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OF THE
South Indian Medical Union.

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PUBLICITY SECTION.

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OUR aim must be to bring into being a strong and influential body of independent private practioners. who can earn an honest living by their skill. intelligence, and perseverance. To accomplish this object, the co-operation of the general public is needed, and there are indications to show that it is forthcoming. If every house-hold amongst the upper and middle classes will have its own family doctor on reasonable terms, there is no need for despair ; and incidentally the public hospitals and dispensaries will be free to bestow greater care and attention on the needy poor.

Dr. S. SUBBA RAO,

Senior Surgeon to the Government of Madras.

BULLETIN

OF THE

SOUTH INDIAN MEDICAL ASSOCIATION.

FEBRUARY 1932.

Editorial Comments.

Major-General Sprawson.—We welcome back to our midst General Sprawson, Surgeon-General with the Government of Madras. General Sprawson had been on leave on grounds of ill health and there were rumours that he might not return to Madras. We are glad that he has come back in full health and one wonders whether those unfounded rumours were not spread by interested parties. General Sprawson's regard and sympathy for the legitimate aspirations of the independent medical profession and his views that efficient medical relief is paramount has made him not very popular with certain vested interests is well known. We know that important problems connected with the above have been held in abeyance and hope that with his return the forward policy that he has enunciated will be set in force before long.

* * *

Retrenchment in the paid Services.—The retrenchment in the services has brought certain welcome results. Those seniors who have been given notice have suggested that they may be allowed to work in their places after their retirement in an *honorary* capacity. We have had no fears about the juniors. But the seniors, brought up under different environments, have been strong opponents of the honorary scheme and this welcome change of view will cheer even the most pessimistic of propagandists. The Union and its Bulletin can now feel proud that the gospel it has been preaching has not been in vain and can claim a big share in the conversion of these diehards. We have also to be thankful to the other medical Journals in the presidency for their persistent advocacy of the 'honorary' cause.

* * *

Educational appointments.—The recent appointments in the medical teaching institutions leave one plenty of grounds for thinking. Except that they have been made on personal grounds there does not seem any justification of the policy underlying the same. Whilst high academic qualifications and teaching experience have been persistently advocated for these places and in the case of some of the acting professors the confirmation definitely depended on the above, the professorship of Hygiene has gone to one whose academic distinction, at least, would not give him the necessary claim. If Hygiene is not an important subject why then maintain a separate professorship. A minor lectureship would save money.

* * *

The other appointments also have their repercussion on medical education. We have heard that the medical schools are being used as training grounds for professorships in the colleges. The translation of a professor of medicine at Vizag medical college into an additional professor at

Madras, that of the professor of surgery at Vizag to the junior post of professor of operative surgery in Madras, the appointment of the Medical and Surgical Registrars of Madras to senior staff positions at Vizag make one feel whether after all Vizag medical college is of an inferior standing to the Madras medical college in its academic aspect and that the professorships in the Madras college are senior places compared to those at Vizag. No better method of bringing down the Vizag medical college and incidentally the Andhra University in the eyes of the students and the public could be devised. We are sure that there has been no such idea underlying these appointments but unfortunately it will lead the public to infer so.

* * *

At the last inter university conference the members unanimously decided on an inter-change of examiners in medical examinations. Ensurance of a common standard was the object which inspired this reform. A very desirable one, no doubt, but more than the examinerships an inter-change of professors would more materially ensure a uniform standard. Financial considerations would stand in the way of such an inter-provincial change but there is no such objection if this example is set in the medical colleges of the presidency. An equality of status and a healthy rivalry would thus be created to serve the best interests of the institutions. If nothing more, at least it would save one question " where have you been working ?"

* * *

A Solomon come to judgment.—Report of the proceedings of the trial at the Old Bailey, elsewhere published, of an unqualified man who assumed the title of " Doctor " and was pulled up for that under the Medical Degrees Act has brought forth certain curious observations from the bench. It is unfortunate that there is a tendency amongst certain judges to pose as epigramists and that alone can justify the irrelevant remarks from the bench. We do not claim any monopoly for the art of healing. There may be laymen who might be able to cure illnesses. An aspirin for headache, or quinine for malaria does not always require a qualified man to prescribe. In fact they are served on the counters. But with due deference to the legal mind of Sir Ernest Wild may we remind him that what he is there for is not to air his personal views and whims but to administer the law as established. Can he testify that knowledge of law is restricted to the members of the Courts of Inns and Temples only. Are there not laymen with better conception of law than even some of the benchers. But would that entitle such persons to assume the title of Barrister-at-law. We can only pray ' save us from judges with a penchant for epigrams '.

* * *

Indispensables.—Having tried various methods of avoiding the axe we are told that a a prominent member of the service has laid in his claim to be retained on the score of indispensability. It seems there is no one to replace him—at least, that is his opinion. We cannot congratulate him or his staff if it is so. If after a decade none of his staff has qualified to take his place or if he has not been able to train one to succeed him it is high time that a more competent and willing head or a more receptive staff is substituted. Anyhow indispensability on this count should be the least claim for the retention of such people.

Education and Exigencies of Service.

Medical education as other branches of education is generally based on the needs of human society. And as these vary a little in different countries medical education also varies. Yet, the essentials of such education are common to all civilized countries and they demand that those who propose to look after the health of their citizens should be well grounded in such fundamentals. In ancient days, from lack of communications, one country was often unaware of the existence of another, and one school was ignorant of the teachings of another. There was then some excuse for the creation and maintenance of different schools each of which probably emphasised only one aspect of medicine or other. Some were schools of experimental medicine while others were famous for clinical medicine. But with the almost annihilation of distance in the present day, the various schools of medicine in all parts of the world adopt a more or less uniform syllabus of education in the fundamentals. Lest there should still be some rip wan winkles in medical education, there are organisations like the Rockfeller Foundation of America and the International Organisation of Medical Socialogy of Paris which collect reports of the varied activities of many schools scattered all over the world and make them freely available to all teachers and interested institutions. Thereby is made known to all what subjects should be taught, who teaches them, how the teachers are chosen and how they teach.

In the light of these developments of modern medical education one cannot help a feeling of regret that progress is slow in this country and in some respects we seem to stagnate. It is not our object here to blame any one. It would be difficult to single out any individual or authority for the blame. But we wish to draw the attention of those who direct medical education in this province to certain defects so that they might be speedily rectified.

Teaching of medicine along western methods was originally introduced into this country by British Medical men. The aim then was to train a fairly efficient set of assistants to work under the instructions of the British surgeons. We have travelled far from those days. The schools now aim at producing a well-educated and well-equipped group of medical men and women who can independently look after the health of the country. In spite of such changes in the outlook we still frequent ly meet with instances suggestive of the old and discarded aim of turn ing out assistants. This mentality manifests itself in diverse forms at different times. Sometimes it is in the method of teaching or the training in the wards. Oftentimes it is in the method of staffing the schools and hospitals. In colleges teaching to the University standard, one would expect the highest available academic qualifications to be the minimum requisite for a teacher. If in addition these men possess to their credit some work of merit, they would be preferred. The University of Madras and the local Government have on many occasions proclaimed that their views were identical. But in the appointments that have been recently made to the medical colleges and schools it looks as if the criterion for the selection of teachers has been the possession of the lowest available academic qualifications. Otherwise it would be difficult to justify the appointment of an assistant administrative officer to the chair of hygiene and public health in the premier institution of the Presidency. If one with high academic qualifications

happens to be at the moment an assistant or deputy Director of Public Health, there could be no objection to his appointment to a University chair. For, one who hopes to teach University students should himself have moved in an academic atmosphere for some years previously. We do not know if these are essentials for an administrative officer. If the newly appointed Professor of Hygiene be a successful administrator and inspecting officer, it were a pity that he should have been lost to the department. And if he was a failure, then it is greatly unjust to the college to have him forced on its staff. We presume that this indefensible appointment has been made on account of a meaningless rule that one of the professors of Hygiene and Public Health in the presidency should belong to the department of Public Health. If there be any virtue in the rule, it were far more reasonable that the head of the department himself be appointed to the chair. The application of this rule in the appointment of professors of Hygiene is highly detrimental to the interests of the institution. We have dealt with the aspect of qualification and fitness for teaching and experimental work. An equally strong argument against the rule is the liability for frequent changes. An assistant or deputy Director of Public Health would naturally aim at the Director's post And the question of seniority would interfere with any one being the professor to the end of his service.

Apart from these defects, we do not understand why this chair alone should be manned by a Public Health officer on a much higher salary when other equally important subjects are taught by officers of the grade of Civil Surgeons and less on a lower pay. And some of these professors have often much higher academic qualifications and longer service. We wonder if the financially harassed government has bestowed any thought on this unnecessary extravagance. We wonder also if exigencies of service could be stretched to more absurd limits We are indeed sorry that we have particularised this instance. We have no interest in the personnel. But the policy underlying the appointment is totally wrong. And as this is the latest instance of a series of wrong appointments, we feel compelled to draw the attention of the authorities that they might rectify these blunders forthwith. We fully trust that there would be no need for us to refer in future to the number of other similar instances in the department of medical education.

Judge Snubs Medical men.

"HEALING NOT THEIR MONOPOLY."

Interesting references to the use of the term "Doctor" were made by the Recorder, Sir Ernest Wild, during the Old Bailey trial of an unregistered medical practitioner who was acquitted on a charge of obtaining money by false pretences with intent to defrand and was discharged.

Sir Ernest said the medical profession had no monopoly of the healing art. It could not merely say "quack" to a man and rule him beyond the pale of the healing universe, though it might like to do so. There were plenty of unqualified men, like Sir Herbert Barker, who survived with great success the dislike of the medical profession. There were osteopaths and others who professed the healing art in various directions and who had as much rights to treat patients as a qualified doctor so long as the public know with whom they are dealing—(*Hindu*)

Municipal Doctors and Private Practice.

Strong exception was taken at a meeting of the Bangalore Cantonment Municipal Commission by more than one commissioner to certain of the remarks contained in a letter from Col. MacPherson, Residency Surgeon, regarding the desirability or otherwise of allowing municipal medical assistants to have private practice. Mr. G. H. Cooke, I. C. S., presided and the meeting was largely attended.

When the Commission took up the item relating to the revision of the pay of Dr. Rahman and Dr. Rangachar, the two Health Assistants of the Department, the President opened discussion by saying that this question had been pending disposal for two years now, and that in accordance with the resolution passed at the last meeting, opinions on the question of allowing private practice was invited from the Residency Surgeon and the Station Health Officer. The Residency Surgeon had expressed himself definitely against the proposal, since the knowledge required of the medical assistants were not exactly identical with those of the medical practitioners in the matter of diagnosis and prescriptions. Moreover the services of the medical assistants should be available at all hours in times of public call, which would be hampered by allowing private practice. The Health Officer also expressed his view against the proposal.

Opening of a new Hospital ward.

Kunnakudi, just half an hour's drive from Pallathur, is a small but important town in this neighbourhood. It is a well known centre of pilgrimage in the district as there is a temple of God Subrahmania on a hill in the town. Besides, there is a monastery or Pandarasannidhi, the chief of which has the management of the temple under his control and whose disciples and followers numbering thousands are distributed over the neighbourhood.

At one end of this town a small but popular hospital has grown up, thanks to the munificence of Rao Bahadur M. R. Subbayya Chetti, a citizen of Karaikudi. Fitted with an operation theatre on up-to-date lines, the hospital can accommodate about sixteen in-patients. Quarters for the staff are also provided. To ensure a perpetual income for the institution he was arranging to endow property worth Rs. 75,000 and in the meanwhile had assigned to it properties from whose annual income of Rs. 6,000, the institution would be run.

The donor was also contemplating the addition of a new maternity ward to the hospital.

His Excellency the Governor, accompanied by Lady Beatrix and Miss Stanley, Major Bootle Wilbraham, Military Secretary, Sir Charles Buchanan and Major Johnstone, arrived at this place at about 10-30 a.m. after having been garlanded *en route* by the Pandarasannidhi of the Devasthanam.

Requesting His Excellency to declare the new ward open, Mr. Subbiah Chetti expressed his gratitude for the head of the province having consented to participate in the function and hoped that this would be a happy augury for the future prosperity of the institution.

The Governor's Speech

His Excellency then declared the ward open amidst cheers. He said :

Rao Bahadur Subbiah Chettiar, and Gentlemen,—During our tour through Chettinad, Lady Beatrix Stanley and I have been deeply impressed by

the strong spirit of service which is held by the wealthy men of the community and our progress seems to have been from one institution to another at each of which we have assisted at some beneficent ceremony made possible largely or wholly by private charity. It says much for the enlightenment of the people of the Chettinad that their acts of charity should have taken such a practical form.

For the establishment of a private hospital, you have, Rao Bahadur, in selecting a site at a place of pilgrimage rendered service both a religion and to charity, and I feel confident that this hospital by administering to the medical needs of those who make their pilgrimage to the temple is catering for a much-felt want.

Bangalore Medical School Day.

The School Day and annual distribution of prizes of the University Medical School, Bangalore, came off on the 6th evening, under the presidency of Dr. S. Subba Rao, B.A., M B., M.R.C.S. (Eng.), D.Ph. (Cantab), Senior Surgeon with the Government of Mysore. There was a large and distinguished gathering present on the occasion.

After tea and light refreshments served on a lavish scale, the guests witnessed the fancy dress parade, which evoked keen competition among the several entrants.

Principal's Report

The meeting commenced with invocation and music by Mr. Raja Iyengar and his troupe. Dr. B. K. Narayana Rao, Principal of the School, then read the report of the School for the year 1930-31, which showed an all-round progress. In the course of his address, he said :—

During the past year (1930-31), there were 124 students in the four L.M.P. classes as against 123 in the previous year. Of these, 17 were women students forming 14 per cent of the total. Owing to pressing demand for admission by large numbers of well qualified students of all communities from all parts of the State, a greater number than usual, namely, 53, were admitted into the First Year Class, bringing the present strength of the School to 158.

A fair amount of research work both in the Clinical and Laboratory aspects is being done by the Medical Officers who are on the teaching staff, and many papers have been published in professional journals and scientific societies. Not a little of this very desirable activity is due to the academic influence of the School which has brought a scientific outlook into the routine clinical work of the wards, thus indirectly improving hospital service.

To further encourage this aspect of school work, more facilities in the shape of improved libraries and laboratories are needed.

Grievances of Licentiates

Two questions of importance concerning the L. M. Ps. have been occupying the attention of the authorities of many Indian Universities at present. Firstly, there is the long-standing grievance that an L.M.P., however capable, is denied all opportunities of obtaining a higher qualification in India on the basis of the credit due to him for the medical education he has already received. While several of our L.M.Ps. have been permitted by the Royal College of Surgeons in England to obtain the membership of the College by putting in supplemental studies extending over only two years, under our present rules, the same L.M.P. would be required to undergo

a general and professional course extending over seven years to obtain the M. B. Degree here. This is really anomalous and hard, and I believe our University authorities also are actively considering measures to ameliorate this hardship.

The second question is the want or reciprocity between the several centres of medical education in India in the matter of mutual recognition of medical courses either of the degree or of the diploma stages. While a Mysore or Bombay or Madras student can get some credit at the hands of a British University or Medical Corporation for the medical courses he has undergone in India, the same student cannot get similar favourable treatment at the hands of the neighbouring Indian Universities. While migration in the middle of a long medical course is, to some extent, encouraged in German Universities, and is allowed in British Universities, it is rendered absolutely impossible in India. This does not ensure any greater efficiency in our students, but only works as a hardship in a few cases as is seen from some applications that have reached us from good students undergoing medical education in other parts of India. I believe this question is under consideration by the Inter-University Board and other authorities.

The reading of the report over, Dr. M. Sreenivasa Rao, retired Sanitary Commissioner in Mysore, proposed the toast of the school, to which Mr. U. S. Seetharam, final L. M. P. student, replied in suitable terms.

Dr. Subba Rao, president of the day, gave away the several prizes in the shape of cups, medals, books to the several successful candidates both in sports and study. Mr. Azadulla Beg was awarded two gold medals and Miss D. Silva's gold medal.

PRESIDENT'S SPEECH

Rising amidst cheers Dr. Subba Rao said in the course of his speech :

I greatly appreciate the courtesy of the Principal of the Medical School and the kindness of the School Day Committee in conferring on me this great honour and privilege of presiding on this occasion. I believe this is the greatest honour that the school can confer on any one ; and I consider it also to be a privilege, as I was connected with the school for over eight years, more than half the period of existence of the Medical School. I am very happy to come back again to my old haunts and to find the same enthusiasm, the same camaraderie between teachers, the same intimate communion between teachers and students, and the same optimistic outlook still prevailing in the school although gloomy and dark clouds may be gathering ahead in the shape of financial distress, over-production and consequent unemployment. Dr. Narayana Rao has told you that almost every one of the 257 licentiates who passed out of the school has obtained employment. With our schemes of extending medical aid to rural areas the thirst of the Medical Department for medical men seemed, at one time, to be unquenchable. But for the existence of our Medical School expansion of medical relief, especially in rural areas, would not have been possible. More than 80 per cent of the Sub-Assistant Surgeons who form the very back-bone of the department are products of this school ; and with some pardonable pride, I may be permitted to say that the large majority of them were my students ; and nothing gives me greater pleasure than to testify to the remarkably good work they are turning out in the service of suffering humanity, very often in uncongenial environment.

PRIVATE PRACTITIONERS

It is not my intention to-day to sound a pessimistic note about the future. Government service is not the end-all and be-all of life especially to a medical man. Most civilised countries possess one doctor for every 1,000 of population, and even then the doctors are kept busy; whereas we, in this country, do not have one doctor for even 10,000 people. The fact that 32 lakhs of patients attend our public hospitals and dispensaries every year is ample proof to show that the general public are awake to the greater safety and utility of seeking treatment at the hands of medical men properly trained in modern scientific methods; and yet we have only a handful of private practitioners in the State. We are travelling in a vicious circle. People do not think of seeking the aid of private medical men, because they are so raw or do not exist at all in many places; and our young men are unwilling to start their own consulting rooms and dispensaries for fear of not attracting a sufficient number of patients. Let me assure you that "the harvest is plenty," if proper methods of cultivation are employed, "but the reapers are few". At all events, those few who have followed this advice and started their own private dispensaries are, I am glad to remark, enjoying fairly lucrative practices untrammelled by "the exigencies of service" and the proverbial "insolence of office." Though few and far between, great is their honour, great is their credit; for, they are the pioneers in the field. Over-production may be a menace in the case of Arts Colleges; but I refuse to believe that it is a factor to be reckoned with in the case of professional schools especially Medical Schools. This Medical School may produce more L. M. Ps. than are required by the Department, but it can never hope to produce more doctors than the country wants. Our aim must be to bring into being a strong and influential body of independent private practitioners, who can earn an honest living by their skill, intelligence, and perseverance. To accomplish this object, the co-operation of the general public is needed, and there are indications to show that it is forthcoming. If every household amongst the upper and middle classes will have its own family doctor on reasonable terms, there is no need for despair; and incidentally the public hospitals and dispensaries will be free to bestow greater care and attention on the needy poor.

GENERAL MEDICAL COUNCIL

A general medical council for the State is in the process of formation. Registration confers on you the right to practise. At present, however, it does not prevent quacks and unqualified persons from practising. As we gain more experience, it may be possible to press for legislation in that direction. The Mysore Medical Association already exists to safeguard your rights and your interests, whether you enter service or join the ranks of the Independent Medical Profession; and I should strongly urge you to enrol yourselves as members.

With the usual vote of thanks, the function terminated with a lusty three cheers to H. H. the Maharaja of Mysore.

Vizag Medical College Day Celebration

The Vizagapatam Medical College Day was celebrated on the 27th February afternoon. The function was largely attended. While the guests were at tea, they were entertained by some of the medical students in fancy dress.

The gathering then assembled in a public meeting in the spacious hall of the New Medical College Buildings,

with Dr. Sir S. Radhakrishnan in the chair. The meeting commenced with the unveiling of the portrait of Rao Bahadur Dr. P. Krishnaswami, a Professor of the College. In unveiling the portrait, Sir Radhakrishnan said there could be no greater proof of his popularity than that the protrait had been subscribed for entirely by both the staff and students of the college.

PRESENTATION OF MEDALS

Captain J. A. W. Ebden, Principal of the College, then requested Sir S. Radhakrishnan to present medals to the candidates that had qualified themselves to receive them.

The anatomy medal founded in memory of Lt.-Col. F. J. Anderson, the first Principal of the College, was won by Mr. V. Sitarama Rao. The pathology medal founded in the name of Lady Goschen by Srimathi P. Annapurnamma of Vizianagaram was secured by Mr. K. Jagannatha Rao. "Dr. A. Lakshmipathi Medal" for pharmacology was awarded to Dr. N. T. S. Yazulu, a graduate of the college for his thesis on "Alpinia Galanga" in Telugu called "Dumpa Rashtram".

Mr. G. Narasimham a fourth year student was awarded a prize in appreciation of his acting in "Madhu Seva" enacted on the College Day last year. Sir S. Radhakrishnan presented the several prizes to the winners.

ANNUAL REPORT

The Secretary of the Vizagapatam Medical College Students' Association then presented his report for 1931-1932.

The report referred to the interest evinced by the Association in sports and athletics and the radio club it was running and mentioned a catalogue of "grievances", among which were the want of a good sports ground, lack of adequate number of holidays, insufficient attention to the medical needs of the students in the King George Hospital, and the absence of M.D. and M. S. Degrees and B.Sc. course in physiology for which there were excellent opportunities in the Vizagapatam Medical College. The report urged the authorities of the Andhra University to take steps to have its M. B. degree recognised by the General Medical Council of Great Britain and the Indian Medical Council now being organised.

On the subject of retrenchment, the report said: "We are fully aware of the fact that this is neither the place nor the occasion, nor are we the people to discuss this thorny question. We only represent the view-point of the students who are already much upset and alarmed by the daily changes in the personnel by the abolition of many teaching appointments both in the college and hospital, substitution of part-time lecturers for full-time specialists, amalgamation of two or three appointments and duties involving serious interference with efficient discharge of their work and the general atmosphere of uncertainty and gloom that have enveloped this institution during last one year. We appeal to the public, to the members of the legislature and the university authorities to consider the situation and do all in their power to ensure that students do not get the idea that there is no use of studying in this college."

TOAST TO THE UNIVERSITY

Rao Saheb Dr. T. S. Tirumurti then proposed the toast to the university. In doing so, he said the students had already catalogued a number of grievances and he would not add to the list. He hoped that the Andhra University, with Sir Radhakrishnan at the head, would see that this college, the only professional college attached to it,

would be preserved intact. Proceeding, he observed that it had been said that the institution spent a great deal more per head then even Madras. Whether there were 10 or 50 students, the same laboratories, apparatuses, etc., would be required. Personally he thought it wrong to base measures of retrenchment on the basis of calculating the amount spent per head. An important question the Andhra University should ask itself was whether the institution really served any need. It had been said that very few Andhra students came to this college in the early days. It was true then. Students sought admission from all over South India, even from Malabar and Travancore. As a member of the Selection Board, he had been closely watching the progress of admissions into that college. At present there was absolutely no place for non-Andhras in this college as so many Andhras sought admission. That being so, they could not say that this college did not serve an important need in the Andhra area. It was true there had been a greater amount of struggle for existence among medical men, but there was increasing scope for them to go out into the country and to serve its needs in villages. It was, therefore, essential that the Andhra University should maintain this institution and make it a university college.

Continuing, he said the students had also complained about conjoint examinations and that too twice a year. They were required to go to Madras, and the difficulties were many. He felt that it was in the best interests of the students themselves that this plan was first thought out, but the time had come for re-opening the question and it was to be hoped that the university authorities would take the steps best suited to the student's needs.

VICE-CHANCELLOR'S REPLY

In responding to the toast, Sir S. Radhakrishnan, Vice-Chancellor of the Andhra University, said that he had listened to the grievances mentioned by the students especially in connection with the unusual number of transfers in the Medical College, with great concern. A college which was established to cater to the needs of the Andhra districts which contributed considerably to the revenues of the province was undoubtedly an obligation of the Government and deserved to be maintained as such, not merely at its present level of efficiency but at an enhanced level. The institution was a source of legitimate pride to the Andhra University and he hoped that the legislature would see that efficiency was not impaired. If any retrenchment was to be effected in the future it was to be ardently hoped that nothing of the kind would be done in the department of social service and public health. Even if circumstances beyond their control necessitated the re opening of the question of the abolition of this college as a measure of retrenchment the Andhra University would not then be found wanting in courage and in its duty, but would certainly see that nothing serious happened.

Continuing, Sir Radhakrishnan said that medical graduates should not complain of unemployment. They might not all be able to obtain good Government jobs, but just under their very noses lay immense opportunities for services. It had been said that every man was either a fool or a physician at 40. But in India every man at 20 and every woman at 15 were physicians. There was any amount of illness and they could not afford to be treated by quacks any more. Scientific training was required for the treatment of disease. The work that faced their medical men in this country was colossal. If only their medical men were imbued with a high motive of public service they could not complain of lack of work in this great country where so much

remained to be done. No country in the world was really free from religious superstition and they must see that religion was not made detrimental to human happiness. It was the duty of medical men to see to it that public opinion was educated in this direction.

Referring to Dr. Tirumurti's suggestion that the Andhra University should open courses for M.D., etc., and run its own examinations the Vice-Chancellor said that all these things should not be postponed for one day longer than was absolutely necessary.

TOAST TO THE COLLEGE.

Dr. Kanakaraju, an old boy of the college proposed the toast to the college in a humorous speech in which he traced the development of the college.

Captain Ebden, the principal, in responding to the toast, said that it had been his lot to wander round the world for 18 years. He had already travelled a great deal over the length and breadth of Africa, in the Far East, Siam, Malaya and Northern India. He knew every hospital in London and a great many hospitals in the provinces and on the continent and was also acquainted with the medical schools attached to them and he assured the gathering that the Vizagapatam Medical College was in his opinion second to none as regards equipment. He said this after much deliberation as he had opportunities which other people have possibly not had. He discovered that enormous strides had been made in this institution during the past few years and it had now become a first class institution. Captain Ebden declared that more than 80 per cent of the work had been done by his predecessor Col. Anderson and it was a very easy matter to merely carry on the work, every bit of which was so very carefully organised by Col. Anderson. The first thing that struck him on arriving in Vizagapatam was the lack of a proper sports ground and he had already addressed another letter to Government on this subject. He was anxious that the Medical College should produce good sportsmen of international fame in rugby, soccer, boxing, etc.

Regarding their desire to have M. D. and M. S. courses, he believed that the students seemed to be flying high. He thought the time for considering a higher degree would come when things were more settled and retrenchment was over. At the moment, the very existence of the college was threatened. The proper aim of this college should not be to produce super-brilliant men, as the super-brilliant could properly well look after themselves. "You are going to work all over the country. We want to raise the standard of medical education in India. We want to turn men out of this institution who are not afraid of hard work. We do not want the terribly intellectual people, but we do want the terribly practical ones. We want men who will not lose opportunities of service when they arise. In this part of the world there is much to be done in the matter of social service, and if this institution can produce men who can thus serve the country, its existence will be more than justified.

The Principal then read a letter which was received from Lt.-Col. Anderson wishing the function every success and regretfully announcing his resignation of the Presidentship of the College Students' Association.

The function terminated after a variety entertainment by the students of the college.

Royapuram Medical Union.

Dr. Muthu, addressing the members of Royapuram Medical Union on the 30th of January, emphasised the tremendous importance of medical men learning how to diagnose pulmonary tuberculosis in its very early stage and said that consumption took a very heavy toll in this country. A million people died every year from this dreadful disease. If the sanatorium treatment in India had not bad a fair trial, it was because the vitality of the patients was very low, and more because the majority of the patients entering the sanatorium were more or less in an advanced condition. By not finding out the disease in an early curable stage the medical profession was incurring a heavy responsibility. To wait for definite symptoms, such as X-Ray findings, tubercle bacilli in the sputum, moist rales, was to wait too late for effective treatment. Tuberculosis takes many years to develop, and nature gave plenty of warning if medical men had eyes to observe and ears to detect the various shades of sounds in the lungs. How much misery, suffering, pain, and not to say financial loss, could be saved if patients had enough vitality and came for early treatment. If advanced cases yielded scarcely 8 per cent of cures, the treatment of early cases brought nearly 80 per cent of arrest of the disease. Therefore one sure way of saving precious lives and reducing mortality of tuberculosis was to diagnose and treat early cases of the disease.

(By Courtesy of the Hindu.)

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The Medical Treatment of Gastric and Duodenal Ulcers.*

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Some time ago, when I happened to mention about a medical treatment for ulcers of the stomach and duodenum to a friend of mine, he at once cut me short saying that there was no such thing as medical treatment for these conditions. It is a very common and fortunately an incorrect opinion amongst doctors that the only reasonable treatment for these ulcers is the surgical one Medical treatment can be applied to more than 80 per cent of cases of gastric ulcers with good results and if such good results have not been available hitherto, the fault could only be ascribed to the slip shod and half-hearted methods of treatment usually employed. Even then, if we compare the results of such average medical treatment with the results of average surgical treatment (leaving out of consideration the results of surgeons like Lord Moynihan and the Mayos), we find, that other things being equal, average surgical treatment is in addition followed by an immediate mortality varying from 10 per cent to 20 per cent and a high incidence of complications such as jejunal ulcer, intractable vomiting and persistent indigestion of various types.

One of the arguments raised against the medical treatment that the ulcer never completely heals under it, is not well founded. Clinical and Radio-

*Read before the South Indian Medical Union.

logical evidences have shown that the ulcers completely heal and sometimes even if they have burrowed into the liver spancreas. Moreover after gastro, jejunostomy even large indurated ulcers have been observed to heal which could only be ascribed to rest and reduction of acidity both results of a kind which ideal medical treatment should be able to provide.

Another argument for surgical treatment has been the fear of the ulcer becoming malignant. About 5 per cent of all chronic gastric ulcers become malignant. If routine gastrectomy is to be performed on this basis it must have an operative mortality less than 5 per cent; unfortunately the death rate is three times that number due to the operation itself. Even if gastrectomy were performed, 4 per cent of the cases get cancer later, a much higher number than the percentage of cancers occurring in the scars of healed gastric ulcers after gastro jejunostomies (2·2 per cent).

A final argument, which especially over here is given out more often than is just, is the economical one. But it has been found that the average period of invalidity for people after surgery was 5 months compared to only 4½ months in the medically treated cases. 10 per cent of the former group died with none of the latter as a result of the treatment, Recurrences were no less with the surgical treatment.

As such, medical treatment can be employed with assured success in all cases of peptic ulcers with the following exceptions:

(1) Ulcers of doubtful malignancy (gastric ulcers only).

(2) Ulcers refusing to heal even after 8 weeks of medical treatment.

(3) Recurrence of ulcers.

(4) Hour glass contraction (stomach only).

(5) Pyloric or duodenal obstruction.

(6) Perforation.

(7) Rare cases of haemorrhage refusing to yield to medical treatment.

Medical treatment can be described under the following headings, *viz.*:

(1) Prophylaxis.

(2) Treatment.

(3) Prevention of recurrences.

(4) Medical treatment of complication.

Prophylaxis has been ably summarized by Bastedo who has stated that a peptic ulcer will not develop in any individual who takes pains to secure a sufficient number of hours of sleep, to take plenty of time for his meals, to avoid indigestible food, to avoid the immoderate use of tobacco and to make sure that he is not harbouring any foci of infection.

Prophylaxis is helpful in the prevention of ulcers in the other members of the family of a gastric ulcer patient, who generally show predisposing symptoms. In people with appendicular and other dyspepsias who are likely victims of peptic ulcers these prophylactic measures will help to prevent the ulcers forming.

Treatment.—Three factors are to be taken into consideration in the causation of an ulcer. The infective factor, the acid factor and the accessory factor.

The infective factor is one which has been very much neglected and has thus been the cause of failures in medical treatment and of recurrences in surgical treatment. It is essential to eradicate as completely as possible all foci of infection before commencing treatment.

Teeth are to be kept clean. The brush should be used in a sweeping manner from the gums towards the teeth on the outer surfaces of the teeth. In mild cases of spongy gums, Tr. Iodine and Tr. Aconite or Tr.

Iodine and Glycerine could be touched daily along the margins of gums with good results. Pyorrhoea Alveolaris should be thoroughly attended to by the dental surgeon. All dead teeth and teeth showing signs of apical infection should be removed.

Chronic infection of the tonsils, chronic nasal and nasopharyngeal catarrh, infection of the nasal sinuses should be whenever possible treated radically combined with the use of autogenous vaccines when necessary. The appendix should be removed in chronic appendicitis. The appropriate medical and surgical treatment should be done in chronic cholecystitis. The prostate should not be forgotten as one of the foci of infection and should be thoroughly examined.

The acid factor is to be treated by diet and drugs as will be described later.

Considering the a ccessory factors tobacco is an important one especially in the pathogenesis of duodenal ulcers. It should be prohi- bited in all cases. Coffee and alcohol are to be avoided.

Fatigue, another accessory factor, should be avoided by keeping the patient in bed. Exercise causes increased acidity of blood and tissues and this interferes with healing (according to Balint). Patients should therefore be kept at rest. It is claimed that complete rest for a sufficiently long time is by itself sufficient to cure any ulcer. Mental rest is not of great importance.

Diet.—The main point to be observed in prescribing a diet is that it should produce as little secretion as possible or must combine with the acid making it inocuous; it should not be irritating and finally it should be sufficiently adequate and palatable. Milk combines all these qualities and as such forms the basis in the diet of ulcer patients. Milk neutralizes an equal volume of gastric juice and so if 1,500 c. c. of milk (*i.e.* 2½ pints) could be given daily so as to coincide with the varying rates of secretion of acid, milk itself could be sufficient to keep the gastric juice neutral (1,500 c. c. is the total amount of gastric juice secreted on an average in a day). In order to make the treatment less monotonous a variety of non-irritating foodstuffs such as sago, barley, arrowroot and oatmeal conjees or mashed potatoes could be given between the milk feeds. Fruit juice could be added to some of the feeds.

Olive oil is prescribed in ulcer cases with the idea of inihibiting and diminishing the ordinary gastric secretions, secretions being reduced to half by the action of olive oil. It also increases the influx of bile which helps in reducing the quantity of acid in the stomach. In addition, olive oil is a food of very high nutritive value each ½ oz. yielding 144 colories. Half to one ounce of the oil before 3 or 4 of the feeds is usually prescribed. Pure cow's ghee in small doses of one to two drms, repeated five to six times daily, as recommended by some Ayurvedic physicians, could be used instead of olive oil with good results. Cow's ghee is more palatable to the Indian taste and is easily obtained. Almond oil is another substitute.

Drugs.—Drugs might be dispensed with in many cases; milk given every hour or every two hours in small doses such as 5 oz. keeps up a neutral reaction in the stomach for a considerable part of the day. Drugs used judiciously hasten recovery.

The alkalies which can be used are:

(1) Sodi. bicab, Mag. carb. Calcium carbonate and Bismuth oxy. carb.

(2) Sodium citrate, Pot. citrate, Mag. phosphate, calcium phosphate, Magnesium oxide, and

(3) Alocol and Neutralors.

The neutralizing power of these above mentioned drugs has been tested by adding excess of these drugs to an equal amount of HCl. (say 5 c. c. of 3% HCl). It has been found that Bismuth oxy. carb, neutralor and alocol never make the solution neutral and in the case of the two patents the resulting acidity is much higher than with Bismuth oxy. carb sodium and potassium citrates. Calcium carbonate, magnesium and calcium phosphates produce a neutral solution while sodium and magnesium carbonates produce an alkaline solution at once the alkalinity being greater in the case of the magnesium salt. These two salts by their producing an alkaline reaction in the stomach when given in excess produce a hypersecretion of the acid juice; given in just sufficiently small doses so that no excess is possible no hypersecretion will occur.

Sodi. bicarb, a favourite drug with the older physicians in the treatment of gastric ulcers is an undesirable alkali because of its secondary hypersecretion, the evolution of gas and the consequent distension of the stomach with the danger of perforation of the ulcer, and its stimulating action on peristalsis.

Magnesium oxide has four times the neutralising power of sodi. bicarb. It does not Evolve carbon dioxide in the stomach. It has a mild aperient action and although its use is followed by a secondary hypersecretion, given in sufficiently small doses, this could be greatly diminished.

Sodium citrate, although not commonly thought of as an alkali, has got a little more than half the neutralizing power of sodi. bicarb, without the latters disadvantage of causing secondary hypersecretion. Added in 2 gr. doses to each ounce of milk it prevents curdling, it helps easy digestion and increases the neutralising power of milk.

The above mentioned three salts together with calcium corbonate (the latter only to a very slight extent) have the power of alkalinizing the blood and when they are used in large doses (as in the Sippy treatment) symptoms of alkalosis, *viz.*, headache, distaste for milk, dizziness, aching in muscles and joints occasionally appear. In such conditions these alkalies are discontinued and alkalis such as magnesium and calcium phosphates which are excreted through the bowels are used. Magnesium and calcium phosphates, only recently found to have neutralising properties have about half as much neutralising power as sodi. bicarb. Calcium carbonate although alkalinizing the blood, does it to a very slight extent only, and has one-fifth the neutsalising power of sodi. bicarb.

Bismuth oxy. carb does not have any neutralising property at all, as we have shown above, when added to the acid; and in the small doses usually employed in ulcer cases it has no soothing properties; as for adhering to the surface of the ulcer and protecting it from the action of the acid, X-ray radiographs have shown that Bismuth given even in large doses does not stick to the surface of the ulcer. Bismuth salts could easily be dispensed with in the treatment of ulcers.

Atropine or Tr. Belladonna preferably the former because it can be given in sufficient doses to inhibit secretion, without producing unpleasant symptoms, is given in doses of 1/200 gr. 4 times a day and a double dose is given at night. Tr. Belladonna could be given in doses of 10 minims T. D. S.

The routine treatment of peptic ulcers will be as follows (Modfied Hurst's regime).

(1) Every alternate hour from 6 a. m. to 8 p. m. 5 oz. of milk with 15 gr. of sodi. citrate and 5 gr. of magnesium oxide (*i.e.* 8 times in a day).

(2) Every other hour from 7 a. m. up to 7 p.m. a 5 oz. feed of arrow root, barley, wheat flour or outmeal conjee to which sugar could be added or mashed potatoes with a little salt.

(3) Half an ounce of olive oil before three of the feeds 7 a.m., 2 p.m. and 7 p.m. feeds.

(4) Atropine sulphate 1/200 gr. in a dram. of water to be used before the 6 a.m., 3 p.m. and 8 p.m. feeds. Double dose if necessary before the 8 p.m. feed.

(5) 1 drachm of calcium or magnesium phosphate or of creta preparata with a little water after three feeds in the morning, noon and evening. An extra powder to be taken whenever heart burn occurs.

(6) Liqd. paraffin if magnesium oxide is not sufficient to keep the bowels moving. Between the ulcer stage and the completely healed stage there is no necessity to change the diet. Still in some cases about the end of four or five weeks before the patient goes on to his normal diet he could at first have in addition eggs, thin bread and butter, fish or chicken to prepare him for his full diet.

This treatment takes about a month to cure an ordinary sized ulcer and about eight weeks when the ulcer is large. Pain in the epigastric region, rigidity and tenderness all disappear very early in the course of the treatment and so are of no help in deciding the healing of the ulcer. The best evidences of healing are the examination for occult blood and X-rays. Occult blood is present in more than 80 per cent of all cases of peptic ulcers, so that we can test whether an ulcer has healed or not by testing for occult blood in the foeces. The absence of occult blood in the foeces gives us a strong evdience of the cure of the ulcer.

Examination by X-rays using modern methods will give direct evidence of the ulcer in every case of gastric or duodenal ulcer and when healing has occured the niche formerly present will be found to have disappeared. The test meal also offers an evidence of healing as after healing the resting juice is reduced in amount and in cases where stasis has been present, the stasis is found to be diminished.

Prevention of Recurrence.—After the healing of the ulcer, the patient must be made to understand that he still has the ulcer diathesis and there is still a danger of recurrence if he returns to his old habits. Coffee and alcohol are to be avoided. Pips and skins of fruits, nuts and all unripe fruit are to be avoided. Vinegar, lime juice, pepper, mustard and curry, excess of salt (as salt has been found to increase gastric secretion) as in salted meat and fish, rough meat and soups of all kinds are to be forbidden. Olive oil should be used as before. Milk preferably with sodium citrate should form the main item in the dietary of the individual.

Adequate rest before and after meals is to be enjoined. Teeth should be attended to constantly. Excessive smoking is to be prohibited and whenever there is the slightest return of symptoms, the patient must go back to a strict diet and stick to bed.

Medical Treatment of Complications.—The complications which could be treated medically are:

(1) Hæmorrhage

(2) Pyloric or duodenal obstruction

(3) Hour glass contraction of the stomach.

In Hæmorrhage the patient should be kept absolutely immobile in bed.

Morphine $\frac{1}{6}$ gr. with 1/100 atropine is to be given repeatedly to keep him drowsy and prevent restlessness. The patient is to be completely starved for at least 48 hours after the last bleeding. 15 oz. of 4 per cent dextrose by rectum alternately with 15 oz. normal saline solution is given by Murphy's drop method every six hours. When there is lot of blood in the stomach, a stomach tube connected with a Senoran's evacuator could be used to empty the stomach and then styptics could be introduced (such as adrenalin about 31) to stop further bleeding Creta preparata, or magnesium or calclum phosphate should be given in drachm doses every 2 hours to neutralise gastric juice, then preventing digestion of blood which has clotted in the mouths of the vessels, stopping further bleeding. Hæmostatic serums and calcium chloride are of doubtful utility. Transfusion of blood might be found useful in serious cases. A very common complication in cases of gastric hæmorrhage, *viz.*, parotitis should be prevented by keeping the mouth scrupulously clean.

Pyloric or duodenal obstruction might be partly due to spasm and functional, partly to inflammatory swelling and œdema round the ulcer, or might be due to cicatricial contraction. Only the last condition is permanent. The other two are amenable to medical treatment and very often obstructions even severe in nature have yielded under it. In pyloric obstruction owing to stasis in the stomach and consequent fermentation, formation of toxins in the stomach takes place. These toxins are said to combine with the chlorides and this removal of the chlorides causes a relative increase of bicarbonate element in the blood, *i.e.*, causes alkalosis. This condition of alkalosis occurs earlier when the sippy method of treatment is used in cases of pyloric obstruction due to the large amounts of soluble alkalies given to the patient.

In such cases complete evacuation of the stomach is practised B.D., all soluble alkalis are discontinued, and where necessary glucose and saline are given by rectum. Am. chloride because of its action in causing acidosis is used in corelating alkalosis (10 oz. of 2% am. chloride solu. being given by rectum.)

Hour glass contraction of the stomach.—Hour glass contraction of the stomach might be associated with (1) an active ulcer or with (2) a chronic ulcer.

In the first variety medical treatment might by reducing the œdema and the spasm, relieve the condition. Even in a chronic ulcer case if sufficient deitetic precautions are taken the patient might be relieved.

Both in pyloric obstruction and in hour glass contraction, the medical measures advised, ameliorate the condition to such an extent, that although they may not be by themselves sufficient to cure the patient, far better results are obtained when finally operations are performed.

The routine medical treatment of gastric and duodenal ulcers although it appears a bit bothersome is really worth while. Even if surgery is found to be necessary later, the patient is in a much better condition to undergo the operation, whereas for the patient who has undergone an operation in the first instance, recurrence of the ulcer offers little chances of recovery both from the medical and the surgical points of view. The last ten years or so have been the monopoly of the surgeons with regard to the treatment of gastric and duodenal ulcers, and the surgeons have now began to feel that surgery is not the last word they thought it would be, and have come to realise that physicians, who have hitherto been trying to avoid their responsibilities, ought to take the leading role in the treatment of gastric and duodenal ulcers.