

of treatment is repeated if necessary in from two to four weeks. No trouble has been experienced and emetine resisting amoebæ are no longer encountered. Great stress is laid on the necessity for giving full doses for a short period. The importance of healthy carriers is emphasised. Fifteen to twenty per cent. of the coolies are shown to carry cysts and "minuta" forms. These carriers are not only a source of infection but are themselves liable to serious attacks of dysentery when their vitality is lowered by some illness like pneumonia or bacillary dysentery. Great stress is laid on the necessity for early treatment of such cases. It is pointed out that when the stool is thin, foul smelling and greenish black, emetine should be given at once even in the absence of amoebæ. It is not uncommon for amoebæ to be absent, as they die in the watery putrid stool before they pass out of the bowels. Fifty-eight to seventy-five per cent. of the cases are regarded as relapses.

THE TEACHING OF MIDWIFERY IN INDIAN MEDICAL COLLEGES.

A VALUABLE note on the teaching of midwifery in Indian universities by Dr. Kedarnath Das, C.I.E., of the Carmichael Medical College, Calcutta, has just come to hand.

In it is summarized the whole history of the action taken by the General Medical Council.

In 1896 the standard required by the Council was raised, but it is said that no notification to this effect was received by the Calcutta University.

In 1907 a further tightening of the standard was made by a resolution of the Council which was carried by 16 votes to 11. This requires a certificate that the student has conducted twenty cases of labour under official medical supervision.

There was a strong feeling at the time that the conditions laid down could not be fulfilled, and it is believed that in many cases they have not actually been complied with even by the English and Scotch universities.

It appears that the first communication from the Medical Council on this subject to the Indian universities was a letter, dated 8th June, 1920, in which enquiries were made as to the facilities that existed in each university for complying with the requirements of the Council as laid down in the resolution of 1907.

Evidently the replies that were received did not satisfy the Council, for the resolution of the Executive Committee referred to in the October

number of the Gazette was forwarded to the Indian universities on the 9th March, 1921.

It is to be noted that recognition of the degrees of the Allahabad University was granted by the General Medical Council in 1914, although there never was any suggestion that the King George's Hospital could provide clinical material on the scale required by the Council in its resolution of 1907.

There is some reason for regarding the action of the Council as being somewhat peremptory if on short notice it withdraws a boon that was granted under conditions which were substantially the same as they are now.

It is asserted that many of the universities of the United Kingdom have not attempted to satisfy the conditions of the Council and the opinions of some of the London teachers as expressed at a meeting of the Royal Society of Medicine in February, 1919, may be noted.

W. S. A. Griffith said: "I am not of the opinion that the value of a hospital for teaching purposes is necessarily improved in proportion to the large number of its beds; this depends on the number being adequate and on the ability of those in charge of it to make the best use of them."

G. F. Blacker said that the standard of teaching midwifery was lower than that of medicine and surgery because most of the practical teaching is done by junior registrars and house surgeons who have recently become qualified. A student may pass through his whole course and never see one of the senior staff conducting an ordinary confinement.

R. W. Johnstone (Edinburgh) considered that one or two cases adequately taught and demonstrated may be of more value, even if they be normal cases, than less adequate teaching on a large variety of pathological cases.

Nobody denies the necessity for teaching the student responsibility and self-reliance; this can only be done by giving him sole charge of cases, but an even greater essential is to drill him first of all in the routine method of conducting normal and abnormal cases. This training can only be obtained in a properly staffed hospital such as is to be found in the large centres in India.

The personal conduct of cases by the student is a real stumbling block in some of the universities, but against this it is argued that the system of training in some of the London hospitals is even more defective as the students have little training before being sent out to conduct cases in the district on their own account.

So great an authority as Dr. Tweedy of Dublin advocates the abolition of the compulsory conduct of a specified number of confinements.

Dr. Das claims that the teaching of midwifery in the Calcutta medical colleges is superior to that in the British medical schools in regard to:

- (1) Hospital accommodation;
- (2) Period of clinical training;
- (3) Facilities for clinical work; and
- (4) Clinical demonstrations.

He also points out that the General Medical Council has shown a constructive and sympathetic attitude to the medical schools of the United Kingdom while it has been destructive and unsympathetic towards the Indian schools.

He suggests that the attitude of the Council towards the Indian schools is one of suspicion, and he adds that "a suspicion has been engendered in the minds of at least some of the members of the General Medical Council by wrong information supplied to them privately to make out a case that things are not as they should be in Indian medical schools."

It is perhaps a pity that Dr. Das should have introduced this suggestion to his otherwise very telling advocacy of the cause of the Indian colleges. However firmly he may believe in his inference as to the cause of the "suspicion," he brings forward no evidence to support it, and as the Medical Council is in the position of both judge and jury, it is hardly tactful to suggest that they have so little sense of their responsibility as to decide the case on hearsay evidence.

When Dr. Das comes to practical proposals for dealing with the critical situation that has arisen, he advocates the appointment of a committee by the Government of India, consisting of two obstetricians of repute from the United Kingdom and two professors from the Indian medical colleges—one official and one non-official—to enquire into the teaching of midwifery and obstetrics in India and to suggest remedies for such deficiencies as may be noticed.

It is likely that the General Medical Council would insist on sending its own nominees to enquire into the teaching of midwifery in India, but there can be no serious objection to this.

Meantime, the first thing to be done is to induce the General Medical Council to stay its hand and to arrange for a conference between the teachers of midwifery in India and the representatives of the Medical Council so as to arrive at a common ground for negotiation.

The sending of notes and ultimatums is not conducive to a satisfactory arrangement, and we on our side should employ dignified and outspoken advocacy of our cause rather than the threats and insinuations that have been so much in evidence of late.

Current Topics.

Tuberculosis in Primitive Tribes and its Bearing on the Tuberculosis of Civilized Communities.

Internat. Jl. Public Health. 1920. Sept. Vol. 1. No. 2. pp. 137—171. With 6 charts.—CUMMINGS (S. LYLE).

The first part of this extremely interesting paper is occupied with some quotations and illustrations of the familiar facts that among communities shut off from all intercourse with the great world tuberculosis is nonexistent or rare, but that when members of such communities come in touch with civilization they then exhibit an extreme susceptibility to tuberculosis of a particularly acute kind.

This susceptibility of "virgin soil," together with the low percentage of tuberculin reactions observed among certain primitive tribes who have been submitted to von Pirquet's test, is inferred to be a proof of the absence or rarity of the tubercle bacillus, and also—which is not so obvious from the nature of the evidence offered—of the non-existence of any degrees of inherent individual susceptibility, in the circumstances of isolation.

Contrasted with this flaring tuberculosis of virgin soil, which is assumed to be wholly due to lack of antigenetic resistance, is the more smouldering tuberculosis of a civilized society so often breaking out in individuals supposed to be marked down by some inherent predisposition to infection. The author examines this question of inherent vulnerability or hereditary predisposition, and suggests that this hypothetical heritage is better explained as individual "absence of acquired resistance."

This suggestion is developed as a "theory of infection and resistance" which assumes that the infant generations of ordinary tubercularized (or civilized) communities are, like the members of isolated primitive communities highly susceptible to tuberculosis, and that sooner or later they are exposed to the communal infection; if, as in an infected home, the young child becomes dangerously infected at the outset, being "virgin soil" it has no opportunity of acquiring resistance; but in ordinary circumstances, where contact with infection is delayed and minimized or limited, some resistance is gradually acquired, and with advancing age ultimately becomes sufficiently protective to modify the pathological effects of a dangerous infection.

How the individuals of a tubercularized community acquire this partial and precarious immunity is suggested rather than declared; it might begin with ingestion of bovine bacilli in milk, and might be augmented by contact with small casual doses of human bacilli in schools, play-rooms, etc. This would carry a majority of the population safely over the "young adult" period of acute tuberculosis. But as the young adults go out into the world, and come more and more exposed to human infection, the balance between infection and resistance may become upset, and the chronic tuberculosis of "middle age" may be the result. The "old age type" of tuberculosis appears to be associated with some particular occupation and tends then to occur in places where the "young adult type" is met with.

The observations of Rouvier lead him to lay great stress on the *insidious* character of tuberculosis in these Colonial patients. While asserting once more the