The Bulletin

OF THE

South Indian Medical Union.

Vol. II. | AUGUST 1930. | No. 8.

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NOTICE.

1. The Union does not accept any responsibility for the views and statements of the contributors as published in the Journal ; all manuscripts, books for review and letters intended for publication must bear the name and address of the author, not necessarily for publication. All communications should be addressed to the Business Editor.

2. Copy, cuts and blocks for advertisement should reach the Business Editor at least before the 15th of the month of issue. Advertising rates will be supplied on application to the Business Editor, who will try to accommodate advertisers' request for suitable space, position and proper display of advertisements.

3. Remittances should be made, by crossed cheques, registered letter or money order, payable to the Bulletin, South Indian Medical Union.

4. Medical Students will be placed on the free mailing list of the Bulletin on application to the Business Editor.

51, Poonamallee Road, Kilpauk, Madras.

South Indian Medical Union, Madras.

PROGRAMME.

SEPTEMBER 1930

Sunday 7th, 2-30 to 4-30 p.m.

GLOBE THEATRE, VEPERY.

CINEMA DEMONSTRATION

(Open to all. Admission by tickets.)*

Tickets may be had on application to General Secretary, 51, Poonamallee Road, Kilpauk.

(Telephone No. 3202.)

Meetings held at 32, Broadway.

Monday 8th, 6-30 p.m.

GOVERNING BODY MEETING

(Governing members only.)

Monday 15th, 6-30 p.m.

RADIUM IN CANCER

BY

Lt.-Col. E. W. C. Bradfield, C.I.E., O.B.E., M.S., F.R.C.S, I.M.S.

First Surgeon, General Hospital, Madras.

(Open to all.)

Monday 22nd, 6-30 p.m.

ORDINARY GENERAL MEETING

(Open to members only.)

Monday 29th, 6-30 p.m.

SOME CORNEAL AFFECTIONS

BY

E. V. Srinivasan, M.B., C.M.

Honorary Ophthalmic Surgeon, Royapettah Hospital, Madras.

(Open to all.)

All members of the Medical profession and medical students are cordially invited to the open meetings.

Have you sent your membership form?

BULLETIN
OF THE
SOUTH INDIAN MEDICAL UNION.

AUGUST, 1930.

GENERAL NOTES.

House Experience.

Recently a selection committee sat to select a number of graduates for paid *and unpaid house appointments.* It is understood that this forms a panel from which future entrants for the Madras Medical Services are to be recruited. A number of unselected graduates have naturally to fall back on private practice. We need *not* assure the authorities that it is those who have to fall back on private practice who need most the experience gained in these house appointments. To let loose on the public a set of raw inexperienced *graduates* is neither conducive to public benefit nor *improvement of the Independent* Medical Profession.

* * *

Less are the opportunities given to the licentiates to gain *any post-graduate* experience. We wish to impress *on the authorities the need for giving* at least a year's hospital experience to all fresh graduates and licentiates in house appointments before their settling down in practice.

* * *

A *scheme* by which the Government does not stand to lose, is by holding the competitive *examination for entry* into the Service soon after graduation and place the selected candidates as *probationers* on a smaller remuneration than the service pay. We used to find this arrangement in the case of the I.M.S. officers on probation. The house appointments paid and unpaid could then be filled by those who have not been selected for service, equal opportunities being given to the graduates and licentiates. We might go even further and suggest that all house appointments in the Medical Schools be restricted to their own students.

* * *

Post-graduate Instruction.

An objection to the entry of these candidates have, we understand, been put forward by *some of the local* Pandits. It is tantamount to getting "*post-graduate training for nothing*", they say. Their interest in the 'nothing' comes in because they get as their remuneration 50 per cent of these fees, at the least. We have heard that in some cases private arrangements have been made before permitting post-graduate students to work in the hospitals. When it is realized that in *teaching institutions, all the service* incumbents are being paid *Teaching allowances,* it seems unreasonable that any further remuneration is claimed by them for post-graduate teaching. In England with its higher national and *per capita* income the fees paid for post graduate instruction are only about Rs. 15 per mensem or Rs. 30 for 3 months. In Madras the fees payable are Rs. 50 *per mensem, half of which goes to the 'Teacher'. Probably this* latter fact explains the higher rates in *this poor country.*

* * *

Faculty of Medicine.

We congratulate Mr. Satyamurti on his resolution to widen the membership of the Faculty and the Senate on its approval of the above resolution in the teeth of opposition from representatives of vested interests. It is not surprising that this opposition came from Medical represen*tatives as it is in this field that* Service and the Independent Medical Profession hold diametrically opposite views. The reason for Service opposition is obvious. We would invite these service experts to study 'The Future of *Medicine*' by that eminent authority, Sir James Mackenzie.

MEDICAL RELIEF.

Thousands of years ago the world's greatest Cynic had said that there was nothing new under the sun. If he meant to prevent thereby the great yearning in human hearts for change, that futile ambition has never been realised. If there is one thing that is constant and continuous in the human mind it is the race for progress and restless change. Men aspire to become angels, and angels have attempted to become gods. As if to lend the colour of reality to a phantom every change has been ushered in with great expectations. In the politics of a country, we have for generations heard it repeated that people have been in the midst of an unprecedented crisis or that they have been on the eve of momentous happenings. In education, every change, has been claimed as a great improvement on the past and present. In science we have been from time to time on the eve of great discoveries which have promised to transform the earth into paradise and men into happy angels.

With all this never ending quest, universal joy and happiness seem to be far away as ever. They are not even on the horizon. Time and again what was hailed as the philosopher's stone has turned out to be common sand stone. Occasionally something like that coveted stone came into man's way; but for want of energy and perseverance, the stone could not be polished and it was left alone as though it were common clay.

The history of the progress of medicine down the long centuries afford us many instances of such great expectations and humiliating disappointments. If we glance over the many theories of disease, varied and conflicting, or pass in hurried review the different methods of treatment advocated from time to time or the physiological principles enunciated at various periods for the guidance of people to lead a healthy and hygienic life, much may be written and a competent person can produce many volumes.

But we are here concerned with drawing the attention of our readers to the other aspect where some useful discoveries in the field of medicine have been allowed to lie in neglect for lack of appreciation and skill or from downright laziness. One illustration is enough. Sir Ronald Ross's discovery of the musquito as a carrier of malaria was hailed as a discovery of first rate importance to the tropics. Advantage of this discovery was taken by the Americans in constructing the Panama Canal. But what has happened here? James tried to work it up in Mian Mir and failed. And after this one failure, it was decided to discontinue any serious efforts in this direction and inactivity is sought to be protected under the pretext of a controversy between the workers as to which of the two methods to be adopted, whether mosquito destruction or building up of the economic improvement of the country. Alongside of the failure to utilise old discoveries for the good of man, there are new proposals to reform and improve the health of the country. Sometime ago it was school medical inspection. Before this could be attempted satisfactorily we had schemes of child welfare centres. Hardly had a few centres been started when we have the new stunt of antenatal clinics. Sometime ago apalling infant mortality was the theme of public health authorities and politicians. Today the sympathy is all for the dying mother. Apalling infant mortality is a fact, preventible maternal mortality is not denied; illhealth among school children exists. But are the methods advised and adopted the most useful to combat these evils?

For the efficient running of these institutions much funds are needed. But there is ever a wail of poverty. Could this new plan of antenatal clinics be carried out without money? These are some of the considerations that arise when one hears of these new proposals for the physical uplift of mankind in Madras. These proposals and the propaganda carried on in their favour remind us of a very common feature of South India. Building of new temples is a great attraction for Hindus. If one goes into any town or village one cannot fail to observe the construction of new temples going on. At the same time and about the same places there are temples neglected and crumbling or temples partly constructed and abandoned. The pious devotee who comes on the scene can renovate the old temple or complete the unfinished one but instead he will insist on a new one, though he may not be sure of completing it or endowing it with the necessary money for its continued working.

More people die of malaria and its consequences. More women die of malarial cachexia than of child birth. If more medical men are available in the villages, many of these deaths could be prevented. Are the government satisfied that they have done their best for these villagers?

Without entering into the larger question of the economic sufficiency of the villages, we feel that a good deal of suffering and death could be prevented by supplying these villages with competent and resourceful medical men. It is admitted on all hands that there is more and more demand in the villages for these medical men. This demand has not yet been met. The State will not tempt medical men to stay in the villages by subsidising them adequately. We do not consider even the recent increase of subsidy adequate enough. But it proposes to find sufficient money to start antenatal clinics to prevent maternal mortality and morbidity in the urban areas.

We are not to be taken to be unwilling to carry relief whithersoever it may be needed. But we believe that in a country where poverty is pleaded at every step, the available funds should be utilised as to get the best value. This is only possible if all people concerned in devising measures of medical relief will seek advice where it can be found, sit round and think out a comprehensive programme of measures which would carry efficient medical succour to an increasing population and which would bring down disease and death to a minimum. We venture to think that when this is done, it would be found that the first link in the chain would be, not measures that are being copied from countries which are rich and have already brought down their rate of illhealth and death to a very low figure by other measures, but the provision of a large number of well qualified, efficient and as already mentioned resourceful practitioners.

PLEASE

DO NOT FORGET

TO

RETURN

FORM (PAGE 158)

TO

REACH THE UNION BEFORE

30th September, 1930.

UNION NOTES.

(By the Secretaries)

It will be seen from the Programme given in the earlier part what a varied fare is being presented. It is earnestly hoped that full advantage will be taken by the members.

We cordially invite all the members of the Medical fraternity, present and future, to attend the meetings. Whatever differences we might have in medico-political views there can be no two aspects in our clinical and social life. We have been able to get the co-operation of members of the staff of various hospitals to give us the benefit of their experience, and we express our thanks to them.

These gatherings, we hope, will remove any differences present and enable the Union to weld the whole profession into one UNITED entity. If sectarian differences are present now, they are due to existing conditions. It shall be our effort to contribute our mite to remove these and eventually obviate the necessity for sectarian organisations to look after various apparently divergent interests.

* * *

Apart from business meetings we *have been able to hold two professional* meetings in August. Both these were well attended and for the first time we heard the complaint from some of our Service colleagues that they were sorry that adequate notice of these meetings had not been received. We send notices of the meetings to their respective organisations and hoped that this would be enough. As it seems to be not so, we will be sending the notices, which *ipso facto* may be considered as invitations, to the various hospitals requesting the Superintendents to give the necessary circulation.

The address by Dr. Lakshmanaswami Mudaliar, one of our few Service members, was extremely instructive and much appreciated. That by Col. Skinner, who had taken pains to bring cases for demonstration was equally appreciated. We noticed in the audience some students as well. It is highly gratifying to see our future members in these gatherings. CATCH THEM YOUNG is our policy.

* * *

September is a busy month. Through the courtesy of Messrs. Havero Trading Co., we are able to give a Cinema demonstration of some subjects of great interest to the profession. As accommodation is limited we have been forced to restrict admission by tickets which may be had free from the Secretaries. If it is found necessary, another one will be arranged on a later date. Will those who have not been able to come for the first meeting kindly communicate to us.

Col. Bradfield has kindly promised to give an address on Radium. Dr. E. V. Srinivasan will read a paper on "Some Corneal affections." An *ordinary* General meeting has been called by the President. In the agenda will be the election of members of the newly sanctioned Publicity Committee.

* * *

Now, may we go on to more sordid affairs?

Will members take a greater interest in acoustics and voice-training? We are sure that many more of our members can read papers and give addresses on not only medical but also on lay subjects of interest. Probably shyness or diffidence seem to be the reason.

The Union meetings will be good training ground for such as they would be in a very sympathetic atmosphere.

We request that those members who will kindly entertain and instruct the others kindly send their names and the subject of their Evening to us.

We wish to give notice of the Union engagements early enough and as the Bulletin goes to press by about the 20th of the month the following month's fixtures have to be arranged by that time.

We request all our members and sympathisers to keep Mondays open for Union engagements.

* * *

The Articles and Bye-Laws of the Union as proposed to be amended by the Rules Committee are published in this issue of the Bulletin for circulation. Members who wish to bring forward any amendments on the same are requested to send the same to the Secretaries, *before the 30th September.*

* * *

Our request for clearance of arrears has not evidently fallen on receptive ears. We do know that it spoils the pleasure of the evening by receiving a visit from our Attender. But as various bills have to be paid we request our members again to favour us with a remittance of their subscription.

* * *

New members who have not sent their subscription are requested to send the same at their earliest convenience, to enable their names being entered on the members' register. Subscription is Rs. 10 for city members and Rs. 3 for mofussil members per annum.

* * *

We request that all communications to the Union may be addressed to the SECRETARIES, SOUTH INDIAN MEDICAL UNION, and not by name.

Extracts from the proceedings of a meeting of the Governing Body of the South Indian Medical Union held on Monday, 11th August 1930.

PRESENT:

Dr. C. R. Krishnaswamy.
" V. D. Nimbkar.
" E. V. Srinivasan.
" U. Venkata Rao.
Dr. M. Sanjiva Rao.
" U. D. Gopal Rao.
" K. Srinivasa Rao.
" P. Rama Rao.
" T. Krishna Menon.

Chairman:—Dr. C. R. Krishnaswamy.

1. The minutes of the Governing Body meeting held on 7th July 1930, were read and passed.

2. The minutes of the General Body Meeting (adjourned) held on 21st July 1930, were read and approved.

Resolved.—That the same be circulated among the members of the Union.

3. The Financial statement for June 1930, was passed.

4. Applications for membership from the following doctors were scrutinised and approved.

Dr. P. B. Somappa.*
" N. S. Krishnamurti.*
" M. K. Sahadevan.*
" A. Janakiram.*
" B. Sukhavanam.*
" S. Venkataswamy Naidu.*
" B. A. Sundaram Pillai.
" B. Venkatanarayana.*
Mrs. Saraswati Achar.
Dr. M. D. Samuel.*
" M. D. Pillai.*
" C. S. Anantakrishnan.*

5. The members of the Honorary Medical Service Committee, *vide* Res. No. D. 3 proposed by Dr. M. Sanjiva Rao and amended by Dr. V. D. Nimbkar and passed at the general meeting of 21st July 1930, were elected by the Governing Body.

President of the Union.
Dr. V. D. Nimbkar.
" G. Zachariah.
" M. Sanjiva Rao.
" P. Rama Rao.
" T. Krishna Menon.

* Mofussil Members.

Convener and Secretary.—Dr. P. Rama Rao.

6. Moved by Dr. U. D. Gopal Rao.

"That a directory containing the names, addresses and special qualifications of all the members of the Union shall be published annually either separately or in the new year issue of the Bulletin."

Resolved.—That the same be considered at a future date.

7. Moved by Dr. U. Venkata Rao.

"That intimations of the Governing Body Meetings be sent to the individual members of the Body through the attender of the Union personally and not by post."

Resolved.—That the same may be left to the discretion of the Secretaries.

8. Moved by Dr. U. Venkata Rao.

"That the Government of Madras be requested to appoint capable Lady *Medical Practitioners as Honoraries* in the various hospitals in the City and mofussil."

Resolved.—That as the above comes under the purview of the G. O. *re* appointment of the Honorary Medical Officers, no further action is necessary for the present.

The meeting terminated with a vote of thanks to the chair.

New Members who have not paid their subscription (City Rs. 10, Mofussil Rs. 3 for the year) are requested to send the same without delay to the Secretaries.

Proposed amendment of the Articles and Bye-laws of the Union.

Submitted by the Rules sub-committee appointed by the General Body and as approved by the Governing Body 1929-30.

CONSTITUTION.

Article 1. Title.

The names and title of this organisation shall be "The South Indian Medical Union."

Article 2. Objects.

The object of this Union shall be:—

(*a*) The promotion of the science and art of medicine in South India.

(*b*) The Union of the Medical profession of South India into one common organisation.

(*c*) The development and diffusion of scientific knowledge.

(*d*) The promotion of friendly intercourse between persons engaged in the pursuit of scientific knowledge.

(*e*) The elevation of the standard of medical education.

(*f*) The enlightenment of public opinion in regard to the prevention of disease.

(*g*) The publication of the results of scientific investigations.

(*h*) To concert such measures as to bring about mutual good will, better understanding, co-operation and a spirit of brotherhood amongst members of the medical profession.

Article 3. Composition of the Union.

The Union shall consist of ordinary members, associate members, and honorary members.

Article 4. Membership.

(*a*) The ordinary and associate members of the Union shall be Medical Practitioners and Dentists licensed by their Home Governments. They shall hold a qualification registrable in the Madras Presidency.

(*b*) Honorary members shall be those who have done meritorious service in furthering the objects of the Union and Scientists working in the sphere connected with medicine and hygiene. They need not necessarily be Medical men and shall be elected unanimously by the Council of the Union.

(*c*) Ordinary members alone shall be competent to hold offices, attend or vote at any business meeting.

Article 5. Council.

The Union subject to the terms of this constitution shall be governed by the Council.

The Council shall consist of the President, two Vice-Presidents, two Secretaries [a General Secretary who shall be in-charge of the general work of the Union and the other, a Secretary in-charge of the Scientific Section], a Treasurer, Twelve members elected at the annual meeting, of whom at least one half shall be members of the outgoing Council.

Article 6. The officers.

The officers of the Union shall be the President or in his absence one of the Vice-Presidents and the General Secretary.

All correspondence in the name of the Union shall be conducted only by the General Secretary.

Article 7. Office.

There shall be an office of the Union under direction of the General Secretary, who shall take care of the archives and conduct the general business of the Union.

Article 8. Funds and Expenses.

Section 1. The expenses of the office of the Union shall be met from the subscriptions. These funds shall be collected by the Treasurer.

Section 2. Funds for meeting other expenses of the Union shall be raised either by voluntary gifts from individuals, medical and other organisations or by special grants authorised for the purpose by the Council from the general funds.

Section 3. Membership subscriptions shall be Rs. 10 and 3 per annum for ordinary and associate members respectively, payable yearly or in half-yearly instalments of Rs. 5 and 1-8 respectively.

Section 4. Subscriptions are due before the fifteenth day of April and October. All subscriptions are payable in advance.

Article 9. Amendment.

Section 1. The Council may recommend any amendment of any article of this Union for consideration at any special meeting of the Union provided that three fourths of the total members of the Council vote in favour of such a change or amendment.

Section 2. The Union may amend, repeal or alter any part of this constitution at any special or annual meeting provided that three-fourths of the members attending such meeting vote in favour of such amendment, repeal or alteration, and same is confirmed by a simple majority of the members present at a meeting to be summoned not earlier than 30 days after passing of the first resolution and that the amendment, repeal or alteration shall not take effect till and after the succeeding annual meeting.

Bye-Laws.

(Chapter 1).

Section 1. Any person who is desirous of becoming a member of the Association shall present to the Council of the Union.

(*a*) A written application for membership on the prescribed form.

(*b*) Satisfactory evidence of the necessary qualification.

(*c*) And on his admission being approved by the Council, the payment of such dues as may for the time being be leviable ;

Provided that a member once elected shall remain a member as long as he conforms to the rules of the Union and irrespective of his place of residence or of honourable withdrawal from the Union.

Honorary members shall be elected by the Council and shall be entitled to retain their membership for the period mentioned in the resolution electing them.

(*d*) Any ordinary or associate member of the Union shall be entitled to retain his membership so long as he pays his dues and otherwise conforms to the provisions of the constitution and the Bye-laws.

Section 2. Any member shall be suspended from the roll of members—

(*a*) for failing to pay his dues to the Union, provided that due notice shall be previously be given to the member by the President.

(*b*) for conduct prejudicial to the interests of the Union, provided that due notice shall be previously given to the member by the Council.

Section 3. When a member is suspended or has forfeited his membership it shall be the duty of the General Secretary to make the necessary entries against the name of that member or to remove the name of such person from the roll of membership and to notify him of the action taken together with the reason therefor.

Section 4. (*a*) Any member who has been suspended for non-payment of dues shall be restored only when all his dues have been paid.

(*b*) Any person who has forfeited his membership shall be re-instated at his request, if approved by the Council on such terms as the Council may decide.

(*c*) Members who are suspended or are in arrears for a period of 3 months or more are not entitled to attend or vote at any business meeting.

1. The Council shall meet at least once every month.

The quorum for any meeting of the Council shall be 5.

Chapter 2.

The President of the Union and the General Secretary shall be ex-officio members of any committee formed by the Association. The *Official* minutes of such committees shall be forwarded to the General Secretary by the *Conveners* of such meetings.

Chapter 3.

Nomination of Officers shall be made by members and a majority of members present shall elect such officers. Nomination and election shall take place at the annual general meeting. Any post left unfilled at the annual general meeting or failing vacant later shall be filled by appointment of an officer by the Council of the Union at the next meeting of the Council.

Any member of the Council who is absent for 3 consecutive Council meetings shall "*ipso facto*" cease to be a member of the Council but is eligible for re-instatement.

Chapter 4. Meetings.

The General Secretary shall use all reasonable means to give due notice of the meetings to the members of the Association. Evidence of posting to the last address given by the members shall be considered as service.

2. *Annual General Meeting* shall be held in the month of April every year or soon after convenient, for the consideration of the annual report which shall include an audited statement of accounts, to elect the officers for the ensuing year, and to transact any other business that is considered expedient.

Members desirous of bringing forward any proposition before the annual general meeting shall send the same in writing to the General Secretary to reach him not later than the 1st day of March preceding the annual general meeting. For annual general meetings a notice of at least 15 days shall ordinarily be given. Members requiring information at the annual general

meetings shall give at least 7 days' notice in writing to the General Secretary, stating the nature of the information required.

3. *Extraordinary General Meetings.*—On requisition in writing of not less than 15 members, stating the purpose of the meeting, the President shall have a meeting of the Association convened with one month of the receipt of the requisition. If the President does not convene the meeting, the requisionists themselves can convene the meeting. Quorum for such shall be 30. Notice of at least 15 days shall be given to the members.

4. *Ordinary General Meetings.*—The President may at any time convene a meeting of the Association for any general or special purpose. For ordinary general meetings a notice of three days shall be deemed sufficient.

5. The President shall preside at all business meetings of the Union. In his absence the members present shall elect one of the Vice-Presidents, or when no Vice-President is available, one from among themselves as Chairman of the meeting.

Chapter 5.

The minutes of all business meetings shall be recorded in a book kept for the purpose by the General Secretary and submitted to the Council at its next meeting.

2. The Council at their first meeting shall provide for the publication of the proceedings of the general meetings and one copy shall be presented to each member and such others that the Council may decide.

Chapter 6.

(*a*) The Treasurer shall be the custodian of such funds as are collected from membership fees or otherwise and shall render to the Council a report of all funds passing through the hands at each meeting of the Council. All money of the Union shall be deposited in the Bank Account of the Union, The General Secretary shall be permitted to keep an Imprest account of not more than Rs. 10. All payments of any sum of Rs. 5 or more shall be only by cheques. Cheques shall be signed jointly by the President and the Treasurer.

(*b*) The Treasurer shall bring to the notice of the General Secretary the names of all members who are in arrears on the 1st of July and 1st January respectively.

Chapter 7.

(*a*) No address or paper before the Union excepting the inaugural or any special address shall occupy more than 30 minutes in delivery and no member shall speak longer than five minutes nor more than once on any subject except by unanimous consent.

(*b*) All papers read before the Union shall become its property and shall be deposited with the Secretary in-charge Scientific Section.

Chapter 8.

These Bye-laws may be amended by a majority vote of all the members present at any general meeting provided that at least 30 days' notice of the amendment has been given to the members and provided that the amendment shall be in force only till the next annual general meeting.

Chapter 9.

The deliberations of this Union shall be governed by standard rules of Parliamentary Procedure such as contained in Robert's RULE OF ORDER, when these are not in conflict with the constitution and bye-laws.

Chapter 10.

An emblem shall be deposited at the Office of the Union and shall be used at all meetings of the Union. A Badge to be worn by all members at all *Official Functions* of the Union shall be designed and issued to each member no admission at a price fixed by the Council.

An appeal to the Rural Medical Practitioners of the Madras Presidency.

Dear Doctor,

I hope that you are aware of the fact, that there is an association of the Rural Medical Practitioners of this Presidency and you might be in receipt of the proceedings of its first and second annual conferences. If you are not aware of the Association, even after four years of its existence, it is high time for you to know about it, and I hasten to assure you that you can have the copies of those proceedings, from the Secretary of the Provincial Rural Medical Practitioners' Association, Madras (Dr. S. Ramasubbu, L.M.S., Viranganur, Salem District.)

This association has lived for nearly over four years during which period a lot of silent work has been done. An article on Rural Medical Relief scheme by Dr. S. Ramasubbu which appeared in the first issue of the "Medical Practitioner" will give you a clear idea of the activities and achievements of our Association, during its existence, copies of which can be had from the managing editor of the "Medical Practitioner," 147, Purasawalkam High Road, Vepery, Madras. For instance, the enhancement of subsidy by Rs. 100 a year which we (L.M.Ps.) are getting now is the result of the hard labour of the united efforts of the Association.

It is quite plain that the Association has acquired some momentum and our united and sustained efforts are needed to stimulate it further. Everything depends upon our own exertion. Self-help is the best help and you should be never satisfied with the impression that your friends are doing everything for you. You should feel it your duty to give your sincere hand for the Association and strengthen it with your moral and material support. If all the rural medical practitioners (about 400 in this presidency) enlist themselves as members of the Association, the Association will grow in strength and will be able to discharge its duties to the entire satisfaction of every member.

Our Association is fortunate in having a very energetic Secretary in the person of Dr. S. Ramasubbu, L.M.S., Viranganur, Salem District, who is sacrificing much of his professional work, time, energy for the common cause of the Association and I appeal to you to co-operate with him and help him to make the Association a real power to espouse our cause. An annual subscription of Rs. 2 to this Association is not very much in consideration of the benefits we receive in return. If every one of us does not make up his mind to enlist himself as a subscriber and send his quota of Rs. 2 a year it will be a hard task for the Secretary to run the Association with a few members.

As it is not possible for all of us in this Presidency to meet very often, district Associations have been formed in several places and it is highly desirable that each district has its own branch, of course, affiliated to the Presidency Association. The District Association should meet at least once a year and communicate to the General Secretary of the Provicial Association, the subject-matter discussed at the District conferences. The Provincial Association should in turn organise yearly meetings of the delegates from the districts and should chalk out a plan of work for the year, discussing ways and means to improve our lot in every way, not excluding the professional aspect of it.

It will not be out of place for me to mention that we have an excellent medium **"The Bulletin of the South Indian Medical Union"** whose editors have been doing all that is possible for them to bring to the notice of the medical profession, the public and the Government, the importance of rural medical relief scheme, its possibilities to give cheap yet efficient medical relief to the masses and the necessity for those who run the scheme to understand the spirit and purpose for which the scheme has been started. So it is our duty to be subscribers of this **Bulletin** and co-operate with the editors in their onerous task to make the rural medical relief scheme a reality.

C. V. SUBBA RAO, L.M.S. (Hyd.),

Rural Medical Practitioner,
Secretary, Rural Medical Practitioners' Association, Guntur District.

BELLAMKONDA, GUNTUR DISTRICT.

31—7—30.

SOUTH INDIAN MEDICAL UNION,

GENERAL
SECTION.

51, POONAMALLEE ROAD,
Kilpauk, Madras.

Dear Doctor,

The Governing Body of the South Indian Medical Union is desirous of collecting information as to the conditions under which the Independent Medical Profession is working in this Presidency and requests that this form be filled and returned to the Secretary before the 30th September 1930. YOUR NAME IS NOT REQUIRED. This reply will be treated as VERY CONFIDENTIAL.

Yours truly,

GENERAL SECRETARY.

PLACE..... **DISTRICT**.....

1. Type of Practice.	Dispensary. Consulting General. ,, Specialist.	Rural. Urban.
2. Qualification.		
3. Year of qualification.		
4. Any post-graduate experience.		
5. Any speciality.		
6. How long in practice.		
7. How long in present station.		
8. Average annual income from *private practice*.		
9. Any hospital facilities.		
10. Any hospital appointment.		
11. Any opportunities for improving medical knowledge.	(*a*) Medical Societies.	(*b*) Journals.
12. Relations with members of the *paid* services.		
13. Any disabilities in your practice.		
14. Any suggestions which you have towards improving the Profession.		

BULLETIN
OF THE
SOUTH INDIAN MEDICAL UNION.

AUGUST 1930.

RURAL MEDICAL PRACTITIONERS AND THEIR LOT.

By T. Krishna Menon, M B.,
51, Poonamallee Road, Madras.

From the ancient times, the village has been occupying a significant place in Indian history. When India is passing through a period of transition, presenting complex issues, at the present time village life and its problem have not been lost sight of. Any problem affecting, therefore, the medical relief of the villagers, who form the main mass of the Indian people, must be of interest and importance, alike to all those interested in the country's medical welfare. Government, realising this, initiated in 1924 a scheme with a view to bring medical relief within easy reach of the rural population One of the ways which the Government have adopted appears to deserve the serious consideration at the hands of the Independent Medical Practitioners, *viz.*, the encouragement of private medical practitioners to settle down in villages for practice aided by the grant of money subsidies and supply of medicines from public funds. Indeed the object with which the scheme was started is laudable when we consider that the original idea was to divert to the villages the large number of unemployed medical men who now congregate in the towns for private practice. Though the system was intended at first as the only practicable means by which the demand for the extension of medical relief in rural tracts could be met under the present conditions, the measure of success with which it met is by no means commensurate with the efforts or energy lavished.

Though it was anticipated that the subsidy given to Rural Medical Practitioners being low would stimulate the medical practitioners to exert themselves and earn the confidence of their neighbours results have shown that it was not high enough to serve as an attraction in the initial stage. The question of building up a practice could be easily solved on paper or the platform. But the villager in the grip of superstition has, perforce, to go a long way before he could understand or to appreciate the worth of modern scientific medicine and its votaries. Much pioneering work has therefore to be done in this direction of weaning the ignorant populace away from the pernicious influence of the quacks who still thrive in the rural parts. To whose lot should this important task fall? Surely to the *men of the paid* Medical Department. Assured of a steady income and not dependent upon the insecure favours of the vacillating public, the field of rural medical relief is not a dangerous ground for men in the Service. If therefore the problem of rural medical relief is in the first instance placed in the hands of these men, the popularity of the scientific practitioners' method is assured. Then is the right time when the departmental men should rightly be replaced by the less costly machinery now known as Rural Medical Service, members of which could render equally efficient Medical relief and continue the work of their paid brethren under more auspicious circumstances than at present.

The Rural Medical Practitioners are not in any sense Government servants. But from the reports available from reliable quarters, the present tendency may be stated as one inclined towards treating them as paid servants of the Medical Department. Duties which have been and which should be properly allocated to men in the Medical or Public Health Services are not seldom forced on the rural practitioners. Actual instances

of these practitioners being asked to do *cholera inoculation* work have come to our notice, though such duties are not contemplated within their functions. Yet another frequent complaint is that some of the practitioners smart under the dyarchic dispensation of being answerable to the District Medical Officer on the one hand and the Presidents of local bodies on the other. I commend the words of a rural Medical practitioner in this connection to the careful consideration of our readers with all the strength that one can possibly command. Observe how the dignity of the Medical profession is sometimes so lightly disparaged. "While the former (the District Medical Officer) would not countenance our independence for a minute and would find fault with our method of maintaining this register or furnishing that statistics, the latter (the Taluk Board President) assumes brief authority and maltreats the Medical practitioner without any regard for his qualifications and social status, which in some cases would be easily heaps above that of the Taluk Board President." When it is realised that a *national* Medical Insurance in this country is not feasible as in Great Britain, the nearest approach to it can only be made by making the Rural Medical Relief a success that it deserves to be. We have not referred to the several ills such as doubtful security of tenure and the trifling income which is all that they can hope for under the existing conditions. It is time that the rural medical practitioners are placed under better conditions than at present, for their contentment means happiness not only to them but also to rural population. To the extent to which they are made contented to that extent alone will the solution of the problem of rural relief become a practical possibility.

[Rural medical practitioners are requested to inform the Union of any specific grievance—Secretary.]

INFECTIONS OF THE HAND—I.

By C. R. Krishnaswamy, M.B., B.S.

(*Late Honorary Surgeon, Government Royapuram Hospital*).

In dealing with the infections of the hand, a working knowledge of the anatomy of the part is essential.

The skin of the palm is much coarser, thicker and denser than that of the dorsum.

The subcutaneous tissue beneath the palmar surface is small in quantity and dense in texture. Opposite the creases in the fingers the subcutaneous tissue is almost absent so that the skin is practically in contact with the anterior surface of the theca at the proximal and inter-phalangeal creases. This fact explains the frequency with which punctured wounds of the creases especially the proximal inter-phalangeal are liable to be followed by primary thecal whitlow.

In the distal phalanx the special arrangements of the subcutaneous tissue is of great importance. It consists of a number of strong fibrous septa which radiate from the periosteum to the skin. In the compartments of the septa is fatty tissue. This arrangement obtains in the distal four-fifths of the phalanx containing the diaphysis of the distal phalanx and the whole forms a sort of a closed space receiving its blood supply from the digital arteries. The epiphysis of the distal phalanx is outside this closed space and receives its blood supply from the digital arteries, no doubt, but before they enter the closed space. When therefore severe inflammation of this part bringing about increased tension obstructs the blood supply, necrosis of the diaphysis results, even in elderly individuals in whom the epiphysis and diaphysis have united. Necrosis is generally limited to the diaphyseal

region, the base remaining intact except in late cases. This anatomical fact influences the surgical procedure in so far as when removal of bone is necessitated due to the necrosis of the distal phalanx, the base is better left behind. Such a sparing of the base of the distal phalanx also saves the attachment of the tendons of the extensor communis digitorum and flexor proper digitorum tendon.

The disposition of the Palmar fascia is of importance. It arises from the lower portion of the anterior annular ligament. As it approaches the bases of the fingers it divides itself into four slips to the four fingers which then breaks into two, to fuse with the theca of the fingers and also to get attached to the sides of the palmar surface of the proximal phalanx. When suppuration spreads from the fingers towards the palm, this arrangement of the fascia prevents the pus going underneath the palmar fascia but is led on to the webs of the fingers.

The webs of the fingers are three in number corresponding to the three intervals formed when the palmar fascia breaks up into four slips.

These webs or the intervals between the slips of palmar fascia form the route through which suppuration extends from the fingers to the sub-fascial regions (underneath the palmar fascia).

The lumbrical muscles along with the digital nerves and vessels being the contents of these intervals, form the guide for the pus to track from the fingers to the sub-fascial region.

The flexor tendons in the palm are superficially the flexor sublimis digitorum tendons beneath which are these of the flexor profundus digitorum. Investing these tendons is the ulnar bursa. This is a synovial sac consisting of a common cavity to the ulnar side of the tendons and three compartments extending in a radial direction one between the tendon and the palmar fascia (Pretendinous), one between the superficial and deep tendon (Intertendinous) and one deep to the tendons (Retrotendinous). Of these from the point of view of drainage, the most important are the retro-tendinous and the common cavity to the ulnar side. The cavity is generally continuous with that of the synovial sheath of the little finger. But in regard to the ring, middle and index fingers the ulnar bursa stops short of the middle of the palm.

The four lumbrical muscles which arise from the radial side of the deep flexor tendons are inserted with the radial side of the dorsal expansion of the extensor communis digitorum tendon of the corresponding finger. By pulling in the dorsal expansion the muscle extends the interphalangeal joints and at the same flexes the metacarpo-phalangeal joint so that in case of suppurative teno-synovitis of the flexor tendons, where there is complete loss of function, the patient can often flex the metacarpo-phalangeal joint.

Underneath the deep flexor tendons are the potential cellular spaces separated from each other by a fascial septum which passes from the fascia posterior to these deep flexor tendons to the origin of the adductor transversus muscle or in other words almost to the III metacarpal bone. That on the radial side of this fibrous septum is called the thenar space and that on the ulnar side the middle palmar space.

The relations of these two spaces will be as follows:—

Thenar Space.

IN FRONT.

The short muscles of the thumb.

The flexor tendon of the index finger.

The I and II lumbrical.

Ulnar Side.

Fibrous septum running from the fascia.

Posterior to the flexor tendon to the III metacarpal bone.

Radial Side.

Radial bursa containing the flexor longer pollicis.

BEHIND.

Adductor transversus pollicis.

Adductor obligus pollicis.

And a small portion of the Dorsal interosseous muscle.

This space is mostly in relation to the metacarpal bone of the index finger and the web between the index and the thumb.

Middle Palmar Space.

IN FRONT.

The flexor tendons of IV, V and sometimes a little of the III finger invested by the ulnar bursa.

Ulnar Side.

Muscles of the Hypothenar Eminence.

Radially.

By the septum running from the flexor tendons to the origin of the adductor Tranversus Pollicis (mentioned already).

BEHIND.

The Interosseous muscles in the III and IV Inter-metacarpal spaces and the metacarpal bones (the whole of that of the Ring finger and a little of that of the III metacarpal bone).

This space is sometimes continuous with another Potential Cellular space known as Parona's space. This latter space is situated above the wrist joint and in relation to the lunar ends of the Radius and Ulna, and is bounded anteriorly by the flexor profundus digitorum and the flexor longus pollicis tendons in their respective sheaths and posteriorly by the pronator quadratus and the interosseous membrane. This space needs drainage in cases of infection of any of the above mentioned spaces or of ulnar bursa when it has burst through the bursa.

Coming to the subject proper *infections of the finger* takes four forms: Sub-epithelial or Subcuticular, Subcutaneous, Thecal and Subperiosteal. A few words regarding each of the varieties will not be out of place.

Subcuticular or Sub-epithelial is known as a purulent blister caused by a septic prick. Here the pus collects between the dermis and the epidermis and raises the latter from the former.

All that is needed in these cases is to open the blister and pare off the epidermis. It has to be borne in mind that what appears to be only a purulent blister might be the manifestation of a deeper ulcer. So that when the epidermis is pared off in any purulent blister careful examination should be made for any deep seated suppurative focus which gets its exit through an hour glass opening. A comparison with what very often obtains in the sole of the foot will not be out of place. Often times when a case of purulent blister is met with in the sole of the foot, the Surgeon who opens only the blister and does not bear in mind a deeper focus which has just burst through the dermis and formed a small collection of pus between the epidermis and dermis and deals with it accordingly is often disappointed with the delayed healing of the case. The proper course of procedure after excising the epidermal cover of the blister is to search for the small hole through which the deeper collection

of pus makes a miserly exit and enlarge that opening and pare the edges of the opening, preventing thereby the falling together of the flaps and forming reaccumulation of septic material in the old septic space.

This analogy between the infection in the hand and foot must always be borne in mind though this state of affairs more often obtain in foot infections than in those of the hand.

Another form of subcuticular infection is what is seen in connection with the nail bed and is known as Para-onychia. In very early and simple cases any sort of evacuation will result in relief. But in other cases where about half of the base of the nail be involved, a general anæsthetic must be administered and an incision made longitudinally upwards in line with the outer edge of the nail extending beyond the nailroot.

The resulting triangular flap must be lifted and the root of the nail must be examined. And if there is any pus to be seen under the root of the nail, one of the sharp blades of the scissors should be inserted under the nail and a portion of the root only of the nail removed.

In more advanced cases where the whole of the base of the nail fold is affected the incisions must be put on either side of the nail instead of on one side only according to the description in the above paragraph. The resulting rectangular flap must be dissected up and the root of the nail examined and when badly damaged and pus has collected underneath the nail, it may be necessary to remove the proximal third of the nail. No more removal is necessary. The pernicious habit of removing the whole nail must be condemned. The distal portion of the nail acts as a protection to the sensitive finger tip.

One is often very tempted to put a medial longitudinal incision, *i.e.*, not in line with the outer edge of the nail and what happens is a permanently split nail.

Subcutaneous.—This like the former may be due to a prick, or scratch or some other sort of injury. The most common site for this type of infection is the terminal phalanx. As mentioned in the early part of this paper, the terminal phalanx area of the finger is a closed space so that in severe inflammation thrombosis of the veins of this area occurs leading to necrosis of the diaphysis by the distal phalanx. When the removal of bone is necessitated during the course of the operation, it is best to leave the epiphysial part on the base of the distal phalanx.

The one important point which will help in determining whether one is a case of thecal infection or a simple subcutaneous whitlow is that there is a general enlargement in the former cases whereas in the latter the enlargement or swelling is localized. The signs of redness and fluctuation are very difficult to elicit, as in these cases the skin is thick and coarse and dirty.

Thecal.—This a suppurative teno-synovitis of the flexor tendons and sheaths, resulting from a prick on the palmar aspect of the finger especially near the proximal inter-phalangeal joint. Such a prick, especially when it is a very small one—bigger ones are not so bad—may directly infect the flexor sheath because of the skin coming in direct contact with the theca in this region with the interposition of very little subcutaneous tissue and occasional hernial protrusion of the synovial membrane lining the flexor sheath through the centre wall of the sheath facilitating such an infection. If the prick does not directly involve the flexor sheath, the latter may subsequently get infec-

ted through the lymphtic vessel. One has to be careful in opening a subcutaneous ulcer as by a careless opening you are likely to infect the deeper flexor sheath.

A few important physical signs regarding the flexor sheath is worth learning in mind :—

1. The finger is held in semiflexed condition.

2. There is a general enlargement of the finger.

3. Inabilty of the patient to actively extend the finger though he may be able to flex it slightly (flexion at the metacarpo-phalengeal joint is accomplished by the lumbricals).

4. Passive extension causes severe pain.

When the little finger or the thumb is affected, the ulnar and radial bursa stand very great risk of infection.

Subperiosteal.—At one time it was thought that this condition occurred frequently. With the terminal phalanx, it was pointed out in the early part of this paper, that this condition is likely to occur as a result of vascular thrombosis.

Treatment of subcutaneous whitlow of the Terminal Phalanx :—Operative interference in infections of the hand had better be carried out under general anaesthesia and after the application of a tourniquet. The plea that the application of a tourniquet lowers the resistance of tissues is more than counterbalanced by a bloodless field of operation. A median incision in the tips of the fingers which one is tempted to put is very undesirable for the following reasons :—

1. The median incision after it heals leaves a very sensitive scar.

2. The nerve plexus at the tips of the fingers is cut.

3. If there is need to extend the incision, you don't encroach on the distal and thereby render easier the chances of a thecal infection.

So the lateral incision parallel to the nail about ⅛ anterior is best. In more advanced cases a double lateral incision, connected with each other at the tips of the finger, thereby enabling the formation of a palmar flap is the most sensible one.