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THE MISCELLANY

583

Managing Editor: Dr. P. A. S. RAGHAVAN

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
INDIAN MEDICAL ASSOCIATION

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P. A. S. Raghavan,
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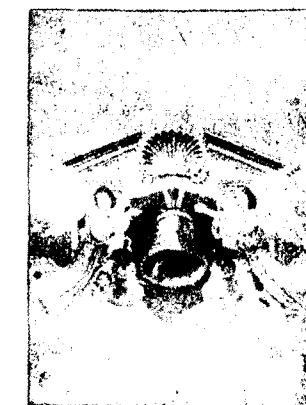
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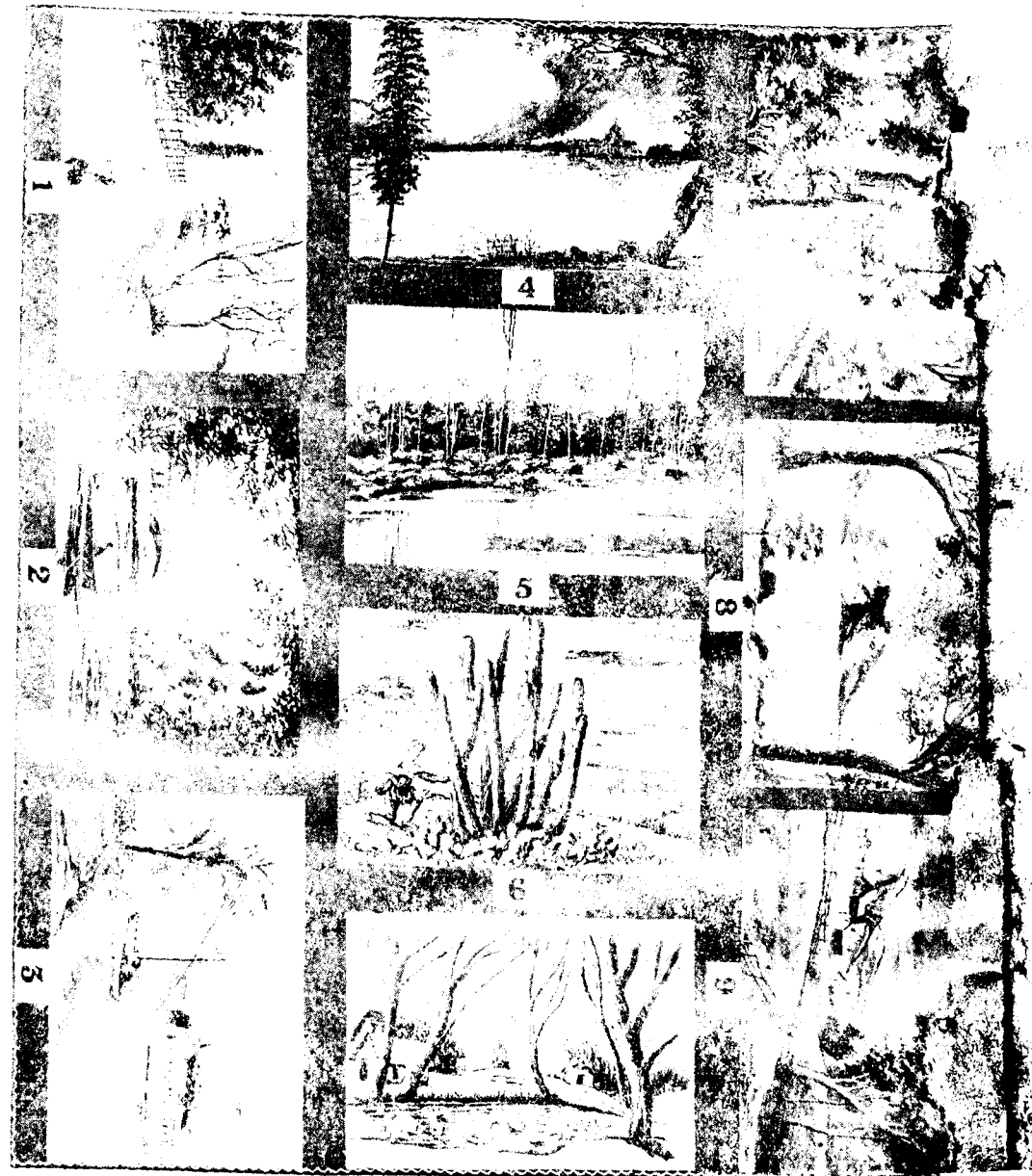
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The MISCELLANY—October, 1951.

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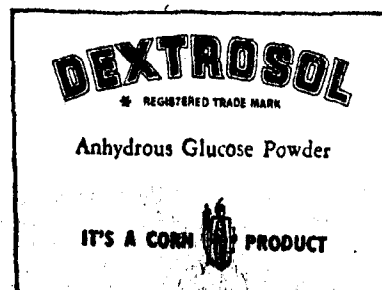
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THE MISCELLANY

MONTHLY JOURNAL OF THE SOUTH INDIAN BRANCH
THE INDIAN MEDICAL ASSOCIATION

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[No. 4

RICE PROBLEM IN NUTRITION

BY

DR. R. SAMBASIVAN, M.B.B.S., TIRUCHY.

(continued from previous issue)

What are the factors that perpetuate the present malady of insufficient and decreasing production in Rice? !

Firstly, there is the factor of varying and uncertain fortunes to the producer, such as an erratic rain-fall, unpredictable levels of water at the irrigation heads, pests, and so on.

Secondly, there is the present high cost of living which falls with intensity on the agricultural producing classes.

Thirdly, there is the ever frightening prospect of an agricultural income-tax with varying possibilities of legislative expropriation of landed property from existing owners.

Producers under such circumstances develop a lack of interest in further production. They are tempted to surrender as little as possible of their produce to the State in order to meet at least partially their high cost of living by a little lucrative dealing in the unauthorised market.

The incentive to further production or increased production is therefore likely to be poor.

Here are some incentives to increased production by agriculturists:—

1. *Pulses*:—Governmental free distribution of seeds for green-gram and black-gram sowing to bring the entire paddy area under pulses after the *Samba* harvest in December. This does not upset the existing village economy—for this does not involve additional manure, additional ploughing, additional irrigation, additional tax, or even additional attention from the agriculturists. Without these additional burdens, the producer is tempted by additional income from his existing cultivated lands after the *Samba* harvest. Further, these leguminous plants by their growth enriches the Nitrogen content of the soil.

2. *Green-Manure*:—Governmental free distribution of seeds for green-manure plants for such fields which cannot grow green-gram or black-gram.

3. No cess or water rate to be levied on black-gram or green-gram cultivation if grown after one paddy crop.

Objectively, what is the present state of affairs among the population? It can be summed up in three words—Mal-Nutrition, Faulty Nutrition, and Sub-Nutrition.

And what is the result?

Almost every family in the country is a miniature hospital. In fact, the whole country has acquired the status of a general hospital. For each patient taking a bed in any State hospital there are at least 100 patients staying out in their homes.

Why should this be so?

The present day conditions in all public hospitals can be summed up thus— shortage of beds, shortage of linen, shortage of food, and shortage of medical equipment.

What is the solution?

The solution lies not in the way of increasing the number of hospitals or the number of beds. The solution lies in raising the "Nutritional Status" of the population. In the best of times before the World War i.e., before 1939, the "Nutritional Status" of this country was deplorably low.

It is now being increasingly recognised by many observers that numerous conditions of chronic ill-health in adults and children and during pregnancy are due to faulty nutrition or sub-nutrition. The problem now is how best to raise the "Nutritional Status" of the population.

The "Nutritional Status" of an individual or a group of people cannot

be raised by synthetic vitamins issued in bottles or through injections. The "Nutritional Status" can be raised only by adjusting the dietetic table in such a way as to ensure the composite intake of all the vitamins and first class proteins through the medium of our available food materials.

On our medical men particularly falls the inescapable duty of facing up to the task of rebuilding the diet of our people, ensuring adequate proteins and vitamins intake.

The "Nutritional Status" can certainly not be raised by cutting down rice-protein below the survival level of 20 gms., daily i.e., equivalent to 10 ozs., of rationed rice per head per day.

The "Nutritional Status" can certainly be raised by a constructive State policy on the following lines:—

1. Manufacture and distribution of Food-Yeast powder by the State as a State enterprise, from molasses (in Sugar Refineries) which are treated now as a waste material. It is being whispered that the Government contemplate using these molasses for production of power-alcohol. Which is now more vital and more urgent? Is it the food problem or the motor-fuel problem?

2. Closing down of sugar Refineries and Edible oil hydrogenation plants, and switching over such plants to other lines of productivity.

3. Prohibition of the import of sage and arrow root.

4. Prohibition of production of coconut oil thereby making the tota

production of coconuts available as food.

5. Every Municipality should be compelled under suitable legislation to keep herds of cattle and milch cows and deliver the milk to the infant-welfare centres to tackle the problem of infant nutrition for all age groups below the school-going age.

6. Prohibition of the use of milk in restaurants.

7. Prohibition of the sale of ice-fruit and ice-cream.

8. Butter-milk feeding to school children in the afternoons with one *Puvan* plantain fruit for each child.

9. The agricultural department to engage itself in poultry keeping and to maintain egg depots in all areas.

10. Governmental banning of hulling of raw rice (Parboiling gives 20% greater output than raw rice and par-boiled rice is 4 times richer in its content of vitamin B-complex than raw rice.

(To be continued.)



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ASSOCIATION NOTES

SOUTH INDIAN PROVINCIAL BRANCH

Minutes of the Meeting of the Council of the South Indian Provincial Branch of the Indian Medical Association held at Karaikudi on 9-9-51.

MEMBERS PRESENT:—

1.	Dr. U. Krishna Rau,	<i>President,</i>	Madras
2.	„ A. K. Rajagopalan,	<i>Hony. Secretary,</i>	Madura
3.	„ D. V. Venkappa,	<i>Hony. Jt. Secretary,</i>	Madras
4.	„ P. V. Sundaram,	<i>Hony. Treasurer,</i>	Trichy
5.	„ S. Subramaniam,	...	Chettinad
6.	„ M. Srinivasalu,	...	do.
7.	„ T. S. Shetty,	...	do.
8.	„ A. G. Leelakrishnan,	...	Coimbatore
9.	„ T. V. Sivanandam,	...	do.
10.	„ S. Ganapathy,	...	do.
11.	„ R. Gopal,	...	Madurai
12.	„ G. A. Naidu,	...	do.
13.	„ P. A. S. Raghavan,	...	Trichy
14.	„ C. R. Chary,	...	do.
15.	„ A. Dharmarajan,	...	do.
16.	„ R. Ganesan,	...	do.
17.	„ T. S. Balasubramanyam,	...	do.
18.	„ V. Veerappan,	<i>co-opted.</i>	Chettinad
19.	„ Muthiah,	...	do.

As per Rule 7 (b) of South Indian Provincial Branch, the President co-opted Drs. V. Veerappan and Muthiah of Chettinad Branch for this meeting of the Council.

MINUTES OF THE MEETING

1. A condolence resolution on the death of Dr. P. S. Mannadiar, L.M.P., a member of the Nilgiris District Branch of the Indian Medical Association was moved from the Chair. It was carried unanimously all standing for a minute.

2. Minutes of the last meeting were read and approved. It was suggested that the minutes of the meeting be circulated to the members as soon as it is ready.

October, 1951]

ASSOCIATION NOTES

3. Business arising out of the last meeting.

(a) The President informed the House that he had conveyed the condolence resolutions passed at the last meeting to the members of the families of late Dr. P. Venkatagiri of Madras and late Dr. M. S. Raghavendra Rao of Tanjore.

(b) Hackim and Village Vaidya Scheme.

The President explained to the house the view point of the Working Committee of the I. M. A. This was approved.

(c) C. F. C. Arrears.

The President explained that at the meeting of the Working Committee of I. M. A. held at Hyderabad, the arrears of C. F. C. from the South India for 1948-49 and 1949-50 were written off by the Working Committee. The President appealed to the members of the various branches to collect the subscriptions as far as possible.

(d) A sum of Rs. 4/- by the South Indian Provincial Branch and a sum of Rs. 10/- by the Centre were sent to Mrs. Lakshiminarasu, wife of the late Dr. M. S. Raghavendra Rau of Tanjore.

(e) It was reported that the 5th Conference of the South Indian Provincial Branch will be held at Calicut on 5th, 6th and 7th October, 1951. It was also decided to hold the Annual Meeting of the Council of the South Indian Provincial Branch at Calicut on the 5th. The Secretary was requested to inform the members later the time of the Annual meeting of the Council.

4. Printing of the Miscellany.

The Sub Committee appointed for the purpose submitted the following report:

“Meeting of the Sub Committee to discuss question of Printing Miscellany.

Present:—Dr. U. Krishna Rao, Dr. P. A. S. Raghavan, Dr. R. Ganesan, Dr. A. G. Leelakrishnan and Dr. T. V. Sivanandam.

The Committee is of the opinion:—

- (1) that the Miscellany be printed and published by the Trichy Branch of the I. M. A. either through Dr. P. A. S. Raghavan or through anyone else if it so chooses.
- (2) that the Provincial Branch of I. M. A. is not responsible for any loss incurred by the Trichy Branch in this matter.

- (3) that the Trichy Branch however do pay a reasonable contribution to the Provincial Branch if they make a profit on the running of the Miscellany.
- (4) that the Trichy Branch do submit to the Provincial Branch the accounts of the Miscellany at the Annual Provincial Council meeting.

The Sub Committee resolves that the above arrangement be continued for a period of three years, at the end of which period the matter may be reviewed.

(Sd.) U. Krishna Rao, (Sd.) P. A. S. Raghavan, (Sd.) R. Ganesan,
(Sd.) T. V. Sivanandam, (Sd.) A. G. Leelakrishnan."

The above report of the Sub-Committee was approved and unanimously passed.

5. *Printing of the Journal of I. M. A. in South.*

The Sub Committee appointed for the purpose submitted the following report.

"Meeting of the Sub Committee to discuss the question of printing Journal of I. M. A. in South:

Present:—Dr. U. Krishna Rao, Dr. A. G. Leelakrishnan & Dr. P. A. S. Raghavan.
Letters received from Dr. K. R. Kini and Dr. D. V. Venkappa were read.

The Sub Committee is of the opinion that for the present the printing of the Journal of the Indian Medical Association may be done at Calcutta.

(Sd.) P. A. S. Raghavan, (Sd.) U. Krishna Rao,
(Sd.) A. G. Leelakrishnan. 8—9—51."

The report of the Sub Committee was approved and passed.

6. *Insurance scheme for members of I. M. A.*

Since the United India had withdrawn the original offer, the South Indian Provincial Council appoints a Sub Committee consisting of:—

- (1) Dr. U. Krishna Rao—President (Convener).
- (2) Dr. A. G. Leelakrishnan
- (3) Dr. P. A. S. Raghavan
- (4) Dr. Naidu
- (5) Dr. S. Subramaniam, M.L.A.

to work out a plan on those lines. They are authorised to contact Mr. Naidu again and see if he will give the benefit of his scheme, for South India at least.

7. *Fixed Deposit amount—renewal.*

Resolved to renew the Fixed Deposit amount of Rs. 3000/- for another year.

8. *Result of the Elections for South Indian Provincial Branch.*

As Dr. U. Krishna Rao was the only candidate nominated for the Presidentship he was declared elected.

The counting of votes for the Vice-Presidents was done and Dr. Y. P. Vasudevan who had obtained 7 votes and Dr. P. Vadamalayan who had obtained 5 votes were declared elected as Vice-Presidents.

9. *Formation of Working Committee for the South Indian Provincial Branch.*

The Council after some discussion decided to drop this matter for the present.

10. *Letter from Coimbatore Branch.*

This was read and in view of the circumstances explained, no action was called for at the present moment.

11. *I. M. A. circulars.*

Nos. 40 to 45: recorded.

No. 46: reply recorded and approved.

12. *Under any other Subjects:*

(1) *Arrears of CFC. for 1948-49 and 1949-50.*

The Treasurer was authorised to write off the Provincial quota due from the local branches for the said period as the Working Committee of I. M. A. had written off the arrears.

(2) *Letters from Salem and South Arcot Branches re. change of Rules:*

As these letters are withdrawn no further action was taken.

(3) *Dr. D. V. Venkappa moved and Dr. Shetty seconded the following resolution:*

"The Council of the South Indian Provincial Branch of I. M. A. meeting at Karaikudi is of the opinion that the proposed amendment of the Government to remove from the Madras Medical Council the power to elect its own President is a retrograde step and goes against democratic principles and requests the Select Committee of the Legislatures and the Government to drop this amendment."

This was unanimously carried. It was also resolved to authorise the President Dr. U. Krishna Rau, the Joint Secretary Dr. D. V. Venkappa, and the past President Dr. P. A. S. Raghavan, to give evidence before the Select Committee if invited. It was also resolved to form a Sub Committee consisting of Dr. U. Krishna Rau, Dr. D. V. Venkappa and Dr. P. A. S. Raghavan to examine the provisions of the new Bill and suggest and forward them to all members of the Select Committee.

With a vote of thanks for the excellent arrangements made by Dr. S. Subramanyam, M.L.A. and Dr. M. Srinivasalu, Honorary Secretary, Chettinad Branch of I.M.A. the meeting terminated.

A. K. RAJAGOPALAN,

Honorary Secretary.

U. KRISHNA RAU,

President.

MATHURAI BRANCH

President: Dr. M. N. Rajan

Vice-President: Dr. T. S. Renga Iyengar

Hony. Secretary: Dr. P. Krishna Menon

Hony. Treasurer: Dr. A. S. Annamalai.

The above meeting was held at 6 P.M. on 22-9-51. Dr. M. N. Rajan occupied the chair. The minutes of the last meeting were adopted. The Secretary announced, amidst applause, the election of Dr. P. Vadamalyan and Dr. Y. P. Vasudevan as Vice-Presidents of the South Indian Provincial Branch of the Indian Medical Association for 51-52. Dr. J. Kvittingen, M.D., Serological Expert of the World Health Organisation and Dr. D. Subba Rao, Asst. Director of Public Health, Government of Madras were welcomed to the meeting.

Dr. K. Balakrishnan, M.B.B.S., T.D.D., Tuberculosis Specialist, Erskine Hospital, Madurai, gave an interesting talk on "THE TUBERCULOSIS PROBLEM IN MADURAI". He referred to the work

of the General Practitioner as constituting the first line of defence against this disease; but regretted that he often came across cases in which the diagnosis of Pulmonary Tuberculosis had been missed even after an X-ray picture was taken. This was due to the inexperience on the part of the practitioners in interpreting the films. Dr. K. Balakrishnan explained the role of T. B. clinics which constituted a second line of defence and pleaded for a large number of such clinics being established all over the country. He pleaded for a missionary spirit amongst medical men in charge of T. B. work. Sanatoria, should, according to the learned lecturer, undertake major surgical procedures on suitable cases and provide for an increasingly large number of free beds for the poor patients. He also

stressed the need for co-ordination between the work of different Tuberculosis clinics.

Dr. Balakrishnan replied suitably to the discussions that followed.

Dr. J. Kvittingen referred to the work that was proposed to be done under the auspices of the World Health Organization through municipalities and other

bodies in this country particularly serological testing of groups of populations. Such screening methods would enable treatment being given to the really infective cases of V. D. particularly to pregnant mothers. He answered a number of questions and explained the rationale of serological testing in V. D. The meeting terminated after a vote of thanks.

INDIAN MEDICAL ASSOCIATION

SOUTH INDIAN PROVINCIAL BRANCH

ANNUAL REPORT FOR THE YEAR 1950-51

LADIES AND GENTLEMEN,

I have great pleasure and honour to submit the following Annual Report for 1950-51.

The Head Quarters of the Provincial Office during the year mentioned was located at Madurai the place of the Honorary Secretary.

The year began with the following 18 Branches:

Bangalore	Chingleput	Coimbatore	Erode
Madras	Madura	Malabar	Negapatam
Nilgiris	North Arcot	Pudukottah	Ramnad
Salem	South Arcot	South Kanara	Tanjore
	Tiruchy	Tinnevely	

During the year a new branch was formed with its Head Quarters at Pallathur and is called "CHETTINAD BRANCH".

The North Arcot Branch has disaffiliated from I. M. A. during the year in December 1950, as a temporary measure. Due to our President Dr. U. Krishna Rau's efforts the Branch will once again become affiliated with I. M. A. at no distant date.

Due to the formation of a Provincial Branch at Mysore the Bangalore Branch of I. M. A. which was originally a local Branch of our Provincial Branch has joined the Mysore Provincial Branch as per the rules of I. M. A. Central with effect from 1-4-'51.

The number of local branches now functioning is 17.

The total strength of our Provincial Branch at the beginning of the year 1950-'51 was 1257. In spite of the two big branches with a strength of about 150 members, leaving this Provincial Branch the total strength now at the end of the Official year is 1335. The number of members enrolled for the year is 150.

It is with deep regret I have to note that three members of our Provincial Branch died during this year.

1. Dr. M. S. Raghavendra Rao of Tanjore Branch.
2. Dr. P. Venkatagiri of Madras „
- and 3. Dr. P. S. Mannadiar of Nilgiris „

The meetings of the Council of the South Indian Provincial Branch were held at the following places on the dates mentioned against each place :

1st meeting	at Mangalore	on 13-10-1950
2nd „	at Madras	on 7-1-1951
3rd „	at Ootacamund	on 8-4-1951
4th „	at Chingleput	on 30-6-1951
5th „	at Karaikudi	on 9-9-1951

The Council of the South Indian Provincial Branch has got a strength of 77 members.

The total number of members from our Provincial Branch elected by the various branches to the Central Council of I. M. A. is 31.

In this connection I would stress the need for the members of the Central Council to attend the Annual Central Council Meeting during the All India Medical Conference, as otherwise the voice from the South Indian Provincial Branch will not be felt during the Annual Central Council meeting of I. M. A. I request the local Branch Secretaries to see that all the members of the Central Council who are elected by the respective Branches to attend the meetings of the Central Council.

The following members of our Provincial Branch were elected by the Provincial Council at its last Annual Council meeting held at Mangalore as members of the Working Committee of I. M. A.

1. Dr. U. Krishna Rau,
2. Dr. P. A. S. Raghavan,
3. Dr. P. B. Anangarachary.

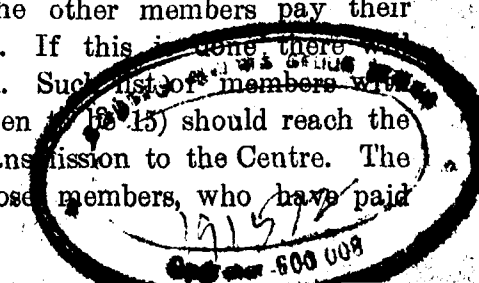
They have been attending all the Working Committee meetings and I am very happy to note that our President Dr. U. Krishna Rau and the other members did yeoman service to our Provincial Branch in the Working Committee meetings of I. M. A.

CENTRAL FUND CONTRIBUTION

The arrears of CFC. for 1948-49 and 1949-50 amounting to Rs. 598 was a big responsibility with us. Since the said amount was not realisable by the various Branch Secretaries for reasons beyond their control, as death and resignations and since the I. M. A. Central Office was pressing us for immediate payment, our President Dr. U. Krishna Rau was good enough to take up this cause at the last Working Committee meeting of I. M. A. at Hyderabad and saw the Working Committee of I. M. A. writing off these arrears as unrealisable. In this connection I would like to press the various Branch Secretaries to see that the CFC. on behalf of their members is collected in time and sent on to the Provincial Office for transmission to Centre. I will also request the Branch Secretaries to see that whenever they enrol new members, they send both the M. A. forms and the CFC. together to the Provincial Office for transmission. Unless and until both these reach the centre together, the Central Office cannot enrol the new members and arrange to send journals to the respective members.

From my experience as the Provincial Secretary for the last three years I would suggest the following to the local Branch Secretaries, for guidance so that their Branches may not be held responsible for arrears of C. F. C.

To send up before October end, the list of members of their Branches who have paid their C. F. C. either in full or 1st half, omitting those members, who have not paid their CFC. As and when the other members pay their C. F. C. they can be reinstated without difficulty. If this is done there be no arrears of CFC. on behalf of that Branch. Such members who have paid their CFC. (even if the number of members happen to be 15) should reach the provincial office before the end of October for transmission to the Centre. The Provincial Office will see that only such of those members, who have paid



their CFC. are in the I. M. A. list, deleting others as a temporary measure and the Provincial Office will request the Centre to take only these members in the I. M. A. list. In course of time when members pay up they can be reinstated. If they do not pay up the local branch is not in arrears.

I am very happy to inform the members of the Council that the arrears of CFC. for 1950-'51 are due only from two branches amounting to Rs. 56/-. If this is cleared we are having a clean slate, and we can be really proud of it.

I request the Branch Secretaries to enrol as many members as possible and see the total strength of the South Indian Provincial Branch is equal to, if not better than that of Bombay or Bengal Provincial Branches.

The status of 'The Miscellany' is now definitely settled by our Council as the Official Organ of the South Indian Provincial Branch.

My thanks are due to Dr. U. Krishna Rao, our President, for all the guidance he gave me, and my only regret is that I could not continue in the office for one more year under the able leadership of Dr. U. Krishna Rao. I am sure the next Provincial Secretary will really feel proud to work under him. I am also thankful to the Joint Secretary and the Honorary Treasurer for all the co-operation they gave me in the discharge of my duties as the Provincial Secretary and the Editor of the Miscellany, the Official Organ of the South Provincial Branch for giving due publicity to all the activities of the local branches which really helped in increasing the membership. I am also thankful to the Secretaries of all the local branches for the kind help and support they extended to me. In my official career I might have written to some of them some stiff letters with regard to arrears of CFC. but I can assure them that whatever I did, it was purely with motives of best interests of our Provincial Branch. If I have annoyed and offended them in any way, I beg to be excused.

My thanks are due to all the members of the Provincial Council for their honest and constructive criticism about the Provincial Office. I believe it is that that gave me filip to work more hard.

Last but not least I must express my thanks to the office assistants Lakshminarayanan and Venkatarathnam for their honest and good work. I have had most loyal and active support from them without which it would have been impossible for me to run the Provincial Office. In this connection I would like to state that the Provincial Office must employ a permanent

Clerk who knows to keep files and ledgers. I would also stress the need of a duplicator and necessary office equipments to suit the status of our Provincial Office.

25th September }
1951 }

A. K. RAJAGOPALAN,
Honorary Provincial Secretary.

Budget for 1951-52

Membership strength of Provincial Branch 1335.		
Provincial Quota for the above at Rs. 3/- each	...	Rs. 4,005
Estimated increase of 200 members and their Provincial quota at Rs. 3/- each.	...	Rs. 600
Total	...	Rs. 4,605

Estimated Expenditure:—

Postage and stationeries	...	Rs. 800
Pay to Secretary's clerk (full time) at Rs. 100/- per mensem	...	Rs. 1200
Pay to President's clerk (part time) at Rs. 50/- per mensem	...	Rs. 600
Pay to Treasurer's clerk (part time) at Rs. 50/- per mensem	...	Rs. 600
Cycle Allowance to clerks	...	Rs. 180
T. A. for the clerks	...	Rs. 150
T. A. to Office bearers of the Assn.	...	Rs. 500
Auditor's fee	...	Rs. 50

Rs. 4,080

Rs. 525

Budget Balance

ABSTRACTS FROM THE CURRENT MEDICAL LITERATURE

THE SCOPE AND RELATIONSHIPS OF PSYCHIATRY IN MEDICINE — *J.A.M.A., June 50—Francis J. Gerty, M.D.*

Recently, psychiatry has been receiving much more notice and of a different kind than in time past. Less than fifty years ago its place in private practice and in medical education was that of the subordinate branch of the minor speciality of nervous and mental diseases. It had a shakily important position in the field of state and private institutional service. The chief public notice accorded it concerned the troubles and shortcomings of mental institutions and the conflicting testimony of alienists in murder trials. Yet, psyche is a pervasive element in human behaviour and that element on which man's claim to superiority over other animals rests. Since psyche is credited with such importance, one might expect that psychiatry would have an important place in the field of medicine. In fact, one might think of its boundaries as being coextensive with those of medicine and expect to learn that in the history of medical progress its role from the beginning had been a major one. Actually, psyche has been considered something superimposed on man and therefore not directly the concern of medicine. Psychiatry was not accepted seriously as a medical speciality even in its institutional form of practice until the nineteenth century. Even now its major relation to the problems of medicine is not readily conceded in all medical schools. Nor do all practitioners of medicine assign it a place as one of the important medical specialities. However, it does enjoy more recognition today than ever before, and the change has come about in a relatively short time. This belated and partial recognition requires comment and explanation.

Comparison of Former and Present Conditions of Psychiatric Practice.

In nothing is the change in attitude

toward the practice of psychiatry more evident than in a comparison of the conditions now existing with what they were formerly. While medicine touched on the problems of mental illness lightly from time to time, until well into the present century psychiatric practice was largely institutional. The emphasis in treatment was principally on humanitarian custodial means; in scientific contributions, more exact clinical descriptions and classifications and study of pathology; in forensic matters, the opinions of alienists on the mental condition of hypothetic persons. Private practice was usually an adjunct to neurologic work, being concerned with consultations and a combination of physical treatments and psychotherapy. The recommended physical means of treatment included sedatives, tonics, massage, baths, rest, exercise and diet. Not a little psychotherapy was used, some of it by design and some unconsciously. Rational psychotherapy proceeded as far as explanation, reassurance and persuasion, and some practitioners consciously employed suggestion and hypnotism. Patients with major psychoses were sent to state hospitals or to private asylums or retreats. There were private sanatoriums and rest cures for patients with what was commonly called nervous exhaustion. Except in institutions, the exclusive practice of this speciality was almost unknown.

Today, the practice of psychiatry is quite different from what it used to be. There are still special mental institutions, and there are more patients than ever in them. The progress that has been made has affected the institutions somewhat, but not as much as one could wish. In some of them the conditions remain essentially the same as they were twenty-five or fifty years ago. Many physicians are engaged in the exclusive private practice of psy-

chiatry. The American Psychiatric Association now has over 5,200 members. It had 176 members in 1890, when it was known as the Association of Medical Superintendents of American Institutions for the Insane. The field of the medical neurologist has been invaded by the neurosurgeon and the psychiatrist. There are more psychiatrists than neurologists in private practice. Subspecialization in psychiatry is common, especially in psychoanalysis but to a lesser extent in child psychiatry. Of the analysts there are several subgroups, though more or less orthodox Freudian psychoanalysis is the predominant analytic therapy in America. A number of general hospitals have opened psychiatric units in the last fifteen years. The patients received in the psychiatric units are usually persons with acute psychoses sent to the hospital for treatment by the new physical shock methods. However, now that the psychiatrist is a regular member of the hospital staff, not an occasional consultant, he is kept busy participating in the treatment of other patients than those received in the psychiatric unit. The psychiatric aspect of all illness is given much more attention in these hospitals than formerly, and the mentally ill patients receive a quality of physical treatment not available to them formerly. Most office practice is concerned with psychotherapy, usually with appointments filled far in advance. The outpatient clinics are too few in number but are kept busy giving the same kind of treatment as that available in private offices. The military services, Veterans Administration, many state hospitals and many psychiatric clinics are offering exceptionally good opportunities at unprecedentedly high salaries for qualified psychiatrists. Unfortunately, the lure of private practice, particularly in psychoanalysis, is such that even young psychiatrists who have just finished their training will not accept such

positions. Without question, a great change has come over the practice of psychiatry in a few years.

Requisite Undergraduate Training

The student of medicine should obtain a good general preparation for the practice of his chosen profession in his undergraduate course of study. Each branch of medicine should contribute its share to this preparation in proportion to its value. A few years ago some approved medical colleges did not offer special courses in psychiatry and most of the others taught little about the subject. Since this was so, one is justified in assuming that recognizing agencies and medical college faculties did not regard the teaching of psychiatry to undergraduate students as an essential part of the preparation for practice but viewed it, rather, as a special branch about which the student should be taught something if time, facilities and the requirements of more important divisions of instruction permitted. Definitely, this view is changing—changing in the face of many difficulties. Once a medical college might have been content to offer a course in psychiatry to senior students, probably of lectures and some clinical demonstrations. The curriculum hours reserved for this purpose were few indeed. In the past twenty years the number of instruction hours assigned to psychiatry has increased greatly in all medical schools where it was formerly in the condition which has been described as having been fairly typical. In most medical schools the course in psychiatry is taught not only in the clinical years but has extended back into the preclinical ones. The effect of Adolph Meyer's influence on undergraduate medical education should not be underestimated. He termed his psychobiologic concept "commonsense psychiatry." It seems to be so in that it attempts to include all the factors that enter into the life experience in their chronologic sequence and

their interrelationships. His school built up slowly between 1906 and 1920, then more rapidly until it reached its peak between 1930 and 1940. During this period the survey of the teaching of psychiatry in American medical colleges was carried on intensively and the American Board of Psychiatry and Neurology was organized. With Meyer's retirement and the coming of the second World War the ground which he had prepared proved much more fertile soil for the growth of psychoanalytic influence in undergraduate education than might have been expected. The tendency is toward much wider acceptance of the view that psychiatry is an essential part of undergraduate medical teaching, not merely a specialist field about which the student needs to learn only a little. As this view becomes accepted—and it becomes accepted through practical demonstration rather than discussion—the implementation of the instruction improves. There are many more full time and part time instructors in psychiatry than there used to be. One of the most fruitful results is the participation in work with other departments of instruction. This brings opportunity to teach students psychiatric techniques and principles in the hospital and outpatient departments of services other than psychiatry. The change is not fully accomplished, but the evidences of progress are there.

Specialist Education—Progress in standardization.

As long as psychiatry remained an institutional speciality or was practised as a sideline of neurology, the training of psychiatrists was accomplished by a sort of apprenticeship graduation of experience through employment in a mental hospital or under the tutelage of a practising neurologist. Until recently there was little attempt to standardize training except locally in a few hospitals and institutes. The quantity and quality of teaching and experience were uneven. Practically no

attention was paid to choosing specialists on the basis of personality fitness for specialization. In forty years there has been much alteration of standards for the training of specialists in psychiatry. The change began with the pioneer work of Adolph Meyer, Albert M. Barrett and Elmer Southard. The great influence of psychoanalysis on this development cannot be denied, but the organization of the American Board of Psychiatry and Neurology in 1934 has had the chief practical effect in standardizing the education of specialists in psychiatry. In place of a few residencies and fellowships under a few eminent teachers and leaders a much more definitely organized and uniform pattern of training has appeared. Besides its other functions the Board is an agency. "To consider and advise as to any course of study and technical training, and to diffuse any information calculated to promote and ensure the fitness of persons desirous of qualifying for a certificate of qualification to be issued thereby." Admission to its examination requires a total experience of five years after a general internship, three years of which shall be a period of study in institutions recognized by the Council of Medical Education and Hospitals of the American Medical Association as competent to provide a satisfactory training in psychiatry and not less than two years of additional practice in psychiatry. At present there are listed over 1,500 psychiatric residency positions in recognized institutions in the United States. Inspection of these institutions is not yet completed; hence, it is difficult to be sure how many of them can give satisfactory training. The Board suggests a program of subject content and of time distribution between the several subject subdivisions. There are a great many candidates for training—even applicants for admission to medical college often express special interest in psychiatry—but many of the recognized training programs

do not attract a sufficient number of candidates to fill their quota and other programs have a surplus of applicants. Specifically, many candidates wish to get psychoanalytic training and admit readily that their goal is psychoanalytic office practice. The combined result of the Board suggestions—often referred to as "requirements"—as to subject matter distribution, and the interest on the part of candidates in psychoanalysis—a type of training which is not included in the Board "requirements"—results in a pressuring of training institutes and hospitals to regulate their training programs to meet the demands of trainees. Applicants generally wish to know specifically and almost always in terms of block time and special courses how the residency meets the Board suggestions. This is somewhat annoying to supervisors of some programs, especially in hospitals where a good experience and training might be had in the total program on a time-equivalent basis. Those residencies are at a premium which offer opportunity for arranging for a personal psychoanalysis or include psychoanalysis within their scope. Psychoanalytic institutes have not been inspected and approved by the American Medical Association as special training institutes, so that this training is still officially in the extracurricular category. The Associated Psychiatric Faculties of Chicago—an organization of persons drawn from two of the universities, three of the hospitals approved for resident training and the Chicago Institute for Psychoanalysis—is attempting to provide an indirect recognition for psychoanalytic training in a special situation. Trainees accepted by this organization may be rotated through the three hospitals, if acceptable to the hospitals, in addition to their analytic training. In return, residents in the hospitals are given priority for analytic training at the Chicago Institute for Psychoanalysis. It is obvious that there is not agreement among psychiatrists that psychoanalytic training should be included

at the resident level. Permission to allow time for a personal psychoanalysis to a resident always involves some problem of adjustment of the major program of training. If the thinking of the resident is that psychoanalysis is the major program, the problem becomes greater. Residents undergoing analysis sometimes do become upset emotionally during the process, and this can produce further difficulty. However opportunity for psychoanalytic training is found only in a few places. The psychoanalytic institutes have waiting lists, seem to be aware of the problems and are screening their candidates with considerable care. At the same time, they are trying to increase their means of financial support, amplify their staffs and other facilities and obtain more recognition in medical circles. The lack of adequate personnel and other means required to provide experience in pediatric psychiatry is another problem calling for solution. General psychiatric opinion is much more uniform on the desirability of including this than it is on the subject of psychoanalysis. However, pediatric psychiatrists do not all agree that the general program can include adequate training. The suggestion has been made that a subspecialty certificate be granted after an additional course of training has been taken and an examination has been passed. The general trend in Board examinations and in the training programs has been to decrease the amount of basic and clinical neurology required for candidates in psychiatry. Many psychiatrists and neurologists deplore this tendency; some psychiatrists, especially those with strong psychoanalytic leanings, believe that it is more important for residents to learn other things. In some respects psychiatry now has interests more closely identified with general medicine and pediatrics than with neurology, as is evidenced by the attention now given to psychosomatic medicine. This is reflected in some of the recommendations made for

modification of the standards set by the Board of Psychiatry and Neurology. One more practical matter concerning the problem of specialist training should be mentioned. Since specialization in psychiatry now requires five years' experience after the internship, residents want better pay. Many of them are married and have families. If they are also paying \$1,200 to \$1,500 a year for psychoanalytic training, it is apparent that they are under financial pressure.

General Attitude of Public Toward Psychiatry.

The public notice given to psychiatry recently is deplored by some in the field, welcomed by others. Certainly it is greater in amount and, on the whole, more favourable than in the past. There is still much unfavourable criticism of conditions in mental hospitals, but a new note has appeared in the kind of attention that psychiatry in general receives. The physical methods of treatment are heralded, but most of the notice seems to be given to psychologic aspects of treatment. Lecture platform, lay press, stage, movies, pulpit and courts of law are all mediums for bringing psychiatry to attention. Patients are much less in awe of the specialized vocabulary than they used to be. In fact, they often use the terms glibly. Many of them want to know whether the physician to whom they have been referred is a neurologist, psychiatrist or psychoanalyst. Psychosomatic medicine, the unconscious, symbolism, dream analysis and narcoanalysis are becoming commonplace words. Some ministers of the gospel would seem to make religion mostly psychiatry. Others see psychiatry as a threat to religion. The relationship of psychiatry to social problems and world affairs is assumed by some psychiatrically oriented persons to be major in importance at this time, and preparations are being made for application of its principles in a practical way and on a wide

scale to these problems. That psychiatrists themselves should become involved in contributing to publicity is to be expected. They are as likely to be its victims as to benefit by it. The hope that they can take advantage of it to promote progress toward good ends beckons but can lead them too far. The direction and force of this current is not easily controlled, and those who enter it are often swept along in unforeseen ways into unhappy predicaments. It is now more necessary than ever that psychiatrists undertake the task of evaluating the contributions of their profession.

Widening Field of Psychiatric Practice.

There are more than 650,000 patients in mental hospitals in the United States. Most of them are persons with more serious types of disorder. Probably many others with major psychoses are to be found outside of hospitals. It is often said that one third to one half of the patients who go to the doctor's office have no physical cause for their symptoms. This is substantiated by hospital and clinic reports concerning large series of patients with gastrointestinal and cardiovascular symptoms. The number of persons who may be classified definitely as having psychoneuroses and personality disorders and maladjustments is certainly large. The most important causes of so-called psychosomatic disorders are probably psychogenic. An increasing amount of attention is being given to cases of this kind. The psychologic encumbrances of ordinary illness are always of some importance and not infrequently influence the progress of the patient. Conversely, all patients with psychiatric difficulties are also subject to the usual physical illnesses. One beholds an ample field for psychiatry. To a greater degree than other specialties psychiatry is interdependent with all the rest of medicine and shows every evidence of bursting through the limits of specialization to make its methods available to all physicians.

Psychiatry may be examined conveniently as to its initial development within the bounds of specialization with respect to its contributions to the treatment of the major psychoses and of the psychoneuroses. This division seems to stress the organic as opposed to the functional, but it is useful for our purpose of revealing the evolution of present day psychiatry. I have no intention of reviewing the full historical background concerning discoveries and concepts as to the organic causation of mental disease and relation of these to the use of physical means of treatment of the major psychoses by date, name and record of accomplishment. All the names would not be those of psychiatrists. One need cite only the contributions of Wagner-Jauregg to the treatment of dementia paralytica (1917) and those of Sakel (insulin shock treatment of schizophrenia, 1933) and of Meduna (pentylene-tetrazole [metrazol] convulsive therapy, 1934) to indicate that physical treatments of the major psychoses have had much to do with some of the changes that have come about in psychiatry. Many patients have been cured or helped; favourable attention has come to medicine and psychiatry; research has been stimulated; the doors of general hospitals have been opened to mentally ill patients, and mental hospitals have become somewhat less forbidding places. Undoubtedly, these and other methods of physical treatment have helped promote the private practice of psychiatry. It is doubtful whether they have changed the state of private office practice greatly, have modified much the teaching of psychiatry to undergraduate medical students or affected the residency training programs remarkably. They have had some effect on all of these, it is true, but private office practice, education of medical students and specialists in psychiatry, psychosomatic medicine and pediatric psychiatry have been much more affected by developments connected with the treatment of the psy-

choneuroses. Explorations to discover the place, value and technic of elicitation and use of psychologic data (in the broadest meaning of the term) in medical examination, diagnosis and treatment had been long overdue.

The treatments formerly depended on principally in the treatment of psychoneuroses were physical in nature. One need not be astonished that Freud's determined invasion of the unconscious by the free association method and all the things he drew from that capacious "grab bag" aroused suspicion and provoked antagonism which persists to this day. His methods were unprecedented and his manner not particularly conciliatory. I shall not review the history of the psychoanalytic movements or attempt to elucidate the principles and practice of psychoanalysis. Neither do I need to trace the origins of its early schisms and later subdivision into psychoanalytic groups and schools of thought. This must be said: physicians, and, of course, first among them neurologists and psychiatrists, whether or not they have turned into one or another kind of psychoanalyst, have been forced to think about, read about, experiment with and discover something about the importance of psychologic data—again giving the widest possible meaning to the term—in medicine. It is this chiefly which has affected the private office practice of psychiatry and made it largely psychotherapy. It is this which recently has changed the kind of undergraduate teaching of psychiatry and has so greatly modified the standards of training of specialists in the field of psychiatry. It is this, too, which has chief responsibility for psychosomatic medicine and much to do with the development of pediatric psychiatry.

The force producing most of these changes was psychoanalysis. Of course, a sustained force of this kind is not easily contained. As it burst through the bounds

of psychiatric specialization it is still bursting through the bounds of medicine even as it did in its early days in the case of lay analysis. Proposals have been made that a different degree in medicine, possibly Doctor of Psychological Medicine, be granted after a different type of undergraduate medical course which would omit some of the traditional courses in favour of other courses more suited for the traditional courses in favor of other courses more suited for the intended purpose. It has been suggested that this might be a means of countering the practice of psychotherapy by unqualified psychologists. Psychoanalysts, perhaps more than others in the field of medicine, tend to move quickly in the direction of offering service in the solution of a great variety of social, governmental and international problems. As sometimes with Freud, a general philosophy seems to overshadow the more definitely medical concepts and technics. There is evidence that psychoanalysts are settling down into the more usual patterns of medical functioning. They are finding their place in medicine and having their effect on it. As they become more generally accepted the need for a protective autonomy will grow less.

Summary

One looks at the future usually in terms of present needs and of hopes as to how they will be met. It is certain that mental institutions need much help from at the branches of medicine,—including, ironically, more from psychiatry than present indications are that psychiatrists will be likely to afford them soon. Some return of benefit to these hospitals should be expected. Research is needed. Although the standards for the conduct of physical types of research were set long ago, implementation, particularly with the best minds in neurophysiology and biochemistry working in association with good clinicians, is imperative. Research in the evaluation

of psychotherapy is definitely needed. It will undoubtedly involve careful observation and recording of all that takes place in psychotherapeutic interviews and the application of refined psychologic testing methods. It would seem that training facilities for clinical psychology should be improved and that psychologists should work in the medical setting. The physical scientist likes to work at the level of the physical substratum of the living person, and it is right that he should, but there is an overlay of experience which by its weight and active concentrations affects the substratum and the whole performance of the individual. It is within the purview of science to investigate this overlay also, though the task is difficult and the means in some stages of investigation may have to be quite different from those used for physical investigations. The interdependence of psychiatry and the rest of medicine becomes steadily more apparent. One can never tell from what direction the help will come to psychiatry for the solution of some of its problems. I would not expect psychoanalysis to survive as an autonomous system in medicine, but acknowledgment must be made of the tremendous contribution of Sigmund Freud and his followers to psychiatry and to medicine. It is well to honor a master ever and to follow him far enough but not to be dependent on him too much or too long. What of neurology? All important human activity, including particularly psychic activity, is dependent on controls and regulations operating in the organic nervous system. In the past neurology has been necessarily much occupied with the study of coarse pathology and its effects. A new neurology rooted in physiology is developing. It will become one of the solid important bases of all medicine. On the psychologic level psychiatry has already moved far outside its former limits into the field of total functioning. The common origin and parallel

interconnected planes of development of neurology and psychiatry seen to augur that in some future day the designation neuropsychiatrist will have a weightier and more certain meaning than it does now.

BURNING SENSATION IN EYES

To the Editor:—Since I had the water softener tank removed the water does not make my eyes burn when I take a shower. What is in the softener to cause burning sensation in the eyes?

S. P. Strange, M.D. San Francisco.

ANSWER.—This query fails to indicate the type of water softening chemicals involved. Hence, this reply comprises generalities. Many wholesome untreated waters are distinctly alkaline, presenting a pH value approximating 8.5, while the pH of tears is 7.35. Slight eye irritation may result from any exposure. On occasion, water-softening systems make use of phosphates, some of which lead to soluble complexes of an alkaline nature. Almost any soap may irritate the eye and notably those rich in alkali builders, which chiefly depend on the action of alkali phosphates. These same phosphates, apart from soap used in bathing but present in the water itself, may lead to eye irritation. In the zeolite process of water softening, the one presently regarded as best suited for household purposes, the pH value of the water is somewhat increased even though the hardness be reduced to zero. Nothing in these statements implies that any properly household-softened water is conducive to any serious eye damage. In industrial

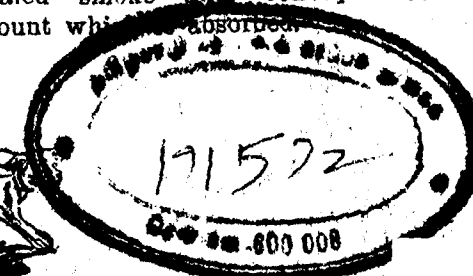
practices, such as in the softening of boiler water, a number of chemicals that might be utilized could constitute damaging eye irritants. This group included sulfuric acid and chromates.

SMOKING TOBACCO

To the Editor:—The recent article on smoking in the Readers Digest has raised questions. The statement was made that smoke from a pipe is greatest in nicotine concentration, cigaret smoke the least and cigar in between. It seems to me that the important factor is not the amount of nicotine in the smoke but the amount of nicotine which is absorbed into the system.

M.D., Nebraska.

ANSWER.—Although more nicotine is absorbed from tobacco smoke inhaled into the lung than from that barely taken into the mouth, studies have shown that this difference is not so great as may be imagined. Nicotine rapidly precipitates from the smoke onto the mucous membrane so that mere quiet smoking, without inhalation, deposits more than half the nicotine from the smoke. Smoking habits vary, and the amount of smoke contained in nicotine which is taken in by smokers either from pipe or cigarets depends on the force, frequency and volume of suction as well as on the nicotine content of the smoke itself. The length of the cigaret consumed and the form of the pipestem and the frequency with which it is cleaned also affects the nicotine content of the inhaled smoke and consequently, the amount which is absorbed.



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ஒவ்வொரு அட்டையிலும் கண்ணாக்கவரும் மூவாணப்படங்கள் ஒவ்வொரு ஷீட்டும் இரண்டு கலரில், இங்கிலிஷ் தமிழ் தேதிகளுடன் முக்கிய கத்தோலிக்கு திருநாட்கள், இந்த முஸ்லிம் பண்டிகைகளுடன் கூடியது.

காலண்டர்கள் டிசம்பர் மாதத்திற்கு முன்பதாகவே வெளியாகும் ஆர்டருக்கு முந்துங்கள்.

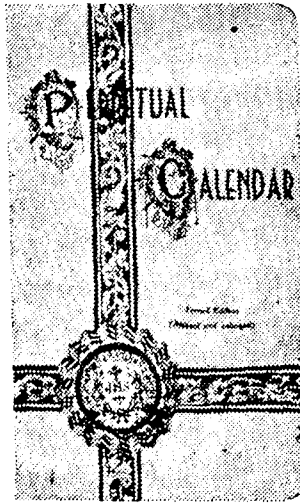
1952-ஸ்த்திய கத்தோலிக்கு பஞ்சாங்கம்

இதில் பிரதி வருஷமும் காணப்படும்

திருநாட்டவணை, இங்கிலிஷ் தமிழ் தேதிகள், ஒவ்வொரு தினமும் குருவானவர் அணிந்து கொள்ளவேண்டிய பூசை ஆயத்தம், ஞாயிற்றுக்கிழமைகளிலும், கடன் திருநாட்களிலும் பூசையில் வாசிக்கவேண்டிய சுவசேஷ குறிப்பும் இப் புதுவருட பஞ்சாங்கத்தில் காணலாம்.

பஞ்சாங்கம் ஒன்றின் விலை 0-2-6

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ODDS & ENDS

A doctor was mistaken for a Physicist and asked whether heat or cold travels faster. The doctor replied it was heat, for one could easily catch a cold.



Grateful client: Doctor, your medicine has acted wonderfully.

Doctor: I am glad to hear of it. How many doses have you taken?

Client: I have not taken your medicine, but the first dose I administered to my uncle, has made me to succeed his property.



Boy: "I had trouble with dyspepsia in school to-day."

"Nonsense, a boy of your age cannot have dyspepsia."

Boy: "I didn't have it. I was asked to spell it and there was trouble."



Two doctors were in earnest conversation.

One said: "I have a number of cases of psychophergic, I don't know what to do with them."

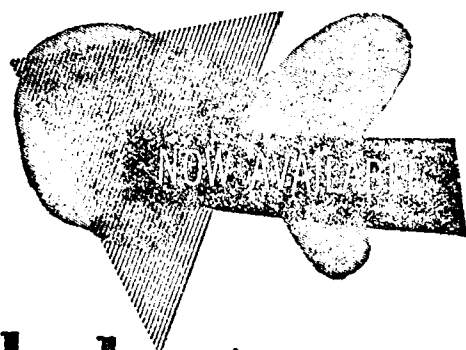
A black-marketer, who was specialising in cornering goods overhearing the above, interferred.

"Hand them all over to me. I shall pay any price you want."



The man was unconscious. The doctor who was called prescribed 4 ozs. of brandy. The lady, after the doctor left, called his son, and asked him to get 1 oz. of brandy. The unconscious man beckoned to his wife and in a feeble voice said "The doctor said 4 ozs. dear."

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WHEN IS IT INDICATED?	Like streptomycin, as an adjunct to other measures in tuberculosis.
HOW DOES IT ACT?	The antibacterial activity of Dihydrostreptomycin usually parallels that of streptomycin in tuberculosis. Resistant strains of organisms appear to develop as rapidly as with streptomycin.
WHAT ARE ITS ADVANTAGES?	Dihydrostreptomycin is significantly less neurotoxic than streptomycin and hence can be given in larger doses and for more prolonged periods. In addition, patients showing allergic reactions to streptomycin have been able to continue with the dihydro form.
HOW IS IT ADMINISTERED?	Only intramuscularly, pending further clinical studies.
WHAT IS THE DOSAGE?	Daily doses of 2 grams of Dihydrostreptomycin Squibb may be given safely for periods equal to those in which streptomycin has been restricted to 1 gram a day, provided there is no renal dysfunction. Average dosage—1 to 2 grams daily in divided doses every 12 hours.
HOW SUPPLIED?	20 cc. vials containing the equivalent of 1 Gm. streptomycin base 50 cc. vials containing the equivalent of 5 Gm. streptomycin base

SQUIBB *a leader in streptomycin research and manufacture*

Manufacturers and Distributors of Squibb Products in India :

SARABHAI CHEMICALS, WADI WADI, BARODA.

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