

Health

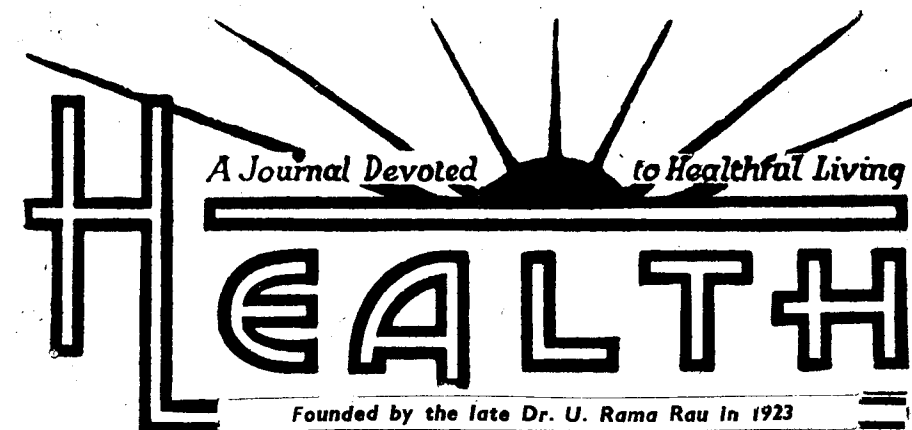
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Consulting Editor: U. KRISHNA RAU, M.B., B.S., M.L.A.

Editor: U. VASUDEVA RAU, M.B., B.S.

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No. 3

MOSQUITOES THAT REFUSE TO DIE

(Increasing Resistance to Insecticides)

THE W.H.O., a special agency of the United Nations has provided financial and technical assistance during the last 12 years and more to several countries of the world for the improvement of the health of the people by controlling and eradicating the numerous diseases that have levied a heavy toll of precious human lives in the past.

During 1961, more than 800 projects will receive assistance from the W.H.O. in some 130 countries. This huge organization has six regional offices located in Manila, New Delhi, Brazzaville, Alexandria, Copenhagen and Washington. In the South-East Asia region 450 projects received help for the control of malaria, tuberculosis, venereal diseases, yaws etc. during 1960.

The magnitude of the work to be done, if the five great scourges of mankind—malaria, typhus, cholera, smallpox and plague—are to be eradicated will be realized from the work so far done on malaria control. Launched in 1955, this campaign involved a population of 1336 million people exposed to the infection. So far nearly 300 million (298 to be precise) live now in malaria-free areas, 612 million are covered by existing programmes, 170 million live in places where activity is just starting, while 255 million are still without any assistance.

In this context it is somewhat disquieting to know from Dr. A. P. Ray, the Director of the National Malaria Eradication Programme who told the World Health Assembly's Committee on programme and budget in

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New Delhi last month that there was increasing evidence of resistance in mosquitoes to insecticides used in malaria eradication operations. In countries where the eradication programme was phased for a long period, it will now become necessary therefore to hasten it, or shorten it rather than lengthen it. The question of resistance by mosquitoes to the insecticides will therefore, have to be looked into with greater attention and circumspection.

An important point which was spotlighted by Dr. RAY is the regrettable fact that there was resistance amongst the people to accept spraying operations. One of the reasons given was the reappearance of bed-bugs when the spraying for mosquito-control was over, which gave the impression to the people that there was no use in having their homes sprayed. Another point was their mental attitude, once the malaria incidence was low they thought that further spraying was needless. This naturally cut at the very root of the eradication programme.

All persons engaged in the programme have now come to realize that what was really important was *not what had been done but what remained to be successfully achieved*. Dr. RAY emphasized the fact that "our firm hope and unshaken faith in the future of malaria eradication

must not be mistaken for airy optimism." Technical feasibility is still sometimes being confused with facility.

We are not a little perturbed to learn that some Governments have not yet provided the solid legal and administrative background which are essential for their programmes; some others are relaxing their interest and financial support during the late phases of the campaign, "just when the cleaning out of the last few cases demands as much or even a greater effort, organization and talent than the reduction of the gross bulk of infections which existed at the beginning of the operation."

"In the South-East Asia and Western Pacific region," says Dr. RAY, "the progress and prospects are less uniform. We are experiencing operational, administrative and financial difficulties." But the authorities feel that there are now clear indications that the prospects for the immediate future in 1961 are encouraging.

We are glad to learn from the proceedings of the World Health Assembly which had an 18-day Session at Delhi last month and discussed various subjects, that DDVP (a vapour insecticide) may be the insecticide of the future and that some aspects of its efficacy are under investigation before it is adopted or recommended for general use.

At a police station in Yokohama an "electronic" approach to drunks has been adopted. The morning after the night before, the drunks are made to listen to a tape recording of the babbling they did after they were hauled in. Worse than a fine, some say.—(U.M.W.J.).

LOW BACK PAIN

BRIAN MADDEN, M.D., F.R.C.S.

FEW conditions excite so much speculation and receive such a wide variety of treatments as low back pain. Every human being suffers from it in some degree so that investigation and treatment of the complaint occupy much of the time of the medical practitioner.

By definition, low back pain should be restricted to pain arising in the lumbar spine, although it is often associated with pain in the buttocks or down one or both legs. The commonest site of pain is at the lumbo-sacral joint, the last articulation between the vertebral column and the pelvis.

Mechanics of the back.—Each individual vertebra consists of a solid body anteriorly and a more slender posterior arch which encloses the spinal cord. The joints between such vertebrae are made up of three sections. Between the vertebral bodies lie the intervertebral discs, tough structures of cartilage and fibrous tissue, the outer investing layer of which is called the *annulus fibrosus*. The centre consists of soft, pulpy tissue, the *nucleus pulposus*, a relic of the notochord of primitive animals. Posteriorly adjacent neural arches articulate through two synovial joints.

Mechanical strain constitutes the biggest single cause of low back pain. Various factors make the human spine particularly

susceptible. The adoption of an upright posture has led to a wider range of movements in a spine basically designed for a four-limbed gait. The greatest leverage will fall on the lowermost joints, the maximum strain falling on the lumbosacral joint. Yet this joint is ill-adapted to stress, as the intervertebral disc does not lie perpendicular to the axis of gravity. The sacrum is normally inclined backwards from the vertical through an angle of 60 degrees, so that in addition to the strain exerted on the lumbosacral joint by any movement of the trunk above it, a constant sheering strain is also present. The more the sacrum inclines towards the horizontal, from bad posture or muscle weakness, the greater this sheering strain will be. Forward bending, the working position frequently adopted both by bench workers and housewives, by shifting forward the centre of gravity of the trunk, increases the leverage and strain on the lumbosacral joint.

Root pain and referred pain.—Between each vertebra a nerve root leaves the vertebral canal, the nerve roots from the lumbar spine being distributed mainly to the legs. Their close relationship to the intervertebral joints makes them liable to involvement in pathological conditions affecting the spine. Such involvement may produce subjective symptoms of pain, sensations like "pins and needles," weakness or numbness in the area supplied by that nerve root, or objective signs of anaesthesia, muscle weakness or reflex changes.

Pain may be referred to the buttock and back of the thighs from irritation of one component of the lumbosacral joint, just as the pain of coronary thrombosis is often referred down the arm. Such referred pain usually fails to conform to the skin distribution of one particular nerve root, and is not accompanied by objective changes.

It is common practice to describe such pains as fibrositis or rheumatism, but these terms have no pathological basis and should be avoided. Lumbago and sciatica are traditional terms describing pain in the back and leg respectively but give no indication of the underlying cause.

Prolapsed intervertebral disc.—Any strain applied to a joint, whether as an isolated, severe episode or a series of minor insults, will cause pain in that joint. In the lumbar spine the first strain is taken by the ligaments and muscles connecting adjacent neural arches, the pain remaining confined to the back.

A more powerful force might in addition disrupt the posterior fibres of the *annulus fibrosus*, so allowing protrusion of the *nucleus pulposus* into the vertebral canal. The pressure of this nucleus on nerve roots is responsible for the pain in the legs, commonly, but not invariably, associated with a prolapsed disc.

Once the nucleus has escaped from its integument it is as impracticable to expect its return as to manipulate tooth-paste back into the tube. The popular

phrase—"A SLIPPED DISC"—is therefore best avoided as conjuring up the possibility of the disc slipping in and out like the torn cartilages of a knee-joint. The sudden dramatic relief obtained occasionally by manipulation is much more likely due to dissemination of the nucleus more widely through the vertebral canal with consequent relief of local pressure.

Even the diagnosis of prolapsed intervertebral disc should be used with caution and restricted to those cases showing definite evidence of nerve root pressure or disturbance of the structures in the vertebral canal. Referred pain from an acute back strain is frequently misdiagnosed as a disc lesion and many claims for cures, particularly from unorthodox practitioners, rest on an unsubstantiated diagnosis.

A force insufficient to rupture the integument of a normal disc may cause a protrusion if the *annulus fibrosus* is weakened by degenerative conditions or previous trauma. Prolapsed discs may therefore, occur in the middle-aged with only minor degrees of strain. They are, however, uncommon in old age as the *nucleus pulposus* loses its moisture throughout life, becomes shrunken and desiccated and is incapable of protrusion.

Diagnosis of low back-pain.—Not all cases of low back pain are due to mechanical causes and back strain as a diagnosis should be accepted only after exclusion of other more serious diseases.

Local diseases of the bone such as infection with tuberculosis or pyogenic bacteria may cause low back pain or root pain. The lumbar vertebral bodies may be the site of new growths, more commonly secondary to tumours of the prostate in the male and of the breast in the female, than to primary growths. Disease of the vertebrae themselves can usually be recognized in X-rays, which often give a definite indication of the nature of the disease.

Prolapsed disc material is not the only cause of pressure on nerve roots. Tumours arising from the nerve elements themselves or their coverings may be responsible. The symptoms tend to be very similar to those of a prolapsed disc with pain in the back radiating down the legs. It is, however, unrelieved by rest and tends to be worse at night. The diagnosis can usually be established by lumbar puncture, when examination of the cerebrospinal fluid will reveal pressure changes and an increased protein content.

Some abdominal diseases can give pain in the back. It may be the only symptom in prolapse of the uterus or cervical erosion, but more serious disease such as intrapelvic growths may involve the nerve roots to the legs as they cross the posterior abdominal wall.

Ankylosing spondylitis is a disease affecting males more than females and often starting in the second or third decade of life. It attacks the joints of the spine, which become quite fixed

through conversion of their ligaments to bone. The first symptom is pain in the back, with later involvement of other joints, of the ribs, shoulder girdles and jaw. The disease produces a marked deformity with forward curvature of the spine, by which time X-ray changes are characteristic. It can often be recognized clinically in the early stages by stiffness of the whole spine and loss of chest expansion.

Finally mechanical instability of the spine can be due to a deformity in the bony structure as well as soft tissue injury. *Spondylolisthesis* is a condition in which the body of one vertebra slips forwards on the body below, and may be due to an abnormality of the posterior articulations of the spine or a defect in the neural arch.

The place of X-rays.—A detailed history and complete examination may establish the diagnosis in low back pain, but X-rays should always be taken to confirm the suspected cause or to exclude bony disease. In most cases of mechanical strain and acute disc prolapse, X-rays will appear quite normal, the *nucleus pulposus* being radio-translucent. In long standing cases of disc prolapse, some narrowing of the disc space may be evident, but this appearance may also be due to gradual degenerative change, affecting all components of the intervertebral joint.

X-rays of the spinal cord taken after introduction of a radio-opaque dye into the cerebrospinal fluid may be indicated in

obscure cases when a tumour in the vertebral canal is suspected, but should be used with discretion in view of the irritant nature of the dye to the nerve roots. It is seldom that these X-rays reveal any more information than can be obtained by lumbar puncture.

TREATMENT:—Treatment of all but the mechanical causes of low back pain is outside the scope of this article.

Cases of mechanical instability sometimes require fusion of the affected joint, but these are a minority and have either a severe localized degeneration or some defect in the bony architecture, such as spondylolisthesis.

Treatment of all back strains should be general as well as local. Under general treatment must be instilled the idea of living with one's back. No form of treatment can reverse the process of degeneration, so when the signs of wear and tear are evident clinically or radiologically, the patient must learn to keep his back protected against further strain. Paramount in this respect is to avoid putting on weight, and most sufferers can afford to lose some.

Conditions of work must be adjusted to minimize strain, and the height of the sink or ironing board are just as important to the housewife as the bench to her husband. Flexion of the lumbar spine must be avoided when lifting or reaching down to the ground and the morning sufferers from 'lumbago' would be well advised to sleep on a

hard bed, and avoid the inevitable flexion strain which occurs with soft springs when the sleeper's muscles are relaxed.

Local treatment may involve mobilization or immobilization. The former is based on the idea of restoring full function to joints weakened by strain and stiffened by scar tissue. It is the treatment of choice in young people and those in whom degenerative changes are minimal. Protection against further strain and improvement in posture should be ensured by exercises designed to build up the spinal muscles.

Advanced degenerative changes and failures among cases from the category above are best treated by a supporting belt. The more rigid support of a plaster jacket is indicated in cases of very acute strain, especially when slight damage to the disc is suspected.

The treatment of prolapse of the intervertebral disc is mainly by rest in the early stages, with the support of a belt once the initial symptoms have worn off. Most cases respond to this regime, but a few relapse or remain unchanged. In these and in cases with severe neurological involvement, operation and removal of the prolapsed nucleus is advisable.

Occasional successes by manipulation are claimed but the legacy of permanent neurological damage, which occurs in some cases of prolapsed disc treated by manipulation, is sufficient warning of the danger of this treatment.—(*Health Horizon*, London, Summer, 1960).

FROM NATURE CURE TO REAL MEDICINE

KATHERINE B. WORLEY, M.B., Ch.B.,
London

(An early diet of nasturtium and dandelion leaves, and a mother who was crazy about Nature Cure did not stop me from becoming a doctor)

My mother believed strongly in Nature Cure. Our diet followed the principle that starch, sugar, and much meat, particularly pork, are bad for you, likely to produce poisons in the blood and so cause illness. We ate raw grated vegetables and fruit, and we always had prunes on Sunday.

Variations were introduced by whichever diet happened to be in vogue at the time. We ate nettle broth, both nasturtium and dandelion leaves, and even grass for a while. We tried the hay diet and Gayelord Hauser's brewers' yeast and molasses. When yoghurt first became popular we had it for breakfast, dinner, and tea. Bread was always of stone-ground wholemeal and very tough.

Food was either good or bad for you. Large breakfasts, mixing fruit and starchy foods, drinking fluids with meals were all bad. Roughage-containing foods, dried fruit, whole-meal flour products, vegetable proteins, and honey were all good. Milk was bad and cheese was good.

Prevention of illness was most important and to this end

we were dieted, cleansed, and hardened off by fresh air treatment. I never wore a hat or scarf, and I slept under a wide open window. My mother, fortunately, was not so bowel conscious as many Nature Cure enthusiasts and, apart from an occasional enema, the evils of constipation were not worried about. We were rarely ill and soon learnt not to complain of minor aches and pains.

When illness did occur it was treated rigorously. The poisons had to be cleansed away. Internally, only unsweetened fruit, juice and water were allowed. Externally, cold-water packs were applied, narrow ones to the neck and broad ones to chest and abdomen. These were covered with flannel and pinned in place. The memory of the discomfort lives with me still.

Medicines and pills were never given as they were held to add more poisons to those already in the blood. They suppressed the illness instead of allowing it to clear the blood of all the dreadful poisons in our systems that had originated from bad living.

The only doctor I ever saw was the school doctor, though for special treatment and advice a Naturopath was seen. Advice would follow the principles mentioned, and treatment would usually be some form of massage or ray treatment.

It is perhaps surprising, and rather wonderful to me, that I was allowed to follow my desire to become an allopathic doctor. The six years of training were long and sometimes arduous. At times our arguments were lively, but I have been able to assess

the value of my mother's views, and she has seen some of the benefits that can result from orthodox medicine.

Recipe for health:—There is a great deal in the Nature Cure way of living that is of value in maintenance of health. For fresh air, sunshine, exercise, enough sleep, and plenty of fruit and vegetables are as good a recipe for health as you will find. It is the guilt implied by bad foods and the over-emphasis on diet that can cause difficulties. I am only just beginning to enjoy a succulent steak or a sizzling sausage without feeling that I am doing wrong. Whether to eat breakfast or whether to eat meat at all can be left to personal choice, provided the overall intake during the day is well-balanced.

There must be iron. I have met two cases of severe dietary anæmia in people on a very strict vegetarian diet, and I am sure that minor degrees must exist among people who never go to doctors. Too much bread, flour, and potatoes will increase weight. This is not healthy, but there is absolutely no evidence that poisons are produced in the blood. So my advice about diet would be to enjoy a varied one and not to make a religion or fetish of it.

Similarly, an obsession with the bowels is unhealthy, but the practice of using roughage in limited quantities for the correction of constipation is sensible. Indiscriminate use of enemas is wrong. Occasionally it leads to ulceration of the bowel and, if a hard nozzle is used, to

perforation. It has nothing to recommend it as an aid to health. The vague headache and malaise sometimes felt with constipation has been proved, by using inflatable rubber tubes, to be due to mechanical distention of the bowel and not to absorbing toxins. You need not be afraid that constipation will poison you.

As for medicines, it is recognised that many are given chiefly for their psychological value. But penicillin, the newer antibiotics, the sulphonamide drugs, digitalis for the heart, anti-histamines to combat allergic conditions, the new diuretics in the treatment of dropsy, morphia for the relief of severe pain, insulin for diabetes, the new steroids and others are all of immeasurable value. To withhold them from one's child could amount to almost criminal neglect.

Treatment of illness by the application of water and the use of massage and lamps does no harm, and the healthful attitude of mind that Nature Cure encourages, helps a lot to overcome minor ills. But it must never be forgotten that the major ones require medical care. I have seen patients who have spent two or three hundred pounds on naturopath treatment and have eventually come to the doctor with a cancer too far gone to have any hope of operative cure. It is these and other serious cases that bring me to make the plea:—"do please consult your family doctor as well as attempting, if you must, a Nature Cure."—(*Family Doctor*, January 1961).

THE MAKING OF A MARRIAGE

INEZ ROBB, U.S.A.

LET me say at the beginning that much of the advice now freely given in print on the subject of marriage is just so much rubbish. One of the chief factors that contributed to a happy marriage in our household is that neither my bridegroom nor I have ever read any of those paralysing tracts on marriage before we exchanged vows in 1929. We just got married and played it by ear.

Only the other day a female expert urged, in print, that a wife be "a hundred women" to her husband, possibly a Turk. A hundred women! Just being one woman exhausts me. And if my husband came home from the office some evening and found me prowling around in leopard skin tights and a sequined blouse, with a rose in my teeth, he'd be terrified. The last thing in the world Addison wants when he comes home is a New Woman. What he craves on the threshold is *peace* and the *Same Old Familiar Face*. He doesn't want to have to guess if this is *Mata Hari* night.

Also, I do not hold with the admonition that a husband must woo his wife in perpetuity, or *vice versa*. Certainly I don't want to be treated like a caught bus. But, in turn, I can think of no prospect more dismal or more certain to blight tender domesticity than having a per-

petual Romeo in the home. There is a time for poetry in marriage, but there also comes a time when the roast ought to be on the table. Marriage is for adults. And none of the experts' dicta annoys me more than the theory that a man is "only a little boy grown up."

Two remarks made by my witty and beautiful Aunt Nell, when I was at an impressionable age, were worth all the professional marriage guidance I might have had, and taught me far more about human relationship in marriage. Aunt Nell was happily married for almost 50 years to one of the most delightful men I have ever known. But one day she confided. "There were days when I wanted to kill your uncle, but I was always glad the next morning that I stayed my hand."

On the second occasion, she burst into the house after a bridge-party to say that her partner had complained all afternoon because she was misunderstood by her husband. Aunt Nell sighed happily and said, "I thank God daily that your uncle doesn't understand me. If he did, he'd leave home without even stopping to pack."

I realize that although marriage is a universal phenomenon it is a highly individual experience. One man's-marriage is another's misalliance. But this is what I believe: that marriage, more than any other relationship, calls for each partner to be the very essence of politeness. By that I do not mean the sort of empty surface manners that shield from the world a hollow union. I mean the kind of gentle

manners between husband and wife that each would instinctively employ toward dear friends.

Marriage is the public facade of a private institution, and there ought to be a lot of privacy in it for each partner. Togetherness is fine for people who are so constituted that they can live in each other's pockets. But some of us suffer from claustrophobia! Every person is entitled to his share of Aloneness and to the sanctity of his soul. The spouse who demands that he share every thought of his partner, is asking for what he gets.

In the bright lexicon of marriage, there should be no such word as "mine" unless it refers to mink. Use of the word "ours" will pour perfumed oil on the waters before they are troubled. And the wife who makes an eternal habit of exchanging the present her husband has taken the trouble to choose may soon run out of both presents and husband.

Marriage, heaven forbid, is

not a signal for general eroding of the person and the intellect. Marriage should be for relaxation, not disintegration. Familiarity may breed more than contempt, but that's sufficient. What more can one say about pin-curls and 24-hour shadow?

Let me speak my piece about taking a mate for granted. To hear the experts sign it, that is the cardinal sin in the marriage Decalogue. However, if one does not trust and enjoy faith and full confidence in the person to whom one is married, why bother at all?

When we go to parties, Addison expects me to make eyes at the boys and I anticipate that he will concentrate on the prettiest women. The only cause for alarm would be the reverse!

At the end of almost 30 years of happy marriage—how happy I have no adequate words to tell—I know that marriage is not only an *honourable estate but the only career essential for my sex.*—(READER'S DIGEST, January, 1961).

Blowing Your Top

Expressing rather than suppressing anger appears better for your blood pressure. Additional evidence of a close relationship between suppressed anger and high blood pressure is reported in a study of 10 psychiatric patients by Dr. Donald Oken of Chicago. Those who suppressed anger showed a higher diastolic blood pressure than persons who vented their anger by voice and actions.—(*Today's Health*, July 1960).

Cool and Collected

The best problem-solvers are not necessarily the cool, calm, collected people, reports Sidney J. Blatt, psychologist at Michael Reese Research Institute, Chicago. Persons most efficient in reaching solutions react with faster pulse and breathing and may perspire more when confronted with challenges. The less-efficient decision-makers show little or no agitation from start to finish.—(*Today's Health*, November 1960).

OUR SKIN—First Class Blood Cleanser

THOMAS J. GORMLEY, N.D.

THE main blood-cleansers are the skin, the lungs, the kidneys, and the liver. On these organs lies the responsibility of filtering the toxins from the blood stream so that the organs of the body will be able to function normally, for human life, like the community life of a town, would be impossible if there were no removal of waste. On the functioning of these four organs, therefore, depends the health of the body, and no illness can result unless one or other ceases to function efficiently.

The skin is not merely a wrapper which prevents the organs from dropping out. The skin is an organ, and it has certain functions to perform so that health may be enjoyed. The healthy working of the skin is essential to the efficient working of the other organs of elimination.

When pimples appear on the skin, or a rash, the *whole* body is involved. Treating the skin locally by applying ointments and lotions may be very satisfactory emotionally, but, alas, the underlying *bodily* condition is little affected by such treatment. It would be more logical to increase the activity of the other blood-filters so that overloading of the skin will cease.

The skin is composed of two layers—an outer, horny layer and an inner, sensitive one.

In the inner layer of the skin are large numbers of sweat glands, which lead directly out to the surface of the skin.

Sweat, by the way, is composed of water, salt, and waste matter, very similar to that excreted in urine. The relationship between the skin and the kidneys can therefore, be appreciated.

Self-poisoning would result if the waste matter were not eliminated. All people who are ill or below par are, to a greater or lesser degree, in such a condition and acute disease is Nature's way of getting rid of accumulated toxins.

Elimination from the skin, which is always taking place in the form of vapour, is increased as a result of exercise or heat. Regular daily exercise is very good for "flushing out" the toxins lying under the surface of the skin. It is a good plan, therefore, to take sufficient exercise every day to cause free perspiration. Probably, for the average person, a brisk walk would be the best way of achieving this.

The waste matter passing from the inside of the body to the outside, *via* the skin, will have a foul smell if the body is not bathed regularly. In people who have a strong body-smell, washing may be required twice or three times daily, accompanied by a complete change of clothes, for the latter tend to absorb the body wastes.

It is for this reason that it is advisable to wear cotton or silk next to the skin, so that the toxins may be absorbed by the underclothes and thus eliminated

completely from the body. Ideally, the underclothes should be changed every day. If wool or some other waterproof garment is worn next to the skin, then the wastes may not be eliminated properly and the blood-stream may become loaded with retained poisons, giving rise to one or other of the three thousand different "diseases" which afflict mankind.

Hot baths may give rise to a weakened and atonic skin—a skin hardly able to function as a blood-filter, and so the other blood-filters will have an extra burden of cleansing to tackle.

Hot water removes not only the dirt which lies on the surface of the skin, but also the sebum—an oil which is produced by tiny glands situated at the hair roots. This oil has a germicidal effect, besides keeping the skin from cracking. When it is removed with hot water and soap, it may be about 24 hours before it is replaced. Therefore, regular hot baths are not advisable; the cold rub is far superior in every way.

Choose the warmest room for a *cold rub down*. If you have a heater in the bathroom, all the better is cold weather. Have it switched on about half-an-hour before you have your rub down.

Run some cold water into the hand basin and drop the hands into it fairly frequently during the rub down. Commence by rubbing the ankles and calves of the legs, then the wrists, the arms, the shoulders and chest, and, lastly, the abdomen. The naked hand is far superior to

anything else and the rub should be a simple back-and-forward movement. The pressure on the skin by the hand can vary according to the desire of the patient. This rubbing is continued until the skin is almost dry, when a rough towel may be used to finish off.

The next important factor to be considered in relation to the skin is the air-bath. With the wearing of clothes man has considerably reduced the normal activity of the skin. The annual increase of circulation to the skin during the winter has been prevented by the wearing of more coverings, which are not removed appreciably even in summer time. Civilized people wear very much the same clothing throughout the year, thus preventing the action of the air on the skin.

The air-bath has the advantage that it can be taken in one's own bedroom, during the day or at night, for light is not necessary. The air-bath merely means exposing the nude body—all of it—to the air. Dr. Rikli, the discoverer of the value of sunlight and air in the treatment of tuberculosis, declared: "Man is made to live in the open air; therefore, when exposed to the action of light, air and sun, he is in his real element."

Nature Cure says 'baths of water are good, baths of air are better, and baths of light best of all.'

A few minutes' sunlight daily will double the quantity of phosphorus in a baby's body in

a fortnight. There are other effects produced by sunlight on the body, but enough has been said already to emphasize the fact that sunlight does definitely affect the body chemistry.

Most people know that to deprive a plant of light produces a pale, sickly growth. The plant becomes sick and does not survive. Much the same effect is

produced in the human being, although the ill-effects may take longer to show due to the storing capacity of the skin and liver; but when we compare the pale face of the city dweller with the ruddy complexion of the country worker, most people would agree that the appearance of the latter is "healthier." —(*Health for All*, January, 1961).

Millions Rely on Laxatives They Don't Need

AT least 100 million Americans have become addicted to unnatural elimination aids because of unfounded worry over "regularity," according to *Today's Health*.

In an article appearing in the October issue of the American Medical Association publication, Charles W. Hook, M.D., Augusta, Georgia, said: "Old-fashioned habits, half-truths, incorrect beliefs, and today's advertising have brainwashed the American public to accept the idea that a daily bowel movement is a necessity for everyone. Your doctor knows nothing could be further from the truth!"

The idea of regularity "has been swept down the ages on a tide of patent medicines," Dr. Hook said. "While the patent medicine-men have had their field-day selling laxatives and purgatives, the chiropractors, naturopaths, and food faddists have found a new wealth in the American worry over regularity," he said.

Americans spent more than \$148 million for laxatives and

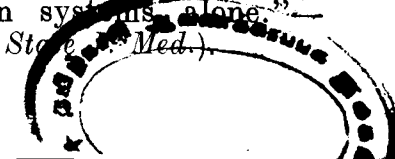
elimination aids in 1958.

Genuine constipation is generally caused by overactivity of the digestive tract. Worries and anxieties often cause the bowel to move too fast and go into spasm or cramp, causing constipation. If the bowel moves too fast but does not go into a spasm, diarrhoea usually results.

Real constipation (hard, dry bowel movements) should be brought to the attention of the family physicians, Dr. Hook cautioned. He will make certain there is no associated organic disease and prescribe a simple, effective treatment.

Dr. Hook warned against the dangers of self-medication, saying that long use of elimination aids makes the bowel lazy and dependent on such aids. He said some physicians believe up to 99% of their patients had become addicted to such aids and were using them to extremes.

The public should be advised "to leave their digestive and elimination systems alone." —(*New York State Med. J.*)



We Need the Human Touch in Our Hospitals

FRANK HART,

(House Governor and Secretary to the Board of Governors, Charing Cross Hospital, London)

HOSPITAL care is not mere medical treatment. It means kindness, sympathy and understanding for the patient and his relatives as well.

Many people, disturbed by incidents which, they feel, should not happen, are beginning to wonder whether or not our Hospital Service is lacking in humanity. This quality, they think, is not provided for in the seemingly mechanical routine of doctors, nurses and administrators.

Recently, the problem was sharpened for me when someone close to me was admitted as an emergency to a suburban hospital.

His mother was informed that his was the second case of its type the hospital had seen within a short time, the other having been *fatal*. During his stay information on his progress was given grudgingly and some of those little concessions, freely offered in many hospitals to worrying relatives were lacking.

In another hospital, until quite recently, the relatives of a deceased patient were coldly informed of his death by a printed form—an example of administrative remoteness that is not uncommon.

The hospital, which plays such an important role in the

community, appears in many ways to be cut off from it. This form of institutional autonomy is inevitable unless it is appreciated and guarded against. Otherwise, it could lead to the implication that the patient exists for the hospital and not the hospital for the patient.

The average hospital patient is not a normal person. He is ill, worried about himself and those he is leaving at home, and, perhaps, concerned about his job and future.

He is prepared for some degree of discipline, but he does not want to be treated as an infant; to be subjected to unnecessary, petty rules and restrictions; to be given peremptory orders or addressed by his surname by young nurses no older, may be, than his daughter; or to be given inadequate information about his illness by curt doctors.

The primary responsibility for the degree of humanity that pervades the hospital must rest with the Board of Governors or the Management Committee (and with the Superintendents of State Hospitals and their Advisory Committees in India.—Ed. HEALTH). It is their task to ensure that every person on the staff is aware of the obligation to carry out his or her duties with humanity, kindness and understanding. By constant support, encouragement and exhortation, they should imbue every employee with these ideals.

The patients should know of this policy and should be told that the hospital exists for them, and that, if they have any suggestions for better service, they should ventilate them without fear of recrimination.

MAR. '61] HUMAN TOUCH NEEDED IN OUR HOSPITALS—F. H. 63

Hospital life as it would be if such a policy were carried out will be somewhat like what is described below:—

The in-patient will already know much about the hospital through an informative booklet sent to him before admission. On arrival he will be met at an expected time by a friendly receptionist who will escort him to his ward and introduce him to the sister. She, in turn will introduce him to her nurses, and to the neighbouring patients.

The sister will be mature and serene. If she finds fault with the nurses, it will not be done in the presence of patients. The routine of the ward will be based primarily on what is most restful for the patient and not on the convenience of the staff.

Visiting will be generous, and when it is restricted the reasons will be explained. Facilities will exist for telephoning home, and relatives' inquiries will be answered sympathetically by the sister or by a trained receptionist.

The doctors will tell the patient broadly how they propose to carry out his treatment. At intervals, one of the doctors will spare time to sit by the bedside and tell him in simple language what is happening. Technical discussions on his condition will not take place in his hearing.

The consultant in charge will appreciate that much more than the patient's confidence depends on the relationship between them. His example will influence all those who work for

him—junior doctors, students and nurses.

In a teaching hospital, the role of the medical students will be explained. If the patient is asked to become a subject for clinical research, the doctors will make sure that he understands the implications of any procedure.

Porters and domestics will treat him as he would expect to be in a good hotel—not with servility, but with kindness and cheerfulness.

Much the same considerations will apply to the out-patient. The time of appointment will be based on the convenience of his doctor and himself. If emergencies interrupt the time-table, the reason will be explained. If he has to wait it will be in comfort. He will undress in privacy. A hot drink will be available if he wants one.

The British Health Service is the envy of the world. The more the human touch can pervade our hospitals—and in many it does—to be allied with the skills and achievements of our doctors, the more will this reputation be deserved.

It could all be done without asking one penny from the Exchequer. But everyone, and the patient, too, must play his part.—(The Observer, London, via World Digest, December, 1960).

[America, too.....In thoughtless hospital-planning, organization, and discipline, the most expendable item is the comfort, if not the safety, of the patient, who has a reputation for non-resistance that is almost universal. (Dr. E.M. Bluestone, writing in "Hospital Management" (USA).]

Death-Dealing Light For Disease Germs

THE dreaded staphylococcus is the scourge of the hospitals. Micro-biologists now have a new and lethal weapon:—"a germicidal death-ray"—its ammunition, high-intensity ultra-violet light, has proved 99.9 per cent accurate in killing infectious germs, among the Staphylococcus, or "Staph," Public Enemy No. 1 in hospitals.

The ray gun's multiple barrels, each a cylindrical chamber housing a tubular ultra-violet lamp ringed by a spiral aluminium baffle, literally gun down germs with light.

What makes the weapon and its multi-chambers lethal is the ingenious spiral baffle. At Mount Sinai hospital in Los Angeles, a mammoth 72-chambered ray gun, each of its 36-inch long, $7\frac{1}{2}$ inch diameter chambers fitted with a baffled UV lamp, quickly kills germs which would otherwise contaminate five operating rooms.

The 6-foot square, 7-foot long anti-germ unit, its highpowered UV rays confined to the kill chambers, is installed in the air-conditioning duct of the surgical rooms. The chamber itself is isolated in the basement.

A smaller germ-gun sterilizes air fed to incubators (and their new-born residents) at Saint John's Hospital in Santa Monica, California.

A giant 81-chamber germ killer is being installed at the

Veterans Administration's big Wadsworth General Hospital in West Los Angeles.

Soon to be marketed for home use is a low-cost germ-gun console, its baffled chambers calculated to isolate your ailing Johnny's contagious germs from his sister, Sue. Ridding air of dust as well as germs, the console also relieves asthmatic and hay fever sufferers (gives relief but works no cure).

Mount Sinai, first U. S. hospital to add the germ-gun to its anti-microbe arsenal, recently startled medicos when it announced "post-surgical infections.....reduced to absolute zero."

After six months of tests and more than 1,600 surgical operations, the hospital reported: (1) not a single post-operative infection, though hospitals world wide normally expect 5 to 14 per cent of surgical patients to develop infection—some fatal; (2) a 99.9 per cent "kill-count" of airborne microbes including such potentially lethal species as "Staphylococcus."

"The 'breakthrough!' explains one ultra-violet expert, "lies almost wholly within the UV chambers themselves."

He refers to ultra-violet's much-touted but often disappointing previous performance as a germ-killer. Although high-intensity UV's prowess as a contact killer of microbes has been long known, ultra-violet has often fallen far short of expectations. Reason: The light's killing power is inversely proportional to the square of the distance from the UV source. Ultraviolet delivers sure death

only to germs which, almost by chance come within about 3 inches of its high-intensity tube. Germs outside this narrow zone often escape unscathed.

The trick, turned by Dr. Potapenko, was to design a baffle which literally forces all airborne germs to commit suicide.

Dr. Potapenko, by a seemingly simple yet mathematically complex baffle, succeeds in routing large volumes of air—100 cubic feet per minute through each kill-chamber—within lethal range of the UV source.

The Potapenko-baffle (a continuous spiral of highly reflective aluminium completely encircling the tube along its entire length) has for the first time turned UV into a positive germ killer.

The spiral, tube-girdling baffle presents to the incoming air stream essentially two exposure paths, both lethal.

Air which would ordinarily "bullet" straight through the chamber and pass well within the lethal 3-inch kill zone, finds its path unimpeded. Thus, its UV exposure time is quite short though deadly.

Air which would pass outside this positive kill zone is baffled along a circular path around the UV tube—both the path and exposure time significantly longer than for near-tube air. Result:—Though such airborne germs receive less irradiation the greater their distance from the UV source, their far longer exposure assures the same positive kill as for germs passing within the tube's lethal zone.

So intense is the UV source that Aseptic-Air's designers claim a "positive kill" after air has passed only the first quarter-length of the tube.

The UV lamp, combined with Dr. Potapenko's baffled-chambers, is totally effective..... against every germ in the passing air-stream."

Dr. W. R. Romig, associate professor of bacteriology, Los Angeles, tested the anti-germ chambers' killing ability and concluded, "a rating of greater than 99.9% (germ-kill) efficiencywould be justified."

Air, sterilized in Mt. Sinai's ray-chambers, reaches the operating room through a perforated ceiling. Small holes drilled in a false ceiling gently direct germ-free air downward, "washing" existing airborne germs to the floor, where they're vented from the surgical room.

More spectacular is the "curtain" of sterile air which, diffused downward through holes drilled in the lens of the big surgical lamp over the operating table, continuously "washes" patients with completely germless air.

The germ-gun's biggest potential users: the nation's doctors who have long been vexed by the fact that their waiting rooms, congested by the sick, tend to spread germs from one waiting patient to another.

Says one doctor, "I've just ordered a three-chambered console.....to sterilize and re-circulate air in my waiting room. I figure it will reduce cross-

contamination...between patients...to just about zero."

Germ-guns designed for homeowners are calculated, on a smaller scale to accomplish the same air-sterilizing job.

Explains one designer, "now when one member of the family comes down with a contagious disease, he invariably exposes

every other member of the family. Isolate him to his room, though, and sterilize germ-laden air of the room through the UV chambered console and the rest of the family stands a better chance of avoiding germs and disease."—(*Science Digest*, Chicago, via *World Digest*, February, 1961).

BRITISH HYGIENE AS SEEN BY A GERM-CONSCIOUS AMERICAN

GEORGE ARMSTRONG,
Chicago

I WILL never forget the first time I watched a London cafe worker making cheese rolls.

I was new to this country then and the incident marked my introduction to that most fascinating but elusive subject—the British approach to hygiene.

The man making the rolls had long, dark, greasy hair which he occasionally lifted from in front of his eyes and piled back on top of his head—without, of course, wiping his hands afterwards.

My life-long interest in how other people go about their jobs, plus a certain sense of self-preservation as a prospective cheese roll consumer, prompted me to ask—in the locular tone employed by top American personnel experts "Hair's a nuisance on a bending-over job, eh?"

He slipped me that covertly sharp look which the British reserve for all their natural enemies and replied, "Well,

cock, the way I see it, you would not want to find a hair in your cheese roll, now would you?"

Then, giving way to a slight self-consciousness, he stealthily wiped his hand—on the seat of his grubby-looking pants.

Contemplating this and equally shocking occurrences over the next few days, I expected to be germ-ravaged and dead in a month.

I instructed my wife to have me interned at Hammersmith Old Cemetery beneath the following epitaph:

"Here lies George Armstrong, American; he gave his life so that men everywhere might know the meaning of 'Cellophane' and the sterile telephone."

Oddly, I lived.

Driven by hunger, I ate British Railways' special soot-covered marmalade and bravely munched neighbourhood bakery tarts that the wasps and other

engaging winged creatures had turned into tiny "bird baths."

I watched flies stoutly waddling up and down the joints of meat at my butcher's and, in my hunger crazed way decided that it must be darned fine food to attract so much custom.

I learned to dip and stir bravely with that one communal spoon on the tea wagon, but still flinched a little in my vitals when the daily help washed Fido's plate right along with mine.

Almost suicidal, by now, I madly dried my hands on wash-room towels, any one of which, if put to the test would have kept 516 research bacteriologists busy classifying for 28 years.

In fact, I almost felt a pang of regret when in one of my favourite ports of call, the men's room at a large store replaced its old-style English roller towel with a new-fangled always-clean American-type one!

I remember a top executive approaching the gleaming gadget gingerly and, realizing I came from the land of its inspiration, asking me wide-eyed, "I say, is there some sort of thin gummy inside there that cleans and dries

the towel as it goes round?" I told him a tiny man in the box did the job and he accepted this equably.

Finally, it dawned on me that I had never been healthier in my life. No more aches, pains or colds. Not even any hypochondria.

I was dropping the bread on the street and eating it with the best of 'em. My food was fondled, often mauled, by human hand and yet I prospered.

And, to top it off, I was forgetting a primary tenet of faith once inbedded deep in my soul—the routine of the daily bath.

The latent Pasteur in me saw the light that the British, so oblique, so sly, had been trying to indicate ever since I landed: with all those teensy daily doses of germs I had built up my resistance to major onslaughts; by overcoming my addiction to baths, I had covered my body with a protective layer of lint, smog stains, cracker crumbs, and spilled ale.

I was inoculated, impregnable, with goodness locked in and germs locked out.—(*London American*, via *World Digest*, January, 1961).

Pleasures of Gardening

Gardening, like all the important and most of the delightful things of life, is worth while only when you do it yourself. The indolent and wealthy can decree gardens and miss every drop of nectar they contain. Only folk with frequently soiled hands and almost permanent cricks in their backs during the growing season are aware of the manifold delights and dismays in the outwardly mild avocation of gardening for fun. Actually it is a furious and nerve-straining pastime. A sixteenth of an acre can furnish space for violent exercise of virtually all human emotions.—(*Fredric Van de Water*).

BRONCHITIS

LONDSEY BATTEN, M.D.,
London

BRONCHITIS means inflammation of the bronchi or bronchial tubes, which are the branches into which the windpipe divides and subdivides until the smallest twigs end in the lung-tissue proper. It is the mucous membrane lining these tubes which actually becomes inflamed, not the tubes themselves, and it is doubtful whether either acute or chronic bronchitis is ever confined to the bronchial tubes as definitely as appendicitis may be confined to the appendix. If the bronchi are inflamed so also are other parts of the air passages and as a rule, inflammation reaches the bronchi from above.

Bronchitis is often associated with asthma and it is sometimes hard to know which has come first or caused the other. This is especially so in young children, in whom attacks of bronchial catarrh very much like attacks of infective bronchitis may really be an infant equivalent of asthma which will later appear in its true colours. If they are of this kind then drug-treatment suited to asthma may bring them quickly to a stop.

Chronic bronchitis is an unsatisfactory affection from every point of view—prevention, treatment or even definition. It is a consequence of attacks of acute bronchitis coupled, usually, with prolonged or recurrent irritation of the bronchi by

dust, smoke from coal or cigarettes, by air both cold and polluted, by a drip of infected mucus from the back of the nose, due to a chronic sinusitis, and by the cough which accompanies each and all of these. It is commonest in men, it runs somewhat in families and is made worse by too much drink and perhaps by too much food. What goes on in the chest is a thickening of the walls of the bronchi with a degeneration of their linings, an increase of the fibrous tissue in the lungs and an over-expansion of the minute air spaces in which the finest bronchial twigs end, so that the lungs never empty themselves either of air or of mucus and become steadily less and less efficient as breathing apparatus.

Cough is the most constant symptom through the whole course of the disease, and is also the immediate cause of most of the damage in the lungs, for it needs emphasizing that repeated coughing and violent coughing does harm—in the end great harm—by overstretching the tubes and air spaces below the vocal cords, which close while the air is compressed in the chest before the cough-explosion. This cough is at first a winter cough and a morning cough, but gradually extends its season to summer and its hours to the twenty-four. It is a “chesty” cough throughout, at first dry, later what is called “productive.” Breathlessness on exertion and in the end at rest, increases steadily through the years, and the heart, by trying to maintain an efficient circulation through the damaged lungs, enlarges, sometimes

grossly and, as a rule, slowly fails. It is a most unpleasant, disabling and finally fatal disease. Viewed nationally it is responsible for a vast amount of lost working time and of N.H.S. effort and expense; viewed individually, it can be thought of as attacking, typically, husbands and fathers in the prime of life and invaliding them increasingly through twenty years or more. Yet, on the whole, collectively and individually we do little about it.

Climate is, by general admission, a big factor in this complaint and at first glance local climate may seem beyond control. Yet any observant Londoner with a memory thirty—let alone fifty-years—knows that the reduction of smoke in the air has not only abolished the “pea-souper” but has greatly reduced white ground fog and haze so that the sun may shine bright and warm in February and March and early leaves stay green. Slowly we get

on with smoke abatement, thinking it a terribly costly business. Perhaps if we realized what we stand to gain in man-hours lost through chronic bronchitis (if we must think like that) we might move a little faster. In the matter of cigarette smoking we do not move at all and propaganda, such as was tried in Edinburgh not long since, is apparently useless. Yet in theory it should be easier to stop smoking cigarettes than to stop putting coal smoke in the air, and even one who contrives to believe that heavy smoking is not a cause of lung-cancer will scarcely maintain that it does not cause a chronic cough.

If we want to reduce and avoid chronic bronchitis we must cleanse the air of smoke, abandon cigarette, learn to control our coughs and treat severe colds seriously and sensibly. All this would not abolish it but would make it far less common and far less disabling.—(*Health Horizon*, Winter, 1961).

THE SECRET OF LONGEVITY

V. FLORENTSEV, M.Sc. (Med.), U.S.S.R.

“Is it possible to live to a hoary old age, keeping one’s memory, remaining agile, and showing a keen interest in everything around?” Answering this question in the affirmative Dr. Florentsev of U.S.S.R., says:—

“In ancient Greece and Rome doctors dreamed of longevity and worked out the simplest of hygienic recommendations. But

these were only the first timid steps, which did not yield any conclusive real results for the bulk of humanity.

In Soviet Russia the age-old problem of prolonging life is being solved successfully. The absence of unemployment, sweeping housing construction, the steady improvement of convenience for the working people, the

drive against noise and the contamination of the air, water and soil, together with the development of a widely ramified network of sanatoria and health resorts have all contributed to the prolongation of life.

Gerontology, the science of old age, together with geriatrics, the branch of medicine that treats old age are progressing. A committee of scientific methods on problems of longevity has been set up. In Kiev there is an Institute of Gerontology and Experimental Pathology of the U.S.S.R. Academy of Medicine. The battle for longevity is being fought here successfully.

Scientists have proved beyond doubt that at dawn of history man lived an extremely short life. From the excavation of ancient burial sites and the study of the remains of our forefathers, we may claim that in the stone and bronze ages people did not live longer than an average of 18 years. In the Middle Ages this figure went up to 20-30 years. We know of a few cases in those far-away years of people who lived an exceptionally long life. Thus, Thomas Parr, an English peasant, died when he was 152 years old. He toiled all his long life, incidentally marrying for a second time when he was 120!

Today the average span of human life has increased considerably, in the first place because child mortality rates have fallen very steeply. It is a matter of common knowledge that under Soviet Government overall mortality rates in the country have dropped to less

than a quarter of what they were before, while child mortality rates have dropped to nearly a seventh. The average expectation of life in the country is 68 years today—twice as much as it was before the revolution. [Even in India, the average expectation of life is steadily increasing but slowly].

The U.S.S.R. has about 30,000 registered cases of people who have lived for a century and more. Makhmud Eivazov, an Azerbaijanian collective farmer, died in his 152nd year only recently. Tabalat Aliyeva, an Ossetian woman, lived to the ripe old age of 181 years.

Most experts think that the natural limit of human life is close on 200 years. What we call old age is actually senility. And this is far from being a synonym. Whereas old age is a natural and inevitable chapter of evolution in the life of any living organism, senility, like any other disease or illness, can and must be cured. It is still better to prevent it by giving up smoking and drinking, by properly alternating work and leisure, by conforming to a strict diet preventing obesity, by doing exercises and inuring the organism, and finally by curing with medicines whatever disorders that occur. It is advisable when past middle age, to go in heavily for vitamins and hormones.

An analysis of the causes of death at ages above 70 shows that most of the even very old people die not from "old age" but from diseases that could be cured or prevented, e.g., cardiovascular diseases, tumours,

colds, and ailments of the alimentary tract.

The most important thing is to prevent and cure diseases in time, especially in old age, bearing in mind that the organism of an old person has much less stamina than that of a young man and cannot cope so readily with the harmful factors of environment.

The great Russian scholar I.I. Mechnikov is of the view that an organism ages, because of self-infection with intestinal poisons. He also suggested a treatment. This was to eat Bulgarian yoghurt (our Indian curds *dahi*) which contains a germ able to change the process of decay taking place in the intestines into lactic fermentation killing

germs that cause rot.

In recent years the Rumanian Academician Parhon postulated that it was possible to "cure" and "prevent" ageing by using various remedies, such as hormones, vitamins, curative substances and so on. One of his fellow workers, A. Aslan, evolved, together with others, a treatment which consists of an intramuscular injection of a 2-per cent solution of novocaine. It is believed that novocaine adjusts the functioning of the central nervous system. This method holds out certain prospects, but needs plenty of testing. It is only pathological cases of premature senility, not physiological, natural old age, that can be cured.

On Prejudice—A Psychoanalytical Approach

ACCORDING to dictionaries, prejudice is a previous, premature or hasty judgement; it is therefore, an emotional judgement. However, there are two types of judgement involved: judgements of fact and judgements of value. In racial prejudice, for example, there is a belief that a certain race has certain characteristics, and a negative evaluation of these characteristics. Psychological factors may influence both types of judgement; that is, they may create a distorted picture of an object of dislike, or alter the evaluation of the qualities possessed by the disliked object. An example of the latter type of distortion can be seen in the backward schoolboy who unconsciously envies his clever

schoolmates, persuades himself that it is worthless to be clever, and comes to despise them. He perceives his school mates correctly, but his lack of self-awareness prevents him from correctly perceiving his feelings about their cleverness. However, such a prejudice usually leads to falsification of the picture of the object also. The schoolboy, for example, may deny that his school-mates are clever, say that they have better memories or better luck, and go on to say that they are arrogant. He then sees them as both stupid and arrogant, which is exactly what, without knowing it, he is himself.

The vast majority of prejudiced dislikes are based on "projections" of this kind.

People tend to split off facets of themselves with which they cannot live comfortably, and to attribute them to other people. Not only traits, or parts of the ego, can be projected in this way, but also super-ego and other internal figures. What is projected is specific to the person. Prim people form prejudices about the supposed licentiousness of others, etc. The probable nature of any person's prejudices can be inferred from the nature of his super-ego and ego-ideal. If such a thing as a group super-ego or group ego-ideal can be defined, it should be possible to say that group prejudices arise from the projection of qualities felt to be disapproved by, or incompatible with, the group ideal.

Besides the mechanisms already described, there is a mechanism which tends to main-

tain a prejudice once it has been formed. Classification of the objects of reality, including good and bad objects, begins early in infancy, often when there is not sufficient evidence on which to base the classification. Later revision of the early systems requires passing through a stage of painful confusion. Some people prefer not to undergo this confusional distress, and ignore any new evidence which would require revision of their systems. Such a mechanism may also initiate a prejudice; so long as people cannot stand the uncertainty of a suspended judgement, their judgement is likely to be hasty. Since prejudice may spread from one person to another susceptible person, it should be studied from the social point of view as well as the psychological.-(*Brit. J. Med. Psychol.*, 33: 205-209, 1960).

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