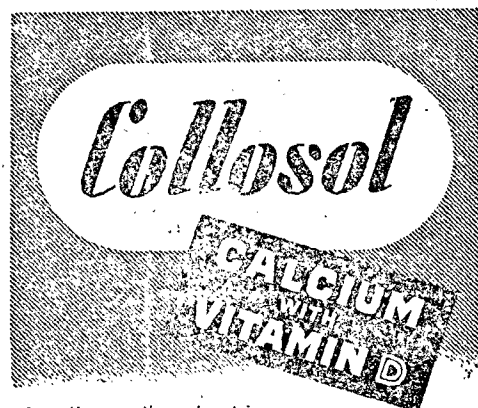
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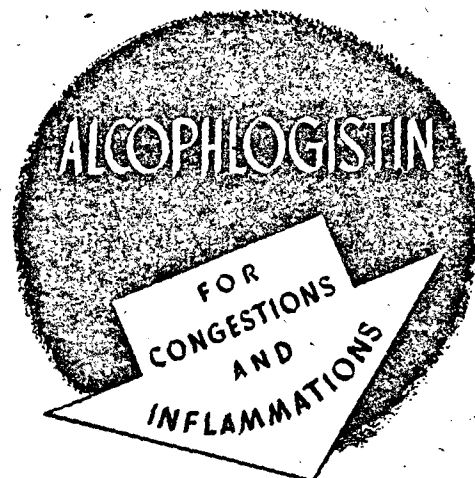
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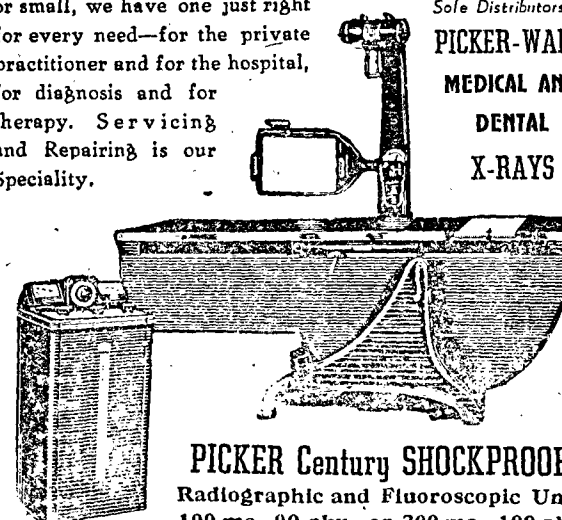
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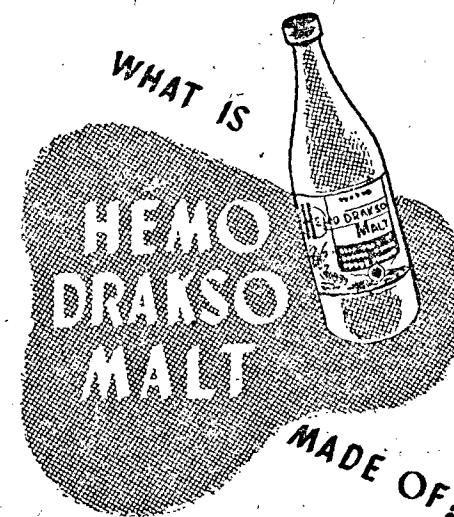
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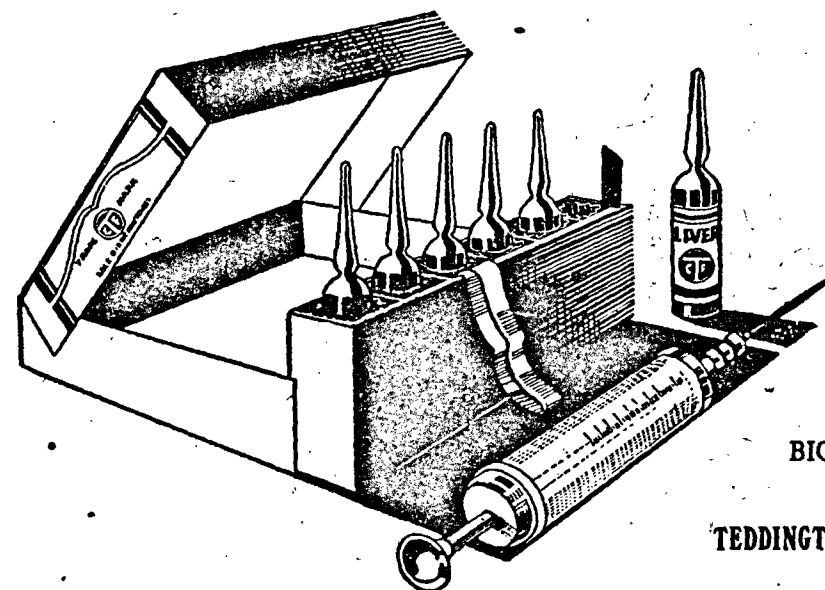
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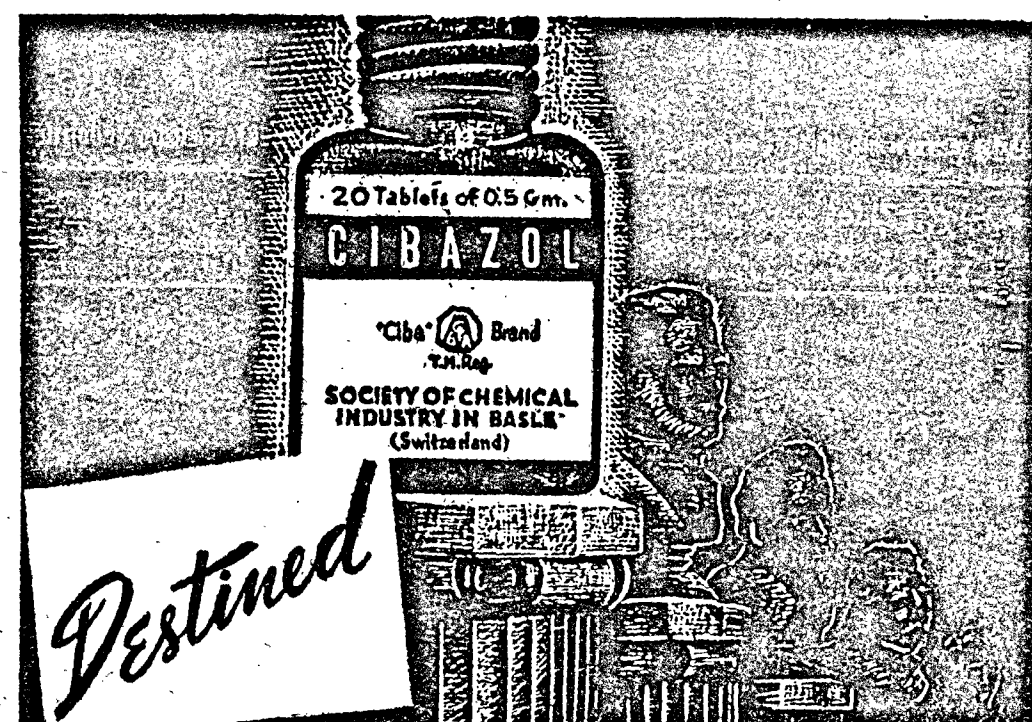
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Indian Medical Journal.

(Journal of the All-India Medical Licentiates' Association with which the Agra Medical Club Journal is incorporated)

Vol. 40, No. 9
September 15, 1946

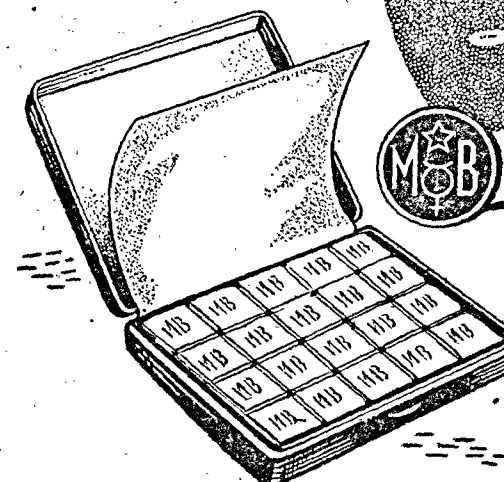
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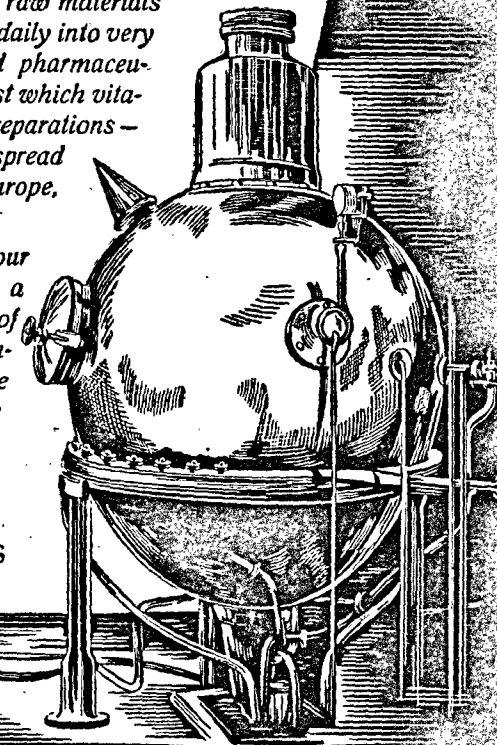
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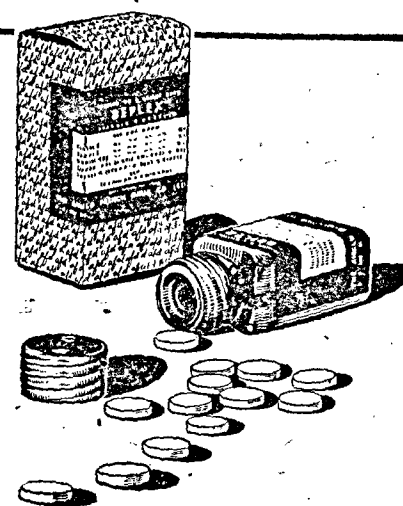
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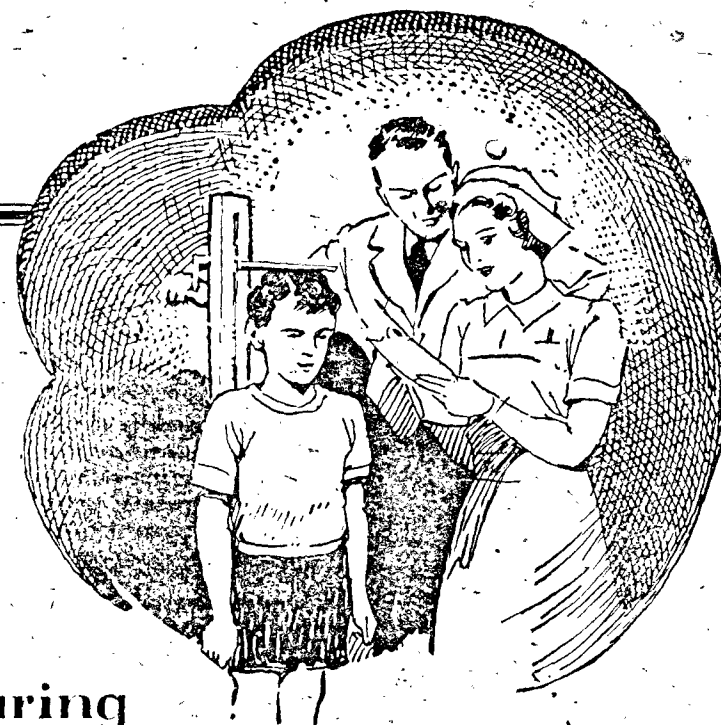
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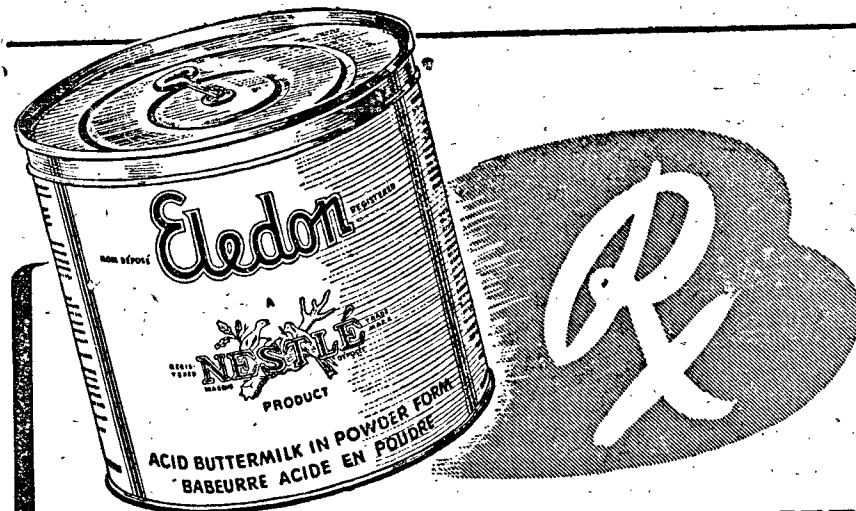
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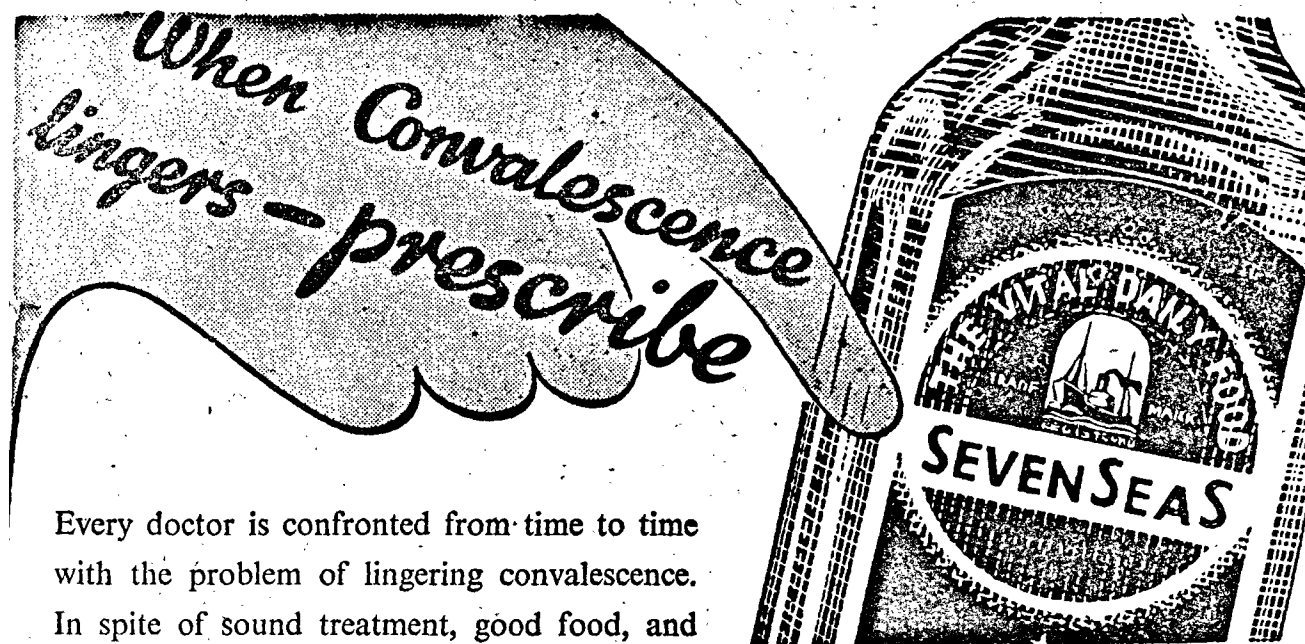
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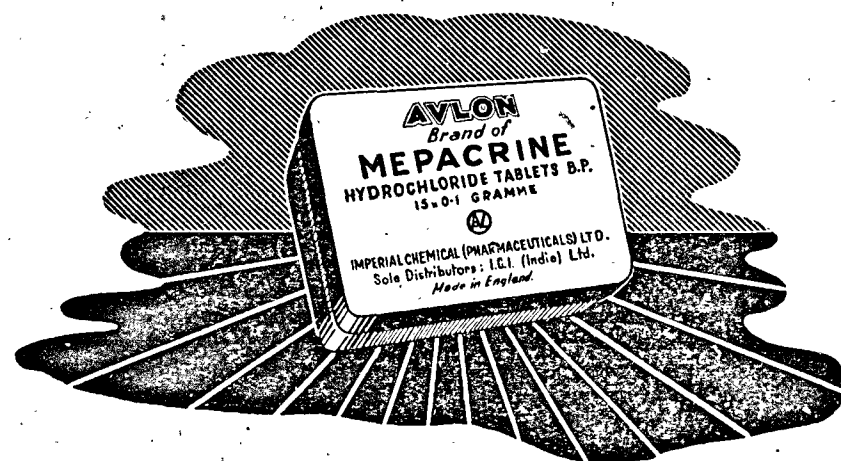
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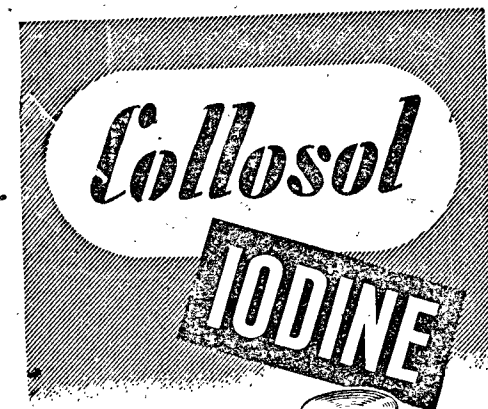
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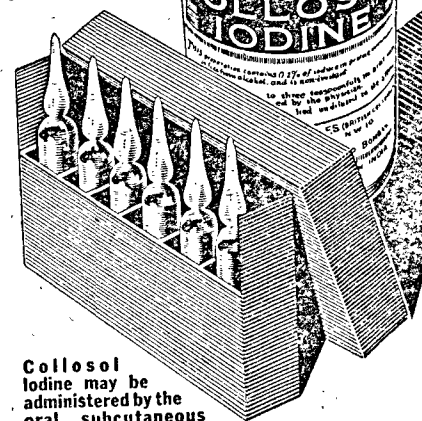
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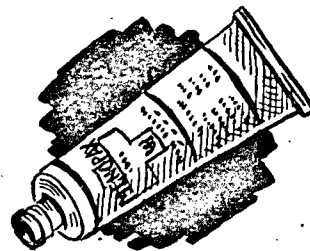
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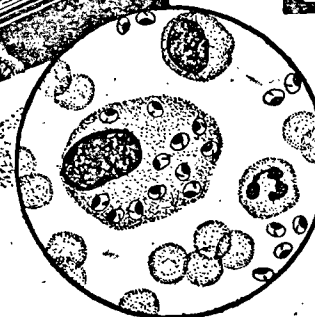
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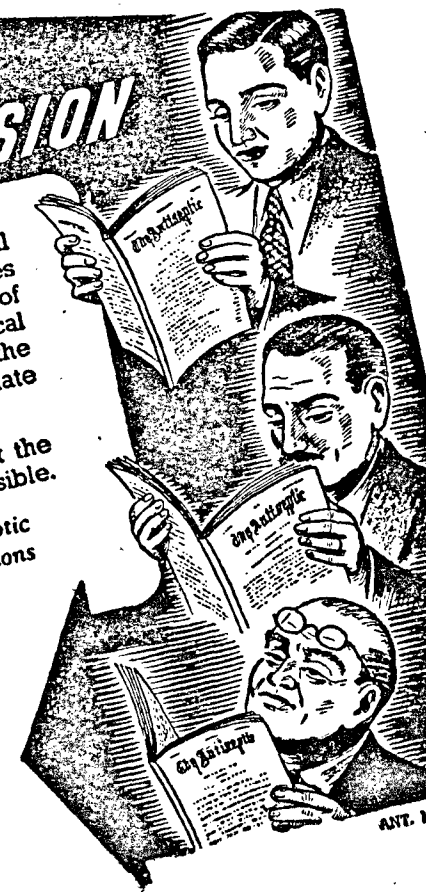
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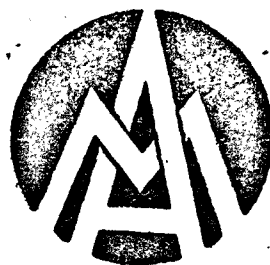
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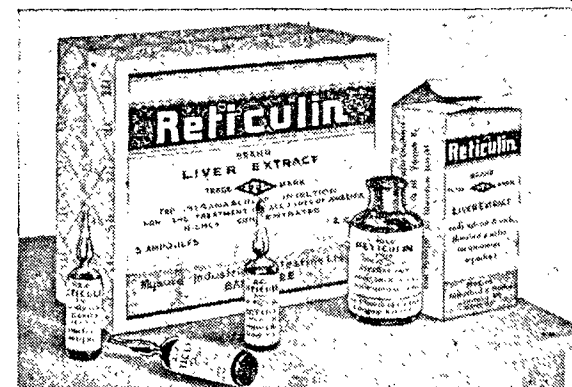
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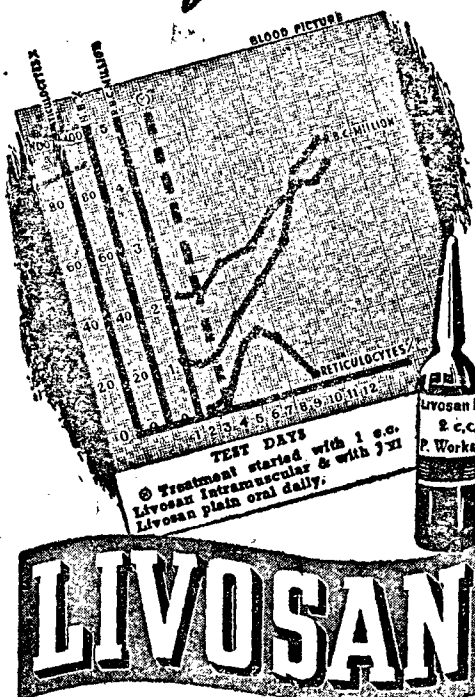
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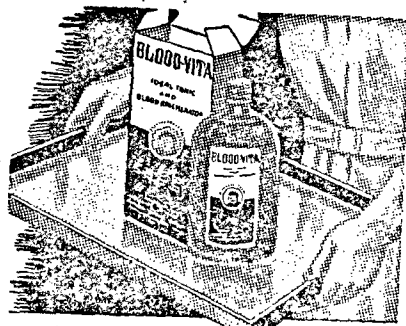
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Vol. 40. Madras : September 15, 1946. No. 9

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OUR MONTHLY SURVEY.

Where the Conflict Lies:—In the Budget presented to the Madras Legislative Assembly in August last, the Congress Ministry has made provisions for the starting of two more medical colleges, one at Guntur and another at Madura, four more schools of Indian Medicine in the four linguistic areas of this province and for the establishment of 200 more dispensaries with 20 beds each in due course of time. During the discussion Lt. Col. Iyengar and Sir A. L. Mudaliar warned the Government against fostering indigenous systems of Medicine as, according to them, they cannot stand the test of science, and said that such efforts are but a wrong manifestation of love of things Indian. Premier Prakasam, in his reply strongly defended the scientific nature of Ayurveda and Unani and quoted the slogan that "Ayurveda begins where Allopathy ends". While we do not share the fears of Col. Iyengar or Sir A. L. Mudaliar, we are however afraid that Premier Prakasam has overstated his case and missed the real point. We are prepared to concede, and to a certain extent believe also, that Ayurveda is quite scientific. But where is the need for fostering separate systems of medicine? The conflict is not between Ayurveda and Allopathy; that could be settled by the leading practitioners of both these systems of medicine, but between practitioners trained exclusively in these two systems. Here the conflict lies and this could not be resolved so long as the Government does not take up the responsibility of formulating one comprehensive type of medical education.

The Nature and the Result of this Conflict:—

At present the students of the School of Indian Medicine are taught the indigenous systems of medicine and elementary physiology and anatomy of the modern scientific type. Modern surgery, midwifery, bacteriology, pathology and medical jurisprudence are not at all taught. The result is that the licentiate of Indian Medicine is essentially a physician, and by virtue of his education he is not at all in a fit position to tackle cases of surgery, obstetrics and gynaecology. In fact, he is a half but not a full doctor. Whereas the student of Modern Scientific Medicine, as represented by our medical colleges, have really no idea of the value and utility of our traditional systems of medicine. The result is, he decries Ayurveda and other indigenous systems of medicine in the name of science or in the name of suffering humanity. This is the nature of the conflict that has resulted from fostering separatism in medical science and two classes of practitioners thus arise claiming equal rights and privileges in medical service of the State and medical administration. We do not know where this conflict will ultimately lead us. The present state is one of confusion.

Could this conflict be resolved?—We have all along held the view that this could be resolved by formulating one system of medical education incorporating all that is best in our traditional medicine into modern scientific medicine. Our present trouble is due to the undeniable fact that the type of education imparted in our medical colleges totally and blindly ignores the existence of traditional medicine, still alive and kicking albeit of 200 years of British rule in our country and has never tried to make suitable adjustments. Thus has arisen a complete lack of historic continuity between traditional and modern medicine in our country. This breach has to be repaired and could be repaired if we give up our prejudices and pet theories. It is obvious to an impartial observer that the present conflict between the practitioners of Indian Medicine and Allopathy is tainted deeply by ignorance and pride on both sides. What is required is a scientific synthesis of the old and the new and this could be effected through medical education organised on this basis. One day or other this synthesis has to be established in view of the deep belief of the people in Ayurveda and Unani; so the earlier this is done the better it would be in the interest of the people and the two rival sections of the profession.

The Guntur and the Madura Medical Colleges:—The Madras Ministry deserves our thanks for the prompt way in which it has responded to this public demand by starting a medical college at Guntur and another at Madura. Sir A. L. Mudaliar uttered a note of warning that since so far these new colleges have not been recognised by the Madras University, they may be subjected to such handicaps in the matter of recognition of qualification as were experienced till recently by the Andhra Medical College. Sir Mudaliar is himself the Vice-Chancellor, and therefore this warning has some significance, and perhaps portends some trouble. We have no doubt that the standards required by the University would be complied with by the Government, except perhaps in the matter of buildings. If the University withholds recognition of these new colleges merely on account of insufficient

buildings it would be deplored by the public as well as by the profession. After all, in a tropical climate it would be foolish to insist on elaborate buildings. We do, however, hope that the University would help the development of medical colleges by taking a lenient and generous view of the difficulties which the Government may encounter in the establishment of new medical colleges.

Bhore Committee's Recommendations:—The Budget discussion in the Madras Assembly shows that the Ministry has not taken any decision on these recommendations. It is reported that the Provincial Health Ministers would meet shortly at New Delhi and take their decision on this subject. There is much that is practical and valuable in the Bhore Committee's recommendations and we sincerely hope that the Provincial Governments would give effect to the main recommendations at an early date.

ADDRESSES AND ARTICLES

Sporadic Types of Cerebro-Spinal Meningitis

By

Dr. PARESH NATH BHUIAN, L.M.F.

Medical Officer, Incharge Maligram P. H. Dispensary,
P. O. Pingla, Midnapore.

Eminent authors have from time to time made many valuable contributions to the various aspects of cerebro-spinal meningitis. But it need hardly be stated that, in the management of the disease, essential as it is to profit by their experience, our individual observations become doubly so for the study of the sporadic cases which, to the observations of the writer, are in many ways dissimilar to the epidemic type.

The present conception of the disease from an epidemiological point is that new epidemics flare up from the embers of infection existing either in the carriers or in the sporadic cases. This view could not be substantiated in the case of more than sixty sporadic cases of c. s. meningitis treated and studied by the writer within the last three years or so in nine villages of the sadar subdivision and two villages of the Contai subdivision of this district. There has been not a single contact case in any family in which these cases were found, though principles of prophylaxis were not at all adopted there. Hence the so-called sporadic cases in urban areas, perhaps the post epidemic cases lingering as residuals, which are not in any way analogous to those found in these villages. Closer observation of such cases may some day reveal many obscure data of this deceptive disease.

Certain facts as regards the transmission of infection indicate that it is contagious; but the sporadic cases in the villages as mentioned above are not so. Poverty, insanitary living, over-work, fatigue, overcrowding, congested air etc., are all predisposing factors in the causation and dissemination of the disease. Perhaps over-crowding and foul air play the most important role in the spread of the disease

in an epidemic form, so that our villages where these two factors are absent, are almost free from its epidemiological invasion. But the transmission of infection of a disease epidemic in nature cannot be entirely judged on the merit of predisposing factors. In that case the question arises about the existence of a non-contagious type of meningococcus. But its existence has not yet been demonstrated though Gordon has differentiated four separate types of meningococci occurring in the cerebro-spinal fluid. Supposing these four types are equally contagious, then the degree to which they are, is very slight and is sufficiently influenced by the predisposing factors, particularly by over-crowding and congested air.

Its seasonal prevalence coincides in time with that of its epidemic form and with the recrudescences of almost all the diseases in which the respiratory tract is involved more or less. This form of meningitis fairly preponderates in malarious villages than in non-malarious ones. Its prevalence reaches its climax during the harvest time (i.e. from December to the middle of February). But to some extent it is endemic throughout the year.

Symptoms and Course:—It takes all the forms,—mild, acute and fulminating. But as usual they never constitute the clinical types. In spite of this some features are almost common in all its various manifestations. Sudden rise of temperature in a patient priorly healthy, with some discomfort or stiffness in the neck attended with some degree of delirium or restlessness is strongly suggestive of the onset of the disease. Vomiting may also be present. But it is more constant in children.

Pyrexia:—Its onset is sudden and course eventful. It is often ushered in by rigor and vomiting. Irrespective of treatment it may assume an intermittent, remittent or continuous type. In most cases it becomes either remittent or intermittent after two or three days. In some cases temperature becomes continuous after a week. Some cases after the preliminary rise of temperature become altogether afebrile for some days with or without improvement of cerebral symptoms. The variable nature of the temperature does not in any way modify the course of the disease or make the prognosis favourable, if cerebral symptoms do not improve with its amelioration.

Delirium:—It is associated with headache and may be violent, mild or muttering. Some degree of delirium or restlessness is always constant even in mild cases. It varies in intensity with that of the temperature. It is often violent when there is hyperpyrexia. In fulminating types stupor and coma supervene. In children below the age of five, whose speech centre is not sufficiently developed, the delirium may often be muttering; or it may be attended with convulsions.

Stiffness and retraction of the neck are constant so that the patient cannot lie on his back. With the progress of the disease stiffness spreads throughout the entire spinal column so that the patient lies on his sides, listless to the surroundings, in a huddled up posture with head bent backwards and legs drawn up. Stiffness of the neck is more pronounced in children than in adults. (During the time of writing this article the writer has under him a female child aged

three whose head has so far retracted backwards that it is almost at right angles to the axis).

There is some degree of coryza on or before the onset.

Pains in the back and limbs are often complained of. Insomnia is constant. Sometimes stupor and drowsiness are mistaken for sleep, particularly when the patient comes under observation during the afebrile state or, late in the course of the disease.

Vomiting is fairly more constant in children than in adults. It is more constant when there is hyperpyrexia. It is often bilious.

Pulse is slow in proportion to the height of fever. In bad cases it may be quick from the onset with diminution of force and volume.

Skin eruptions have never been found in any of these sporadic cases. Herpes is usually found on the lips. Sweating is a less pronounced feature of this disease.

Polyuria is constant but retention of urine supervenes in unconscious patients.

Bowels are often constipated and there may be some degree of rigidity of the abdominal muscles in the second or third week, giving rise to a dull tympanic note. Abdominal distension due to muscular weakness may be present in some cases.

Tongue is sluggish and coated and tremulous in bad cases. When temperature runs a prolonged course, it becomes heavily coated giving rise to the suspicion of the supervention of enteritis as a complication. With the improvement of cerebral symptoms it clears up readily.

Nutrition is grossly affected and it is progressive and out of proportion to the severity of affection.

Diagnosis:—About the diagnosis of cerebro-spinal meningitis Horder has very aptly remarked: 'the chief difficulty lies in not suspecting the presence of the disease.'

During the first part of its course the manifestation of the disease is very variable; this combined with its sporadic outburst makes timely diagnosis all the more impracticable. In villages where such sporadic outbreaks of the disease are common, the physician cannot take advantage of the epidemic nature in the matter of diagnosis.

Sudden rise of temperature attended with other cardinal symptoms, e.g., stiffness and retraction of the head, intense headache, vomiting, delirium or restlessness goes strongly in favour of the onset of this disease.

(Care should be taken to exclude stiffness of the neck caused by trauma, local inflammations, otitis, enlarged glands etc.)

The presence of Kernig's sign in conjunction with the above cardinal symptoms settles the diagnosis almost with certainty. But the time of its onset varies with the severity of the affection. When the fever is very high and delirium violent, it manifests almost concurrently with the cardinal symptoms. Children attacked with enteric or local pneumonia may also present this sign. It is fairly found in children with wasting due to any cause. This sign has practically no import when found in infants,

The manifestation of Kernig's and Brudzinski's signs depend on the degree of stiffness. They appear late in the course of the disease i.e., when the affection is mild. Brudzinski's sign may be elicited when the head retraction is not well marked; but it is best elicited in children whose bodies are supple and small. The former is of diagnostic value in meningitis of all types.

Differential diagnosis:—The season and the presence of the cardinal signs will immensely help in making a correct diagnosis.

In malarious zones the disease is often confounded with cerebral malaria. The presence of cerebral symptoms, rigor, vomiting or convulsions in both malaria and meningitis may mislead the practitioner to some extent in differentiating one from the other. The sporadic nature of the disease complicates this diagnosis all the more. Most of these cases of meningitis that came under the writer for consultation, were either treated as cerebral malaria or toxæmia. The victims of c.s. fever are not comatose just at the onset of the disease. If there be loss of consciousness in meningitis, it is periodical and alternates with delirium. The pulse, if at first increased in rate, will become slower as the intracranial pressure becomes marked. The temperature of c.s. fever is variable and exceedingly irregular. Respiration may also be irregular. In children below five the shivering of malaria is not infrequently replaced by convulsions which may also usher in an attack of meningitis, but in the latter it may arise at any time in its course. In malarious places c.s. fever is mistaken for malaria as the physician is more occupied with the advantage and efficacy of the early administration of quinine to the latter than with the suspicion of the presence of the former.

Next comes toxæmia that fairly misleads him in the recognition of c.s. fever. The symptoms of toxæmia are similar and also variable; but the synchronisation of all the cardinal symptoms in meningitis will help greatly in differentiating it from toxæmia. If there be still any confusion, the physician has to take into account the presence of the Kernig's sign and to guide himself accordingly. In grossly doubtful cases the ultimate confirmation of his opinion entirely rests on the results of lumbar puncture.

Children ailing from enteric fever are apathetic, drowsy, or complain of severe headache attended with meningismus closely resembling the chronic stage of c.s. fever.

In tuberculous meningitis the onset of cardinal symptoms is gradual.

Prognosis even in children is always favourable if specific treatment is rendered early. Therefore timely diagnosis is essential. Even the so-called fulminating and hyperacute cases respond favourably to treatment, if commenced early. But it is almost grave when from the onset of the disease the force and volume of the pulse are diminished along with increased frequency, and do not improve with proper treatment.

Complications are few in a well managed case. The commonest of them are:—flaccid paralysis, painful stiffness of one or more joints (such stiffness

lingering in some cases for even two or three years after the cure of the disease) and arthritis. In protracted cases enteritis is a fairly common complication.

Treatment.—Among general measures the patient should be placed in an airy and quiet room with protection against strong light and avoidable visitors. Isolation is unnecessary. High bed is of advantage, but in villages where adequate and skilled nursing is rare, it is better to put the patient in a dry bed on a high floor for the purpose of averting possible injury to him, when violently delirious.

Mouth, tongue, nostrils, eyes and ear holes should be scrupulously cleaned at least twice daily.

Symptoms should be treated according to the need and requirement of the individual case. For pyrexia and stiffness of the neck and trunk, tepid sponging is good and soothing. For delirium when it is violent, an injection of morphine to adults may be required; and if the patient can swallow this may be supplemented with oral administration of chloral and bromide each in 10 to 15 grs. doses thrice daily. If ice is not available running cold water may be applied to the head. No stone should be left unturned to combat insomnia. Apart from the administration of barbiturates and in older patients, opiates, regular tepid sponging is a valuable adjunct in effecting sedation. For bilious vomiting chlorbutol combined with luminal and fractional dose of calomel may be tried in the early part of the onset. Vomiting mixed with undigested food material may rather be left alone. Bowels should be moved on alternate days and urine, if retained, should be relieved by catheter with strict sterile precautions.

Dehydration is the most marked feature of this disease. All autopsy cases of meningitis show marked dehydration. Griffith and Mitchell say that dehydration may be a probable result of acidosis. Their view holds good in such cases of meningitis. So in the words of Palmer it may be stated that it is safe to consider acidosis a symptom from which the patient needs adequate relief, and care should be taken to prevent any recurrence of the condition.

To combat dehydration liberal supply of fluids in the form of glucose c. soda water, green coconut water, orange juice, mild effervescing alkaline drinks etc., may be freely allowed. Alkaline saline with glucose (sodium chloride 80 grs. sodium bicarbonate 60 grs., glucose 1 oz to a pint of squa distillata) four ounces every four to 6 hours may be given rectally high up by Murphy's drip method. If the reaction of urine to litmus be acid, 10 c-c of sodium bicarbonate sol. (ready made ampoules of 7½ per cent solution of sodium bicarbonate are available) may be added to glucose sol. given intravenously. Moreover according to the requirement of the case the intervenous administration of glucose may be combined with 5 to 10 c-c of 40 per cent hexamine sol. At least five to eight pints of fluid in food and drink are required for an adult; if more, better. To enhance absorption of saline the colon may be flushed before the saline is pushed.

Glucose seems to improve circulation and respiration besides providing readily utilizable carbohydrates and combating ketosis thereby. It may

preferably be given intramuscularly in the acute stage of delirium. In some cases aggravation of delirium has been noticed after intravenous administration of glucose. For the maintenance of mental balance calcium may be added to glucose.

In children, after the subsidence of fever to normal with specific treatment, and if there be some degree of muttering delirium, daily injection of 1 to 1 c-cm. of colloidal calcium may be given for restitution of mental balance.

When at the onset of the disease there is diminution of the force and volume of the pulse with its increased frequency, along with glucose and calcium, coramine may be given either orally or parenterally according to indication. Specific treatment with serum may better be put off till the heart improves; and as an interim measure the patient will be put on sulphanilamides alone. Strychnine may be avoided in this stage.

Vitamines:—Subclinical vitamin deficiency states are common in our average population. This renders them more susceptible to the development of relative deficiency states in the presence of the increased demands associated with this disease well up to convalescence. Vitamin B particularly the B₁ is a remarkably specific oxidative and catalytic drug that plays an important role in the metabolism of carbohydrates. It is therefore of double importance to the patient who cannot feed by mouth and whose main source of energy is glucose solution by veins. Vitamin B given in conjunction with C improves appetite, muscular control, speech and gait, lessens pain and makes joints loose. For the normal metabolism of calcium vitamin D is also an essential adjunct.

Specific treatment:—Success rests on the early administration of serum. It does not so much depend on the quantity of the serum or the route by which it is given, as on its early administration and potency. If after the first dose of serum the patient does not show any improvement of the cerebral symptoms, the brand used should at once be replaced with a different one without wasting time in speculation over its quantity or route of injection. The writer here lays down his method of serum administration in about 60 cases of c.s. meningitis in sporadic forms.

On the first day as soon as the diagnosis is established, the patient is desensitized with gradually increasing doses (1/8 c-cm. to start with) of serum mixed with saline. Tucker advocates an intramuscular injection of 30 c-c. of serum four hours before the intravenous injection is given. This method is dangerous and should not be followed as a measure for desensitization. After proper desensitization 10 cc. of warm saline is given intramuscularly. Then after two to three hours 25 cc. of serum or less suitable to the age of the patient, is given as before. Then after 6 hours an equal quantity of serum is given intravenously. In a typical sporadic case some degree of improvement will be noticed with the above dose. The patient who was delirious, restless or incoherent before, becomes sensible to the extent of giving rational replies to queries made about his troubles. Even in some very comatose cases improvement was seen even after the first 10 cc. dose of

serum given intramuscularly. If there be improvement after the above 60 cc. doses, the next dose may be delayed till the day following; and if not, the brand of serum should be replaced with a different one. Daily injections are then tapered off by giving 5 to 30 cc. of serum on the second day, 25 cc. on the third and fourth. Serum should be supplemented with sulphanilamides given parenterally. Serum is scarcely needed in any case of any severity for more than four days. Children below the age of five improve sufficiently with 10 cc. of serum daily. If the patient does not improve with the prescribed doses, he will not improve with bigger doses. The defect is either with the serum or with the diagnosis.

Children should be sufficiently guarded against naphylactic shock and serum sickness by proper desensitization and oral administration of a mixture containing proper doses of cal. lactate, pot. citrate, iot. bromide, tincture belladonna, tincture ephedra, iot. thrice daily after food, a day or two preceding the expected time for the onset of serum sickness. For itching 1 per cent carbolic in lotio calamine may be applied locally.

When to stop serum:—It may be stopped with improvement of cerebral symptoms i.e., cessation of delirium, restoration of sleep, mitigation of difficulty in swallowing, absence of headache when the patient is afebrile and lessening of rigidity of the neck and spine. The subsidence of fever may be taken with these, but it may linger in an intermittent form (in some cases attended with headache during its effervescence but not defervescence) for some days or weeks without calling for any specific interference. The physician has to keep vigilant watch over the relapse of cerebral symptoms. Stiffness of neck and spine in a moderate degree may continue for some days after the cerebral symptoms have altogether subsided. When stiffness improves, the patient will be able to lie on his back comfortably.

Massive doses of serum cause irritation of meninges; hence its administration is not justified when cerebral symptoms have sufficiently improved.

Residual fever after disappearance of the cardinal symptoms is in some cases very refractory to treatment. It then assumes an intermittent type and may even be associated with some degree of rigor or chilliness. This fever does not disturb sleep or cause restlessness. Its diurnal duration is short and there will be no headache when the patient is afebrile. It does not respond to quinine, sulphanilamides or mixed vaccine. In very doubtful cases pointing to malaria one or two test doses of quinine in injection form may be tried. Such fever stops after two or three weeks with tepid sponging, good nursing and suitable diet combined with multiple vitamin and calcium. Vitamin and calcium improve appetite and temperamental changes.

The results of treatment in these cases reveal the striking effectiveness of meningococcus antitoxin. Lumbar puncture is unnecessary if treatment with antiserum is started early. Spinal canal may be tapped for drainage and relief of pressure in neglected cases. Late cases with coma or stupor are often profoundly dehydrated so that spinal puncture in them ends in a dry procedure.

Of the sixty cases coming under the writer's consultation or treatment only one was subjected to lumbar puncture for the relief of pressure. 55 cases recovered rapidly following either intramuscular or intravenous administration of serum. Of the two cases that died even with serum therapy, one was a very late case and the other a boy of 12 who had been primarily treated as a cerebral malaria case with 3 injections of quinine 10 grs. each, supplemented with two injections of coramine, one injection of ardenalin, one injection of pituitrin, two injections of strychnine etc. 'to correct the heart' so to say. He was found in a very bad state suffering from the treatment given him already. The other three cases were my early cases who were principally treated with sulphanilamides orally and parenterally.

Sulphanilamides in the treatment of this disease are valuable adjuncts. Very mild cases i.e. cases with practically no delirium and temperature below 102, may be treated with them. The writer treated some such cases with very mild cerebral symptoms with Dagenham sol. i. v. Sulphanilamides are best indicated in the later part of the acute cases when with serum, the cerebral symptoms have sufficiently improved. They are best used in conjunction with serum.

Schwentker has claimed good results with their intraspinal administration. But the writer has no such experience. It is not justifiable to put an acute case solely on them if serum administration is not contraindicated.

A Review of Cerebro-Spinal Meningitis based on Observations of 105 Cases at Kumbhirgram Project from December 1942 to August 1945.*

BY

DR. H. K. CHAKRAVARTHY, L.M.P. L.T.M. (Cal).

This paper is an attempt to record some of the observations on cerebro-spinal meningitis that had occurred at Kumbhirgram Project during the above noted period.

This was one of the very important diseases running more or less a mild epidemic form at the Project.

Population.—The average population of the Project comprising both the Indian Tea Association labourers and the Bengali labourers, mostly recruited from the Eastern Bengal, ranges from 6 to 9 thousands during first half of the Project, although it was much less in the later half when the disease too was running in a sporadic form.

It is needless to describe the whole clinical picture of the disease here, but it may be worth mentioning some of the important observations.

Season.—Most of the cases occurred during the months of November, December, April and May.

* A paper read at the Assam Provincial Conference, A.I.M.L.A., Feb. 1946.

proving the fact that it is mainly a disease of winter and spring (O. and F. Price).

Overcrowding.—It might be a factor as the disease was much less when the population was reduced in the later half of the Project. The houses of the labourers were 50 ft. X 20 ft. each with 20 beds 2½ ft. apart. If we take the view that the beds 2½ ft. apart in barracks reduce the cerebro-spinal fever, in our series it was not of much importance.

Race.—The Tea Garden labourers were mostly the victims of the disease. A feature worth noting is that this disease is now in a sporadic form in the Tea area of Cachar. It was very seldom found in this area during pre-war time. The ratio of sufferers between Bengalee and garden labourers was 1:4.

Sex and Age.—Of course the sex was only males at the project and the age ranges from 20 to 40 years.

Susceptibility and Contagiousness and Carriers.—The Tea Garden labourers were more susceptible. It seems that the disease was imported to these non-immune folks during the War period.

As the disease is supposed to be spread by droplet infection no case was recorded amongst the people who were always attending these patients but a hospital nurse who used to administer them medicines got the attack of the disease proving that the disease is contagious but the degree is slight. A carrier was detected amongst one of the garden labourers who had an attack of acute sore throat. The smear from his throat was positive for meningococcus.

Onset.—The onset was generally with nasopharyngeal catarrh, headache and pain all over the body.

Temperature.—There was not a single case with hyperpyrexia.

Temperature ranges from 99 to 102 F. It is noteworthy to mention that 14 cases were apyretic. In these apyretic cases only the general apathy of the patients and their vacant idiotic looks induced lumbar puncture and the diagnosis was confirmed.

Vomiting.—It was present in most of the cases.

Onset with Dysenteric Symptoms.—It is interesting to note that in 16 cases the onset was with dysenteric symptoms—frequent passing of stool with mucus and a peculiar odour which the experienced nose can only tell, mild vomiting, sudden collapse with sunken eyes and husky voice and thready pulse. The laboratory examinations of the stool revealed no signs of dysentery. The stiffness of the neck and kerning's sign was absent in such cases. The first one or two cases of this type were probably missed but it was Dr. G Fraser who fortunately found after post-mortem examination one of such cases was true C. S. Meningitis, whence our attention was drawn and lumbar puncture was done as routine in these types of symptoms where stool was negative for dysentery.

This nature of onset was not mentioned so far in any other epidemics. The rare onset with symptoms of definite enteritis was mentioned by Federic Price in his Text Book of Medicine.

Stiffness.—of the neck and kerning's sign—Most marked in about 40% of the cases only, less marked in 35% of the case, not marked at all in rest of the cases.

It is interesting to note that cases with dysenteric onset had no rigidity of the neck or leg muscles.

Unconsciousness.—Coma was noted in eighteen cases with widely dilated pupils and loss of conjunctival reflexes. Most of the cases were in stuporose condition, could be roused by an effort at examination, some could answer all the questions and some were in a state of mental confusion.

Convulsions.—Generalised convulsion and wailing cry was present in 3 cases only. Spasms of flexor and extensor muscles of the limbs were noted in these cases. Some cases had obstinate delirium.

Retraction of the head.—Marked retraction of the head or opisthotonos was not noted in any case.

Hyperaesthesia along the spine and severe pain in the back muscles causing all movements difficult was noticed in some cases.

Redness of conjunctiva and photophobia.—Noticed in a few cases—these patients used to take shelter under the bed clothes and assumed the huddled posture and were incidentally detected while doing so in the camp.

Aphasia.—Only one case had motor aphasia. The peripheral mechanism of speech was alright. He had slight rigidity of neck and leg muscles. Aphasia was alright after 24 hours with treatment by M & B 693.

Retention of Urine.—Was noted in only 2 cases where etherisation was necessary every 6 hours for the first 24 hours of treatment.

Anuria.—Complete anuria was not noticed in any case, although in some cases of severe nature there was partial anuria.

Urine.—2 cases showed only traces of albumen.

Laboratory Findings.—In all cases examination for malarial parasite and total and differential leucocyte count was done.

In three cases M. T. Malaria was associated with turbid C. S. fluid and high leucocyte count. One of these cases ended fatally. Average total leucocyte count was 15 to 30 thousand per c. m. m. of blood, polymorpho nuclear leucocyte varying from 76 to 85 per cent.

C. S. Fluid.—Pus cells were present in all cases of smears examined. Turbid C. S. Fluid with pus cells was of diagnostic importance where Meningococci was not found.

Intracellular gram negative diplococcus was not found in many cases. Some cases showed extracellular ones. There was no relation between the severity of the disease and absence of Meningococcus or with presence of Intra or Extra Cellular organism. There were fatal cases in both. The severity of attack was also same with the above findings.

Pneumococcus was found in the smear in two cases with negative findings in the lungs. Both of the cases ended fatally.

Complications and Sequela.—There were no severe complications in any of the cases. Herpes labialis and arthritis of the knee joint was noticed in one case only amongst the series.

Otitis, Deafness, Panophthalmitis, Iritis, Orchitis, Ch. Hydro-Cephalus, Transient paralysis were not seen in any of the cases. Skin rash also was not seen in any of the cases.

Treatment.—In no case was Anti-Sera used. Lumbar puncture and Sulphapyridine was the only resort.

Lumbar puncture was done in all cases as a routine. The fluid was removed till we come 40 to 50 drops a minute. This amounted nearly 10 to 12 c.c. in ordinary cases. It was repeated in cases with convulsion and delirium every 8 to 12 hours till nearly 40 c. c. of the fluid were withdrawn.

M & B 693 was given in comatose and unconscious cases or cases with convulsions and delirium and where oral medication was not possible, the drug was given intravenously slowly and repeated every 5 hours. (1 gm of the drug was dissolved in 10 c. c. of distilled water). Generally the patients could take it by mouth after 12 to 18 hours of treatment while the rest of the treatment was carried by oral route.

In some cases when the ampules were not available 2 to 3 grms (4 to 6 tabs. of the drug was suspended in nearly 10 ozs. of water or milk and was given by nasal route in the above noted cases. A few whiffs of chloroform was necessary in too violent cases for this administration. Fluids and food were also given in similar way. In ordinary cases it was always given by mouth. Total 12 to 17 grams (25 to 30 Tabs) generally cured most of the cases in 3 to 4 days.

Plenty of fluids was always given, at least 5 to 6 pints in 24 hours. In few of the cases the fluid was given in intravenous way (glucose-saline) i.e. in unconscious patient.

General treatment: For delirium: Morphine or whiffs of chloroform in obstinate, bromide or other sedative in the less severe cases.

Swelling of joints.—No special treatment was required. For vomiting—sodibicarb and glucose drink, glucose intravenously in obstinate cases.

Discussion.—Treatment of C.S. Fever with Sulphapyridine is quite satisfactory. Among cases which came under treatment early and diagnosed early the rate of cure was 100%. Amongst the 14 deaths in this series treated only with sulphapyridine, 5 cases of fulminant type died before any treatment could be given to them, either on way to Hospital or just after reaching the Hospital.

Comatose or unconscious patients came to their senses after 12 to 18 hours of intensive treatment. Patients were completely cured and discharged from the hospital in average 12 to 14 days.

Summary.—105 cases of C. S. Meningitis have been described of which all cases were treated with lumbar puncture and Sulphapyridine. The death rate was 13.3 P. C.

16 cases had onset with dysenteric symptoms, 14 cases were apyretic, a note-worthy feature noticed in this particular epidemics. No severe complications were noticed. Many moribund cases recovered after intensive treatment with M & B 693.

The Tea Garden Labourers were most susceptible.

Acknowledgement.—My thanks are due to Dr. G. Fraser M. D. (Edin) D. T. M. & H. (Eng) the Chief Medical Officer of the Project for his instruction and guidance in treatment of these cases, and Major

Vere Fox (Rtd. I.A.M.C.) for his kind permission to publish it.

My thanks are also due to Dr. H. C. Paul D.T.M. (Cal) and others for their efforts in helping me.

Mepacrine and the Relapse-Rate of Malaria.

By

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In my articles "Role of Mepacrine and Quinacrine in the treatment of Malaria" (I.M.J. Vol. 39 No. 11, November '45) and "Role of Mepacrine in the Suppressive treatment of malaria" I.M.J. Vol. 40, No. 2 February '46) I have tried to show the efficacies and advantages of the drug both in the curative and suppressive treatment of Malaria by facts and figures. Curative treatment with these drugs has been introduced since the middle of December 1945. Suppressive treatment was given to the staff only from 15-4-45 to 15-11-45 in doses of one tablet of 0.1 gm. daily.

A chronological study of the malarial figures from 1935 to 1946 (January—March) will show the beneficial effect of the drug on the relapse-rate of Malaria.

January— March	Total Malarial cases	Staff on sick certificate for malaria	Total days lost due to malaria
1935	787	...	...
1936	744	...	...
1937	805	...	...
1938	711	...	...
1939	763	...	...
1940	785	...	...
1941	756	...	...
1942	847	...	...
1943	1785	936	5,517
1944	1751	819	6,290
1945	820	500	3,254
1946	156	41	259
			Population of staff roundly 4,000

Explanation.

1. The strength of the staff increased by more than double on account of the emergency conditions of the locality during the period 1943-1946.

2. Figures from 1935 to 1944 are almost the same in proportion to the strength of the staff at different times and that is definitely due to relapses.

3. The fall in figures in 1945 is due to the fact that all the sick staff were kept under close observation under sick certificate, and given full course of treatment; thus decreasing the relapse rate by minimising the number of carriers.

4. The miraculous fall in 1946 is due to all sick staff getting full course of treatment reinforced by suppressive therapy during the previous year and thus diminishing the relapses.

5. "Crescent" carriers were treated with plasmoquine and thus controlling the relapses.

Precautions Adopted.

During both curative and suppressive treatment each individual was advised, and reminded frequently to take sufficient quantity of water and keep their bowels free.

Other Advantages.

1. Not a single case of black-water fever occurred during the year under review.

2. The number of Cerebral Malaria cases among the staff was 3 (April '45 to March '46) as against 19 during the last year (April '44 to March '45) and those are also among the irregular intakers, irregularity for some reasons or other.

3. No cases of cerebral excitation were observed on account of the treatment (curative and suppressive).

My thanks are due to Dr. F. C. Lees, M.C., L.R.C.P., M.R.C.S., District Medical Officer, B.A., Railway, Lumding and Dr. P. C. Datta, M.B., C.L.B., (Edin.), L.R.C.P., (Lond.) M.R.C.S., (Eng.), F.R.C.S., (Edin.), D.P.H., (Edin.), The Chief Medical Officer, B.A. Railway Calcutta, for their kind permission to publish this note.

Management and Treatment of Cholera in Acute Stage.

By

DR. H. L. SANYAL,

Medical Officer, Chasulla Colliery, Manbhum.

A patient suffering from cholera, generally comes with the following signs and symptoms.

- (1) Sunken eyes.
- (2) Husky voice.
- (3) Shrivelling of the fingers.
- (4) Cramps in the limbs.
- (5) Cold clammy skin and cyanosis.
- (6) Imperceptible pulse or no pulse.
- (7) Suppression of urine.
- (8) Rice watery stool.
- (9) Vomiting.
- (10) Extreme thirst.
- (11) The rectal temperature above normal.

Comma vibrio is responsible for the above sign and symptoms in cholera. It acts by endogenous toxins and by amines produced by the chemical changes of the amino acids derived from the food-stuffs. The permeability of the blood vessels of the gut are increased and the fluid and saline contents of the blood are drawn inside the lumen of the gut which are expelled by vomiting and purging. The increased permeability of the blood vessels also causes intertubular oedema and fall of blood pressure and consequently there is anuria. The great loss of fluid from the blood leads to the rise of specific gravity of blood. In a healthy person the normal sp. gr. of blood is 1054, and this may rise upto 1070. The sodium chloride contents of a normal healthy blood is found to be 0.85 percent, and in a cholera patient the chloride contents of the stool is found to be 0.53 per cent on an average. The alkalinity of the blood is markedly reduced from a normal of about N/25 to N/80. In a case of fatal uraemia, this reduction comes to the high degree of N/100.

Treatment:—The patient should be kept covered with blanket just to keep him warm. Next the rectal temperature to be noted. If it is found to be above 98°F iced water enema to be given before administration of saline treatment.

Orally:—A dose of stimulant mixture to be given at once and next the following powder to be continued just to control vomiting and favour elimination of toxins from the small intestine, the site of the disease.

R.

Hudr. Subchlor gr. 1/8
Chloretone gr. 1/2
Sodi Bicarb gr. 2
Mft. pulv. 8. one such every 1/2 hourly.

Injections:—Atropin sulphate gr. 1/75 is injected to prevent pulmonary complications and also to guard the heart from its failure. But atropin is contraindicated in cases of high axillary or rectal temperature and also in cases having tympanitis.

The frequent collapse in a cholera patient is always counteracted by administration of repeated intravenous saline and this is strictly guided by the sp. gr. of blood. The patient should be very carefully watched, when the stage of vascular equilibrium is reached, the patient will keep normal and reasonable pulse and pass a fair amount of urine. Given one or two days after, the patient may collapse not due to any actual loss of fluid from the system but due more to the weakness of the heart. Saline transfusion in such conditions should always be guided by the sp. gr. of blood, or it may prove fatal.

If the patient is received within 24 hours of appearance of symptoms and is in a collapsing stage, hypertonic saline is indicated for administration (Sodium chloride 120 grs. Cal. chloride 4 grs. Aqua redistilled one pint) intravenously. The quantity of saline to be pushed depended upon the sp. gr. of blood, 1056 is taken as normal sp. gr. of blood and the increase in sp. gr. of blood for every two in number from 1056, one pint of saline is indicated. If the patient is received after 24 hours of appearance of symptom and is in a collapsing stage, or if the patient is again in a collapsing stage after the administration of the hypertonic saline,—normal saline with sodium chloride 90 grs. sodi bicarb 60 grs. aqua redistilled one pint) is the choice for transfusion intravenously. After the lapse of 24 hours the patient loses sufficient fluid and salt and at the same time the alkalinity of the blood diminishes; consequently the patient gradually develops acidosis and if the duration of this condition is allowed to prolong the patient runs on to the dangerous uraemic stage. Considering all these conditions it is advisable to transfuse intravenously normal saline with sodi bicarb in this stage. It is wise to push less quantity of saline at a time and to repeat it as often as necessary than to overload the system with maximum amount of saline at one sitting.

Sometimes fatal complications may arise such as cardiac failure, oedema lungs, or tympanitis. Under no circumstances more than 6 pints of saline to be pushed in one sitting. The redistilled water used for transfusion should be pyrogen free or it causes severe rigor and high rise of temperature

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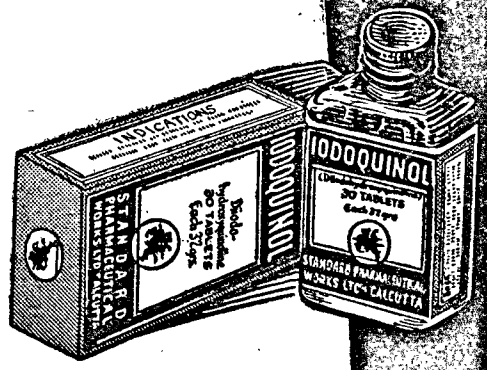
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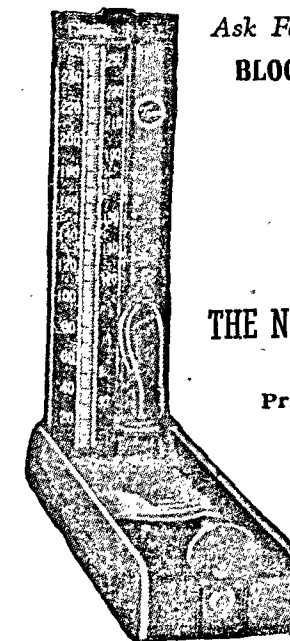
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(10)
Inflammations of the Eyeball,*
BY

DR. R. S. AGARWAL,
(Eye Specialist, Delhi.)

Inflamed Eye:—The inflamed eye usually shows the symptoms of redness, watering, sensitiveness to light, pain, dimness in vision etc. According to the parts which are affected, the inflammation of the eye is called by different names—OPHTHALMIA (general inflammation of the eyeball), ACUTE CONJUNCTIVITIS (inflammation of the conjunctiva), IRITIS (inflammation of the iris), KERATITIS (inflammation of the cornea), SCLERITIS (inflammation of the sclera), CYCLITIS (inflammation of the ciliary body), INFLAMMATORY GLAUCOMA, etc.

Tension:—The tension of the muscles and nerves of the eye is the most important factor in all the inflammatory conditions. When a person has glaucoma, eye tension can always be demonstrated, because when the eye tension is relieved and corrected, the inflammation of glaucoma subsides. Patients with ophthalmia, iritis, scleritis etc., are suffering from tension. When the tension is relieved, the eye disease disappears.

In some cases, it is more difficult to relieve the tension than in others. No matter whether it is difficult or not, there can be no cure of the eye disease unless the tension is corrected. This tension, besides affecting the eyeball, is also manifest or can be demonstrated in any or in all parts of the body. A person who has glaucoma is under not only tension of the eyes, but a tension or an unusual contraction of the muscles of the arm, the hand, or all the muscles.

Tension of the internal muscles is always present when a patient has a disease of the chest, and it can be demonstrated that he is also suffering from tension, not only of the chest, but also of other muscles and nerves in other parts of the body. There is a tension that contracts the bronchial tubes which interferes with the proper circulation of air into the lungs and out of the lungs. People with pneumonia, tuberculosis of the lungs, or tuberculosis of any part of the body are all suffering from eye tension, and when the eye tension is relieved, the tension in other parts of the body is also relieved. It is an interesting fact that all diseases of the eyes and all diseases of the body are generally associated with eye tension.

A very remarkable case of tension was that of an opera singer who suddenly lost her ability to sing. Specialists on the throat examined her very carefully and they were united in the statement that she had paralysis of the muscles on the left side of her larynx. In connection with her paralysis there was a tumour growth on the left vocal cord. Her symptoms of paralysis were caused by tension, because when the tension was relieved, the paralysis of the vocal cord was also relieved and cured. The tumour which had grown on the left vocal cord disappeared.

There were two things about this case which can be discussed; one is that the paralysis was caused by tension and the other that the tumour of the vocal cord was also caused by tension. When we analyze her case and try to give an explanation of what the

* This concludes the series of articles by this author.

before the required quantity of saline is pushed into the system. Of course this reaction rarely proves fatal. The temperature of the saline solution should be of normal body temperature.

After the saline transfusion 7-9/2 grs. of caffeine et sodi benzoate is injected, which will make the urine free and at the same time keep up the tone of the heart.

Gradually the colour of the stool changes from rice watery to yellow and the tongue becomes clear and moist. At this stage the following mixture may be given orally at 4 hours interval.

Bismuth Carb	gr.	15
Kaoline	gr.	15
Sodi Bicarb	gr.	10
Aqua ad	oz.	1

The number of stool then slowly comes down. In the next stage mist ferri et strychnine to be given orally twice daily.

Diet:—In the acute stage the patient always cries for cold water, when small pieces of ice to be given to suck to control both vomiting and thirst. If there is no vomiting the patient may be given plain barley water, lime, and green cocoanut water freely. In the convalescent stage the patient may be given rice and butter milk.

Cholera Phage:—I have tried this in several cases but the results not very hopeful. It gave satisfactory results only in few mild cases among children.

Anti-cholera Serum:—This serum treatment gave me good impressive results in some severe type of cholera cases, specially when there is vasomotor failure, and repeated saline injections could not improve the volume of the pulse and the patient was very toxæmic. It was not tried in cases of children. Serum was given early, within 24 hours and in 40 c.c dose intramuscularly, and repeated in 20 c.c dose after 12 hours. But very rare cases required the second injection.

Sulphaguinadine:—This drug is found to be much effective in the treatment of intestinal infections particularly in bacillary dysentery. It was used in the treatment of cholera with the idea that the drug has got specific lethal action on the vibrio comma. It has been estimated that when used in high doses in cholera cases the drug is not absorbed in much more concentration than 5 grm. per hundred cc.; so there is very little chance for this drug to produce any toxic effect. In some toxæmic cases of cholera, and where the patient is having repeated collapse, the administration of sulphaguinadine in tablets for 24 hours have shown good results. It improves the general conditions of the patient and also controlled the repeated collapse. Ten tablets of sulphaguinadine was given stat and then 5 tablets were repeated at every 4 hours interval for 24 hours. Then the administration of this drug was stopped. Symptomatic saline treatment to be continued during the administration of this drug. Very few cases required the repetition of saline transfusion with this drug.

tension accomplished, we will probably say a good many things which are not correct. It is exceedingly difficult to answer the question "Why?"

We may have cases of eye diseases in which it is difficult to relieve the tension, but it may be easy to relieve the tension in the muscles of the stomach or in the various groups of muscles in the arm, or hand, and when such tension is relieved, that of the eye muscles is relieved, and in this way, the disease of the eye, no matter what it may be, can always be relieved or cured. This is a very important fact, because when understood and practised, some very severe forms of diseases of the eyes can thus be cured, and in no other way so well.

The question that comes up more prominently than any other is: What can the patient do to bring about relaxation of any group of muscles? A man, by the name of F. M. Alexander, of London, England, has accomplished a great deal in the cure of all kinds of diseases. He says that all diseases of the body are caused by tension. They all can be cured by the relaxation of the tension. He has offered many methods of bringing about relaxation in the most interesting, although seemingly incredible way and the most successful is to bring about relaxation by having the patient state that it is desired.

For example, a patient sitting in a chair or lying down on the floor, which is easier, says: "I desire relaxation of the muscles of my neck, so that my head can be lifted forwards and upwards." This is sometimes repeated one hundred to a thousand times. Alexander has always succeeded in having the patient bring about relaxation of the muscles of the neck by this method.

Mr. Alexander goes further and brings about relaxation of the muscles of the chest, both outside and inside, by having the patient say: "I wish my shoulder to relax and to move downwards and backwards. I wish my chest to relax and move backwards. I wish my whole body to relax and move backwards. I wish my foot to move backwards without effort, without strain of any muscles of the body."

It has been a great shock to many orthodox physicians to observe the cures Alexander has made. Epilepsy, considered by the medical profession to be incurable, has been cured by relaxation, without the use of any other form of treatment. Of course, rheumatism responds perhaps more quickly to relaxation than a great many other diseases, but there are cases of so-called rheumatism affecting the shoulder in which all parts of the joint become immovable.

One patient was afflicted with Parkinson's disease; all the joints of the body became so fastened together, so immovable, that the patient was unable to produce any voluntary movement of the hand or the arm. As time passed, the voluntary and the involuntary muscles gradually became useless from tension. Mr. Alexander had the patient relax those muscles which she could relax most readily. When this was done, the more difficult muscles became relaxed, until finally she was cured completely by the relaxation of tension.

Dr. Bates mentions the following interesting case: "A coal heaver whose face and hands and all parts of

his body were covered with black particles of coal, came to the clinic. His right eye was suffering from an ulcer of the front part. The case interested me very much and I took him in to see the surgeon in our department, a man who believed very strongly that an abscess in any part of the body is caused by germs, and when there is a collection of pus, it is the physician's duty to drain it and get rid of it. I said to him:

"Would you drain that pus?"

He answered; "Certainly, a man would be crazy not to drain it."

I then said: "Doctor, do you know that some patients in this condition, who have had the pus drained have lost an eye, and oftentimes both eyes from sympathetic ophthalmia?"

I don't care; it ought to be drained," he said.

"Just watch me," I said.

Without cleaning the patient's face or eyes, a pressure bandage was placed over his eye and tied so tightly that his face became much swollen. I told him that in two days, his eye would be cured. The surgeon said:

"Impossible."

I said, "Take a good look at him so that you will recognise him if you ever see him again."

At the end of two days, the man came back, very much annoyed with me. He said that the bandage nearly killed him.

"Take it off," I said.

He took it off and the pus had disappeared. The surgeon who saw it said that I had not cured him, that the man did not have an abscess to start with, that he had a perfectly healthy eye, and that anybody who said that the eye was full of pus two days before was wrong.

Strange it may seem, the pressure bandage relieved the tension in the eye to a considerable degree, with the result that the pus in the anterior chamber was entirely absorbed. The eye recovered its health in forty-eight hours and the eyeball became very soft, because the tension was relieved."

It is well to demonstrate the results produced by tension. When the letter "O", for instance, is remembered imperfectly, the white centre becomes a shade of gray and the black part of the letter becomes less black and often covered with a gray cloud. To remember an imperfect letter "O" requires an effort. The effort tires the eyes and mind. The memory of imperfect sight lowers the vision of other letters. When the effort becomes sufficiently great to blur the letter "O" more completely, the tension becomes increased, the eyes feel uncomfortable and may suffer considerable pain. This pain may be felt in the head, back of the neck, in the arms and in other part of the body.

The memory of perfect sight does not produce fatigue, pain or any other form of discomfort. The memory of perfect sight can be accomplished easily. Any effort, strain or tension spoils it. When the sight is perfect, it is possible for the memory to be perfect, because we can only remember what we have seen; when the memory is perfect, the imagination is

perfect, because we can only imagine what we remember. When the imagination is perfect, the sight is perfect, because we can only see perfectly what we imagine perfectly.

Effective Methods:—Sun treatment, palming, mental pictures and swinging are very helpful methods for relieving the tension. Enema, purgatives, vapour bath, nasal drops, deep breathing and massage are effective methods in the cure of all inflammatory conditions of the eye. Drugs used by mouth or injections should be such that they do not cause any harm to the system.

Pain:—Painful eyes are treated with soothing eye wash and drops. Fomentations or steam bath to the face and bandaging are frequently done. If there is intolerable pain, mild fomentations are done around the eye and not on the eye; bandage the eye with warm milk cream over the lids. If the pain is accompanied by much redness in the eyes, application of leeches on the temples and vapour bath may also be tried.

Thick Discharge:—If the inflammation is accompanied by thick yellowish white discharge (purulent discharge) bandaging is avoided. The eye is frequently washed with lemon juice diluted with water or saline lotion or any other antiseptic lotion. MB 693 or sulphamide tablets may be given by mouth. Penicillin may be tried. Usually the discharge soon stops but in some cases vaccine or serum injections are given.

This form of treatment acts on the same principles as the vaccines or serums do. The advantage is that the powder can be easily prepared then and there.

Diet:—If there is purulent discharge from the eye milk, curd, sugar, sour things, potato and meat are contraindicated. Green vegetables, fruits, porridge, bread are to be given.

If the inflammation of the eye is not accompanied by purulent discharge, milk, ghee, butter, vegetables, sugar, bread, rice are useful things; but sour things, oil, meat, brinjal and chillies are contraindicated.

Swelling:—If there is much swelling of the eyelids and conjunctiva, the following treatment proves very efficacious.

"Take some fine ginger powder and dust it on an eye pad. Wash the eye and ask the patient to close the eye; apply little vaseline on the eyelid skin and then put the pad dusted with the ginger powder on the eyelids. Bandage the eye and let the bandage remain on the eye for about an hour at least. The patient will complain of irritation but he should be persuaded to keep it on. This process should be repeated morning and evening. The result in some cases is wonderful. The inflammation soon subsides and the discharge stops.

After Treatment:—When the inflammation subsides the patient is instructed to continue Resolvent 200 or Resolvent 500 or Opacitox Occulose along with sun treatment. If the sight is affected, he is advised to practise central fixation exercises on the Snellen test card and to read fine print daily. He makes it a habit to blink frequently. He practises long swing and plaming before and after sleep to prevent eye strain during sleep.

Extracts from the Memorandum Submitted by Dr. M. L. Kapur, President of the A. I. M. L. A. to the Provincial Ministers of Health, dated June 1946.

(1) *Representative character of the Association:* Before we proceed with our representation, we think it proper that we should acquaint you with a short history and activities of our Association. It was founded in 1909 with the objects of (1) ameliorating the position of the medical licentiates in the provincial subordinate medical service, (2) associating itself with all useful Public Health measures and extension of medical relief organised by the Government and (3) establishing a uniform minimum standard of medical education and abolition of the existing compartmental system of medical registration and medical services in our country. It has on its roll more than 6,000 members, and 200 Branches. It aims to represent the vast body of medical licentiates of this country. Its representative character has been, since its formation in 1909, recognised by the Central as well as the Provincial Governments.

(2) *The Association welcomes the formation of popular Governments:*—We heartily welcome the formation of the provincial governments on a popular basis, and we assure these Governments our Association's fullest co-operation in all matters pertaining to Public health and Medical Relief. With this end in view, the Association has already directed its Provincial Secretaries to get in touch with the Provincial Ministers of Health and render them such co-operation and help as is possible and open to them. The Association in turn hopes that the Provincial Ministers of Health would accord to it opportunities for close association and consultation.

(3) *Brief History of Medical Licentiates:*—Medical licentiates are the products of Medical Schools in India, who are running independently 100 percent institutions located in rural areas, comprising 90 percent of total population of India and although the annual budget allotment for their hospitals and dispensaries for medicines, instruments and staff is rudimentary as compared to Hospitals in urban area and even though they enjoy no facilities for post-graduate training in special subjects, due to their laborious and simple habits they have shown to the medical world in India that they are capable of rendering equally efficient service if given opportunities.

It is therefore clear that whereas a few thousand medical licentiates are suffering humiliation and untold miseries in the profession, millions of people in India who wholly depend on their medical skill and the equipment available to them, as a result of this shabby treatment in the profession, are allowed to suffer and die from avoidable diseases.

(4) *The Purpose of this Memorandum:*—We beg to draw your attention to the disabilities which the medical licentiates in Service are labouring under. Owing to various causes, they had not been given that attention by the authorities which they really deserve. To remove these disabilities, the organised profession in our country has been suggesting the following measures.

(i) Institution of one unitary type of Medical Service, open to all registered medical practitioners—whether they be graduates or licentiates.

(ii) Absorption of the existing Sub-Assistant Surgeons into this unitary type of Service.

We would also, in the course of this memorandum, draw your attention to the need for a clear cut policy in the matter of resettlement of the demobilised Licentiates Medical Officers.

(5) *Institution of one Provincial Medical Service*:—At present Medical Service in the Provinces is composed of

(i) A quota of I.M.S. officers as fixed by the Government of India Act, 1935.

(ii) A Provincial Medical Service wholly composed of medical graduates.

(iii) A subordinate medical service mostly composed of medical licentiates.

The Licentiates' Association is of considered opinion that there is little or no justification for the continuation of this triune services, either from the point of view of expediency or efficiency. Leaving apart the question of I.M.S. which is a subject to be dealt with by the Government of India, there would remain the other two, viz., the Provincial Medical and subordinate medical services. We submit there is no reason for dividing the Provincial Medical Services into water-tight compartments as the alleged differences in qualification between a medical graduate and a medical licentiate are no longer so substantial as to warrant the continuance of the services as they are. So far as professional education is concerned, both the medical graduates and the licentiates read the same text-books on the same subjects and examined by nearly the same examiners—the difference being in the length of the course, the former studies for 5 years and the latter for 4 or 4½ years. This short difference by a few months in the duration of their respective studies is not so material as to warrant the existence of great disparities in pay, prospects and facilities for study leave, etc., between a graduate and a licentiate in service. The existing line of demarkation is purely arbitrary, based on unaccountable prejudice, and fostered by vested interests. The prevailing main disparities are shown in a tabular form for ready reference:

Scale of pay approximate Provincial average.	Medical Graduates Rs. 200 to Rs. 1,000	Medical Licentiates Rs. 65 to Rs. 200
Prospects	Can rise to any administrative position district or provincial	Only about 1 per cent get a chance to act as Assistant Surgeon.
Education Facilities for P. G. Medical	Given study leave on full pay	None.

If the licentiates are judged by the services they have so far rendered, from the point of view of both quality and quantity, there would be much less justification for perpetrating two types of services with such glaring and unjustifiable difference in their conditions of service. The report of the British Medical Mission 1943 has expressed the opinion that the licentiates are capable of full medical responsibility, which up to now, together with the status and emoluments of members of the profession they have been denied

and that they are not inferior in intelligence and capacity to a large number of graduates. They came to this conclusion after taking evidence from all sources and exhaustive enquiry. It was on the basis of this report that the Government of India instituted the I. A. M. C. and made the licentiates eligible to the King's Commission more or less in the same manner as the Graduates. The recent Conference of the Administrative Medical Officers (Nov., 1945) recommended unanimously that there should be one Provincial Medical Service and that the scale of pay of the licentiates should not be less than Rs. 150 to Rs. 450 and of the graduates Rs. 200 to Rs. 450.

The Association therefore appeals to the Provincial Ministers of Health to study this question and to take such steps as would result in fair and equal and equitable conditions of service for all registered medical practitioners, whether they be graduates or licentiates.

(6) *Absorption of the existing Sub-Assistant Surgeons into the Provincial Medical Service*: The question arises as to what to do with the existing sub-assistant surgeons. Our suggestion is that they should be absorbed into the Provincial service, and their initial pay fixed on the basis of half the number of years already served and on the scale of the pay of the Assistant Surgeons. In other words, let all those who have put in more than 3 years of service in the S.M.S., be given an antedate of 50% of the period of their service and start as assistant surgeons on the corresponding scale of pay; those under 3 years may be subjected to a competitive examination, who, if they pass, may be given the same 50% antedate, and those who do not pass the test may be disbanded. The motive underlying this suggestion is to show to the Government that we ask for no favour and that we depend on our merit only. That this is an equitable arrangement is quite obvious and we sincerely hope your Government would consider it so.

Another reason why the existing sub-assistant surgeons should be so absorbed into the Provincial Medical Service is that, in most Provinces, medical schools are abolished and there would be no fresh recruitment of licentiates to service. Under such a circumstance, it would be an act of fairness if the existing Sub-Assistant Surgeons are absorbed into the Provincial Medical Service. Every Provincial Administrative Medical Officer would undhesitatingly testify to the fact that the Sub-Assistant Surgeons have been discharging their duties with commendable efficiency and industry.

(7) *Resettlement of demobilised licentiate Medical Officers*: The Association is quite confident that your Government would see that these Officers are helped in all possible ways in their resettlement. These officers fall broadly under two categories:

(i) Those who volunteered from service—Government, Local Bodies, etc.

(ii) Those who volunteered from Private Practice.

Those who volunteered from service would, of course, have a lien on their previous appointment. But, in view of their distinguished services as Commissioned Officers, the Association urges on the Government to give them permanent berths in the Provincial Medical Service as Gazetted Officers. Anything less than that would be unjust and inequitable.

Those who volunteered from private practice should be given encouragement to settle in practice, and the younger members provided with suitable appointments in State Service.

(8) *Government's committal to Medical licentiates during the second world wide war*:

(i) Government of India's *Communique* abolishing S.A.S. rank in Military:—

"The old name of sub-assistant surgeon was originally given to hospital assistants who at the time required far less in the way of educational and other qualifications than the medical licentiates who serve as sub-assistant surgeons in the Indian Medical Department today. The present day sub-assistant surgeon is well educated and qualified man and is felt that there is no reason to retain the title which suggests that he holds the same subordinate status as his original predecessor."

(ii) The inauguration of the I.A.M.C. in April 1943 after enquiries by the British Medical Mission in India in January 1943 granted the following terms:

Medical Graduates	... Rs. 450 p. m.
Medical Licentiates	... Rs. 400 p. m. after six months Rs. 450
	Medical licentiates were considered eligible direct as specialists in the rank of Major.

(iii) "The Medical Licentiates of India have grasped the hand of opportunity held out to them in time of war. They have made good and established their position as medical officers. Never can they, as a class, be thrust back to their former subordinate status and menial pay."

General Sir Gordon Jolly, ex-D.G., I.M.S.

(iv) "These men possessed a store of professional wisdom and experience such that no doctor associated with them could fail to learn from them, and I certainly learnt much from their clinical and therapeutic acumen and judgment..."

"The inauguration of the Indian Army Medical Corps has brought with it the final recognition of the professional status of the licentiates by their admission to His Majesty's Commission in the Indian Land Forces as full fledged officers of a Medical Corps, entitled to rise by seniority and merit to any rank in the Corps including that of Specialists....."

(9) *Conclusion*: Medical Profession is one of the noblest professions and its work is to ameliorate the sufferings of the people. In their work, it is essential that the Government should deal with the medical personnel under their employment with every consideration in respect of their emoluments and other conditions of service. It is our duty to point out to you that the medical licentiates who attend to the medical needs of 90 percent of our population are not treated properly. They are given beggarly wages, which, in these days, do not even keep them and their families above starvation. Time has now come to undo this injustice. Since professionally there is little difference between Licentiates and Graduates, we submit that both of them should be dealt with in an equal manner. With this object in view

we have suggested the absorption of the existing Sub-Assistant Surgeons into the Provincial Medical Service and the institution of one unitary type of medical service open for all statutorily registered medical practitioners. This is the considered opinion of the organised medical profession in our country. The Association therefore hopes that the popular Governments would respect this opinion and translate it into action at an early date. None should be allowed to say, that the rural area is suffering because a large number of medical men required there are not available in this country, but let it be clear to the world that the sufferings of the people were the result of want of funds required to give the rightful place to the medical licentiates in the profession and not want of men in the country

LETTERS TO THE EDITOR

Lack of Unity among Licentiates in Railway Service

As a constant reader and regular subscriber of the I.M.J. I have to point out that there are few sub-assistant surgeons on the Indian Railways who pay any attention towards unity amongst their own class. I have retired after 28 years of service on a 1st Class Railway in India. I have found no unity, at least on the railway I served, amongst our class. The result was victimization, injustice, and favouring a few, who had no back-bone to join in a regular united effort of appeal to redress the common grievances of the class.

It is now high time that Railway Medical Licentiates muster strong and form their own associations on different railways, and all these associations must merge themselves in the A.I.M.L.A. if at all they desire to live with times.

They must make a common cause, and join hands. I have seen and suffered. There is great injustice, as regards grades and promotions on the B.B. and C.I. Railway. I have worked for 28 years and though I was top-most, I was left out from any promotion whatsoever even though I had passed the regular examinations, as stipulated by the Chief Medical Officer's various circulars, and even though the District Officers' Reports were in my favour. Many such were left out and a favoured few, who did not join in the appeal to redress such wrongs, were granted promotions though they were junior to me by many years in pay and service.

There seems to be no uniformity in the so called Government Railway (Since 1941 this Railway has been taken up by the Government for administration), the will of the Head of the department is law, and this has been, in almost all cases, substantiated by the General Manager and even by the Railway Board, when an appeal is made. People at random are getting promotions and no justice as regards re-engagements and extensions is seen. I can quote innumerable instances of this if need be.

When will our men realize that united we stand and divided we fall."

N. V. Raval,

Retired Sub-assistant Surgeon B.B. and C.I. Rly.

Higher Medical Qualifications for I. A. M. C. Officers

Sir,

Ever since the formation of the I. A. M. C., the question of affording liberal concessions to Licentiate Commissioned Officers of that corps, to enable them to obtain the M. B. B. S. degree, engaged the minds of the leaders of the A. I. M. L. A., which resulted in the Indian Medical Council passing a resolution recommending to the various Indian universities to prescribe a course of studies extending for 18 months (in clinical subjects only) for the M.B.B.S. degree, in the case of the above mentioned officers. It is over a year since the World War II ended, but as far as is known to me, this resolution as such has not been given effect to by any Indian University. This apart, it is a doubtful point, as to how many demobilised Licentiate Officers, will really be able to spend such a long period in studying for the M. B. B. S. in India or for a matter of that for the L. R. C. P., M. R. C. S. in England. The reasons are not far to seek; to mention a few—financial condition, family commitments, age, desire to return early to private practice in view of the paltry pay and subordinate status offered in Civil Medical Departments etc. In short, it is only a fortunate few who will actually be able to take advantage of the present condensed M. B. B. S. course offered to Licentiate Officers.

If the Universities and the powers that be are really out to help a very large number of Licentiates (both I.A.M.C. and others), they cannot do better than introduce an "evening session" in every Medical College. This will enable every Licentiate to learn while he earns—for he will have enough leisure to attend to both his practice and studies. In some Arts and Science Colleges of this Province, such extra sessions have recently been introduced to meet the increasing demand for seats. Why then can the same not be introduced in every Medical College? The A.I.M.L.A. should do its best to see that this object is achieved.

Apart from the universities, there are a few Examining Bodies in our country, who confer higher medical qualifications. The State Medical Faculties of the Punjab, U. P. and Bengal conduct the M. S. M. F. examinations and the College of Physicians and Surgeons of Bombay that of the M. C. P. S. The M. C. P. S. (Bom.) has recently been placed on a par with the M. B. B. S., by the Indian Medical Council, whereas the M.S.M.F. has not been so recognised; however, the M.S.M.F. is considered by many to be as good as the M. B. B. S.

The State Medical Faculty of Bengal and the College of Physicians and Surgeons of Bombay have not offered any concession whatsoever to Licentiate Officers of the I. A. M. C., who desire to appear for their respective Membership examinations. The A. I. M. L. A. should see that these two Bodies give a fair deal to Licentiate Officers.

On the other hand the State Medical Faculties of the Punjab and U. P. have been liberal and generous enough, to allow every Licentiate who has at least six months of Army Service to his credit to appear directly for the Membership examination (M.S.M.F.), without undergoing a further course of study, subject to the proviso that he holds the Licentiate qualification

of that Faculty. It is obvious that this is a concession of far greater practical value to the demobbed Licentiate Officer than what the universities have hitherto offered. If these two Faculties will graciously extend these concessions to all Licentiate Officers of the I. A. M. C., who possess qualifications registrable with the Provincial Medical Councils of the Punjab and U. P., hundreds of Licentiates all over India will be benefitted to a great degree. I appeal to the A. I. M. L. A., through the columns of your esteemed Journal, to take this matter up at once with the State Medical Faculties of the Punjab and U. P. Certain interested quarters have already commenced demanding the abolition of all Examining Bodies except the universities. Before this demand materialises, the A.I.M.L.A. should make a move in the right direction and move quickly too.

Yours faithfully,

Ahmedabad, } P. R. PANDIT,
19th August, 1946. } Captain, (Late of I. A. M. C.)

Reference the letter which was published in our June, 1946 Issue under the caption "Disillusioned", D.G., I.M.S., replies as follows:—

An Army Instruction (India) regarding the grant of permanent commissions to Licentiate Officers is under issue. In the meantime applications in respect of such officers have been called for from all the Commands.

Applicants considered suitable will be called for interview by a Selection Board as is done in the case of Graduates.

It is intended that those selected will be required to undergo a further period of study to enable them to obtain the graduate qualification before being actually appointed to a Regular Commission.

BOOK REVIEWS

Physical signs in Clinical Surgery.—By Hamilton Bailey, F.R.C.S., Tenth Edition, 1946. John Wright and Sons, Ltd, Bristol.

Those who value clinical diagnosis in Surgery will find this book extremely useful. Each important physical sign is clearly and fully described—and what is more it is demonstrated by coloured pictures. We heartily recommend this book to the medical students as well as general practitioners.

The Chemistry and Metallurgy of Dental Materials.—By J. Campbell Smith, B. Sc., Blackwell Scientific Publications Ltd., Oxford 21 Sh. Nett.

This is designed as a text book for the use of dental students and shows the correct application of the principles of Chemistry, Physics and Metallurgy to the manipulation of dental materials. We warmly recommend this book to the dental students as well as the Dentists in this country.

Some Chapters in Cambridge Medical History.—By Sir Walter Langdon-Brown, Cambridge University Press. Price 6 Sh. Nett.

This interesting little book is dedicated to all Cambridge Medical graduates and shows briefly how Medicine developed at Cambridge as a result of the endeavours of its great luminaries like John Caius, William Gilbert, Clifford Albutt and others. It would be an useful addition to the Practitioners' Library.

ABSTRACTS

COMPARATIVE EFFECT OF SULFONAMIDE AND PENICILLIN IN PNEUMONIA

A series of 126 patients over the age of 35 years suffering from pneumonia was divided by random selection into two groups, one of which was given sulfathiazole, the other penicillin. All patients received the same symptomatic treatment and general clinical control.

The distribution of factors known to influence the course of the disease was the same in the two groups.

Each method achieved fairly similar results. In three patients, however, it was thought penicillin had produced an unexpected recovery.

There is no reason for abandoning properly controlled sulfonamide treatment for the average case; and it is suggested that penicillin should be used for selected patients, usually in combination with a sulfonamide. Indications for the use of penicillin are tentatively suggested.

The cause of delayed resolution is discussed.—ANDERSON, T. and FERGUSON, M. S.; Comparative effect of sulfonamide and penicillin in pneumonia. *Lancet* 2: 805—808, December 22, 1945.

STUDIES ON SPECIFICITY OF INTRADERMAL TESTS IN DIAGNOSIS OF FILARIASIS

While it has not been possible for us to perform experiments which would yield direct evidence on the question of infective larvae of nonhuman filarial worms producing filarial sensitization in man, our results clearly show that extracts of these parasites are markedly antigenic when injected into mammalian skin, and that the resulting immune response is demonstrable by skin tests employing either specific or nonspecific filarial antigens.

We are, therefore, justified in supposing (a) that nonhuman filarial worms can influence the serologic reactions of man, and (b) that many of the hitherto unexplained false-positive skin reactions following the use of *Dirofilaria immitis* antigen are due to immune responses produced by filarid larvae of animals. The matter should receive thorough field investigation.—AUGUSTINE, D. L. and L. HERISSON, C.; Studies on specificity of intradermal tests in diagnosis of filariasis. *American J. Hyg.* 43: 38—40, January 1946.

X-RAY TREATMENT OF BLADDER CARCINOMA

Of 68 patients with advanced carcinoma of the bladder treated between 1934 and 1940 with 800-kilovolt roentgen irradiation, 10 are so far clinically well and cystoscopically without evidence of disease. Seven of these are well and have remained well for more than 4 years.

A small carcinoma of a primarily infiltrating type is better handled by surgical excision, if this is feasible. If the lesion is so located that a complete bladder resection is the only surgical procedure possible, interstitial irradiation, preferably in the form of implantation of removable radium needles, is probably superior to roentgen therapy, provided the actual size of the tumor is not beyond about 3.5 cm. in diameter.—BUSCHKE, F. and CANTRIL, S. T.; Indications for roentgen therapy of bladder carcinomas; recognition of suitable cases. *Surg. Gynec. & Obst.* 82: 29-35, January 1946.

MORPHINE AND RESPIRATION

Contrary to popular opinion morphine does not increase the depth of respiration, according to Dripps and Comroe of the University of Pennsylvania, who administered the drug to 49

normal persons ranging in age from 19 to 82 years, and from 42 to 99 kilograms in weight.

Following intravenous injection, morphine produced maximal depressant effects within 3 to 7 minutes in the majority of instances. Respiratory minute volume, rate and tidal exchange were diminished. The intensity of action of morphine on respiration is not significantly increased by intravenous administration.

The maximal respiratory depression following morphine is approximately the same whether the morphine is administered intravenously or intramuscularly.—DRIPPS, R. D., and COMROE, J. H.; Clinical studies on morphine. *Anesthesiology* 6: 462-468, September 1945.

ADVANTAGES OF GLOBIN INSULIN

Globin insulin is as good or better than protamine zinc insulin in the moderately severe diabetic, requiring one large dose of protamine zinc insulin for proper regulation. It may be of advantage in those cases exhibiting allergic reaction to protamine and in those subject to nocturnal hypoglycemia. Globin insulin did not show such uniformly good results in the more severe diabetics in whom separate injections of protamine and regular insulin are necessary. However it is worth a trial in such patients, in the attempt to eliminate extra injections of insulin. Six of ten patients required less globin than protamine for satisfactory diabetic control. The other four cases were regulated with the same doses of both types of insulin. Of 6 patients stabilized with protamine and regular insulin, only 2 were able to secure similar regulation with globin insulin alone.—TRASOFF, A.; BORDEN, S. S.; Globin insulin, clinical study. *Am. J. Digest Dis.* 12: 313-315, September 1945.

TREATMENT OF GONORRHOEA IN WOMEN

Commercially produced sodium penicillin, administered according to identical time dose schedules, is as efficient in the treatment of gonorrhea in women as in men. No difference in response to treatment can be demonstrated in different races. No naturally penicillin-fast strain of gonococcus has been encountered nor any indication of the development of penicillin fastness under treatment. With sodium penicillin, which is now available, a 4-hour treatment schedule suitable for use by private physicians and clinics has proved satisfactory.—THOMAS, R. B. and MEYER, E.; Penicillin in treatment of gonorrhea; results with six hundred and seventy-five women. *Ven. Dis. Inform* 26: 94-98, May 1945.

TREATMENT OF SEVERE ACUTE TONSILLITIS

The use of sulfonamides in the treatment of severe cases of acute tonsillitis results in a prompt drop in the temperature with some relief from symptoms. But there is usually a secondary rise in temperature at the time untreated cases are being discharged. The number of hospital days is increased from 5.3 to 9.1 and added to this is the clinical observation that the patients did not feel as well on the tenth day as the untreated cases did on the fifth. No conclusions are drawn concerning the use of an initial dose only since in view of the other findings it seems highly suggestive that the use of sulfonamides in the treatment of acute "strep" tonsillitis is not only of no benefit but actually detrimental to the welfare of the patient.—CLODFELTER, H. M.; Treatment of severe acute tonsillitis with and without sulfonamides. *Internat. M. Digest* 48: 9-11, January 1946.

ALLERGY AS FACTOR IN SURFACE ULCERS

Allergenic foods and other substances may produce inflammation and other reactions in the endothelium of the blood vessels, in the same way that they produce the more familiar sensitizations of the epithelium. Six cases are cited: (1) Two patients had pruritus and eczema; (2) three had varicose ulcers of the leg, one of the neck; (3) two had angina pectoris, showing involvement of the coronary arteries; (4) there were two cases of thrombosis of the femoral vessels. In each of the cases described complete relief of symptoms was obtained by adherence to diets based on avoidance of allergenic foods, as demonstrated by cutaneous tests. In three cases lapses from the prescribed diet brought on recurrence of symptoms.—TURNBULL, J. A.; Allergy as factor in surface ulcers, varicose veins, phlebitis and thrombosis. *Am. J. Digest Dis.* 12: 272-276, August 1945.

INFARCTION AND CORONARY THROMBOSIS

Evidence is again presented that infarcts which are antero-septal in location, as shown by diagnostic changes in leads from the right precordial area, often fail to produce equally significant changes in the limb leads. In cases of coronary arterial disease some of the attacks of pain which have usually been considered prodromal symptoms of myocardial infarction, actually represent the development of a small, antero-septal infarct, and the more characteristic symptoms of acute coronary thrombosis which often occur later are due to an extension of this initial lesion. The true situation must be recognized if such patients are to be treated properly.—ROSENBAUM, F. M.; WILSON, F. N.; and JOHNSTON, F. D. Changes in precordial electrocardiogram produced by extension of antero-septal myocardial infarction. *Am. Heart J.* 30: 11-18, July 1945.

OTITIS EXTERNA ACUTE

At this activity 60 cases of acute otitis externa were treated daily with penicillin and glycerin wicks, 500 units of penicillin per cc, of glycerin. The cases included in this series were those with secondary infection resulting in cellulitis, characterized by pain, redness, swelling and edema, purulent discharge, and maceration. The following are conclusions reached from this series.

1. Penicillin in glycerin will not result in a cure in all cases. Five of these cases required admission to the ward with additional therapy of local heat, analgesics, and sulfadiazine or penicillin intramuscularly. Penicillin intramuscularly was used in 3 of these cases with excellent results. In addition to penicillin in glycerin, 4 patients were given sulfadiazine orally at onset because of severity of symptoms.

2. Relief occurred gradually over a period of 24 hours in the majority of cases, and not immediately or dramatically. This relief was gradual and progressive in the majority of cases.

3. Unless the condition was relieved within 3 or 4 days, it was necessary to change to some form of therapy for subacute or chronic otitis externa. Failure to change resulted usually in a stationery condition and occasionally in an exacerbation.

4. In no case was there suppuration, or necessity for drainage.

5. In severe otitis externa, the use of penicillin in glycerin will result in relief, and will obviate admission to the ward in a larger percentage of cases than with any other routine of local treatment.—WELLS, J. L., Commander (MC) U.S.N.

REPEATED THORACENTESIS IN PNEUMOTHORAX

The effectiveness of repeated thoracentesis in the treatment of 225 patients with hemothorax is apparent in the incidence of infection of only 16.8 percent, as compared to an incidence of infection of 45.9 per cent in 74 patients not aspirated.

Early thoracotomies employed in the treatment of chest injuries designed to stop hemorrhage or to prevent infection have frequently been followed by these complications. This is particularly apt to be true if the chest is closed without drainage. Of the 156 initial thoracotomies, 487 percent were complicated by an infected hemothorax, 30 percent by a hemothorax, and 6 percent by an organized hemothorax. The operative group includes the more severe injuries and the likelihood of complications is greater, but it also includes a number of patients that could have been treated as well by conservative means—KAY, E. B., and MEADE, R. H., JR.: War injuries of chest. *Surge., Gynec. & Obst.* 82: 13-24, January 1936.

EXPERIMENTAL PREVENTION OF "PEPTIC ULCER"

Evidence from studies on Mann-Williamson dogs, which consistently develop postoperative jejunal ulcer, shows that the daily parenteral administration of an intestinal extract, concentrated in regard to enterogastrone, prevents ulcer from developing in approximately 80 percent of the dogs. When the therapy is discontinued after several months, the animals are resistant to the occurrence of ulcer for periods of from 18 to 46 months. It has been demonstrated also that a relatively crude extract of intestinal mucosa is orally effective in preventing ulcer in M-W dogs.—IVY, A. C.: Potential physiological contribution to prevention of "peptic ulcer" in man. *Federation Proc.* 4: 222-225, September 1945.

PENICILLIN IN THE TREATMENT OF TETANUS

Two cases of severe tetanus are reported in which recovery followed treatment with large amounts of antitoxin, surgical excision of the wounds, and administration of large doses of penicillin.

Bacteriologic studies revealed that *Clostridium tetani* could no longer be isolated from wounds in these patients 24 hours after the first administration of penicillin. The already demonstrated antibiotic influence of Penicillin on this organism in vitro therefore appears to be confirmed in vivo.

The use of penicillin in tetanus appears to be most valuable in cases in which multiple lesions, not all of which can be removed by surgical means, are present or in which no focus of infection is detectable. This antibiotic agent is not intended to replace the administration of antitoxin, excision of wounds, adequate sedation and maintenance of normal state of nutrition and hydration, but appears to be a highly important adjuvant to these other therapeutic measures.—WEINSTEIN, L., and WESSELHOEFFT, C.: Penicillin in treatment of tetanus. *New England J. Med.* 233: 681-684, December 6, 1945. (Courtesy, *Naval Medical Bulletin, U. S. A.*)

ULTRAVIOLET BLOOD IRRADIATION THERAPY OF APPARENTLY INTRACTABLE BRONCHIAL ASTHMA

Summary.—The results of further study and clinical observation of the effects of ultraviolet blood irradiation therapy in 120 patients suffering from apparently intractable bronchial asthma have been tabulated. Of the 120 patients carefully followed up, 77 (64.1 percent) were found to be relatively symptom free or definitely improved, 27 (22.5 percent) were slightly improved, and 16 (13.4 percent) were unimproved.

Conclusion.—1. A marked and relatively permanent alleviation of severe dyspnea and cyanosis plus an obvious increase in general resistance has been observed in a relatively large percentage of patients suffering from apparently intractable bronchial asthma after the application of this method.

2. Blood irradiation therapy must be repeated at intervals of 2 to 8 weeks in cases of advanced asthmatic disease.

3. Six to ten months of treatment may be necessary before obvious improvement is noted.

4. Patients with advanced, severe, apparently intractable bronchial asthma cannot expect permanent alleviation of symptoms but often can be consistently relieved under constant treatment.

5. Patients with early, apparently intractable bronchial asthma respond more rapidly and maintain their improvement for longer periods than do those in an advanced stage.

6. The management of apparently intractable bronchial asthma requires, in addition to ultraviolet blood irradiation therapy, adherence to certain fundamental principles, e. g., elimination of predisposing aggravating influences, avoidance of instrumentation and nasal operations, and temporary use of epinephrine inhalants.

7. Autumnal aggravation of asthmatic symptoms occurred in approximately 30 percent of all patients under treatment but was purely temporary.

8. Children and young adults respond especially well to this type of therapy.

9. The Knott technique has been found to be a safe and efficient method of controlling apparently intractable bronchial asthma, with 77 of 120 patients (64.1 percent) who received constant treatment and observations showing and maintaining definite improvement.—MILLEY, C. P., SEIDEL, R. E., and CHRISTENSEN, J. A.: Ultraviolet blood irradiation therapy of apparently intractable bronchial asthma *Arch. Phys. Med.* 27: 24-29, January 1946. (Courtesy: *Naval Medical Bulletin, U.S.A.*)

THE 34TH ALL-INDIA MEDICAL LICENTIATES' CONFERENCE
POONA 1946

CONFERENCE NOTICE

The 34th All-India Medical Licentiates' Conference will be held in Poona on 18th, 19th, 20th and 21st October 1946, in the Sir Parashuram Bhau College, Tilak Road, Poona City. The following is the provisional programme:

Friday 18th October 1946:	9-30 P. M. Meeting of Delegates
Saturday 19th October 1946:	9 to 12 A. M. Inaugural Sessions 12 noon to 2 P. M. Interval 2 to 5-30 P. M. Scientific Session 5-30 to 6 P. M. Tea 6 to 8 P. M. Scientific Session 9-30 P. M. Subjects Committee Meeting
Sunday 20th October 1946:	9 to 12 A. M. Open Session for resolutions 2 to 5 P. M. Scientific Session 5 to 7 P. M. Tea and Excursion 9 P. M. Dinner 10 P. M. Musical Entertainment
Monday 21st October 1946:	9 to 12 A. M. Scientific Session 2 to 5 P. M. Open Session

The Delegates' camp will be located in the Sir Parashuram Bhau College premises. Delegates should reach Poona by the evening of Friday the 18th October, 1946.

Volunteers with badges will be meeting all incoming trains and also will be posted near the II class booking office. The climate of Poona will be pleasantly cool in October and Delegates should bring adequate clothing with them. Delegates are requested to intimate the time of their arrival to the General Secretary, Reception Committee, 502, Narayan Peth, Poona City.

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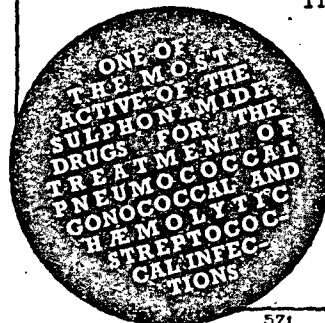
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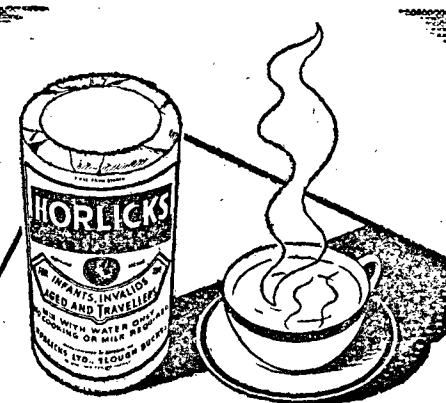
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Dionine	2 8	1 4	40. Procain & Chloretone	3 0	1 8	67. Penicillin Cum		
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20. Yellow Oxide of Mercury	2 8	1 4	51. Pilocarpine Cum Dionine	3 0	1 8	Shark-liver oil 20%	2 8	1 4
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Yellow oxide of mercury	3 0	1 8	53. Quinine Bisulphate	2 8	1 4	74. Dionine Cum Iodide	3 0	1 8
22. Halibut-Liver oil Cum			54. Yellow oxide of mercury			75. Tyrothricine Cum		
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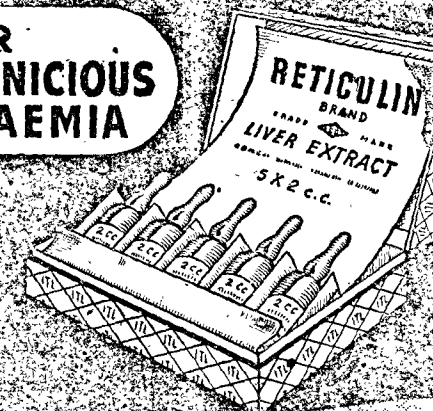
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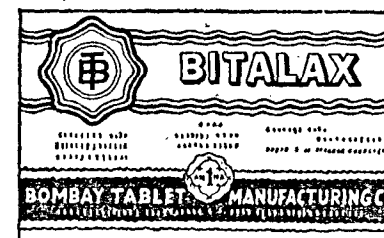
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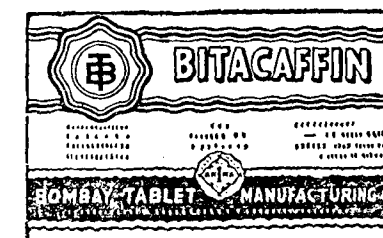


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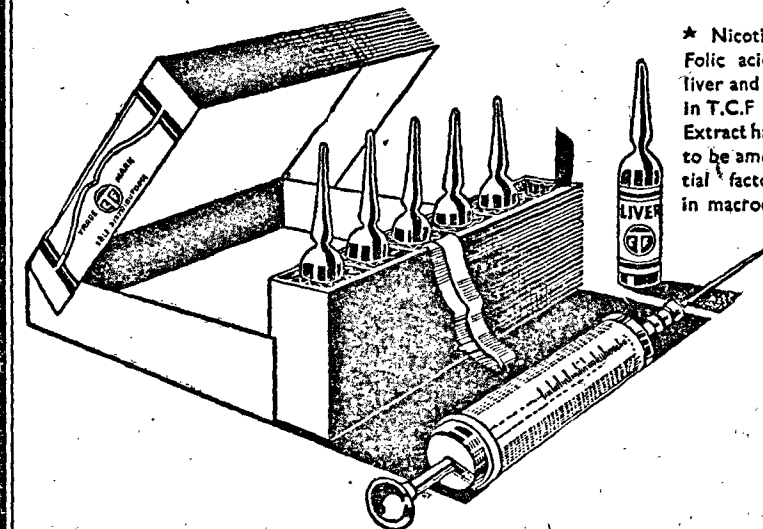
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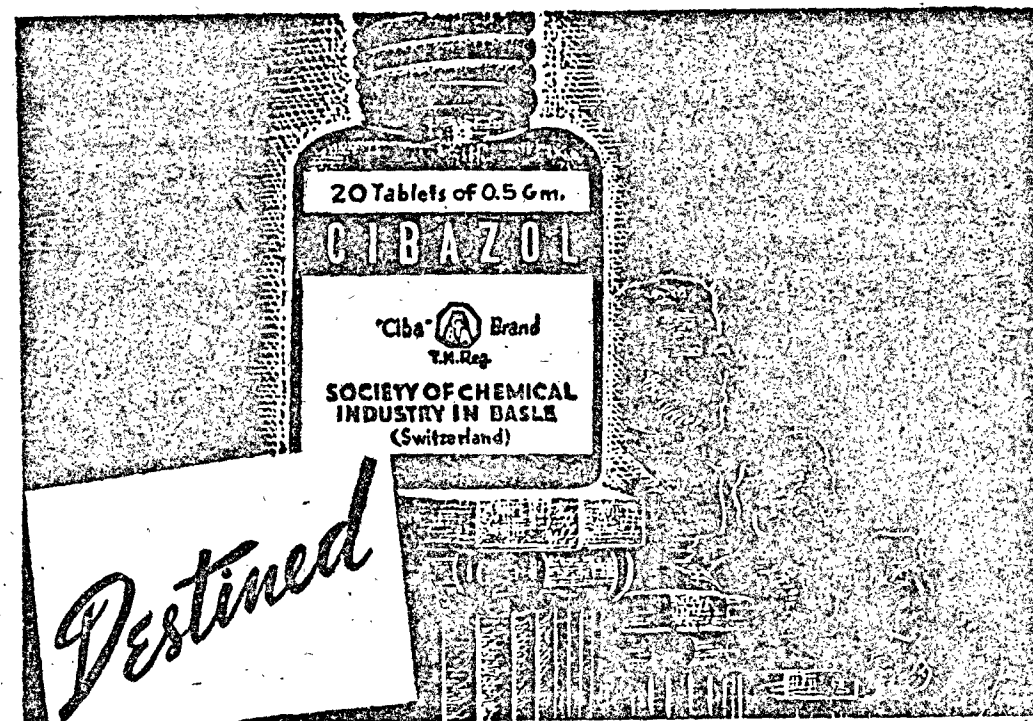
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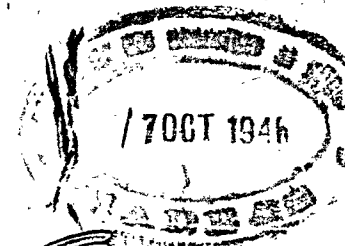
Indian Medical Journal.

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October 15, 1946

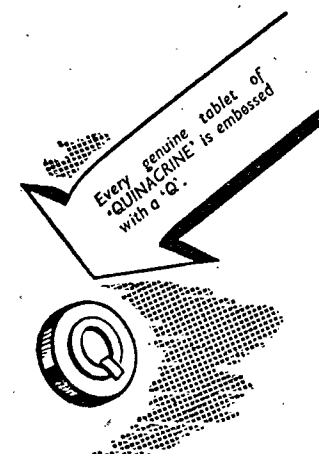
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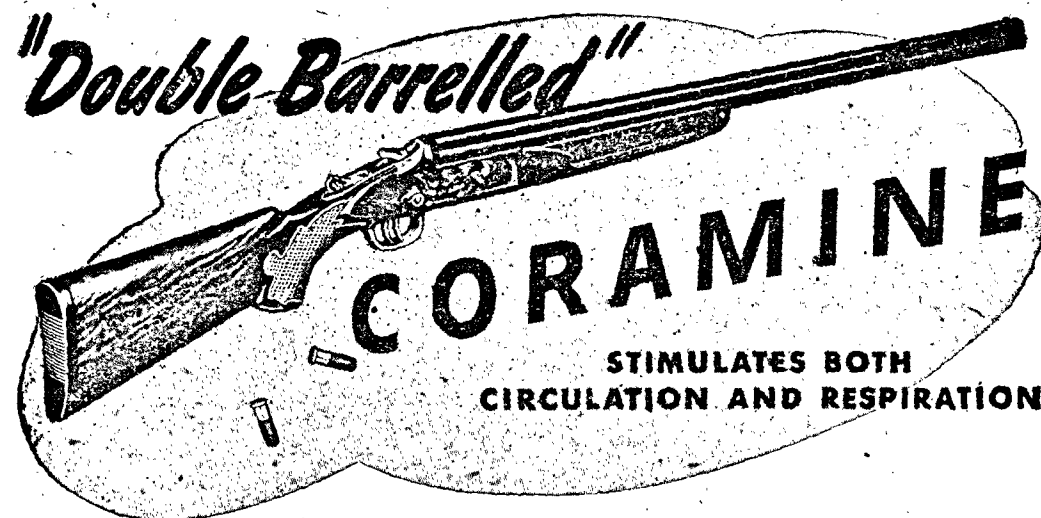
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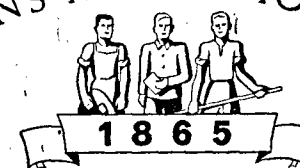
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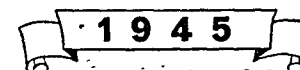


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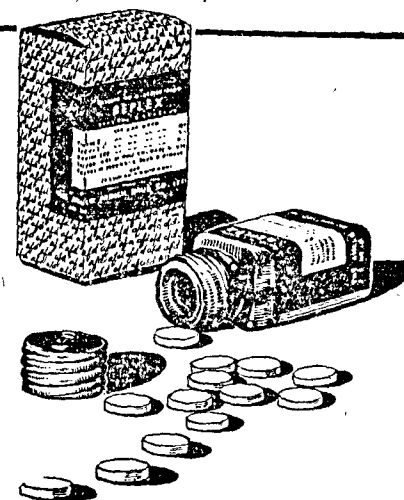
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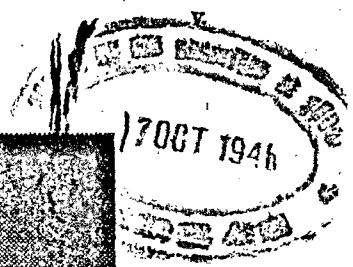
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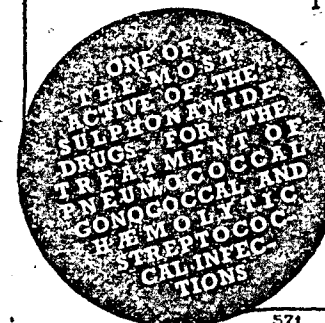
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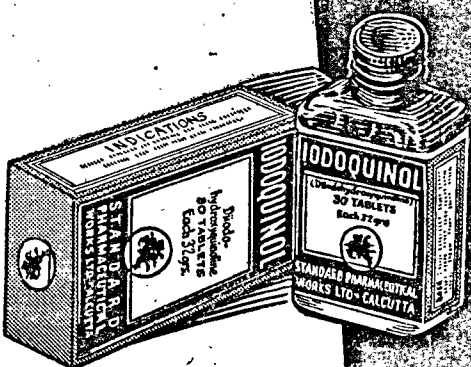
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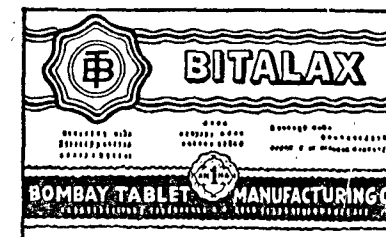
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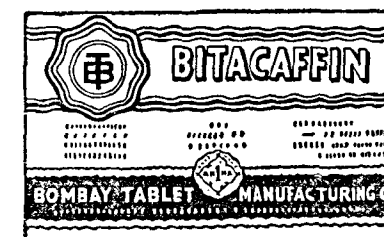


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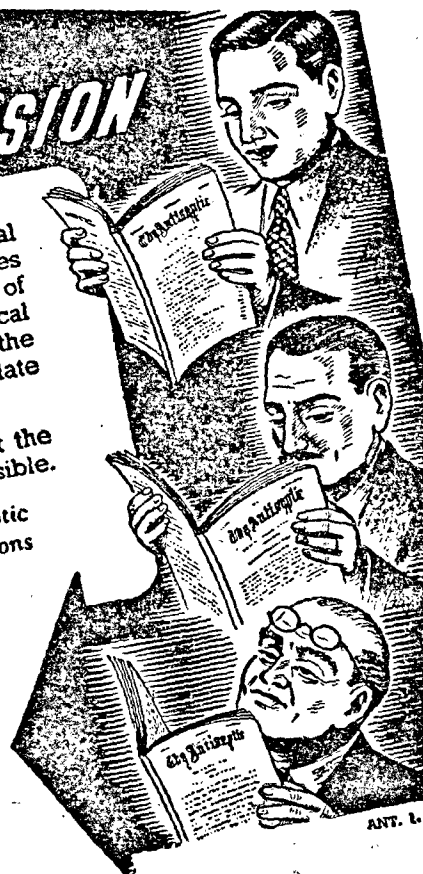
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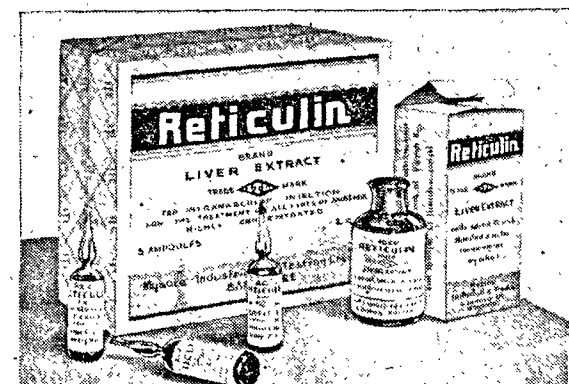


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(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras: October 15, 1946. No. 10

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All-India Medical Licentiates' Association

34th CONFERENCE

- ★ Will be held at Poona on 19th, 20th and 21st October 1946.
 - ★ A Special feature will be Symposium on "Nutrition in India".
 - ★ A Medical and Scientific Exhibition is also being arranged.
- More details re: reception of delegates, their accommodation and programme of the Conference will be announced duly in this column.

V. G. PARANJPE,
General Secretary.

Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras, October 15, 1946 No. 10.

ANNOUNCEMENT

Rai Saheb Dr. Manohar Lal Kapur has been re-elected as President of the All-India Medical Licentiates' Association and of the 34th Conference of the Association to be held at Poona from 18th to 21st October 1946.

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OUR MONTHLY SURVEY

A Correct Policy:—We sincerely congratulate the Minister of Health (Madras) Mrs. Lakshmi-pathi, for her wise declaration of the Government policy in respect of development and progress of Medicine, and it is exactly on the lines we suggested in our editorial in our last month's issue of the Journal. She said, in reply to the Budget discussion.

"The intention of the Government is not to have in this country various systems of Medicine, Siddah, Ayurveda, Unani etc., but to have one unified system which would be neither Western nor Eastern, but a combination of both. The purpose of the scheme under consideration of the Government is to give a general training to the medical graduates of the allopathic system in the Indian system of Medicine so that a synthetic system could be evolved from both Ayurveda and Allopathy."

This is indeed a correct policy which the organised profession in our country can heartily endorse and help the Government in its fulfilment. And this policy has been so clearly and categorically enunciated by the Minister of Health that, instead of quarrelling between themselves, the practitioners of both Ayurveda and Allopathy should join hands in developing and organising one combined system of medicine. This, in our view, is best done by remodelling our University medical education on this basis.

Poona Conference:—The All-India Medical Licentiates' Association will hold its 34th Conference at Poona, and as usual large number of delegates would assemble and deliberate on many issues of great importance. We wish the Conference every success.

Wanted a Dynamic Policy:—From the large amount of correspondence we receive from our readers, we are convinced that the licentiates as a whole are discontented at the "wait and see" policy of the Association. They point out that apart from the war-time emergency commission, they have not gained anything substantially and their position in every province is not only bad but definitely deteriorating. They are fed up with memoranda and deputation and insist on "Direct Action". This is the temper of the average licentiate of to-day, and we urge on the Conference to take note of this fact, and initiate a dynamic policy and implement it with all the resources at its command.

Our Suggestions:—Now that all the Provincial Governments are committed to the policy of abolition of medical schools, it would be better if we drop this item from our programme of work in the coming year. We must concentrate on achieving the establishment of one type of medical service, and absorption of the existing sub-assistant surgeons into this type on equitable basis. We must so devise a plan of action that would convince the provincial Governments of the justness of our demands and prompt them to take necessary action. If our Association wisely mobilises its forces and brings into one focus its energy which is, at present scattered over diverse immaterial issues, the success of this item of work is assured.

The second item in our immediate programme of work is the internal organisation of our Association. Its present structure is unsuited to the needs of the times. The executives are blamed for what is really due to the faulty system under which they have to carry out their duties. The departments of the Association must be centralised and an efficient and paid secretariat should be established in a central place like Delhi. If this is done, it will facilitate quick decisions and concentrated work, and unless this is done we will only be beating about the bush without being able to achieve anything substantial. This question is postponed or side-tracked every year. The result is what it cannot be otherwise—inertia in every aspect of its fundamental work and the growing discontent among medical licentiates in our country. Mere dependence on the justness of our cause is insufficient. We have to develop the necessary strength to see that justice is done to us.

ADDRESSES AND ARTICLES

Procedure to be adopted in Diagnosing Comatose patients with or without Pyrexia.*

BY

DR. M. H. HAZARIKA, S.A.S., (Retd.)

I have chosen this subject because a comatose patient is not only a matter of grave emergency but also his life entirely depends on prompt diagnosis and immediate treatment, leaving aside the medico-legal

* A paper read at the 11th Assam Provincial Conference, A.I.M.L.A., during Feb. 46.

importance of the matter. Before one starts with the procedure to be adopted in coma cases, the doctor in-charge should be well conversant with its causes so as to be able to come to a definite conclusion. The common conditions in which coma is a feature are: (1) Atypical Malaria (2) Apoplexy (3) Alcoholism (4) Alkalosis (5) Anaphylaxis (6) Epilepsy (7) Eclampsia (8) Injury of the head (9) Opium poisoning (10) Uraemia (11) Lethargica Encephalitis (12) Carbolic acid poisoning (13) Diabetes (14) Cerebral Malaria (15) Cerebro-spinal meningitis.

Any fever caused by virulent organism may ultimately develop into a typhoid state in the later stage and thus may give rise to a state of coma. Snake-bite and sun-stroke may also give rise to coma. Hysteria and poisoning by hypnotics should also be remembered. A word of caution to my colleagues is that the main cause of coma may remain untraced and the superficial one may be taken to be the cause. Alcoholism may be the main cause of coma but the co-existent head injury due to a fall in drunken state may be erroneously taken to be the cause of coma. Again there may be co-existence of two diseases viz., cerebral malaria with cerebral haemorrhage, diabetic coma with cerebral haemorrhage or meningitis and ascariasis with malaria specially in children.

Investigation.

First of all age, sex, general constitution and appearance have to be taken into account. Children are often found in comatose condition from epilepsy, cerebral malaria, meningitis, ascariasis and cerebral haemorrhage of whooping cough. Middle aged and fatty persons with flushed face give rise to suspicion of cerebral haemorrhage due to high blood pressure, whereas a thin emaciated person with skin affections like chronic eczema gives rise to a suspicion of diabetic coma. When the whole of the surface of the body is yellow tinged and accompanied with fever it leads to suspect one of B.W. fever. If the extensive portion of the body surface is made up with scar tissue, it leads to think of a fall over fire or hot-water during an epileptic fit. In females the cause of coma from hysteria should always be remembered.

The second point of investigation is history (from attendants). History of pre-existing illness like diabetes, acute infectious fever, syphilis, previous attacks of convulsions and coma and previous treatment are to be taken into consideration. We have to exclude hypoglycemic condition from an over-dose of insulin, or morphinism with an extensively damaged liver and kidney.

The third item of investigation is the mode of onset. Sudden onset of coma is a rule in epilepsy, and apoplexy. Gradual onset is found in poisoning, inflammatory conditions of brain and in many toxic conditions of blood. The onset of coma is always gradual in meningitis and meningitic type of malaria. Enquiries should be made about the onset whether it was with or without convulsion and headache.

The fourth item of investigation is physical examination. Inspection and palpation of head for trauma, and neck for retraction and rigidity of muscles, must be done with care. Inspection of ears, eyes, nose and mouth should follow. Ears should be examined for escape of blood or blood stained fluid,

C.S.F., brain substance or middle ear disease. Inspect the conjunctiva for congestion due to increased intra cranial pressure, black-eye from whooping cough rupture, or any icteric tinge. Palpate the eye ball to note the tension. A soft eye-ball is not only a serious consequence of diabetic coma but is a sign of most diagnostic importance. A note should be made about the conjugate deviation of the eyes and head.

Elicit the corneal reflex, pupillary reflex and look for the condition of the pupils. These reflexes are all abolished in very deep coma of apoplexy, uraemia, diabetes and opium poisoning. Look into the anterior chamber for pus and blood. I leave the ophthalmoscopic examination to the eye-specialists for retinal haemorrhage and other findings.

Nose is to be examined for signs of bleeding and smell of the breath for acetone, alcohol and opium. Face is to be examined for asymmetrical condition. Mouth is to be examined for foams and froths of epilepsy and of pontine haemorrhage. Tongue is to be examined for eschortic marks of carbolic acid poisoning or biting injury of epilepsy.

Cardio-Vascular system needs examination for the following as regards high blood pressure and endocardial conditions:—

- (a) Size and sounds of heart for hypertrophy.
- (b) Presence of adventitious sounds, specially of mitral stenosis to exclude the possibility of embolism.
- (c) More specially aortic second sound, because a specially accentuated second sound means high arterial pressure.
- (d) Course of the arteries with condition of their wall.
- (e) Pulse to be carefully studied.
- (f) Record of B. P.

Respiratory Systems.—Respirations are to be carefully studied as regards its type. Lungs need examination for presence of pneumonia or tubercular affections because comatose condition may be a secondary manifestation of pneumococcal or tubercular meningitis.

Abdomen.—Note its contour—full, flat or boat-shaped. Test the superficial reflexes, muscular rigidity and presence of enlargement of spleen and liver.

Muscular System.—Note any movements in the limbs or any convulsion. Test for muscular tone by grip and by raising the limbs turn by turn for flaccidity, rigidity and for paralysis.

Nervous System.—Test the tendon jerks. Elicit also the kernig's sign, Babinski's sign and Brudzinsk's sign. Note the differences of temperature in two axillae.

The fifth item is the most important of all. Remember the three body fluids to be examined in the laboratory.

A. Blood for M.P., meningococci, total count, differential count, culture, W.R. and also pathological R.B.C. and condition of haemoglobin.

B. Urine for physical, chemical and microscopical findings of casts, crystals and cells.

G. Lumbar puncture is needed in case of necessity for diagnostic purpose.

Note the colour of C.S.F. and its tension. Take smear for bacteriological and cytological diagnosis and also about 2 c.c. to be taken for serological, cultural and chemical tests.

In some cases bio-chemical changes of blood give the real clue. For instance urea retention tests in uraemia and hyperglycaemia with absence of sugar in urine due to renal inefficiency from sclerotic condition or from disturbance of fat metabolism with formation of ketones owing to withdrawal of carbohydrate food in diabetic conditions.

Again in some cases stomach washings may be necessary to detect the nature of poison in suspicious cases.

In some doubtful cases of head-injury or when exact cause of coma cannot be detected skiagraph of the skull may be needed.

Another word of caution to doctors working in out of the-way place is: Do not seek for rare causes in coma, rather think always of the common ailments. Of the common ailments one would do very well to remember comatose malaria, cerebral haemorrhage and cerebro-spinal meningitis, uraemia and diabetes.

These can be easily differentiated:—

Comatose Malaria:—

- (a) Mostly of sudden onset with high fever followed by coma.
- (b) Icteric tinge of the conjunctiva with bilious vomiting.
- (c) Palpable spleen and liver.
- (d) Presence of M.P., high monocytosis and pigment granules of haemozoin in W.B.C.

Cerebral Haemorrhage:—

- (a) Sudden onset of fits in persons of middle or advanced age with high B.P.
- (b) Eye changes and inequality of pupils.
- (c) Unilateral paralysis with loss of reflexes but a positive Babiniski's.
- (d) Absence of pyrexia except in pontine haemorrhage with pin point pupil.
- (e) Stertorous respiration.

Cerebro-spinal Meningitis:—is a simple matter to be diagnosed when there is an epidemic.

Otherwise:—

- (a) Patient will be found in lateral decubitus with offensive smell in the breath.
- (b) Signs of meningeal irritation—tossing about the bed and photophobia.
- (c) Absence of icteric tinge in the conjunctiva, absence of palpable liver and spleen and absence of M.P. in the smear.
- (d) Presence of meningococci in blood-slides with constant leucocytosis.
- (e) Relative bradycardia.
- (f) Glycosuria without Ketonuria.

(g) Spinal puncture—purulent or turbid fluid coming out with tension, with decrease of glucose content but increase in protein content and may show leucocytosis and meningococci under microscope.

Uraemia is diagnosed by:—

- (a) Glycosuria with low tension of the eye-balls and tachycardia.
- (b) Acetonemia and hyperglycaemia.
- (c) Acetonuria.
- (d) Smell of acetone in the breath.
- (e) Apyrexial condition unless there be a septic complication.
- (f) Plantar reflex is flexor,

In any case of doubt between a comatose malaria and cerebro-spinal meningitis, specially in a remote place, I should like to employ one more therapeutic test for diagnostic purpose and that is, quinine bi-hydrochlor injection by intra-muscular route. (10 grs. of quinine bi-hydrochlor with 5 minims of liquor Adreanline and 2 c.c. of distilled water in the morning and 10 grs. in the evening and another 10 grs. after the lapse of 24 hours in the buttock.) This will not harm the patient even if it be not malaria. 3 c.c. of 40% solution of hexamine intravenously may also be given. The efficacy of this test will depend upon the amelioration of the condition when we shall be justified to push quinine orally or intravenously as the case may be.

Failing all the above procedures the duty of the doctor should be to tend the patient by attending to bladder, bowel and bed sore. Watch him and apply cold to the head till you can diagnose or the patient recovers or dies.

The Pharmaceutical Industry of India

BY

DR. N. R. CHOWDHURY, L.M. & S.

(Rangoon) D.T.M. (Cal.)

The medical profession is intimately connected with the pharmaceutical industry. The skill of the physician depends not to a little extent on the reliability and efficacy of the drugs prescribed. It is therefore obvious that sufficient attention must be given to see that the drugs on which the medical profession so much depends should have uniform standard of potency and usefulness. Of late there have been legislatures which have put a restriction on the indiscriminate appearance into the market of spurious medicines which every right thinking person will support in the interest of the ailing population of the country. While this is one aspect of the picture, curiously enough, there has been little suggestions as to the ways and means that can be adopted to produce in India medicines of all kinds so as to avoid dependence on foreign supply. There is perhaps no other country in the world with the population and culture of India which has not its own pharmacopoea. It is an admitted fact that the effect and dose of the therapeutic substances vary according to climate and race. The results obtainable in Europe and America may not be applicable to the tropical climate of India and the Far East. It is for this reason that the authorities of every nation have set up a pharmacopoea of their own consistent with the peculiarities

of their own country. A therapeutic substance for instance in the British pharmacopoea may be found to have varied in strength or proportion in the French, German or American pharmacopoea although the drug in question is a recognised scientific product.

But in India conditions are different. Here one has to base one's medical education on the foundations of European conditions and peculiarities. Hardly do we know the names and nature of the medicinal plants of India although the flora of India is the richest in the world. Now that India is on the threshold of gaining of independence, it is only timely that our attention should be drawn towards this important question, namely to make India self sufficient in her medicinal requirement. While the political leaders are engaged in politics, the economists in the sphere of trade and commerce in general, it is the duty of the medical profession in collaboration with the scientists of allied sciences to see that efforts are made to organise the manufacture of all medicinal requirements in India. Unless we are prepared on this point from now, it will be found even if we gain independence today, we shall have to indent on foreign countries for our medicinal requirements of tomorrow. Unless complete economic independence is attained, political independence will have only a narrower import and utility. In outlying the above suggestion, I have not been unconscious of the appalling poverty of India and the innumerable difficulties that stand in the way of her industrialisation. As a nation, we are poor, nay, very poor indeed. Our poverty demands cheap remedies for the sick population of our nation. Foreign products are too costly for our purse. Despite this paradox, foreign remedies have a deep rooted position in our soil, the reason being the lack of adequate industrialisation. The war has opened our eyes in this respect. Our utter helplessness during the war time has been amply exemplified by the toll of many lives. A few Indian concerns however took the initiative of meeting the situation with their limited capacity and resources. Even though their efforts were too inadequate compared to the needs, the value of their service cannot be ignored. Even if one life has been saved by their enterprise, we should be thankful and appreciative of their services.

There is another aspect which requires serious consideration, I mean the question of standard and purity. Manufacturing concerns who are out to make a profit only with the sole intention of preparing spurious and understrength products deserve the strongest condemnation. This adversely affects other concerns with honesty of purpose, and a feeling of serving humanity. The attention of the medical profession is specially drawn to this matter. Let them condemn those who deserve to be condemned but let them not lose their faith in Indian concerns altogether for the wrongs or misdeeds of a few. Let them remember that even an honest enterprise has its defects and shortcomings. This sympathy and support from the medical profession is the greatest capital that the indigenous manufacturers can possess.

It is now too well known how foreign products are preparing themselves to oust the Indian from the Indian Market. The Indian have markets only in India. Their products have little export if any outside India. If they are pushed out of the field in their own

country, the future of Indians enterprise will be seriously affected. It is in the hands of the medical profession of India to protect Indian interests so far as our pharmaceutical industry is concerned.

(Read at the Assam Provincial Conference, A.I.M.L.A. Silchar, 17-2-1946.)

Human Amoeba.

BY

Dr. D. N. CHAKRAVARTY,

Burnie Braes Tea Estate.

Amoeba is the first living organism met with in the animal kingdom. It is homologous with the whole metazoal individual and may therefore be regarded as a non-cellular animal. Of the six amoebae upto now found living in human alimentary canal such as, *E. coli*, *E. Gingivalis*, *E. Histolytica*, *I. Butschli*, *E. Nana*, *E. Fragilis*, only *E. histolytica* is pathogenic to men, others are only harmless commensals and do not invade tissues nor produce any disease.

Incidence:—Infection with *E.H.* is world-wide about 10% of the humanity is infected. The figure for India is certainly higher, about 15 or 16%.

Habit:—*E.H.* lives and multiplies in the submucosa of large intestine, feeds upon tissue juice and red cells but in culture it lives on starch and bacteria. It has also been found to ingest cysts of its own kind. Of late it has definitely been established that it can live free in the lumen of the large gut feeding on bacteria but multiplication would not occur there. We meet *E.H.* in two forms (1) the trophozoite form (2) cystic form, and sometimes what is called the precystic form. Of all the human amoebae with which we are apt to confuse with *E.H.* is *E. coli*.

Life history:—The cysts of *E.H.* are swallowed with food or drink. The cyst wall is insoluble in gastric juice but soluble in trypsin. Hence the swallowed infective cysts pass through the stomach unchanged. In the small intestine, the wall is dissolved liberating 4 or 8 amoebulae. Here I may mention that only the mature tetranucleate cysts are capable of survival, others are not effective. The liberated amoebae find a suitable resting place in the sacculated caecum and waits for a suitable change such as intestinal stasis, fluid condition of the contents of the colon, presence of hemolytic streptococci, irritated condition of large gut when they attack the mucous membrane directly or pass down the crypts into submucous tissue. It secretes a powerful proteolytic ferment leading to dissolution of tissues where it finds a nice home to live in merrily with predigested tissue juice and R.B.C. to feed upon. Here they divide by binary fission and multiply. As they constantly come in contact with fresh living tissue, they attack, dissolve and destroy it. After a time, for some reason or other, the surroundings become unpalatable and scarcity of food may occur. Driven by a natural instinct of saving ones own species from being extinguished the amoeba now comes out of its home into the intestinal canal, rounds up, throws out all R. B. C., secretes a strong cyst wall, takes glycogen food reserve, lays down chromatoid substance in the cytoplasm and forms a

cyst. The nucleus here divides into two, then into four and the cyst becomes mature. The mature cyst along with others of the group, secure in its relatively resistant structure, is liberated with stool where it awaits to be carried by flies or other means to the human host, so that it can start its life afresh.

Pathology:—After the invasion of the large intestines by free amoeba, small abscesses are formed. These look like small nodules of the size of a pin head. The abscess ruptures giving rise to a typical ulcer with raised undermined margin and a necrotic area at the centre. The amoebic ulceration may be slight or widespread. The amoebic nidus is typically situated in the submucosa, the base of the ulcer is usually the muscular layer. Rarely, it penetrates into the serous coat resulting in peritonitis.

Transmission:—It occurs from contamination through a carrier or through infected water supply and vegetables.

(1) **The Carriers:**—Now let us begin with a community where 15 to 18% of the people harbour *E.H.*, in their large gut, the so called healthy carriers as they complain of no symptoms. But are they really healthy? Ulceration, however minute, is present—the host is constantly struggling to repair the damaged tissues. The host and the parasite are just living in a state of balanced mutual toleration. When ulcerations are formed in rapid succession and the repairing machinery cannot cope with it, the symptomless carrier shows signs of acute amoebic dysentery. But this is actually a rare complication of amoebiasis. Exactly why infection with *E.H.*, gives rise to amoebic dysentery in one person and in others to no symptoms at all is very difficult to say.

(2) **Sub-acute chronic dysentery:**—Under the present day treatment a good percentage of patients is usually in a condition of clinical cure, or the condition may be so from the very inception as the patient gives no previous history of dysenteric attack. This variety is most important and forms the greatest bulk of amoebic cases. The patient may come to the physician with any odd complaint not knowing at all that he is suffering from amoebiasis. He is most resistant to treatment and sometimes baffles all known methods. No free form but only cysts are passed in the stool of such patients.

(3) **Burnt-out case of amoebiasis:**—Here all sorts of investigations fail to show any free or cystic forms. The patient always complains of an indifferent and delicate health. He is lacking in vigour. In spite of one or two regular motions daily he does not have the satisfaction of evacuation. This is probably due to (1) lot of scarring left after the ulcers have healed up (2) irregular peristalsis (3) adhesions due to previous localised peritonitis.

(4) **Mixed infections:**—Mixed bacillary and amoebic dysentery are not uncommon. It is about 20% in our series. Amoebic ulcerations may be superimposed on a healing bacillary infection, but this is rare. 2 to 3 or more examinations are necessary to establish cases of mixed infection.

(5) **Amoebic lesions in other organs:**—These are always secondary to primary infection in the large gut. Liver is the commonest site. 14 to 15% of the unhealed cases develop hepatitis and 30 for

liver abscess. The amoeba are carried to the liver by portal circulation. When the liver cannot deal with the number of invading parasites a definite abscess formation results. Abscess cavity is full of pus and as a rule the contents are sterile. Amoeba are very rarely found in the pus but found in large numbers in the growing margins. In chronic cases cirrhosis and cholecystitis may also develop.

Treatment

In acute stages emetine is a specific. In order to be successful we must aim at maintaining continuously a safe and sufficient concentration of the drug in the blood. Here the cumulative action of emetine is helpful. It would not be so successful if intervals between injections are too wide. I remember a case in the hospital who received 23 injections of emetine, one grain each, twice a week during the course of 11 weeks. Dysentery was still present and the stool showed actively motile *E.H.* The ideal is probably half grain twice a day for 8 to 9 days. 1 gr. a day is the usual practice. I don't know if there is anything as emetine-fast cases. But I think that sublethal or irregular doses of emetine make *E.H.* resistant to this drug and an early relapse is probable. An European lady showed *E.H.*, after 9 days following a course of 8 injections of gr. 1 each. Another, an Indian gentleman, showed non-motile *E.H.* after completing a course of 6 grs. $\frac{1}{2}$ to 1-drachm dose of bismuth may be given 2 to 2½ hours before the due time of emetine injection.

E.H. does not by itself produce any toxin. But ulceration products and bacterial toxins are absorbed from intestinal mucosa. So elimination by a dose of castor oil to start with followed by a small dose of saline every morning is very helpful. Kaolin, better collo-kaolin or bismuth, will also diminish absorbable intestinal toxins. We should also remember about the toxic effects of emetine on the heart and nervous system. I have seen a case of emetine neuritis which required about 2 years to come round. Emetine though dramatically relieves the patient, fails to give him a cure. So the emetine course should be followed by a course of oral E.B.I. or Iodoquinoline—drugs which act better in chronic cases with persisting cysts.

Sub-Acute and Chronic cases:—Some are of the opinion that as the patient is not passing any vegetative amoeba emetine is not indicated. It is a fact that for some unknown reason emetine is not so efficacious in a chronic case. So much scarring has already taken place that emetine fails to act on the intestinal lesions. Yet I personally always start with a course of emetine—this at least clinically improves the patient at once. Then I give a course of E.B.I. or arsenic or iodine or kurchi compounds as dictated by the results of stool examination. Retention enema with yatrien or enterovioform is of great help in eradicating the infection. Sometimes these preparations fail to give satisfactory results due to superimposed secondary infection. Stool should be plated and autovaccine or autophage or both may be tried. In these days of sulpha drugs and penicillin these are also worth trial—sulfaguianidine is the best and safest.

Finally thiamin, or B. Complex, calcium, parathyroid, liver extract injections have to be given to effect a complete cure.

Here I may add a word of caution regarding arsenic preparations. Some patients' tolerance to it is very poor. There should be a safe interval of 3 to 4 months between two courses. One lady developed acute arsenical dermatitis on the second course of carbarsone taken almost immediately after the first course; ultimately the woman died.

The following procedure adopted in the army may be advantageously followed:—

Hospitalisation for 31 days.

1st to 8th day—Emetine injections.

7th to 12th day.—E.B.I. 2 or 3 grs. at night.

5th to 14th day.—Yatren retention enema 2½%.

13th to 25th day.—Arsenic—one course.

20th to 25th day.—E.B.I. 2nd course.

26th to 29th day.—Rest.

29th to 31st day.—Final examination.

The tendency of acute amoebic cases to become chronic and non-responsive to treatment are at least partially due to:

- (1) Sublethal doses of emetine.
- (2) Irregular administration of emetine.
- (3) No follow up treatment for the cysts.
- (4) Patients not taking rest in bed during treatment period.
- (5) Unsuitable diet.
- (6) Low calorie diet rendering patient's vitality too low to deal with the residual infection.

Review on Treatment of Wounds

BY

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The art of healing wounds has been progressive with the advancement of knowledge of science and civilisation. Since the days of primitive man who perhaps licked his wound like the dog, the modern surgery would appear to be nothing short of miracle. To make a complete survey of the process of this development is a long story. However I would mention only a few outstanding landmarks, viz., the principle laid down by John Hunter in the 17th century—"Where there is pus let it out"; Lord Lister's antiseptic treatment of wounds in the 19th century; use of anaesthetics to patients in the 19th century; discovery of Röntgen Rays in the 19th century; discovery of Chemotherapeutics and Penicillin in the 3rd and 4th decade of this century. The Great War and the World War which caused staggering casualties on mankind, have made considerable advances in our knowledge about the treatment of wounds. In the last Great War and after, the intermittent irrigation method of 'Carrel-Dakin', the use of mag-suph. solution or paste, the method of B. I. P. P. treatment of wounds and the method of immobilisation of wounds with application of absorbent dressings and non-interference for a long period, have been advocated with great zeal by

particular schools and their followers. This method of immobilisation and non-interference has since been developed considerably; to-day wherever possible the limb is encased in plaster of paris.

The discovery of chemotherapeutics and Penicillin has revolutionised the treatment of diseases and in this World War, extensive use of these drugs have made a rapid stride in the knowledge of treatment of wounds. It is well known that sulfa drugs are being used locally as well as systemically in various medical and surgical conditions. Penicillin has been a wonderful remedy for so many diseases which are unamenable to Sulfa drugs or too painful to be treated by other agents.

With this brief references, the general outline of the treatment of infected wounds may now be discussed. The soft tissue wounds, compound fractures, wounds of the chest, abdomen and head are being satisfactorily treated with sulfa drugs and penicillin. After the usual surgical cleaning of wounds has been completed, several grammes of sulfa powder is applied over the wound which is then covered with sterile dressings. Sulfa tablets are administered every four hours, or injectable products administered parenterally to keep up the concentration in blood. It has been found by controlled experiments that local application of sulfa drugs has very little or no effect in controlling the infection but the systemic use has remarkable actions in this respect. Voluminous literature describing the role of action of these sulfa drugs and their selection, their doses and the method of administration have already been published. They are too well known and need hardly any mention here by me.

The preparations of penicillin available for use are calcium penicillin for local use and sodium penicillin for systemic use.

(i) Calcium penicillin is used in 3 forms. (1) solution—1000 units per c.c. of sterile distilled water, (2) powder—500-5000 units per gramme mixed with sulfa drugs, (3) cream—250 units per gramme mixed with wax. All these should preferably be used within a week of being prepared as they lose their potency by storage. Powder or cream is suitable for open wounds and burns. The local application has to be repeated every 24 hours at least. If penicillin reaches every part of the wound sterility is usually obtained in 36-72 hours. Sodium penicillin in 15,000 units in 2-3 c.c. of sterile water is administered intramuscularly every 3 hours or intravenously by drip method in saline or glucose solution, 10,000 to 20,000 units being given thereby in 24 hours. The treatment is continued for 5 to 7 days or even longer, if required. For wounds of the eye penicillin solution, 500 units per c.c. of saline is instilled every hour for 24 hours and then continued every 2 to 4 hours. An average of 75,000 units of sodium penicillin for local use is required per case.

(ii) Although the role of action of sulfa drugs and penicillin have very considerably been defined, yet the choice between them remains to be clearly established. For the main pyogenic cocci, gonococci and meningococci and Clostridia of gas gangrene, penicillin is superior to sulfa drugs. But for simplicity of administration, cost, availability etc., sulfa drugs

are to be favoured. Again there is always the risk of toxic reaction of sulfa drugs due to irregular administration and other factors, whereas there is little or no toxic effects of penicillin. And for severe haemolytic strepto infections and clostridia of gas gangrene, penicillin will succeed even when the sulfa drugs have failed.

(iv) As a major wound is always associated with shock, so resuscitation of the wounded is an important part of the treatment. Shock should be treated on the following lines:—(1) rest to the patient, (2) morphia 1/3 to 1/2 hypodermically or 1/6 gr. I. V. with transfusion, (3) warmth to the patient, (overheating electric cradle is injurious), (4) fluids to replace the lost body fluids by transfusion of blood, plasma etc., drinks by mouth.

In head injury cases morphia is contraindicated and this is used only before an operation is to be performed. Paraledhyde is used in these cases for restlessness.

In wounds involving injuries to blood vessels the haemorrhage should be controlled as early as possible. The dressings firmly applied is sufficient to check minor bleeding. In open wounds with bleeding blood vessels both the divided ends should be ligatured. In cases where it is found that the blood vessel is injured but incompletely divided or large blood vessel is contused or thrombosed ligature should be applied to the proximal and distal part of uninjured segment and the undivided or thrombosed segment should be excised. Not only this protects from primary haemorrhage, but also prevents secondary or reactionary haemorrhage, gangrene etc.

The following factors influence considerably the healing of wounds, hence the treatment is adopted accordingly. (1) age. (2) vascularity of part, (3) degree of movement, (4) type of tissue e.g., nerve can only be replaced by accurate apposition, muscle cells have little capacity for repair, therefore the gap is filled up by fibrous tissue, (5) presence of infection—this is very important and has been dealt with already, (6) vitamin content, e.g., Vit. K & C.—lack of vit. K—deficient prothrombin function and undue tendency to bleed; lack of vit. C.—deficient collagenation—slow repair, (7) Nitrogen intake (8) accuracy of apposition.

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- Ind. Med. Gazette, 1940 Page 681.
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Read at the General Meeting of the 24 Paraganas Branch A. I. M. L. A., on 28-7-46.

Development Anamoly of Sex Organs.

(A case Note.)

BY DR. J. N. DAS SARGUMAL,

Sylhet.

Recently I have come across an interesting case of developmental anomaly of the external sex organ which I like to report here.

On the 21st November 1945 at about 2 A.M. I was called to attend a case of a retained placenta. Attended the case immediately and the placenta was delivered manually and I returned happily.

To the best of my knowledge, I remember that I saw the child healthy and it was of female sex. The garden midwife who is duly qualified and experienced reported to me that the child was female. Accordingly I recorded it in the birth Register and sent the vital statistics to the Government stating that the child was female.

After about a month, the midwife told me that there was something very funny with the child. She brought the child to the Garden Hospital. I looked at the external genitalis very carefully and noticed that the Labia Majora united to form a rudimentary scrotum which however was empty on palpation. There was no testes, neither in the scrotum nor in the inguinal region.

The clitoris was growing in size and taking the shape of a small penis. It looked like a small knob with a short prepuce which resembled the nymphae of the clitoris. The so-called penis is imperforated. The protruded clitoris had drawn the urethra under it. The external opening of the urethra was under the penis just at its base. The midwife and the parents said that the child was female after birth. I brought the case before my Chief, Col. C. S. P. Hamilton, L.R.C.P., M.R.C.S., D.S.O., who was kind enough to examine the child very carefully and told me that the case was very interesting and advised to take a photo of the case and send it to the Journal for publication. Unfortunately, I failed to take a photo of the case for want of a camera. To-day, the child is 86 days old but still there is no trace of testes neither in the scrotum nor in the inguinal canals.

Discussion.

The simultaneous possession of both male and female sex organs is known as Hermaphroditism. This condition, however, occurs in different degrees. The true Hermaphroditism means the possession of internal sexual organs of both the sexes as testes and ovary and the false or Pseudo Hermaphroditism means that the developmental anomaly is confined to the external organs only i.e., a person with a gonad of one sex and with the external genitals of the other sex. Thus an individual with a gonad of a male and with a female type of external genitalia is known Female-Pseudo-Hermaphrodite. This condition perhaps occurs due to fusion of Labia Majora and protrusion of the clitoris which drags the urethra under it as in our present case under discussion.

The main developmental anomalies of the sex organs are described above. Now we are to find out what is the sexual status of this case. This child may be called a female-pseudo-hermaphrodite; but I think it is still too early to say anything definitely about the sex of the child now. It is wise to wait till all the secondary sexual characteristics develop. The abnormality we have been noticing in this case is really due to incomplete and faulty development though the child was born healthy and full termed.

I am thankful to my Chief, Col. C. S. P. Hamilton and also to my Manager, Mr. J. Turney, for their kind permission to report the case.

References :—

- (i) I. M. J. April 1943,
 - (ii) Lyon's Medical Jurisprudence for India.
- Read at the Assam Provincial Medical Conference, Silchar, on (17—2—46).

SELECTIONS.

Ophthalmia Neonatorum. *BY ARNOLD SORSEBY F.R.C.S., *Reproduced from The Medical Officer, London, Aug. 3, 1946. with due acknowledgments.*

The view generally held that ophthalmia neonatorum is synonymous with gonococcal ophthalmia is erroneous. Though there are differences in detail, most series of cases of ophthalmia neonatorum show that the affection is produced by a great variety of organisms, and in many series the gonococcus is not the predominant causal organism. It was responsible for about 25 percent, of all cases in a series of 737 seen at the ophthalmia neonatorum unit at White Oak Hospital between 1939 and 1945. Staphylococcus aureus accounted for about 35 percent of cases, whilst the meningococcus, pneumococcus, streptococcus and other coccal organisms each contributed a small percentage. Bacilli were responsible for about 20 percent of cases, diphtheroids being the commonest, but the Koch-Weeks bacillus was not a curiosity as a causal organism.

Recent series, like the older series, contain some ten to twenty percent of cases in which no micro-organism can be found in the smear or culture. Most of these "negative" cases represent not faulty bacteriological examination, as was once held, but are examples of ophthalmia neonatorum due to a virus infection. This virus has not been isolated in culture, but its existence has been demonstrated by animal inoculation, and by the presence of inclusion bodies in the conjunctival epithelium a finding responsible for the designation of inclusion ophthalmia neonatorum, or inclusion blenorrhoea. Inclusion blenorrhoea is part of a clear cut venereal disease. In the mother of the affected baby a scraping of the epithelial cells taken from the transitional lining at the os generally also shows inclusion bodies. To complement ophthalmia neonatorum in the baby and inclusion cervicitis in the mother there is the non-specific urethritis in men where inclusion bodies can also be demonstrated in epithelial scrapings. This virus infection appears to be fairly widespread in the community, it gives minimal clinical symptoms, and not infrequently it is sub-clinical.

Prophylaxis in Ophthalmia Neonatorum.

The essential measure of prophylaxis in ophthalmia neonatorum is the treatment of maternal infection during pregnancy. In the light of present knowledge this means more than the treatment of active or chronic gonorrhoea, or even of leucorrhoea. Ophthalmia neonatorum will be eliminated only when maternal infections are eliminated.

The more immediate method of prophylaxis associated with the name of Crede is immensely valuable but has distinct limitations. The mechanical part of the procedure—the cleansing of the lids as soon as the head is born and before the baby is allowed to open its eyes, and the care taken to prevent any contaminated bath water reaching the baby's eyes—is now part of the routine of delivery, and is consistent with the principles of asepsis. The chemical component of the procedure—the instillation of silver, or some other disinfectant into the eye—is of doubtful value and is a relic of Listerian antisepsis. It is a moot point whether an infected conjunctival sac will be disinfected by the application of one drop of an antiseptic. There seems to be no reason for using silver nitrate, as this is far from being a foolproof agent. There is nothing to indicate that it is superior to the organic silver preparations, which at any rate are innocuous. If anything is to be put into the baby's eyes it is best to put in two or three drops of 20 percent argyrol, rather than 1 percent silver nitrate. There is nothing to be said for drops of sodiumsulphacetamid ("albucid"), they are largely ineffective locally. Nothing as yet is known of the value of penicillin as a disinfectant of a presumably infected surface.

Treatment of Ophthalmia Neonatorum.

The classical methods of treatment have no place in the treatment of ophthalmia neonatorum to-day. Those methods consisted essentially of ceaselessly washing away all the pus from the infected eye to prevent the pus from damaging the cornea, and waiting for spontaneous healing which generally took some weeks. Such adjuvants as were used—antiseptic drops and occasionally shock therapy by milk injections—probably had little effect on the infection. The classical methods of treatment, therefore, did little more than prevent complications. Their value against the infection itself was always problematical.

In contrast the modern methods of treatment deal with the infection primarily. Two alternative procedures are available.

Sulphonamide Therapy.

Employed locally the sulphonamides are useless in ophthalmia neonatorum as they are inactivated by pus and break down products of the tissues. Given by mouth they are highly effective. When the baby is first seen a swab of the pus is taken both for a smear preparation and for culture. The eyes are then irrigated with bland lotion, such as half-normal saline solution at room temperature. Guttae atropinae sulphas 1 percent and drops of medicinal paraffin are instilled as a routine measure, and half a tablet of sulphamezathine (0.25 g.) crushed into powder is given by mouth in a teaspoonful of water or milk. Sulphamezathine administration is continued in doses of 0.125 g. every four hours, day and night, until 48 hours after a clinical cure is obtained. Local treatment consists of three hourly irrigation with saline solution during the first day in cases with profuse discharge; as a rule there is no need for further irrigation on the subsequent days. After irrigation medicinal paraffin is instilled as a precaution against the sticking together of the lids. Atropine is instilled three times daily in cases with corneal haze or ulceration.

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With this treatment swelling of the lids generally subsides within 12 hours after admission; purulent discharge disappears within 24 hours, so that a threatening purulent ophthalmia becomes a simple conjunctivitis giving no anxiety. The eyes are either dry or very nearly so within 72 hours.

The dreaded corneal complications of ophthalmia neonatorum do not develop. Some 40 percent of all babies show complete clinical cure within three days, and 90 percent are cured within eight days. Such cases as are resistant to treatment are only relative failures with a somewhat prolonged course, which however, does not give rise to anxiety, as there is conjunctivitis rather than purulent ophthalmia. Isolated cases of complete resistance to sulphonamides have however been observed.

Babies tolerate oral sulphonamide well. Nothing is to be gained by using doses smaller than these indicated, and it is important to continue the sulphonamides for 48 hours after clinical cure, as the too early suspension of treatment may lead to a relapse.

Penicillin Treatment.

Unlike the sulphonamides penicillin remains effective in the presence of pus. It can, therefore, be used as a local agent, and has one other advantage over the sulphonamides in that cure is even more rapid and dramatic. For the present, however, treatment is rather exacting, and it is not as yet as standardised as oral sulphonamide therapy.

In the use of penicillin, concentration and frequency are all important. Though some cases of ophthalmia neonatorum clear up readily on the instillation of penicillin drops 500 units per c.c. at hourly intervals, more fail to respond. Better results are obtained with a concentration of 1,000 units, and better still with one of 1,500 units per c.c. There are only occasional failures when a concentration of 2,500 units per c.c. is employed. As drops in such a concentration are well tolerated, nothing is gained by using lower strengths. A concentration of 2,500 units per c.c. must therefore be regarded as the standard preparation for the present.

With increasing frequency of application the course of the affection is cut down considerably. Distinctly better results are obtained when drops are put in at half hourly instead of hourly intervals, whilst results are better still when the instillations are made every five minutes. With penicillin in a concentration of 2,500 units per c.c. instilled at intervals of five minutes all pus is suppressed within a matter of a few hours, and occasionally even within an hour. But even intervals of five minutes are too long, for penicillin drops are rapidly washed out from the conjunctival sac. Instilled at intervals of one minute all tendency to pus formation is generally suppressed within half an hour, though the swelling of the lids will persist for several hours.

For the present the routine procedure in penicillin treatment of ophthalmia neonatorum consists of the following stages.

(1) A swab of the pus is taken for bacteriological examination.

(2) The eye is then irrigated with half-normal saline at room temperature to wash away the pus.

(3) A nurse seated on a chair takes the baby on her lap, and another nurse is responsible for putting in two drops of penicillin, 2,500 units per c.c. every minute into the eye.

(4) Pus does not tend to reform whilst this treatment is in progress. Any secretion formed can readily be wiped off with pledgets of cotton wool.

(5) Within 20 to 30 minutes the picture is changed. Whilst the lids are still swollen, and the conjunctiva still remains moist, there is now no tangible secretion.

(6) After 30 minutes of this treatment the baby is returned to its cot. One drop of atropine 1 percent is instilled as a precautionary measure.

(7) Penicillin drops are now continued at five minutes intervals for half an hour.

(8) At the end of this half hour penicillin is continued at half hourly intervals for three hours, and subsequently at hourly intervals for six hours. By this time the eyes are generally normal.

Failures with local penicillin treatment, as with oral sulphonamide therapy, are few. In such cases these agents may be used in combination.

A striking feature of both sulphonamide and penicillin treatment is their efficacy over the whole range of causal organisms including the virus of ophthalmia neonatorum. Gonococcal cases respond rather more quickly than non-gonococcal cases to oral sulphonamide treatment, and it is possible that those due to diphtheroids respond rather less readily to local penicillin therapy than the cases due to other organisms. These, however, are minor differences and do not materially affect the dramatic and gratifying response of ophthalmia neonatorum to the modern methods of treatment.

The Hundredth Year of Anaesthesia, A Short Survey of Modern Anaesthetic Practice: BY G.S.W. ORGANE, M.D., D.A. (*Reproduced from British Medical Bulletin Vol. 4 No. 2, 1946 with due acknowledgments*).

On 21 December 1846, a major operation was performed under general anaesthesia for the first time in England. After nearly a hundred years it seems appropriate to review the progress and present practice of anaesthetics in this country.

In London and in many of the larger provincial centres the work is done mainly by specialist anaesthetists. It is now a condition of appointment to the staff of a hospital attached to a school of medicine that one should be engaged solely in the practice of anaesthetics; it is recognized that, with advancing knowledge and consequent elaboration of technique, the highest standards cannot otherwise be reached. This is a comparatively recent development and there are many of the older anaesthetists who are also general practitioners. A few of these remain resolutely opposed to modern methods, but there can be little doubt that many of the recent advances in surgery have been made possible by these methods.

AGENTS

Ether

Of anaesthetic agents, ether—the first to be employed in this country—remains the most popular, though some anaesthetists have abandoned it entirely. I find there are still many cases in which its use is appropriate—in spite of some extravagant claims there is as yet no drug or combination of drugs that is universally applicable. It is no longer held that the inhalation of ether vapor is an important factor in the production of post-operative chest complications.

Chloroform

Chloroform is still used in some cases where there may be risk of explosion from the diathermy cautery. Some obstetricians prefer it for midwifery; although primary heart-failure is almost unknown, there is no good reason to suppose that pregnant women are less liable than others to the toxic after-effects.

Ethyl Chloride

Ethyl chloride is widely regarded as being unnecessarily dangerous, but it is still used, because of its rapid effect, for induction of anaesthesia in children and for short operations such as tooth-extraction.

Vinyl Ether

Vinyl ether (vinesthene) is not much used because of its high cost, though it is greatly superior to ethyl chloride in similar procedures. Some anaesthetists use a mixture of vinyl ether with ethyl ether which combines many of the advantages of each.

Trichlorethylene

Trichlorethylene (trilene) has been given an extensive trials but is not generally accepted. Its high potency and low volatility make its use extremely economical and it has the advantages of being relatively non-irritant and non-inflammable. Cardiac irregularities are frequent though, probably, unimportant and it may produce a marked tachypnoea—the respiratory rate may rise to 80 or 90 per minute. Muscular relaxation is poor, and it should not be used to produce deep anaesthetic. For light anaesthesia used as an adjuvant to nitrous oxide, it is probably quite safe. Some deaths have been reported following its use in a closed circuit. Lethal decomposition-products resulted from its interaction with the hot soda-lime used to absorb carbon dioxide.

Ethylene

Ethylene has not been used to any extent since the introduction of cyclopropane. Cyclopropane is widely popular and is especially suitable for intrathoracic and for upper abdominal surgery. It is not irritant to the lungs and can be used with a high proportion of oxygen and, being a marked respiratory depressant, it lends itself easily to the technique known as "controlled respiration." Following a period of over-ventilation of the lungs, at a suitable depth of anaesthesia, spontaneous breathing ceases; artificial respiration is then maintained by the anaesthetist and is timed to avoid interference with the actions of the surgeon. Normal breathing can be

restored very rapidly, at will, by reducing the concentration of cyclopropane. Recovery of consciousness is as rapid as after nitrous oxide.

Nitrous Oxide

Nitrous oxide is the agent most commonly used for minor dentistry and for other minor operations in ambulatory patients—always with oxygen. Opinion is divided on its mode of use with more potent agents such as ether, in major surgery. Some hold that it part is merely that of a vehicle for ether vapour and accordingly, will reduce its concentration to equal parts with oxygen; others, including myself, feel that it can be made to play a much more important part with consequent reduction in the quantity needed of the more toxic agents. We aim to produce a steady basal level of anaesthesia using, most commonly, about 85% nitrous oxide with 15% oxygen, and to vary the depth below this basal level by varying the concentration of ether. Nitrous oxide is now widely used in the same way, as an adjuvant to intravenous anaesthetics. Its use in midwifery will be discussed later.

Barbiturates

Thiopentone (pentothal) has largely replaced hexobarbitone (evipan). Some anaesthetists use it for all types of operation including even upper abdominal and intrathoracic surgery. Others regard this as unwise because of the prolonged post-operative unconsciousness that follows the large doses required. Used with nitrous oxide and oxygen the necessary dose is halved and its scope thereby extended. In many hospitals it is the practice to induce anaesthesia with thiopentone whatever the main agent is to be, a move that finds great favour with the patients. A firm of English manufacturing chemists has recently produced thiopentone by three different methods and the samples are now undergoing clinical trial. It is interesting to note that, although chemically indistinguishable, each shows slight pharmacological differences from the others and from pentothal. A new thiobarbiturate, kemithal, is shortly to be described in the medical press. Although less potent than thiopentone, the course of anaesthesia and recovery is very similar and it appears to have some advantages, notably, less marked respiratory depression and a much reduced tendency to cause laryngeal spasm, which constitute the chief dangers with thiopentone.

TECHNIQUES

Ethyl chloride, ether and chloroform are frequently administered by the open drop-method, using a Schimmelbusch type of mask. The Nuffield Department of Anaesthetics has produced a device, the Oxford Vaporizer, which is calibrated to deliver known proportions of ether vapour, up to 25%. As generally used, air is drawn by the patient's inspiration across the surface of liquid ether. The ether is maintained at a constant temperature by a water-bath, buffered by an intervening layer of hydrated calcium chloride crystals which melt at 29° C. This represents a great advance on any other method of administering ether and has proved especially valuable for battle casualties.

Most inhalation anaesthetics are given with a nitrous-oxide-oxygen-ether apparatus, some form of which is now available at hospitals throughout the country. The gases are supplied from cylinders attached to the apparatus or, in some of the more modern hospitals, are led by pipe-line from a centrally-situated battery of large-capacity cylinders. In such institutions oxygen is laid on to each ward, and there is available also a supply of nitrous oxide which may be required for the performance of painful dressings. The gases are measured by flowmeters—the Rotameter is the present favourite and seems to be sufficiently accurate—one each for nitrous oxide and for oxygen and one for carbon dioxide or cyclopropane. In the standard type of apparatus there are two bottles through which the gases can be passed, one containing ether and the other chloroform, trilene or vinesthene-ether mixture.

Carbon-dioxide-absorption

Closed-ether anaesthesia without absorption of carbon dioxide has largely been abandoned as undesirable and archaic. The carbon-dioxide-absorption technique is widely used, having been developed mainly since the introduction of cyclopropane, the high cost of which made some closed system essential to avoid waste. It is extremely economical in use and is particularly valuable in districts where supplies of anaesthetic gases are not readily available. It also makes it possible to employ inflammable anaesthetics in cases where the surgeon is using the diathermy cautery. The warmth and moistness of the inspired gases make an appreciable contribution to the prevention of operative shock. Carbon dioxide is absorbed in a canister of soda-lime which may be placed close to the patient's face or, in the circuit type of apparatus, is mounted on the anaesthetic trolley. There are two main types of closed circuit apparatus manufactured in this country—the M.I.E. (Medical and Industrial Equipment, Ltd.) and the Coxeter-Mushin (A. Charles King, Ltd.). Both are very efficient.

Tracheal Intubation

There have been no important recent changes in the technique of tracheal intubation. There is a widespread tendency, with which I do not agree, to use the oral rather than the nasal route where possible, on the ground that a tube of larger calibre can then be employed. Some anaesthetists intubate the trachea on all possible occasions, to ensure a free airway. This is an abuse of the method; it is better to restrict it to maxillo-facial, intracranial and throat-and-nose surgery where the anaesthetist has not free access to the head, to cases where there is danger of blood, pus or vomitus passing down the trachea, and to intrathoracic surgery. For nose and throat operations the addition of a pharyngeal pack gives full protection; where, as with intestinal obstruction, profuse vomiting may be expected or where an airtight fit is needed for closed-circuit anaesthesia a tube is used provided with a rubber cuff which can be inflated in the trachea.

Local and Regional Block

There has been a revival of interest in local and regional nerve block following its adoption by anaes-

thetists. A bilateral intercostal nerve block, usually combined with light general anaesthesia, has been found especially valuable for difficult upper abdominal operation. Using amethocaine (decicaine) or nupercaine, anaesthesia and muscular relaxation last well over three hours. The latest development is the bilateral vagal nerve block at its point of emergence from the skull. Although complicated by the fact that the glossopharyngeal nerve is commonly involved, it is likely to prove of value for such operations as laryngectomy. Extradural block by the method of Dogliotti has been tried, but it is generally felt that its advantages do not compensate for the risks involved. Extradural caudal block is used by James, Galley and some others and can be employed even for upper-abdominal surgery.

Spinal Block

Spinal anaesthesia has its antagonists and protagonists, both group holding extreme views, but, in general, it is less frequently employed than before. Nupercaine is the drug of choice, though amethocaine and procaine (novocaine) are preferred by some anaesthetists. Great concern has been caused by the occurrence of a number of cases of meningitis, many fatal. Some have been shown to be due to gross faults of technique, but others remain obscure. Continuous spinal anaesthesia has been used by Lee.

General Condition of the Patient

Much has been learnt about the treatment of wound shock and the prevention of operative shock—work that is falling more and more within the province of the anaesthetist—as a result of experience will battle casualties and air-raid casualties. Emphasis is laid upon the restoration of circulating blood-volume by intravenous infusion for serum, plasma and blood, which is thought to be more effective than the injection of stimulant drugs in shock. The same measures are now used more frequently to prevent or delay shock in severe operations; a slow drip transfusion of blood is the rule in major thoracic surgery. I have given as much as five litres of blood during a transthoracic gastro-oesophagectomy for a carcinoma that would, until recently, have been considered inoperable. It seems probable, with advancing knowledge, that a time may come when no operation, within the competence and the endurance of the surgeon, will be thought impossible even on a patient in poor condition. It is not thought that the choice of anaesthetic agent in a patient suffering from shock is as important a factor as the skill and experience of the anaesthetist, but it is best to keep general anaesthesia at as light a plane as possible, using free injection of local anaesthetics to produce any necessary muscular relaxation.

SPECIAL APPLICATIONS

Plastic Surgery

All major plastic surgery is undertaken under general anaesthesia, with tracheal intubation where indicated by the site of operation. Recent severe injuries to the lower jaw present a difficult problem as the airway is often already partly obstructed and will become completely so with loss of consciousness. In such cases it has been found best to give a rapid

injection of one gramme or more of thiopentone—in otherwise fit patients—to clear the throat of blood or debris under direct vision down a laryngoscope and then to pass an endotracheal tube with an inflatable tracheal cuff. Anaesthesia is maintained in the usual way.

Nose and Throat Surgery

Tracheal intubation is also the rule in nose and throat surgery, including tonsillectomy, except in very young children. Intravenous anaesthesia for such cases, without intubation, is considered dangerous because of the risk of aspiration of blood. Bronchoscopy is performed under local anaesthesia in adults, sometimes with thiopentone as well. For oesophagoscopy general anaesthesia is preferred; after some alarming experiences with thiopentone, which have been shared by others, I feel it is wisest to use an oral endotracheal tube. Some anaesthetists use regional block anaesthesia for operations on the maxillary antrum, apparently with great success.

Intrathoracic Surgery

Spinal anaesthesia has been tried for intrathoracic operations and abandoned because of the great fall in blood pressure. For lobectomy and for operations on the heart or main arteries, it is customary to use an endotracheal cuffed tube; where, as with bronchiectasis, there is much secretion, this is aspirated from time to time through a catheter passed down the tracheal tube. For pneumonectomy endobronchial intubation is convenient as, by this means, the affected lung is completely shut off. Some anaesthetists use, instead, a catheter fitted with an inflatable rubber cuff which is passed down a bronchoscope into the main bronchus of the affected lung. The bronchoscope is then withdrawn, the cuff inflated, and an ordinary cuffed tube passed, beside the catheter, into the trachea with the aid of a laryngoscope. This method can be used for lower lobectomy, the endobronchial cuffed catheter being passed beyond the opening of the upper lobe bronchus. Controlled respiration is maintained under cyclopropane anaesthesia or, more rarely, with thiopentone. Thoracoplasty is performed, usually, under local anaesthesia composed of brachial plexus block, intercostal or paravertebral block and local infiltration of the line of incision.

Children

It is considered important, where possible, to employ some form of basal narcosis before anaesthesia in children over one year old. Hexobarbitone, thiopentone paraldehyde or bromethol (avertin) are given per rectum, or pentobarbitone (nembutal) or seconal by mouth. Nitrous oxide with oxygen and minimal quantities of ether is entirely satisfactory for maintenance of anaesthesia, even in very young children, but requires more than usual care as the margin between anaesthesia and anoxia is small.

Midwifery

For midwifery there are almost as many methods as there are practitioners. The most important drugs in use are omnopon-scopolamine, pethidine (dolantin, demerol), pentobarbitone, trilene, chloroform and nitrous oxide. My own preference is for pethidine in

the early stages of labour, nitrous oxide intermittently in the later stages and cyclopropane during the actual birth. Midwives are allowed to use nitrous-oxide-air in fixed proportions and the apparatus designed by Minnitt for this purpose has proved of value. Galley and some others are ardent advocates of extradural caudal block. For caesarean section, general anaesthesia with cyclopropane or nitrous-oxide-oxygen ether is usual. Intravenous anaesthesia has been used but leads to more frequent stillbirth, partly because of foetal respiratory depression and partly because the increased uterine irritability may lead to delivery. Dogliotti's extradural block has been used by pupils of Dawkins. The suitability of spinal anaesthesia for delivery by any route is a matter for dispute that is as yet unresolved.

LETTERS TO THE EDITOR

Strike Work

Sir,

Our Association is passing resolutions after resolutions and sending memorandum after memorandum hoping thereby to improve the pay and status of the licentiates in service.

But we are pleading in vain. Why should it not be so? We are too insignificant in the eyes of the Government. We claim that we look after the health of the poor millions, but does the Government care for the poor?

If we were looking after the health of rich people like the medical graduates our condition would have been different.

For the last 40 years or so we have been struggling hard to improve our conditions in service but there has been no appreciation of our labour.

But we are not prepared to go on begging and begging. We must strike work throughout India and see how many medical graduates go to serve the poor village folk on Rs. 70 a month. However a Jolly or a Hance may praise us, the Provincial Governments will not give us our dues unless we compele them to do so.

Assam,

H. BARDOLOI,

Our Membership Strength in Bihar

Sir,

The latest electoral-roll prepared by the Council of Medical Registration, Bihar shows:—

- | | |
|--|------|
| (A) The total number of doctors with Licentiate and similar qualifications registered in the Province of Bihar is | 2377 |
| (B) Those who have registered their names in Bihar, but residing in other provinces being | 182 |
| (C) Approximate number of those who have died or ceased to practise, yet their names have not been erased from the Register, being | 195 |

The total of (B) and (C) being 377 this has to be deducted from (A) 2377—2000 being the existing number of members.

Now the approximate number who have become members of our Association being 750, it is equal to 37½% of the total of 2000. This shows 62½% of our total strength are still remaining outside our Association.

This is the present state of affairs of our Association in Bihar and Orissa, which is no doubt, most deplorable as well as pitiable. For this one section of our community (i.e., the office bearers of our Association) cannot be blamed; those who are remaining outside are equally responsible.

Our brethren should no more slumber; rather come forward and join their Association immediately and make it more strong to give a successful fight to achieve our legitimate dues.

Chaibasa,

P. S. SEN.

ASSOCIATION NOTES.

Central India and Rajputana:—Standing Committee meeting held on 19-2-1946. The following resolutions were passed.

- (1) Dr. Pustake was elected President and Dr. R. A. Bhaḡwat as Secretary.
- (2) The Memorandum to the Holkar Minister was approved.
- (3) Resignation of Dr. A. G. Motiwala from the membership of the Standing Committee, owing to reasons of health, was accepted and Dr. V. V. Oak elected in his place.
- (4) Appeal to the Government of India and of Rajputana States for proper and equitable resettlement of demobilised I. A. M. C. Officers.
- (5) The Association gave a grand reception to Dr. M. L. Kapur, President of the Association who was a visit or to the State.

Muzaffarpur. (Bihar):—The annual meeting of the Branch was held on 17-3-46 at 7-30 p. m. with Dr. B. C. Sarkar in the chair. The following resolutions were passed.

- (1) Unanimously resolved that the following office-bearers be elected for the new year 1946-47.
Dr. B. C. Sarkar. ... President.
Dr. S. P. Singh. ... Secretary.
- (2) Resolved that Re. 1/- be charged as annual subscription from the four members specially to meet the initial expenses of the branch.
- (3) Resolved that the A. I. M. L. A. may be amalgamated with the I. M. A. but there should be a sub-committee to safeguard the interests of the Licentiates therein.

Mhow (Central India):—Meeting held on the 26th May, 1946.

Dr. Bhaḡwat gave an account of the work done so far by the A.I.M.L. Association and success achieved. He paid a glowing tribute to the work done by Dr. Rajendra Singh as the Secretary of the Branch for such a long time, and Dr. Radha Mohan the President of the Branch for very kindly guarding the interests of the Branch, and requested them to enroll those few Licentiates as the members of our Branch who have not joined us so far.

The following office bearers were elected:—

- (1) Dr. Rajendra Singh. ... President.
- (2) Dr. Doss. ... Vice-President.
- (3) Dr. D. N. Chaddha. ... Treasurer.
- (4) Dr. M. K. Matkar. ... Honorary Secretary.
- (5) Dr. L. C. Sharma. ... Joint Secretary.

(A) Bombay Branch:—The Annual General Body Meeting was held at Brandon's Hotel on 9-12-45. Business done in the meeting:

- (1) The minutes of the last General Body meeting were read and confirmed.
- (2) The annual report was read and passed.

(3) The following office-bearers were elected.

- | | |
|-----------------------|-----------------------|
| Dr. A. D. Mastakar. | ... President |
| Dr. M. S. Sankholkar. | ... Vice President |
| Dr. A. D. Patel. | ... Joint Secretaries |
| Dr. N. P. Shah. | ... |

Members of the Managing Committee:—(1) Drs. L. K. Rao, (2) P. S. Mulay, (3) G. W. Wadhwani, (4) U. B. Narayan Rao, (5) V. C. Palekar, (6) S. S. Pai (7) P. Vinayak and (8) V. K. Desai.

(4) The Budget for the ensuing year was passed after which members were introduced to each other during the course of the dinner. There was a happy exchange of views. The meeting terminated with a vote of thanks to the Chair.

(B) January 1946:—The meeting was adjourned due to disturbed condition of the city.

(C) February 1946:—Minutes of the last General Body Meeting were read and confirmed. A small committee was appointed to enroll more members for the Association from different parts of the city and suburbs. A Scientific discussion on Small Pox interested the members. Dr. U. B. NARAYAN RAO was congratulated for his being elected as President of the I.M.A. Bombay Branch.

(D) March 1946:—Minutes of the last General Body Meeting were read and confirmed. There was a discussion on Sulfa-group of drugs and Penicillin.

(E) April 1946:—Besides the usual work of the Meeting, the important function of the day was a party given to Dr. ROCHIRAM AMESEUR, the President of I.M.A. and a member of our Association by courtesy of Dr. A. D. Mastakar our Branch President. Points of vital importance to our Association were touched by Dr. Amaseur and all present were deeply interested. Drs. A. D. Mastakar and U.B. Narayan Rao made appropriate speeches befitting the occasion.

(F) June 1946:—Minutes of the last General Body Meeting were read and confirmed. The members unanimously suggested the name of Dr. M. D. Pustake of Gwalior, as President of the ensuing annual conference at Poona. It was resolved to elect delegates for the conference in the next General Body meeting and a member of our Branch, delivered a short but interesting lecture on Blood-test in Typhoid. A resolution was passed requesting the Ahmedabad Branch to combine the amounts of the two Thesis Prices into one name as RAMCHANDRA IYAR-JOSEPH BENJAMIN PRIZE. The meeting terminated with a vote of thanks to Dr. A. D. Mastakar.

(G) July, 1946:—Minutes of the last meeting were read and confirmed. It was resolved to send the Thesis prize resolution passed, to the General Secretary, Calcutta, for placing it before the annual conference at Poona. The letters from the General Secretary regarding conference of Ex.I.A.M.C. Officers at Calcutta and report of sub-committee for Bhore-Committee's report were read before the members and the matter was postponed for the next General Body Meeting for further discussion and opinion. The following delegates were elected for the annual conference at Poona.

1. Dr. U. B. Narayan Rao.
2. Dr. A. D. Mastakar.
3. A. D. Patel.
4. Dr. L. K. Rao.

Substitutes:—1. Dr. P. Vinayak. 2. Dr. A. D. Joḡlekar. 3. Dr. V. K. Desai, 4. Dr. M. E. Mahayi.

Gujrat Branch. (Ahmedabad) Summary of the working of the branch from 1-2-46 to 30-4-46. In all, three clinical meetings and one Managing Committee meeting were held:

Clinical Meetings:—

Date.	Speaker.	Subject.
1. 28-2-46.	Dr. K. J. Bhatt.	Psychology and Sex.
2. 23-3-46.	Dr. K. K. Jhaveri.	Otorrhoea.
3. 29-4-46.	Dr. H. D. Patel.	Common Diseases of Eye.

All the meetings were very well attended to by the members. Managing Committee Meeting was held on 29-4-46 when the following business was conducted:—

1. Proceedings of the meeting on 31-1-46 were read and confirmed. 2. Resolved that the amount of Rs. 25/- sanctioned for Dr. J. Benjamin "Portrait Unveiling Ceremony" be spent from the local funds of the branch.

3. Resolved that the Provincial Secretary be requested again to supply this branch with a copy of last provincial election results branch-wise for its record.

4. Resolved that the following two subjects are selected for Dr. J. Benjamin and P. Ramachandra Iyer Thesis prizes for the year 1946.

Dr. J. Benjamin Prize—Rs. 35—Subject: Infantile Diarrhoea
Dr. P. Ramachandra Iyer Prize—Rs. 25—Subject: Rheumatism.

5. Resolved that in the Prize Selection Committee appointed on 16-8-44, for the year 1945 the following alteration be made, Dr. H. G. Jambhekar in place of Dr. H. I. Jhala.

6. Branch Secretary's bill of Rs. 15/2/- from 1-2-46 to 30-4-46 was sanctioned.

7. It was resolved that a Reception be held in honour of two members of the branch:—Dr. H. V. Desai and Dr. C. J. Patel, on their being elected as members of the Bombay Legislative Assembly. The Managing Committee is authorised to spend a sum not exceeding Rs. 75/- from the local funds for the function.

During the period under report 12 new members were enlisted, 4 members revived membership and in all 28 doctors were contacted. The total membership has thus come to 132. With a vote of thanks to the Chair the meeting terminated.

Wadhwan City Branch: (Kathiawar.) I. A meeting of the above branch was held on 25-3-46. In the meeting there was a discussion on a few cases of cerebral Malaria and Meningitis that we came across. The efficiency of Penicillin Sodium was also discussed.

It was decided that on 25th of each month we should meet. This was our first meeting after the affiliation of the branch.

II. A meeting of the above branch was held on 25-4-46 at 6 p.m., at Dr. R. A. Shukla's house. The minutes of the last meeting were read and the following resolutions were passed.

(1) This meeting of the city branch of A.I.M.L.A., congratulates the authorities concerned for their success in converting the B. J. Medical School, Ahmedabad, to B. J. Medical College.

(2) This meeting of the city branch of the A.I.M.L.A., requests the Director of Food Controller and Supplies to consider the difficulty in obtaining sugar for a sick person in spite of the production of a bonafide certificate by a treating doctor. There should not be any delay in supplying the necessary quantity of sugar mentioned in the certificate issued by a bonafide practitioner. It is hoped that the matter is given prompt attention.

(3) After having passed the above resolutions a discussion on a few interesting cases of enteric fever and complications; Small-pox, Diphtheria etc., was held.

III. A third meeting of our Branch was held on 25-5-46 Saturday at 6 p.m. A discussion on a few interesting cases of Enteric fever with Encephalitis, foreign bodies in the nostrils, Diabetes etc., was carried out nicely. The meeting lasted for half an hour and dispersed with a vote of thanks to the chair and the members present.

IV. An urgent meeting of the branch was held on 18-6-46 at 6 p.m. In the meeting the circular No. 13 and 14 was read and it was unanimously decided to nominate Dr. A. D. Mukherjee for the Presidentship ensuing session. There being nothing further the meeting was dissolved.

Surat: (Bombay).—The following resolution was passed at a meeting of the above branch held on 16th June 1946.

The Surat Branch of the A.I.M.L.A., is of opinion that Dr. A. D. Mukherjee of Calcutta be appointed as President of the ensuing 34th Annual Conference of our Association to be held at Poona during the month of October 1946.

Gorakhpur (U.P.) Annual Report:—During the year under review we had 7 monthly meetings and two meetings of the Ex-Committee. Some of our meetings could not be held for want of quorum. One of our monthly meetings was held in Deoria in the last month and Dr. Jagat Singh so kindly arranged for it and provided us with excellent lunch and tea. We owe him our thanks.

Dr. Harbans Sahai, one of our members, kindly extended to us an invitation to arrange to hold a monthly meeting at this place in Bansgaon sometime in February 1946 but due to epidemic conditions it had to be postponed. I hope the invitation stands and we are looking forward to hear from Dr. Harbans Sahai in the near future on the same subject again.

A special feature of our Local Branch has been to have weekly social meetings every Sunday by rotation at the respective places of the members.

Almost in every meeting we used to have clinical discussions besides some fun and laughter. These meetings did certainly create a healthy atmosphere of friendship and fellowship. We must try as far as possible to continue them and members should

also try to attend these meetings as far as possible. The Balance sheet for the year ending is as follows:—

	Rs.	A.	P.
Through the annual contributions.	152	0	0
Expenditure			
1. C.F.C., for 25 members @ Rs. 4/- per head.	100	0	0
2. Part Time Peon's Salary	11	8	0
3. Postage Stamps and Cards.	10	4	6
4. Stationery	4	8	0
Total	126	4	6

Balance in hand Rs. 25-11-6.

Deposited in the Post Office S.B. Account Rs. 26.

The extra amount of Rs. 0-4-6 is deductible from the next annual contribution.

Mussorie: (U.P.)—Meeting held on 16th June, 1946. The following resolutions were unanimously passed.

1. The Mussorie branch nominates Dr. R. N. Lal, Rai Saheb, for the Presidentship of the All-India Medical Licentiates' Conference to be held at Poona in October 1946.

2. The Secretary to prepare the annual report and send to the General Secretary.

3. Dr. J. R. Goyal be elected as a delegate to attend the annual conference at Poona and in case he is unable to go, Rai Saheb Dr. R. N. Lal is elected to represent the branch as a delegate.

4. Resolved that in the best interests of the medical profession and the public it is necessary that there should be one medical service for all persons having a registered qualifications and all persons having such qualifications should be registered in All-India Medical Register to be maintained by the All-India Medical Council and as such in the opinion of this branch the coming conference should get the All-India Medical Act amended accordingly.

5. The Annual Conference should also approach the Provincial Governments to close all those existing Medical schools which can be converted into proper medical colleges.

Montgomery: (Punjab)—Meeting held on 23-6-46 at 3 p.m., at the Civil Hospital, Montgomery. Dr. K. C. Wohra read a paper on Head Injuries and it was thoroughly discussed.

Resolved that this meeting of the A.I.M.L.A. Montgomery Branch, is of considered opinion that for a satisfactory and equitable resettlement, the abolition of the subordinate medical service is an essential and unavoidable pre-requisite. This meeting therefore urges upon the Punjab Government to abolish the Subordinate Medical Service and start them on an initial pay of Rs. 150 per month as is said to have been recommended by the A.M.'Os. Conference held in November 1945. Further resolved that the recent announcement of the Punjab Government fixing the pay of the Sub-Assistant Surgeons from Rs. 80 to Rs. 200 p.m., is very inadequate and humiliating. The Punjab Government be urged to raise it from Rs. 150 to 550 p.m., and the pay of those already in service be fixed according to their grades.

Further resolved that an extract of the above be forwarded telegraphically to the Inspector General of Civil Hospitals, Punjab and a copy being sent by post.

Resolved that the Provincial Secretary be requested to make arrangements for holding the Provincial Conference at an early date.

Resolved that this branch nominates R. S. Dr. Manohar Lal Kapur as the President of the All-India Medical Licentiates' Association of the annual conference to be held in Poona in October, 1946.

Resolved that this branch elects Dr. Lok Nath, Chichawatni, and Dr. Balkrishan Okara as delegates and Dr. Munshi Singh, Sipalpur and Dr. Amar Singh Kueke, Bahawal as substitute delegates.

Simla:—Meeting held on 23-4-46 under the presidentship of Dr. Narayan Singh. The following resolutions were passed.

(1) Resolved unanimously that in view of the high prices of clothing and food material as well as of other bare necessities, still prevailing, it may be requested that the Simla allowance be raised to 45 per cent of pay as granted last year.

(2) Resolved unanimously that a Licentiate be posted as Sub-charger of Ripon Hospital, Simla, as the posting of a Graduate in this capacity eliminates the Licentiates from the Ripon Hospital and deprives them of their legitimate right. In view of the meritorious services of the Licentiates in the I. A. M. C. as Kings' Commissioned Officers in the present Emergency acknow-

ledged and appreciated by the authorities concerned, it is expected that this request will be favourably considered.

(3) Resolved unanimously that the revised scale of pay for Medical Licentiates in Subordinate Medical Services of the Punjab is exceedingly meagre and humiliating. In view of the meritorious services rendered during the present Emergency by the Licentiates on the I. A. M. C. who proved to be equally capable and efficient and as the above fact has already been acknowledged by the authorities concerned, it is requested that their pay be fixed at a reasonable rate. It is suggested that it should be fixed at Rs. 150-450 p.m. as recommended by the Administrative Medical Officers of the various provinces.

II. Meeting held on 3-6-46 and the following resolutions were passed under the presidentship of Dr. Naurang Singh.

(1) Resolved unanimously that the General Secretary be approached to acquaint the public with the fate of Licentiates by advertising in the leading newspapers of various provinces as well as in Cinemas and has also to contact the present Medical School students for helping our propaganda.

(2) It has been further resolved that as the Government is indifferent it is useless to request for the increase of pay or to close the Medical Schools as it has been unsuccessful.

(3) Resolved unanimously that the opinion of the General Secretary be asked if a circular be issued to all the Service Licentiates throughout India as to whether they are willing for a strike as a protest for not redressing their grievances as to status, pay, designation, registration and closure of Medical Schools etc.

(4) (A) Resolved unanimously that like all foreign countries, the chemists and druggists should not be allowed to sell Injectable Drugs, Syringes and Poisonous Drugs to laymen without a Registered Doctors' prescription.

(B) The rule prohibiting non-qualified practitioners as Hakims, Vaidis and Dispensers, Homopaths etc., to inject various medicines, be strictly observed and authorities be asked to keep a strict eye on this.

(5) Resolved unanimously that the authorities be approached that all the medical manufacturing firms be prevented by law to advertise in the lay press regarding their preparations. It is dangerous in public health interest. They should only be permitted to do so in the Medical Press. All other ways to prevent quackery be adopted.

Ex-I. A. M. C. Officers' Association, Punjab.—The conference of the above Association was held on 16th June, 46 at Amritsar, and the following office-bearers were elected:—

1. President: ... Captain Samuel Ram Singh.
2. Vice-President: ... Captain Haji Mohd Yakub, M.C.
3. General Secretary: ... Captain Harbans Singh Mahal.
4. Joint Secretary & Treasurer: ... Lt. Mohd. Ikram Qureshi.

5. Executive Members:—

1. Captain Mohd. Yaqub.
2. Captain Maunihal Singh Grewal,
3. Captain Fazal Illahi Shah Chisti.
4. Captain Chaman Lal Vasesi.

The following resolutions were passed in the conference.

(1) Resolved that this Association of Ex-I.A.M.C. Officers should work under the auspices of All-India Medical Licentiates Association as a branch, in accordance with the express wishes of the President of All-India Medical Licentiates' Association, with present Headquarters at Amritsar.

(2) Resolved that in recognition of their war services and professional experience gained during the period, all Ex-I.A.M.C. Officers be permitted to appear in final M.B.B.S. examination without undergoing any further training provided they have had five years' clinical experience after their licentiate qualification before they appear in the examination. It is further resolved that facilities for short clinical Courses be provided to the Ex. I.A.M.C. Officers who may so desire to avail of them at the Medical College Hospitals.

(3) Resolved that this conference is strongly of the opinion that in the Post-War Scheme there is no need for the continuation of the licentiate course of medical education and that all existing Medical Schools be converted into colleges as early as possible or closed, since there is a strong need for a uniform standard of Medical education.

(4) Resolved that the Provincial Subordinate Medical Service be abolished and that there should be only one cadre of medical service in the Province, i.e. P.C.M.S. and that all new entrants whether graduates or licentiates should be taken in the lowest category of the service and their further promotion depend upon individual efficiency and capability. It is further resolved that all Ex-I.A.M.C. Officers returning from the Military Service be immediately placed in the P.C.M.S. Cadre.

(5) Resolved that all I.A.M.C. Officers who were temporary civil employees before joining the military, should on return be confirmed forthwith in their civil jobs, or be given all the benefits admissible to emergency commissioned officers who have no lien in the Civil Service.

(6) Resolved that all Ex. I.A.M.C. Officers belonging to the Civil Department and released under class "A" Release Regulations of the Indian Army, be provided with all the release benefits including the release and overseas service leave at the military rates of pay, in accordance with the provisions of the said regulations.

(7) Resolved that a deputation of the Ex. I.A.M.C. Officers should wait on the Inspector General of Civil Hospitals, Punjab and the Minister of Education, Punjab, to represent their case in the form of a Memorandum.

Badarpur: (Assam) Meeting held on 15-6-46 with Dr. P.R. Purkayastha in the chair. The following resolutions were unanimously passed:—

1. The aim of this branch of A.I.M.L.A. Badarpur should be to increase the number of members of the A.I.M.L.A. particularly amongst the licentiates serving under this Railway.

2. The status of the licentiate doctors in this Railway should be raised to the upper subordinate cadre and the designation of Sub-Asst. Surgeon should be withdrawn and called as Medical Officer.

3. That there should be an uniform standard of scale of pay for the licentiate serving under different Government and Local Bodies and starting pay should not be less than Rs. 150 per mensem.

4. Resolved that this Badarpur Branch of A.I.M.L.A. requests the Railway Administration that study leave should be granted to the doctors with full pay who are desirous of having higher studies on specialist courses.

Habiganj. (Assam). A meeting of the medical licentiates was held on 2-5-46 under the presidentship of Dr. P. Guha. The desirability of reviving the defunct branch was unanimously decided.

The following office-bearers were elected:

1. Dr. P. Guha ... President.
2. Dr. M. A. Hussain Chowdhury ... Secretary.
3. Dr. A. C. Roy ... Joint Secretary.
4. Dr. J. Purkayastha ... Treasurer.
5. Executive Committee;

Besides the office-bearers the following doctors were elected.
1. Dr. B. Dhar Chowdhury, 2. A. K. Sen, 3. Dr. M. C. Roy, 4. Dr. Mrs. Mazumdar.

One of the members to form quorum, with a minimum of 3 members, Provincial Secretary Dr. S. P. Nath to be written about necessary help to be given to this branch. After the formation of the branch a condolence resolution was passed at the instance of Dr. M. A. Hussain Chowdhury on the death of our veteran and silent worker of the Association Dr. R. M. Kar. All stood in reverence silently for two minutes wishing his soul to rest in peace.

Tingri Valley Branch: (Assam). Proceedings of the General Meeting of the above branch held on the 16th June 46, at Keyhung T. E. with Dr. B. N. Chowdhury on the chair.

Five members were present. The following transactions were passed: 1. The General Secretary's Circulars No. 13 and 14 and the Provincial Secretary's circular No. 263-88 were read and filed.

2. This branch nominates Rai Saheb Dr. Manoharlal Kapur as the President of the All-India Medical Licentiates' Conference to be held at Poona.

3. Discussion was held on the epidemic of Naaga Sore which is prevalent in this Circle at present.

4. Resolved that this branch elects Dr. S. C. Dutta, L.M.F. of Balijan T. E. as a delegate to attend the 34th Annual Conference of the A.I.M.L.A. to be held at Poona.

Nowgong (Assam).—Proceedings of the Annual General Meeting held on 6th April, 1946. 11 doctors were present. The following resolutions were passed:

1. This meeting condole on the death of the father of Dr. J. K. Barooah, moved from the chair all standing.

Further resolved to send a copy of the resolution to the members for the bereaved family.

2. After some discussion on the case of Dr. S. Phookan, this Branch expresses its sympathy on the matter and requests the authority concerned for help.

3. This meeting is of opinion that the existing scale of pay of Medical officers under Nowgong Local Board is very poor and need immediate improvement.

4. The General Secretary be requested to send all the papers to the new secretary. The following new office-bearers were been elected for the year:

1. Dr. H. K. Chaudhury: *President.*
2. Dr. Joshoda Kanta Barooah: *Secretary.*

with an executive body of seven members.
Drs. H. K. Chaudhury in a short speech welcomed those present and stated all the affairs of the branch and pressed all the members to strengthen the Branch especially at this present moment.

Dr. L. K. Barooah and Dr. D. Phukan also spoke to the members present and welcomed the new office-bearers.

11. Nowgong (Assam):—Meeting held on 2-6-1946. Dr. H. K. Chowdhury occupied the chair. The following resolutions were passed:

1. The proceedings of the last Branch Meeting held on 6th April be confirmed.

2. That the Hony. Secretary be authorised to issue appeals to all members and non-members to contribute their annual subscription of the Branch and to subscribe the official organ of the Association, the I. M. Journal.

3. Provincial Secretary's letter No. 211-38 of 25-5-46 was read and discussed.

This meeting is of opinion that the steps taken by the Standing Committee in this connection should be put before the central pay commission for acceptance.

The following papers were read; the members took a keen interest in the discussion.

1. Asthma—by Dr. H. K. Chowdhury.
2. An interesting case of Pyogenic infection—by Dr. H. Nath.

3. The problems of vitamin "A" deficiency—by Dr. J. K. Barooah.

(1) Silchar (Assam).—Minutes of meeting of the branch held on 27-4-46.

Lt. Col. P. H. Cummins, Civil Surgeon, Cachar, presided over the Scientific Section.

Dr. Md. Basirulla read a paper on Chemotherapy. It was highly interesting and the members present took part in discussion and expressed their personal experience. The President suggested that from the next meeting clinical lectures and discussions on interesting cases will be made.

The following resolutions were passed:—

1. Minutes of the last meeting were read and confirmed.
2. Provincial Secretary's Circular No. 1 and appeal were read and resolved that the members will take active part in "Membership-drive" movement.

(2) Silchar Branch.—Meeting held on 26th May, 1946. Lt. Col. P. H. Cummins, M. B., Ch. B., I.M.S. Civil Surgeon, Cachar, led the members to the different wards of the Civil Hospital and demonstrated some interesting Surgical and Medical Cases. Doctors present took part in discussion and it was felt that this procedure is very useful and instructive and will be of much help to the members. The members then attended a Pathological Postmortem on a case of liver abscess. The Scientific section terminated with a vote of thanks to Col. Cummins for the keen interest he has taken.

The members then met under the presidency of Dr. M. R. Chakrabarty and the following resolutions were passed:—

1. Minutes of the last meeting were read and confirmed.
2. Circular No 2 of 29-4-46 and letter No. 221-38 dated 25-5-46 of the Provincial Secretary were read. The members are of opinion that before we can decide to take any drastic action, we should enlist all the Licentiates as the members of the Association. This Branch approves of the action taken by the Standing Committee of the All-India Association and suggests that the scale of pay of a doctor should be Rs. 150 to 500 with unification of service and abolition of the rank of sub-assistant surgeon.

3. Accounts of the branch upto-date were checked and passed.

Silchar:—Minutes of the meeting of the Silchar Branch held on the 29th June, 1946. Lt. Col. P. H. Cummins, Civil Surgeon, took the members round the wards of the Civil Hospital and gave clinical lectures on some very interesting cases. He exhibited case records and X-Ray plates of some cases. The members present took part in discussion and were impressed with the action taken.

The Scientific Section terminated with a vote of thanks to Col. Cummins.

The members re-assembled under the presidency of Dr. S. P. Nath and the following resolutions were passed:

1. Minutes of the last meeting were read and confirmed.
2. Accounts of the Branch upto-date were checked and passed.

3. General Secretary's Circular No. 13 and Provincial Secretary's letter No. 263-88 were read and discussed.

4. Rai Saheb Dr. M. L. Kapur was unanimously nominated for the Presidentship of the All-India Medical Conference to be held in Poona.

5. Drs. K. Purkayastha, D. N. Chakrabarty and S. K. Dutta were elected delegates to the All India Conference to be held in Poona. If they fail to attend Drs. S. Sen Gupta, A. Chatterjee and M. R. Chakrabarty will be the substitutes.

6. Annual report of the Branch as presented by the Secretary was read and adopted.

7. The Branch records its deep sense of sorrow at the death of Rai Bahadur Dr. B. M. Das Gupta, Director of Tropical School of Medicine, Calcutta. He was one of the jewels of the Association and his death is not only a loss to the Association but will be keenly felt by the Medical profession all over the world.

Lumding. (Assam.)

(1) Meeting held on 14-2-46. The following resolutions were moved and passed unanimously:—

1. In view of the fact the members of Lumding Branch cannot always attend the Association meetings at Gauhati or Nowgong, resolved that a separate branch should be opened at Lumding.

2. Resolved the following office-bearers be elected for the year 1946.

Dr. M. Z. Chowdhury.	... President.
Dr. P. K. Ghose.	... Vice-President.
Dr. M. C. Ganguly.	... Secretary.
Dr. S. B. Sen.	... Asst. Secretary.
Dr. P. B. Bhowmick.	... Treasurer.
Dr. M. N. Ghosal.	... Auditor.
Dr. J. K. Paul.	... Member, Executive Committee.
Dr. A. C. Dhara.	... Member, Executive Committee.
Dr. J. C. Raha.	... Member, Executive Committee.
Dr. M. A. C. Sen.	... Member, Executive Committee.

3. Resolved that the Provincial Secretary may be requested to the branch affiliated at an early date.

Lumding.

(2) A meeting was held at Lumding on 4-5-46 at 19 Hrs. with Dr. J. K. Paul, on the chair. 6 member were present.

The following resolutions were passed unanimously.

1. The circular No. 2 dated 29-4-46 issued by the Provincial Secretary was read and discussed. This branch strongly supports the resolutions of the Standing Committee of A.I.M.L.A. held in Delhi on the 4th, 5th March, '46 and as per above quoted circular every efforts should be made to move the authorities in express their final decision regarding our demands failing which is ultimatum should be served to take up a strike ballot by the All-India Medical Licentiates (under A.I.M.L.A.)

2. Resolved that Dr. M. C. Ganguly and Dr. J. K. Paul, elected members of the Provincial Standing Committee,

3. Resolved that all the members of this branch are requested to contribute towards the finance of this branch.

4. An interesting case of "Cerebral Malaria" complicating Arotitis was discussed. The meeting dissolved with a vote of thanks to the chair.

(3) A meeting of this branch was held on 2-6-46 at 7-30 hours with Dr. T. M. Dhar in the chair. Nine doctors were present. The following resolutions were passed:

1. General Secretary's letter No. 1808 dated 13-5-46 was discussed and resolved that the Secretary B. A. Rly. Employees Association, Lumding Branch be requested to inform this branch that whether the Railway Sub.-asst. Surgeons will join the strike.

2. Provincial Secretary's letter No. 211-38 dated 25-5-46 was discussed and this Branch appreciates and strongly supports the views and scales of pay submitted by the Standing Committee of A. I. M. L. A. to the Government of India.

3. An interesting case on "SPINAL INJURY" was discussed.

(4) A meeting of the executive body of the Licentiates was held on 19-6-46 with Dr. T. M. Dhar in the chair.

The following agenda were discussed.

1. To elect President and delegates for the 34th Annual conference.

2. To move the authorities to give effect to the scale passed by I. R. C. A.

3. Any other matter that might be taken up.

I. Resolved that the General Secretary, A. I. M. L. A. be requested to move the Railway Board to this effect that the scale of pay for the Licentiates in the Indian Railways which was passed by the I. R. C. A. to be given with immediate effect.

II. Resolved that Dr. M. L. Kapur be elected as President of the 34th Annual Conference.

III. Resolved that Dr. M. C. Ganguly and Dr. J. K. Paul be elected delegates to the 34th Annual Conference.



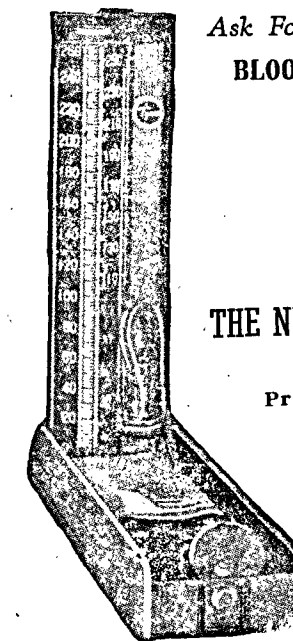
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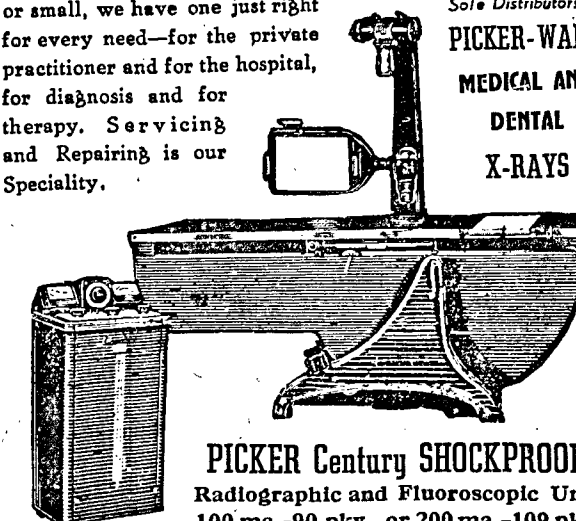
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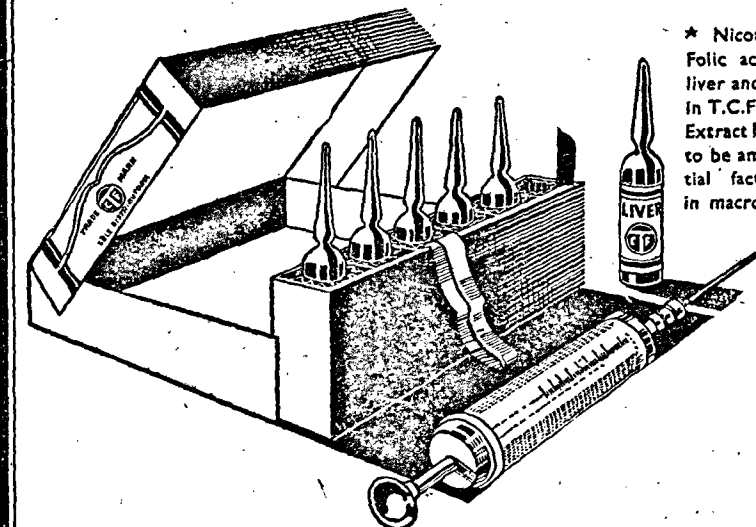
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ON BEHALF OF THE ALL-INDIA MEDICAL LICENTIATES' ASSOCIATION. PRINTED BY MR. R. RAVAIMANICKAM
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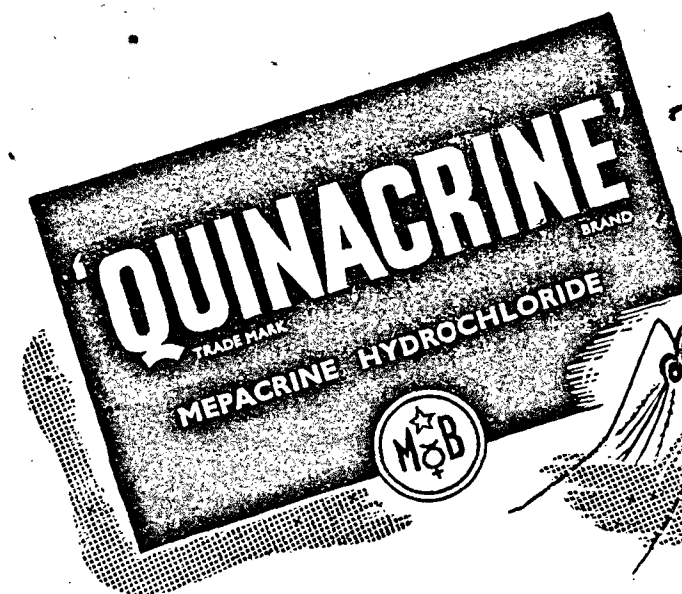
Indian Medical Journal.

Journal of the All-India Medical Licentiates' Association with which the Agra Medical Club Journal is incorporated.

Vol. 40, No. 11
November 15, 1946

Editorial and Publishing Office
32, Sullivans Garden St., Mylapore, Madras

Annual Subscription:
Members Rs. 4.0
Non-Members " 6.0
Foreign " 7.8



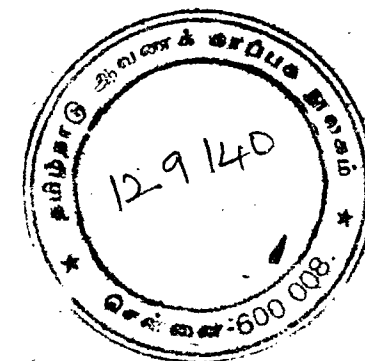
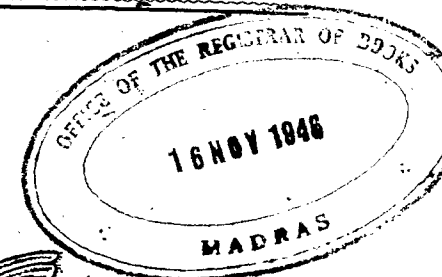
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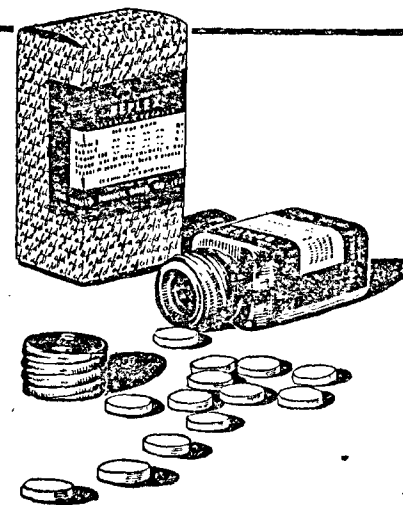
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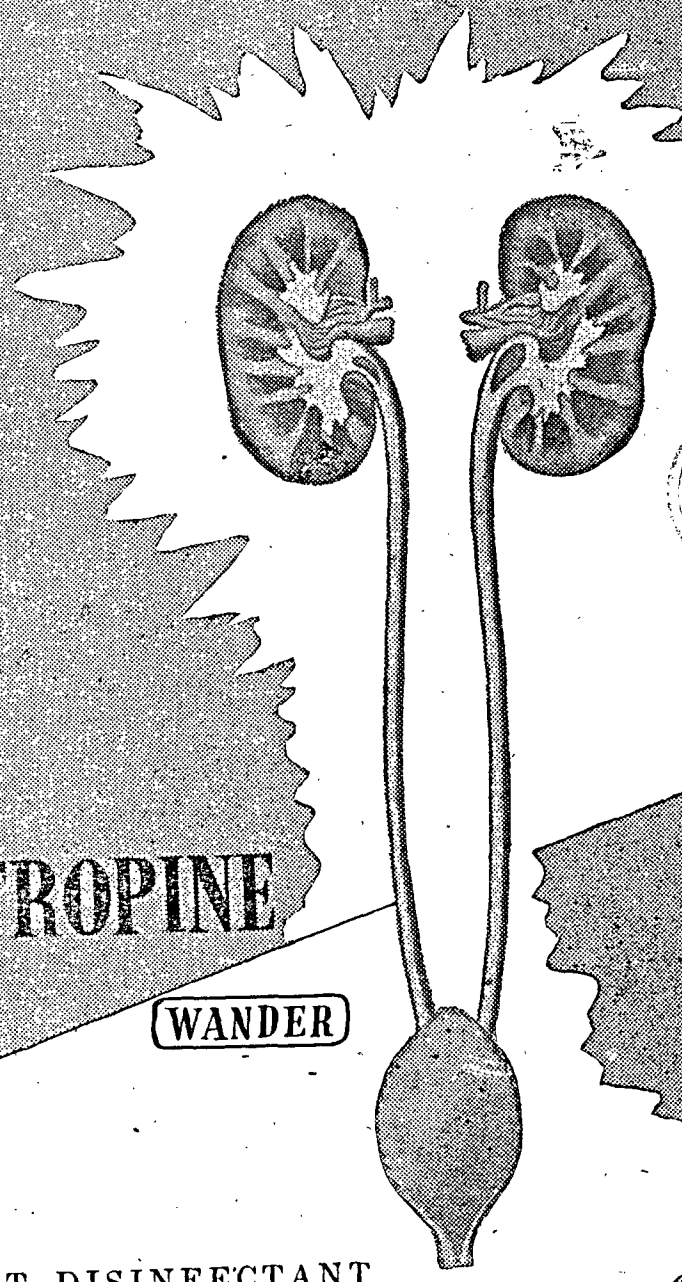


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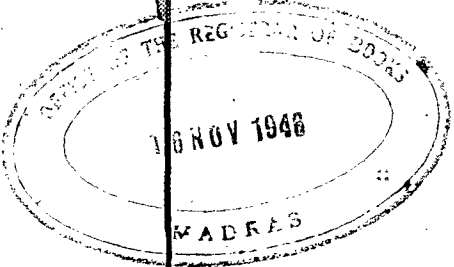
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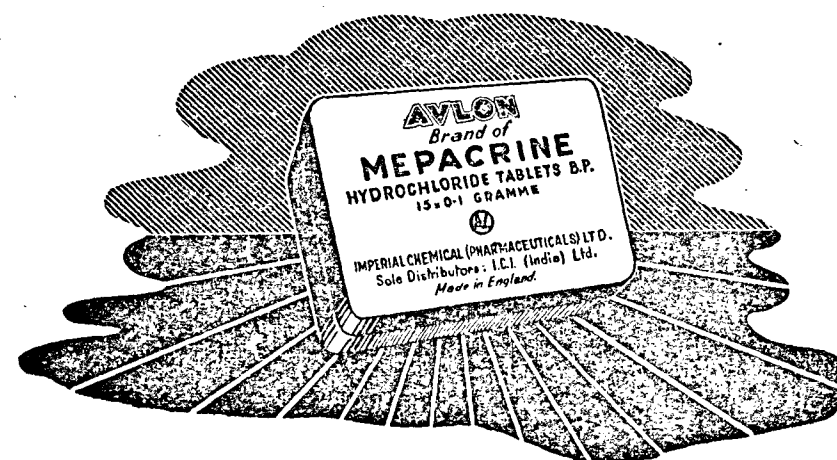
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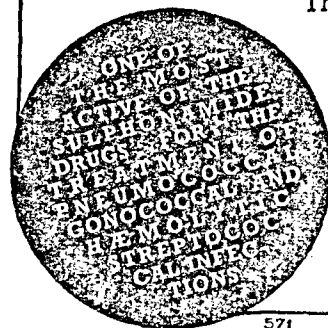


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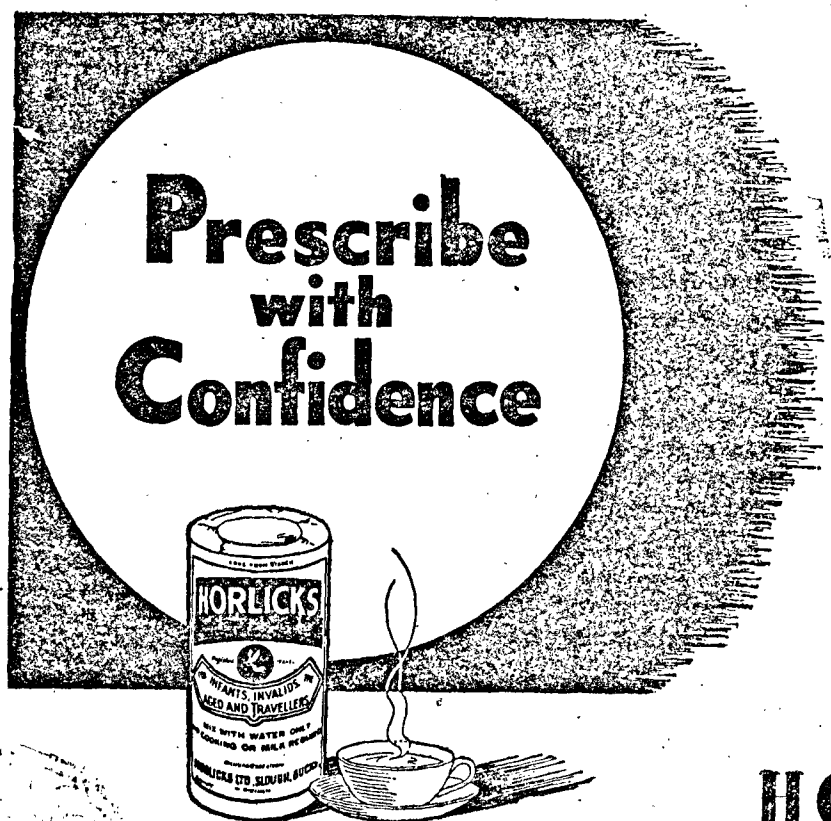
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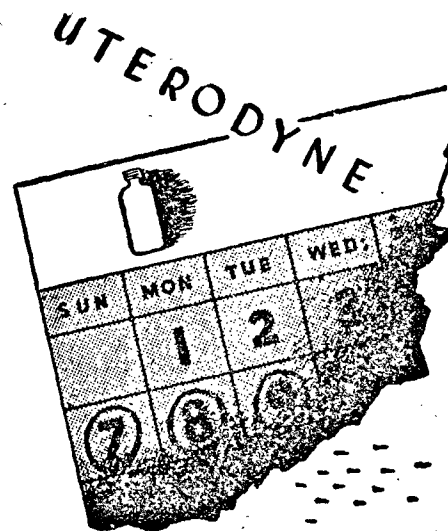


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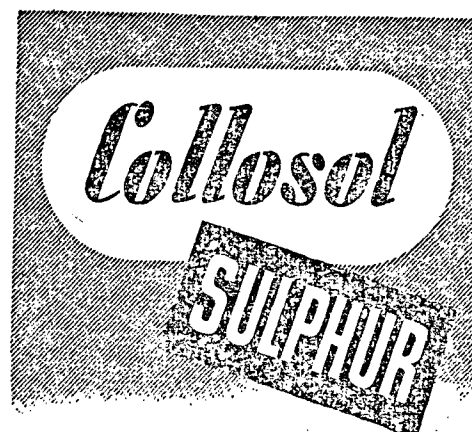
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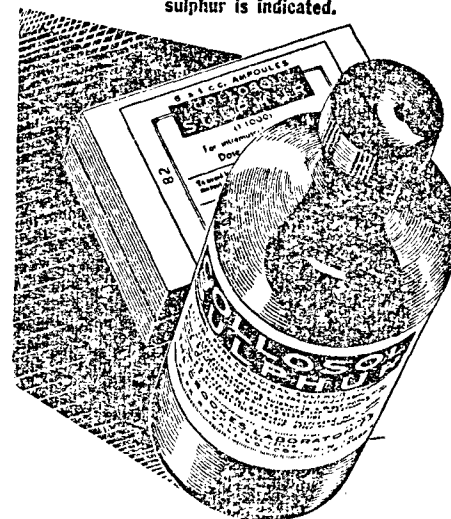
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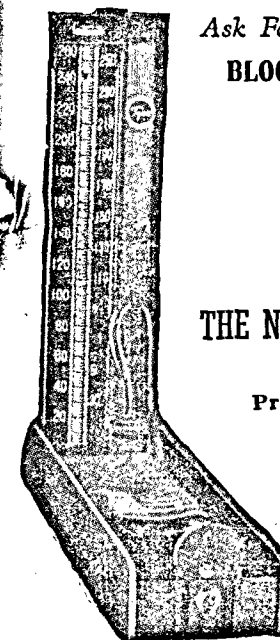
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* Wakeley, C.P.G. (1942) *The Practitioner*, 149, 50.

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Indian Medical Journal

(Journal of the All-India Medical Licentiate's Association)

Vol. 40. Madras: November 15, 1946. No. 1

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OUR MONTHLY SURVEY

Work done by the Indian Research Fund Association during 1945:—It is neither easy nor possible to review the whole range of work done by the workers in the I. R. F. A. We are therefore giving below results of their work on some of the more important diseases commonly met with by general practitioners. They should not be taken as conclusive but only indicative of the line work pursued or worth pursuing.

Sulphaguanidine in Cholera:—Three grammes of this drug suspended in an ounce of water was given every 4 hrs. for 3 days and then twice a day for 3 days. Out of a total 456 cases of clinical cholera, mortality was only 11 (2.1%) while in the control cases of equal number mortality was 40 or 77%. This is in confirmation of the results of the previous year. Sulphadiazine does not appear to be superior to Sulphaguanidine.

Treatment of Filariasis:—This disease still affords successful treatment and the following drugs were tried during the year under review with results mentioned against each.

Anthiomaline: (A Trivalent compound of Antimony—May & Baker)—It was given in 1 to 4 c.c. doses intramuscularly twice or thrice a week. Total injections 20. It seems to be beneficial in controlling attacks of acute lymphangitis so common in the early stages of filarial infection.

Mapharside: (P. D. & Co.): Administered intravenously at weekly intervals from 0.02 to 0.06

gm. Patients seem to respond well, especially those with acute lymphangitis or chyluria.

Penicillin: No beneficial effects were observed.

It may be noted that none of the above drugs showed any lethal effect on the parasite even after full course of treatment.

Leprosy:—Penicillin was tried in white rats infected with rat leprosy bacilli but this did not prevent the development of generalised infection. It had no beneficial effects when tried in human cases of leprosy. Efforts are being made to prepare Chaulmoogric and hydnocarpic derivatives of sulphanilamide for use in the treatment of this disease.

Attempts at cultivation of lepra bacilli proved again a failure.

Of the 600 new cases with bacteriologically negative skin lesions bacilli was not found in even a single case in nasal smears. This shows that the bacilli are rarely found in nasal smears from neural cases in whom the skin lesions are bacteriologically negative.

Naga Sore:—Repeated examination of smears stained by different methods and by dark ground illumination showed fusiform bacilli, particularly in early cases. Experiments on transmission were all unsuccessful. The sores were distributed over the lower extremities below the knee. Thirteen gave a history of cut or injury as having initiated the sore. In the rest, the sore originated spontaneously as a vesicle or bleb.

Kala-Azar:—50 cases of Kala-azar (and two post Kala-azar dermal leishmaniasis) were treated with sodium antimony gluconate (Stibatin-Glaxo) containing 20 mgm. of sb. per c. c. of the solution. The immediate results have been satisfactory. The use of penicillin, intramuscularly and locally, in the treatment of cancrum oris complicating Kala-azar has been beneficial in all the cases.

ADDRESSES AND ARTICLES

The Doctor's Dilemma

BY

DR. KUMARES CHANDRA BANERJEE, M.B. (Cal.)
P/o. Bhalpara, 24 Paraganas

Doctors are very often in a great fix—the knotty dilemma before them requires great patience and courage to undo. Delicate and difficult as they often are yet so much depends on his judgement and specially when one tries to simulate a disease.

These patients fall under two classes.

1. Neurotic and 2. Dishonest.

The second group of cases are often met with in mills and factories, among office assistants and soldiers who in order to obtain a certificate of discharge or for compensation or some other advantage during service will simulate symptoms of a disease or will bring it about. During the period of my service I have found people inflicting injuries on their persons to get

Psoriasis

BY

M. P. RANJAN, L.M.P.,

Hospital Road, Laheria Sarai.

Definition:—A common condition of the skin characterised by flat, dry, reddish or red-brown patches of varying extent and covered with profuse whitish, silver-grey or asbestos like scales without any disturbance in general health.

Etiology:—Unknown

- (i) Age—Early life: rarely under 7
- (ii) Sex—Both sexes (Blue-eyed, Fair-haired type)
- (iii) Hereditary predisposition
- (iv) Season: Winter and Spring (Exposure to cold)
- (v) Septic foci in teeth, tonsils, cervix, sinuses.
- (iv) Pre-disposing factors:—

- (a) Rheumatism
- (b) Arthritis
- (c) Tonsillitis
- (d) B. Coli affection

Pathology:—On histological examination, there is abundant overgrowth of the epithelium associated with the downward growth of the interpapillary process. The papillae are proportionately enlarged. There is misformation of the horny layers (Parakeratosis) and leucocytes found in between the layers. The cells of the sub-papillary layers are infiltrated around the papillary vessels.

Clinical picture:—

(i) **Distribution:**—Almost invariably symmetrical—shows a marked predilection for surfaces that are exposed to friction.

Tips of elbows, front of the knees, hairy scalp, trunk (both front and back,) waist region and rarely on face, neck, nails palms and soles.

(ii) **Eruption:**—Usually commences as a tiny papule (P. Punctata) surmounted by a silvery scale. Gradually the enlargement of the papule reaches the size of a pea or a three-penny piece (P. Guttata). When the coin-like size is attained (P. Nummulata) they become circular or ring-like (P. Circinata) and the rings having fused together form gyrate figures (P. Gyrata). The crusts are usually very thick on scalp (P. Rupoides) where the scales cannot fall out due to hairs. In cases where the lesions are confined only to follicles, it is called P. follicularis.

The eruptions are usually few and develop slowly. They are scaly and elevated from its very onset. They are always dry and on scratching the top scales, bleeding hyperaemic papillae are exposed. After attaining the nummular stage, the lesions become stationary for a few weeks or months. Healing starts usually at or near the centre and the atrophy leads to the circinate stage.

The eruption usually starts as a papule of pin-head size, at first red but becoming white as the scales begin to form. Spreading centrifugally, the papules form patches generally roundish or oval when small, and becoming more irregular as they grow larger. The scales may vary from a thin film to a dense, heaped up mass. On removal of the scales, a smooth,

dry, shining, hyperaemic surface is seen studded with spots that show various gradations of colour deep to bright red; the bright red points being the tops of inflamed papillae.

While the disease is active, the individual patch is encircled by a narrow zone of redness but when it is not spreading this fades away. Sooner or later, the involution takes place and redness which the lesions leave behind them soon disappears though in protracted cases a brown stain may persist and in rare instances there may be superficial atrophy.

On nails, small pin-head sized pits are seen forcing the whole nail in its bed resulting in consequent ridging and the elevated free border. Nails get brittle.

(iii) **Other symptoms:**—Little or no itching (unless complicated by secondary coccal invasion). General health undisturbed.

Diagnostic points:—

- (i) Patches with sharply defined border covered with hard, shining scales.
- (ii) Hyperaemic surface beneath, dotted with red points.
- (iii) Typical distribution.
- (iv) Absence of exudation.
- (v) Less intense and less constant itching.

Differential diagnosis:—

- (i) **Scaly syphilide:**—
 - (a) More infiltration
 - (b) Rare affection of elbows and knees. Mostly on palms, soles and flexor aspects,
 - (c) Scanty scales, less silvery, no bleeding points on scratching.
 - (d) Centre of the patches usually depressed, stained and healing.
- (ii) **Seborrhic dermatitis:**—
 - (a) Patches less crimson.
 - (b) Scales scanty, greasy and orange coloured, flatten to touch.
 - (c) Extends over the whole surface e.g., middle of the chest, back and front, flexor aspects of the limbs, scalp, face and neck.
 - (d) Patch surrounded by the satellites
- (iii) **Psoriasis rupioides:**—
 - (a) Base not ulcerated.
 - (b) Negative history and W. R.
 - (c) No response to specific treatment.
- (iv) **Lupus Erythematosus:**—
 - (a) Adherent scales.
 - (b) More elevated edges of the patches.
 - (c) Greyish tint like mortar but not silvery.
 - (d) Patches limited to face, scalp, ears, and fingers.
 - (e) Cheeks and nose usually attacked.
 - (f) Scarring of the patch-atrophy of the ears and other parts.
 - (g) Distinctive plugs in the orifices of sebaceous ducts.
- (v) **Lichen planus:**—
 - (a) Intense itching.

- (b) Typical shining, smooth papules with scales.
- (c) Ground-tint black or purple.
- (d) Patches formed by aggregation of a number of papules or by centrifugal extension,
- (e) Lesions on flexor aspects, wrist and knees.

(vi) **Tinea circinata:**—

- (a) Large number and very wide distribution of the lesions.
- (b) Absence of fungus which is the cause of cutaneous ring worm.
- (c) Unbroken falling out of hairs

(vii) **Maculo-Papular syphilide:**—

- (a) Absence of infiltration—
- (b) Lighter colour.
- (c) Palms of hands usually spared.
- (d) Lack of concomitant syphilitic signs.
- (e) Absence of positive W.R.
- (a) Constant and profuse desquamation.
- (b) Papery scales in which epidermis is shed.
- (c) Vivid redness of the eruption.
- (d) Rapid and universal diffusion.
- (e) Serious impairment of health.
- (f) Frequent absence of itching.

(ix) **Pityriasis Rubra Pilarsis:**—

- (a) Scaly patches on palms and soles.
- (b) Dry eruption covered with eczematous looking crusts.
- (c) Characteristic follicular papules.

(x) **Pityriasis Rosea:**—

- (a) Patches very slightly raised and thinly covered with scales.
- (b) Pale—Pink colour.
- (c) Behind elbows and knees.
- (d) Less inflammatory character.
- (e) More rapid onset.
- (f) Neglected situations more vulnerable to psoriasis.
- (g) Absence of hyperaemic spots on the surface under the scales.

(xi) **Seborrhoea corporis:**

- (a) Dryness of the scales.
- (b) Much less chronic character:
- (c) Lesions clearing up in few weeks:

(xii) **Eczema:**

- (a) Marked itching.
- (b) Moist surface on removal of scales.
- (c) Lesions made up of aggregation of papules and papulo-vesicles.
- (d) Yellowish, dull and friable layers of the scales.

Course:—Usually chronic: very obstinate and tends to recur even after an apparent cure. May remain stationary for a long time and slowly disappear or continuing to spread may become confluent. May be most abundant in best of health or disappear during serious illness.

Treatment:—

(A) **General:**—

- 1. Rest in bed.
- 2. Daily alkaline bath.
- 3. Daily removal of the scales with soft soap and rectified spirit.
- 4. General improvement of health.
- 5. Sulphur bath, sulphur emulsion or colloidal sulphur (chronic stage)
- 6. Spa treatment
- 7. Keep off dyspepsia by regular use of laxatives.

(B) **Medicinal:**—

(i) **Orally—(a) Mixture of:**—

Sodii Sal (Nat)	—	gr. 20.
Sodii Bicarb	—	gr. 30.
Tr. Card Co.	—	m. 10.
Syrub Simplex	—	dr. 1.
Aque anethi dest	—	oz. 1.

— One dose thrice daily.

(b) **Mixture of:**—

Mag. Sulph	—	gr. 20.
Vinum antimonialia	—	m. 10.
Aqua menthe pip.	—	oz. 1.

— One dose thrice daily.

- (c) Vitamin B Complex (TCF) or Bi-vita-B-Phial.
- 2 teaspoonfuls in water thrice daily.
- (d) Pot. Iodide gr. 10 thrice daily in milk.
- (e) Liquor Arsenicalis 3 drops thrice daily in water.

N.B.—May be increased upto 6m. per dose—Should be used only in chronic cases and the treatment should continue for 8 weeks only.

(f) Colloidal suspension of metallic gold (10 drops contain gr. 1/10 of metal)—Ten drops in water thrice daily between meals.

(g) Colloidal Manganese pills—One pill thrice daily.

(ii) **Injectables:**—

- (a) T. A. B. Vaccine 25, 50, 75, 100 millions—with 5 c. c. sterile normal saline I. V. once weekly.
- (b) Auto-haemotherapy: 5, 6, 7, 8, 9 and 10 c. c. patients' own blood injected intramuscularly once weekly (in gradual increasing doses for 6 weeks).
- (c) Manganese Butyrate (1 or 1½ c.c. of 1% sol.) I. M. twice weekly.

N.B.—Manganese and gold to be alternated with one another for 6 weeks.

(d) Enesol (Clinical Laboratories) containing mercury arsenic and rest salicylic acid.

— 4 to 8 c. c. I. M. every third day or 4 to 10 c. c. I. V. (very slowly) every fourth day.

(C) **Local:**—

(i) **Paint the lesions with any of the following:**—

- (a) Pyrogalllic acid 10%
- (b) Sulphur emulsion 3 to 5%.
- (c) Acid Salicylic 3 %:
- (d) Acid Chrysophanic 5% (twice daily after bath.)

(e) Equal parts of tar, soft soap and spirit of wine.

(f) Plain vaseline first; later 1 to 2% salicylic acid in olive oil.

(g) 20% Chrysarobin in chlorbutol—once weekly and covered with layer of collodion.

(ii) Ointments :—

Acid Salicylic, Chrysarobin, Zinc Oxide ointments in various usual combinations may be used.

(D) Physical :—

For mild cases, pastille doses of x-rays.

(E) Patent Preparations :—

(1) Ointments :—

(a) Annaxeryl (Bailly) containing xeranthrol, thioelaidins sulphonate of Sodium, Balsam of peru, bitch oil and resorcin.

(b) Anti—Psoriasis Dermose (Cusi) containing sulphur precipitatum and washed zinc oxide, fossil earth each 10, oil of cade 20 with fat 50 parts.

(c) Cignolin (Bayer) contains dioxyanthranol.

(d) Engallol (Knoll) contains Pyrogallolmonoacetate.

(e) Pompinolin (Shiono) alcoholic solution of salicylic compounds.

(ii) Injectables : (a) Ektobrom (Gustrow) containing sodium bromide 10% in isotonic solution. Q.V. about 40% 3 to 5 c.c. i.v. every 2 days.

(b) Psathanol (Galier) containing bismuth, organic arsenic in aqueous form. 3½ c.c. amp. i.v. or i.m.

(c) Thymocrin solution (Harrower) Thymus gland preparation. I.M. daily for 5 day in week

(F) Diet :—

No fixed diet; nourishing diet, change in diet very essential; avoid alcohol.

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SELECTIONS.

Adiposity BY RAYMOND GREENE, M.A., D.M., M.R.S.P. FROM *Post-Graduate Medical Journal*, London June, 1946, with due acknowledgments).

The Causes of Adiposity.

Despite much sound research and vague speculation, the cause of adiposity remains obscure. Newburgh (1942) has considered the claims of various hypotheses.

1. Do fat people over-eat?

Considerable authorities have gone so far as to say that almost all fat people are fat because they eat too much. That an element of gluttony is common cannot be denied, but experience shows that most fat people can only remain slim by eating much less than the average amount of food and that most slim people can over-eat with impunity. The most that it is justifiable to say of gluttony is that it will inevitably bring out any constitutional tendency to adiposity.

2. Is there a disorder of the use of energy?

We have said that some people who eat well remain thin, whereas others who eat little grow fat. This observation might be explained by a difference in basal metabolic rate, but Boothby and Sandiford (1922) have shown that such an explanation is untenable. Of 94 adipose patients, 81 had a normal B.M.R. Strouse, Wang and Dye (1924) found no difference between two series of adipose and normal people. Grafe (1933) found only three with a low B.M.R. among 180 grossly adipose patients. A definitely low B.M.R. in an adipose person can probably be explained always by another abnormality, usually myxoedema.

Another possible explanation of adiposity might be found in a reduction in the specific dynamic action of food in fat people, and many investigators have claimed to have established that this in fact can be found. The subject has been considered most critically and investigated afresh by Strang and McCluggage (1931) who established beyond doubt that there is no significant difference in this respect between fat and thin people. Lauter (1926) indeed had shown that the normal variations in specific dynamic action are so great that nothing short of its total absence can be considered significant.

The hypothesis of "Luxuskonsumption" has also had a considerable vogue. Specific dynamic action comes to an end within twelve hours, but Grafe and Graham (1911) sought to show that a high intake of food produces an increased metabolism over a much longer period whereas a low intake reduces the metabolic rate. Such a mechanism would be capable of very exact control over body weight, and its failure would explain adiposity. The hypothesis appears to be supported by clinical experience, but a more careful scrutiny shows that it is only half true. Wiley and Newburgh (1931) showed that in fact the consumption of excessive food does not stimulate metabolism. That starvation diminishes it is, however, certain (Schondorff, 1912; Grafe and Koch, 1912), and some of the lowest basal metabolic rates are to be found in cases of anorexia nervosa. An explanation is afforded of the failure of starving people to die as soon as might be expected, but not of the phenomenon of adiposity.

3. Is there a Disorder of Absorption?

It is clear that if some people absorb more food than others, the more efficient absorbers would tend, other things being equal, to be fatter. This hypothesis was disposed of by Neuenschwander-Lemmer (1936), who showed that the residual calories in the food of fat people are not significantly different from

those of thin, and that the utilisation of dietary calories, nitrogen and fat is also equal.

4. Is there a constitutional abnormality of the Adipose Tissue?

Von Bergmann suggested that there is an increased affinity for fat in the adipose and Hetenyi (1936) that the adipose tissue of these persons "hung on to the fat" and prevented its use as fuel. These suggestions are not borne out by experiment. Indeed the opposite is apparently the case (Newburgh, 1942).

In his recent Sharpey-Schafer Lectures before the Royal College of Physicians, Lawrence (1946) postulated the existence of a lipopexic hormone. He described a woman who suffered from complete disappearance of all body fat, hyperglycaemia and glycosuria without ketosis and hyperlipaemia. He suggested that owing to a deficiency of his hypothetical lipopexic hormone, the patient was unable to store fat and that in consequence the fat derived from her dietary carbohydrate was forced to circulate in her blood stream.

We must finally be prepared to admit that we do not know by what process adiposity comes about. An approach to the problem may however be made by considering the roles played by some of the endocrine organs known to be concerned. (This portion is omitted. Ed. I. M. J.)

The Treatment of Adiposity

It has been made clear that we do not yet understand the causes of adiposity. The treatment therefore can be based on no sound rationale. It must be symptomatic. There are however two points of view to be kept simultaneously in mind. The patient is suffering from both fat-retention and water-retention. To neglect either is to obtain only partial success.

Diet

Whatever the cause of the abnormal deposit of fat, the law of the conservation of matter applies. Fat must come from food, and whether we believe with some authorities that all fat people eat too much or with others that they do not, it remains certain that if the patient eats less food than he requires for energy, he must lose flesh. Experience shows that in starvation, fat is lost more rapidly than more useful tissues. Partial starvation is the essence of treatment.

A simple reduction in calories, leaving the proportions of fat, protein and carbohydrate unaffected, is often successful. With a clear-sighted and collaborative patient it may be enough to say "Whenever you help yourself, think how much you would take in the past and then take half as much." With others, the Lawrence Line Diet designed for the treatment of diabetics, may be more useful. Each "line" of this diet gives approximately 150 calories, made up of 10 gms. of carbohydrate, 7½ gms. of protein and 9 gms. of fat. It is only necessary to explain the very simple working of the scheme and to prescribe so many lines a day. The patient has a very wide choice of foodstuffs and need not be confined to a fixed menu. In cases in which I have used this method, I have usually prescribed about half the calculated requirements of the patient in question.

The ordinary requirement of a sedentary adult is about 2,600 calories. For such a patient I would order about 1,300 calories a day; that is about 9 Lawrence Lines. The loss of weight on such a diet, provided the patient collaborates honestly, is slow but steady. It is necessary to ensure that enough protective foods are consumed. Green vegetables are, in the Lawrence diet, allowed *ad libitum*, and the patient must be encouraged to eat of them a sufficient quantity to ensure an adequate intake of vitamins A and C. In these days of meat shortage it may be as well to prescribe an additional source of the B vitamins and of iron. Provided that green vegetables are eaten in good quantity, hunger is not a serious disadvantage after the first few days.

In those patients, and they are numerous, in whom the element of water-retention is obvious, a delay may occur on such a diet before the loss of weight begins. There is reason to believe that starvation itself may cause temporary water-retention to a degree which may mask the loss of fat. Even if this is not so, the failure to excrete the excess of water may be at first depressing to the patient. This phase is, however, temporary. In any case, the phase of water-retention may be eliminated by the use of a diuretic. It is possible that carbohydrates may have a water-retaining action (Foldes, 1933). It is certainly true that in cases of gross obesity, in which water-retention is invariably great, the best results are not achieved if attention is focussed entirely on calories and if a diet low in energy value but normal in constitution is prescribed. In such cases better results are achieved by the drastic reduction of carbohydrates. Fats at present need not concern us. Experience shows that the amount of fat at present available is harmless.

It is my practice to give to all those patients in whom a great and rapid reduction in weight is necessary a very simple if somewhat onerous diet.

Salt in the diet should be kept as low as possible, for a high salt intake leads to water-retention.

It is surprising how large a proportion of fat people are ready to abide by these instructions for many months. When once a comparatively normal weight has been achieved, it is possible to "slacken off." Obviously a larger intake of food can be allowed when once it is no longer necessary to absorb less than the amount necessary for maintenance. Nevertheless the constitutionally adipose patient can never return to a normal diet without a return of corpulence. The treatment of obesity is purely symptomatic. The constitutional abnormality remains.

DIET FOR OBESITY

Foods to be avoided:

1. Bread and everything else made with flour.
2. Cereals, including breakfast cereals and milk puddings.
3. Potatoes and all other white root vegetables.
4. Foods containing much sugar.
5. All sweets.
6. Salt. If possible, no salt should be used in the cooking; other members of the family adding it at the table.
7. Fluids should be limited to 2 pints a day.
8. Fats should not be eaten in excess, but the small amount at present available is generally permissible.

You can eat as much as you like of the following foods:

1. Meat, fish, birds.
2. All green vegetables.
3. Eggs, dried or fresh.

4. Cheese.

5. Fruit, if unsweetened with saccharin.

You should weigh yourself once a week at the chemist, using the same chemist and wearing the same clothes. On this diet you should lose between one and two pounds a week. If you lose more than two pounds, you are being unnecessarily strict. If you lose less than one pound, you are not being strict enough.

This diet makes no claim to scientific accuracy, and allows the consumption of certain carbohydrate foods (e.g. beetroot) and disallows certain foods with little carbohydrate (e.g. turnip). It is, however, easy to remember and therefore easier to follow than a regime more accurately constructed. It is found that patients are discouraged by over-detailed instructions. The diet may be made less monotonous by the use of the carbohydrate-free foods manufactured by reliable firms (e.g. Callard & Co.), but it must be remembered that most of these preparations contain a small amount of carbohydrate. The proof of the pudding is in the eating, both with these and ordinary foods. If the patient can eat a certain carbohydrate food and still lose weight, there is no need to adopt a doctrinaire attitude. Alcoholic drinks should be forbidden, not only because they have food value in themselves, but because they increase the appetite.

Thyroid

It has been pointed out that thyroid deficiency is not an important cause of adiposity. Nevertheless, thyroid extract undoubtedly has a use in treatment. Its value probably lies less in its capacity to raise the general metabolism of the body than in its effect on water balance. Volhard's water test, often abnormal in obese people, may be restored to normal by thyroid treatment. The delay in weight reduction which often occurs on a simple dietetic treatment may be prevented by the simultaneous prescription of thyroid extract.

The initial dose of thyroid in adults should be $\frac{1}{2}$ to 1 grain. If the patient does not lose weight satisfactorily, at a rate, that is, of 1 to 2 pounds a week, the dose may be increased cautiously by $\frac{1}{2}$ to 1 grain at fortnightly intervals. An increase in the resting pulse rate, a loss of weight greater than 2 pounds a week, the occurrence of hyperpnoea on exertion or of palpitations, the appearance of symptoms of sympathetic overactivity such as flushing or sweating or an increased nervousness, are all danger signals. The thyroid should be stopped for a fortnight or until all signs of overdosage have disappeared, and begun again with a smaller dose. It is rarely necessary to prescribe more than 5 grains a day.

Thyroid extract should only be used in patients who can be kept under close observation. Though permanent hyperthyroidism is rarely produced by overdosage with thyroid, it has occurred (Bruun, 1945; Lous, 1945), and the possibility must always be kept in mind.

There is no necessity to use proprietary preparations of thyroid, the ordinary B. P. preparation of thyroideum siccum by any reliable maker satisfying all requirements. There is no point in using mixtures containing anterior pituitary extract, which is inactive by mouth and has no effect on obesity by any route; nor is there any need to give thyroid by injection. It is the only glandular extract which is fully effective when given orally.

Diuretics

Diuretics are of the greatest value, and many of the grosser cases of obesity can only be improved if they are used in conjunction with dietetic measures. Mersalyl has been used often, but the treatment of severe adiposity takes a long time and there are theoretical objections to its continued use. The most satisfactory drug in my hands has been urea, which can be taken harmlessly in large doses for an indefinite time. One heaped teaspoonful of the crystals (equal to approximately 5 grams) is taken three times a day. To many the taste is somewhat objectionable and I have found no effective way of masking it. Fruit juice appears to be the best vehicle.

Benzedrine Sulphate

Amphetamine or benzedrine sulphate is sometimes useful in reducing the appetite of those who find a rigid diet too difficult to follow. It should be given in doses of 5 to 10 mgm. in the early morning, so that sleep is not impaired. It is preferable to obtain the collaboration of the patient by more natural means.

Exercise

Exercise is helpful, but not as helpful as is often supposed. This is partly because a little food makes up in energy for a lot of exercise, and partly because exercise often increases the appetite disproportionately. A 'varsity' crew usually puts on weight while in training, though it is true that the increase is in muscle, not in fat. On the other hand, the loss of salt in the sweat may help towards the desired negative water balance, provided that the patient does not drink more than he would if he were not taking exercise and does not replace the salt. In short, exercise is useful when the patient is prepared to stick to instructions, however hungry or thirsty the exercise may make him.

Turkish Baths

In a Turkish bath, rapid loss of weight occurs owing to sweating. The loss of salt is a great advantage if the patient is on a low salt diet, for he has no means of replacing it, and even if he drinks a large volume of fluid after his bath, the kidney excretes it in order to maintain the electrolyte concentration.

Anterior Pituitary Extracts

A so-called whole extract of the anterior pituitary is well spoken of in the advertisements of the less reputable hormone-mongers, but nowhere else. It is inactive when given by mouth, and ineffective when given by injection. There is neither rationale for its use nor evidence of its value.

There is, perhaps, some reason for the injection of the thyrotrophic factor, but it is much cheaper to give thyroid extract by mouth.

Oestrogenic Substances

These are often prescribed for those women who put on weight excessively at the menopause. The metabolic changes at this period have already been discussed. The period is one of general endocrine readjustment, and it is doubtful whether ovarian deficiency is directly the cause of the adiposity. On this insecure rationale, various preparations are prescribed. Ovarian extracts are inert by any route. The so-called "natural" pure oestrogens, such as oestradiol, though mildly active by mouth and highly potent when given by injection, appear to have no

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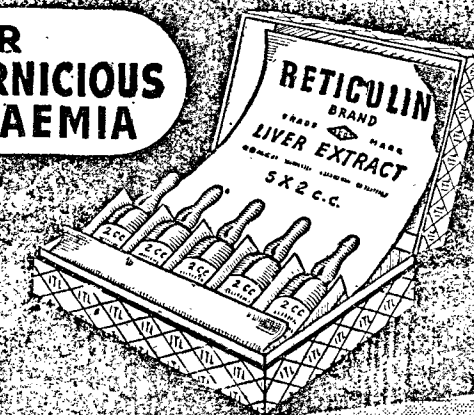
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value in reducing body weight, and their tendency to increase water-retention may even have the opposite effect. The synthetic oestrogens, such as stilboestrol, are equally valueless for this purpose.

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Summary

The slimming of fat patients is important, not only for aesthetic and psychological reasons, but because adiposity predisposes to many more serious disorders and shortens the span of life.

The causes of adiposity remain obscure. Though many of the ductless glands have probably some effect in determining body weight, it is not at present possible to ascribe the fault accurately in most cases of human obesity. There is, however, good reason to guess that in many the hypothalamus and the posterior pituitary must bear the brunt of the blame. The fact that gross adiposity, and perhaps also milder degrees, show evidence not only of fat retention, but of water-retention, has been stressed too little in the past. When this fact is borne in mind, many apparent anomalies in the reaction to treatment are easily explained, and the results of treatment are far more satisfactory.

The law of the conservation of mass cannot be circumvented. The reduction of the diet below the energy requirements of the patient must eventually cause a loss of fat. That it does not always cause a great loss of weight is due to the disturbed water balance. A fat person is like a wet sponge and much of the excess weight is due to water rather to fat.

For this reason a diet low in calories and preferably low in carbohydrate, salt and fluid should be supplemented by the use of diuretics, of which urea is the safest and most effective. Thyroid extract has a small place in treatment, and benzedrine may occasionally be helpful. Endocrine products other than thyroid extract are valueless, and other substances which increase the metabolic rate are too dangerous to use.

It is often difficult to persuade the patient that there is no comfortable road to normal proportions. *Il faut souffrir pour Etre belle.* If, however, co-operation can be obtained, excellent results are almost always to be obtained by dietetic and medical measures.

Common cases seen in the V. D. Department BY EVELYN GOURLAY, M. D. (From Post-graduate Medical Journal, London Aug. 1946, with due acknowledgments).

About 80 per cent of the cases attending our Venereal Department last year have been finally diagnosed as non-venereal, and only the remaining 20 per cent were actually infected with syphilis, gonorrhoea or soft sore.

This large percentage of non-venereal cases, which I think is usually much the same in the return of

most women's V. D. clinics, seems to surprise many people, and they may ask why so much public money should be expended on treating such a large number of uninfected cases.

I thought it might be of interest to talk of the problems presented by these non-venereal cases which often give us much more trouble in treatment than the straightforward case of syphilis or gonorrhoea. To begin with, when the patients come up often it is by no means certain whether they are or are not infected until tests have been repeated several times. During the war years we have had a great number of Service contacts where the husband or contact has written to say that he is infected and to ask wife or friend to be examined. Some are obviously infected or show positive pathological results at once. Some appear to be quite free from infection when first seen, and later develop positive signs while being observed. Others have escaped infection and are finally discharged as fit, often after 3 to 4 months of observation, but must be classified as non-V. D.

Then again in some cases where we are almost certain at first sight that the condition is non-venereal, the patient has been distracted with worry and has been the cause of much trouble to her own doctor. A definite diagnosis and treatment of such cases is important. I shall divide the cases for diagnosis into two groups:—

1. Those of the nature of vulvitis and vulval ulceration to be differentiated from syphilis.

2. Those with a vaginal discharge to be differentiated from gonorrhoea.

Vulvitis and Vulval Ulcerations.

I feel sure in my own mind that years of war diet and deficient fats have altered the condition of the skins and mucous membranes of many of the population, and that as a result we have had more cases of non-venereal vulvitis than I have ever seen in pre-war years. This coupled with a great increase in the number who have taken risks of infection and the resulting alarm about their condition, probably explains the large numbers of such cases attending. The varieties which come up may be put under the following main headings:—

(a) A superficial surface ulceration probably associated with some local infection which has caused irritation. These may or may not be a *Trichomonas vaginalis*. The vulva has usually been scratched and frequently treated at home with some strong irritating disinfectant. The characteristic appearance is the staining of the outline of the ulcers with gentian violet after the stain has worn off the unabraded surface. There is often acute oedema of the labia, but only small septic inguinal glands are palpable.

(b) A menopausal kraurotic ulceration often seen in women in the late forties or rather older, showing some kraurotic staining and ulceration patches. The condition is usually associated with some septic condition of their less resistant vulval and vaginal mucosa.

(c) Acute Monilia vulvitis.

This condition may be associated with a typical monilia vaginitis with its characteristic thrush-like patches on the vaginal mucosa. The vulva is red, swollen and granular, often with much oedema of the labia. The whole area is acutely tender to the touch.

and the patient can hardly bear to walk. This condition is common in the pregnant patient, but may occur in others, and even in small girls before puberty. The diagnosis is soon established as the monilia spores are easily found in a film from the ulcerated or abraded area.

(d) *A simple furunculosis* characterised by the infection of the hair follicles of the pubic and labial hair.

(e) *Herpes of the vulva.*

This may be easily recognised by the characteristic lesions and distribution, and frequently by its painful character. It may be less easy to diagnose if it takes the form of small painful punched out herpetiform ulcers of the labial mucosa, bilateral and irregular in distribution.

(f) *A pre-puberty vulvitis with surface ulceration.*

There seems to be no obvious cause for many of these cases, but the ulcerated surface shows the characteristic staining with gentian violet as previously described.

(g) *Seborrhoeic Dermatitis.*

This condition frequently involves the skin of the labia majora and mons veneris, extending out to the groins and back to the rectum. Sometimes the labia mucosa and introitus are acutely inflamed and sometimes it seems to be an external skin condition only.

(h) Less common are the last two conditions of Vincent's ulceration of the vulva or a Doderlein infection. The Vincent's ulceration is usually diagnosed by finding the spirochaeta Vincenti and B. fusiformis in a routine film, but it must always be remembered that a Vincent's infection may be superimposed on secondary syphilitic ulceration.

The Doderlein infection is not common, and is seen in small girls, where the Doderlein bacillus of the healthy adult vagina has become pathogenic and caused rounded punched out ulcers with a greyish base and an acutely red area round the rim of the ulcer.

A rapid method of differential diagnosis as to whether any of these conditions are syphilitic or not is by palpation of the inguinal glands. In primary and secondary syphilitic ulceration the inguinal glands are large, elastic and painless, and frequently seem enlarged out of all proportion to the size of the vulval lesion. In the absence of such glands it is always doubtful if any vulval lesion is syphilitic. This assessment of the case must be checked by taking smears for spirochaetes from any suspicious ulcer and repeated blood for Wassermann reaction.

I always feel that the more dramatic the history and description of the condition given by the patient the less likely is it to prove to be venereal. The chancre of syphilis often passes unnoticed by the patient and it is amazing how little they seem to have been troubled by appalling condylomata. Intense vulval soreness and painful inguinal adenitis usually contra-indicates a diagnosis of syphilis unless there is some secondary infection, or the ulceration has been treated with some irritating disinfectant.

Now for the second group of cases, the vaginal discharges to be differentiated from gonorrhoea; the pouring discharge with offensive smell, causing acute vulval soreness and irritation rarely turns out to be

gonococcal. The profuse offensive discharge is most likely due to:—

(a) *Trichomonas Vaginitis.*

This causes a characteristic frothy yellow discharge with an acute granular vaginitis. The cervix is red all over but usually shows no endocervicitis as is the case with gonococcal infection. If the granular inflamed vagina of a Trichomonas vaginitis is painted with hydrogen peroxide, the raw granular prominences of the rugae are picked out on white patches. This is a very characteristic appearance diagnostic of the infection.

(b) *The Monilia infection.*

This also causes an acute vaginitis, particularly in pregnant women. The vagina and vulva are acutely inflamed with curdy white patches of thrush on the vaginal walls right down to the introitus.

(c) *B. Coli and septic infections.*

These infections are clinically similar to the Trichomonas vaginitis and may sometimes be responsible for involvement of the Bartholin glands.

(d) *Vulval and vaginal warts.*

These warts which should be described noncommittally before tests as "vulval warts" are in themselves simply the outcome of the irritation of a chronic discharge over the mucous membranes of the vagina and introitus or the skin of the labia, perineum and anus.

The two essentials for their production is the presence of irritation with the type of skin and mucosa which becomes granular and warty in response. The patient who has vulval warts is not often Gc. positive on the cervical film. Often we know that they have been cases of gonorrhoea who attended originally for treatment and then lapsed, only returning when alarmed by the warts. These cases are usually negative in their films when the warts have appeared. Most frequently I do not think that they have had gonorrhoea at all, but have neglected a chronic septic or Trichomonas vaginitis which has caused the warts by irritation.

The blonde and red head seem to have particularly susceptible skins and in all patients the warts proliferate enormously with pregnancy. The small clumps of warts round the anus in the absence of any rectal discharge are, I think, due to the trickling back over the perineum of a scanty vaginal discharge which collects in a pool over the anus causing warty proliferation of the skin. Many of the bad wart cases can be treated as out-patients, but in pregnancy the condition may be so bad that hospitalisation is essential.

To finish I am giving the outlines of the few simple local treatments which we use for these conditions:—

Trichomonas Vaginitis

1. Gentian Violet or Bonney's Blue to cervix. Stovarsol vaginal tablets and tampon.

2. Negatol 100 percent to cervix and vagina. Negatol pessary 10 percent.

This must be preceded by a swabbing out with bicarbonate of soda to remove all mucus.

Vulval and Vaginal Warts

Treat any discharge by one of above methods, leaving the vagina as dry as possible. If necessary

fill the vagina up with powder to dry. Podophyllin Resin (25 percent in castor oil) to warts, dust warts and vulva well with powder. A good drying powder is:—

Bismuth Subgallate	1 part.
Zinc Oxide	2 parts.
Mag. Carb. Levis	2 parts.

Cremor Zinci should be given to the patient for application at home as the surface is very sore when the warts fall off.

Non-Venereal Vulvitis

Local.—The vulva must be protected from water. Gentian Violet 1 percent is applied and Cremor Zinci continuously. As little bathing as possible.

Sulphathiazole Cream 5 percent to any septic ulceration. If really bad, confinement to bed is essential.

Oral.—Radiostoleum or Adexolin.

Nicotinic Acid 50 mgs. t.d.s.

Riboflavin 1 mg. t.d.s.

In menopausal cases—Hexoestrol 1 mg. t.d.s.

Some Danger Signals in Midwifery BY EDITH M. HALL, M.D., F.R.O.S., F.R.C.O.G., (FROM *Post-graduate Medical Journal*, London, Aug, 1946 with due acknowledgments).

In midwifery practice most patients have a normal straight-forward delivery but in the small proportion where complications occur it is of the utmost importance to recognise the early indications of trouble ahead. The prolonged first stage, foetal distress and the high head are three conditions where failure to recognise early the departure from the normal may result in unnecessary damage to mother and danger to the child.

1. The Difficult Cervix

Delay in the dilatation of the cervix can be divided into three groups:—

(a) Lack of a good dilator; this includes malpresentations, tumours in the pelvis, cases of disproportion, etc.

(b) Lack of good contractions.

(c) A cervix that will not easily dilate in spite of good pains and a satisfactory presenting part. Apart from cases of organic rigidity of the cervix resulting from operations on the cervix, extensive scarring of the cervix, previous treatment by radium, presence of growths such as cervical fibroids, carcinoma of the cervix, there are several types of cervix which give considerable trouble:—(1) The tough cartilaginous cervix; (2) The thin cervix with the knifelike edge; (3) The tubular cervix which is very tightly stretched over the low presenting part, so that the junction of the vaginal wall and the cervix is difficult to reach though the presenting part is almost shewing at the vulva. Such a condition with slight dilatation of the cervix after a considerable time in labour with good pains is an indication of true rigidity of the cervix and an indication for lower segment Caesarean section. The treatment of this condition by *accouchement force* is too dangerous. Caesarean section may also be necessary in the case of the tough cartilaginous cervix and the knife edge type. Often these cases dilate to two fingers and make no further

progress. A cervix that is dilated to four fingers will usually go on to complete dilatation if other factors are favourable.

It is important to examine the cervix before doing a surgical rupture of the membranes for conditions such as toxæmia, for the tough and tightly contracted cervix may not easily dilate and there may be considerable delay in the onset of labour. In such cases the pains may start and stop so that several days may pass before the patient is really in labour and then the tough cervix may need several more days to reach full dilatation. When termination is urgently required for conditions such as toxæmia, and the cervix is tough and tightly contracted, Caesarean section may be the best method of treatment. Another indication of trouble during labour is the flapping cervix, i.e., the cervix hanging down in the vagina with the presenting part high above it. This is an indication of serious trouble for it means that for some reason such as disproportion or malpresentation the presenting part is not applied to the cervix. Such a cervix may not continue to dilate as the membranes have usually ruptured and there is no satisfactory presenting part to complete the dilatation. It may even become smaller later because of the occurrence of oedema. A sudden and extensive oedema of the cervix can occur during labour when a globular swelling forms usually on the anterior lip of the cervix. There is also the case of the unfortunate patient who has been allowed to bear down for hours in the first stage of labour with consequent oedema of the cervix. A powerful sedative such as heroin gr. $\frac{1}{4}$ should be given and elevation of the foot of the bed may help. It is important to remember that when the greatest diameter of the head has passed through the cervix, no further dilation will occur, also that prolonged manipulations may result in the reformation of a rim of cervix in a case where full dilatation has previously been present.

II. The Problem of the High Head

In a primigravida the head is mobile above the brim in 20 per cent to 40 per cent of cases at the end of pregnancy. Many of these cases are due to deficient flexion of the head, posterior positions, obliquity of the uterus, a full bladder, or loaded rectum. Provided that the head can be pushed into the pelvis there is usually no cause for anxiety but when the head cannot be pushed down there may be disproportion between the head and the pelvis, malpresentations of the head such as face and brow, pelvic tumours, or placenta previa. Still more serious is the case with the head above the brim when the patient is in labour and the membranes ruptured; it is very important in such a case to do a bi-manual examination for the moulded head with its caput may appear to be low in the pelvis, and may even appear at the vulva, and yet if the left hand is placed on the abdomen most of the head may be above the brim. Note should also be taken in such a case of the amount of the overriding of the sutures. Caesarean section may be required in these cases. The occasional occurrence of marked contraction of the outlet with normal brim and cavity must be remembered. A routine vaginal examination during pregnancy in every primigravida should prevent an unpleasant surprise in the second stage of labour.

III. Foetal Distress

It is in the first stage of labour that foetal distress may present a difficult problem. It may be due to prolonged, powerful and frequent uterine contractions and whiffs of chloroform may be the best emergency treatment in such a case to control the pains. Search must be made for other causes of foetal distress such as prolapse of the cord, excessive stress and strain due to disproportion, prolonged labour, etc., and in cases where the membranes are unruptured and no cause for the distress can be found there is always a possibility that some weakness or abnormality of the child may be present. Temporary improvement in the rate and quality of the foetal heart beat may be obtained by the injection into the mother of stimulants such as Coramine, Camphor and Lobeline, and it is always wise to give an injection of Vitamin K. should definite foetal distress occur in the first stage of labour and there is no response to treatment). Caesarean section should, in my opinion, be considered if conditions make this a practical proposition. In the second stage of labour foetal distress is best treated in the majority of cases by forceps delivery. The injection of Vitamin K and a stimulant such as Coramine to the mother does, in my opinion, improve the child's chance of a survival but expert use of the mucus extractor with the child's head held low is by far the most important method of treatment of the child.

NEWS & NOTES

The Deputation consisting of Dr. M. D. Pustake, Vice-President, A.I.M.L.A., Dr. R. A. Bhaḡwat, Provincial Secretary, Dr. Shivnath Chand, Dr. M. A. Faruqi, and Dr. Bhaḡwan Prashad, waited upon Colonel E. W. Hayward, F. R. C. S., Principal Medical Officer, Jodhpur (Rajputana) on the 20th June 1946. They discussed with him the various demands of the Association.

It is very gratifying to note that the pay of the Licentiate in the Jodhpur Government has been increased and the new grade starts from Rs. 75 reaching up to Rs. 250. Few Specialists' posts carrying more salary than the original grade, have also been given to the Licentiates. The Jodhpur State, which is a premier State in Rajputana, deserves special congratulation, for giving lead in this matter to many other States in Rajputana, and we feel sure, that other States will also follow the same course.

The question of the ban on the Association; facilities to the demobilised I.A.M.C. personnel; abolition of the rank of the Sub-Assistant-Surgeon; representation of the Association in all official committees and conferences convened by Jodhpur Government, and the like were discussed, and the deputationists were quite satisfied with the assurances given by the Principal Medical Officer. It is also note-worthy to write here that they have abolished the rank of Sub-Assistant Surgeon, and have named them as Medical Officers.

At 12.00 noon the deputationists waited upon the Councillor to His Highness the Maharaja Sahib Bahadur, Government of Jodhpur, and placed before him the demands of the Association, who said that the ban on the Association will be lifted very

soon and assured the deputationists to give his fullest consideration to the points raised by them. In the evening an At-Home was arranged by the Branch, which was attended by the Principal Medical Officer, Assistant to the Councillor to H. H. the Maharaja Sahib, Jodhpur, and other leading medical personalities. The Provincial Secretary addressed the Licentiates and acquainted them with the work and the demands of the Association. The Principal Medical Officer, in his short speech, assured the Licentiates that he would do his best to help them as far as he possibly could. On the 21st June, at 11.00 a.m. the deputationists waited on Hon'ble Col. Sir Donaldfield, K. T., Chief Minister, Jodhpur Government, and acquainted him with the demands of the Association. He gave a very patient hearing to the deputationists and assured them that their demands will receive his best consideration. At 3.00 p.m. Dr. Pustake and Dr. Bhaḡwat, had a very frank and heart to heart talk with Col. Hayward, and they discussed the local and general points raised by the Deputationists. At 5.00 p.m. the deputationists were invited for tea, by Mr. Harish Chandrajī Assistant to the Councillor to H. H. the Maharaja Sahib, Jodhpur, with whom also the deputationists had a very free talk about the demands of the Association.

It is gratifying, that all the officials on whom the deputationists waited, were very kind, cordial and sympathetic, and they all seemed inclined to help the Association in whatever way they could.

It is hoped that the ban which has been placed on the Association will shortly be lifted and the Licentiates will have a free air to breathe.

The Medical Council of India at its 25th session held at Delhi to day adopted a resolution accepting "in general the broad principles laid down by the Bhore Committee with reference to Professional Education."

As regards the details of the Committee's recommendations, the Council felt that "when the Central Government have decided to implement these recommendations the Council will be prepared to give their comments in detail."

Lt. Col. Dr. A. S. Erulkar, President of the Council, addressing the meeting said, "In addition to fulfilling our object of establishing 'a uniform minimum standard of higher qualifications in medicine' and maintaining such a standard—by no means a mean achievement—the Council has taken steps which, we hope, will bring Indian States in line with the rest of India, bring about for the whole of India one uniform standard of medical education, one Register, and one modern medical profession without compartments."

He added that the Executive Committee of the Council had noted from time to time the defects and limitations of the Medical Council of India Act and would in due course submit to the Council its considered suggestions for changes in the Act by the Government.

The President informed the Council that post-war schemes and plans for the establishment of new Medical Colleges or up-grading the existing Medical Schools had been received from various Provinces and States and were receiving the consideration of the Executive Committee of the Council.

Drs. P. Rama Rao and V. K. M. Rai writes: At the first Indian Congress of Radiology, held at Madras during 13/16th February 1946, it was decided to publish a Journal entitled "The Indian Journal of Radiology" under the auspices of the above Association. This will be a Quarterly and will be supplied to all members of the Association and also to Radiologist all over the world.

May we, as Editors, request you to co-operate with us by sending original articles or case-reports for publication in this Journal? The journal will be published on art paper and therefore we shall be able to publish reproductions of Radiographs, illustrations, skiagrams, etc., if any.

Remarks on the report of the Standing Committee of the A. I. M. L. A. on the Bhore Committee's Report, by the Director General I.M.S., Delhi.

(1) The recommendations of the Bhore Committee are being considered by the various Provincial Governments and it is hoped that in due course there will be a joint discussion. It would be as well therefore for your Provincial Associations to lay their views before their respective Governments before they have consolidated their plans for implementing the recommendations of the report.

(2) The report of your Sub-Committee has been read with interest and a few remarks are appended which may be of assistance—the references are to the paragraphs of your report.

(3) *Paragraphs 1 to 7.* The primary unit health organisation recommended would consist of a staff trained in both preventive and the curative aspects of medicine whose work will be co-ordinated to provide an integrated service in which domiciliary and institutional facilities will be made available to the people. In para 7, your Association seems to identify primary units with dispensaries.

(4) We agree that merit should be the important criterion when considering the points mentioned in paras 8 and 9.

(5) *Para 13.* The views of the Bhore Committee are expressed in Chapter XVIII (Professional Education) Vol. II (Pages 356-358) and in appendix 28 of Vol. III (Page 108).

(6) *Para 14.* This recommendation is endorsed.

(7) *Para 15.* Though it is expected that graded and recognised ex-I.A.M.C. specialists will be given the benefit of this added experience, it is doubtful whether the latter part of your recommendation would be endorsed by public opinion.

(8) *Para 18.* The Bhore Committee's recommendations are contained in para 485 on pages 458 and 459, Volume II of the Report. A uniform standard of medical education ought to remove these difficulties in the future.

(9) *Ref: Para 19.* The suggestion made will receive consideration.

(10) *Ref: Para 20.* We have nothing to add to the recommendations made by the Bhore Committee.

Remarks by the D.G.I.M.S. on the proceedings of the Ex-I.A.M.C. Officer's Conference held under the auspices of the A.I.M.L.A.

(1) The proceedings have been studied in this office and the following remarks are submitted for information,

(2) *Para 1.* Suggestions have been made to Governments regarding the dropping of the 'subordinate' title in these references. It is felt that it is just a question of time before it will be agreed to, but it should be remembered that it does not affect the medical services alone.

Para 3. The S. G. or the I. G. C. H. is the officer-in-charge in each Province, except where he has delegated the work to a special officer.

(4) *Para 4.* Arrangements for concessions and courses for ex-service I.A.M.C., M.Os. have been discussed with Governments and the results have been, and will be, published in orders or bulletins, or both, for serving officers to see.

(5) *Para 5.* Release leave, when not granted owing to civil requirements, is credited to the officer's civil leave account, as arranged by the War Department with Civil Government.

(6) *Para 7.* (sub para 2.) A licentiate is already included in the Provincial Medical Re-settlement Committees of Madras, Punjab, C. P. and Berar, Bihar, U. P., Sind and Assam. There is no Medical Re-settlement Committee in either Orissa or N.W.F.P. An enquiry has been made from Bengal to ascertain if they have any licentiate representative. The matter was left to the discretion of Provincial Governments.

There is no licentiate in the Central Medical Re-Settlement Committee.

(7) *Para 9.* This is for the War Department to deal with.

(8) Copies of all bulletins issued from this office are enclosed for information.

(9) Pending the issue of an Army Instruction (India) regarding the grant of regular commissions in the Indian Army Medical Corps, applications from Licentiates of all the commands have been called for; it is intended that those selected as suitable will be required to undergo a further period of study to enable them to obtain a graduate qualification before being actually appointed to a regular commission.

Officers are already being permitted to retain honorary ranks under the existing rules.

The resettlement of medical officers, including Licentiate Officers in Provincial medical Services is already being proceeded with in consultation with the Provincial Governments.

The question regarding the grant of Emergency Commissions to the recovered Prisoners of War belonging to the late I.M.D. and the grant of amnesty to I.N.A. personnel is primarily one for the military authorities to consider to whom the matter has been referred.*

LETTERS TO THE EDITOR

Bombay University and Medical Licentiates

Early in May 1946 rumour was afloat that the University of Bombay would shortly be granting concessions of far reaching importance to Licentiates who desire to appear for the M.B.B.S. examination. On requesting the University to furnish me with further information on the subject, I received a reply,

* Vide I.M.S., July 1946, pp 207-210 for original proceedings.

(letter No. 12108 dated 16th May 1946) and I give an extract therefrom below:—

".....The University authorities have resolved that the Licentiate should be granted certain concessions when they choose to appear for the First, Second and the third M.B.B.S., Examinations. But these concessions are conditional on an undertaking being received from the Government of Bombay and the College of Physicians and Surgeons, Bombay, that no admissions will be made to examination of any student who enters the college for the L.C.P.S. course after June 1946. As this undertaking has not been received so far it will be sometime before a final decision is reached in the matter. These concessions when granted, will, however, be restricted only to the Licentiate holding the qualification awarded by the Governments of Bombay and Sind and the College of Physicians and Surgeons, Bombay. I may make it clear that to be eligible for admission to the M.B.B.S., course such Licentiate must have passed the Inter Science Examination of this University with Physics, Chemistry and Biology as their optional subjects or an examination equivalent thereto....."

Any one will conclude from this that the proposal of the Bombay University is purely retrograde and their attitude towards the Licentiate is entirely step motherly. The following points, I presume, will interest your readers:—

Firstly, the University of Bombay have entirely ignored the recommendations made by the Medical Council of India in their resolution passed on 28th March 1944. This no doubt is a bitter disappointment to Licentiate Commissioned Officers of the I.A.M.C.

Secondly, it is not understood why this University should insist on the Licentiate possessing the "Inter Science" qualifications, before admission to the M.B.B.S. examination, when other Universities in India don't e.g., Calcutta and Madras. It looks as though the Bombay University is trying to create all sorts of obstacles in the way of Licentiate desiring to obtain higher medical qualifications.

Thirdly, Licentiate should be examined in clinical subjects only and not in all subjects for the M.B.B.S. examination. The reasons for this are patent.

Lastly, one fails to understand the meaning behind the intention of the Bombay University in restricting the concessions only to those who have obtained their qualifications from certain Bodies within this Province as stated in their letter. This University should also cater to and not ignore the needs of the *bona fide* permanent residents of this Province who have obtained Licentiate qualifications outside the Province of Bombay. Hence, the right course would be for the University to extend the concession to all Licentiate who are borne on the Bombay Medical Register on a particular date.

I appeal through the columns of your esteemed Journal to the A.I.M.L.A. and other Medical Associations and to everyone interested in the further education of Medical Licentiate to see that the University of Bombay, actually grant concessions to Licentiate aspiring to obtain the M.B.B.S. degree and not create 'road rocks' in the path of progress.

Finally, for reasons obvious, Licentiate studying for the degree course, should have an altogether separate course of lectures, demonstrations, etc., from the regular students of the M.B.B.S. course. This is best done by arranging an "evening sessions" in every college. Will the present Congress Ministry of this Province give a thought towards this?

AHMEDABAD,
2th September, 1946. }

P. R. PANDIT,
Captain, Ex-I.A.M.C.

The 4th Bombay Provincial Medical Licentiate's Conference, Poona, 18th October 1946.

Dr. U. B. Narayan Rao, who inaugurated the Conference, said in the course of his address:

The most essential problems that affect our class to-day are, to put them in a nutshell, Medical Education, Medical Registration and Medical Services. It is a matter of gratification to note that after years of struggle by the Association, the question of Medical Education in our Province can be said to have been solved to a great extent by the upgrading, this year, of the three existing medical Schools, to Colleges. There now remains only that Examining Body, so called autonomous body—the College of Physicians and Surgeons. It is unnecessary for me to go deep into the past history of this College. Suffice it to say that the organised medical profession both the Indian Medical Association and our Association have unanimously decided that all such Examining Bodies should be scrapped forthwith. Even the Goodenough Committee on future Medical Education in England have recommended that there should be only University degrees and diplomas and that all other Examining Bodies should close down. And yet, in Bombay, the College of Physicians and Surgeons, does not like to be benefitted by these decisions. It has of late instituted diploma courses in various specialities—parallel to those of the University, but supposedly inferior to them. And with a powerful backing of vested interests, the institution is thus trying to perpetuate its existence. What is more: recently the University has resolved to allow Licentiate to appear for all the three examinations leading to University degree in case the C. P. S. and the Government give a guarantee that no more licentiate will be admitted to the course. The Government has given the guarantee and stopped the L. M. P. but this Licentiate loving College does not seem to close the course. This Conference should therefore give a proper lead to the Provincial Branch to permanently eradicate this plague spot in the heart of the City of Bombay.

The other two problems of Medical Registration and Medical Services should have become easy—once the Compartmentalism in Medical Education is abolished. Especially so, after this War, in which the Licentiate were offered Kings' Commission. The significance of this offer has been truly interpreted by no less a person than General Hance, Ex. D. G., I. M. S., who on the eve of retirement from India told the Association, at a send-off party given to him on 5th March '46: "It is therefore a source of peculiar satisfaction to me that the war which has so recently terminated has seen the Licentiate rise to the rightful position of one possessing a registrable medical qualification—that of a commissioned Medical Officer." Regarding services, General Jolly, as early as in 1945, January, opined that "never can the Licentiate as a class be thrust back to their former subordinate status and menial pay." And these were the two heads of the Government of India under whose strong assurances the Association accepted the formation of the I. A. M. C. in principle, and carried on an All-India recruitment drive. Unfortunately, these two men have now retired and it is apparent that their promises have also retired with them, because, we see that the demobilised I.A.M.C. officers are asked to go back to their jobs on the same scale of pay and status that they held prior to joining the war. The Association should not tolerate this ingratitude. The Government has been trying to sidetrack the issue of our just demands by making too much of the concessions granted to the Licentiate for obtaining the Graduate degree and the P. G. Diplomas of England. But similar concessions were being allowed in the past and if at all, a

few hurdles might have been removed now. But it should be realised that these concessions would be availed of only by a very small number out of the thousands who joined the I. A. M. C. Let us therefore make it very clear to the Government that the Association did not accept the Kings' Commission for the sake of converting a few Licentiate to the Graduate standard. It demanded the right of Kings' Commission for the Licentiate at a 'whole class', which signified, as General Hance succinctly put it, recognition for registration by the I. M. C. and equal chances to go up to the highest rung of the ladder in medical services for every deserving, pure and unadulterated licentiate. Let us hope that the newly formed Government of the people will accept our just claims for recognition. It is with the greatest pleasure that I now declare the sessions open.

Dr. M. P. Joshi, Chairman of the Reception Committee, said in the Course of his-Speech:

I have great pleasure in extending to you all a most cordial welcome on behalf of the Reception Committee of the 4th Bombay Provincial Medical Licentiate's Conference, Poona, to this ancient, historic and growing city of Poona.

I shall briefly refer to some of the problems concerning our status in the field of medical profession. The Licentiate are being treated as inferiors in the profession. The system of education in the Medical Schools itself is responsible for this inferiority complex. Our Association has been agitating for the removal of this dual system and to have a uniform standard of Medical education. Now we are glad to see that the Medical Schools at Poona and Ahmedabad and the National Medical College, Bombay, have been recently transformed into Colleges which are affiliated to the Bombay University and thus the aim of uniform standard of education has been achieved.

As a result of the abolition of L. C. P. S. and L. M. P. courses a new question arises and that is with regard to the students who are under training. They will have to complete their studies no doubt, but those of them that want to appear for the M. B., B. S. course should be permitted to appear for the same after some extra study. Those who have passed the L. C. P. S. and L. M. P. examination already should be also allowed to appear for the M. B., B. S. examination without being compelled to fill in the terms. It is heard that the question is under consideration by the University Senate, but a great stumbling block is there in the form of the College of Physicians and Surgeons, who are not prepared to forego the L. C. P. S. course for reasons best known to themselves. We utterly disapprove of the attitude taken by the College of Physicians and Surgeons of Bombay.

Then there are the problems about the Provincial Medical Councils and the Indian Medical Council which you will have to discuss. The question of honorary appointments has not yet been satisfactorily solved. The question of S. M. S. Service also requires an urgent consideration. It requires immediate abolition, and in its stead a composite provincial medical service should be instituted. I am sure that this Conference will thoroughly discuss all these questions and give its opinion on all the points at issue.

Dr. V. D. Sathaye delivered his presidential address as follows:

Fellow-Delegates Ladies and Gentlemen,

I consider it a great privilege and honour to address you on this occasion. During the year great changes have taken place both in the country and our province, and unless we are on the alert our interests will suffer by default. I will touch here today on the points which should engage our attention during the next year. It is needless to repeat the same grievances and platitudes from year to year. So I think we should concentrate during the year on the following:—(1) Abolition of the Licentiate course in the province. (2) Reform of the Provincial Medical Council. (3) Abolition of the S.M.S. (4) New orientation of the Health policy in the Province. (5) Medical Licentiate should be given facilities for University Post-graduate, diplomas (6) Recognition by the I.M.C. (7) Hon. appointments in public maintained hospitals.

We have been demanding the abolition of the Licentiate course for the last several years, and it is indeed gratifying to note that the Government has converted the two Medical Schools at Poona and Ahmedabad into medical colleges. Similarly the National Medical College has also now been converted to a degree College. So it is now for the Government and the Bombay Medical Council to see that no more students are admitted to the Licentiate course, in any form whatsoever from June 1947.

(Continued from the next issue)

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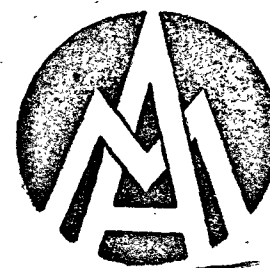
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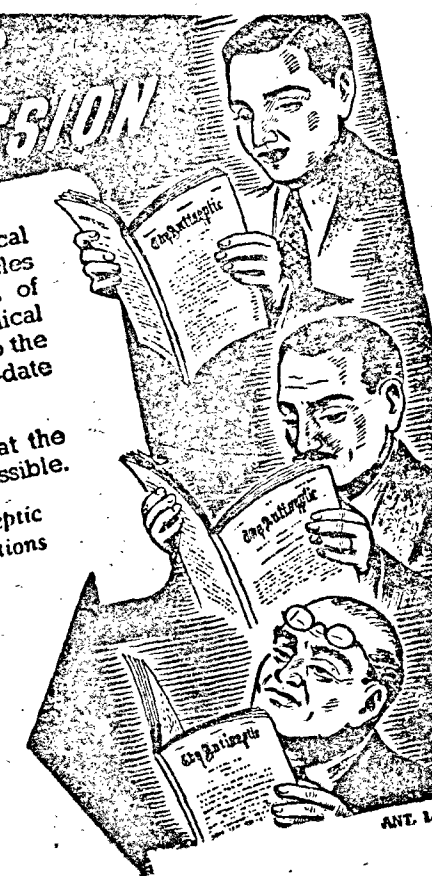
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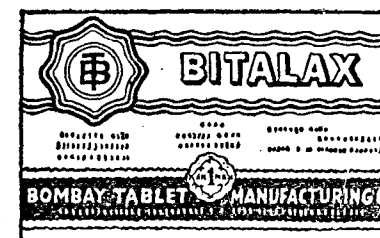
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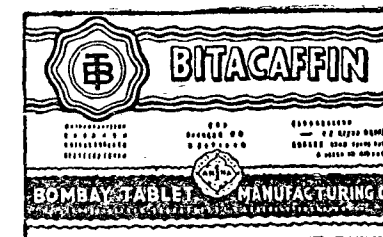


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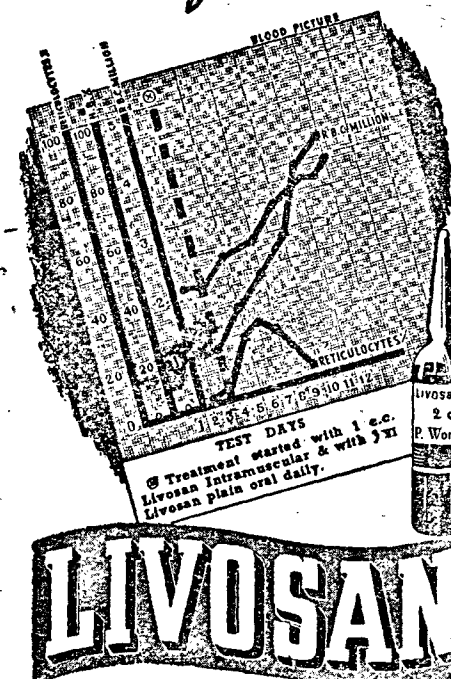
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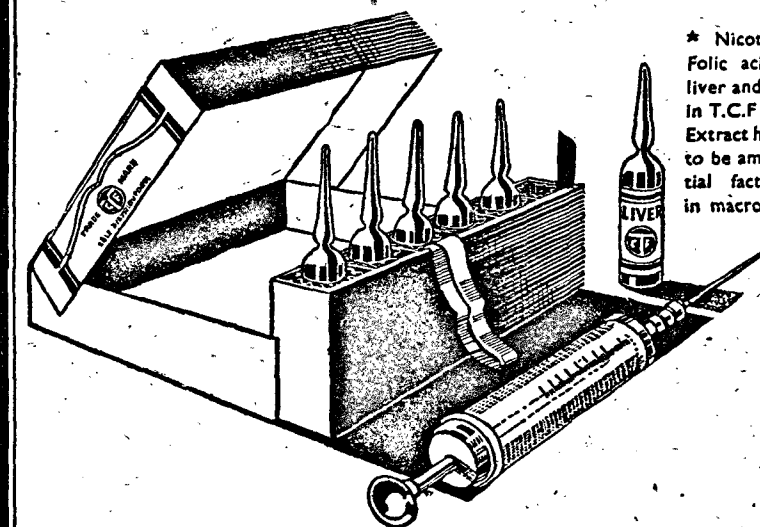
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Vol. 40, No. 12
December 15, 1946

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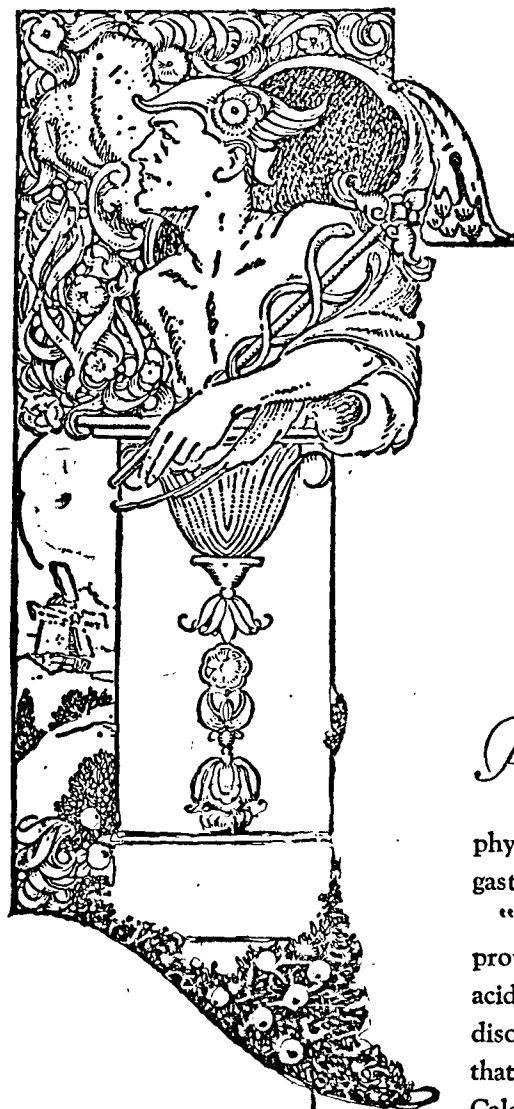
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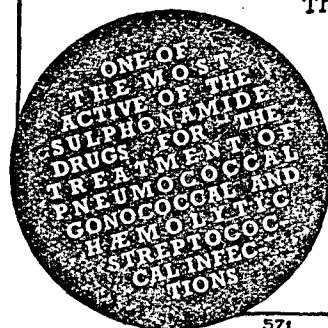


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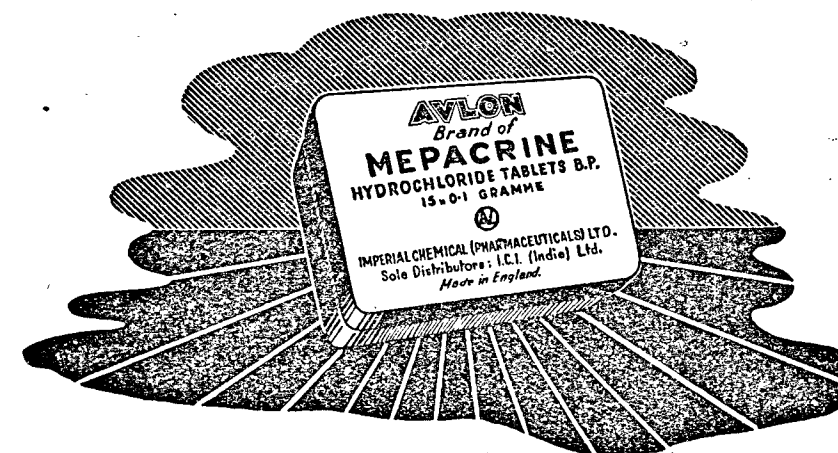
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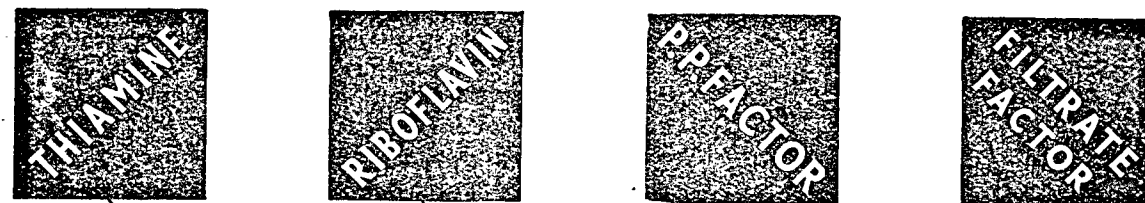
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Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras: December 15, 1946. No. 12

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Indian Medical Journal

(Journal of the All-India Medical Licentiates' Association)

Vol. 40. Madras, December 15, 1946 No. 12.

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OUR MONTHLY SURVEY

The Thirty-Fourth Conference of the A.I.M.L.A.:—Held at Poona from 18th to 21st October, 1946, the Conference was a great success from every point of view. Over 150 delegates from the different parts of our country and nearly 400 medical men from the province of Bombay attended the session and took a keen interest in its deliberations. Mr. B. G. Kher, the Premier of Bombay, inaugurated the Conference while Dr. Tendulkar as Chairman of the Reception Committee welcomed the delegates and visitors. Dr. M. L. Kapur, the President elect, delivered his address which covered most of the subjects of topical interest and which was listened to with rapt attention. The Conference discussed many subjects and has passed unanimous resolutions which are published elsewhere. The arrangements which the Reception Committee made for the comforts of the delegates and visitors were excellent—spacious rooms, good food and excursions, magic performances and musical entertainments. The scientific section too was well organised and the symposium on Nutrition was a brilliant piece of medical literature. We heartily congratulate Dr. V. D. Sathaye and his loyal colleagues who made this Conference not only successful but also attractive and who laboured hard to cater to the comforts of every delegate and every visitor.

Premier Kher's Speech:—He took the House by pleasant surprise by addressing it in Hindustani. It was ridiculous, he said, to address an Indian audience in English and he advised the Association to conduct its future deliberations in the National

language. Regarding Bhoré Committee's Report, he observed that its main recommendations were accepted by the recent Conference of Health Ministers and that his Government would put them into effect as early as possible. He therefore appealed to the medical profession to help the Provincial Governments in this great task of establishing a comprehensive National Health Service. Regarding medical education he announced that in the province of Bombay, the licentiate type of medical education would be abolished. We hope this would result in the winding up of the College of Physicians and Surgeons, which, as an Examining Body, has been a clog in the wheel of progress of sound medical education, both post-graduate and under-graduate. Regarding the position of Licentiates in medical service, the Premier made no reference, probably because he was unaware of the hard-ships which the service Licentiates are undergoing in the province of Bombay as in other provinces. We would appeal to him to look into this matter also and do justice to the claims of Licentiates for equity and equality in the medical services.

Dr. Tendulkar's Address:—Dr. Tendulkar, in his welcome address, appealed to the Provincial Governments to institute one composite Provincial Medical Service open on the basis of competition and merit alone. "Those who talk against the residuary posts and injustice in the I. M. S.," he argued "completely forget the greater injustice and humiliation which is done to hundreds of our professional brothers." He also protested against debarring the licentiates from honorary appointments at the Government Hospitals. "It is public money," he said "which is maintaining these hospitals and they should not be a monopoly of a chosen few."

Dr. M. L. Kapur's Address:—The Presidential Address of Dr. Kapur is an excellent, if brief, survey of the existing position of Licentiates in respect of medical service and medical education. He said that the service conditions of the Licentiates are too humiliating to be borne patiently any longer, and that reason and justice require the immediate abolition of subordinate service and the absorption of the existing licentiates into the provincial medical service. Referring to the miserable position of the demobilised Licentiate I.A.M.C. Officers, he stated that the Government have not fulfilled their war-time promises and deplored the whole-sale betrayal of the interests of these officers who implicitly believed in the words of the Government and the Association during the War. He also protested against the way in which the Indian Medical Council is trying to bolster up a compartmental All-India Medical Register. He made the attitude of the Association clear in this respect. "It demands the recognition of Licentiates' medical qualification as it has honestly endeavoured and successfully carried out the programme of abolition of medical schools. This recognition has no value to us unless it is under the Schedule I of the I.M.C. Act and involves our representation in the Council." Dr. Kapur is against fostering separate systems of Medicine—Ayurveda and Allopathy—and questions the significance and importance of the policy of encouraging medical education under these two systems separately. He is of the view that there should be only one type and one system of medical education and

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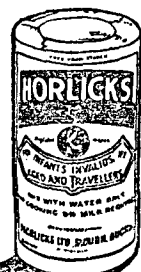
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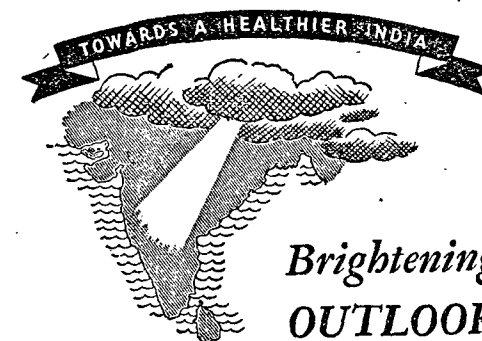


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that this is best done by remodelling our University Medical Education on this basis. We believe that Dr. Kapur has voiced in his address the opinions and feelings of the Licentiates on matters that directly affect them. We particularly draw our readers' attention to that portion of his address which appeals to the Licentiates not to accept jobs on low pay or jobs which are derogatory to their self-respect; and advises them to choose private practice rather than Service. We heartily endorse this advice. The Licentiates must vindicate their position by refusing to enter subordinate service which is dismal in every respect. We would even advise those who are already in it to come out of it at the earliest possible moment. Their apprehensions that they would not be able to start and succeed in private practice are not real. If they could but devote half the time and energy which they give in service, their success in practice is quite assured.

Resolutions:—The resolutions passed at the Conference are published elsewhere in this Issue. Each resolution is more or less self-explanatory and deals with a specific subject in a satisfactory manner. We particularly invite our readers' attention to the resolutions on the service question and the re-employment of I.A.M.C. Officers. These would show that the Association is doing its best in the matter of redressing many of the difficulties and grievances of the licentiates of our country, and given time, patience, help and co-operation, it is bound to succeed in its mission in the very near future. As. Dr. Kapur in his presidential address said:—

"We need all the strength and all the unity which each medical Licentiate could contribute to the successful solution of all our tangled problems."

34th Conference of the All-India Medical Licentiates' Assn. (Poona 18th October to 21st October 1946)

Presidential Address by Dr. Manoharlal Kapur

BROTHER DELEGATES & FRIENDS,

Our Branches have elected me again as the President of the Association and of this Conference for the second term. I am indeed profoundly thankful to them for their renewal of confidence in me. Last time when I presided over the Calcutta Conference in March, 1945, I appealed to the Provincial leaders of our Association and the Secretaries of our Branches to lend me their co-operation and help in the discharge of my onerous duties. I am glad to acknowledge to-day that the response to my appeal has been good and great, and to that extent I have been able to discharge my duties with some effect and satisfaction. I seek again the same co-operation and help during the second term of my office, and pray to the Almighty to give me sufficient strength and

wisdom to guide the Association through the still more difficult times ahead of us. The one object of our Association, viz., abolition of medical schools, has been successfully achieved. Two other important objects remain to be achieved viz., Recognition of the Licentiate Medical Qualification by the Indian Medical Council, and the abolition of the Subordinate Medical Service and absorption of the existing sub-assistant surgeons into the Provincial Medical Service. In the coming months, we must bend our energies to realise these two objectives; and the moment these are achieved, we shall merge our interests in a common pool of endeavour towards the achievement of a comprehensive National Health Service for our people.

I appeal to every one of you to respect your workers, strengthen their hands and enhance, in all ways open to you, the prestige and the power of our Association. We need all the strength and all the unity which each Medical Licentiate could contribute to the successful solution of all our tangled problems.

Association's Greetings.

Although it is just 18 months between our last Conference and now, yet vast has been the changes in the affairs of our country. When we met at Calcutta in March, 1945, we only had the Advisers' Regime in almost all the provinces and the old Executive Council of the Viceroy at the Centre. To-day the picture is entirely different. At the Centre we have a cabinet formed by our acknowledged national leaders, and in the provinces we have a democratic Government lead by the party in majority. Permit me, on your behalf, to send the greetings of our Association to the Central and the Provincial Governments and to assure them of our co-operation in matters of Medical and Public Health administration. The excuse of an alien Government would no longer be available for the complacency of the authorities in the matter of maintaining an equitable system of Medical Service and of organising medical relief and public health measures on a scale commensurate with the needs of our people. I am sure that, given time and patience, the popular Governments would initiate schemes of medical relief which would effectively cater to the medical needs of our rural population. As effective and extensive medical relief requires an extended and popular medical service, they are bound to look into this matter also and see that the Medical Service is so organised as to avoid the caste system rampant in it at present. We must also so organise our activities in a way that would merit the sympathy and attention of the popular Governments both at the Centre

and in the Provinces. The Association, in its turn, hopes that the Provincial and the Central Ministers of Health would accord to it opportunities for close association and consultation. There is a belief among some of the members of the Government that our Association is parochial in its views and narrow in the interests it represents. That this is a wrong belief is obvious to us, but not so to the authorities. It is our duty to explain to them how their belief is wrong. Although palpably the abolition of medical schools is against our interests, yet in the interest of a united profession and effective and reliable medical service to the people, our Association has consistently stood for one type of medical education, and thank God, it has almost succeeded in this work. Could this be called parochialism? Our Association has been protesting against the non-recognition of the Licentiate qualification by the Indian Medical Council, thus leaving out nearly two thirds of the profession from out of its schedule altogether. Could this be called as representing ourselves in a narrow and selfish manner? The bulk of medical relief, particularly in extensive epidemics, and normal medical help in inaccessible rural areas, is administered by the medical licentiates. Yet their position in service is miserable with starvation wages and inappropriate treatment. Could agitation against this rank injustice be construed as being prompted by self-interest or selfishness? I take this opportunity to appeal to the Central and the Provincial Governments to look into these problems with due care and deliberation and we will honestly help them to come to correct decisions.

Post-War Position of I.A.M.C. and of the Licentiate I.A.M.C. Officers.

The War, which ended so happily last September, has conclusively shown what medical licentiates are capable of, if given full responsibility and initiative in the execution of work entrusted to their care. They successfully worked first class hospitals in the deserts and marshy forests of the middle east. They risked themselves to be dropped as para-troops from planes to render medical help to the wounded in the isolated places of battle. Thus they have fully justified the inauguration of I.A.M.C., by the Government of India. What is the post-war position of I.A.M.C., and of licentiates as permanent commissioned officers in it? Nothing definite is known at present. Perhaps no decision has been taken by the War Department till now, or could be taken in view of the impending constitutional changes. We appeal to the War Member in the Interim Government to see that the I.A.M.C. is retain-

ed as a permanent branch of our Army, and recruitment to the Corps is drawn from the best men in the Profession, medical graduates and licentiates alike. I may however inform you reliably that all the Commands have been instructed to forward the application of Licentiate Officers to permanent commissions and if found suitable they will be called for interview by a Selection Board as is done in the case of graduates, but that those so selected will be required to undergo a further period of study to obtain the graduate qualification before being actually appointed to a regular commission. I wonder why the graduate qualification should be made compulsory in the case of such candidates and I hope the authorities would give up this intention and make the acquiring of graduate qualification optional and not compulsory. This would be in line with the experience in the last War that licentiates as such were not unequal to the graduates in any normal or emergency work. In the face of this experience, it would be mere prudery and prejudice to insist on obtaining the graduate qualification for eligibility to regular commission. If the deliberations of the Constituent Assembly end in the successful shaping of India's future political constitution—all of us hope and pray that it may successfully evolve a proper constitution—the Army is bound to be reformed and recast on modern lines, including its Medical Branch. Our Association has necessarily to exercise full vigilance in this matter and should be ready to send its spokesmen to the Government when the time for it arrives and for the present to form a sub-committee charged with the duty of studying the subject and submitting well-considered proposals to the Defence Member of the Government of India.

You all know that in the last War our Association was entrusted with the task of recruiting medical licentiates to the I.A.M.C. But it is strange to find now that its advice is not sought in the resettlement of demobilised officers.

I feel it my duty to inform the Government of India that there is acute discontent and disappointment among the licentiates in the permanent service of the Army and the Emergency Officers who are being demobilised. Those officers who were commissioned from among the ranks of the I.M.D., are asked either to rejoin their substantive appointments or to resign. Those emergency officers, commissioned or otherwise who had a lien on the subordinate medical service, of the Government or of the Local Bodies, are asked to revert to *status-quo-ante* with "its menial pay and status" as Sir Jolly characterised it so

truly. The position of private practitioners who joined the I.A.M.C. is precarious and they are left out without any kind of help whatsoever. Those temporary-service licentiates who joined the I.A.M.C. are told on return that they could not be given even the temporary jobs which they held before volunteering. It is obvious that the Government is shirking its responsibility. All the fine promises that were made while we were helping the medical recruitment seem to have vanished in thin air when the time for fulfillment is at hand. We quite realise the present difficulty of the Government in finding jobs for all the demobilised officers, but it is not right on their part to be without a definite policy in this matter. To make these officers wait till the comprehensive Health Service of the Bhore Committee comes into operation, if at all, is to make them wait till doomsday. Nor should the Government feel self-satisfied in providing only for those who had a lien on permanent service and that too in the subordinate cadre. It is absurd to post a released commissioned officer to act as sub-assistant surgeon. This means that their military service has not in any way helped them to improve their civil position which they were occupying before they joined the war. This is nothing but a whole-sale betrayal of the interests of these officers who implicitly believed in the words of the Government and the Association. The Government of India as well as the Provincial Governments owe a duty to these officers which I hope they would not evade. At the same time, I earnestly appeal to the released medical officers not to wait in hope that the Government would find them suitable jobs but to start their private practice.

I understand that a few licentiates in subordinate medical service in one or two provinces, who joined the war and who were subsequently selected to the King's Commission in the I.A.M.C., were, on their release, posted as temporary Assistant Surgeons. There is no reason why other provinces should not follow this procedure which is so just and reasonable. This is the least which the Provincial Governments are expected to do, and if they are reluctant to dole out even this minimum justice, they stand self-condemned before the bar of public opinion. I think a strong and wide-spread propaganda on our part is necessary to make the Provincial Governments do the right thing, and I would suggest to this conference to appoint an influential sub-committee to organise this work and to approach the Government for proper redress. It may even be necessary for this sub-committee to tour the different provinces to collect correct data and to interview the res-

pective Ministers of Health and to guide the local activities in this matter.

MEDICAL EDUCATION.

Under-graduate and Post-Graduate.

Now that all the Provincial Governments are committed to the policy of establishing a unitary type of medical education, it is not necessary to stress on this subject at the present time. But what should be the content of the unitary type of education deserves our attention. The Bhore Committee has recommended some important alterations in the present curriculum of the M.B.B.S. and suggested a course of four years with a compulsory internship of 12 months. If one studies these recommendations, he would find them to be nothing more than the curriculum enjoined for the acquisition of the now much condemned licentiate diploma. Be that as it may, the Bhore Committee's recommendations in this respect are quite acceptable, though I have grave doubts whether the Universities or the Indian Medical Council would ever accept them, constituted as they are at present by persons with vested interests and with prepossessions of various kinds. Neither the Universities nor the Indian Medical Council have so far expressed their opinion on these recommendations. But so far as our Association is concerned, the Sub-Committee, which met at Calcutta during March this year, has expressed the view that the existing licentiates may be considered as possessing the qualification prescribed for the "Basic Doctor" by the Bhore Committee. In other words, it means that our Association accepts the recommendations of the Bhore Committee in respect of under-graduate medical education leading to what that Committee calls "Basic Doctor," and at the same time maintains that the existing licentiates are up to the recommended standards.

Facilities for post-graduate medical education for licentiates are woefully lacking. They are not admitted to the University post-graduate courses. Only a few Provincial Governments have organised post-graduate studies in some subjects outside the University to which licentiates are eligible. But the seats are so limited that many licentiates have to remain without any opportunity for such education. There is very little hope that the universities would allow the licentiates to study for their post-graduate courses and it is therefore necessary that each Provincial Government should make adequate arrangements for post-graduate studies of the licentiates. Not only post-graduate studies but also refresher courses for the general practitioners are necessary. Each Province should be self-contained in this

respect, so that the candidates may not be put to unnecessary expenditure by way of extra fees they have to pay if they were to go to other provinces which consider them as "foreign" students and therefore levy double fees, and of extra expenditure towards their lodging and boarding charges.

The so-called 'concession' of allowing the licentiates to acquire the M.B.B.S. qualification of Indian Universities is but a drop in the ocean. Hundreds of applications are being rejected by the medical colleges in our country, notwithstanding the appeal of the Indian Medical Council to the Universities to permit as many licentiates as possible to study and appear for the M.B.B.S. examination. At the present rate, there is absolutely no hope of even hundred licentiates acquiring the M.B.B.S. degree within the course of next ten years. In my opinion this 'concession' is practically unavailable and therefore it is useless. I would suggest to those who desire an University Medical Degree not to hanker after it—it is a sign of inferiority complex if they were to do so. Is the acquisition of this degree worth the trouble it involves? It is not going to add to their knowledge or to their income in practice. If the door to acquire this degree is freely open, it is of course a different matter. But it is not so. It is hedged in by so many conditions and so much limitation in admission even if all these conditions are fulfilled.

The Government of India have started a separate Medical College (Lake Area Medical College) for the benefit of Ex. I.A.M.C. licentiate officers who desire to acquire the M.B.B.S. degree. But we have no voice in its working.

No Need to Foster Separate Systems of Medicine.

I think it would be appropriate if I deal with Ayurvedic and other indigenous systems of Medicine in the context of Medical education. All of you are aware that all the Provincial Governments have established and still continue to establish schools imparting education in indigenous systems of Medicine, and have instituted Boards of Indian Medicine to regulate their studies and to register the names of the candidates after their obtaining the prescribed qualification. At the same time they are increasing the number of allopathic medical colleges. I do not at all understand the significance and importance of this policy of encouraging medical education under these two systems separately. Where is the need for fostering separate systems of medicine? The conflict in my view is not between Ayurveda and Allopathy but between practitioners trained exclusively in these two systems. If this policy continues unbridled

and unchecked, the Bhore Committee's recommendations towards the achievement of a comprehensive National Health Service would be no more than a dream. Our present trouble is due to the fact that education imparted in our medical colleges totally ignores the existence of traditional medicine still believed by a large majority of our people and the need for suitable adjustments in this respect. Thus, there has been a complete lack of historic continuity between traditional and modern medicine in our country. I think that if this breach is repaired it is possible to formulate one type and one system of medical education. There is no use in fostering separate systems of Medicine. This is bound to lead to chaos and confusion at the end and this is already visible. It is regrettable to note that the Bhore Committee has failed to put up proper recommendations as to how far and how best the indigenous systems of medicine could be absorbed into the modern scientific system. Mere publication of an Indian Pharmacopoeia and a chair in the History of Medicine are not the means by which this synthesis could be achieved. Surely a suitable curriculum could be made out on the basis of a proper standard of instruction and examination in the combined systems of medicine. Recently the Minister of Health, Madras, Mrs. Lakshmi-pathy, has rightly enunciated the policy of the Government in the following words:—

"The intention of the Government is not to have various systems of Medicine in our country—Siddha, Ayurveda, Unani etc—but to have one unified system which would be neither Western nor Eastern but a combination of both. The purpose of this scheme under consideration of the Government is to give a general training to the Medical Graduates of the allopathic system in the Indian System of Medicine so that a synthetic system may be evolved from both Ayurveda and Allopathy."

This, in my opinion, is a correct policy which the organised profession in our country can heartily endorse and help the Government in its fulfilment, and this is best done by remodelling our university medical education on this basis.

Indian Medical Council.

All of you are aware that one of the reasons why the licentiate medical qualification was not included in the first schedule to the I. M. C. Act was that it would jeopardise the obtaining of foreign reciprocity for the Indian Medical degrees. After 13 years of its existence, Dr. Abraham S. Erulkar, its present President, declared in the last session of this council that "it has failed to secure honour abroad". It

is unable to remove from its second schedule two of the British qualifications which have been considered by this Council as below the standard. Nor has it been able to get the recognition of the General Medical Council for the Andhra University medical degrees and for the medical degrees of the Patna and Calcutta Universities granted after 1935 and 1936 respectively. Nor are the Medical Councils of other countries willing directly to recognise the Indian Medical Council except the three politically insignificant countries, Malta, New Zealand and Burma. Is this not more or less a nemesis of retribution? The council refused to recognise the vast bulk of medical men in its own country—the medical licentiates—in the hope that the rest of the profession which constitute but a small part of the profession—the medical graduates—may be recognised by other countries. The result of injury to one's own soul has inevitably manifested itself in this manner. May I respectfully point out to the Medical Council that the continued non-recognition of the licentiate medical qualification is not going to enlarge its prospect of obtaining foreign reciprocity?

Dr. Erulkar, in his address to the Council in its 24th session, has informed the profession that the Council has recommended the institution of medical register which will be divided into three groups.

- (1) Those holding the qualifications included in the present Schedules of the Act.
- (2) Those who possess qualification granted by Licensing Bodies in British India.
- (3) Those Indian Nationals who hold foreign qualifications not recognised by the Indian Medical Council and registered by the Provincial Medical Council.

It is said that this is not a permanent arrangement but will remain only till such date when there is established a minimum standard of medical qualification throughout the country.

The meaning of this statement is somewhat obscure. Does not Dr. Erulkar know that all the provinces except Bengal have abolished medical schools and that even in Bengal arrangements are afoot to convert some of the medical schools into colleges? Does this not constitute establishment of minimum standard of medical qualification throughout the country? Why then talk of temporary arrangements and evade the issue of frankly recognising the existing licentiates by including their qualification in Schedule I of the Act? In the suggested temporary arrangements, there is no mention at all of the representation

of the licentiates in the Council. I hope Dr. Erulkar is aware of the considered and insistent opinion of the organised medical profession that if the All-India Medical Register is established there should be only group and not three groups as recommended by the Council in its last session. This view of the organised profession is more purposeful and dignified than the clannish and make-shift arrangement recommended by the Council.

Dr. Erulkar seems to be satisfied that even though "honour abroad" is at a discount, yet "efficiency at home" has been achieved. What after all has been achieved during the last 13 years is no more than co-ordination of the existing standards of teaching and examination. This, in my view is not such a great achievement as to warrant self-satisfaction or self-approbation. Has the Council so far formulated frankly what would constitute a uniform minimum standard of medical education and qualification for our country? Its present preamble is: Establishment of a uniform minimum standard of higher qualification in medicine for all provinces. May I ask frankly Dr. Erulkar and his colleagues in the Council whether they really expect at any time to achieve either efficiency at home and honour abroad with this preamble at the back-ground? Thirteen years of experience should be an eye-opener to them unless they want to blind themselves by the fervour of false imagination or to veil the truth by sub-conscious prejudice. The first essential thing therefore, is to change this preamble so as to indicate that this Council's essential function is to establish and maintain a uniform minimum standard of qualification in Medicine and then to set about doings in right earnest.

In the course of his address to the Council, Dr. Erulkar claims that the Medical Council of India has been largely responsible for the abolition of licentiate teaching in our country. I respectfully submit that this is an incorrect statement. Since 1910, long before the I.M.C. Act was passed, our Association has been pressing on the authorities to abolish licentiate education. If its suggestion had been followed the Medical Council of India would have been born as a healthy child in 1933. Its suggestion however was not taken seriously. The result was the birth of a monster—an evolutionary freak. Since 1933, our Association redoubled its activities in this matter and succeeded, largely due to its own endeavours, in abolishing medical schools in many provinces. Often, we have urged the Medical Council of India to state frankly what constituted, in its opinion, the minimum standard of medical qualification. But it did nothing of this kind.

Now that most of the provinces have abolished the medical schools, the Council claims that this is its handi-work!

Our Association's attitude towards the Indian Medical Council in its present form has been clear and straight-forward. Nothing has happened so far as to make it change its attitude. It demands the recognition of the licentiate medical qualification, while at the same time it has honestly endeavoured and successfully carried out its programme of abolition of medical schools. This recognition has no value to us unless it is under Schedule I of the Act and unless it involves our representation in the Council.

Bhore Committee's Recommendations.

I do not propose to deal at length with the voluminous report of the Bhore Committee. My own personal views were published in the *Indian Medical Journal* in its July 1946 issue. The views of our Association's sub-committee on these recommendations were also published in the same issue of the *Journal*. So far as I am aware, public opinion, as found expression in the news-papers, seems to be very sceptical about these proposals in as much as they involve a huge bill of expenditure. It is said that all the Provincial Ministers of Health would very soon meet at Delhi to consider the Bhore Committee's proposals. These proposals fall broadly under two heads:

- (1) Recommendations regarding Professional Education.
- (2) Recommendations regarding the Comprehensive National Health Service.

I have got grave doubts whether any of these recommendations would be accepted and carried out by the Provincial Governments. When they are not in a position to equip the existing dispensaries with sufficient drugs, accessories and medical personnel, it is not easy to presume that these Governments would meet the enormous bill of health expenditure which the Bhore Committee's proposals involve, however good and ideal these proposals may be. When they are following a dual policy with regard to medical education producing two sets of medical practitioners—Ayurvedic and Allopathic—it is inconceivable how they would carry out the intensive programme of increasing the medical colleges so as to produce 30,000 doctors at the end of next ten years! and how they would fit the Practitioners of Indian Medicine into the Bhore Committee's primary and Secondary units! They are sure to claim the same privileges as the allopathic practitioners are given, and the Government cannot ignore their demands since they are their own creations. Nor do

I believe that the Indian Medical Council and the University Medical Faculties, constituted as they are at present, would easily accept the shortened course of 4 years of medical education plus twelve months of compulsory internship. That my belief is not incorrect is obvious from the fact that so far none of these Bodies have whispered anything in favour of Bhore Committee's proposals in regard to this subject.

The programme of increasing the number of Medical Colleges, as given by the Bhore Committee, seems, to my mind, to be impracticable at present. As each new Medical College would cost at least a capital expenditure of about 30 to 40 lakhs of rupees and take at least five years to bring out qualified doctors, the Committee should have recommended the introduction of the shift system of teaching in the existing Medical Colleges. This would immediately facilitate double or treble the number of admissions in each medical college.

These criticisms of mine do not mean that we, as an Association, are against Bhore Committee's recommendations in general. A very close scrutiny of the report would reveal that the committee has been discretely silent over the following points:—

- (1) Whether the existing licentiates would be employed in the primary and secondary units on the same terms and conditions as are made available for medical graduates.
- (2) Whether it recommends the recognition of the licentiate qualification by the Indian Medical Council.

These two points are vital to our Association since it is devoted to the interests of about 40,000 medical licentiates in this country, and no one can expect our Association to hail these recommendations with joy and fervour if they fail to satisfy on these two points. I am sure that the members of this Committee are aware of the services of the medical licentiates in the upkeep of national health and also how shabbily they are treated in every respect with no justification whatsoever. Yet it is strange that they have made no mention in their recommendations that the existing licentiates should be given an equal place as the medical graduates in the proposed Health Service. I am also sure that the members of this Committee are aware of the opinion of the organised profession that the licentiate qualification should be recognised by the Indian Medical Council. Yet they made no reference to the immediate propriety of recognition of the licentiate qualification by the Indian Medical Council. It is difficult to say whether these omissions had been intentional or otherwise.

But unless we have a definite and authoritative assurance on these two very live issues to us, it is difficult on the part of our Association to express any opinion, for or against, in part or whole, about the recommendations of the Bhore Committee. By saying so, let me not be understood as implying that our Association is not interested in evolving a comprehensive plan of National Health Service. It is certainly interested in the health of our people, but there is no use of proposing or supporting a scheme which is unworkable under the present circumstances. Any scheme which ignores these circumstances is not likely to be found workable or even acceptable to the Provincial Governments.

An Immediate Plan of Medical Relief.

The Bhore Committee's plan of National Health Service is obviously not capable of immediate application. It is therefore necessary to formulate an immediate plan of medical relief acceptable to the Provincial Government under the existing conditions in which they are working. This means we have necessarily to start on the existing basis, taking into account that this is not the time when one should recommend plans of medical relief which would involve a financial burden beyond their capacity. I would suggest to the Provincial Governments the following plan of action in respect of medical relief.

- (1) The existing rural dispensaries and Taluk head-quarters Hospitals should be sufficiently equipped and staffed. This should be first attended to, in as much as these hospitals are not in a position to give effective relief owing to shortage in drugs and instruments and to understaffing.
- (2) A graded programme of extension of such dispensaries and hospitals into more rural and urban areas. An annual addition of 50 such hospitals would be within the financial capacity of any of our provincial Governments.
- (3) Better equipment and staffing of District head-quarter hospitals, particularly in the Specialities.
- (4) Clerical work should not be given to Medical Officers as much of their valuable time is lost in this way at present.
- (5) Provincialisation of all medical services in a province, thus bringing together all the Medical Officers of the Local Bodies, subsidized rural medical practitioners etc., into one provincial

service on an equitable pay and other terms and conditions.

- (6) Establishment of itinerant dispensaries in areas situated far from rural and Taluk dispensaries.
- (7) Establishment of out-door dispensary in urban areas for every 10,000 of the population.

Even this modest programme would cost the Provincial governments not less than a crore of rupees every year, but this I believe is within its financial resources. On one thing I want to lay particular emphasis, and that is on the need to have a Medical Service, contented and devoted to its work. Such a service should be of unitary type and with a uniform rate of pay to all its incumbents and promotion to higher positions based on merit only. That is why our Association has been demanding the abolition of subordinate medical service and the absorption of existing men there-in into the provincial service and future recruitment to it on the basis of competitive examination. In this connection I would strongly request the Provincial Governments to adopt the suggestion of the Conference of Administrative Medical Officers held in November last that both the licentiates and the graduates should be designated as Medical Officers and that their scale may be fixed from Rs. 150 to 450, graduates however starting on Rs. 200 per month. This is a sound and practical suggestion which I hope, would be accepted by the Authorities, both Central and Provincial. This would go a long way in redressing the grievances of the Licentiates in Service.

Abolition of Subordinate Medical and Public Health Service.

We have succeeded in abolishing the medical schools, and we must now set ourselves to the task of abolishing the subordinate medical service—a natural and necessary corollary to the first. If the licentiates are judged fairly and impartially, there would be very little justification for perpetuating two types of medical service with such glaring and unjustifiable differences in emoluments and prospects. The difference in the professional education between the licentiates and the graduates is not so material as to warrant the existence of wide disparities in their respective service conditions.

The following statement would show the real position of medical personnel in services in our country.

Statement showing the position of Medical Personnel in Services in India.

	I.M.S.	Medical Graduates.	Medical Licentiates.
Education.			
Minimum General Qualification:	Matriculation of a British University or I.Sc. of an Indian University ...	I.Sc.	About 50% I.Sc. About 50% Matriculation.
Professional:	5 years course ...	5 years.	4 or 4½ years.
Main subjects Taught:	Anatomy, Materia Medica, Physiology, Pathology, Medicine, Surgery, Midwifery, Medical Juris, Ophthalmology, Hygiene etc. ...	Same as for I.M.S.	Same as for Medical Graduates. Even Text-books are the same.
Pay:	Rs. 450 to Rs. 3,500 ...	Rs. 200 to 1,030	Rs. 60 to Rs. 200.
Facilities for Post-Graduate Studies.	Given study leave periodically ...	Same as for I.M.S.	Nil.
Administrative position.	100 % ...	20%.	Nil.
Contact with population.	001 % of population ...	10%.	90%.
Position in Last War.	Pay of rank and overseas allowance ...	Same as for I.M.S.	Started as 2nd Lt. on Rs. 400 and as Lt. after 6 months on Rs. 450, thereafter same as for I.M.S. up to Lt. Col.

The only difference is in the length of the medical course—the graduate studies for 5 years while the licentiate for 4 or 4½ years. Now that the Bhore Committee has suggested that four years course would be sufficient to impart medical education, much bone could not be made out of this difference. The report of the British Medical Mission (1943) has clearly and unequivocally expressed the opinion that the licentiates are capable of full medical responsibility and that they are not inferior in intelligence and capacity to a large number of graduates. They came to this conclusion after an exhaustive enquiry. The recent conference of Administrative Medical Officers (Nov. 1945) recommended unanimously that there should be one Provincial Medical Service on a scale of pay of Rs. 150/- to 450/, the graduates being given an initial start of Rs. 200/ p.m. It is thus obvious that the existing line of demarcation between subordinate and provincial medical service is purely arbitrary, based on unaccountable prejudice and fostered by vested interests. Reason and justice require that the subordinate service should be abolished and that the existing licentiates in that service are absorbed in the Provincial Medical Service.

I sincerely trust that the authorities would consider this arrangement as just and equitable to all concerned.

That there is acute discontent among the licentiates in service is beyond question. Their present pay and other conditions of

service are too humiliating to be borne patiently any longer. The following letter published in the current issue of our *Journal* would show the temper of our men in service.

"Our Association is passing resolutions after resolutions and sending memorandum after memorandum hoping thereby to improve the pay and status of the licentiates in service. But we are pleading in vain. Why should it not be so? We are too insignificant in the eyes of the Government. We claim that we look after the health of the poor millions, but does the Government care for the poor? If we were looking after the health of rich people like the medical graduates our condition would have been different. For the past 40 years or so we are struggling hard to improve the condition of medical service but there is no appreciation of our labour. But we are not prepared to go on begging and begging. We must strike work throughout India and see how many medical graduates go to serve the poor village folk at Rs. 70/- a month. However a Jolly or a Hance may praise us, the Provincial Governments will not give us our dues unless we compel them to do so".

This letter shows very clearly how our men in service are feeling in this matter. It is quite possible that the Pay Commission set up by the Government of India and that similar committees, recently constituted by

some Provincial Governments like Madras and Bombay, may recommend an increase of pay. But I wonder whether such so-called relief would satisfy the medical licentiates in service, since their fundamental contention has been that there should be no invidious and unjustifiable distinctions and differences between graduates and licentiates seeking service and that there is no more a need for maintaining two classes of medical service—a lower and a higher—when the nature of work expected from both of them is the same.

I suggest that our Association should concentrate on the work of abolition of subordinate medical service and the absorption of the existing licentiates into the Provincial Medical Service during the next two years, and see that One Service comes into existence on the basis of a competitive examination.

Before I end this part of my address, I would like to appeal fervently to the young medical licentiates of our country not to accept service on the existing scale of salaries—menial pay and status as Sir Gordon Jolly truly called it. In fact, the meeting of our Standing Committee held last March has issued the following advice:—

"The Association would advise the medical licentiates of this country not to accept any job on less than Rs. 150/- a month, to start with, or jobs which are derogatory to their self-respect as members of the profession, but to enter private practice where there is splendid opportunity for service as well as for earning."

Food Shortage.

Dr. Rajendra Prasad said in his speech at Patna last month:

"I think it would be possible to tide over the critical food situation in the coming months without any person having to starve if only we are a little less greedy, less selfish and a bit more self-sacrificing. The Government is doing all that is within its power to help the people to increase the production of food grains and to import food from foreign countries."

We as medical men have also a duty to discharge in this respect. In our professional work, we come in contact with a large number of families, and are therefore in a position to offer advice to those families with regard to intelligent conservation and use of available food-stuffs, not only of cereals but also of vegetables, fruits, eggs, fish etc. Reduction in cereal supply may well be made up by a more liberal use of vegetables, fruits and milk. Dr. A. C. Ukil's advice is worth remembering:

"Use only unpounded rice as far as possible and do not throw away the rice water after cooking rice. Thus you will need less 20% rice for your nutrition."

"Grow more vegetables in the compound of your house and cook them in a proper way as to conserve nutrient materials."

"If you cannot get milk, eggs, fish or meat, take a certain quantity of sprouted grams, pulses or soya-beans."

"Economise rice by taking wheat-products at least in your night meals."

It is our duty as medical men to inculcate proper food habits to our people. This is particularly the time when we can do this effectively.

It is of course a pity that in a vast agricultural country like ours there should be food-shortage and frequent famines. For more than a century, the British Government neglected land and everything connected with agriculture such as irrigation, manure, improvement of seeds and agricultural methods. It is said that in British India alone, about 150 million acres are officially classed as a "Cultivable waste". In spite of big and small rivers coursing through the country, she has yet to depend on a favourable monsoon for proper harvest. I hope the National Government, in the Centre and in the Provinces, would soon adopt measures to make our country self-sufficient with regard to its own food supply. Until this is done, our people would be frequently facing food-shortage and food-famine, and the already poor health of the Nation is bound to deteriorate still further.

Amalgamation.

As per the resolution of our last Conference, I convened two meetings of our Amalgamation Sub-Committee.

The report of these two meetings was duly communicated to the President of the of the Indian Medical Association and will be placed before this Conference for its consideration.

OUR ASSOCIATION.

The strength of its membership and the number of its Branches are steadily on the increase, showing full well that the licentiates in our country have realised the need for unity and corporate existence, and for concerted action. But we must not become complacent. Still there is a great scope for improvement and until at least 75% of the total number of licentiates join our Association and until at least each taluk comes to have a branch of its own, we must not be rest content. I appeal to all the licentiates to make this possible during the course of next 5 years.

The business of our Association has increased so much that it demands a perfect and co-ordinated organisation at the Centre with all the chief executives—Editor, Treasurer and General Secretary—at one place, preferably at Delhi. If this could be brought about, if not immediately but in the near future, it would certainly facilitate effective organisation and secretariat work. It is for you to consider this suggestion and give it a practical shape.

Conclusion.

I have now come to the end of my address. I am conscious that I have omitted to discuss many of the usual topics that go to make up the formal presidential address for the simple reason that I wanted to be brief and practical in what I had to say. But I think I have covered all subjects which are relevant to our interests and to the objectives of our Association. I must thank you for your patient hearing and wish you success in your deliberations.

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Welcome Address By Dr. G. P. Tendulkar.

Sister and Brother Delegates, Ladies and Gentlemen,

I deem it a proud privilege to welcome you all to this historic city of Poona on the occasion of the 34th Conference of the All-India Medical Licentiates' Association on behalf of the Reception Committee. I know that many of you have come here from distant parts of the country at a very great sacrifice of time and money and at great personal inconvenience. It has been specially very difficult for the delegates from Bengal to leave their homes in these times of trouble and turmoil through which their province had to pass during the last few months. We were requested to postpone the conference to a later date, but the arrangements were already complete and it was also problematical whether the disturbed conditions in the country would improve in the next few months or get worse. So, we had to adhere to our old programme.

Those of you who have never visited Poona may naturally like to know something about its past history and culture and would also like to know about its modern development and growth. The Reception Committee has published for your information a Conference Souvenir which will give you a good idea about the city. But here I may briefly state that Poona has played a prominent part in the past and present history of our country. It was in the Poona district that the Great Shivaji was born at Shivaneri fort, a distance of 55 miles from this place. It was here that he was educated and laid the foundation of the Great Maratha Empire. After Shivaji a successive line of Peshwas ruled the destinies of this vast sub-continent for about 100 years. In the time of Bajirao I, this city busied with the whispers of politicians and the clang of armour of his Sardars and their Shiledars. His historic palace, the Shanwar Wada, stands to-day in the midst of the city with its bare walls, a cruel reminder of the great glory that was Poona.

To-day it is the second capital of the Government of Bombay as it has a most temperate and salubrious climate. It is situated amongst the most picturesque surroundings at the confluence of the two rivers Mula and Mutha. It is one of the greatest intellectual centres in the country. It has to-day 5 Arts Colleges, B. T. College, College of Women, College of Engineering, College of Agriculture, Post-graduate College, now the newly graded B. J. Medical College and several High Schools and other cultural institutions. The Great Lokamanya Tilak and the Hon. Mr. G. K. Gokhale spent their lifetime in this city. To-day also it is associated with such historic events like the Yeravada Pact. In the near future it will have a University of its own, the proposed Maharashtra University. To such a historic city it was to have been my privilege to welcome you in 1944, but due to various circumstances we had not the good fortune to do so.

It is indeed a great coincidence that the last time we had the privilege to welcome you was in Christmas 1919 on the occasion of the 14th Conference just after the termination of World-War I. To-day also we are meeting after the termination of World-War II. Another coincidence is that in 1919 we met here after the 13th Conference at Calcutta and to-day we are meeting for the 34th Conference after the 33rd Conference held at Calcutta last year.

It is but natural that on this occasion I should pay my tribute to the memory of the late Dr. K. G. Lohokare, one of the stalwarts of our Association and our Class, who delivered the welcome address last time from this platform. In his address he mentioned the following grievances of our class: (1) Improvement in teaching and the courses at the Medical Schools, (2) adequate representation on the Provincial Medical Councils, (3) proper recognition of the Medical licentiates in the Army Medical Services, (4) honorary appointments for the licentiates, and (5) abolition of the subordinate medical service.

To-day, after 27 years, though much water has flown down the bridges we find that we are still clamouring for the same rights and privileges. In fact our position in one respect has been made worse, due to the establishment of the unnatural and anti-national Indian Medical Council, a body which is neither respected here nor recognised abroad. I appeal here to the Indian Medical Profession not to let down the medical licentiates and see that they get full and equal recognition in a really representative Indian Medical Council which should now be created by the National Government at the Centre.

It is indeed gratifying to note that no more medical licentiates will now be created from any of the Government Medical Schools in this Province, and I appeal to the Government to see that fresh admissions to the licentiate course in any form or guise whatsoever, are definitely stopped in the Province from the year 1947. I make a similar appeal to all Provincial Governments to take similar steps in their Provinces as well and thus help in unifying the medical profession in the country.

Regarding the representation on the Provincial Medical Council, I earnestly hope that the Provincial Medical Acts in the different Provinces are amended on the lines of the Madras Medical Act.

Regarding the Army Medical Services, there has been a great cry that the I. M. S. should be a purely military service, but now after the experience of the last War, it is time for us to demand for its abolition altogether and to see that the I. A. M. C., which was started as a war measure, is recognized on a permanent basis for the future.

Regarding honorary appointments at the Government Hospitals, the medical licentiates with their vast experience and professional skill should not be debarred from holding these appointments, simply in preference to a few letters. It is the public money which is maintaining these hospitals and they should not be the monopoly of a chosen few.

Last but not least, I will mention the S. M. S. Service. Is it not the time now to abolish this service and institute one composite provincial medical service, open on the basis of competition and merit alone? Those who talk against the residuary posts and injustice in the I. M. S. completely forget the greater injustice and humiliation which is done to hundreds of their professional brothers. I am sure by our deliberations in this Conference and the united action backed by your support taken during the next year we will have achieved a large measure of success for our demands and aspirations.

We are trying our best to make your short sojourn in the city as comfortable and happy as possible. But due to the present difficult times there are bound to be some shortcomings and inconveniences for which you will kindly excuse us.

I again welcome you, the delegates of this Conference and the distinguished guests, who have cordially responded to our invitation for this inaugural function.

In the end I take this opportunity to welcome the Premier of this Province, Mr. B. G. Kher, who has consented to inaugurate this Conference at considerable inconvenience and in spite of urgent pressure of work. We indeed are grateful to him for this honour he has done to us by responding to our invitation. I will now request him to inaugurate this Conference.

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Mr. B. G. Kher, Premier of Bombay, inaugurated the Conference, and in the course of his speech, he appealed to the doctors to settle in villages. He further said that the Bombay

Government would implement the proposals of the Bhoré Committee as far as possible and at the earliest possible time. He also assured the House that the licentiate medical education would be completely abolished in Bombay.

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**Report of the working of the All-India Medical
Licentiates' Association for the year 1945-46
presented by Dr. A. N. Roy, General Secretary.**

I have the pleasure to present the following report on the working of the Association for your adoption. After the conclusion of our last Annual Conference at Calcutta in April 1945, I took charge of the office of the General Secretary in May 1945 and the report covers the period of work from May, 1945 to September, 1946. Our Calcutta Conference did not fix the venue of the next Conference and consequently the matter of its selection came before the Standing Committee. Circular inviting the branches to hold the 34th Conference was issued accordingly. By majority of votes Madras got the chance of holding the 34th Annual Conference but our Madras brethren withdrew in favour of our Poona branch under whose auspices we are meeting today. Our thanks are due to Poona colleagues who undertook the responsibility of arranging this conference at this critical time when there is a general unrest in our country. We wish our Poona Conference success and hope that this Conference will give a lead to the Association in shaping its destiny and in guiding it along the path of progress and advancement bringing in honour and prestige to the Indian Medical Profession.

Standing Committee.—During the period under review we had two meetings of the Standing Committee held in November, 1945 and March 1946 and it is encouraging to report that in spite of transport and other difficulties these meetings were well attended. This shows the keenness with which our members take interest in the welfare of our Association. Proceedings of these two meetings were duly published in the Indian Medical Journal.

Post war resettlement problems facing our members joining military service necessitated more meetings of our executives but the big composition of our Standing Committee made us feel the necessity of a smaller working committee which could often meet to deal with urgent problems and we hope this conference will give a serious consideration to this aspect of our organization which is before the minds of many members. In fact the discontent and disaffection amongst our members in military service ran so high that a special Conference of Ex-Army Medical Officers was convened at Calcutta to discuss the various problems that were presented to the Association. The resolutions passed in this Conference were forwarded to the heads of both Central and Provincial Governments for favourable consideration. Along with this representation was appended the findings of our Bhoré Sub-Committee and memorandum submitted by the President of our Association. The reply received from the Government of India is published in the Journal in its issue of November 46, p. 271.

Amalgamation of A.I.M.L.A. and I.M.A.—The question of amalgamation of our Association with the Indian Medical Association received sincere consideration of the amalgamation Sub-Committee which held two meetings—one at Delhi in July 1945 and the other at Amritsar in December 1945.

The proceedings of the meetings of the Amalgamation Sub-Committee were published in the Journal in its issue of February 1946, p. 48.

Indian Medical Council.—Indian Medical Council Act, rightly described by our Association since its inauguration as the Black Act of 1933, received the condemnation it deserves in the hands of the Indian Medical Profession in general and the Medical Licentiates in particular. From the day this Act found its place in the Statute Book of the Central Legislature, it has been condemned every year. In fact the 20th of September has become with our Association as the day of observance as the Anti-Indian Medical Council Act Day and this Act is considered by us as the greatest affront to the Indian people in general and the Indian Medical Profession in particular.

We are anxiously looking for the day when this Act will be so amended as to include all qualified medical men of our mother-land within its purview and remove the stigma of inferiority complex and ignoble position the backbone of the Indian Medical Profession viz., the Medical Licentiates, has been put to by this Black Act before the medical world. No suitable language is found to express the depth of painful

feeling with which our members look upon the Indian Medical Council Act 1933. Copy of a press statement made by the president in connection with the relation between the medical licentiates and the Indian Medical Council was sent to the members of the I.M.C. for favourable consideration.

Anticipating that the present members of the Central Legislative Assembly will do their best to fulfill the national aspiration of the people of the land, the Standing Committee at its meeting held on March, 1946 formed a Sub-Committee to amend the Act for consideration of the Legislature. Opinion of the members has been invited and as soon as their opinion is received action will be taken to approach the president and leaders of the Central Legislative Assembly to amend the Act.

Health Survey and Development Committee:—(Bhoré Committee)

Bhoré Committee's Report.—The Health Survey and Development Committee has made a very comprehensive study of the Health Problem of our country. To study the recommendations of the Bhoré Committee, the Standing Committee of our Association in its meeting held on March, 1946 appointed a Sub-Committee consisting of Drs. M. L. Kapur, A. N. Roy, A. Viswanathan, A. D. Mukharji, G. K. Kulkarni, and V. D. Sathaye which met at Calcutta from 12th to 15th June, 1946 and formulated its opinion on the findings of the Bhoré Committee. The opinion of this Sub-Committee has been sent to the Government along with proceedings of the meetings of the Ex-I.A.M.C. Conference held from 15th to 16th June, 1946 at Calcutta.

Direction of Calcutta Conference.—All the resolutions passed by the 33rd Conference held in Calcutta in April, 1945 were forwarded to the proper quarters for favourable consideration. All provincial Governments acknowledged their receipt. The Government of Orissa was good to agree to take a representative of our Association in the Provincial Drug Advisory Board. With regard to the resolutions in connection with reorganisation of Provincial Medical Councils, and discontinuation of medical education falling short of the recommendation of the Indian Medical Council, it is felt that our representatives in the respective provincial medical councils have much to do to push these proposals in their councils. Initiative taken by our representatives in Bengal Medical Council in moving a resolution to this effect proved successful. Bengal Medical Council has unanimously recommended not to continue the school standard of medical education after 1950 and to have a joint election in the medical council and to have a register on the model of Madras. We commend our members in all provincial medical councils to follow a concerted policy.

With regard to resolution in connection with Railway service we tried in vain to arrange a deputation with the Railway Board. Railway Board's silence on our appeal to receive a deputation appeared to be not in keeping with the spirit of public service for which the Board is meant. Discontent and unrest amongst our members in Railway service ran so strong that the General Secretary had met personally the Secretary of the Board and laid stress on the importance of a talk between the representatives of the Association and the members of the Board to allay the suffering of our members in Railway service. Following this interview and further correspondence, the Board replied that "Railway Board have already taken *ad interim* action in certain directions and the whole question is being considered in connection with revision of scales of pay and other staff matters in the post-war period. Under these circumstance Railway Board do not consider that any useful purpose would be served by a meeting as suggested by the Association." Still we pressed for a deputation again without effect. We appeal to the Railway Board to pay consideration to our representation.

Pay Commission

As soon as a press note gave us to understand that Government of India was instituting a pay commission to study the terms and conditions of service under the Government, we sent representation to the Committee urging adoption of the policy enunciated by our association viz., abolition of compartmentalism in service, selection of candidates by open competition, uniform scale of pay on the line of I.A.M.C. We have also requested the Commission to grant us personal interview to place our views before the members of the Commission.

Representation to British Authorities.—An opportunity occurred to us to send an envoy to the British authorities in Great Britain to lay stress on the dearth of facilities for our members for post-graduate study and the hardships faced by our members to practice medicine in British Dominions. Occasion arose for Dr. A. M. Malik—the President of the Calcutta Branch of our Association—to visit Europe in Novem-

ber, 1945 and we seized the opportunity and requested him to see the Secretary of State for India and the President of the British Medical Council. The Secretary of State for India in acknowledging the receipt of our letter authorising Dr. Malik to meet him appreciated highly the service rendered by our Association in ameliorating the suffering of our ailing countrymen in the Army and the President gave an interview to our representative and gave hopes that he would place our representation before the Council. Our thanks are due to Dr. Malik for this service rendered to the Association, and our thanks are also due to the President of the British Medical Council for receiving the deputation. We thank the Secretary of State for his appreciation of our service and hope that the problems raised before him will receive the consideration they demand.

Following this deputation we made correspondence with the Examining Board of the Royal College of Physicians, London inquiring into the facilities offered to our men for post-graduate study. All informations regarding concessions for our members are published in our Journal, April 1946, p. 128.

Our Organizational Work.—We have got two hundred and sixteen branches all over India under nine Provincial branches viz., Assam, Bengal, Bihar and Orissa, U.P., Bombay, C.P. and Central India and Rajputana, Madras and Punjab. Assam, Bengal, Central Province and Berar, and Madras had held Provincial Conferences at Silchar Howrah, Chaibasa, Bilaspur, and Madura respectively. It is hoped that the lead given by the provincial conferences to their respective provinces will bring forth life and activity to the regional branches and the unity, faithfulness and discipline needed for the progress of the organization will be borne by action. Direction given by the Central Office to the provincial branches to meet the provincial health ministers and administrative medical officers was given effect to by the following provincial branches who waited upon the authorities mentioned below with a deputation.

Assam: The Hon'ble Minister-in-Charge of Health, 15th April, 1946.

Bengal: Surgeon General with the Government of Bengal, 11th March, 1946.

Bombay: Hon'ble Minister of Health, April 4, 1946.

Madras: Surgeon General with the Government of Madras, 15th January, 1946.

C.P. and Berar: Inspector General of Civil, Hospitals 8th January, 1946.

C.I. and Rajputana: The Hon'ble Minister and the Inspector General of Hospitals, Holkar State, 20th April, 1946.

The Chief Minister and the Principal Medical Officer, and the Councilors to the Jodhpur Government June, 1946.

Hon'ble Minister and the Director Medical and Health Services, Rewa State, 17th September, 1946.

U.P., Bihar and the Punjab Branches have formed committees and will soon wait upon the respective provincial medical heads with deputation. These deputations have done much in apprising the provincial Governments of the activities of the Association with regard to health and medical education problem for which a co-ordination is necessary and we hope the provincial governments will give due consideration to the representations made by our provincial branches.

All provincial branches were unanimous in laying stress on the abolition of compartmentalism in service, abolishing medical schools and bringing in one uniform cadre of service giving facilities for any member to rise to the highest position by dint of merit without distinction of caste or creed and to revise the pay scale of the medical service from Rs. 150 to 450 P. M. as per recommendation of the Administrative Medical Officers' Conference held in November, 1945 under the presidency of the Director General, I.M.S.

Indian Medical Council's recommendation for higher study and the Indian Universities. Our thanks are due to the Calcutta University for the facilities given to our members to go in for M.B. examination. They have not accepted the recommendation of the Indian Medical Council in toto but as partial measure a medical licentiate with approved war service can appear in the M.B. examination after prosecuting a study for 2 years and a member having no such service after 2½ years. We hope the Calcutta University will reconsider its policy as per recommendation of the Indian Medical Council. With regard to facilities for post graduate study at the All-India Institute of Hygiene and Public Health the authorities inform that persons with approved war service are exempted from payment of tuition fees.

In order to give a fillip to our less active branches a list of active and inactive branches was made and our provincial secretaries were requested by circulars to stimulate the less active branches. A membership campaign drive was inaugurated on the assumption of office from the outgoing secretary and the result of the campaign was borne by an increase of 610 new members and affiliation of new branches at Karimganj (Assam), Viramgam (Bombay), Gondal (Bombay), Wardhan City (Bombay), Wardhan Camp (Bombay), Seoni (C.P.), Labac (Assam), Coalpara (Assam), Badarpur (Assam), Palgaon (C.P.), Lumding (Assam), Contai (Bengal), Sunamganj (Assam), South Arcot (Madras), Ahmednagar (Bombay). Our Army Medical Officers in the Punjab after demobilization have formed a branch named Ex-I.A.M.C. Officers' Branch of the A.I.M.L.A. at Lahore. Our thanks are due to the provincial branch secretaries and regional workers under whose initiation and activity these branches had come into existence. Our special thanks are due to Dr. Trivedi in this connection. We wish these branches strong life and success.

Congress Medical Mission and our Association.—We have taken active part in the Congress Medical Mission sent to Malaya. Many of our members joined the mission and brought us honour by their selfless service. It has created a feeling of good will between Malaya and India. Many of the volunteers offered their service and the matter was communicated to the organiser of Congress Medical Mission.

Our Future.—With the cessation of this Conference our Association will attain the 41st year of its birth and during the last forty years we have not been able to bring within our fold all the medical licentiates within our country. It is high time that we formulate a constructive scheme to make a countrywide campaign to send the message of our Association to every corner of our country and it will be a fitting memorial to the foundation of our Association if we take a vow to celebrate the foundation day of our Association by membership campaign on the memorable day and observe the whole foundation month as "Membership Campaign Month" during which all branches will make an honest and determined effort to enlist all the brethren as members of the Association.

I am sorry I am unable to append the list of branches with their activities due to paper economy. Our active branches are awake to the problems before them and their co-operation and activity have kept the strength of the Association so far and we hope they will play greater part in making this organization stronger, popular and more representative. Last postal strike and the Calcutta riots have so disorganised the postal service that our works were upset but branches kept on working in their regions. Relief organization under the guidance of the Association is an important branch of service for which our branches are crying. It is for you to decide on this matter.

Resolutions of the 34th Conference A.I.M.L.A. are published on page 297 of this Issue.

**The 4th Bombay Provincial Medical
Licentiates' Conference, Poona,
18th October 1946.**

[Continued from page 273 of previous Issue]

DR. V. D. SATHAYE'S SPEECH—(Continued)

Some time in 1938, I moved the following resolution in the Bombay Medical Council—"whereas it is desirable to have one uniform minimum standard in Western Medical Education. This Council recommends to Government to amend the schedule to the Bombay Medical Act, 1912 as per section 20, in the following manner. Delete the following from the list of qualifications:—A list of 12 qualifications like L. C. P. S., L. M. P. etc. granted in the different Provinces. N. B.—The amended schedule not to apply where the qualifications are obtained before the amended schedule comes into force or not to apply to those students who commence their medical studies before the date which the amended schedule comes into force."

I regret to state here that the motion was lost—3 voting for end 5 against the motion. So you can very well judge who wants to perpetuate this system. In the course of the discussion recently held on a similar resolution, it was stated that even if the Bombay Province abolishes the licentiate course, what about the other provinces. Well, the other provinces will gradually fall in line and on the principle of reciprocity, the remaining province or provinces will have to adopt the general policy.

To speak about our own Province, to-day, there are two Bodies which grant the Licentiate diploma. The Government created Medical Faculty will now cease to function for every future candidate by the simple stroke of a pen. But the other Licensing body, whose very life and soul depends upon the L. C. P. S. course, is now trying its level best to continue its existence. I now ask here, for whose benefit are they now continuing? A Body which never cared anything for either the welfare or uplift of its own students for several years has now suddenly started to sympathise with the Licentiates; they are now starting all sorts of known and unknown post-graduate diplomas. Not only that but their Fellowship Examination is now suddenly thrown open to the Licentiates. Where in the old days it was almost herculean to get the membership diploma of the College, we find that the F.C.P.S. is now made a very easy comfortable prize for any one who cares to take it.

May I now appeal to the College of Physicians and Surgeons to convert their institution into a post-graduate and research institution which may in future develop as a model institution in the country. The united medical profession has voted against the dual system in medical education, both for the qualifying examinations as well as the post-graduate courses.

In 1942, the medical licentiate association tried its level best to persuade the college not to raise the L. C. P. S. course artificially, to 4½ years. So ultimately we had to suggest to the Government to institute a special diploma with the same 3½ years' course which existed for the L. C. P. S. till 1942.

At that time we were accused of all sorts of motives. But even to-day I fail to understand how you can raise the efficiency and value of any qualification by simply increasing the number of years. For to do this you require not only a change in the time-period but also an improvement in the equipment and also the teaching. The equipment and the teaching remained the same but only 3½ years were changed to 4½ years, because that did not require any thought or trouble for the man who passed the resolution. So if merely years can change the value of the course, then they could have changed the course to 6 years and persuaded the Bombay University to accept the course for the M. B. B. S. What the college did was to enact the drama of Hamlet in 4 hours instead of 3 hours and simply change the number of Acts. The actors and the substance of the drama remained the same. In any way, the cat is now out of the bag. The L. M. P. is now going, then, why hesitate to stop the L. C. P. S. now? Even the different post-graduate diplomas started by the college are branded with an inferiority complex. May I ask here whether any of the college diplomas will get the same recognition in comparison with similar University diplomas. The answer is a definite No. In the interview which we had with the Health Minister of Bombay he said that the post-graduate diploma of the College will be recognized but that only in preference to an ordinary qualifying degree. So it is for this reason that at the last Amritsar Conference in 1945 it was resolved that only the different University Medical Faculties should be allowed to grant qualifying and post-graduate degrees and diplomas.

Reform of the Provincial Medical Council.

It is now high time to change the present constitution of the Bombay Medical Council. Resolutions were passed both in the Bombay Medical Council as well as in the Provincial and All-India Medical Conferences held during the last ten years to amend the Act on the lines of the amended Madras Medical Act. The last popular Bombay Government had in fact a Bill in preparation for this purpose, but you all know that their existence was only of a short duration. Now that the Congress Ministry has again come into power, it is only a matter of a few months before this long standing and necessary reform is carried out in our Province.

New Orientation of the Health Policy.

This is indeed a subject which will require very careful thought and planning. It is a subject which is engaging the attention of the public in all countries. Fortunately we have now before us the Bhore Committee's report. This report is acclaimed as a most useful and valuable work in all quarters. So far as our Association is concerned we have already pointed out the defects in the report from the stand-point of the Medical Licentiates in the Memorandum which we submitted after our deliberations in Calcutta in June 1946. I will here mention only one point, that the Medical Licentiate as he stands to-day has shown his professional equality with the medical graduate and as such he must be considered a Basic Doctor with the full implications and privileges of that term. The suggestion that the medical

licentiate should be given a short training to bring him up to the level of the Basic Doctor has many implications behind it, and we must oppose the move in an unmistakable manner.

But before any new scheme of health services is introduced we must begin with a clean slate. To do this it is necessary to abolish the present divisions in the medical services. The time has now come to abolish the S. M. S. cadre and absorb the present personnel into a new composite health service for the province. Unless we have a contented and unified medical service, the whole basis of medical relief will not be placed on a sound footing. So we must raise the present health service to the level and standard envisaged in the Bhore Committee's report. Before instituting the new service, the old conditions must be improved to the new standards. In any case the medical licentiates must get their due share in the reorganization of the existing health service, as well as in any new services which will be started in the future. Having said this much about the place of the medical licentiate in the evolution of a new health programme, I will now deal with a few practical applications of the Bhore report to our province.

I think the Bombay Government should lose no time in applying the proposals of the Bhore report to the fullest extent in this province. Today the total expenditure pooled together by the Bombay Government, the Bombay Corporation and the other local bodies in the province comes to more than 2½ crores which includes Rs. 73 lakhs spent by the present Public Health Department in the province. So this money if properly utilized equals the amount needed for the short term programme designed by the Bhore Committee. At this stage we must press upon the Government to amalgamate the medical and public health departments immediately and the head of the two amalgamated departments should not hold the charge merely on the basis of seniority but he must be a man with outstanding research work to his credit.

I hope that a Provincial Health Council will be established in this province under a provincial ministry of health at no distant date and in that council the provincial branch of the All-India Medical Licentiates' Association should get a due representation.

It is also necessary to state here that a co-ordination between the proposed health service and the various voluntary hospitals in the province should be made to utilize their enterprise and thus avoid duplication of work and efforts. The proposed national health service in England has already considered the question and has included in their scheme the voluntary hospitals without intruding upon their independence. All these questions will have to be carefully considered by the Provincial Health Council. Today it has been an accepted fact in the modern state, that food, clothing and education, good housing and health protection are the cardinal responsibilities of the state. If such a broad and enlightened health programme is undertaken by the National Government, the question of finance will be solved in many instances even by voluntary contributions as is at present done for the various voluntary charitable hospitals. It is indeed gratifying to note that the new National Government has seen the vital need of immediately undertaking a new health programme.

Inaugurating the Health Ministers' Conference in Delhi on 10th October, 1946, Pandit Jawaharlal Nehru said:—

"Political and other matters might brook some delay, but problems like health, which, if not given proper attention in time, could not be rectified. Hitherto not much attention has been paid by the State to problems like health and education. Lack of funds was the explanation. If funds could be available for big wars, there was no reason why they should not be provided for the fight against ill-health, which was like an enemy from within and weakened the nation. Various questions faced the country some of which were controversial. But health is a basic problem which forms the foundation of a nation's edifice and if the foundation is weak, the building is likely to collapse."

I may also state here that an efficient health service is the pre-requisite of a programme of social insurance and security. Fortunately for us we have before us the Adarkar Report as well as the Bevin Report published in England. The Government should also take early steps to bring into action the recommendations of the Adarkar Report. Besides benefiting the masses it will completely solve the question of medical unemployment and raise the level of medical practitioners from the economic point of view.

We appeal to the University of Bombay to throw open its post-graduate medical diplomas to the medical licentiates. The

Cambridge University gives the D. O. to any one registered with the General Medical Council, irrespective of his being a medical graduate or not, and the Bombay University should now take a liberal policy and do the same. Except for the M. D. and M. S. degrees all the other medical diplomas should be thrown open to all persons registered with the Bombay Medical Council. This will further implement the resolutions passed by the Medical Profession in India, that the University alone should be allowed to give qualifying and post-graduate degrees and diplomas in medicine.

Similarly medical licentiates who have recently qualified may like to take up the degree course. So the University should suitably modify its regulations without sacrificing efficiency but at the same time keep them consistent with practical considerations.

Indian Medical Council.

The creation of this Council in the reactionary days of 1933 has hurled only insult and injustice on the medical licentiates. The new National Government at the centre should lose no time in scrapping the whole 1933 Act. They should now create a new Council which will do justice and bring honour to the medical profession in India. If that is done, the present cleavages in the medical profession will disappear and we will have a united medical profession which is now a necessity for the proper development and working of a new health policy for the country.

Public Hospitals and Research Work.

The medical licentiates have been consistently kept out from holding honorary appointments in the public hospitals and they are also denied opportunities of doing research work. This is due to the red-tapism and obsolete regulations which are now in force. In spite of this, the medical licentiate wherever he has got the opportunity has shown his mettle in spite of unequal odds. The names of Rai Bahadur Mathradas and the late Dr. Das Gupta of the Tropical School of Medicine are a fitting reminder of what the country would have lost if these persons would not have got the chances in their early life-time. However experienced or competent a medical licentiate may be the public is denied the use of his services and skill. A third rate medical graduate who has probably obtained his qualifying degree after several attempts manages to go to England and comes back with a few letters and he is given preference over a really first class licentiate whose only fault was his poverty. In the old days we used to raise a hue and cry against I. M. S. officers holding appointments in different subjects. A physician of today used to be a gynaecologist of tomorrow or even a surgeon at will. The same things are being done even now for honorary and other appointments. People qualified in midwifery are working as physicians and what not, but due to vested interests we are not raising any protest.

The public hospitals are maintained from public funds and should not be a monopoly of a chosen few. If medical licentiates can treat the public privately they have a right to get their share in the administration of the public hospital. It means those who can afford to pay can choose their doctor but persons who are either poor or forced to go to a public hospital have no option but to go to a doctor who very often has no sympathy with him. So even the public has a right to demand a change in this policy. Even in England to-day the General Practitioner is now raising his protest against the present policy of hospital administration in that country. It is now being considered to throw open a portion of the hospital beds to the patients who will be under the care of their own family physicians. I think a similar change must be made in our hospitals as well. A due proportion of both the nursing home and general beds should be set aside for patients who wish to be under the care of the doctor of their own choice. This will also set up a healthy competition, and in the long run improve the working of the hospitals.

One Medical Association.

I will now come to the future of our Association. I am firmly of opinion that we should not suspend our activities unless our main demand of full and unqualified recognition and registration in the Indian Medical Council is granted. Even to-day we are working hand in hand with the Indian Medical Association. Our efforts are only implementing the decisions of the medical profession of the country as a whole. We have never been a reactionary body, but at the same time we must be sure of our foundations. Others will not fight for your rights with the same zeal and sincerity, though they may say many things on paper and in words. These are practical considerations. To give you

a small example, we had the S. M. S. officers conference in Poona in March 1946 where various grievances of their service were ventilated. This was given enough publicity even in the press. But the Maharashtra and Karnatak Provincial Conference held at Bijapur in May 1946 completely ignored the grievances of the S. M. S. I purposely kept silent as I wanted to find out how much others will help us without our asking. So let us work for amalgamation by first joining the I. M. A. Let us take our share in its working in all branches and activities. For a few years we will have to spend Rs. 4 extra per year for our own Association but it is nothing compared to the subscription of the I. M. A. which is now anywhere from Rs. 12 to 36 Rs per year. I appeal to the Central Council of the I. M. A. to stop these vagaries in their subscriptions. The maximum should be fixed once for all which should not be exceeded by any of the branches so far as general membership with its rights and privileges is concerned. The I. M. A. should aim at enrolling every available medical person as a member rather than collecting more money. The subscription should be so kept that no person will have any cause to keep out of the Association on the ground of high subscription.

In the end I will again appeal to the Government to abolish the S. M. S. cadre and institute a composite provincial health service and grade up all existing health services to the level suggested by the Bhore Committee. They should immediately appoint a Provincial Health Council in which our Association should get due representation and consider ways and means to carry out the short term plan of the Bhore Committee as early as possible. I appeal to the Central and Provincial Governments and the leaders of the medical profession to see that a really national Indian Medical Council is now created which will make amends for the injustice done to the huge majority of medical practitioners in the country. I appeal to the University authorities to give up their insular spirit and take up a more liberal attitude and throw open the various post-graduate medical diplomas to the medical licentiates. To you all I appeal to get united and take an active part in the working of this as well as the Indian Medical Association. You should also keep yourself alert and take your due share in the great schemes of development and reconstruction which will now take place in all spheres of life.

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Annual Report of the Bombay Provincial Branch. Report for the year ending September 1946, by Dr. V. G. Paranjape, Provincial Secretary:

Ever since the inception of our association at Bombay in the year 1906, our association has made tremendous efforts for raising the status of our class. Bombay Provincial Branch does not lag behind in its work of organization.

Branches: There are 52 branches in the Province, and the branches like Bombay, Ahmadabad, Poona, Belgaum & Dhulia are very active. The work of the Poona branch is very promising and this branch holds regular monthly clinical meetings, which are attended by a fairly large number of its members. Ahmadabad branch is also very active through the efforts of Dr. P. R. Trivedi. During the year under report five new branches have been started and a few old branches have been revived.

Membership: The total Membership strength of our Provincial Branch as it stands to-day is about 1,100. I am glad to report that about 200 new members have been enrolled during this year. It will not be out of place if I mention that some of our brother members like Dr. P. R. Trivedi of Ahmadabad, Dr. V. K. Watve of Poona and Dr. S. V. Kulkarni of Ahmadnagar have enrolled many new members by arranging special tours for this purpose.

Circulars: During the year under report the total number of letters and circulars issued by the Provincial office is 910. Amongst a few important circulars, may be mentioned a circular to the Government of India about S. M. S. Officers' grievances:

Important activities

- (1) S. M. S. Conference—The first S. M. S. Conference under the auspices of the Bombay Provincial Branch was held in Poona on 23rd and 24th of March 1946 in the premises of the Sassoon Hospitals under the Presidentship of Dr. V. D. Sathaye, Lt. Col. Dabholkar, the Ex. Director of Public Health, inaugurated the conference, which was attended by a large gathering of about 70 S. M. S. Officers. Many vital problems regarding the subordinate medical service were discussed and

a few resolutions were passed and sent to the Government. A special Report of the Conference has been published which will give the idea of the work done in the conference. A 'Service Committee' was formed consisting of the Provincial President, Provincial Secretary and 3 members with a view to represent the various grievances of the S. M. S. Officers to the proper authorities.

Deputation to the Health Minister.

On behalf of the Bombay Provincial Branch a deputation was sent to meet Dr. Gildar, the Minister of Health at Bombay in the month of April 1946. A memorandum dealing chiefly with the grievances of S. M. S. Officers and also of our class was submitted to the Health Minister. I may mention here a few points of our demands in the Memorandum (1) Abolition of S. M. S. Designation and institution of one unified Provincial Medical Service. (2) Revision of the present scale of pay. (3) Suitable appointments to the I.A.M.C. Officers returning from Military service. (4) Combination of Medical and Public Health departments (5) Abolition of Medical schools. (6) Opportunities to fresh Licentiates to take up the degree course. (7) Recognition of the Licentiates by Indian Medical Council. (8) Representation of our class on the committees & conferences convened by the Government.

Thanks:—I take this opportunity to express my gratitude and thanks to our Provincial President Dr. V. D. Sathaye, who has immensely helped me in carrying out the work entrusted to me. I have also to thank all the Branch Secretaries of this Province, who have co-operated with me in the Provincial Work. I must also thank Capt. M. R. Vaze, Ex. I. A. M. C. who at a very short notice represented our province in the meeting at Calcutta, arranged by the All India Association to discuss the question of I. A. M. C. Officers, returning back from Military Service.

POONA

V. G. PARANJAPÉ.

18th October 1946.

Provincial Secretary.

* * *

Resolutions Passed at the 4th Bombay Provincial Medical Licentiates' Conference. Held in Poona on 18th and 19th October 1946.

(1) This Conference resolves that (i) the existing S. M. S. Cadres in the Medical and Public Health departments and Railway and States Medical Services be abolished forthwith and that (ii) there should be one composite Medical Service, wherein all the existing Officers of the S. M. S. including the temporary ones be absorbed on the basis of 50 % service antedate. (iii) recruitment to this service in future for fresh entrants, should be made by competitive examination alone.

(2) Now that the Government Medical Schools in the Province have been abolished or upgraded, this Conference requests the Government to enact legislation prohibiting any medical institution teaching Western System of Scientific Medicine from imparting Medical education and or conducting examinations for any diplomas that fall below the University standards.

(3) This Conference welcomes the recent concessions proposed by the University of Bombay for enabling medical licentiates to obtain the M.B.B.S. by appearing for the examinations leading to the degree without keeping regular terms and requests the College of Physicians and Surgeons to stop the L.C.P.S. course forthwith, and thus satisfy the conditions imposed by the University.

(4) This Conference congratulates the following members of the medical fraternity, viz., Drs. M.D.D. Gilder, J. N. Mehta, Hariprasad Desai, K. B. Alibhai, D. Patel, C. J. Patel, B. C. Lagu, K. B. Antrolikar, and M. N. Natu on their being elected to the Bombay Legislative Assembly and sincerely hopes that they would prove to be an asset to the advancement of medical relief and medical education in the Province.

(5) This Conference recommends the Government to give effect to the recommendations of the Bhore Committee, as early as possible, as it thinks that they are based on sound principles and are calculated to raise the level of national health.

(6) This Conference requests Government to give representation to our Association in all Committees and Conferences convened by the Government in respect of their schemes of medical relief and public Health and cognate matters, and reserve some nominations for the Association wherever they exist in such bodies as the University, Local Boards etc.

(7) This Conference reiterates the former resolutions passed by the medical profession protesting against the practice of counter signatures on medical certificates, granted by registered medical practitioners.

(8) This Conference requests the Bombay University to allow the students of the National Medical College admitted in June 1946 to keep terms for the M.B.B.S. with retrospective effect from June 1946.

(9) This Conference appoints a sub-committee of the following with powers to co-opt, to formulate a scheme to be submitted to the Government, to give effect, at an early date, to the short term plan of the Bhore report.

(1) Dr. V. D. Sathaye (2) Dr. Narayanarao (3) Dr. V. K. Watve (4) Dr. S. V. Kulkarni (5) Dr. M. R. Vaze.

(6) Dr. V. G. Paranjape.

(10) Resolved that this Conference urges upon the Government to impart medical education in the Province, in the Hindi language at an early date.

(11) This Conference requests the Government that S.M.S. Officers should be permitted to attend the annual Conferences of the Association and they should be given special concession to do so, without affecting their casual leave.

(12) Resolved that the Government should be requested to lay down a definite policy within a period of two months regarding the future of the present temporary S. M. S. Officers.

(13) This Conference protests against the present policy of Insurance companies in making distinctions between medical graduates and licentiates, in their appointments and remunerations and resolves that necessary steps should be taken to get these differences removed.

(14) This Conference requests the University of Bombay, to throw open its postgraduate medical diplomas except M. D. and M. S. to all persons registered with the Bombay Medical Council.

(15) This Conference welcomes back all the licentiates returning from the Military services and congratulates them upon their performances. The Conference also puts on record its appreciation of the services rendered by the Civil Licentiate doctors in successfully coping up with the heavy duties without any extra remuneration. The Conference is of the opinion that all the licentiates in service deserve equal rights and be treated on equal basis as regards their postings, promotions etc., irrespective of their Military or Civil service.

(16) This Conference resolves that the grievances of the licentiates who are serving private limited companies such as sugar factories, local bodies, etc., should also be taken up by the Service Committee of the Association and their interests should be safeguarded by the Association.

(17) This Conference draws the attention of the Government to the grievances of the permanent Epidemic Medical Officers of the Public Health Department and requests the Government once again to improve their status and prospects immediately as recommended by the Bhore Committee.

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Indian Medical Journal.

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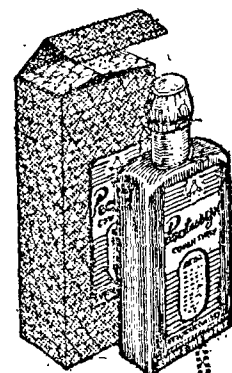
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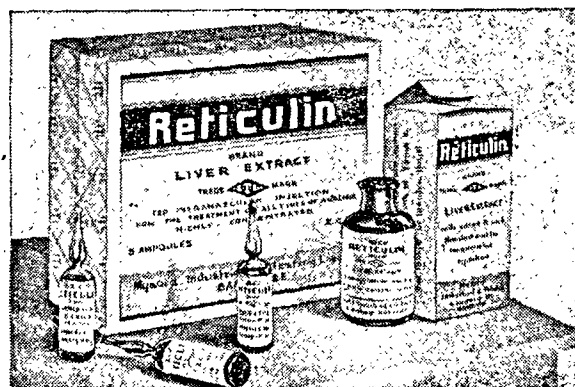
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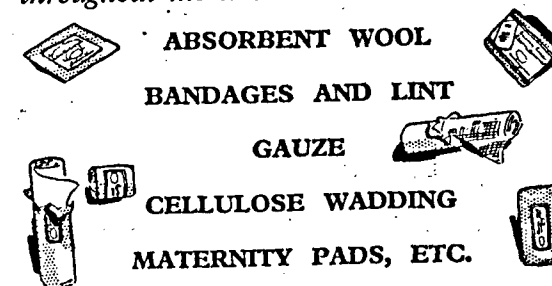
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Resolutions Passed at the 34th Annual Conference of the All-India Medical Licentiates' Association

Condolence

1. (a) This Conference places on record its profound expression of grief on the demise of the following licentiate I.A.M.C. Officers who lost their lives in action during the last war in its several theatres and conveys its heart felt condolences to the members of their bereaved families.

This Conference greatly appreciates the spirit with which they volunteered to join I.A.M.C. at the call of the Association and the services they have rendered to the Indian Army with great sense of duty and devotion at the risk of their lives.

List of I. A. M. C. (S. M. S.) & (S. M. S. C.) personnel who died or killed in action during the period 3rd April '43 to date.

I.A.M.C. (S. M. S.)

1. Major H. A. T. Wells, M. B. E. Died 30-3-44 Shahjehanpore, C. I. M. H.
2. Captain H. B. Blaker " 8-11-44 Ceylon.
3. Lieut. E. H. Gillson " 2-12-44 Bangalore, BMH. (Retd. re-employed).
4. Lieut. G. G. Cox, " 23-12-44 Jubblepore, Sun Carriage Factory. (Retd. re-employed).

I. A. M. C. (S. M. S.—C. C.)

1. Comdr. I. M. H. Timmins " 3-6-43 Paiforce.
2. No. 1819 Sub-Mohindar Singh " 22-6-43 Alipore, I. M. H.
3. No. MC-384 Sub. B. B. Dimari Drowned at sea 11-7-43 M. E. E.
4. No. ME-461 Sub. K. C. Das Killed in motor accident 27-7-43 S. E. A. C.
5. No. ME-267 Sub. B. P. Bannerjee " 19-12-43 P. C. W. Malaya.
6. No. ME-484 Sub. A. K. Chaudry Killed in action 8-2-44 M. E. F.
7. No. 1751 Sub. Akbar Khan Died 24-2-44 Barielly 135 IBGH. (I.T.)
8. No. ME-564 Sub. S. P. Majumdar Died of wounds 27-2-44 S. E. A. C. (No. 12 Ind.) Mobilesur gical unit.
9. 1772 Sub. Amrik Singh Died 1-4-44 Ambala, I. M. H.
10. No. ME-547 Sub. V. I. Reddy " 12-4-44 Lucknow, 129 IBGH (I.T.)
11. No. 2367 Sub. D. J. Reay Died 27-5-44 P. O. W. Malaya.
12. No. MC-212 Sub. M. C. Endaw Died as a result of tram Accident 31-3-44 M. E. F.
13. No. MR-125 Dhillon Sub Tara Singh Died 9-11-44 Amritsar, V. J. Hospital.
14. No. MC-282 Sub. T. V. Ramanathan Died 22-12-44 Poona, I. M. H.
15. No. MC-539 Sub. Abdul Majid Died 9-5-45 S. E. A. C.

16. No. 1547 Sub. Maj. Chiranji Lal Shah Died 18-5-45 Dehra Dun C. M. H.
17. No. 1427 Sub. Atar Singh Dhindra Killed in action 1942 Malaya
18. MC-78 Sub. Shiv Lal Killed in action 1942 Malaya
19. MR 114 Sub. S. P. Khosla Killed in action 1942 Malaya

List of I. A. M. C. (S. M. S.) and (S. M. S. C.) personnel who died or were killed in action during the period 3-9-39 to 2-4-43, casualty reports in respect of whom were received after 3-4-43.

I. A. M. C. (S. M. S.)

1. Lieut. A. E. Lewis Killed in action 12-2-42 Malaya

I. A. M. C. (S. M. S. C. C.)

2. Ss/Condr. L. D. Ross Killed in action 11-2-42 P. O. W. Malaya
3. Condr. R. H. Smith Died of Wounds 17-2-42 "
4. Condr. J. P. Monises Died 3-9-42 "
5. M.E.-34 Jem. Surinder Singh Died 16-12-42 Sudan
6. Condr. W. T. J. Monnise " 31-1-43 Imphal, 19 CCS.
7. 2222 Jem. Raghbir Singh " 13-3-43 Dehra Dun, C. I. M. H.
8. MC-Jem. Budhi Parkash " 21-3-43 Delhi I. M. H.

List of Officers who were killed in action.

No.	Rank.	Name.	Corps.	Date of Casualty.
MZ-20217	Lieut.	Bali, B. L.	I.A.M.C.	31-5-45.
M-21106	"	Barua, A. C.	I.A.M.C.	18-9-44.
MZ-11945	Captain	Bhala, S. L.	I.A.M.C.	22-11-44.
M-18533	"	Chaudhury, A. M.	I.A.M.C.	27-4-44.
MZ-21978	Lieut.	Chaudhury, S.	I.A.M.C.	30-8-44.
M-6803/197	"	Kacker, R. N.	I.A.M.C.	18-6-45.
M-8456	Captain	Kashsham, M. A.	I.A.M.C.	30-1-46.
M-21005	2/Lieut.	Lahari, N. C.	I.A.M.C.	15-4-44.
M-11958	"	Lal, Sikander	I.A.M.C.	23-11-43.
MZ-13472	"	Rai, S.	I.A.M.C.	27-11-43.
M-11954	"	Ramakeishana, S. V.	I.A.M.C.	20-5-44.
MZ-22465	Captain	Roy, G. P.	I.A.M.C.	4-9-45.
M-572	"	Roy, P.	I.A.M.C.	27-7-45.
MZ-11084	"	Siddique W. A.	I.A.M.C.	11-1-46.
MZ-11926	"	Singh, N.	I.A.M.C.	7-10-43.
MZ-11926	2/Lieut.	Talati, S. M.	I.A.M.C.	29-10-43.
MZ-13982	"	Ahuja, J. L.	I.A.M.C.	7-8-43.
M-22477	Captain	Bornshin, W.	I.A.M.C.	7-9-45.
M-6803/310	"	Chakarborty, S. B.	I.A.M.C.	4-2-46.
M-22168	"	Fennell, P. G.	I.A.M.C.	16-12-45.
MZ-11416	Captain	Malwade, A. C.	I.A.M.C.	28-11-45.
M-18698	2/Lieut.	Vaid, S. N.	I.A.M.C.	10-2-44.

The List of Officers who have been killed in action.

M.314	Lieut	Biswas, N. R.	I.A.M.C.	23-1-45.
M.20760	"	Dass S. C.	I.A.M.C.	6-6-44.
M.20646	Captain	Joglekar, N. G.	I.A.M.C.	29-10-45.
MZ-20457	Lieut	Khalikar, D. R.	I.A.M.C.	7-2-44.
M.15418	"	Sausman, S. R.	I.A.M.C.	7-9-44.

Lt. S. C. Das,
Lt. G. K. Sarma,
Subedar T. Roy,
Capt. M. M. Chaudhury.

(b) This Conference places on record its deep sense of grief at the sad demise of the following members of the Association during the year and conveys its heart-felt sympathy and condolences to their bereaved families.

- (1) Dr. B. M. Das Gupta—Director of Tropical School of Medicine, Calcutta.
- (2) Dr. Ch. M. Jamdar (C. P. & Berar)
- (3) Dr. Mrs. N. S. Das,
- (4) Dr. Syaed Ali Hossain.
- (5) Dr. R. K. Zave (Ahmedabad)
- (6) Dr. S. G. Vyas.
- (7) Dr. Izak.
- (8) Dr. S. K. Kundu.

Greetings to National Governments, Central and Provincial

2. This Conference welcomes the formation of National Governments in the Centre and in the various provinces of the country and assures them of the full co-operation of the Association in matters of Medical and Public Health administration.

This Conference approves of the broad principles recently laid down by the Hon'ble Pandit Jawaharlal Nehru, Vice-President of the Central Cabinet in matters of Health policy to be followed by the Central and Provincial Governments.

This Conference hopes that the Central and Provincial Governments would reorganise the medical services in such a way as to avoid the caste-system rampant in it at present, since this is a pre-requisite to an effective working of the organisation related to Medical and Public Health relief.

Abolition of The College of Physicians and Surgeons

In view of the fact that the policy of the Association has been to abolish licentiate medical education throughout this country in order to establish a uniform standard and one portal system of medical education; in view of the fact that this has been accepted by all the Provincial Governments without any exception and being acted upon by them by abolishing their medical schools and converting some of them into colleges, this Conference feels that the continuance of the issue of diplomas by the College of Physicians and Surgeons Bombay and other medical schools in India is detrimental to the sound growth of medical education, both post graduate and undergraduate, and therefore urges on the Government of Bombay and other Provincial Governments to take such steps as would lead to the abolition of these unwanted institutions, and the Government of India to so amend the Indian Medical Degrees Act (1916) as to abolish all examining boards, like State Medical Faculties, College of Physicians and Surgeons etc.

Abolition of Subordinate Medical Service and Absorption of the Existing Licentiates there-in into the Provincial Medical Service

4. In view of the following facts that

- (1) The difference in professional education between the Licentiates and the Graduates is not so material as to warrant the existence of wide disparities in their respective service conditions.
- (2) It has been acknowledged by eminent men that the quality of the professional work done by the licentiates in service is in no way inferior to medical graduates in service.
- (3) The British Medical Mission which visited our country in 1943 has stated clearly as

its opinion that the licentiates are capable of full medical responsibilities and that they are in no way inferior in intelligence and capacity to a large number of graduates and that therefore they should be made eligible to the King's Commission in the Medical Branch of the Indian Army.

- (4) The Government of India have, during the last war, granted the Licentiates the King's Commission to those who volunteered for the war and made them eligible even for the specialist rank of major.
- (5) The Conference of Administrative Medical Officer held in Nov '45 has recommended unanimously the establishment of one Provincial Medical Service.

This Conference strongly urges on the Central and the Provincial Governments to abolish the subordinate medical service on the same grounds which led the Central Government to grant King's Commission to the Licentiates, to absorb the existing licentiates in S.M.S into the Provincial Medical Service on the basis of 50 per cent antedate and on the scale of pay of Provincial Medical Service.

Indian Medical Council

5. This Conference is of the opinion that the proposals put forward by the President of the Indian Medical Council in the address to the Council at its last session in respect of establishment of an All-India Medical Register, are unsatisfactory because:

- (1) They aim to bring out a compartmental Register which is against the real purpose of medical Registration.
- (2) They do not involve representation of the medical licentiates in the Council.

In view of the fact that all the Provinces except Bengal have abolished the medical schools and that even the Bengal Government have accepted the principle of abolition of medical schools, this Conference appeals to the Indian Medical Council and also the Government of India to recommend the amendment of the I.M.C. Act in such a way as to effect recognition of the Licentiates qualification granted to those who may be admitted to the Medical Schools before the end of 1948 under schedule I of the Act which would automatically result in the establishment of an All-India Register in a normal and permanent manner and representation of the licentiates in the council.

Provincial Medical Councils

6. This Conference urges on all the Provincial Governments to amend their Provincial Medical Acts in such a way as to establish a common Medical Register without compartments as is now the case, and to throw open the majority of seats in the Medical Council for general election by the Registered Medical Practitioners, and recommends to the Provincial Governments to adopt the Madras Medical Council amending Act (1937) as a model in this respect and which is approved by the medical profession as a whole.

Medical Education—Under Graduate and Post-Graduate

7. This Conference approves whole heartedly the recommendations of the Bhore Committee in respect of under-graduate medical education with a four year academic course and a year of compulsory internship, and urges on the Indian Medical Council, and the medical faculties of the Universities to adopt the same as the standard for the M.B.B.S. Degree.

This Conference urges on the universities to allow the medical licentiates to study and appear for their post-graduate examinations in special subjects in view of the fact that medical schools are abolished in almost all the provinces and that consequently the need has arisen for the establishment of one type of post-graduate medical education, as in the case of under-graduate education.

I. A. M. C.

8. This Conference places on record its sincere appreciation of the response of the licentiates to the call of the Association in the matter of recruitment to I.A.M.C. and of the meritorious services rendered by them and acknowledged as such by military authorities.

9. This Conference observes with great concern that release benefits viz., release leave, victory leave gratuity etc., are denied to the I.A.M.C. Officers before reversion to Civil Service, and trusts that rules regarding the above will be strictly adhered to in future and that those already released without release benefits should be given these benefits as announced from time to time in the different Army Instructions without any further delay.

10. This Conference records with concern that although demobilisation has long commenced, the Government of India have not yet announced their policy regarding the permanency of I.A.M.C. vis-a-vis the position of Licentiates who have served the Army during the strenuous period of world War II, which lack of settled policy is borne out by the fact that a large number of demobilised licentiate officer of the I.A.M.C. are being relegated to their former ranks in I.M.D. and provincial subordinate medical services. This meeting urges upon the Government of India to announce the

- (i) permanency of I.A.M.C.
- (ii) abolition of I.M.D.
- (iii) eligibility of licentiates to permanent commission in I.A.M.C.
- (iv) absorption of I.M.D. officers transferred to I.A.M.C. (Special section) into the permanent I.A.M.C.
- (v) absorption of I.M.D. officers who held temporary commission in I.A.M.C. into permanent I.A.M.C.
- (vi) to direct Provincial Governments to absorb the demobilised commissioned licentiate officers into the provincial medical service and on the basis of 50 percent antedate and on the scales of pay of the Provincial Medical Service.

Government of India be further requested that emergency Medical Officers in the special section of the I.A.M.C. be given the honorary rank of Captain on demobilisation and that no differentiation should be made between them and the Medical Officers of the I.A.M.C. holding emergency commission in the matter of resettling them in Civil jobs.

11. This Conference regrets to note that neither the Central nor the Provincial Governments have enunciated their policy with regard to the Resettlement of demobilised Licentiate I.A.M.C. Officers. Neither have these Governments given the All-India Medical Licentiates' Association official representation in their resettlement offices and committees although, during the War, the Association was responsible to help the Government in the recruitment of medical licentiates, which it did effectively and to the full satisfaction of the Government.

So far as resettlement is concerned, this Conference is of considered opinion that none of the demobilised Licentiate Officers should be posted back to subordinate medical service, as is done now, but that they should be taken into the Provincial Medical Service immediately.

This Conference also urges on the Central and the Provincial Governments to give official representation to the parent and the provincial branches of the Association in the central and provincial medical resettlement offices and committees respectively in order to voice and safeguard the interests of demobilised Licentiate I.A.M.C. Officers.

In case the above conditions are not agreed to by the Government, the Association will be forced to take further measures it may deem fit under the circumstances.

12. This Conference condemns the action of the Government of India in asking the licentiate I.A.M.C. Officers to pass the graduation examination for permanent Commission. In view of the fact that licentiates' efficient work in world war I and II has demonstrated the capacity of the Licentiates for holding charge of medical units of various categories and of military hospitals, this Conference urges upon the Government to grant permanent commission to licentiates having licentiate diploma as basic qualification upto at least 50 percent of the total number of medical commissioned officers.

Amalgamation.

13. Read and considered the report of the Amalgamation Sub-Committee. In view of the fact that the Indian Medical Association has not yet given its reply to the resolutions of our Sub-Committee, this Conference resolves to postpone the consideration of this question pending its reply.

Licentiate Officer in the Office of the Provincial Administrative Medical Officers.

14. In order to safe-guard the interests of the licentiates in service, this Conference strongly urges on the Provincial Governments to appoint a senior Licentiate Medical Officer in the office of the Provincial Administration Medical Officers of the Provinces in India.

Auditor's Report.

15. Resolved that the General Secretary's report and the auditor's report be adopted. Resolved further that copy of the auditor's note with their observations be sent to the office bearers for giving their opinion on the auditor's observations.

Unqualified Practitioners.

16. This Conference strongly urges upon the authorities to stop all practice in Allopathic, Ayurvedic and other indigenous systems of medicine by unqualified practitioners.

Railway Doctors.

17. Resolved that a Sub-Committee consisting of the President, General Secretary and Dr. H. K. Chaudhury with powers to co-opt, be formed to go into the grievances of the Railway Doctors and place their report before the Standing Committee within three months for necessary action. Resolved further that the committee be requested to devise ways and means to have the A.I.M.L.A. recognised by the Railway board to represent the grievances of the medical licentiates in Railway Service.

Licentiates and M.B.B.S. Qualification.

18. This Conference thanks those universities who have accepted the resolutions of I.M.C. giving facilities for the licentiates to qualify for M.B.B.S. and requests the other universities to fall in line with the rest.

In the meanwhile, as an interim arrangement, this Conference requests the Central and the Provincial Governments to take steps in these provinces whose universities have accepted the Medical Council's resolution, to provide suitable teaching by utilising as far as possible the existing medical schools and colleges, as well as establishing new institutions, wherever possible and necessary.

Facilities for obtaining Conjoint Board Diplomas.

19. This Conference thanks the Conjoint Board of the Royal College of Physicians and Surgeons, England for the concessions given to the medical licentiates of approved war service for the examination of L.R.C.P. and M.R.C.S. and the post-graduate studies and appeals to the authority to extend the same facility to all medical licentiates and draws the attention of all India Universities to give similar facilities for post graduate studies to all licentiates.

Licentiates in British Colonies.

20. This Conference learns with concern that medical licentiates serving in British Colonies are debarred from medical practice on their retirement or on their resignation from colonial service and requests the British colonial Secretary to remove this disability of the medical licentiates who decide to settle in practice after retirement or resignation, failing which the Government of India be requested to disallow medical men qualifying from British Colonies to practise in India.

Other Resolutions.

21. Resolved that a suitable capital grant be sanctioned, if necessary after proper enquiry and being approved by the Standing Committee, from the fund of the Association for helping members of the Association and their dependents who have been affected by the carnage of Calcutta or elsewhere.

22. This Conference looks with horror and dismay the depth of the communal passion prevailing in the country. The tension is so great that in communal outbursts all cannons of civilised behaviour are forgotten so much as not to spare the members of the medical profession and institutions as was evidenced in the terrible communal riots in different parts of the country.

This Conference appeals to the leaders of the country to find a democratic solution of the communal tension and combine to fight communal aggression from any quarter.

This Conference appreciates the services rendered by the members of the Association in the relief of the wounded and appeals to the members of the profession to be above communal passions and continue their humanitarian activities.

23. Resolved that an expression of our deep sense of gratitude be conveyed to His Highness the Maharaja Sahib Bahadur of Jodhpur for the improved status and conditions of service lately sanctioned to the Medical Licentiates in Jodhpur Government service and hope that the Jodhpur Government will give a lead in giving effect to the recommendations of the A. M. O's Conference resolutions.

Resolved that our deep sense of grateful appreciation be conveyed to Dr. J. N. Madan, F.E.C.S. (Eng.) for his keen efforts in raising the status and emoluments of the Medical Licentiates in Jodhpur Government Service.

24. Resolved that the Bills placed before the house by the General Secretary be sanctioned subject to the consent of the Finance Committee.

25. Rule No. 231 be amended as follows: "Inter Class" for third class and substitute Rs. 2 a day for Re. 1 a day and that clerks attending the Poona Conference be given T. A. according to this amendment.

26. Resolved that the audit report 1942-43 as placed before the Conference be approved with the request that the directions given by the auditor be given effect to as far as possible and that the account of the Association for 1943-44 be audited by auditor to be appointed by the Finance Committee of the year 1946-47.

27. Budget for 1946-47. Resolved that this Conference approves of the Budget of income and expenditure for the year 1946-47 as placed before the house.*

28. Resolved that the Conference expresses its sincere thanks to the Hon'ble Mr. B. G. Kher, Chief Minister Bombay, for having kindly consented to open the Poona Conference.

29. Resolved that this Conference do express its sincere thanks to the Chairman, Secretaries and members of the Reception Committee and also the volunteers for the excellent arrangement they made for the comforts of the delegates and the visitors to this Conference.

30. Resolved that the Conference do express its sincere appreciation of the services of the retiring office bearers and thank them for the same.

31. This Conference places on record its best thanks to the authorities of the Sir S. P. College for allowing facilities to hold the 34th Conference at the college compound.

32. This Conference places on record its appreciation of the assistance rendered to the Reception Committee by the manufacturing concerns by their participation in the scientific exhibition and by their social entertainment to the delegates and visitors.

33. This Conference places on record its appreciation of the services rendered by the student volunteers during the Conference session.

34. This Conference places on record its appreciation of the co-operation of the news papers of India by giving due and timely publicity of the addresses delivered and the proceedings made at this Conference.

* Text of the Budget and the election of Office bearers will be published in our next Issue.—Editor.

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(Journal of the All-India Medical Licentiates' Association)

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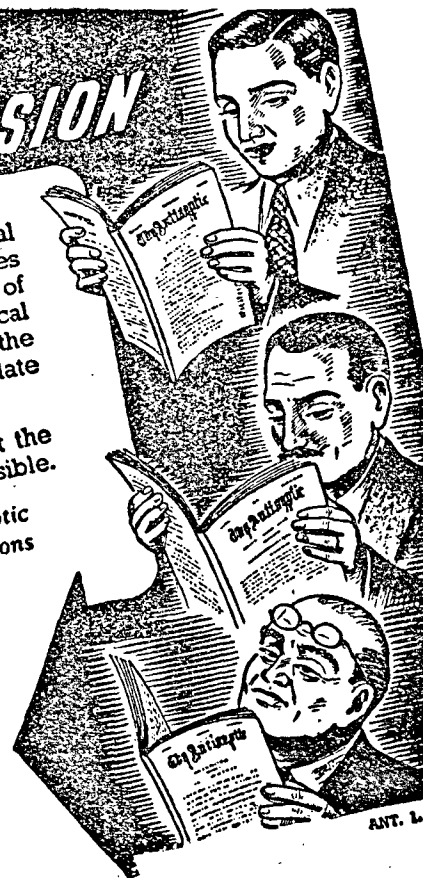
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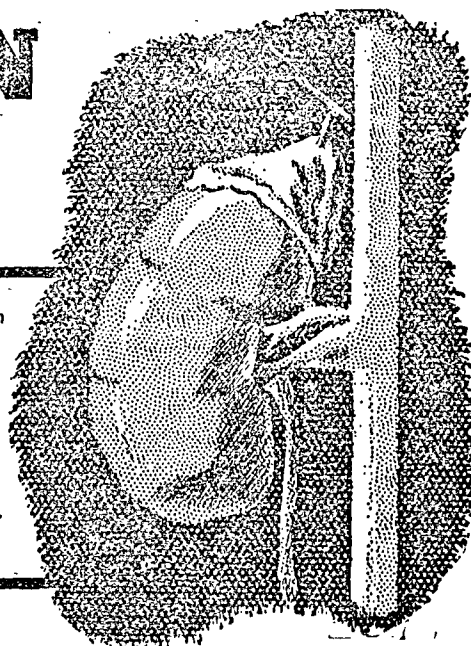
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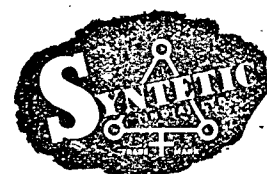
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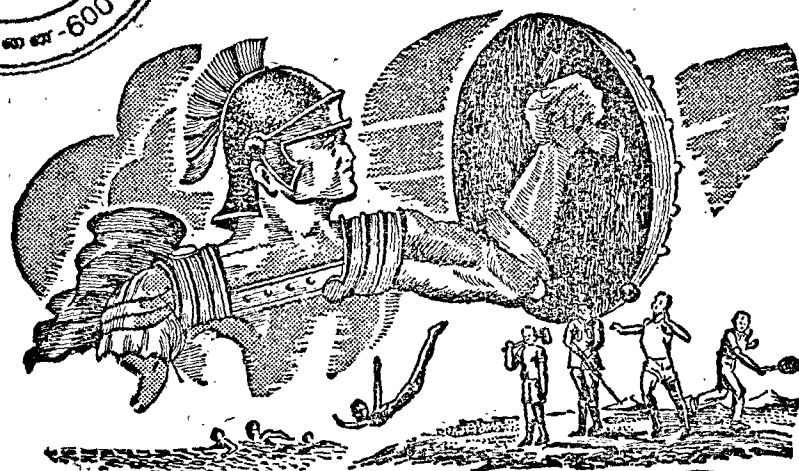
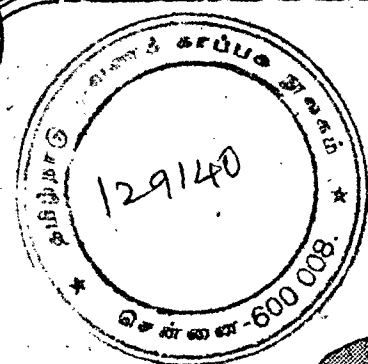
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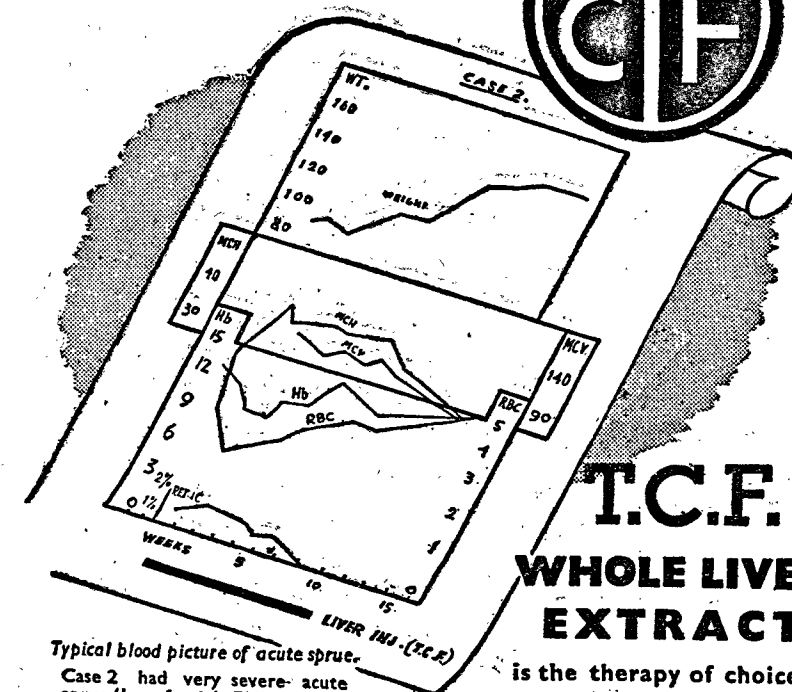
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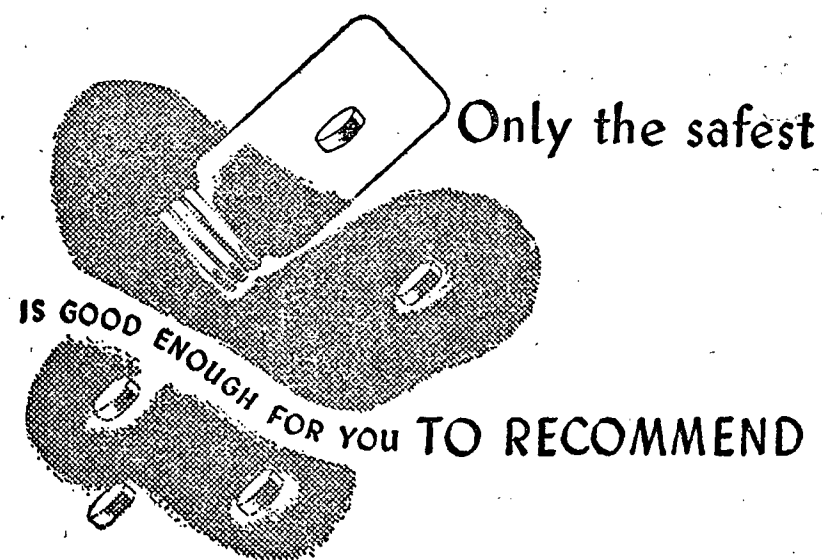
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compensation or leave from work—specially when honest truth would very often prevent them from getting leave from authorities. I can here mention of the cases of the self inflicted wounds on the limbs of beggars who enlist the sympathy of the passers-by on the roads of every big cities.

During the war a soldier was admitted in the hospital for incurable diarrhoea. He was kept under observation and all the methods of examination proved a failure; later an enquiry was made as to any extra special diet he had been receiving from outside. Nurse informed the doctor that he was only receiving milk from his mother, which, on examination, was found to contain Soda Sulph as much as about 240 grains. This young man wanted to avoid the trenches.

Another young man would mix up sugar in his urine and would complain of Diabetes.

I know a gentleman in the railways who had a quarrel with his superior officer which ended in a free fight. He sued for damages for loss of memory etc., but lost his case due to his foolish admission of dates.

Reports show in Europe that during war time lot of people would mix Koch's bacilli (Acid fast bacilli) in their sputum to avoid conscription. In private practice one has got to be very careful when such malingerers approach him, more so when his reputation and judgement are at stake by dishonest propaganda.

On the other side there are people who are neurotics or psychopaths simulating diseases or perversions without being in their interest to do so. Their troubles are the result of 'auto-suggestion' and are best treated by 'hetero-suggestion'.

Dr. Emile Sergent describes a condition as 'Mythomania' where a constitutional tendency to alteration of the truth to lying and simulation is the chief underlying character of the disease. The learned doctor classified the condition as Mythomania.

- (a) from vanity
- (b) from cupidity and
- (c) malignant or perverse mythomania.

Dr. Bidhan Ch Roy mentioned to us a case in our student days (1925-1926) where the girl thought that she has turned into glass and would break at any impact. Malignant Mytho-Maniac may slander even his or her own doctor and from Dr. Emile I will quote a case. Lieutenant de-la-Ronciere was tried in 1834 for misconduct. The daughter of his general who wanted to marry him sued him in court. Judges found him guilty and jailed him. It was in 1849 that the girl admitted her lie and Lt. Ronciere was restored to honour.

I have seen a case where a lady shammed paralysis of her lower limbs as her husband would not look at her.

As far back as 1926-27 we had a case in the Carmichael Medical College Hospitals where a gentleman who had served long term confinement in jail for subversive activities had a fixed idea that he had been harbouring a snake in his stomach.

Dr. Emile refers to a case where a person complained of incurable gastric troubles and was

treated in a hospital for long without any relief. His idea was that he had eaten a 'wormy apple' and his stomach was full of worms. X-Ray and various suggestions would not help him. The learned doctor actually had to show this patient worms in the stomach washings by an ingenious method of his to get a cure.

I would conclude with the following quotation:—"I would deliver up to the law Courts the sham invalids who knowingly and deliberately from motives of self interest simulate diseases from which they are not suffering."

As to the unfortunate Psychopaths, who quite often against their own interest simulate grave maladies, I would confine them to a good physician, who would set himself to restore the disturbed equilibrium of their minds" (Revue Des Deux Mores—Paris).

Ascariasis*

BY

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This is a very common disease in children in India. Sometimes and in some cases it puzzles the medical practitioners.

Ascariasis is a disease caused by a kind of worm called *Ascaris lumbricoides* which enters the human system by mouth and lodges in the intestine producing some local and toxic symptoms.

These round worms belong to the nematode group and inhabit chiefly in the intestine. The worm is elongated and bisexual. The length of the female worm is from 6 to 8 inches, sometimes it measures from 10 to 14 inches. It is reddish white in colour as soon as it comes out of the intestine but it gradually becomes white. The female lays eggs. It is said that each female worm discharges 160,000 eggs on an average at a time.

The eggs are oval or elliptical with a thick outer cell. The contents are granular and brownish yellow in colour and is surrounded by an albuminous sheath which is irregular or serrated. The whole egg is filled up when matured. The eggs are excreted with faeces.

Uncleanliness and the nasty habits are the predisposing causes of this disease. The infection is generally carried through the vegetables, flies and the individuals themselves. It is commonly believed that the children are the common victims of this disease, but the adults are infected also. The males and females are equally infected.

It is believed by some authors that the ascaris lays eggs in the intestine. The embryo then enters into the lung through the liver where the development stages are passed. They then pass through trachea, pharynx and oesophagus and to the intestine again.

If this theory is taken to be as correct it may cause obstruction to air passages or may cause perfo-

* Read in the A. I. L. A. Darbhanga Branch.

ration of the lung tissue causing severe haemoptysis. It may pass into the bile duct causing obstruction to the bile passage producing severe jaundice or may also pass into the gall bladder causing symptoms like gall stone. It may lodge in the liver causing hepatitis or liver abscess.

I personally know a case where a boy aged about 6 years, quite hale and healthy, returned in the evening to his home when he suddenly started haemoptysis. Eminent doctors were called in, no proper diagnosis could be made, no history of injury could be traced, the poor boy died after 3 or 4 hours. How could we account for this? This particular case, if pathological postmortem was done, could be diagnosed as ascarial haemoptysis.

Ascarial infection cannot be by passed as an ordinary thing. There are cases on record where the ascaris has caused perforation passing through gastro-duodenal ulcers, typhoid or dysenteric ulcers. The worms collect as ball like mass and cause obstruction to the intestine, producing symptoms like intestinal obstruction. In some cases it may cause symptoms like appendicitis in which case the worms pass into the appendix. It sometimes causes colitis also. In other words in diagnosing a case the medical practitioners, before giving final opinion, should always think of ascarial infection, specially in children.

The ascaris produces a form of toxin which has severe action on the human nervous system, but other systems are also affected. I give below some of the special symptoms which are commonly seen in patients infected with ascaris (I have classified these symptoms from my own practical experience).

1. *General*—There is loss of appetite, in some cases, there is canine hunger. The growth is diminished and also other mal-developments simulating rickets. General weakness is also marked. Watering of mouth is very common.

2. There may be skin rashes simulating urticarial rash.

3. *Lungs*—Chronic bronchitis and in some cases asthmatic symptoms are noticed.

4. *Circulatory*—The patient is anaemic. The extremities in some cases remain cold. Heart is also affected in some cases.

5. *Thermic*—There is high rise of temperature or there is remittent or intermitent temperature simulating enteric fever. There is hectic rise of temperature leading to the suspicion of T. B. Lung.

6. *Nervous*—Convulsions in smaller children are common but older children are also affected. There is vertigo, itching of nose and anus. Intestinal pain is common. In some cases neuritis is also noticed. There may be fits like hysteria or epilepsy, unconsciousness or coma, bad dreams, hallucinations, cutting of teeth during sleep. Night sweats are also common.

7. *Alimentary System*—Colitis, diarrhoea and vomiting in some cases simulating cholera are present. Dysentery is also common.

8. *Urinary*—There may be odema of legs and feet simulating Bright's disease. The ascarial

children generally pass urates in excess, sometimes phosphates also. In some very rare case anuria is also noticed.

9. *Eye*—In some cases there is dim vision and in very rare cases night blindness is noticed, which is mostly seen in ankylostomiasis.

10. *Blood*—There is pathological change in the blood also. The eosinophiles are largely increased.

The diagnosis of the disease is easy. There is practically no difficulty in diagnosing a clear cut case. The difficulty arises when the disease is a chronic one and simulates other diseases. It is needless to point out to you that where the case is misleading we should take the help of a laboratory before giving a final opinion and we shall then in 90% of cases be successful.

Treatment—The treatment of the disease is very easy. We all know that santonine, oil chenopodium, buteasemina etc., are effective but I want to remind you that in dealing with ascarial cases we must pay special attention the hygienic condition of the individual. The patient should be made to understand that the infection comes through flies, vegetables and nails of the patients themselves; so they should try to avoid these.

Diet—The diet of the patient should be plain, simple and nutritious. Sugar and sweets should be curtailed from the diet as far as possible.

Before closing this article I wish to put before you two of my cases treated by me which will interest you also.

1. While I was working as a Medical Officer of Raj Dispensary at Jhanjharpur I treated a very peculiar case of ascarial infection. I was called in to see a Hindu girl aged 11 years complaining of sudden watering of mouth, after which the patient became delirious. These symptoms lasted a few minutes and then she returned to normal state and resumed playing or moving as usual. I went and examined and asked about the previous history and duration of this illness. She was suffering from this disease since last two years. She had no history of injury of head or other symptoms excepting she had recently malarial infection. I examined her thoroughly and I found no other abnormality excepting enlargement of spleen. I enquired also about passing of round worms but I could not get any definite history. I gave her a dose of santonine. You will be surprised to know that this single dose of santonin perfectly relieved her from these symptoms. She was later on treated for Malaria and was ultimately declared cured.

2. Here is another case of mine, published in the *Antiseptic* of March Issue of 1942. A Mahomedan child aged ten years after taking his meal in the noon, started for a nearby field for playing. When he went half-way he suddenly fell down unconscious, froth began to dribble from his mouth and began to get convulsion and his whole body became like a ball as the party said. After sometime the convulsion subsided but the boy remained unconscious whole day. I was called in to see him in the evening.

I found the child unconscious and did not respond to call. I made thorough examination and found everything normal. I then enquired whether the boy had any fits like this before but the parent replied in the negative. I further enquired whether he passed any round worm or not. To this, they said that he vomited three living round worms three days back. This led me to diagnose this case to be of ascarial origin.

I prescribed santonin which was given to the boy who could swallow and after half an hour the boy regained consciousness. He passed a few worms next morning.



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