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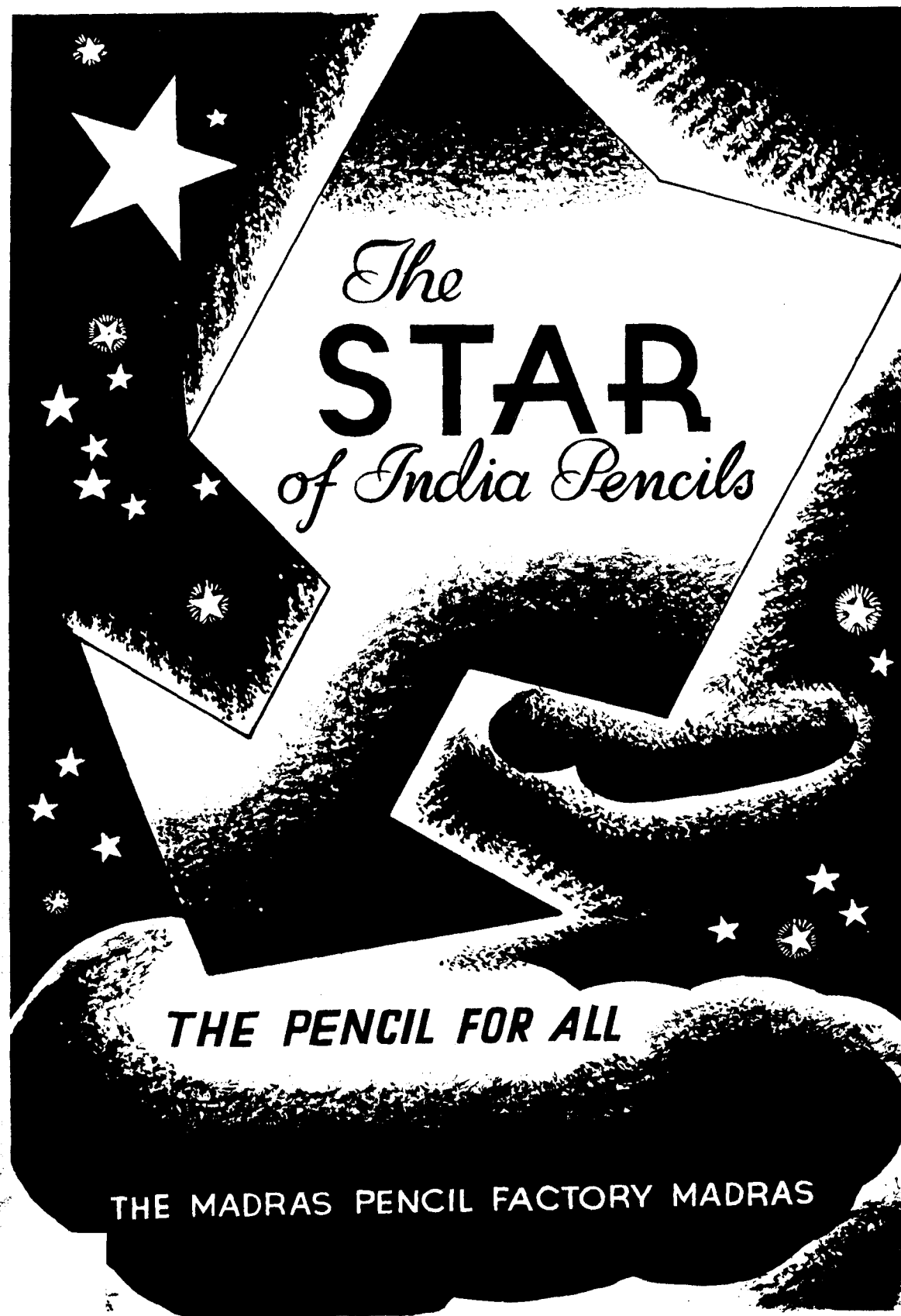
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341 PEOPLE'S HEALTH

VOL. III * EDITOR: A. V. RAMAN * NO. 1





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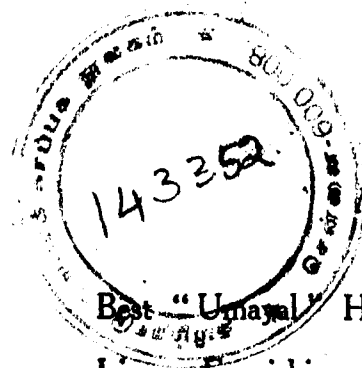
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PEOPLE'S HEALTH

A Pioneer in the Field of Public Health

Vol. III

OCTOBER, 1948

No. 1

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Our Master's Voice



VOL. III No. 1

OCTOBER, 1948

ISSUED MONTHLY

EDITORIAL . . .

For true reform in public health as in other matters, we must be content to labour and let others enter into our labours.

HEALTH OFFICERS' CONFERENCE

A Welcome Feature

The Health Officers of the Madras Public Health Department held a conference from 3rd to 5th October 1948. A welcome feature was that invitation was extended to us not only to attend the opening of the conference but also to participate in the discussions. This is the first time that non-official public opinion on health matters was associated with the proceedings of an official conference. We hope such co-operation would be enlisted in future conferences also.

THE DIRECTOR'S OPENING SPEECH

The Director of Public Health, Dr. R. M. Mathew, welcomed the health officers and the invitees in a short speech. He quoted figures of mortality from cholera to show that Madras

Presidency was not free from the epidemic even for a single year in the past 40 years. The Public Health department, notwithstanding the admittedly efficient organisation, had not been able to achieve anything in the direction of control of the epidemic. This is sad.

The Director of Public Health very properly appealed for the cooperation of the public and the Press in helping the department to carry on its stupendous task. As we have already pointed out in these columns, on another occasion, cooperation is a two-way passage. The public and the Press are equally entitled to ask the cooperation of the department in the larger public interest; but does it come? Last year we extended our hand of cooperation

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to the department to publish the proceedings of the last conference of Health Officers. The Director appreciated the offer but did not send copies of the proceedings for publication. At the moment, every one is in the dark as to the outcome of the discussions of the last year's conference; even the Minister had to refer to this in his address. Despite our repeated requests, the Director of Public Health has not been pleased to send us a copy of his opening speech nor a copy of the resolutions passed at the conference now held. Is this the way of cooperating with the Press and the public?

THE MADRAS PREMIER'S OPENING SPEECH

Sri Omandur Ramaswamy Reddiar, Premier of Madras, opened the conference in a well-written speech in English. He has very rightly stressed the necessity for a missionary spirit motivating the activities of the department; but the general trends of his speech indicate that his address would have been more appropriate to a conference of medical officers practising curative medicine. We would have greatly appreciated had he spoken out his mind in Tamil, in which language he is generally accustomed to speak effectively. He would then be able to pour out his heart in a most appealing manner. We would strongly commend to him to speak at such and

similar conferences in Tamil and speak out his own mind. It is then bound to grip the hearts of the hearers.

SRI A. B. SHETTY'S SPEECH

The Minister of Health, Madras, in an address to the Conference stressed that environmental sanitation which is the root of healthful living, should be given special attention. He also stressed the urgent necessity of opening training centres in public health engineering. From his speech, one can rightly infer that his heart is in his job; but the pity of it is that the Minister of Health occupies a weak position in the Cabinet. His well-meant efforts are strangled by his colleagues, who would not extend to him that measure of support and cooperation which is required for furthering the health of the people. When the Premier has so well recognised the pre-eminence of health improvement for the people why is it that the position of the Minister of Health in the Cabinet is so weak?

The need for the provision of drinking water to the people is recognised at all hands. The plea of want of any programme could not be put forward any more. The Special Committee, appointed by the Ministry on the Water Supply and Drainage problems of the Province, has placed its report at the disposal of Government quite a long time ago. We are told that

the report is still under the consideration of Government. If the Minister of Health is permitted to hold a strong position in the Cabinet, he would have successfully persuaded his colleagues to permit him to proceed with the implementation of the recommendations of the Committee. The truth of the matter appears to be that the Ministry renders but lip-service to ameliorate the living conditions of the masses. They do not mean business at all.

Prohibition has been introduced in the Province notwithstanding the far-sighted advice tendered to them by friends, to move slowly. The members of the Legislature who forced the hands of the Ministry were more keen to get a notoriety for the Province for having introduced total prohibition in the country for the first time rather than look beyond their nose. Why the members of the Legislature, who forced total prohibition in the Province, keep silent on the provision of drinking water-supply to the people, passes one's understanding. Perhaps, we cannot expect better from members of our Legislature. It is time public opinion mobilises itself and demands from the Ministry the prime necessities of safe water, clean surroundings and better living conditions in every village. The electorate must throw out any Ministry which does not cater to the elemental needs of the

common man. Let the adults who have been recently enumerated remember this when they exercise their franchise on the next occasion!

FINANCE: THE STUMBLING BLOCK

At every turn and on every conceivable occasion the plea of paucity of funds has been put forward as an excuse for repeated postponement of the measures calculated to promote the health of the people. The Prime Minister of India has told us that when enormous funds are made readily available for war against nations or countries, necessary funds ought to be made available for the war against disease.

Statutorily, the local bodies are compelled to earmark a certain percentage of their income to be spent on public health. Why should not the Government themselves so earmark a percentage of their revenues for promoting the nation's health?

It is curious that the Finance Minister was absent at the conference. Had he attended it, he would have possibly understood the realities of the situation. The Finance Minister should realise that, without health, no progress is possible either in Agriculture or in Industries or in any other field, not excluding Education. The Cabinet should be conscious that the lot of the villager could be improved only by better health services and amenities and that every other item of

governmental activity depends on maintaining the health and efficiency of our people at a high level. The first act of every popular Ministry should be to allocate ample funds for health development and implement a planned programme.

A PUZZLE

The Surgeon-General was present on the opening day. He was not present on the subsequent days, when specific subjects were discussed. Apparently, he was not invited to be present and give the benefit of his experience to the conference. The Medical Curative department is in charge of Tuberculosis, Leprosy, training of personnel, isolation hospitals and the like. The Surgeon-General is now recognised to be the highest technical authority in all matters relating to the health of the people. He should have been therefore invited to be present throughout the conference and take active part in its deliberations. Why was this not done?

Further, when the subject of the amalgamation of the Curative and Preventive side was raised in the opening speech of the Director of Public Health, a discussion should have centred round this point and a decision reached, at the conference. But the subject was not in the agenda at all! It would appear that the Director of Public Health has made

out a strong case to Government that such amalgamation should take place without any further loss of time. It would also appear that his recommendations were made direct to the Ministry, and not through the Surgeon-General, who should have been given an opportunity to have his say. We have repeatedly urged that the amalgamation of the two branches of the Medical profession should not be put off any longer. With the example of the Central Government, United Provinces and West Bengal before them, and with the resolution of the first conference of Health Ministers to back them, we fail to see why the amalgamation has not yet been effected in our Province. Our Minister of Health, in spite of his well-meant efforts, has not yet made his mark in the 18 months of his office. If only he acts forthwith and implements this one resolution of the Health Ministers' conference, his name would go down as the Minister who reformed the Health organisation in the best organised Province in India.

The presence of the Surgeon-General at the conference would have also helped to consider the desirability of prohibiting private practice of the Government medical officers. It is this additional advantage which is responsible for the medical men crowding the curative side of the profession and fighting shy of the preventive

side. The Minister of Health deplored this in his address. The remedy lies in his hands which has been considerably strengthened by the resolution of the Health Ministers' Conference held in August 1948. Will he act boldly for once and not truck to vested interests?

PUBLIC CLEANSING AND HEALTH OFFICERS

It is sad to reflect that the Public Health (Medical) department should persist in clinging to conservancy notwithstanding their incapacity to do justice to the work. What is the contribution of the Public Health (Medical) department to this subject? It is essentially an engineering problem and it should have been entrusted to engineers. The absence of public health engineers is put forward as an excuse for the Medical Public Health department continuing to be in charge of conservancy. What is styled as Municipal Engineering in this country is really public health engineering. In municipalities where engineers are employed, why should not conservancy be transferred to them? The Ministry should no longer vacillate as to what decision should be taken on this subject. There is absolutely no justification for entrusting public cleansing to medical officers of health. The argument which might be advanced that public cleansing has a direct

relationship to the health of the people may be advanced with greater force in support of the medical officers of health being in direct charge of water-supply and drainage, housing and town-planning and rest of it all. It is a pity the conference was rather halting and half-hearted on this subject. The transfer need not await the training of public health engineers. Even an engineer, ill-trained in public health engineering as such, will any day better handle cleansing than a well-trained Public Health (Medical) expert. The Health Officers do not seem to realise that their training as medical men first and thereafter as public health specialists lie altogether in a different and far wider field of work. Surely they have not so forgotten their profession or so ignorant of modern trends in public health development that they should still cling to the latrine and the dung heap!

WHY NO SCIENTIFIC SUBJECTS DISCUSSED?

As we have pointed out that in such conferences the most important feature should be discussions on the latest scientific developments pertaining to the health of the people. It is indeed sad that no subject of scientific importance was brought up for discussion. The public are entitled to ask whether these scientific experts have forgotten all about the profession

for which they have been specially trained.

Public Health Education and Propaganda

It would appear that the Director of Public Health, Madras, has put forward proposals to Government for permission to publish a monthly bulletin giving the so-called statistics of births and deaths, and in addition to publish extracts from current literature on the lines of the American Public Health reports. These statistics are published in the *Fort St. George Gazette*. If the intention is that these figures should go down to Health Inspectors, nothing is easier than supplying the staff with reprints of the statistics sheet of the *Fort St. George Gazette*. Why another "bulletin"?

As regard the current literature, there is nothing to indicate that the officers are in touch with it at all! If they are following the current trends, nothing would have been easier than taking extracts subject-wise and circulating the extracts to the officers of the department. The distribution of professional circulars is a recognised method of keeping the field officers uptodate in their knowledge of the several subjects. The correct method is to print professional circulars for the guidance of the members of the department who may not have access to them. When a circular on a parti-

cular subject becomes out of date, it should be replaced with a new one giving uptodate knowledge. This is the manner in which the field officers' knowledge should be kept uptodate. Why have recourse to periodical bulletins passes our comprehension. A resolution passed on the subject favouring the publication of a periodical bulletin cannot be considered to represent the view of the conference as a whole.

The incapacity of the department to write uptodate articles would be evident from the fact that not a single article by the officers of the department had been furnished to the *Madras Information* in compliance with the orders of Government in this behalf. Nor have the officers of the department been conspicuous by their contributions to the existing medical and public health journals. Either they are bankrupt in professional experience worth-writing about, or they are incapable of reducing their experience and findings to the form of a readable, scientific article.

WHO SHOULD PRESIDE?

In conferences of this nature it is undesirable for the Head of the Department to preside and lead the conference by its nose. It does not give freedom to the Health Officers attending it to express themselves freely and frankly without fear or favour. The Health Officers should be at liberty to elect their own President.

There has been ample evidence to show that they had to put their seal of approval to resolutions sponsored under the direction of the Director. No one dare raise a dissentient voice when the Director himself has given the lead. After all, no Health Officer would like to prejudice his prospects in service by opposing the Head of the Department at an open conference.

PREVENTION IS BETTER THAN CURE: PRACTISE IT PLEASE

To combat the threatening epidemic of cholera in the city of Madras, the Corporation had been given special powers under the Public Health Act.

The other day, at the Health Officers' conference in the city, wholesale mass inoculation of millions of people during the last epidemic of cholera in Egypt was referred to. We do not consider it impossible to repeat a similar performance in our country. We are of the opinion that all medical personnel, private or governmental, should be mobilised to carry through the campaign of mass inoculation. It should be made clear that the rations will not be distributed to the holders of the ration cards unless those cards bear a certificate to the effect that the members referred to in them, had been inoculated by a specific date.

The medical profession had been shedding tears over the miseries of

mankind. It claims to have come into existence to render a humanitarian service. Here is an acid test whether it really means what it had been professing. Without remuneration of any kind, it should undertake to inoculate as many people as possible within a specific date. Those medical men who fail to discharge this public duty should be black-listed. We do hope and pray that the authorities will have the cooperation of one and all.

But then, our administrations believe in compartmentalism also in addition to communalism. The curative medical department is dissociated from the preventive. This exclusion is at times so rigorous as to verge on non-cooperation. The authorities can ensure cooperation by one measure only—and that is by amalgamating the two departments giving the preventive side its proper place. The United Provinces and West Bengal have done it and they are all the better for it. They have no difficulty in getting the curative personnel practise preventive medicine. The Government of India have amalgamated the two branches of the medical profession under the Director-General of Health Services. We fail to see why they are unable to persuade all the other Provincial Governments also to effect this much-needed reform—a reform so strongly advocated by the Bhole Committee.

GREAT PUBLIC SATISFACTION : A MESSAGE



by

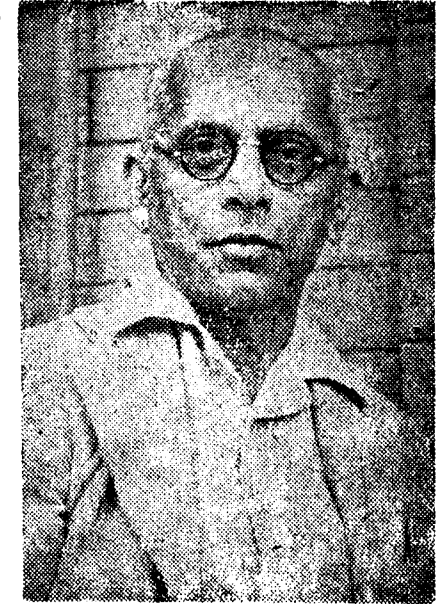
N. Gopalaswami Ayyangar

Minister of Transport, Government of India.

It is a matter for great public satisfaction that the "PEOPLE'S HEALTH" has completed two years of very useful work in the cause of the people. I send my greetings to the first Number of the 3rd volume and wish it a long career of even greater usefulness. The matter it has purveyed to its readers has been both reliable and well-written. Its get up was bright when it started ; it has grown brighter and brighter with every issue. There is no gainsaying the fact that a well conducted journal of this description supplies a want which we cannot afford to ignore.

Mr. Raman, the Editor, is extraordinarily well-informed and well-equipped on all subjects which can be dealt with in "PEOPLE'S HEALTH". He is an enthusiast and is consumed with passion for promoting the public good ; and he does whatever work he undertakes in a clean manner and without fear or favour. I trust, in this self-imposed task of his, he will receive, both from Government and the public, a fuller measure of support than he has received, so far.

ADDRESS at the HEALTH OFFICERS' CONFERENCE



by

A. B. Shetty

Minister of Health, Madras.

A MESSAGE TO "People's Health"

I am glad your magazine will enter upon the third year of its life with the next October issue. The valuable articles appearing in it have done good service in spreading health education among the people. You have been unsparing in your comments and criticisms about men and matters. Anything said with good intentions and without personal malice will surely whip up all health workers and make them alert and active in performing their duties. Your determination to carry on your journalistic work in spite of the pecuniary loss and other difficulties you have to face is commendable.

With best wishes for continued success in your work.

Fort St. George,
22nd Sept. 1948.

A.B. Shetty

I am glad this conference has given us an opportunity of meeting so many of the Health Officers who have come here from all parts of this province. Early last year you had a similar conference. I would like to know what has been achieved as the result of it. It is desirable that we should periodically meet and consider what lines of further progress we could take up in the future. War has given a great impetus to the progress of medical science. Surgery has learned much on the battlefield. The new discoveries of medicine have been applied with great success in combating various forms of infections and diseases. D.D.T., for instance,

has done much to control malaria, filariasis and other tropical diseases. The triumphs of medicine and surgery have attracted notable attention. Though there has been a great deal of progress in the sphere of preventive medicine and remarkable results have been achieved in improving public health, there is not sufficient public appreciation of the importance of the preventive aspects of medicine. Service in the Public Health Department does not attract the best men in the medical profession. They prefer clinical work which pays them better. The physician who helps a patient to get over an attack of cholera or typhoid fever is regarded as a great benefactor. The prevention or control of any major epidemic disease which might have involved thousands of lives must surely be regarded as a greater achievement. Great emphasis is laid today on preventive medicine. The field of preventive medicine is everyday growing larger and there has emerged from it the newer conception of "Social Medicine". It seeks to study patients as human beings, their lives, home surroundings and social backgrounds which affect in many ways their health, efficiency and happiness. The improvement of environmental hygiene leading to healthy living conditions and the improvement of nutrition have contributed in recent years to raise the standard of public health to a high level of excellence in several western countries. There has been a tremendous fall in those places in infantile and general death rates and an increased life expectancy during the last few decades. A dramatic reduction has taken place in illness and deaths due to infectious diseases which affect principally the young. The greatest achievement of modern medicine is said to be its understanding of the nature of infectious diseases. The measures adopted by health workers for the prevention and control of infectious diseases have led to the practical elimination of cholera, typhoid fever and several other communicable

diseases in many European and American countries. We cannot point to any such continuous record of improvement in our country's health during this century. A large part of the effort put forth by our health staff is directed towards epidemic control. Yet we continue to have periodic waves of the epidemics of cholera, plague and small-pox. The spectacular manner in which these major epidemics sweep over the land attracts considerable attention as is evident from the number of questions frequently asked in the Legislative Assembly and the articles and comments appearing in the press. Several other communicable diseases such as tuberculosis, leprosy, filariasis, guinea worm, etc., have become a growing menace to the health of our people. Malaria is an ever-present problem found all over the land.

Much of the sickness in our country is preventable. Here, as elsewhere, an overwhelming majority of the diseases are due directly or indirectly to the lack of the elementary requirements of health, namely, proper food, safe water supplies, suitable housing and efficient sanitation. These essential conditions of healthy living are wanting in our villages and towns. There is nothing surprising, therefore, if epidemics frequently occur among ill-nourished people living in unhygienic conditions. The first world-war was followed, as you know, by a great epidemic of Influenza with all its respiratory complications. The second world war has brought many major social disasters and among these the rise in the incidence of Tuberculosis in Europe stands out prominently. The evil effects of this source of infection in the midst of the under-nourished, ill-clad and badly housed population of Central Europe and the steps needed to meet this disaster have become matters for anxious consideration to the United Nations Health Organisation. With food deficit and the present overcrowding of dwellings due to the increased population in our towns, we too,

are faced at present with new dangers to the health of our people. We are a century behind the times in our public health outlook and sanitary arrangements. Problems of housing, of food, of water-supply and drainage and of conservancy are awaiting to be tackled on modern lines. These public health services have to be built almost from their foundations in our country. Though the Public Health organisation is better developed in this province compared with the other provinces, the health staff we have been able to provide is too inadequate to meet the needs of the situation. We have yet to start a public health engineering service for dealing with water supply and drainage schemes which have to be put in the forefront of our health programme. The local bodies are handicapped by want of funds in the performance of the health duties entrusted to them. The financial resources of the Government also are limited.

We cannot afford to wait till we are able to implement our post-war schemes of development. We have to make the best of a bad situation with the limited resources available to us in men, money and materials. The District Health Officers have a wide jurisdiction and they are saddled with duties of varied nature. The number of Health Inspectors working under you is too small to provide adequate service to the large populations entrusted to their charge. Much of their time is taken up in vaccination verification work and in epidemic control work. The health staff must be able to do more of other constructive work that can be better appreciated by the people. With a little longer and better training our Health Inspectors and Vaccinators can turn out more efficient and useful work. The intensive course of 6 months' training now provided to enable the existing second-class vaccinators to qualify as sanitary inspectors may help us to carry out this idea. A revised syllabus has been drawn up for the Sanitary Inspectors' course also. The Director of Public

Health has suggested the amalgamation of the Health Inspectors and I Class Vaccinators into one service and the division of the Health Inspector's range into four circles, one of which is to be in charge of the Health Inspector and the other three in charge of Vaccinators who are to do all health work in addition to vaccination work. It has been recommended that vaccinators should be designated as 'Health Assistants' and given revised scales of pay. These proposals may be discussed at this conference. It is worthwhile considering whether this class of health workers can be trained to render first aid in accidents and to treat minor ailments in villages where no better medical aid is available. I think it is not necessary that Health Officers should go through the same course of studies as is laid down for physicians and surgeons and then have an additional year of study. Your period of training can be shortened and your curriculum needs revision. You can give consideration to this matter and make proposals to the concerned authorities. The difficulties experienced by you in carrying out the provisions of the Public Health Act can be discussed by you and the amendments required in it may be suggested. In any plan for improving the health of the community, the highest priority has to be given to the provision of pure drinking water. You are expected to take particular interest in helping the successful carrying out of the Rural Water Supply scheme. The Maternity and Child Welfare work is another health service, the development of which deserves your special attention. We shall have to tackle the problem of training a larger number of midwives, health visitors and women medical officers who are required for taking charge of maternity and child welfare work. You and your health staff must take every opportunity to impress upon the people that their physical welfare depends above all upon the houses and surroundings in which they live, the food they

eat and the water they drink. Your attention must be directed primarily to these pre-requisites of healthy living. You must see that at least a few people in a village build model cottages with sufficient light and air, keep their surroundings in a sanitary condition, put up good latrines and keep their drinking water wells free from contamination. Examples of this sort will have much better effect than mere exhortation and advice. It is necessary that your health staff should acquire the newer knowledge of nutrition so that they may educate the people in the choice of food and in the safeguarding of articles of food and drink from adulteration and contamination.

It is a common sight to see people answering the calls of nature on the side of roads and lanes and on the banks of streams and rivers. The sales of eatables on the roadside exposed to dust and flies are also frequently seen. You will have to put down such unhealthy habits and practices by enforcing the legal provisions in the Public Health Act. Provision of sanitary conveniences in sufficient number is very essential. Septic tank or water-borne types of latrines are not found at present even in many of the Government and public buildings, theatres, schools, hospitals and travellers bungalows. I am interested to know that the District Health Officer of Salem will put before you a simple and cheap design of latrine which does not require daily attention. The Food Minister of the Central Government has drawn attention at the Agmark Ghee Conference at New Delhi last month to the wide practice of the adulteration of ghee and the inadequacy of the steps taken at present to put down this evil. It is proposed to amend our Food Adulteration Act with a view to raise the penalty for offences against its provision. The proposal to set up regional laboratories with a view to extend facilities for water and food analysis and for diagnostic investigation of communicable diseases is awaiting implementation.

If our bigger municipalities could follow the examples of Madras and Madura, and establish their own public health laboratories, it would be a great help. By exercising proper control over contamination of water supplies and the adulteration of foodstuffs, valuable preventive work can be done. Stricter supervision over hotels, sweetmeat shops, bakeries and aerated water factories, more frequent inspection of rice mills and closer watch over the quality of milk, ghee and oil supplied to the people has been enjoined on you by the Director of Public Health in a recent circular. These instructions should be faithfully carried out by the health staff to the extent possible.

A considerable amount of ill-health is due to sheer ignorance. Vastly extended and improved education in matters of health is one of the most important tasks facing those concerned with preventive medicine. This education in health should be given not only to the children in schools but to all age groups and by every vehicle available to us at present such as press, the radio, the movies, etc. The celebration of "Health Weeks" will help to develop the health consciousness and promote formation of health habits. Exhibitions should be arranged as frequently as possible at fairs and festivals. Let people see models of sanitary wells, improved types of latrines and demonstrations in spraying for destruction of mosquitoes.

The Health Officers have been told that they should not confine themselves to routine work, that each officer should study the health problems peculiar to his area and interest himself in some particular kind of work which would be of most benefit to the people of the locality. It may be anti-malarial work in one place, the eradication of guinea-worm disease in another, the prevention of the spread of leprosy in a third place or something else in other places. The Health Officers are required to send a periodical report of the progress made in carrying

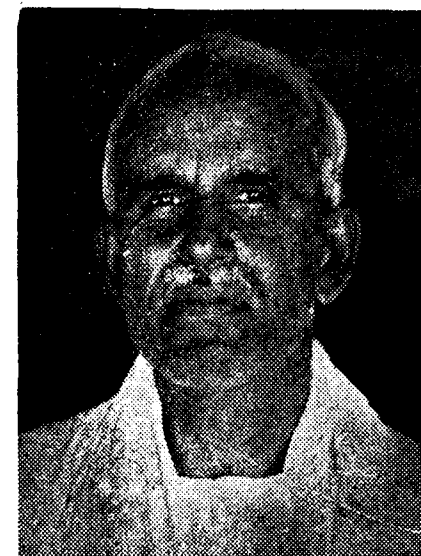
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CONFERENCE OF MADRAS PROVINCIAL PUBLIC HEALTH WORKERS OPENING ADDRESS

by

O. P. Ramaswamy Reddiar

Premier, Madras.

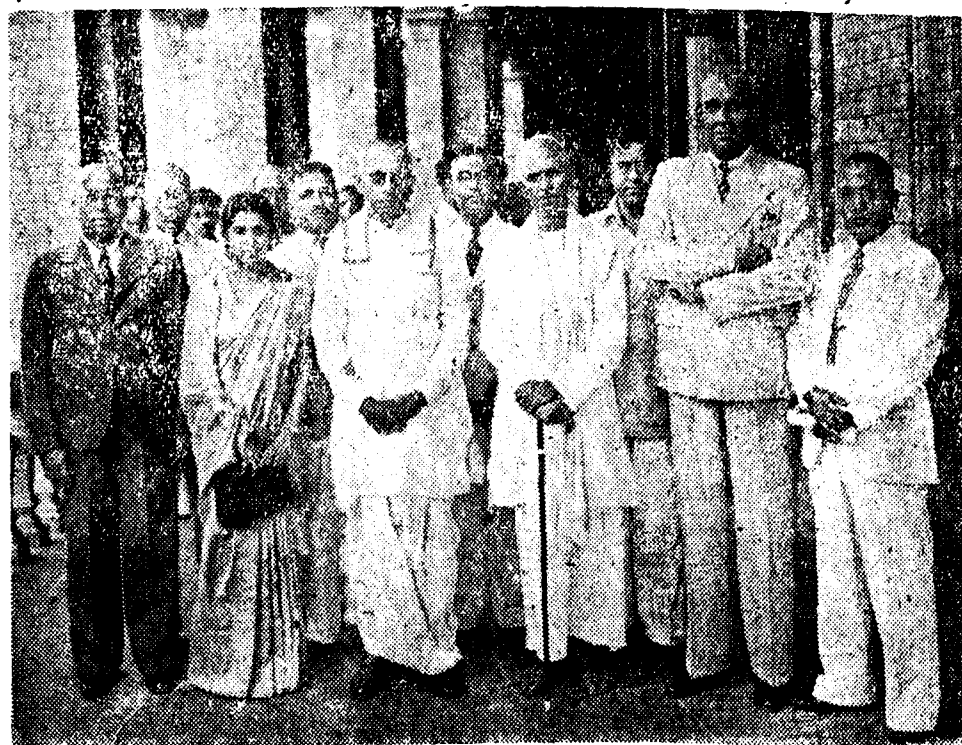


I have great pleasure in inaugurating this Conference of Public Health Workers; for I consider them as guardians of people's health, and therefore of their wealth and welfare.

Public Health Workers everywhere have a heavy responsibility to discharge. The human body is an exquisite and wonderful handiwork of God. It may be perishable as dust, and chemically as carbon; but pulsating life concerns itself with it and the Divine Spirit chooses to dwell within. It is a glorious harp and to the extent we keep it properly tuned will it be able to strike rhapsodies of piety and selfless service to humanity. The Public Health Worker has the responsibility to see not merely that the single individual body, but the entire community is kept in good health. The range of his interests and responsibilities therefore naturally extend over a vast field. They are personal as well as environmental; preventive as well as curative; and he has to be a specialist as well as a "basic" doctor. Improvement of drainage and sewerage, provision of adequate and satisfactory water supplies, scavenging, isolation of cases of infectious diseases, disinfection of premises, supervision of contacts, careful in-

vestigation of possible sources of infection, port sanitary controls, supervision of housing conditions, clearance of slum areas, provision of open spaces and cleaner atmosphere, analysis of foodstuffs, research on nutrition and dietetics, supervision of production and distribution of milk, elimination of tuberculosis from dairy cattle, control of slaughtering and inspection of meat and vegetables, inspection of premises used for storage of food, maternity and child welfare, and a hundred other activities connected with preservation of young life and old come under this scope.

If the range of duties of the Public Health Worker is wide and his responsibilities onerous in any country, they are much more so in India. I should say they are formidable and colossal. We have the highest death rate, and the lowest average expectation of life among civilised countries. Consequent on the disintegration that came in the wake of a transition from the rural to urban economy, from handicraft production to machinery, the continuous drift from villages to cities due to agriculture becoming unremunerative, and the pernicious habit of drink spreading as a result of a thoughtless excise



FRONT ROW—Left to right:

Dr. A. Lakshminarayana, Dr. (Miss) H. M. Raja Manickam, Mr. A. B. Shetty, Minister of Health, Mr. O. P. Ramaswamy Reddiar, Premier, Madras, Dr. R. M. Mathew, Dir. of Public Health, Dr. R. Subramaniam.

SECOND ROW:

Doctors K. K. Shenoy, Anantam Pillai, K. P. Thomas, and K. S. Visvanathan.

policy—consequent on all these, malnutrition, disease, vice and crime are stalking the countryside. Infant mortality is the highest in the world. Nearly half the total deaths are among children under 10 and of these, one-half takes place within the first twelve months of a child's life. 100 millions suffer from malaria and about 2 million die every year of it. 2.5 millions have tuberculosis and half a million die of it. Infectious diseases play havoc with the lives of the people and endemic diseases such as leprosy, filariasis, guinea-worm and hook-worm result in unparalleled morbidity, if not mortality; and Madras has a proper share in the all-India incidence in all these matters.

Besides these maladjustments, personal and environmental, Public Health Workers in the Province have to fight against two other evils, namely, ignorance and superstition on the one hand and selfishness and vested interests on the other. The success of a Public Health Service, as you are aware, depends more than in anything else on an enlightened and widespread public health education; and this education must be related to the basic life and practices of the people. It must begin at home; in the cradle, and extend to the school and college and touch every aspect of our being and living. Such an education we did have in the past. It was interwoven and co-extensive with life itself. Manu's

precept and practice in the daily routine of life, which, through religion attained compelling sanction, would on analysis be found simple and effortless expedients to fight the innumerable air-borne and water-borne diseases with which Nature returns to Man's charge. The cow-dung and the cow-urine were the most easily accessible and universally powerful germicidal products known to the Indian housewife and the cow became the object of veneration. The prevention of water courses from pollution was the surest way of warding off diseases; and water came to be worshipped as Goddess Ganga. In our latter day decadence no doubt a thick mist of ignorance and superstition came to envelop the inner meaning and significance of many of these ancient practices. A great work therefore lies ahead of the workers in the field of Public Health not only to educate, but to re-educate the large masses of people in the correct principles of hygiene and sanitation. As modern life becomes more and more complicated, diseases spread through myriad sources of infection, of whom the dhobi, the barber and the hotel are perhaps the most potent agencies. To cope up with this, modern Public Health Service has to be thorough and pervasive.

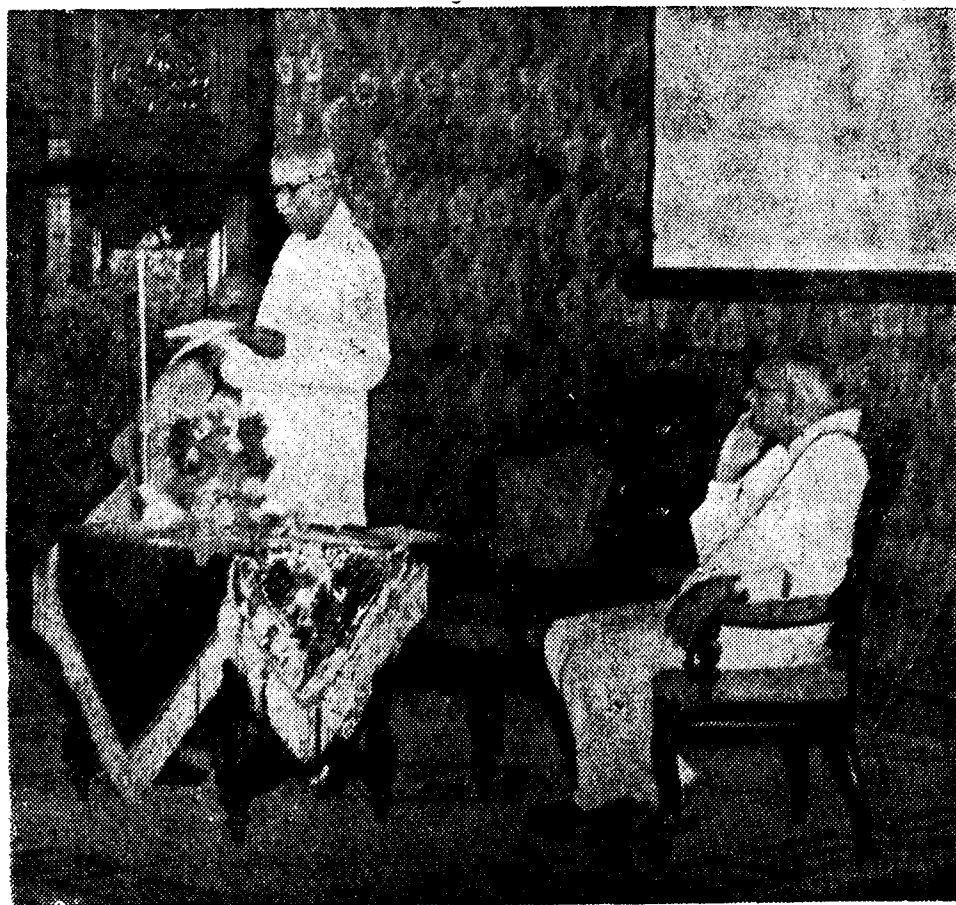
All these make their work appear almost an uphill task; but there is nothing to despair of. Fortunately in our Province, we have an enlightened public opinion. The medical profession is greatly respected; and above all, the standard of public service in our local bodies, allowing for a few aberrations, here and there, is fairly high. Added to that is a fact that ours is the only Province where it has been statutorily laid down that every municipality shall earmark not less than 30 per cent of its income from all sources other than Government grants for expenditure on the advancement of Public Health in its local area, including expenditure of medical relief, and every district board or panchayat shall similarly earmark not

less than 12½ per cent of its income from such sources.

I would, on this occasion, like to make a few frank, but friendly, observations direct to the men of the medical profession, without which I feel my address today will have been in vain. I referred to the almost universal respect with which the profession is held in this country today. It is largely due to your own work and you richly deserve it. At the same time, an impartial observer of social affairs cannot fail to take note of certain tendencies which mar the ideals of your noble calling. I refer to the attitude certain men of western medicine in this country adopt towards the indigenous system. The New Learning, unfortunately, has brought with it a certain amount of dogmatism, and with it an intolerance of the theories and practices other than their own. Genuine science should teach us humility and make us remember that what we have learnt is but a handful, and a whole sea of knowledge lies unexplored; that wisdom often cries out in the streets and the true scientist should be prepared to read sermon in stones and books in running brooks.

It is sad to find therefore that the Bhoze Committee report is divided on the subject of recognition to be given to the indigenous systems and cite for their purpose the examples of China, Japan and Russia who have banned the practice of indigenous systems. I do not claim to know anything about the indigenous systems of Chinese, Japanese and Russian Schools of medicine; but I can say this much of our Indian system that what is today practised as the western science of medicine has its origins in India from where it travelled to Arabia, Persia, Greece, Spain, and Western Europe and has now come back to us in a new garb and with a new jargon. I have no less an authority than Lord Ampthill to support me.

The records of Hindu medicine begin with the Atharva Veda; appended to Atharva Veda



Mr. O. P. Ramaswami Reddiar addresses the conference; Mr. A. B. Shetty is seated.

is the Ayur Veda or the science of Longevity. The Rig Veda mentions over a thousand medicinal herbs, and more significant than all these is the fact that physicians and surgeons were differentiated from magic doctors, and were living in surroundings surrounded by gardens in which they cultivated medicinal plants. Atreya anticipated Weisman by 2,400 years and held that parental seed is independent of parent's body, and contains in itself in miniature the whole parental organism. Dhanwantri, Sushruta, Charaka, Vagbhata, Bhava Misra are names to conjure with in any scientific system of medicine. The latter in his voluminous work on anatomy, physiology and medicine

anticipated by a hundred years Harvey's theory of circulation of blood and prescribed mercury for the then novel disease, syphilis. Nor was it all merely empirical and confined to the field of medicine. Surgery was also highly developed. Sushruta describes many surgical operations, cataract, hernia, lithotomy, Caesarian section etc., and 121 surgical instruments including lancets, sounds, forceps, catheters and rectal and vaginal speculums. He advocated the dissection of the dead against all religious scruples. He was the first to graft upon a torn ear portions of skin taken from another part of the body and thus laid the foundations for the modern Rhinoplasty. Almost every major

operation except the ligation of the arteries was performed. Limbs were amputated, abdominal sections were performed, fractures were set, hemorrhoids and fistulas were removed. Elaborate rules were laid down for preparing an operation, and Sushruta's suggestion that the wound be sterilised by fumigation is one of the earliest known efforts at anti-septic surgery. Both Sushruta and Charaka mention the use of medicinal liquors to produce insensibility to pain. In the 10th century A.D. two surgeons trepanned the skull of a Hindu King, and made him insensitive to the operation by administering a drug called *Samohini*. Diagnosis by inspection, palpitation and auscultation was widely practised; so was also taking of the pulse and urine analysis. Vaccination was known to Dhanwantari in the 6th century A.D. Many of the laws of sanitation by Sushruta and the Dharma Sastras are based on the germ theory of disease. Hypno-therapy, hydro-therapy and naturo-pathy were also known. Yuan Chwang who visited India records that Hindu medical treatment began with a seven-day fast; in this interval the patient often recovered; if the illness continued, drugs were at last employed. Even then drugs were sparingly used; reliance was placed upon diet, baths, enemas, inhalations, urethral and vaginal injections, and blood-lettings by leeches or cups. In the art of concocting antidotes for poison, the Hindu system stands unrivalled even today. To the many of the so-called incurable diseases, the indigenous systems have powerful and almost certain cures. An almost parallel development has taken place at many points in the Siddha system of medicine in the South.

I have recounted to you at length the achievements of what I might call, the Hindu system of medicine, not with a view to patting ourselves on our backs, which no doubt is legitimate on certain occasions, but to show how surprisingly modern are some of the theories and practices

of our ancient systems. No doubt latterly the indigenous medical science and practice have become moribund and quacks have abounded like weeds covering the green corn; but it is for men of science like you to separate the grain from the chaff and bring to light all that is best in our systems, instead of pooh-poohing the entire body of knowledge that has come to us from the days of our ancient Rishis. If you men of science do not do this, no State, whatever recognition it gives, may be able to do it. There is no conflict, there need be no rivalry between the ancient and modern systems of medicine. If only you wish, you can attempt at a synthesis of the two, where the one would be a complement to the other; and in doing so you may even arrive at medical marvels that may well prove India's distinct contribution to modern medicine. The problem of medical relief in our country is so colossal, and our financial and technical resources so meagre that without such a synthesis, I fail to see how we can effectively organise any satisfactory system of Public Health Service within a reasonable point of time.

If you bear with me for a few more minutes, I will have one more point made—a point which I am never tired of repeating at conferences after conferences; and that is, the spirit of service that should animate your profession. The art of healing is the noblest of all callings, and many men in history who have been the "ministering angels" to the sick and the suffering are revered as saints all over the world; but all that is so, precisely because service was the dominating passion; money a secondary thought. You have all taken the oath of Hippocrates, who has been hailed as the Father of Medicine; but I should say there is an even more pregnant passage in Charaka's *Samhita*: "Not for self, not for the fulfilment of any earthly desire of gain, but solely for the good of suffering humanity should you treat your patients and so excel all".



BOTTOM ROW—Left to right:

Mr. R. D. Paul, Secy. to Govt., Local Admn. Dept., Mr. K. M. Unnithan, Inspector of Municipalities and Local Boards. Mr. A. B. Shetty, Minister of Health, Madras.

SECOND ROW:

Mr. A. V. Raman, Editor, "People's Health", Mr. O. P. Ramaswami Reddiar, Premier, Madras, Lt. Col. S. L. Bhatia, Surgeon-General with the Govt. of Madras.

The way our present health service is organised is no doubt partly responsible for subordinating the service aspect to the money aspect. In Sweden, I am told on reliable authority, doctors are paid not on the basis of number of patients they cure, but on the number of people whom they prevent from falling a victim to disease. The doctor is paid a reasonable salary, irrespective of the number of patients he treats. In England, according to the latest scheme of National Health Service introduced by Mr. Bevan, medical benefit is given to all, irrespective of their ability to pay; and I understand the same is the case in Russia. I do not know how many years it would take us to organise a

Public Health Service based on prevention rather than cure and provision of medical benefit to one and all regardless of payment. Ours is a poor country; the rural masses are steeped in crushing poverty and it behoves our medical men to practise their profession with patience, generosity and a patriotic urge.

I hope my appeal to you, men of science, will not go in vain. The times are out of joint. The food crisis has brought with it many problems that may well tax all your qualities of head and heart. Great work confronts you in the preventive sphere regarding dietics and nutrition. Nutritional diseases are as much a result of inadequate rations as of incorrect diet habits.

(Continued on page 23)

PREFABRICATION

by

L. M. Chitale,

F.R.I.B.A., F.I.A.A., A.M.T.P.I.



The decision of the Government of India to set up factories for mass production of Prefabricated houses would be welcomed as a measure affording quick relief in respect of the acute housing shortage in this country which is further aggravated by the influx of large numbers of refugees into the cities.

From the announcement, it would appear that Dr. Koenigsberger, Director of Housing and Chief Architect to the Ministry of Health, Government of India, has been commissioned for this job. The proposal seems to be to set up 3 factories, one in Delhi to start with, 2nd in Bihar and 3rd in Bombay or Cutch to follow, with capacity to manufacturing about 5,500 houses per annum in each of these factories. Each house is supposed to have 500 s.ft. plinth area costing about Rs. 2,500. This proposal would appear to be very encouraging but it needs further scrutiny in the interest of economy and health.

Prefabricated houses on a mass scale would accelerate the progress of housing. But to maintain economy and easy operations, and maintenance, prefabricated houses built to suit Indian conditions and with local materials would be essential. Prefabricated houses planned and

constructed on western models and standards and with foreign materials would not be suitable to India under the tropical climatic and social conditions which are varied. Prefabs are not likely to be a success in this country.

The idea of prefabricated houses was born in U.S.A. for economic reasons during the First World War. Prefabricated houses are a type of houses which are fabricated in workshops and brought to site to assemble. Factory production rate is roughly one house every 12 minutes. Complete erection needs 30 to 40 man hours. There are over 250 concerns in U.S.A. in the field of commercial prefabrication. Publicity and campaigns were tremendous. In Great Britain people were very much in opposition to prefabricated houses. Great Britain wholly depending upon outside supplies and her problems of slums and acute shortage of housing mainly due to the terrific blitz that Britain had experienced, she was forced to build prefabricated houses to meet the heavy demand.

Prefabricated houses are known to be constructed in wood or concrete or steel or aluminium framework. Panels are filled in plywood, steel, concrete and aluminium. These houses are generally one storey in height. This means greater area

of land will have to be covered by mass of single storey houses for low wage earning classes which would not be an economic proposition. Life of a prefabricated house is estimated at about 5 to 10 years and they need maintenance and repair also. If these houses are to be scrapped in a short period, it would spell disaster to national economy. Short term prefabricated houses would appear cheap in initial outlay but it would be bad business, since its life is considerably less. Again if they are imported or built on western methods and standards, they would be unsuitable to Indian climate and conditions of living and this may create problems for the Ministry of Health to tackle.

All House Planning and Construction Schemes should satisfy these essential tests:—(1) Weather tests, i.e., sun, rain, storm, cyclone, vibration and insulation. (2) Structural tests, i.e., loading on soil, floor and roof.

Any home to live in must satisfy the following prerequisites: (1) The plan should be suitable to Indian methods of living. (2) It should be comfortable and weatherproof under the trying tropical conditions. (3) Expectation of its life should be comparable with the permanent traditional house. (4) Sense of Indian aesthetics should be maintained. We cannot plant Paris or London or Berlin or New York on Indian soil. (5) Maintenance should be easy and should not create risks, even in the distant future.

While the speed of erection is the great advantage of the prefabricated house, it is confined to the shell only, finishing generally is complicated and involves a similar process as in case of a permanent house.

If at all prefabricated houses have to come to stay, they should be like the ones built by the military personnel in India during the Second World War. They would be much better than the type of prefabricated houses that are being considered by the Government. It must be realised that what suits the West may not suit

the East in plan, construction, social habits and custom. Whatever we build must suit the Indian conditions. Research as to type and kind of material, tests, experiments and building code must be established to suit the varying climatic and social conditions, health durability and economy. Piece-meal approaches and solutions to such vast and vital problems would not be helpful. A definite and healthy organic growth with short and long term policies would be a practical solution. Here to-day but what of to-morrow like many things imported in India on which we glorify ourselves but completely become helpless and bankrupt when imports stop. Such a feeling is very dangerous to foster in the citizens of to-day or tomorrow. India must depend upon her own resources to make herself provided with all things that she needs to meet any emergency.

We doubt very much whether the prefabricated houses will not cause more congestion at one end of the industry than relief at the other. It is also likely that it may create stagnation in the building trade and damp the initiative, enthusiasm and resourcefulness of the indigenous labourers, while in the long run it may create problems of unemployment.

The best thing in the circumstances would appear to be to have a planned method of encouraging indigenous builders by advice, relief and research. Mass production might be achieved by the use of standard spans, heights, roofs, staircases, doors and windows, etc., which will cut down the cost, but this would be impossible if the plans are individual. Mass building of prototypes would lead to more monotony. We think the aim should be towards the production of mass-produced units capable of varied assembly, rather than mass produced units each of which comprise an identical house.

The aim of domestic architecture should be the happiness of human beings who live in the

houses. Comfort, a sense of repose and good planning and proportion go to make up the best domestic architecture. Possibilities of future development and the integration of architecture into the general pattern of future civilisation need serious thought. It is utterly ridiculous to prophesy the kind of future architecture that will be created. Functional solution of all practical needs being taken for granted, the aesthetic problem will be primarily the organisation of space and volume, the adaptation of forms to the perception of quick moving masses

and the expression of social integration of the respective communities. Technical, social and artistic problems, which a modern building or group of buildings necessarily represents, can be achieved only by teamwork. Social orientation must balance function expression.

We hope and trust that any scheme of housing, the Government of India might conceive, would be healthy, practical and comfortable for the occupants of future houses taking into consideration the tropical climate and the conditions of living of this land of ours.

ADDRESS AT THE HEALTH OFFICERS' CONFERENCE

(Continued from page 14)

out such work and to leave a note on the matter to their successors when they go on transfer. Government propose to help local bodies who carry on anti-mosquito work, for combating filariasis, by giving one-third grant in endemic areas and one-fourth grant in other places. In combating epidemics and in your campaign for the improvement of public health, you must attempt to get the cooperation of the medical men in your area and you must also secure wider public support.

The battle against disease is not to be fought solely by medicines and preventive inoculations.

The improvement of environmental conditions and the raising of nutritional standards are the principal factors in preventing disease and maintaining the national health. There must be a simultaneous advance in several nation building activities if we are to improve the living standards of the people and raise the level of national health in this country. Improvement of agriculture, development of industries, spread of education, extension of communications, building up of the economic life of the people—this is the wider problem which has a bearing on the health of the individual and the community.

CONFERENCE OF MADRAS PROVINCIAL PUBLIC HEALTH WORKERS: OPENING ADDRESS

(Continued from page 20)

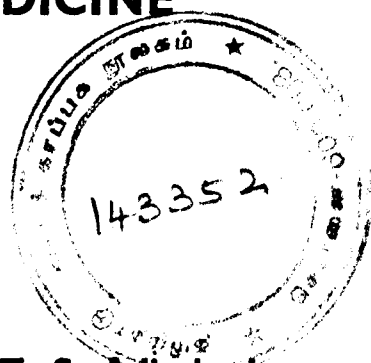
Food adulteration practised on an unconscionable scale aggravates the problem. Much can be done by you by way of nutritional education and correct diet habits. Much more can be done by you to prevent food adulteration and suggest simple inexpensive supplementary foods. Let me sincerely hope that this Conference will be of use in finding correct and practical solutions to all these weighty problems, and lay the

SECOND HEALTH MINISTERS' CONFERENCE

The review of the proceedings of the conference by a *Study Circle*, was received too late for inclusion in this issue. We shall publish it in the November issue of *People's Health*.
—Ed., P. H.

foundations of an improved Public Health Service to the Province. May God guide you in all your deliberations.

RECENT ADVANCES IN INDUSTRIAL MEDICINE



by

Dr. T. S. Adisubrahmanyam

M.B.B.S., B.S.Sc., D.I.H.



Dr. Adisubrahmanyam was deputed to study the recent advances in Industrial Hygiene in foreign countries. He returned to India recently. From all accounts and reports he had done excellent work under the able guidance of well-known experts under whom he had the privilege to study. He gave a clear and lucid exposition on the subject at the recent conference of Health Officers, Madras, on the 5th October 1948. We publish with pleasure a summary of his lecture. It is to be hoped that he will be given ample opportunities in this country to put in practice what he has learnt. —Ed., P. H.

Though, in the 17th century, an Italian physician named Ramazzini, and in the 18th century, an English physician called Thakrah have written treatises on industrial medicine, this subject, in its modern sense, began to get important only towards the beginning of the present century. It was about this time, that Legge, who is considered to be the father of modern industrial medicine was appointed as the senior medical Inspector of Factories in England. He is well known for his work on lead poisoning, anthrax and glass blowers' cataract, and for his efforts

to bring factory legislation up to date. In America too, the subject started getting important at about the same time; and now, America is even ahead of England in many respects. In India, industrial medicine, is practically non-existent at present.

WHY IS INDUSTRIAL MEDICINE IMPORTANT?

In the United States, about 25% of the population is engaged in organised industries; and in England, about 20%. In India, this figure

is only about 2%, besides being exposed to the same disabilities and diseases as the general population of a country. Its industrial population is exposed to the hazards peculiar to the industry, in which it is engaged, and requires special study and treatment. Unlike general diseases, those caused in industry, have a definite causation, which gives a definite clue, to their prevention and treatment. Some industries like the coal mining industry in England, also occupy a place of national importance. This industry particularly in South Wales, has been seriously threatened in recent years, by prevalence of pneumokolosis among the workers and every year about five thousand workers are being certified as disabled. The disease is characterised by the presence of fibrosis in the lungs. But it is not yet definitely known whether it is a silicosis or just a dust fibrosis. A special research unit has been set up at Cardiff to investigate it and on its work would depend to some extent the fate of an industry which is of such vital importance to the industrial prosperity of England. It is clear therefore why a specialised study of industrial medicine is important?

OBJECT OF AN INDUSTRIAL MEDICAL SERVICE

Many years ago, Legge laid down three dicta for preventing industrial hazards. They are:—

1. Unless the employer does everything to prevent a hazard the worker can do nothing by himself. The truth of this is evident.
2. If you bring an influence to bear external to the workman you will be successful; and if not you will be never wholly successful. The provision of dust masks in dusty occupations illustrates the truth of this. Even in cold countries it is very difficult to get workmen to use them, and it will be much more so under the hot and humid conditions in India. Therefore, the provision of local exhaust ventilation is

essential in dusty jobs, and dust masks would only be a confession of failure.

3. Every worker should be taught something about the hazards of his occupation, so that he would be in a position to protect himself.

The function of an industrial medical service in obeying these dicta could be summarised in two sentences:—

1. Make the worker fit for the job.
2. Make the job fit for the worker.

The worker is made fit for the job by:—

1. Preplacement examination, i.e., by giving him a thorough examination at the time of his entry into industry.

Thus a cardiac case could be kept away from heavy jobs, a man with lung disease from dusty occupations and a man with a defective sight from jobs like crane driving which require good stereoscopic vision.

2. Periodic examination, which may be at anything from weekly to yearly intervals according to the hazardous nature of the industry so as to discover the earliest signs of occupational disease and take the worker off the job.

3. Casualty or vice whose object is to give prompt treatment in the case of accidents and industrial disease.

4. Provision of ancillary services like eye and dental clinics.

The job is made fit for the worker by careful and periodic check of the environment in which he works with particular reference to temperature, humidity, lighting, ventilation, hours of work, restpauses, toxic hazards, and dangerous machinery.

What is being done in highly industrialised countries to fulfil these objects?

In countries like England and U.S.A., the problem of man power is important and everything is being done to keep the worker at his job. In the U.S.A. some firms when they advertise for hands even go the length of stating

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that all necessary measures are taken to safeguard the health of the worker.

In the U.S.A. most industries have their own medical service. Every State has its industrial medical department with a team of medical engineering and chemical experts who give consultant service to all the industries within the state. As each state is autonomous in respect of this subject, varying standards of efficiency are met with. Some of the departments are very good while others are not so good. At the centre is the industrial hygiene division of the United States Public Health Service which acts in a purely advisory capacity.

In England also, most industries have got their medical departments. There is a team of medical, chemical and engineering experts under the Chief Inspector of Factories which gives consultant service to all the industries in the country. After the recent introduction of National Health service, there is a proposal to introduce a national industrial medical service. There is also a tendency to widen the scope of industrial medicine so as to include all occupations outside the organised industries, and change the name to occupational medicine.

In Sweden and Denmark the industrial medical departments are modelled on practically the same lines as in England.

In all these countries, besides the routine work indicated above, particular attention is also paid to vocational guidance, rehabilitation work, treatment and employment of disabled persons, industrial housing and aspects of industrial psychology, like fatigue, boredom, accidents and time and motion study.

REFERENCE TO INDIAN CONDITION

The position in India is quite different to that in the highly industrialised countries like England and U.S.A. Here man power is cheap and easily available and there is unemployment everywhere, and so there is no incentive

to do much to safeguard the health of the worker.

But this situation is bound to change before long. The country is rapidly getting industrialised, and labour is beginning to be alive to its rights and privileges. The industrial prosperity of a country depends very much on the existence of a healthy contented labour, and we would be forced to take early steps in this direction to ensure similar conditions in India.

Till now in India, legislative powers concerning industrial matters have been vested in the Centre, and the provinces have been responsible for carrying out the enactments. This arrangement would no doubt be conducive to uniform standards in every province, and obviate the lop-sidedness we see in the different states in the U.S.A. It is not known what shape the future constitution would take and whether the provinces will have complete autonomy in these matters.

Till now, the steps taken to improve the lot of workers have been more theoretical than practical and nothing much has been accomplished so far. It is true that some industries have their own medical department, but they have till now only rendered dispensary service, without practising real industrial medicine. Nearly twenty years ago, the Whitley Commission on labour produced an authoritative report on working conditions in factories and plantations in India. In 1945, the Health Survey and Development Committee came out with their epoch-making report on health conditions in India. They recommend the formation of an industrial medical service in the country soon after the formation of a National Medical service. In the meantime they have recommended the formation of industrial medical departments in each province, provision of chairs in industrial health in the various universities, training of industrial medical officers, and provision of rehabilitation services. They have also made

important recommendations with regard to housing of labour. In the U.S.A. industrial housing is largely the responsibility of private enterprise and in Sweden housing co-operative societies take up this work. But these countries have the best paid labour in the world, and investment on their housing is profitable. In England housing is largely the responsibility of the local authorities assisted by the Government. Capital can no longer be relied on to provide housing like Bourneville and Port Sunlight. So, the committee goes on to point out that in India, industrial housing should be the responsibility of provincial Governments acting through the local authorities.

Also in 1946, the Government of India invited Dr. Bedford of the Industrial Health Research Board, England, to tour the country, inspect some of its important industrial areas and to advise them on measures to be taken to improve working conditions. He has produced a very useful report.

In the same year, the Government of India appointed a Labour Investigation Committee to report on the working conditions in various industries. This committee has surveyed about fifty different industries and produced as many reports which throw a great deal of light on the conditions prevailing in them.

In 1948, the Indian Factory Act has been amended to bring it in line with the English Factory Act.

Again this year, a measure of far-reaching importance has been taken, affecting the social securities of about two million industrial workers. This is the State Insurance Corporation which has recently been inaugurated, and it seeks to provide medical, sickness, disability and maternity benefits to these workers. True the scale of benefits is not very high, but it does not, in any way, minimise the importance of the measure.

SUMMARY

The above is a brief outline of the importance of industrial medicine, the scope of an industrial medical service, a brief account of what is done in highly industrialised countries, and the position in India at present. In some respects we are in the fortunate position of being at the threshold of an industrial epoch and we could very well profit by the mistakes made in other countries. The provision of a National Industrial Medical service would take time, but the other recommendations made by the Health Survey and Development Committee could be implemented at an early date.

WHAT THE PUBLIC SHOULD KNOW ABOUT TYPHOID FEVER?

"Permanent successful control of typhoid fever to a low reasonable index in a community depends on the attention paid by its inhabitants to basic sanitary principles".

M.S. Campbell.

Pioneers in Public Health

TO OUR YOUNG FRIENDS

by

Mohan



Theophile Lænnec, 1787-1826

COMRADES !

May all be healthy and happy !

It is over nine months since I last wrote to you. This inexplicable laziness on my part is blameworthy. I have not escaped reprimands either. Comrades Ghosh and Bannerjee of Bengal have written to the Editor. Their letters spark of Bengali fire from beginning to end. I shall quote them :—

"Your Brother Mohan is a fool and a fraud. I won't like to have a brother like him".

I plead guilty and shall endeavour to make amends.

When we think of the doctor, we always think of the stethoscope. This instrument has become so symbolic that sometimes even an ass, with a stethoscope passes off for a doctor. This is bye-the-bye. I propose to tell you this month about one Lænnec, a French doctor, who was

responsible for giving the medical profession its trade mark. In this connection, I would like to point out that somehow or other, the life of Lænnec is ignored by most compilers of biography. I searched in vain for a long time to get adequate particulars about Lænnec's life. Eventually, I found a book called "Great Men of Medicine" by Ruth Fox published by Random House, New York. Try to get it. It is worth reading.

Theophile Lænnec was born in 1787. He was the son of a flippant lawyer who, not content with one marriage, had married again to give the child a step-mother. Fortunately, Theophile had an uncle who was a dependable doctor at Nantes. The doctor took an interest in his nephew from the very outset. Fearing that the child may acquire the loose habits of his father, Theophile's uncle took the child under his care. The doctor decided to make his nephew undertake a medical course. Lænnec



Lænnec uses a "Stethoscope" for the first time.

also exhibited a welcome desire to follow the footsteps of his uncle. The rural coaching given to him did not satisfy the boy. He yearned for the school at Paris. His uncle who knew the boy's desire was also anxious to send him to France's capital city. But a course at Paris meant money, and, of this commodity, Theophile's father had little or nothing. Eventually, the lawyer managed to send six hundred francs to finance his son's trip to Paris and so, with six

hundred francs in his pocket, our hero started from Nantes, on foot, for Paris on 20th April, 1801.

He joined the Institute of one Jean Corvisart a prominent medical man of the day. The short, thin, mofussil scholar was looked down upon by the Professor's other students. Their dislike towards him was heightened when he exhibited his superiority over them in medicine.

His first triumph in the metropolis came about this way. In Corvisart's Institute, a certain case was being discussed by the students. While Broussais—a fellow scholar—opined that it was a case of pneumonia, Lænnec openly contradicted him and diagnosed it as emphysema. The academical discussion tended towards a personal conflict which, had it taken place, would have distinctly been an unfair fight for the diminutive Theophile was but a David in comparison with the Goliath-like bulk of his adversary. Fortunately, Corvisart entered at the psychological moment and after an examination of the patient endorsed the view of Lænnec, much to Broussais's dismay. All the same, it was a good omen for Lænnec who made his mark as a doctor.

In 1802, at the early age of twenty-one, Theophile Lænnec published a paper on peritonitis—a disease which had embarrassed many a doctor. Such and similar exploits brought our hero name and fame but no money. The young man's interest was chiefly in diseases of the chest. As everybody knows, percussion plays an important part in the diagnosis of the diseases of the lung. Originally, the scientist who introduced percussion was one Aëunbrugger. Corvisart was one of those who practised percussion as a means of identifying diseases of the lung. Lænnec found that percussion in itself was not an adequate method of diagnosis. He felt that the actual hearing of a patient's heart would go a long way in the diagnosis of chest diseases.

One day in 1816 Lænnec who was at the Necker hospital was called in to examine a lady suffering from heart trouble. The patient was young and fat. Lænnec could not muster enough courage to put his ear to her heart and yet there was no other way of diagnosing her ailment. He remarked on his fear to do so thus: "Even if I did I could not hear anything. Why do

women let themselves get so fat?" Leaving the patient alone, he went out for a stroll. Here he came upon a group of boys playing. One of them was scratching with a pin at the far end of a rod while others wonderingly heard the noise at the other end. On seeing this simple trick to illustrate the magnification of sound as it passes through a solid object, the doctor had a brain wave. He rushed to the hospital, where, rolling up a piece of paper into a cylinder, he placed one end of it to the girl's chest and heard her heartbeat at the other end. He had triumphed!

He also found that various diseases gave different sounds when heard through his instrument which he had perfected now into a simple wooden cylinder with an annular canal in the centre. He wanted to name his invention. His uncle, the old doctor suggested thoroscope from the Latin 'Thorax' and Greek 'Skopein' to examine. But Lænnec preferred stethoscope from 'stethos' the Greek for chest. Thus, the stethoscope was born. In August 1819 he publicised his invention in a book on the subject. Stethoscopes were sold in the market at 16 francs each. The new-fangled tool did not attain immediate popularity. This initial opposition is, as we all know, common when a great man invents a new thing. But Lænnec's ideas spread far and wide mainly through some of his illustrious patients. He began to move in court circles and money poured in too.

Chief among Lænnec's opponents was Victor Broussais, his old rival. The fat Parisian swore that he would crush Lænnec and his theories at all costs and the two men were involved in a great medical feud. Broussais had evolved a theory by which he stated that irritation was the cause of all diseases. He also mentioned that bleeding was the sole cure. If Lænnec's theories achieved popularity, Broussais's large

(Continued on page 35)

MADRAS HEALTH OFFICERS' CONFERENCE—A REVIEW

(Contributed)

It is good that field workers meet periodically and exchange their experience. Such conferences are expected to serve as a clearing house of all technical knowledge and field experience of the workers. The conference of the officers of the Public Health department was held from the 3rd to the 5th October 1948 in the Museum Theatre, Madras. Quite a large number of the Health Officers attended the conference but a few officers were conspicuous by their absence. The benefit of their experience was unfortunately not made available to those who met. This was perhaps the result of picking and choosing officers of the department to attend the conference. In a measure, this procedure has defeated the aim in view.

WHY?

If the authorities responsible for the convening of the conference had been circumspect and kept in view the larger interest, they would have unhesitatingly invited not only all the Health Officers of the department but also the retired ones. Officers of the allied departments were also conspicuous by their absence. They should have been invited not only to be present but also to participate in the discussions. It would eventually lead to better coordination and co-operation. It is surprising that the Sanitary Engineer to Government was not also present at the meeting; apparently the invitation reached him after he had fixed up his programme of inspection. If, at least, notice had been given to him of the proposed conference, he would have taken care to be present at the conference and participated in its proceedings.

DIRECTOR'S WELCOME ADDRESS

The Director of Public Health, Dr. R. M. Mathew, welcomed the gathering in a well-

thought out speech. He made special reference to the paucity of provision for the improvement of environmental sanitation. He drew attention to the inadequacy of staff for the huge population entrusted to his care. He reviewed the cholera position in the Province during the past half a century. The figures furnished by him helped to create an irresistible impression that the long existence of an organised Public Health department has not apparently justified itself. He also referred to certain important aspects of food control. Unfortunately, the discussion, which ensued, did not deal with those subjects adequately, nor were definite conclusions arrived at.

MADRAS PREMIER'S OPENING ADDRESS

The opening of the conference by the Premier was an outstanding event. It should be taken as a token of the importance of public health in all governmental activities and the priority of interest which the Premier attaches to this subject. His opening address was very erudite. The high lights of Ayurvedic achievement were well brought out and a plea was made by the Premier for synthesis of the several systems of medicine. So far as prevention of disease goes, Ayurveda as well as allopathy follows similar lines. It is in the realm of cure that they diverge. That the Premier should have drawn attention to this divergence in a meeting of preventive personnel should be taken to indicate the view of the Government, that the cure and prevention should form a combined service to the people. In fact, the Premier made pointed reference to the Swedish system of public health service and the National Health service recently introduced in England and said that he did not know when India will be able to organise a public

health service based on prevention rather than cure and provide medical benefit to one and all regardless of payment.

People's Health has been repeatedly urging in its columns the unification of the curative and preventive services which are most unnaturally bifurcated at present, in our land. One is gratified to find that the Madras Premier thinks on the same lines. There is absolutely no justification for the note of despair which the Premier thought fit to introduce. Proposals for unification are already before the Ministry of Health. If only the Premier chooses, he can effect, what he professes to be a desirable reform, even tomorrow, by a stroke of the pen. Can't he pull out the connected papers from the archives of the Secretariat?

We congratulate the Premier in the call he made to those assembled to do their work in a spirit of service. Health work is essentially a social service. Nothing but a true missionary spirit will produce lasting results. This is exactly the appeal which the Governor-General of India made in the message to the Second Health Ministers' Conference in August 1948. In fact, in every branch of governmental activity which is meant for the welfare of the common man, this spirit should pervade. The Premier, who is himself, apparently by such spirit, may naturally be expected to give the same call to all other services of the Government, if and when he has the opportunity to meet them in a body.

MINISTER OF HEALTH SPEAKS OUT HIS MIND

The address of the Minister of Health was straight and frank. He began by reference to a similar conference held last year and wanted to know the results achieved. This conference is a departmental one. The decisions taken at these conferences are considered by Government and implemented to the extent they

felt practicable. The Minister of Health should have been fully aware of the ultimate results of the previous conference. What the Minister probably wanted to know was whether the Health Officers themselves were aware of the results. The first item in the agenda of such conferences should be a report on the outcome of the previous conference. If such a report had been inserted in the notes for the conference, the discussions on the other items of the agenda would possibly have been different. There is an air of familiarity in the majority of the items brought up for discussion. There are probably hardly annuals recurring in every conference. A knowledge of the past progress would be of real help for further discussion.

The Minister observed that service in the Public Health Department did not attract the best men in the medical profession and that the medical men preferred clinical work, which paid them better. We congratulate the Minister on giving expression to the fundamental fact, which lies at the root of public health service. One of the resolutions passed at the Health Ministers' Conference in Delhi in August 1948, was that private practice for Government medical officers should be progressively prohibited. If only the Madras Government were to implement that decision, the attraction which clinical work has for medical men would vanish. If the pressure of vested interests was to prevent the administration from implementing the Delhi decision, the alternative is for the Minister to make the enrolments in the preventive side of the service attractive enough to secure the best talents in the profession for prevention.

The Minister deplored that they could not find any continuous record of improvement in the country's health during this century. While the public health staff spent their time and energy in epidemic control, periodical visits of cholera, smallpox, plague, etc., continue to occur. The Minister believes that this position could be

rectified by increasing the public health staff and starting a public health engineering service. He also frankly admitted that the local bodies as well as the Government were handicapped by want of funds for the performance of the health duties which they are responsible for. It must be poor solace to the members of the service as well as to the public to hear the confession of a Minister, that they have to make the best of a bad situation with the limited resources available to them. If the health of the people were the prime concern of the State, we fail to see what prevents the Cabinet from allotting a specific portion of the revenues for public health development. What the Public Health Act imposes on the local bodies, the Government should impose on themselves!

The agenda for the conference was varied, although one could detect important omissions like venereal disease, etc. We should like to draw attention to one important feature in the conference, i.e., the organisation of visits to several institutions. We wish this step is a feature in every service conference. We also wish that this feature be expanded and that more of the time of the officers is given to such visits.

LEAD BY BRITISH INFORMATION SERVICES

No doubt the high-light of the conference was the use made of the occasion by the British Information Services. Such voluntary and hearty co-operation is a unique feature. They came forward to show several interesting films on each day of the conference. They also quietly put up a very interesting exhibit on the second day. We have in our Province a Health Propaganda Board, a Red Cross Society and a National Health Association of South India, three voluntary bodies, whose sole object in existence, is health education. These bodies would do well to take a leaf from the book of the British Information Services. They should

have done what the British Information Services did. We would also point out that the work of the British Information Services during this conference is a pointer to the "technique" of health education for the Health Officers themselves. It is up to them to get similar equipment, it is up to them to thrust themselves into every conference and gatherings of people, and it is for them to educate the people in a telling manner and without any show of effort.

HEALTH MINISTER GAINS FIRST HAND KNOWLEDGE

The most important feature of the conference is not the opening by the Premier nor the address by the Minister of Health, nor any of the other points which have been brought out above. The striking thing was the continued presence of the Minister of Health throughout the entire discussions of the conference on all the three days. No Minister has to our knowledge done this before in any departmental conference. The presence of Sri A. B. Shetty throughout the proceedings shows his deep interest in the activities of the department. His desire to learn things first-hand and to meet the personnel of his department at close quarters, impelled him to be present throughout the discussions. We are sure, he has benefitted himself as he expected. Although the discussions were fairly free, there is just a possibility that the presence of the Minister might have deterred some of the officers from giving full expression to all that they felt. If the Minister has started the proceedings with an assurance that no officer need feel embarrassed by his presence and if he had called for a full and frank expression of views possibly the discussions would have been different.

We should also congratulate the Minister on the publicity given to the conference. Invitations were extended to the Press and their co-operation specially sought for.

UNDESIRABLE FEATURES

We are compelled to draw attention to other features. Officers of the allied departments were invited apparently only to the opening function. The Government Analyst was requested to participate in the discussions on "food adulteration" but the participation of officers of all allied departments in discussions on other subjects was not arranged for. It would have been good, for instance, if the Surgeon-General or the Principals of Medical Colleges were present when the subject of training of personnel and of isolation hospitals were discussed. Similarly, the Sanitary Engineer to Government should have been invited when the problem of rural water supply, sanitary convenience and the standardisation of conservancy tools and plant, were discussed.

Although most of the subjects were important ones, we could not see that the discussions on all of them were on a high level. A conference of technical personnel should deal with every subject in a level far above that of minor details of practice or procedure. The fundamental principles should be laid down. The policy should be discussed and methods of application should be thrashed out. One who listened to the observations made by Health Officers on different subjects would probably go away with the impression that the officers were more worried about the finer points of procedure or powers than with radical needs and the main lines of policy. We would quote one example in support. In the subject of Nutrition and Food control, the note of the Director of Public Health dealt extensively with the Nutrition work done in the Province. It also dealt with certain aspects of food control and food adulteration. None of the speakers on this subject made any reference at all to the nutrition work. Their minds were apparently far away from this important subject. They had not apparently thought of nutrition as such, or perhaps, in their

day to day work, they were not asked to concern themselves with this important feature of health work.

Many Health Officers were present, but few were prominent in the discussions. The Director with his intimate knowledge of the personnel could have called upon more officers to participate in the discussions usefully. The District Health Officer, Chingleput, was the one person who made himself unduly conspicuous. He was a speaker on almost on every subject; one would even suspect whether he drew up the agenda himself! Being immediately available at headquarters, he must have been naturally pitched upon for exhibition of special affection.

LECTURES OF INTEREST

Mention should be made of the two lectures of interest delivered by Dr. Adisubramaniam and by Dr. Cochrane. The former gave the conference the benefit of his recent study of Industrial Hygiene in foreign countries; the latter is an accepted international authority on leprosy and his talks were always stimulating.

FIRKA DEVELOPMENT AND PUBLIC HEALTH

One should also bring out the fact that Firka Development figured in this conference. It is a sign that there is a glimpse of proper perspective in those high in authority. Whatever else Firka Development may mean, it must provide first for the health and safety of the common man in the villages. Firka Development programme should therefore include as its first item the improvement of the public health services and facilities in the villages. It was perhaps in recognition of this principle that the Minister for Firka Development was invited to address the conference giving at the same time an opportunity for the Health Officers to discuss the subject.

FINANCE

The Director, the Ministers and in fact, all persons in authority who spoke at the conference, unanimously deplored the lack of finance as the bar to public health improvement. It would have been better if the Finance Minister was invited to attend the conference and to watch the entire discussion even as the Minister of Health watched it.

A LIVELY DEBATE

An apology is due to the Editor of *People's Health* for bringing out the most striking feature of the conference as the last point. We refer to the participation in the discussion by the Editor. It is very unusual in a departmental conference to invite a non-official to participate in its deliberations; that the Minister should have gone out of the way to request Sri A. V. Raman to participate in the conference is a singular feature. Mr. Raman took part in the discussions on Rural Water-supply and on Health Education and Publicity. In fact, Mr. Raman's speech was the only portion

of the whole of the discussions which was listened to with rapt attention by the members present at the conference. One can only hope that the many practical suggestions and advice given by him backed by his wide technical knowledge and vast field of experience, would be implemented by the Director, the Minister and the officers of the department.

PUBLISH AUTHORITATIVE SUMMARY

The publicity given to the conference has evoked the interest of the common man in the Province. The public are now looking forward to an authoritative account of the decisions of the conference. They are also looking forward to the rapid implementation by the Government of the decisions. The Director of Public Health should therefore issue a Press Note embodying the decisions of the conference; the Ministry in their turn should issue one or more Press notes taking the public into confidence as to the Government's ultimate decision on the resolutions of the conference.

PIONEERS IN PUBLIC HEALTH

(Continued from page 30)

practice would go to the dogs. Hence, the latter's anxiety to nip Lænnec's theories in the bud. Both the doctors lectured openly against each other; but Broussais had the better of the fight being an orator which Lænnec was not. More and more people denounced Lænnec's theory. Lænnec's energy failed him and in 1824 he left the raging Paris to its destiny and went home. In December that year he married and settled down in Paris again; but the doctor knew he had not long to live and in May 1826 he returned to Brittany. His wife feared he would die soon and she was right. Lænnec died leaving behind him only a wooden cylinder!

It took many more years of controversy between the supporters of Lænnec and Broussais before the former's theory was well established. But this was post-mortem recognition and Lænnec had died when yet his theories were severely disputed. The stethoscope today has been made more *deluxe* but the principle behind it all the same, was Lænnec's own.

I do not know when I will write again; but surely I will try to escape from Broussais-like vituperations of my readers!

Your loving comrade,
BROTHER MOHAN.



THE TREATMENT OF ALCOHOLISM

by
Lewis Inman Sharp

In independent India, Madras Presidency is unique in that it has introduced total prohibition of alcohol throughout the Province even in the face of advice tendered to the Madras Ministry to proceed with circumspection. How far this experiment would prove a success is open to serious doubt.

The other day, the Madras Premier declared, at a public meeting held at the Lakshmiapuram Young Men's Association, Royapettah, that the problem which confronted him was how to reform the *civilised drinkers*. He felt that so far as the ordinary toddy drinkers were concerned, he was not bothered; he was confident that they could be reformed by opening tea-shops, amusement centres and the like. We wish him success.

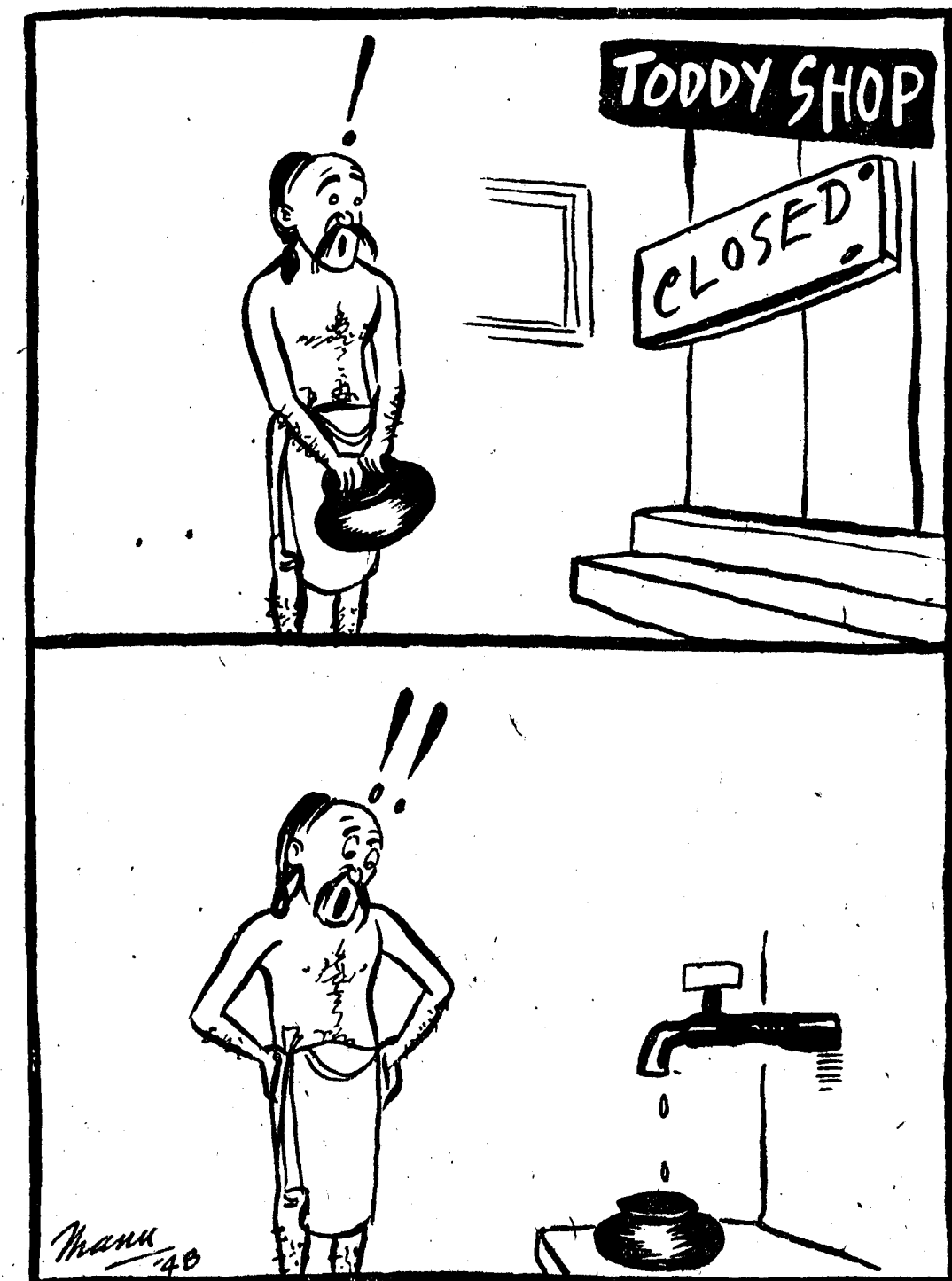
The articles which we reproduce hereunder from *HYGEIA*, the Health Magazine, published by the American Medical Association, is the first of a series of seven articles on the subject. A perusal of this and the succeeding articles should set the authorities and *civilised drinkers* alike, thinking.

—Ed., P. H.

The attitude of society to alcoholism today is similar to the attitude of society to the psychoses in the eighteenth century. Until the general public accepts the concept that alcoholism is a disease and the alcoholic a sick person little headway will be made toward coping with, let alone solving, one of our major public health problems. The current attitude of the general public to the alcoholic is moralistic. The alcoholic is considered at best a weak-willed character—at worst a human monster.

A psychiatrist from abroad was observing an American commitment proceeding. The sub-

ject of the commitment was an alcoholic, hospitalized many times, who, when drunk, brutally abused his wife and daughter. Finally the poor woman reluctantly accepted medical advice and requested commitment of her husband to a state hospital. The wife and daughter were in the courtroom. The judge heard the testimony of the wife, daughter and attending psychiatrist. He then asked the patient if he wished to be heard. The man pleaded for another chance; begged not to be "put away" and promised never to touch another drop. The judge, much to our visitor's consternation, took



determine general hospital policy. At present, most privately endowed general hospitals do not have alcoholic wards, so that, at its inception, the treatment of the alcoholic is seriously impaired unless he is wealthy enough to afford private hospital care.

An alcoholic service in every general hospital would help to settle the question that alcoholism is a disease and alcoholics sick people. Special diagnostic procedures would be facilitated and consultants would be available for psychiatric, surgical and other consultation if deemed necessary. The management of the cases would be under the supervision of trained personnel. Treatment would be placed on a rational basis. Physiologic factors important in the early toxic and post-toxic phase and the need for drugs, vitamins, fluids, salt, sugar and hormones would be determined. Individual psychotherapy, group psychotherapy, the conditioned aversion technic, electric shock and contacts with Alcoholics Anonymous would be prescribed for suitable cases. And last, but not least, new opportunities for research into the personal, physiologic and biochemical factors leading to alcoholism would be available.

Alcoholics Anonymous is an important therapeutic resource available in most communities to the alcoholic. Unfortunately, I know of no scientifically valid analysis of the results obtained by this group. Enthusiasts claim that 50 to 80 per cent. of alcoholics seeking help from Alcoholics Anonymous are significantly benefited. My impression is that 20 per cent of non-symptomatic alcoholics are more or less permanently helped. This in itself is a very high figure and one which medicine has not yet begun to approach. However, it must be emphasized that any numerical claims or estimates of therapeutic results with alcoholics are suspect, since diagnostic categories are frequently lumped together and inadequate follow-up is the rule rather than the exception. A critical analysis

of long-term therapeutic methods and results would be of great value, but such a study requires money. At this point it seems appropriate to point out that approximately 5 per cent of our national income (\$7,000,000,000 in 1944) is spent by the people of the United States on alcoholic beverages. Surely a portion of this colossal sum should be utilized for financing studies of the above mentioned nature and in the larger sense to finance a comprehensive approach to this great public health problem.

Alcoholics Anonymous is made up of people who frankly admit they are alcoholics and therefore unable to partake of alcohol in any form. In order to abstain from alcohol, they must look to a power greater than themselves, actively participate in group activities entailing public self examination, and help other members through the pitfalls of their illness. This is obviously a large order and explains why many alcoholics are unable to get help through A.A. Successful members of Alcoholics Anonymous emphasize the importance of the religious factor. They describe what appear to be conversion reactions and indicate that unless a member of Alcoholics Anonymous experiences such a conversion, then his or her chances for rehabilitation are poor. My own experience tends to confirm this impression, as the alcoholics I know who have rejected A.A. give as the major reason for their rejection their inability to accept the religious element of Alcoholics Anonymous.

What other methods of treatment are available to the general practitioner? The conditioned aversion treatment is helpful in breaking the vicious circle of compulsive drinking. The technic is elaborate and requires hospitalization. It aims at producing an aversion to all liquors, wines and beers by establishing a conditioned response of nausea to alcohol in these forms by using a drug called emetine as the unconditioned nauseating stimulus. This method has not had sufficiently widespread scientific

application to determine its value and place in the treatment of alcoholism. In all probability, it will prove to be a useful point of departure in selected cases for individual and group psychotherapy, but again its general application depends on the opening of general hospitals to the alcoholic.

Group psychotherapy may prove to be of great value in treating alcoholism. It was of value in treating psychiatric casualties in wartime. The paucity of well trained psychiatrists and the relatively high incidence of neurotic reactions in America makes the exploration of this method of psychotherapy imperative. It may well be that this type of approach is peculiarly suited to certain alcoholic character disorders, for example, those that found the group activities of Alcoholics Anonymous of value but could not accept the religious aspect of A.A. Again, if general hospitals had both inpatient and outpatient facilities for the alcoholic, then group therapy would be relatively easy to apply and evaluate over a long-term period.

A certain proportion of alcoholic character disorders require longterm hospitalization. How many, it is very difficult to estimate; more at present, I am sure, than would be the case if this problem were accepted and treated as a medical problem by society. Even under ideal circumstances a proportion of alcoholics will require involuntary hospitalization, for the protection of both society and the individual. At the present time, psychopathic personalities who become habituated to alcohol, and alcohol addicts who, for one reason or another, are

unable to respond to short-term hospitalization and outpatient treatment, should be in hospitals for alcoholism. The alcoholic psychoses should be transferred from the more specifically psychiatric hospital to a hospital for chronic alcoholics as soon as the psychosis has subsided.

Such a programme will cost a lot of money, but the saving in terms of human suffering is inestimable. How can one put a money value on the salvaging of a family on the rocks of alcoholism? The saving to industry alone in improved worker efficiency, reduction of absenteeism and generally improved management-labour relations would, in my opinion, more than pay the cost of an ideal alcoholic treatment programme in every community in the United States. The logical source of the money to finance such a programme is from revenue raised by the taxation of alcoholic beverages. Surely it is only just that the alcohol industry pay the bill for preventing alcoholism and rehabilitating the alcoholic.

In summary, the treatment of alcoholism is a complex problem involving the total personality in its cultural setting. First and foremost the public must change its present moralistic attitude toward the alcoholic to a medical attitude. This change in attitude will bring about many important and necessary changes in the treatment of alcoholism, the chief being medical education and training of the physician to treat this illness. Moreover, beds and clinics in general hospitals should be made available for alcoholics, and facilities for rehabilitation of those who require such long-term care.

THE HUMAN PROBLEM OF URBAN DISPERSAL.

Planning, no matter how well-conceived, must always leave the path open to further growth and development, for that is the way of life; and one of the reasons that people fear planning and resent it is that they suspect that the planner is substituting his private thoughts and

purposes for their own. The way to overcome that fear is not through propaganda, but through giving the citizens who move to the new town a whole set of unfinished tasks through whose fulfilment they will make that town their own.

LEWIS MUMFORD.

a deep breath and with an eye to the mother and daughter said to the patient, "The doctors say you are sick and should be sent to a hospital, but I say you are a criminal, a beast, and should be sent to jail; but out of consideration for your wife and daughter I will send you to a hospital."

The judge looked self-righteous and pleased with himself and the mother and daughter were greatly impressed, but what was happening to the patient? Although he cringed under the tongue-lashing of the judge, you could see the hostility and aggression well up within him.

As we were acquainted with this man's case history, we knew that standing before this unsympathetic and rejecting judge he was recapitulating forgotten childhood reactions of hostility and aggression toward a similar rejecting and unsympathetic figure of authority, his father. These feelings were suppressed before the judge and would probably remain more or less repressed during the period of hospitalization. But they would continue to ferment and, after his discharge from the hospital, would probably explode in a sadistic alcoholic orgy directed against these two poor women and a society symbolized by the judge who treated him as a criminal and not as a sick person.

Once alcoholism is accepted as an illness it will be possible to obtain beds for its treatment in general hospitals. Most general hospitals today do not provide such beds. If the alcoholic is accepted as a sick person, adequate facilities will be provided by the state as is done for the psychotic, for the treatment of chronic alcoholics who require long-term hospitalization. Legislatures will pass laws permitting the enforced treatment of alcoholics who are unable to control their dependency on alcohol. When these changes occur—beds for acute cases in general hospitals, long-term facilities for chronic cases and laws to implement the treatment of alcoholism—the medical profession, starting with the general practitioner, will begin to treat the

run of the mill alcoholic, and the physician will be trained in medical school to recognize and treat this illness.

For practical purposes, types of alcoholism may be classified in two main groups:

1. Symptomatic drinking.
2. Alcohol addiction or character disorder.

The symptomatic drinker is a person who has an underlying illness, of which one of the symptoms is an excessive dependency on alcohol. The commonest of such conditions are the psychoses, psychoneuroses and psychopathic personalities. It is obvious that a schizophrenic who is drinking excessively is not going to be cured of his schizophrenia by "going on the wagon."

The treatment of the symptomatic alcoholic is, first, to make the correct diagnosis and then treat the underlying condition. Except in the case of the psychopathic personality, most symptomatic drinkers stop drinking shortly after the treatment for the basic condition is commenced. Attempts to treat the psychopath are almost invariably a failure. It is important to stress this fact as some of society's indifference and callousness to the whole problem of alcoholism is based on its sad experience with this type of alcoholic. If anything is ever going to be done for the psychopath, including those who are alcoholics, treatment to be effective must start at a very early age, as most of the evidence available today indicates that the psychopath is the product of a violently disturbed child-parent relationship during the first five years of life. It is obvious that a profoundly new social orientation will be necessary before such treatment is feasible.

The second great group is alcohol addiction or alcoholic character disorder. This group is sometimes divided into primary and secondary addiction, but for our purposes this breakdown is not necessary. In fact, the concept of a primary addiction is open to serious question

as it may well be a variant of psychopathic personality.

The alcohol addict is the product of many factors, cultural, social, economic, racial and psychobiologic. The precise way these factors operate is not known and it may well be that there are other important factors yet unrecognized. Research is vitally needed to clarify this whole problem. A common example of the alcohol addict is the person who makes a fairly satisfactory adjustment to his environment until he starts having an occasional cocktail before dinner at night. This practice gradually increases both in frequency and intensity and eventually leads to a "few" before lunch, then an additional "few" in the afternoon—finally, in the face of some domestic or economic stress the first "lost weekend" occurs. The phase of compulsive drinking has now commenced and, generally speaking, the alcoholic who has reached this stage is unable to stop without help. He is now psychobiologically habituated to alcohol.

In order to treat the alcohol addict it is necessary to know something about his character structure. Writing in the *Journal of Studies on Alcoholism*, Tiebout believes that the alcoholic has an unconscious need to dominate, a hostile feeling tone, a sense of loneliness and isolation, simultaneous feelings of superiority and inferiority and a striving for perfection. Others have emphasized the frequent presence of parental figures in early life who are alternately domineering and submissive, thus disturbing the identification process at a vital stage of its development. In line with the faulty development of the identification process or perhaps dependent upon it goes a psychosexual disturbance characterized by failure to achieve adult sexuality, with fixation or a tendency to regress to homosexual and oral behaviour. However, "racial" or cultural factors must not be forgotten; for example, the incidence of alcoholism is low

among the Jews and high among the Irish, yet the incidence of personality disorders is not correspondingly low among the Jews nor correspondingly high among the Irish. In *Survey Graphic* of February, 1945, A. Myerson has written a provocative article dealing with this as well as other aspects of the alcohol problem.

The ideal treatment for the alcoholic character disorder would be to help the patient remould his character structure and become a well integrated adult personality, able to use alcohol as an adjunct to graceful living or leave it alone if he so wishes. This is rarely possible by any method of psychotherapy available today. Fortunately, it has been learned through clinical experience that if an alcoholic can permanently abstain from alcohol then the liabilities of his personality are not released and he is able, with help, to become a reasonably well adjusted and contented person again.

The problem, then, is to convince the person with an alcoholic character disorder first of all that he is sick, and secondly that he can never, under any circumstances, take alcohol or other narcotics in any form as long as he lives.

The general practitioner must be the cornerstone of the rational treatment of the alcohol addict. He must make the alcoholic feel that he is accepted as a sick human being and is not a moral weakling. The general practitioner frequently has the opportunity of observing the onset and development of the dependency on alcohol. If he recognizes his obligation to the alcoholic he will advise the patient and his family how to cope with the total situation, just as he would if the patient had tuberculosis. In this way he may be able to nip the process in the bud and not wait until the compulsive phase of drinking has commenced.

In order to do his job properly, the general practitioner must be able to hospitalize his alcoholic patients in general hospitals. This entails a change in attitude of those who

FROM EVERY WHERE



WHAT DO THEY SAY ABOUT IT?

Readers can contribute to this section. They are requested to send extracts of current literature which, in their view, would interest the people. —Ed., P.H.

BILL TO CONTROL CYCLE RICKSHAWS

In order to prevent vehicles which might be a danger to other traffic from coming on to the roads of Calcutta and its suburbs, a Bill to amend the Calcutta Police Act, 1866, and the Calcutta Suburban Act, 1866, has been drafted by the Government of West Bengal for introduction in the Legislative Assembly.

The Bill empowers the Commissioner of Police to prohibit the use or the driving of certain types of vehicles in streets or public places.

Another Bill has been drafted to amend the Calcutta Hackney Carriage Act, 1919, with a view to controlling cycle rickshaws, which are appearing in increasing numbers in the suburbs of Calcutta and in mufasil towns.

(The Director of Publicity, West Bengal, Writer's Buildings, Calcutta, August 24, 1948.)

EFFECTS OF MASS PRODUCTION OF FOOD

The staple foods may not contain the same nutritive substances as in former times. Mass production had modified the composition of

wheat, eggs, milk, fruit and butter although these articles have retained their familiar appearance. Chemical fertilisers, by increasing the abundance of the crops without replacing all the exhausted elements of the soil, have indirectly contributed to change the nutritive value of cereal grains and of vegetables. Hens have been compelled, by artificial diet and mode of living, to enter the ranks of mass producers. Has not the quality of their eggs been modified? The same question may be asked about milk because cows are now confined to stable all the year round and are fed on manufactured provender. Hygienists have not paid sufficient attention to the genesis of diseases. Their studies of conditions of life and diet and of their effects on the physiological and mental state of modern man are superficial and incomplete and of too short duration. They have thus contributed to the weakening of our body and our soul. And they leave us without protection against the degenerative diseases, the diseases resulting from civilisation. We cannot understand the characteristics of these affections before having considered the nature of our

mental activities. In disease as in health, body and consciousness, although distinct, are inseparable.

(*"Man The Unknown"* by Dr. Alexis Carrel pp. 115-116).

MALARIA, OTHER INSECT-BORNE DISEASES AND INSECTS

Insecticides against Bed-Bugs In Air-Raid Shelters.
Public Health, London, (April, 1942).

In this article the Bed-Bug Infestation Committee of the Medical Research Council recommends 3 insecticide formulae for use in air-raid shelters. These formulae consist of:

- (1) Pyrethrins in kerosene, 0.6 to 0.8 per cent.
- (2) Thiocyanates, 6 per cent "Lethane 384" in kerosene, or 3 per cent lauryl thiocyanate in kerosene.
- (3) Heavy coal-tar naphtha with cresylic acid; 5 per cent cresylic acid dissolved in heavy coal-tar naphtha.

The precautions to be observed in the use of these preparations are given together with methods of application. It is stated that the elimination of harbourages is considered effective in preventing infestations.

—C. H. ATKINS.

(P. H. Engng. Abstrs. Vol. XXII, No. 9)

RATS—THE LOSS THEY INFLICT

A rat census is obviously impossible. It is quite certain, however, that they breed more rapidly than they are destroyed in many places in the world. We can appraise the rat population only by the numbers that are killed in organised rat campaigns and by the amount of destruction they cause. In about 1860, Shipley tells us, there was a slaughter-house for horses on Mont-faucon, which it was planned to remove farther away from Paris. The carcasses of horses amounted to sometimes thirty-five a day, and were regularly cleaned up completely by rats in the following night. Dusaussais had the idea

of trying to find out how many rats were engaged in this gruesome traffic. He set horse-meat in enclosures from which the exit of rats could be prevented, and in the course of the first night killed 2,650. By the end of a month, he had killed over 16,000. Shipley estimates that there are about forty million rats in England at one time. In 1881 there was a rat plague in certain districts of India. The crops of the preceding two years were below average and a large part of them had been destroyed by rats. Rewards offered for rat destruction led to a killing of over 12,000,000 rats. Shipley estimates that a single rat does about 7s. 6d. worth of damage in a year, cases ("negative exposures"). The total number of exposures in each group was small, but the proportion of negative exposures in unirradiated class rooms decreased regularly with increase in the proportion of susceptibles. Thus, there were no secondary cases from 13 exposures to chickenpox in classes with less than 20 per cent susceptibles, while of 11 exposures in classes with more than 60 per cent susceptibles, eight were followed by secondary cases. With measles the proportion of exposures in a given susceptibility group, that resulted in secondary cases, was greater than with chickenpox. The irradiated classes showed, for all susceptibility groups and for all three diseases, a higher proportion of negative exposures than the unirradiated classes. Taking measles, as an example, in the irradiated schools the proportion of all the exposures that were negative was 11/17 in classes with less than 60 per cent susceptibles and 15/18 in those with 60 per cent or more. The corresponding proportions in the same susceptibility groups and age grades in the unirradiated schools were 4/15 and 2/5. Among the uncontrollable factors that are responsible for some of the failures with irradiation are a high relative humidity, and the occurrence of direct droplet infection.

R. E. O. WILLIAMS.

RAT SURVEYS AND RAT PROOFING

B. E. Holsendorf. *American Journal of Public Health*, Vol. 27, No. 9, September 1937. pp. 883-88.

A discussion of the economic loss and sanitary risk incurred by this least useful and most dangerous rodent. The rat population is estimated to be equal to the population in any given community.

Rat control programmes are undertaken for the double purpose of disease prevention and the reduction of economic loss. Rat surveys are necessary to the proper planning of any rat extermination programme. The principal harbours are double walls, space under floors, the space formed by sheathing in the ceilings, in cellars, bins, and lockers, burrows in dirt floors and storage of supplies and rubbish. Methods of rat proofing of new and old structures are discussed.

Permanent rat control can be secured only by careful attention to building details and equipment design and maintenance that will build the rat out. Studies of the life habits of rats make control methods more efficient.

—EARNEST BOYCE
(P. H. Engg. Absts.)

FAMILY HISTORIES IN TUBERCULOSIS

—Simpson, S. E.

Amer. Rev. Tuberculosis. Sept. 1945.

"Many physicians, surprisingly enough, and the majority of the lay people still cling to the old idea of heredity as playing an important part in the spread of tuberculosis in any one family." So says the author, and his carefully constructed and convincing family histories are a sufficient answer. As he put it, "the family charts convey a visual image of the path of infection from one individual to another, from one family to another through contact." He

presents five types of family history. *The first* traces the disease from a grandmother to her daughter and grand-daughter. The daughter was the first to be discovered. *The second* family shows the infection of eight out of ten children and all the grand-children. Two died and four others required treatment. *The third* group includes two families, the youngest sister of the first representing the source of a case later found in the second. Both patients are now dead and two others had active tuberculosis when first examined. The original cases were two grand-mothers and possibly the mother, all now dead. *The fourth* group consists of a series of cases, chiefly among unrelated but closely "contacted" Rumanians. Of 21 persons examined, seven were found to have active pulmonary disease, of whom four have died of the infection and two more still have active disease. *The fifth* group contains nine families, five of them related or connected by marriage. Their tuberculosis is very interesting but is not described in detail here. "Commitment of positive-sputum cases to an institution" says the author, "relatively easy in larger cities, is very difficult in rural areas. This is due in part to the fact that the part-time health officer is the family physician and in part to the apathy of the public who are unaware of the infectious nature of the disease, believing that heredity plays the most important role in the spread of tuberculosis." The histories are well charted, various signs indicating "advanced", "moderately advanced," "minimal," "tuberculin-positive," etc. Now that the tracing of family histories is amplified, as regards tuberculosis, by X-ray studies and Mantoux tests, we may hope for large numbers of this kind of examination which, itself, puts our views on the spread of tuberculosis into a very much more exact expression than was previously possible.

—R. E. O. WILLIAMS.

ALCOHOL DOES

Enter the blood stream, at a rapid rate, through the stomach and intestines. It is carried by the circulation to all parts of the body. The greater the weight of the drinker, the more diluted is a given quantity of alcohol in his blood stream. Hence, other factors being equal, a heavy person can drink more than a lighter one without reaching the same degree of intoxication. But, independent of weight, variations in metabolic processes and psychological balance produce wide variations in individual reactions.

Act upon the brain and central nervous system, slowing down reaction time, perception, and reflexes, but without physically affecting tissues. It acts first upon the centres controlling judgment and inhibition; next, it affects speech, muscular coordination, and vision.

Provide relief, quickly but temporarily, from many painful physical and psychological conditions, by dulling perception of pain, cold, and discomfort.

Relieve anxiety and tension through its anaesthetic action on the higher centres of the nervous system.

Stimulate appetite by increasing flow of gastric juices, when taken in moderate quantities. In large quantities, alcohol interferes with or stops digestion.

Provide calories (210 per ounce by weight), but delivers no vitamins, minerals, or proteins, and may impede their absorption. Therefore, it is a food, though an inadequate one which, taken in amounts disproportionate to other elements in the diet, over long periods of time, leads to diseases of dietary deficiency.

ALCOHOL DOES NOT

Increase efficiency or ability to perform mental or physical work of any sort. It may, in individuals excessively hampered by inhibitions and anxieties, enable them to accomplish tasks they

hold back from, but not as efficiently as they could if their mental block were removed by psychotherapy.

Act as a stimulant, although, by reducing consciousness of fatigue, it seems to stimulate.

Act as an aphrodisiac, except to the extent that it lessens inhibitions.

Cause insanity, epilepsy, neurosis or glandular disturbance. In cases of psychosis, and perhaps in all others, alcoholism is a symptom of an underlying disturbance, not its cause. Delirium tremens (which affect 4 per cent of alcoholics) and other rare "alcoholic psychoses" are recognized as symptoms of vitamin deficiency and respond to high-vitamin therapy.

Cause alcoholism, any more than sugar causes diabetes. Individual idiosyncracies, physiological, psychological, or both, cause inordinate cravings for alcohol, low resistance to its effects.

Injure the heart or kidneys or contribute to hardening of the arteries.

Cause cirrhosis of the liver, which is a diet deficiency disease attacking 3 per cent of alcoholics.

Cause ulcers, which are generally recognized as a psychosomatic ailment. Moderate drinkers tend to develop them less often than non-drinkers.

Cause polyneuropathy, a nervous disorder with burning sensations and pain in legs, eventual paralysis in legs and arms; or "bear heart", an enlargement of the heart and weakening of its muscles. Identical symptoms are found in Oriental beri beri, a diet deficiency disease; the same treatment with Vitamin B1, produces cure.

Make you fat, by itself. But it is quickly oxidized and converted into caloric energy. Thus, while the energy in alcohol is rapidly burned up, other food taken in may be stored as fat.

Cure colds, although it will make the patient feel better, perhaps help him to get relaxation and sleep which will aid in recovery, if he stays in bed. Heavy drinkers, whose resistance is

lowered by generally poor health habits, die of pneumonia ten times more often than others.

Differ in effect according to the beverage consumed, except slightly. The concentration of alcohol ranges from 3 to 20 per cent in brewed and fermented beverages (beer and wine) to 50 per cent (100 proof) and higher in whisky, gin, rum, brandy, and other distilled spirits. If "hard liquor" is diluted to the same concentration as beer or wine, it will have virtually the same physiological effect. Vegetable substances, including vitamins, are found in beer and wines. The effects of these ingredients are minor. Absorption of alcohol in any form is delayed by presence of food in the stomach; hence a drink before dinner acts more quickly than one during dinner.

("Science," *Illustrated* Vol. 3, No. 6)—June, 1948.

DEATH RATE AMONG THE VARIOUS STRATA OF SOCIETY

"Rowntree in 1900 selected three areas of York, containing the poorest, middling and the best-paid working class populations respectively. The sanitation and other living conditions of the three classes were roughly proportional to their wages. The death-rate of the first class was 27.8, of the second 20.7, of the third 13.51. The proportion of their children who died in the first year of their lives was in the first group 247 per 1,000 births, in the second 184, in the

third 173, while among the servant keeping classes of the town it was but 94! The demonstration of the connection of poverty and ill-health is here entirely convincing: yet we may note that the infant mortality of the richest folk in York was worse in 1900 than that occurring in most of the poorest slums in England today, and may deduce that improvement in social conditions is not a panacea."

"Century of Science"—By Sherwood Taylor.

TROPICAL WHITES AND THEIR BOAST OF GOOD HEALTH

For every tropical white who boasts of his continued good health, his fine children, etc., one can find a repatriate many years sick or broken for life. Much repatriation for reasons of health is in a sense unnecessary; so also are many premature deaths. Over-indulgence in alcohol is a well-known affliction which directly or indirectly may explain a large fraction of the casualty list. It is worth noting that the attention to the bar in warm countries springs fundamentally from a need for stimulation which the climate fails to give. A daily set of tennis or some other vigorous exercise in place of the extra highballs would be the best solution. However, unsatisfactory social environment is often the immediate cause for seeking alcohol.

From "Climate and Man" Yearbook of Agriculture—U.S. Dept. of Agriculture

THERE ARE SIX KINDS OF DRINKERS!

Moderate. Drinks small amount, usually beverages of low alcoholic content, before or with meal, for taste and mild effect. Can stop drinking with no feeling of deprivation.

Habitual, Social. Drinks practically daily for "kick" and social relaxation, not sufficiently to injure health, but enough to be potentially dangerous automobile driver. May gradually increase amount and so become.

Heavy or excessive. Can get along without drinking, desires to, but drinks large quantities and frequently. Runs some risk of becoming addictive or impulsive drinker, more of becoming chronic alcoholic.

Addictive, impulsive. One whose life is dominated by use of alcohol, who cannot stand up to responsibilities or disappointments without recourse to heavy drinking. Cannot give up alcohol voluntarily even when he knows it is harming him and he desires to give it up.

Chronic alcoholic. One who has developed a body of mental disorder as a consequence of prolonged heavy drinking.

Inebriate. According to some definitions, includes heavy, excessive, and impulsive drinkers. An inebriate is not a chronic alcoholic unless alcoholic disease is present.

(Courtesy—"Science," *Illustrated*)

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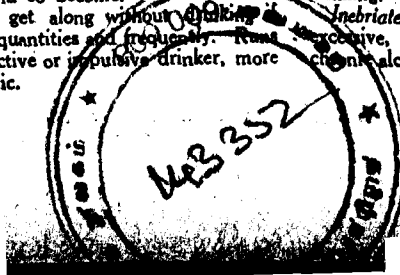
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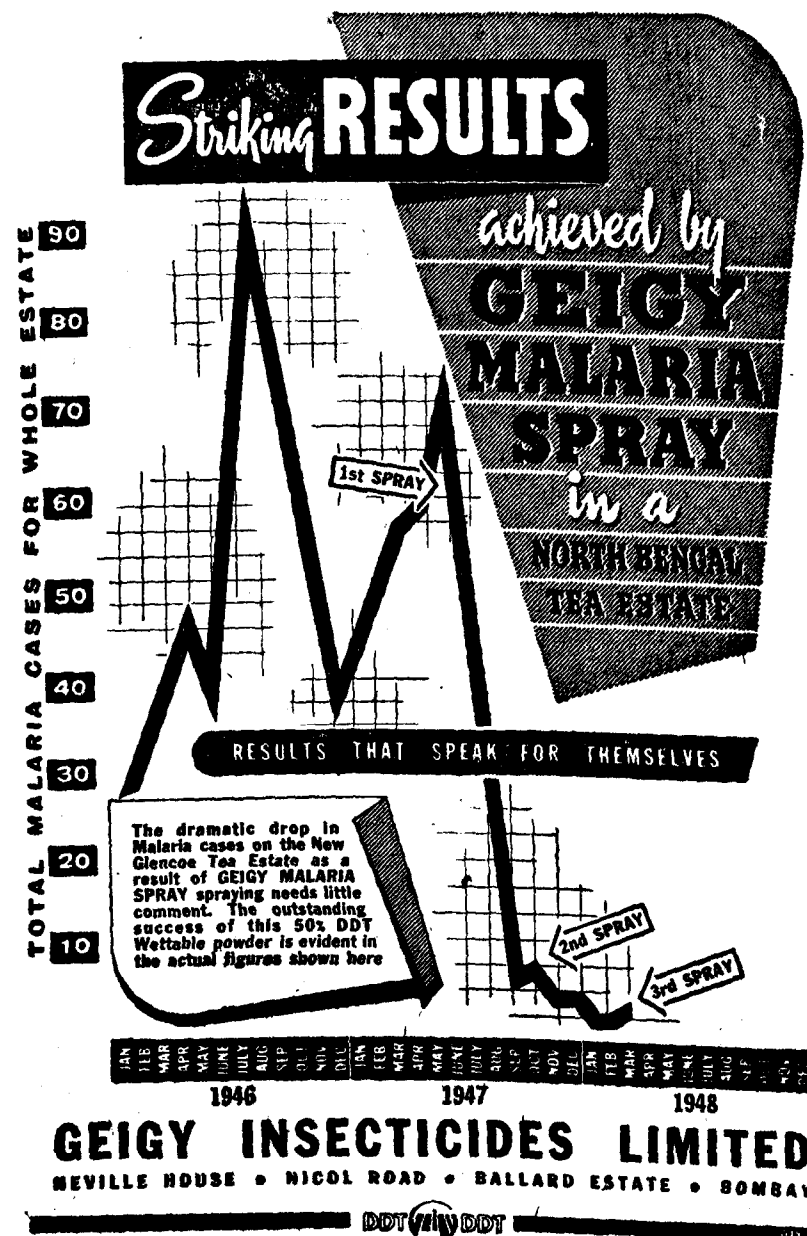
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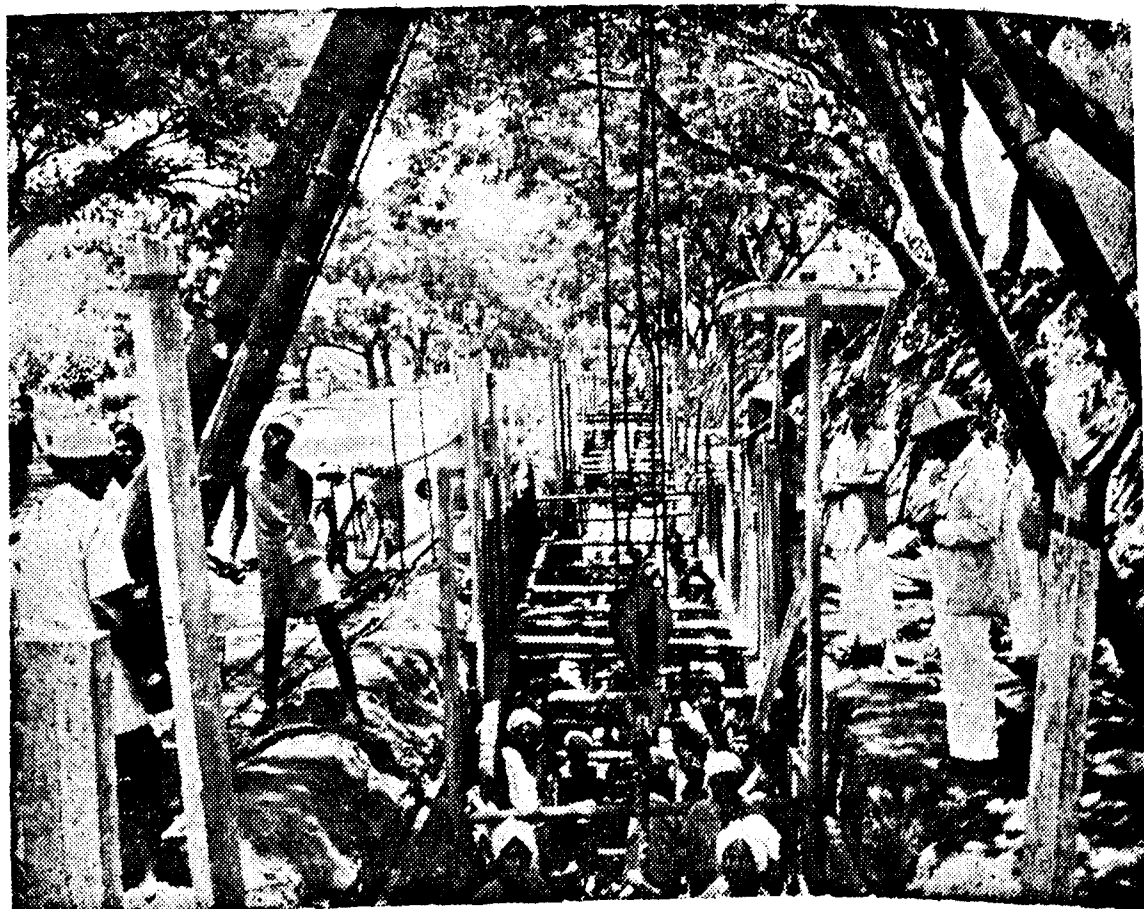
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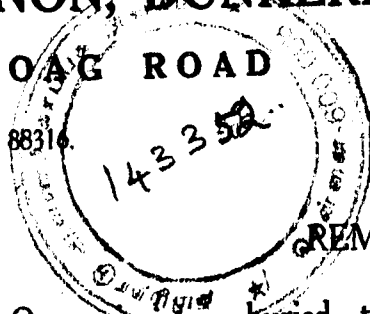
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