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### REFLECTIONS ON THE CHALLENGE TO THE MEDICAL PROFESSION IN INDIA\*

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NEW India refers to an independent and ten-year-old republic comprising some 400,000,000 people (380,000,000 in the 1951 census) governed as a parliamentary democracy. The Constitution of India begins with the phrase, "We the People," and guarantees freedom of speech, freedom of assembly, acquisition and disposal of property, religious freedom and the practice of any profession or the carrying on of any occupation, trade or business. Nothing proclaimed in the Indian Constitution remotely resembles the Soviet system or totalitarianism. It is democratic in spirit and form, and similar to the constitutions of the other nations that form the British Commonwealth of Nations. Because of the pronounced allergy to the word "socialism" in the United States and because India avowedly adheres to "a socialistic pattern," it may be pointed out that in Indian usage socialism is synonymous with *social justice* and indicates a growing equality of opportunity, social and human development of all groups, and an over-all economic progress that will establish an adequate living standard. The socialistic pattern now already accepted in the United States would be a desired yet at the present time visionary goal for India's millions.

The hundred and fifty years of British rule left many legacies for the new India. One legacy is a trust shared with this country—the English language. The very fact that in this century the two largest democracies of the world can express their hopes, goals and ideologies in a common language is a fortunate accident of history. In the absence of a language barrier to communication only a heedless preoccupation with our own affairs can stand in the way of the development of an understanding between our peoples.

Fluency in the English language is a universal possession of the educated classes in India. Medical instruction is conducted in English. However, India

is multilingual, and the language question is charged with emotionalism in the young Republic. The 1951 census recorded 845 languages and dialects, but at least nine tenths of the population use one or another of 15 main languages in their daily affairs.

The extent of illiteracy is overwhelming. The 1951 census recorded 82.1 per cent of the people aged ten or more years as illiterate. This creates a formidable barrier to reaching the simple folk with health education. Illiteracy perpetuates superstition and the negativism of ignorance, which block a constructive relation between patient and physician even if medical care is made available. In contrast to the prevailing illiteracy of the lower economic classes, city dwellers and villagers alike, the famous universities of India have developed, over centuries, brilliant, sophisticated scholars in both Eastern and Western learning.

It is worth while to remind ourselves at this point that literacy cannot be equated with education, nor does the combination of literacy and education imply intelligence. Mahatma Gandhi was not referring to literacy or education when he said, "If the village perishes India will perish too. India will be no more India. Her own mission in the world will get lost." Gandhi was referring to the innate intelligence or common sense of simple folk the world over. Although often untamed emotionally, they form a reservoir or depository of intelligence in the literal sense, measured by their ability to distinguish between moral, political and religious values. The rural village is symbolic of productive work, of patience in the face of adversity, of family loyalties and filial piety, and of traditions and religions that have taken deep root because they are adapted to the needs of a particular folk. The village is a social unit in which people come together in communal living. To borrow a word from physiology, the rural village can be interpreted as an homeostatic organ of the culture as a whole. The resistance of the peasantry to change counterbalances the quick and erratic pursuit of novelty characteristic of the city dweller, and interaction of rural and urban components shapes the expression of the culture and,

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in Gandhi's phrase, the mission of the society in the world. As the Indians interpret the challenge facing the new India, it is to receive and accept the material benefits of Western technology without "being no more India."

Of the 400,000,000 people, approximately 85 per cent live on the land in villages of classic Asian type. The village has no counterpart in the United States, and to understand it one has to see it through the eyes of the social scientists who have made peasant villages in all parts of the world objects of intensive study. Suffice it to say that although the United States over decades has received agricultural peasants from all over the world, our free and compulsory educational system has brought the assimilation of them and their children on the basis of the equality expressed in our Constitution. Universal education is the basis of freedom of opportunity in our open fluid society. A peasant class of tillers of the soil, hewers of wood and drawers of water is unknown in our nation. Considering Macaulay's famous prediction that the United States would collapse through its inability to "restrain a distressed and discontented majority," Garfield answered in 1873 that this statement failed to consider "the great counterbalancing force of universal education." Our sputnik-triggered anxiety to turn out more and more technical experts can well be tempered by the knowledge that education, particularly education in technology, cannot be equated with education in the universals — with intelligence.

From a political aspect the sudden extension of adult suffrage to this vast mass of illiterate humanity constitutes a bold experiment in democracy that introduces time as a determinant in the future course of India. The factor time appears in the rate at which basic education and an elevation of the standards of living can be introduced. This rate, so far as the preservation of democracy is concerned, must be balanced against the self-restraint of millions who now barely exist in the marginal zone of starvation.

The smallness of individual land holdings in itself perpetuates poverty. More than half of these are of less than 2.5 acres. The villager uses few manufactured goods, lives in a hovel without light and ekes out a meager existence for himself and his family on the products of his labor. All but the eldest son must leave the land because it can no longer be subdivided. Those who must depart the land crowd toward the cities seeking work and sleep in the streets or squat in improvised shelters around the outskirts forming a fringe of human poverty and misery.

The poverty in the rural areas of India is not solely a product of the small land holdings but also finds origin in the low yield per acre for the crops that are raised. This is in part attributable to poor seed and exhausted land tilled with primitive methods, and in part to the undernourishment of the workers.

It has been the experience of American employers in countries where laborers suffer from chronic malnutrition that the output of work may double after the first payday when the man has been able to buy food. In India a woman who is earning wages offers a minimal risk in childbirth, in contrast with the housewife or the unemployed woman, who faces childbirth depleted by malnutrition and anemia. A hemoglobin level on admission of 10 to 20 per cent from iron-deficiency anemia is a common finding in patients in Queen Mary's Hospital in Lucknow. Childbirth, like labor of any sort, should be a normal physiologic event. In India both are faced under abnormal or pathologic conditions. Malnutrition in patients handicaps all undertakings in curative medicine and surgery. In the peasant, malnutrition is an important determinant in the low yield in crops.

### POPULATION

Widespread malnutrition points up the conventional Malthusian doctrine that poverty can be remedied only by control of the growth of the population. Some politicians, and a few doctors as well, privately express the belief that medical and health measures should be slowed down until the food supply is increased. Put crudely this is to say, "Let the villager continue to drop his plow to have his chill because it would be fortunate if his too many children died of black-water fever." Judged by humanitarian ethics, such a proposition is intolerable; is it tenable from a cold scientific basis?

Population is indeed an outstanding disease of India, but it does not follow that growth and density of population are responsible for the disease of poverty. Measures to reduce the birth rate have been instituted, and there are neither religious nor cultural reasons that prohibit technically guided family planning. There are, of course, the hurdles of illiteracy, ignorance and expense and perhaps as significant, the lack of an effective and acceptable method. Actually, the rate of population growth in India is not unusual considering what is going on elsewhere in the world. In 1951-55 the Indian surplus of births over deaths averaged 13.2 per 1000, as compared with 15.1 per 1000 in the United States. For India this rate means an increase of 5,000,000 a year. If births and deaths remain at the current level, chartists indicate a population of about 682,000,000 in India by 1981. With a reduction of 50 per cent in both these rates the population might reach only 562,000,000 in 1981.

What is called the population problem has customarily rested in the laps of economists and statesmen; medical scientists have worked chiefly on the technical aspects of control of birth rate, and this in a peripheral and sometimes halfhearted way. It might be productive if biologists were to look seriously at population explosions as they have looked at dis-

ease. The first half of this century has identified the components of the problem with as great precision as, for example, the nature of cancer has been defined. Only in these recent decades have the kinds and quantities of foods essential to maintain health in a human being become known. In addition, surveys of the food-producing capacities of the world and the trends in crop production are available. These data now supply a background for more basic biologic studies. Alan Gregg,<sup>1</sup> in a short but imaginative note, actually sketched out the analogy with the cancer problem at which I have hinted. Is the human race, he asks, an example of uncontrolled and abnormal growth that has in its mounting numbers and heedless arrogance pre-empted living space with complete disregard of the balance of life on our planet? Gregg posed an interesting question: "Do we need a new concept of human self restraint?"

An example from the biology of normal growth in wound healing may be added to Gregg's note. The rapid migration and proliferation of individual cells cease spontaneously when the space of a defect is occupied and contact thereby established with other cells of their own kind. The nature of this self-restraint in cell units is unknown, but it appears to be lacking in the cancer cell. Will an understanding of the force that restrains the proliferation of a single cell reveal the conditions under which a similar mechanism might restrain the action of the organism as a whole? Or is the answer to be found in technology that may be merely symptomatic treatment? The population of rats can be controlled by reducing the food supply. Are men rats?

In the absence of a real understanding of this complex problem and without low cost and effective technical methods, family planning (Fig. 1) is being pushed in India by measures that inculcate restraint based on loyalty to and responsibility for the family unit. In Asia the key social unit is the joint family, and it is possible that this approach will prove unexpectedly effective because it builds on this basic norm: unexpected, as compared with the effectiveness of a similarly directed effort in a society such as ours in which family units are conditioned to installment buying and suffer from explosive extensions of consumer credit.

### MEDICAL SOCIOECONOMICS

A consideration of medical socioeconomic in India must reckon with an estimated 95 per cent medical indigency in the rural population and 50 per cent in the urban population. Expressed in round numbers this means 370,000,000 medically indigent people, over twice the population of the United States and living in an area less than half the size. A small-scale social-insurance program, which supplies sickness and maternity benefits to permanent industrial and mine

workers, is in operation. The persons covered represent only 1.5 per cent of all working men and women in India, and no form of social insurance on a contributory basis has been devised that can offer protection to the mass of agricultural workers — 85 per

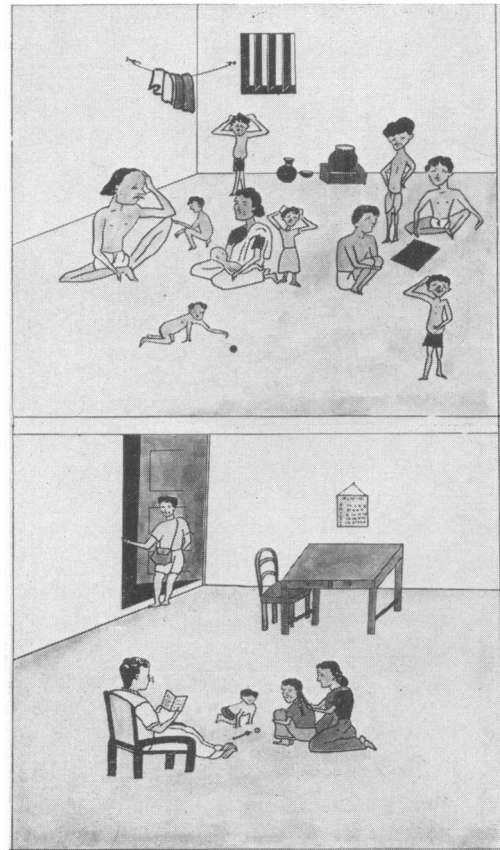


FIGURE 1. *Visual Aids Used in Family-Planning Instruction Contrast the Overpopulated Home with the Planned Family.*

cent of the whole population. So much for the sheer magnitude of the challenge of medical need.

### MEDICAL AND SURGICAL PRACTICE

Certain traditions that still shape the activities of the general practitioner are of ancient origin. In feudal days the physician was retained by a wealthy man and rewarded by quarters and food along with others of an extensive retinue. Notable personal services by the physician might be rewarded on occasion by special gifts. The drugs administered were simples compounded from herbs or minerals that might because of great rarity require a high price to obtain. As a relic of this tradition a practitioner customarily is not paid for advice given in his office but is not expected to supply medicine. He finds his living in the medicine he dispenses in addition to the gifts he may receive. His office in consequence is equipped as a dispensary, and a young man or woman known as a compounder prepares his

mixtures. Not infrequently the compounder, having learned the secrets of what is administered for a cough or a bellyache, departs and establishes himself in practice as a folk doctor. Practitioners estimate that about 50 per cent profit can be made from their dispensary. Gifts in recognition of the efficacy of treatment may appear at some subsequent — often long delayed — time, usually in the form of foodstuffs or products handmade by the patient or his family. The practitioner may make a direct charge for medicine given by syringe and needle and for operations conducted in his dispensary. The surgeon, as a result of his origin as an itinerant craftsman, is paid for the operation performed.

As the scope of surgery has increased from the lancing of boils and the dressing of ulcers, the pattern of the British nursing home has developed on a small scale. Usually, this is limited to a more formally equipped operating room than the office provides and accommodations for a few patients in the dwelling house of the surgeon or an adjacent annex. So one may have the privilege of entering the house of an eminent practitioner in a sizable city to sit with an elderly and dignified physician as he hears in turn the complaints of a long line of patients and the compounder fills his prescriptions. On the far side of the partition his surgically trained son is applying internal fixation to a fracture of the tibia, possibly with greater safety than in some of our own staphylococcus-infested hospitals. In more remote regions the patient or his family would be expected to obtain and bring with them the ether for anesthesia and the plaster of Paris for the dressing. In the larger cities, when a surgeon can acquire the needed capital the domiciliary nursing home has been replaced by a small and well equipped private hospital. Although a change in the traditional custom of not charging for professional advice is under way, the field of free-enterprise private practice is a limited one in both surgery and internal medicine. In the latter, a physician customarily charges a fee for house visits and consultations.

With few other exceptions, physicians and surgeons practice as agents of the Government medical service, and medical care is provided in Government hospitals, dispensaries and health units. These facilities are under the administrative and budgetary direction of provincial, municipal or district governmental units. Monetary subsidies flow from larger to smaller echelons, and it is only the larger governmental units that are able to undertake major costs of construction and equipment. The decentralization policy of the Congress party manifests an ancient Hindu tradition and displays a more realistic interpretation of socialism than prevailed in nineteenth-century thinking. India has avoided the pitfall of nationalization as a step toward social salvation. Doctors employed by the governmental medical service of a province have usually been free to supplement by private practice

the meager salary budgeted under the austerity program of the Government. Fees are not sanctioned for services rendered in Government-owned hospitals, but only as payment for permissive collateral practice. Private patients, however, may be admitted to Government hospitals.

This policy can best be illustrated by a specific example. A medical graduate finds employment in a district dispensary that serves a nearby village with several hundred inhabitants. Patients appearing at the dispensary receive free treatment, medicines and preventive measures. For a house call during the day the doctor may collect 1 rupee (21 cents) and for one at night, 2 rupees. To my knowledge no means has ever been devised that is as effective as an initial cash charge to bring the demand for medical attention somewhere near the actual need for medical care. Any system of government-sponsored medicine will do well to preserve it, particularly in the face of a shortage of doctors. A flaw, however, in such a provision is obvious. Infections become generalized. Cancers grow, and appendixes rupture. In a similar manner people with open tuberculosis may continue to spit, or cholera may be spread until a public-health officer, who works independently of the dispensary doctor and is responsible for the control of epidemic and infectious disease, becomes aware of the situation.

In the cities the permissive private practice of doctors who are receiving salaries from the Government medical service offers greater complexities. Fees for domiciliary care are privately arranged, and the demand for privacy during illness is greater. The central Government is commonly under attack for what is labeled favoritism toward the private sector of industry, and similar criticism of its attitude toward medicine is often heard. The point of attack on the profession centers on the relative expenditure of time and energy that an individual doctor actually devotes to the two sectors, public and private. This may become particularly acute when the doctor adds a third activity — the teaching of medical students. His responsibility as a teacher lies in the public domain, and his salary, like those of all teachers, is an austere one. The prestige attained through faculty position adds to the demands for his services.

On January 31, 1958, the government of West Bengal made all posts in the cadre of its Health Service nonpracticing. A teaching allowance or special pay of 100 rupees a month (\$21) was awarded professors, with somewhat less to other ranks. Although modifications of the original directive are being negotiated, the trend is an unmistakable one.

No account of the contemporary medical system in India is complete without reference to the indigenous cults and other systems of healing. Irregular and indigenous practitioners outnumber regular physicians and surgeons ten to one. The largest system of indigenous medicine is the Ayurvedic School. In addi-

tion there is homeopathy in the form in which it flourished in Germany and in this country during the nineteenth century. Homeopathic remedies are imported from manufacturers in the United States. The disappearance of homeopathy in Western medicine has been used by Shryock<sup>2</sup> as dating the advent of the quantitative and critical procedures of modern medicine. In sequel I shall consider the contradictions of thought that enable a contemporary professor of a medical science in a first-rate medical college to argue in all sincerity that the tenets in homeopathic therapy are valid.

With the magnitude of the projected task of supplying medical care to some 340,000,000 medically indigent and rural people and of doing so with some reasonable expectation of keeping apace with awakening demands, it will be surprising if sooner or later the entire profession does not become incorporated into governmental systems of medical-care distribution. Certainly, the time is at hand when more precisely drawn definitions are warranted that will guide the individual doctor in the relative expenditure of his time between the public and private components of his daily work unless he demonstrates his own ability to make the distinction with clarity. It would be not less than foolhardy for India to plunge into a centralized system of free medical care. The pharmacy bill alone could wreck the entire economy.

The Union Health Minister, Mr. D. P. Karmarkar, is keenly aware of this dilemma. "We go on multiplying doctors, and doctors may go to villages and towns," he said, but asked "if the cost of treatment is beyond the resources of the common man, how can we provide the benefits of modern treatment to the masses at large?" Other ministers rightly point up the fact that there are other areas of development such as agriculture, education, industrialization and so on that for the immediate future deservedly take budgetary priority over medical care. It is futile to cure a man of tuberculosis and expose him to death from starvation. (It is hoped that control of this particular disease, which is rampant, may be found in B.C.G. inoculation.)

It may be expected, therefore, that India will experiment in a realistic manner with various systems of practice designed to bring medical care to its people. There can be no insistence on a priori general principles such as "free choice of doctor" or "fee for service" that may be cherished by other societies. Even the policy of the present central Government to preserve two sectors in medical practice — public and private — may be found impossible to implement, certainly without more precise definitions respected at the level of the individual doctor. These have, of course, been instituted for consultants in England. In industry it is feasible to measure public and private sectors by the yardstick of rupees expended in capital investment; in medicine, simple folk in need of help

will ever find cause to be impatient if the doctor is found preoccupied with the demands of patients who can pay a fee.

When Mr. Nixon in February named India as a country whose freedom and independence were vital to the security of the United States, he was asked why the United States was extending assistance to countries whose economies were "socialistic." India has embarked on a number of experiments designed to bring the benefits of Western medicine to her millions of simple and impoverished people and is striving to do so in a manner in which these benefits will be accepted and effective. The profession of the United States would do well to comprehend the realities of the situation and not to be tempted to raise the alarm of "socialized medicine." If this indeed is "socialized medicine," it has my unqualified support.

### MEDICAL EDUCATION

Western observers of the medical education of India have recognized "defects which, in their opinion, made it wasteful and ineffective and hindered the realization of its true aims and objectives . . . [and] pointed out that this education was too bookish and mechanical, stereotyped and rigidly uniform. . . . The stress on examinations, the over-crowded syllabus, the methods of teaching, and lack of proper material amenities tended to make education a burden. Another great handicap was the large number of pupils in each class, making it impossible for the teacher to establish close personal contacts with his pupils or to exercise proper educative influence on their minds and character . . . the dead weight of the examination has tended to curb the teachers' initiative, to stereotype the curriculum, to promote mechanical and lifeless methods of teaching, to discourage all spirit of experimentation and to place the stress on wrong or unimportant things in education."

Although the excerpts placed in quotation marks repeat almost verbatim the comments of Western medical educators, actually they are quotations from a report of the Secondary Education Commission<sup>3</sup> appointed by the Government of India in 1952. Of the 9 Commissioners, 7 were Indians, and only 2 from the West. These quotations and other appraisals in a similar vein show that medical education cannot be withdrawn from the context of the previous educational experience of the student. It cannot be judged as an independent and separate entity, nor is it likely that a remedy can be found for its shortcomings if it is approached solely on this basis. The defects apparent to Indian educators and those from the West alike are part of a consistent pattern that extends from primary schools through secondary schools and universities.

The examination of medical education in India against the background of its entire system of educa-

tion shows that comparisons that attribute the defects to certain characteristics found in British medical education during the early decades of the present century are valid only in part. In my opinion these resemblances are only superficial; one must probe more deeply. British medical education has always been eminently practical and direct. It seems to me that India has selected, intensified and preserved certain attitudes and technics found in both British and American medical education during the last century, and long since abandoned.

I have been impressed by the light thrown on Indian education by the lucid studies of Professor F. S. C. Northrup,<sup>4</sup> of Yale. His writings clarify many of the aspects of the Asian scene that are confusing to a visitor from the West. Northrup suggests that contrasts between Asian and Western ways of thought and between cultural, social and moral norms of East and West center in "two fundamentally different ways of knowing nature." An example cited by Northrup from the Chinese scholar Chiang Monlin will be amplified and paraphrased to make it pertinent to a medical essay. The Asian way of knowing nature, he wrote, is by "naïve observation." This is an approach based on immediate personal experience, the kind of experience one might enjoy when sitting in the moonlight observing the shadows and listening to the chirp of the crickets as these sounds and visual images are sensed and blended into the mood induced by the serenity and stillness of the night. Asian people, Chiang Monlin observes, "are devoted to nature, in the sense of cultivating the poetic, artistic, or moral sense of lovers of nature." They are not lovers of nature in the sense of finding or perceiving natural laws.

A Western nature lover in this same moonlight setting might behave in a different manner. He would become aware that the chirp of the crickets seemed more (or less) rapid than before. This observation would not be passed over as some subtle change in the mood of the observer or of the cricket. He would take out his watch and count the number of chirps per minute. After establishing the fact that the rate of chirping actually varied from evening to evening he would seek a correlation with some other happening that might have varied. A correlation with the phase of the moon might occur to him, and he would jot down the rates of chirp in his notebook opposite the days of the month. With an inability to detect a correlation with the moon it might occur to the Westerner on some chilly evening when the rate was notably slow that a correlation with temperature should be undertaken. It would not be long before the notations of rate of chirp when plotted against readings of temperature could be expressed on coordinate paper as a significant relation. Here would be one more supporting morsel of evidence with reference to a universal law of nature that relates

the rate of life processes with temperature. To derive this conclusion, however, required precise and objective — not naïve and subjective — observation. Since the renaissance of Greek learning this way of knowing nature has formed the basis for the development of Western science and culture.

Medical educators in India today are faced with two quite separate tasks. The first is the development of a way of thinking in their students — a way of knowing nature — that has been the basis of Western medicine. The want of this manner of thinking is manifest in the entire educational system. Only when he comprehends this approach and develops the mental processes that are second nature to a Western doctor will the doctor of India be able to understand and apply Western methods effectively and economically. Similar considerations surround the introduction of Western technology or know-how in industry and agriculture.

A step toward this objective in education is found in the All-India Institute of Medical Science under construction in New Delhi. Selected to bring education and research together, the faculty is undertaking experiments in medical education that can be expected to throw light on the particular learning habits of Indian students and on methods of instruction adapted to their needs. Emphasis will be placed on the introduction of ways of thinking, Eastern or Western, that will prepare the physician to meet the needs of India. Research will emphasize the medical problems of India in both scientific and socioeconomic terms. Even a modest investment of funds by the central Government in this Institute cannot but reduce the vast sums that will be required for medical care in the future. These sums will be truly formidable if the Government attempts to distribute expensive drugs through the hands of practitioners who are not fully conversant with their use.

If the All-India Institute of Medical Science is to realize its full potentials it requires shelter from two hazards: confusion of its function as a catalyzer with that of the established medical colleges to which the task of producing doctors for the immediate needs continues to be assigned; and a temptation arising from within or from without to transfer educational patterns from the West that are likely to prove irrelevant to India.

The second task of the medical educator is to produce doctors in sufficient numbers to satisfy the demands of the awakening populace for medical care. This is real and has reached sensitive political ears. As a general practitioner in a small city said, the villager is demanding everything, and wants it all at once.

The last words of Gandhiji to his disciples were, "Go to the villages." These words are frequently addressed to young doctors. But merely the production of doctors in increasing numbers will not fill the

villages. Production must be correlated with the program of building and equipping health units and hospitals in which doctors can work effectively. Considered alone, both the needs and the demands for doctors are overwhelming, but a doctor in a village with no equipment or even simple medicines to dispense is little better than the hakim or other indigenous practitioner. The doctor likewise must peddle colored water. The basic agricultural economy of India is largely dependent on rainfall, which can well mean that the ability to employ and utilize doctors at a given rate of production will also fluctuate. This calls for consistency in politicomedical planning. Under these circumstances it is my opinion that the statesman, who in theory at least has his finger on all pulses at the same time, has been forced into the position of continuing tolerance toward irregular practitioners. At least they may serve to fill a gap temporarily, and their herbal remedies have the great virtue of being inexpensive.

#### INDIA'S URGENT NEEDS

The question may well be asked, What is the outlook and what does India need most urgently? I shall deal with the latter first. I hope the question what this country can do to help will occur to some. The answer to this is easy. The present Five Year Plan must not be allowed to bog down because of lack of external financial aid.

As to urgency of needs, for me, a doctor, to propose education and health before this audience as items that take precedence in the long list of things to be done would be unconvincing and bring forth the criticism of prejudiced vision. So I consulted a recent book by W. S. Woytinsky,<sup>5</sup> who is described on the cover jacket as an economist of world-wide reputation. I was startled by the humble statement that the root and basis of economic progress lie in man himself and that the source of the potential strength of India lies in the human factor. Knowing little about economics, I had supposed that the source of economic strength of a nation was found in heavy industries, in coal and oil reserves, in industrial production or in the thorium and uranium deposits available for atomic power. After all, these factors won the world war — or did they?

In answer to his own question of what India needs most urgently, Mr. Woytinsky places education and health at the head of the list.

#### INDIA AND CHINA

I have already referred to Mr. Nixon's statement that the freedom and independence of India are vital to the security of the United States. The dialogue between China and India has already taken form: China attached to the Soviet Union, and India looking toward the West. The remainder of Asia and

perhaps Africa are the spectators. Two systems of thought are being tested: the democratic freedoms of the Constitution of India and the regimented totalitarianism of the People's Republic of China. India is cognizant of the fact that the opening scenes may go against her. It is easier to make rapid and spectacular advance under a system of disciplined regimentation. This fact is familiar to anyone who has lived through the wars of this century. But India has elected the long-range course — partly because of her own way of life and partly because she has been schooled in the British traditions.

In my opinion the American press has not grasped the true nature of this beginning soft-spoken dialogue, largely to be expressed in dry figures and economic facts. This material does not yield as exciting headlines as those inspired by postures against militant communism. A clue to its significance may be found in the turn of the American Administration from the former emphasis on military defense to emphasis on economic aid.

#### PERORATION

By time-honored custom an oration is concluded by a peroration. The question concerning the outlook can now be answered by symbolism, a traditional Hindu method. In the course of our journey we acquired two water colors. The first is by a mature artist of Madras, Thyaga Raj. A villager — the common man of India — is plowing with his bullocks and almost escapes notice against the background of the vast land mass. Every muscle of his emaciated body is strained by his back-bending task, and every force opposes him. Even the furrow appears as a rushing torrent against which he contends. The brush strokes depicting the land flow downhill against him. The trunks of the palm trees are bent and show that prevailing winds are against him. Only a slight breeze is stirring the leaves in his favor.

The second water color was done by an unknown art student scarcely eighteen years of age. He is studying in a Government vocational school in Lucknow. A villager is leaving his hut for the day's work; the sky is overcast, but there is a break in the clouds and the sun is streaming through. He calls his composition "Morning Light."

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The following sources have been helpful in developing points of view and for some but not all of the quotations used. India is a large country, and illustrative descriptions are of necessity drawn from particular localities.

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