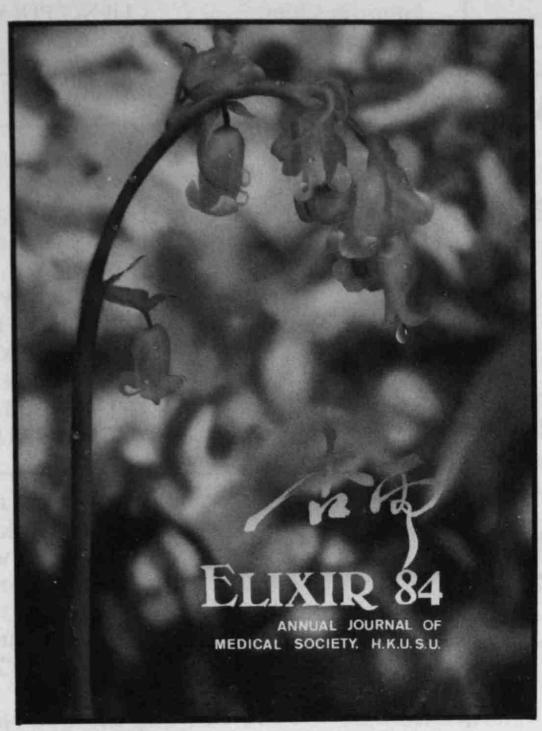
ELIXIR



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H.K.U.S.U.

ELIXIR'84

Cover: 'Elixir is supposed to be a drug or essence with the property of indefinitely prolonging life. Elixir of Love is an orchid, a native of Java'*

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* adapted from 'The Oxford English Dictionary' Vol. III P. 91 (1933)

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EDITORIAL

While the Sino-British Joint Declaration held the front line of events in 1984, Elixir has gone through her thirty-fifth year since her establishment in 1950.

By just glancing through the table of contents, one can easily notice the innovation brought about in this issue. In addition to an expansion of the regular articles such as *Our Classes, Departmental Survey,* reports from *Our Medso,* many new features are included in this issue. Just to name a few:— more than thirty pages are devoted to *Message from Departments,* in line with the editorial policy of serving as a bridge in our faculty. Elixir also goes continental for a general view of our counterparts in China. Meanwhile, some of our inquisitive reporters probed into every corners of *Our Campus* — from the most-frequented medical Library to the Medical Illustration Unit well down the Sassoon.

To our great delight, the aridity of our *Contribution* is much alleviated this year. Elixir '84 are highly honoured by articles of brilliant scholars overseas. Professor Y.W. Kan who graduated from our University in 1958 tunes us into the success of his career in his inspiring article — 'On a Slow Boat from China'. This article is best described in Professor D. Todd's words, "a heart-warming and stimulating account of Professor Kan's career to date." Another scholar, Professor F.P. Lisowski who is the ex-head of Department of Anatomy in our faculty expresses his insightful ideas in his 'Health care and Medical Education'. Other contributors — Dr. V. Wong Taam in her behind-the-scene account of her visit to medical school in China, our legendary Mr. Chi-kin Lo（盧子健）in his disillusioning article '奔向自由' .... — all have written something you should not miss.

On behalf of the Editorial Board, I would like to express the deepest gratitude for those who have, in one way or another, given their immeasurable contribution in assembling this issue. The following list of people whom we must acknowledge for their invaluable help and advice is by no means exhaustive:

Professor F. Mak-Lieh and all the staffs of Department of Psychiatry.
Heads of all departments in Faculty of Medicine
Dr. C.R. Kumana
Dr. R. Fielding
Dr. J.P. Fowler
and all contributors of article.

Last but not least, to all the members of Editorial Board go my heartfelt thanks for their painstaking effort that set this issue in motion. Without their patience and skill to overcome the innumerable hitches and snags, Elixir '84 can never come into being. It is my earnest hope that this late-coming 216-page issue is worth all your waiting.

Editor-in-Chief
Cheng Pui Wai

Message from our Dean

Life is full of surprises. When I wrote the message for the Elixir 83, I reported to you the commencement of curriculum review by the preclinical and clinical syllabus committees and the slow progress of the proposed expansion of the Medical Faculty by 50% or 75 students intake per year. I also discussed briefly how we should prepare our medical graduates for their careers and service to the community after 1997. I myself was looking forward to addressing you again this year and the year following since my term as Dean was expected to end in mid 1986.

As you are aware I resigned from the Deanship at the end of 1984 in order to take up the appointment as Pro-Vice-Chancellor. I must admit that this decision was made with some reluctance. Working closely with the teachers and students of the Medical Faculty for 6½ years (5 years as Subdean and 19 months as Dean) has reinforced my respect and affection for the Faculty to which I feel I always belong.

We have now been informed by the University and Polytechnic Grants Committee that the Medical Development and Advisory Committee has concluded that the present plans for the expansion of HKU Medical Faculty involving the use of East Kowloon Hospital should be deferred indefinitely. This decision by the M.D.A.C., I understand, is based largely on a revised forecast of shortfall of doctors in Hong Kong in the 1990's. As a result, planning of the Faculty for the large scale expansion has now ceased. It is not certain at this point in time whether a modest expansion is needed.

Personally I take this "setback" as a blessing in disguise. We can now focus our attention on the curriculum review which has progressed satisfactorily, consolidation and long term planning for each department and the development of postgraduate professional training. The two syllabus committees have worked hard to come up with some very useful proposals to improve the present curriculum and to accommodate the newly introduced subjects such as General Practice and other subspecialties. I can assure you that the total number of teaching hours will not be increased nor will the frequency of examinations or class tests. The Curriculum Review Committee including student representatives will soon meet to discuss these proposals. I am confident that the task will be satisfactorily concluded before the end of this year.

What are our plans for the future, before and after 1997? The Sino-British joint declaration signed by the leaders of China and Britain last December provides a frame-work within which the current social, economic and educational structure of Hong Kong will be preserved for 50 years after 1997. Furthermore, if the terms of the declaration are successfully implemented, Hong Kong will play an even more important role in China's open door policy and modernisation program. In medicine as in other scientific disciplines, Hong Kong will be a vital link between China and the Western countries. For this reason,

I feel that our University and our Faculty must retain their individual character and their freedom to establish academic exchange with other medical schools in the world.

There will be more exchange with medical schools in China. As we become better acquainted with the medical education and health care system in China, we may have to change the order of priorities in our undergraduate curricula and professional training in order to enhance our contribution to China. But this does not mean that we will adopt the same policy as the medical schools in China e.g. we may wish to retain English as the medium in formal teaching. China has already made its views clear that not all its Universities' need be the same. Our medical schools and graduates must maintain an international outlook before they can play their part in the development of our country.

Finally while the idea of having a local institution responsible for the coordination, provision and accreditation of postgraduate professional training has been conceived for a long time, it is only recently that the profession, the government and the community have given their unqualified support. Our Faculty will necessarily have a very important role to play in this worthy task ahead.

1984 has been an eventful year for all of us. But I think we have emerged from it wiser and more hopeful, though not necessarily happier. With you, I look forward to more encouraging news next year from the new Dean, Professor John Leong.

ExDean
R.T.T. Young

Message from our President

It has been an active, exciting and busy year for the Medical Society. A series of educational, social and community activities helped to nurture some valued qualities of medical students of today: industrious, intelligent, interesting, and caring.

Thanks to all officials of the Society for their time and effort; all members for their enthusiasm; and the public for their support.

Wai-Ying Chan-Lui
President
Medical Society
H.K.U.S.U.

■ ■ ■ ■ ■

Presidential Address '84

MATURATION AND DEVELOPMENT, THE CHILD AND THE DOCTOR

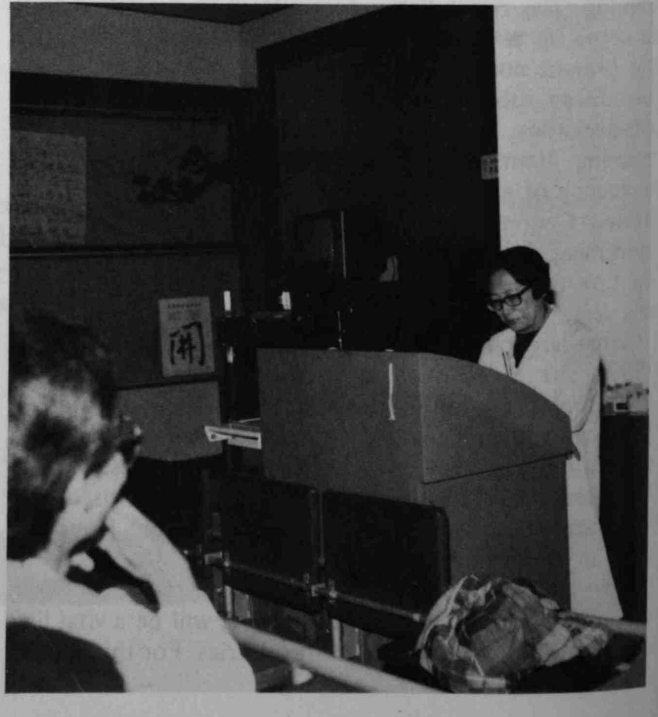
● **Dr. W.Y. Chan-Lui, M.D.,D.C.H., F.R.C.P.,F.R.C.P.E.**
Reader, Department of Paediatrics

"The child is not a miniature adult". I do not intend to substantiate or challenge this statement today. Instead, I propose that we all critically look at ourselves as adults and as doctors, that in our own development, while we may be well developed and mature in many aspects, we may still be developmentally arrested at very early levels in some areas.

First, let us look at the biological phenomenon of neurological development. It is a continuous process occurring both before and after birth. Neuroblast multiplication occurs 10-18 weeks after conception, with neuronal differentiation around 18 weeks followed by migration of neurons to their destined location in the CNS. Dendritic growth with proliferation of synapses follows from the 18th week to 2nd postnatal year. At the same time, spongioblast multiplication with increasing glial formation and myelination proceed, with rapid rate of myelination up to the 4th postnatal year and a more gradual maturation thereafter.

This period of 18th week after conception to the 4th postnatal year has been called the human brain growth spurt, a period where the developing brain is particularly susceptible to the often irreversible effects of even subtle but prolonged adverse influenzes. By providing an optimal environment and minimizing possible adverse factors during this period, one hopes to ensure a sound basis for the maximal cognitive, emotional and social development of an individual within the potential endowed by his innate biological elements.

It is not difficult to see the analogy here, between the neurological development of a child to that of the development of a doctor. This human brain growth spurt may be considered equivalent to the period of one's undergraduate medical education and first few years of postgraduate medical training.



As we examine some detailed observations on the development of a child, we may obtain a better perspective of ourselves and our friends as adults and doctors. After all, we are all human.

Before birth, the exteroceptive reflexes develop earlier than the propriopceptive reflexes. Rooting reflex at 12 weeks gestation, palmar grasp at 13 weeks and withdrawal reflex at 16 weeks are early indications of survival mechanisms. Proprioceptive reflexes such as muscle stretch, tonic neck, vestibular, righting, placing and standing reflexes develop after 16th week gestation and are concerned with the orientation of head and body postures in relation to space. Brain stem reflexes such as pupillary reaction and visual pursuit develop as early as 28 weeks gestation. Background electroencephalogram is detectable at this time although auditory and visual evoked cortical potentials do not appear until after 32 weeks gestation. Thus at term birth, while the motor behaviour of the newborn is largely under the control of spinal cord and brainstem reflexes, evidence of some cortical function is already obvious. While awake during 1/3 to 2/3 of the day, the full term newborn can turn his eyes and head toward light and see a human face within 2 feet and follow the moving face in big steps of ocular pursuit, especially when the face is accompanied by female voice.

At one month after birth, the infant's eyes can accommodate up to 75 cm. When his mother speaks to him, he makes mouth and tongue movements similar to those of his mother. Irregular open-close movement of his hands can be seen as a precursor of voluntary grasp. He sucks more vigorously hearing his mother's voice. He is easily conditioned that his mouth starts to suck when he is put in the feeding position. His cry assumes different characteristics with different forms of distress that the mother can recognize and attend to. At two months, his two eyes can function together with an acuity of 6/180. He prefers familiar faces and has eye to eye contact with his mother. He smiles and exhibits different facial expressions reacting to and inviting mother's changing interactions but loses interest and appears distressed by TV recording of his mother's rigid social approach. Thus, while the normal infant manifests habituation against stereotyped reflex reactions, he becomes increasingly active in social interaction. With better head control, increasing cortical overriding of brainstem primitive reflexes, improved visual acuity of 6/60, colour discrimination, perception of space, shape and form constancy at 3 months and binocular vision and smooth visual pursuit at 4 months, the infant becomes increasingly interested in his surroundings other than his mother. He starts to have voluntary grasp and learns through touching, sucking and biting objects. At 6 months head supported, rolls, and bears some weight on his legs. His hand movement becomes less ataxic. He can see up to 1.5 m and beyond, and has less astigmatism so that he can see details in all directions. He learns to differentiate and imitate different emotional intonations. With increasing maturation he stands at around a year of age. His finger manipulation and eye hand co-ordination improve. He can understand some words and verbal instructions and learns further through play and observation. At 1½ he walks steadily. He can feed himself. He knows body parts, recognizes pictures, and uses gestures in communication. This is a crucial period of development when he builds up his language and learns through parents' teaching and observation before he can express himself verbally. At 2 years, he goes up and down stairs 2 feet per step. He runs, kicks and jumps with 2 feet. His perception and eye-hand coordination have further refined that he can place a, O, □ or △ block into its proper slot. With a pen he imitates vertical and circular strokes. He now speaks and increasingly enters into true dialogue with his elders.

This period from conception to two years after birth constitutes the founding stones for neurological, cognitive and social development. While an intact biological system is essential for neurological maturation, adequate and timely environmental stimulation is vital for cognitive and psychosocial development. This period may be considered comparable to the undergraduate years of medical students, where a sound knowledge in preclinical subjects forms the theoretical structure for better understanding of the manifestations, diagnostic approach and logical treatment of diseases. Where medical students need the ability and motivation to study, adequate teaching material and methods are essential to ensure their learning through observations and comprehension.

The 3 to 4 year old child is completely independent in locomotion. He can jump well, stand on one foot without losing balance and can go up and down stairs one foot per step without help. He can button up and unbutton in dressing himself, and can copy 0, + & □. He is increasingly curious and asks questions which need to be answered. With his increasing motility and communication he broadens his experience and learning situation while at the same time gets into more conflict between his impulses and parental disciplines.

This is an important stage to learn parental and social rules. He needs firm and consistent parental handling in shaping his behaviour within the acceptable social norms. It is not infrequent that in the absence of an adult he has no control of himself and blames others for his own misdeeds. Even the five year old may be emotionally labile and may alternate rapidly between "good" and "bad" behaviour.

The 6 to 7 year old reads, copies △ and ◊ , notices similarities and knows right from left. He starts to interact with his age peers, identifies with his sex role and not uncommonly "gangs up". He is still unable to differentiate reality from his own fantasy and apts to tell tall tales. At this tage he needs clear directions, structured learning situations and encouragement.

This stage of child development is perhaps similar to the first few years of postgraduate training. The young doctor learns to apply his theoretical knowledge to the reality of clinical practice. This is a time to learn the variability of disease manifestation, different strategies in diagnostic approach, and influenze of human and social factors on treatment and clinical response. He sharpens his clinical acuity by learning through mistakes and experiences. He learns to communicate with patients and their relatives of various personalities, educational and social background. Not infrequently, his work demand conflicts with his personal interests, and he needs to acquire increasing degree of self restraint. At this stage, the young doctor needs clear systematic instructions as well as understanding and encouragement from his seniors.

The 8 and 9 year old child has a better understanding of cause-effect, right-wrong, and reality-fantasy. He develops diversified interests and has better attention, memory, problem solving and planning abilities. He may be sensitive to success and failure, and becomes overdemanding on himself and easily discouraged. He starts to have "best friends" and enjoys team games although he may be hostile to the opposite sex.

I see this period comparable to the stage of a doctor when he becomes more confident in his own specialty and yet recognizes his limitations to value multi-disciplin consultation. He may feel discouraged seeing that m patients cannot be cured or even helped.

From 10 year on, the child has increasing ability f abstract thinking, independent and critical analysis. He interested in exploration, adventures and various forms intellectual pursuit. He adopts moral codes and valu systems and increasingly assumes responsibility for h conduct. However, his moral codes and value systems ma be too rigid to allow him comprehend other people behaviour. Much more life experiences in adulthood ar required for him to develop flexibility within the fram work of basic principles and be capable of obtainin perspectives from all angles.

This has the analogy of a doctor's development wh despite of the reality and limitation of medical science, h contributes all he can to relieve the suffering of h patients and their loved ones. He increasingly emphasize health education and prevention of physical an emotional disorders. He encourages effective parenthoo by helping parents understand child development an offering concrete guidelines in child rearing. Moral and ethical issues involving life and death, right and quality of life and death can be better resolved with increasing capability of multi-faceted analysis.

I have used the analogy of the child developing into a adult to the development of a doctor. It is my hope tha after this presidential address, we could all have a bett understanding of ourselves and our friends. While we rel on our teachers and seniors to guide us in the early stage it is far more important that we ourselves can continue t learn, to develop, and mature.

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主席的話

香港前途問題，在政治層面的階段已暫告一段落，接著是進入一個技術性調整的階段，在這個所謂過渡性時期中，所有的制度都將會作出適應性的轉變和發展。

醫療界所受到的影響是極大的，而且轉變已經靜靜地進行中。

關注與否，本來是同學們的自由，但這是個對同學的將來有重大影響的問題，醫學會實應確立在這方面所扮演的角色和展開實際工作，引發討論，收集意見，以備可以對一些外來的壓力和挑戰作出快速而又有代表性的回應和有所行動。

而同學們到了這個時候，已經不可以再沉默，這是個切身利益的問題！以前大家可以認爲那些是遙不可及的東西，是有理想的大學生的悶人玩意，如今，只是問一句「要錢要命」，當然大家堅持要「感歎無助無能」的話，我們便只有一起在「鐵達尼」號上祈禱。

去年十月廿三日，亦即於中英協議草擬公佈後不久，香港醫學會會召開了一個內部論壇，討論草擬內容及醫學界的將來，並且邀請了一些醫學院的同學出席。事後，香港醫學會總結了一些觀點，寫成了一份意見書交與民意審核署。

有出席該次論壇的同學，大致都會知道問題的端倪。

現時，最着緊的便是發展本港的專科訓練和專業資格審定，以免將來與英國的體制失去正式的聯繫時，會引致香港的專業水準下降，失去其國際性的地位。這一方面的工作現已經展開了好一段時間，但最受到影響的我們，卻似乎依然是所知不多，我想，醫學會在這方面是可以有扮演一定的角色。

另外，如何看待國內醫學院畢業生的專業資格，也將是一個大問題。他們原則上可以在港擁有行醫權嗎？怎樣去使他們接受及明白香港的審核制度呢？更進一步地，我們可以爲國內發展一個完善的專業資格審核制度和訓練盡一點力嗎？

還有現時的專業法律及賠償保險會否因脫離英聯邦而不再被接受，以致可能要自行建立一個類似的組識呢？將來本港的專業道德守則會否面對甚麼可能的轉變？（大家知道現時國內的醫生專業守則嗎？應該去看看!）

或許，這一切一切都可以如今天的一般保持五十年不變，但五十年之後又將如何呢？終歸的轉變，都會是我們這一代去決定。

就算不談這些與九七有關的事，今日香港亦存在有很多問題，例如，越來越多人提議要改變現時香港私家醫生的註册制度，設立定期重新審核專業水準考試，要求政府推行全面性醫療服務保險制度，管制中醫、跌打、針灸等一大堆問題，都是與我們的專業有切身關係。忽視這些問題不單會導致專業利益受損，更重要的是社會大衆的健康保障受損。

醫學會歷年來作爲一個提供福利，文化康樂體育活動的學生會方面，無疑有很優秀的表現，更值得讚賞的是所負責的同學大都只是一年級的幹事，但在團結內部，作一些高層次參與和爭取方面就比較遜色了。在民主意識日漸高漲，一切變得政治化的前途氣氛下，醫學會的方向應該在理想之餘，還需兼顧一些比較實際和切身的事情。關注醫療，將會是不可或缺的一環。

黃玉庭

八三至八四香港大學學生會醫學會幹事會主席

王與黃眼中的醫學會

今年杏雨訪問了王榮祥和黃玉庭兩位，抒發了他們對醫學會的感受，更提出不少具有前瞻性的意見。

祥：王榮祥（香港大學學生會醫學會83－84年度評議會主席）

庭：黃玉庭（香港大學學生會醫學會83－84年度幹事會主席）

目標與工作

問：醫學會作爲一個院會，工作可大致分爲服務、認知和帶領三類，而重點却應放在那方面呢？

祥：由於地理上的隔離，文康福體等工作是極其重要的。當然帶導和認知性等工作亦是不容忽視，但是醫學會的重點却要視乎當年幹事會的政綱。

「搞活動的人……很可能將自己內心理想化的形象投射於整個團體上……」

庭：我亦同意醫學會的工作重點是隨着時間而改變的，但最決定性的因素是同學當年的「需要」，幹事會應考慮羣體的需要，而定出適當的工作方針。

但一個無可避免的事實是，「搞」活動的人通常是會積極於一些比較高層次和理想化的目標，他們很可能將自己內心理想化的形象「投」射於整個團體上，而作出了與團體需要有所出入的取向；這情形在文康、福體等服務性活動裡是比較少發生的，但於時事認知、立場帶導方面却常出現幹事與團體的分歧，例如戴信事件；所以適當的妥協是必須的。

問：那麼近年來醫學會與同學之間，又有沒有太大的分歧或衝突呢？

庭：就八四年來說，幹事會比較着重服務性的活動，即使外務方面，都是着力於推廣和認知時事的工作；情形與七十年代學運時期不同，並沒有太極端的立場和態度，所以沒有什麼衝突可言。

祥：有一點值得注意的是，同學們對於一些推廣和認知的活動，普遍都表現得很冷淡；但對於一些有關切身利益，前途的事情時，却反應得十分熱烈，戴信事件便是一例。

問：就帶導性的工作而言，你們又作何理解呢？

庭：其實帶導可作兩個層次的理解，第一是帶出問題加以討論，第二是經過適當的討論後而定出一個主導的意見，亦即是所謂立場。

反觀醫學會的帶導，多只限於前者的討論，而絕少有立場的表示，除非是得到大多數同學的支持，因爲幹事是要對全體同學負責任的。

祥：我同意庭的說法。

架構與運作

問：無論從人手和支出來看，醫學會的活動和架構比起其他院會都多和大很多，你們覺得現況是否已經到飽和的地步？

庭：團體的架構是一樣非常動態的東西，是應隨着情況的需要而變動，因爲架構的功用是在於彌補人事上的不足，令各人能明瞭自己的職份，團體的操作和行政才能做到一個最理想的境地。

而就現時情況來說，架構已十分理想，反而更重要的是人與人之間的合作。

祥：作爲學生團體來說，操作的成功與否，並不單是完整的架構，及清楚的分工，而重要的是「搞手」間的合作和默契。

庭：有一點是需要補充的，無可否認，現時的三個常設委員會——啓思、健委和杏雨，工作時太過獨立了，我意思並不是說權力不應獨立，問題是在於大家各自工作，互相缺乏之默契和合作。

問：同學與學院之間的溝通，醫學會担任了一個很重要的角色，但醫學會又是否有此代表性呢？

庭：事實上，醫學會的確是有不少學生代表（注意，並不是表示代表學生）與校方接觸，例如在教務和院務委員會的學生代表，又或是圖書館委員。但由於校方只會認爲他們只代表部份學生的意見，所以根本不應質疑他們的代表性，反而值得討論是的，在許可的情況下，他們應對同學作出消息上的交待，但這方面就好像一向以來都缺少了，這可能與他們在被選時都不很明瞭自己的工作有關。

祥：我認爲這些代表既然是經由全民投票或者是評議會選出，他們便有作爲溝通渠道的義務，評議會亦有此責任通知和催促他們。

庭：由人來解釋工作範圍給他們聽，是會很受制於人爲因素的，與其這樣，不如在醫學會的constitution 或

by-law 內列明。

祥：這倒是一個好主意！

問：以全民投票選出或者是公開論壇（quorum）這兩種方法，又能否增加其對同學要求的認識和對自己職份的自覺性呢？

庭：公開論壇的原意是很好的，它令同學有機會向準執事同學詢問及發表他們的意見。

但由於幹事會和各常設委員會上庄時間差不多，做成了在短時期內有過多的公開論壇，這不但對同學造成一定程度的騷擾，亦令他們的反應更加冷淡。所以，除非能夠克服這技術上的問題，否則公開論壇的功用便大打折扣。

祥：我認爲如果公開論壇是眞的有其價值，我們是應該盡量解決技術上的困難的。

問：有人批評周年全民大會（AGM）內，勉强湊夠所要求的最低與會人數（quorum）的做法，你們覺得如何

庭：基本上，AGM的功用是不容置疑的，我們是需要一些制度或者方式去監察執事同學的工作，希望醫學會的工作不會與羣衆的要求有所分離。

實際上，同學反應非常冷淡，所以我們應該作出一定程度的妥協，一方面令AGM順利進行，一方面不會「奪」去同學「挑戰」執事同學的權利。

祥：AGM是對全部同學交待的好機會，而最重要的不單是監察本身，而是通過質詢及討論，達到前瞻的目的。其實，評議會更可以做到監察的角色，因爲每一個同學皆可以在每一個評議會發言或詢問，這比在一切事情都過去的AGM更有積極意義。

問：那麼，又應否執着於10％的quorum 呢?

庭：quorum 原意是希望保証相當的與會人數，避免一面倒或者是不公平的討論。

而10%的 quorum 只是一個由人訂的妥協；所以，我認爲 quorum 並不是最重要，反而最重要的是要事前作好足夠的通知，令同學知道要討論什麼，至於到會與否便由他們自己決定了。

不「搞」好AGM 的內容和形式，而去減低或甚至除卻fuorm ，是不負責任的。

祥：我認爲10%的 quorum 已經是最低限度的了，問題所在是要令到同學有興趣到會，不「搞」好AGM的內容和形式，而去減低或甚至除却 quorum，是不負責任的。

問：AGM又如何能夠做到有「吸引力」呢？

祥：同學不去AGM，最主要是由於會議時間太長，又有多少同學可以捱「通宵」開會呢？另一方面是同學對所討論的問題沒有興趣。所以，其中一個可行的辦法是預先（例如在評議會內）選擇了值得討論的題目，才在AGM討論，這便可縮短開會時間。

庭：其實，我認爲好像現在跟着整份周年報告來討論，是有點費時失事的，所以選擇性地來討論是必要的，但要做得好，是一定要爲所討論題目作最充份宣傳，使同學知道。

問：評議會作爲除了AGM外最高的權力架權，操作得是否令人滿意呢？

庭：評議會的架構已經十分完善了，而操作的成功與否是取決於評議員的主動性，但通常一年級的評議員大多數比較少發問和提意見，另一方面，最初的時候，他們都不甚明瞭評議會的程序。

祥：問問其他評議員吧！

問：對今年幹事會有何評價呢？

庭：今年幹事會上庄的時候，事前預備並不十分理想，幹事間起初都不太熟絡，但低班的幹事是很需要高班作精神上的領導和支持的；再加上外務副主席的辭職，各方面都做得不太理想，到後來互相合作熟了，又到落庄時候。

祥：今年醫學會工作雖然比較平靜，但是大部份的幹事都做得非常之稱職，成績相當令人滿意。

曾經有人批評今年健委的工作成績和方向，但我認爲他們已做好了應做的事，……

問：對各常設委員會又有何意見呢？

庭：曾經有人批評今年健委的工作成績和方向，但我認爲他們已經做好了應做的事，在缺乏高班同學支持和人手的環境下，對健委的要求是不可以太高的。自己對杏雨沒有什麼特別的評價。反而是我認爲醫思應可以有能力做得更好，他們可以嘗試跳出報紙的框框，與幹事會多些合作，他們可對曾經探討的問題，例如實習醫生，作更深一步的研究和行動。

祥：我同意庭的說法，啓思作爲一個這麼健全、人手充足，及有高班同學參與的委員會，是可以做得更多，討論得更多的。

庭：其實，啓思亦可嘗試發表自己的意見，不必純是報導。雖然啓思是醫學會的會報，但編委會是完全可以發表自己的意見的。

人力、物力

問：就財力和人力而言，是否足夠支持醫學會的活動呢？

庭：每年的電影籌款已可提供足夠的活動經費，而人手方面亦頗充足，但是由於高班的經驗傳遞和精神領導不足，做成每一屆都好像是從頭開始。

祥：現在高班的同學也有出現評議會提意見，是一個非常可喜的現象；至於財政方面，其實電影籌款亦有其隱憂，所以希望各活動負責人可以量入爲出。

庭：另一點值得一提的是，每年醫學會的活動都是受到時間上的限制，各同學上庄的時候是在第一個學期尾，可以做的東西很少，到第二個學期，可以算是黃金時間，但由於未能適應，幹得都不十分理想，到第三個學期，各同學要預備M.B.，活動都沉寂下來；到暑假時，又有健展、迎新和Gala要「搞」，幾乎用去所有人手；及至到下一年的第一個學期，又正接近尾聲，再加上同學要預備落庄。於是乎，同學要將活動攪好是很難的。

對外關係

問：最後，醫學會的對外關係又如何呢？

庭：就對校方關係而言，是相當良好的，院方是十分尊重醫學會之意見的。雖然醫學會未能眞正影響校政，但亦提供了不少受到校方參考的意見。

祥：我覺得現在最需要增進的對外關係，是與中大醫學院的聯絡，多些溝通和瞭解，即使日後工作的時候，也會合作得好些！

■

幹事會

外務副主席

醫學會的外務工作，主要是由三名幹事所承担——內務副主席負責與大學本部有關的校政參與，時事秘書負責除了醫療方面的時事，而外務副主席則要出席學生會的評議會，與及處理和學生會的關係，而今年新增的醫療組，關注香港的醫療時事，亦由外務副主席負責。

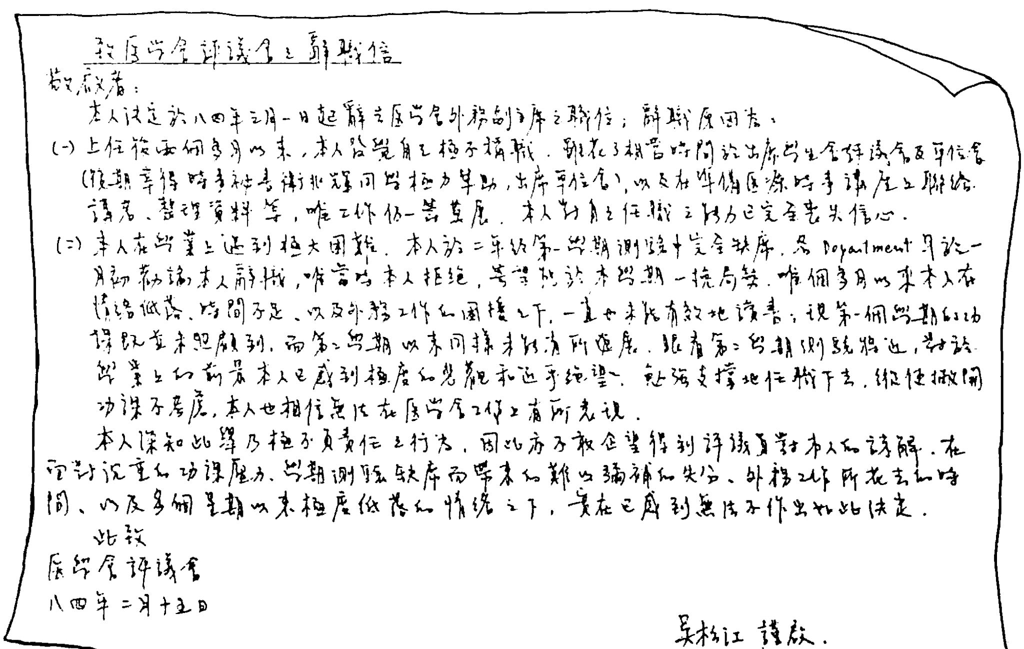
就出席學生會評議會來說，醫學會的代表是會有很多限制的。首先，由於地理上的隔離，本部的消息是很難傳至醫學院，在評議會中討論的問題，例如必然會員制，可能已經在本部作過很多的討論，但在醫學院活動的同學却可能只知一二。再加上那邊大多數評議員都已經很熟絡，而自己便會缺少了他們那種討論時的默契。所以，幹得好不好是取决於外務副主席能否用多些時間在那邊「活動」，知道多些消息和打好與其他評議員的關係。

對於醫療組這個新組成的委員會來說，很多不完善和有困難的地方是可以預見的。關注時事的工作，通常很容易流於紙上談兵，和採取了一般局外人的批評態度，而關注醫療時事亦不例外。由於差不多全部醫療組的都是二年級或以下的同學，未曾到過病房學習，未體驗過醫療的實際境况，結果便只能從表面的統計資料方面着眼，又或者過份依賴了外間一些個別批評作爲參考，很難體察眞正的情况，而往往作出了過於理想化的評論，缺乏了適當的妥協。爲了能夠避免這個情况，惟有盡量諮詢高年級同學的意見，最理想自然是他們能夠親自參與，以希望能做到中肯客觀的地步。但這又是課程壓力之下難以做到的。

另一方面，除了內部研討外，醫療組是會邀請講者來開講座，增進同學對問題的認識。但是，由於有關醫療時事講者人選已經很有限，加上肯對現行制度作出公開評論的人更少，所以大大削弱了講座的吸引力，結果，除了是切身問題，例如實習醫生制度，醫生出路問題等，同學的反應是很冷淡的。

自從當上外務副主席這個職位，及至辭職到現在，我對自己及事物的看法都已有很大的改變。對於香港醫療的評論，自己已由「偏激」而至取「中庸」之道，這都是由於看多了、聽多了；逐漸能夠體會各方面的限制，作出了不再過份理想化的妥協。另一方面，幹事的工作令我更了解自己的能力和興趣所在，明白自己並不適合做一個「領導者」，未能發動人手去做事，亦只怪當初高估自己的能力和興趣而又低估了這份工作的份量，我深深覺得要做一個好的活動「搞手」，是很需要犧牲大部份的讀書時間，如果不是眞有興趣和能力，又何苦繼續支撐下去呢？不能讀好本份的書，甚至基本的醫學知識也沒有，一個醫學生又甚麼有資格去批評醫療制度呢？？

吳松江



致醫學會評議會之辭職信

敬啟者：

本人決定於八四年三月一日起辭去醫學會外務副主席之職位；辭職原因為：

(一) 上任後兩個多月以來，本人發覺自己極不稱職。雖花了相當時間於出席學生會評議會及幹事會（後期幸得時事秘書衛兆雄同學極力幫助，出席幹事會），以及在籌備醫療時事講座之聯絡講者、整理資料等，唯工作仍一籌莫展。本人對自己任職之能力已完全喪失信心。

(二) 本人在學業上遇到極大困難。本人於二年級第一學期測驗中完全缺席，為 Department 曾於一月初勸諭本人辭職，唯當時本人拒絕，希望能於本學期一挽局勢。唯個多月以來本人在情緒低落、時間不足、以及外務工作的困擾之下，一直也未能有效地讀書；現第一個學期的功課既並未照顧到，而第二學期以來同樣未能有所進展。眼看第二學期測驗將近，對於學業上的前景本人已感到極度的悲觀和近乎絕望。勉強支撐地任職下去，縱使撇開功課不考慮，本人也相信無法在醫學會工作上有所表現。

本人深知此舉乃極不負責任之行為，因此亦不敢企望得到評議員對本人的諒解。在面對沉重的功課壓力、學期測驗缺席而帶來的難以補償的失分、外務工作所花去的時間、以及多個星期以來極度低落的情緒之下，實在已感到無法不作出如此決定。

此致

醫學會評議會

八四年二月十五日

吳松江 謹啟

時事秘書

(一)風起雲湧話八四

對香港來說，一九八四年是多事及令人難忘的一年：一月，的士罷駛，後來更引起黑色星期五的騷亂。二月，立法局首席非官守議員羅保推出羅保動議①，引致左派的筆伐。

四月，賀維訪華後到港公佈英國於一九九七年後將正式完結在香港的管治。

五月初，鍾士元等兩局非官守議員訪英；至此港議員正式認清英國政府的本來面目②亦不再對之存有幻想，更促成六月間部份議員赴京。

同月，鄧小平在電視上駡黃華、耿彪「胡說八道」③；被指爲家長作風，不注重法制。

九月，香港前途聯合聲明草簽，內容公佈，出乎意料的詳盡。同月北京天安門廣場舉行三十五週年國慶激光表演，耗費頗鉅。

十一月，代議制白皮書正式公佈；進一步開放現存的政制。

十二月，前途聯合聲明正式簽署，香港將來的前途遂以中英聯合聲明的形式確定下來。

(二)一國、兩制

香港於十二年後（即一九九七年）的轉變，主要可歸納爲以下兩點：

(a)主治權的轉移

聯合聲明確定了整個香港將於一九九七年七月一日回歸中國大陸。

(b)高度自治的特別行政區

港人將組織自己的政府，中英均沒有官員到來直接管治那時的政府。

(三)民間的呼聲

一月的的士罷駛，復再反映了香港現存諮詢政治的不足；的士司機們對政府政策不滿，卻不能在制度內運用自己的權利，致使他們訴諸罷駛、停車在路上等違法行爲。黑色星期五的暴亂④，更提醒了港府此等不滿所會直接或間接地引起的惡果。

八月底，代議制綠皮書公佈後，八十九個團體⑤於紅磡高山劇場舉行「代議制綠皮書聯席會議」，更聯名簽署要求港府逐步開放政制，於八八年必須在立法局實行部份直接選舉，更要求逐步實行全面直接選舉；至此，要求港府開放政制的呼聲達到一個高峯。

五月，鍾士元等人訪英，提出「港人」「六大焦慮四大建議」時，雖其意見確能反映出部份港人的意見，但無論英國議員及一些學界團體皆質疑其代表性，再次顯示出如果在此十二年間，港府不逐步開放政制，其統治的合法性及權威性將遭到挑戰。

(四)港府的回應——開放政制

的士事件的完結，是以立法局議員答應會於立法局會議上一致否決該項加稅的措施爲結幕的。在是次事件中，值得注意的是立法局議員們首次一改市民對於他們作爲「橡皮圖章」的印象；這雖然反映出一次統治者對民意的尊重，但卻不能改變諮詢政治的本質。

早在五月英議員訪英時，已透露出將七月發表的代議制綠皮書，進一步開放香港的政制。

七月綠皮書公佈，港府擬於八八年開放立法局的議席，實行部份間接選舉及提出功能團體之設以代替一直沿用的全部委任制。

在這裏首先一談港府的一些考慮：

(a)面對中國收回主權這個現實，港府必須在香港實行非殖化的過程。爲了能夠逐步達到香港的高度自治及銜接九七後的轉變，港府必須開放其政制以讓更多市民參與：

I 如果九七年前不能達到眞正的港人自治，九七年前的英人角色將會爲中國方面（可能是不願意的）干預，以及不能銜接中英聯合聲明裏的九七年後「立法機關由選舉產生」的決定。

II 以增加其統治的合法性及權威性。

(b)在開放的過程上，不希望在港之左派或一些草根⑥人士取得過大或具影響性的權力，否則會影響香港的繁榮和穩定；因此：

I 不能立即推行直接選舉。

II 傳言港府嘗試培養出一些較可信賴的接班人，如學者、專業人士等。

十一月公佈的代議制白皮書正符合上述的考慮。

爲了加速非殖化的過程，白皮書公佈之立法局開放程度較原本綠皮書計劃的更大；港府答應提早於八七年檢討政制改革的結果，及於八五年之立法局選舉中實行更大的開放，加大間選及功能團體的席位。

另一方面，間接選舉亦巧妙地減少了左派工會大量動員及佔據立法局議席的機會。

功能團體之設更富創意，中英聯合聲明中訂明立法機關將由選舉產生，而中國方面與英方簽署聯合聲明時

亦相信不會將所謂「功能團體」當作選舉；故此功能團體的議席將不會在九七後的立法機關出現。十一月公佈（當時已獲悉中英聯合聲明內容）的代議制白皮書卻仍計劃於立法局設功能議席，應爲鼓勵專業人士或中產階級將來的參政而作的巧妙安排。

（五）公民意識的提高

在這個民權高漲的時代，在這個政權轉移的前夕，政制逐漸開放已是必然的趨勢。隨之市民的公民意識亦有必要大大的提高。

對於香港未來的主人翁，政府當然特別重視；教署已宣佈將會在中學的課程裏加入公民教育，而最近（一月）首席助理政務司梁仁文亦透露港府將鼓勵中學成立學生會，欲增强中學生對社會的認識等等。

相對於以前在中學校方加諸校內學生組織上的限制，將來應會隨著社會形勢的發展，而有一些較開放的趨勢，反而現在要看的是同學本身的態度了。

（六）學界以至醫學會的發展

十年之前，不論其方向正確與否，學界正在熱烈的從事「放、認、關、爭」的活動，時代不斷進展，一些以前的積極分子亦已「歸隱」了，有的從事娛樂界，有的從事商界，總之各行各業等；只有少部分仍能夠保持著一份關注及參與的熱誠。

到今天，同學間的參與程度有目共睹。

十年之後，又怎樣呢？

而醫學會又應該怎樣發展呢？

在整個外務工作的發展上，最重要的就是考慮社會的形勢；隨著整個社會的公民意識的提高及政治形勢的轉變，同學們亦將會變得較前爲醒覺及關心週遭的事物，再配合香港整個政制的漸趨開放，醫學會應担當一個較爲面向社會的角色；就政府政策的一些不妥善之處，應提出她的意見，尤其就醫療制度這個直接影响到全港市民的問題，醫學會更見其獨特的角色去發展自己的見解。

最後，隨著中英聯合聲明的簽署，新時刻的來臨，對醫學會的路向更應作出反省，就讓我們一起去創造她的未來吧！

衛兆輝

註①該動議原文爲 "The council deems it essential that any decisions on the future of Hong Kong should be debated in the council before any final agreement is made." 此動議被指爲議員欲破壞談判的保密。

②英國國會議員們恐怕鍾士元等人提出的「不應關太平門」的意見令導致香港大量市民移民英國，因此主動質疑議員們等意見的代表性。

③黃華、耿彪就香港將來的對外貿易自主及駐軍的發言，被鄧小平指爲不是中央的意見。

④暴亂據悉不是的士司機所爲，而是一些滋事分子趁機引起的

⑤其實其中有部分團體的成員是身份是重覆的。

⑥他們被稱爲「免費午餐派」。

國際事務秘書

除了與外國醫學生保持良好關係外，今年醫學會的國際事務是包括了兩次比較大型的對外活動，其中一項是在新加坡舉行的亞州醫學生會議，而另外一項，亦都是印象最深刻的，就是在十二月組團前往廣州醫學院參觀。

醫學會是第一次派同學前往廣州醫學院參觀的，而各參觀同學都得益不少。在學術方面，我們有機會了解中國內地的醫療教育制度，和目睹中國的＊三級醫療制，使我們對這兩個發展迅速的制度有了初步的認識。在對外關係方面，這次參觀增進了港穗醫學生的關係，雖然大家生活方式不同，但是却相處得極之融洽。

「我覺得國際事務秘書的工作重點可放於與中國（甚至是台灣）醫學生交流方面，除了是因爲語言、行程和經費上困難比較少外，更重要的是由於我們的關係密切，如果能夠讓香港的醫學生知道多些內地醫學生學習時，及至畢業後行醫時的情況，是非常有利於將來香港回歸時雙方的合作。

「除了中國之外，我覺港大醫學生應該參加多些國際醫學生的活動。例如亞洲醫學生會議和國際醫學生聯會，我相信我們有足夠資源和條件去積極參與。」

「做了一年國際事務秘書，除了認識到一班活躍的同學之外，最有得着的，便是有機會接觸來自各國的醫學生，包括亞洲、歐洲、中國等。始知道原來世界上有着一班和我們一樣抱負的年青人。」

陳俊賢

＊：已撰文於杏雨八四，爲同學報導從化縣的三級醫療制度。

內務副主席

幹事會的內務工作主要分兩大方面，一方面是協調醫學會內各項活動，另一方面是參與校政，而今年的重點是放於後者。今年內務工作已簡單報導於週年工作報告，在此不再敘述。

首先讓我們介紹校政參與的工作，這大致可分爲四方面：

㈠教政參與——在港大裏教政的參與是比較容易爲各方面所接受。師生諮詢會議的主旨在改進教學的質素。而在課程方面，醫學院成立了課程檢討委員會，這委員會亦設有三個學生席位。

㈡學院事務——醫學院內的行政事務主要是由學生院務委員及內務副主席參與。

㈢大學行政——香港大學的行政決定及對全體學生的政策，近一些的例子是新校長遴選。主要是由學生教務委員及內務副主席參與。

㈣學生福利——如文娛中心、飯堂和圖書館等的服務，主要是由福利秘書和醫學院圖書館委員負責。

總括來說校政參與是一項意義重大，但參與價值却備受懷疑；影響深遠却與現時同學關係不大的事務。

學生在校政參與上，着實遇到不少困難。其中一個很大的限制是同學對校方以及行政對有關事情的不甚掌握，以致在提出意見時過分保守。同學反應未如理想也是校政參與的一大障碍，同學的意見就是參與的本錢，沒有他們的支持作爲基礎參與便沒有意義，更無法成功。同學反應冷淡，原因可能是由於……

部份同學認爲校政參與只是形式上的諮詢，沒有實際上的效用，又因爲通常所討論的校政，例如課程檢討，多數與現時被諮詢的同學沒有切身的關係。另一方面，校政參與是極之需要知道同學的傾向和意見的，但在醫學院內搜集同學意見是非常困難的，舉個例說，課程檢討是需要與高年級的同學討論的，但是由於他們功課忙碌，很少能夠作出足夠的反應，而低年級的又沒有足夠的經驗；再加上很多校政的消息是不會太早公開的，到公佈及要搜集同學反應時，却又距離決定時不遠了。

雖然校政參與是有着這麼多的限制，但是自己却認爲來年幹事會內務的重點仍應放於這方面，因爲校政對同學是有着切身的影響（可能並不是現在的同學），但是却沒有很多的學生知道，更談不上能夠和主動參與。

自己個人是不喜歡寫什麼感受的，但現在希望說的，是覺得醫學會活動雖然日益擴大，但同學反應却很是冷淡，執事的同學眞有點不知爲誰工作、爲誰忙的感覺；還有的是，對別人工作的埋怨是沒建設性的，應該經常反省一下自己有否盡本份才對，在困難發生後，我們更應該積極面對，負起責任，不應抱怨他人不把事情弄妥。

趙啓明

常務秘書

在醫學會的憲章內註明，常務的職責是負責文書的工作，處理及管理所有的文件和書信。但幹了這職位一年的我，却覺得這些工作是很難做得好的。

首先，這職位本身不像其他幹事所做的，它缺乏了一個明確的目標，舉個例子，文康秘書要「攪」一個醫學生節，從人手招募及籌備開始，直至節目進行及比賽結束，都是有鮮明的目標與及實質的工作，但常務秘書的工作却是缺乏了以上的要素，我幾乎一踏出醫學會辦公室，便等於沒有工作可做，形同一份刻板式的白領工作，所以工作上的滿足感是很低的。另一方面，理論上，我的工作是包括了紀錄和整理所有有關醫學會的活動，（所有大字報、比賽結果和各幹事的工作等，亦成爲紀錄的對象），但問題却出現了：可能因爲班級或者是「活動範圍」（Habitat）的分別，常務秘書是很難熟知每一個幹事的工作，再加上少了一份工作上的迫切性，將這些工作疏懶了是很難避免的。

如果時光可以倒流，我是很可能不會做這份工作的，（雖然會考慮其他幹事的職位），但這並不表示這個職位是不可爲，這只是表示了它不適合像我一般，連自己的筆記也不能整理好的人！

黃河山

福利秘書

對於某些同學來說，醫學院所提供的福利服務，就只是令他們可以方便買到文件夾或螢光筆等文具，其實，小至圖書館的報章雜誌，大至文娛中心的行政決定，福利秘書都是有機會參與決策時的討論；而其它一些活動或事件，例如捐血和爭取校巴，都是屬於福利秘書的職責範圍。

而今年自己的工作，除了保持經常性福利服務外（例如賣文具和汽水），主要是集中於學校福利的行政參與，而這方面的工作，主要是通過校方的 Committee of Student Amenities，這兩年來，醫學會的福利秘書都有機會出席這個委員會，而它的職務主要是大學的兩間飯堂和文娛中心的行政方針和作出決策，自己在會內盡量反映同學的意見，希望爲大家爭取多些權益；另一方面，能夠和有關人士打好關係，加强溝通，例如Catering Officer 張準先生，對於日後與他們磋商有關福利事議時，亦有事半功倍的好處。

今屆幹事會由於上庄比較忽忙，再加上選舉時又因爲選票沒有蓋印，而令上庄日期一再延遲，結果在第一個學期時，缺乏了對工作方針和計劃的足夠討論，令到第二個學期這個籌辦活動的黃金時間內，幹事會不能籌辦一些比較重要的活動；再加上外務副主席的辭職，外務工作更出現「羣龍無首」的情況。總括來說，今年各幹事都是集中於自己份內的工作而很少互相合作，在缺乏高班幹事的精神領導下，各幹事的士氣在相當程度上是打了折扣的。

無可否認，醫學會的活動和規模都實在太多和太大了，而且還有逐年擴大的趨勢，很自然地人手便出現問題，就以今年爲例，部份幹事要兼顧一些非常性委員會（Ad Hoc Committee）的工作。儘管如此，這却又是無可奈何的，因爲將一些傳統活動削減，一定會導致部份同學的不滿，但「攪」活動的同學又多，希望有所創新而增添了活動數量。

如果讓我再選擇，我是肯定會當上福利秘書的。雖然有些工作頗令人有些沮喪，例如經年要求而仍不得更換的宿舍洗衣機，但是自己却很高興能參與Committee of Student Amenities 的行政討論，一方面自己覺得可以爲同學作更高層次的權益爭取，另一方面，校政參與和其中的討論亦是自己的興趣；通過討論（無論是上述委員會、學生評議會或甚至是幹事會內部的討論），自己的思考能力是着實得很好的訓練。

趙朗峯

文康秘書

理論上，醫學會的文康秘書是要爲各年級的會員提供舒暢身心的文娛康樂活動，但是高年級同學參與程度偏低却是不爭的事實。當然，一個很明顯的因素是他們功課繁重，但是亦可能由於他們已經參與過這些文康活動，而導致興趣減弱。所以，通常只是一年級的文康秘書，是應該嘗試跳出傳統的框框，籌辦一些比較有新意的活動，再加上多些諮詢各班同學和作好事先宣傳，便或可以盡量照顧到多些同學的需要。雖然自己今年在這方面幹得不足夠，但亦期望來年文康秘書能夠對此多些關注。

做了一年文康秘書的我，深感 Sociability 的重要性，因爲統籌文康活動，不但要有足夠的人手和充份的合作，更要與參加者熟絡，否則，即使做得死去活來，亦未必能夠做得令人滿意。另一方面，自己今年並沒有爲同學帶來一些大學本部或甚至是學校以外文康活動的消息，例如是電影或是演唱會，我相信對於忙碌於書本間的醫學生來說，是很有建設性的。

就在收筆的時候，杏雨老總硬要我寫感受，如果我說沒有感受就只是騙人的，但「有趣」的是，自己心裡的感受却是講不出，寫不出的啊！

何美華

財務秘書

重哼起那舊調：Reach out your neighbour, let him know you really care, reach out ! reach out!

決定「上」時，好朋友勸道：Medic 裏什麼都可以攪，就是千萬別做 EXCO。

一年過了，平平淡淡，沒有「九龍灣」，沒有「戴信」，連所有人都拭目以待的九月草議公佈，Medic 都是靜俏俏的。各人忙着各人的事，我又算不算交到幾個「好朋友」？

如今落庄了，又想做迎新。那勸我千萬別上 EXCO 的朋友又說：「那大概是因爲你太 insecure 吧。」

人生在世，如果沒有朋友，誰不感到insecure ？即使知交滿天下了，各人卻有各人的事忙着。一個、兩個冷冷清清獨對滿案叢書的晚上，誰又從未曾感到過忽然無端的惆悵？——

那些時候，我遂只有說，畢竟我有過一班朋友，儘管各人已有各人忙着的事，仍相信這班朋友裏任誰一個有難，旁的都不會袖手，那就算是這一年EXCO生涯，沒白過了。

郭文偉

體育秘書

體育秘書最主要的工作是安排參加院際運動比賽和籌辦院內的班際運動比賽。就前者而言，因爲這個比賽開始於十月，而要直到下一年三月才結束，於是便橫跨了兩庄的工作年度，亦即是說，每一屆體育秘書都是很難熟知及控制整個院際比賽的局面，因此，一年與一年之間的經驗傳遞更形重要了。而班際比賽方面，對於一個院會來說，規模是實在太大了，但爲了要照顧多些同學的需要及作爲院際比賽的培訓，縮減却是不甚可能的。

「其他工作包括了出席體育聯會的評議會，但由於地理上的隔離而致聯絡經常很差，今年更很遺憾地得到一次vote of censure。另外亦舉辦了一些非定期性的體育節目。

總括來說，體育秘書的工作可說是非常間歇性的。當上述兩項重要比賽進行時，雖然有兩個體育秘書來分担工作，仍感人手不足，亦要有賴各隊長的幫助才能使比賽順利進行；但當比賽結束或暫停進行時，例如在暑假，我們却又清閒得很。

最後，反觀現在的體育項目，都是爲一些水準比較高的同學提供「服務」，但其實院內亦有很多同學很喜歡運動的，只因未達到比賽的水準，致不能參與院際及班際比賽，我們希望將來的體育秘書可以將體育中心的消息（如訓練班日期及借用方法等等）帶回醫學院，使同學們更能善用大學的設施，有適量的運動來舒展身心了。

體育秘書的工作是苦樂參半的。安排比賽、賽前通知、宣傳及臨場觀賽等都是頗花時間及沒有變化的工作，而且很多時候我們都要默默地工作而沒有人察覺的，更談不上欣賞的份兒。有時候是有點失落的，體育秘書難道只是兩名「勞工」。

「樂」的一方面，我們可以透過工作來認識不同年級的同學，這是一點收獲。而經過一年的工作，對醫學會是多了一分歸屬感，自己亦找到了一個身份（Identity），這感覺在觀看比賽中尤爲强烈。可能一份歸屬感和一個身份是一些不實在的東西，但它帶給我們的是喜悅以及美麗的回憶。

姜建鈞

歐陽錦全

啟思

(1)「第一次約會」

許多人都認爲實習醫生制度是不完善的。「從醫學生到醫生」這個專題，特地搜集了各方面的意見，其中並包括實習醫生本身的親身感受。校園版以醫學生拍拖爲專題；還有訪問吳定夷醫生、黃德明博士，中山醫學院，一天遊感想、訪問實驗動物中心……

(2)第二期

「難得來時瀟灑、去亦從容」，是介紹聖母醫院所提供的善終服務。校園版則談及護士學生的生活；其他有學生節八三，有關法醫官的「蛛絲馬跡」、「濃霧中的牙科學生」等等。

(3)「衝刺」

「急症室的暗病」，主要提出了濫用急症室的情況：「圖書館行旅」介紹了所有大學本部的圖書館；「奧運在沙宣道」是整年醫學院內體育比賽的總結；其他還有「滿江紅」、「誰在飢饉」、「前途宣言後記」……

(4)「縱橫經緯——天南地北話旅遊」

「醫療九七、九七醫療」這個專題，是藉着中英草簽聯合聲明這個機會，訪問了黃麗松校長、楊紫芝教授及另外兩位醫生，有關他們對香港前途的看法：「天南地北」是各位同學暑假到外地的遊踪；還有「MEDIC華大俠」、「電影籌款八四」、「別了安達臣」……

(5)「曲子已奏過，若你聽過……」

「醫學生看九七」是承接上一期的，透過問卷、街訪及討論，搜集港大及中大醫學生對九七的看法；校園版則以黃麗松校長辭職及新校長人選的問題爲專題；其他內容有醫學生節八四、「我們的心和肺」、「加風在沙宣」……」

一年的任期過了，也應好好總結一下一年來的工作。

要我衡量啟思的成敗得失，除了報紙的質素外，還得從編委會的團結及合作性着眼。

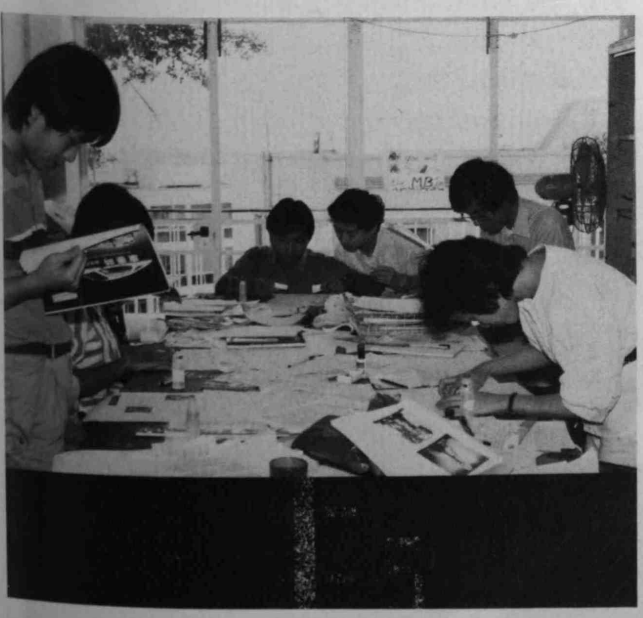
大體來說，啟思的內容，大致是循着我們在年初計劃的路線走；而我亦相信啟思有它醫學生報紙的獨特性，最低限度，大家拿起啟思會比拿起運旋或其他院系的報紙來得親切罷！在表達手法、版面設計、包製及標題命名各方面，我們也下過不少功夫，未知各位讀者有否留意？

專題版的着眼點，主要是放在醫療問題上；我們相信醫學生會較容易掌握及了解這些資料，而且這些也是大家應知多一點點的。不過，部份專題似乎太過資料性了，乏缺了一些討論及分析；時間迫促是一個主要原因，許多時，資料剛搜集好，已經差不多是截稿的時間了。

這幾年來，啟思和同學都只有單向的聯繫，很少同學會願意主動給啟思一點意見、一點批評。有見及此，我們便趁着九七這個話題，透過街訪及問卷，主動地接觸同學，這對啟思編委及被訪同學來說，也不失爲一個有趣的經驗罷！

至於校園版，不單篇幅比以前多了，內容也不再局限於沙宣道所發生的事，我們把觸覺伸展到整所大學一上至黃麗松校長辭職，下至紐魯詩樓失火，我們都搶先報告，使校園版更加名乎其實。除了校聞之外，我們也嘗試發掘一些大家身邊的小環節，除了表達手法出現了問題外，一般的反應也不俗。

三版之中，似乎只有綜藝版是停滯不前，個人甚至覺得有點倒退的現象。雖然問題不致嚴重到稿件不足，但主動投稿的同學畢竟很少，而且老是那幾位常客。其實自己也應負上多少責任，沒有把截稿日期公佈，也沒



有好好地宣傳一番；但假如我做了的話，會有分別嗎？我眞的懷疑。

今年的啟思房的型式也改變了。每期啟思房由不同的編委執筆，好讓各位同學透過文章，對啟思編委會及其成員有更深的認識。

× × ×

今年一夥兒工作的編委雖然不多，但大部份都能夠貫切始終，十分投入地工作，特地在這裏感謝各位編委，在過去一年付出了許多精神和時間。

的確，出版一期啟思，需要個多月的時間，四出訪問、搜集資料，繼而討論、寫稿、校對及貼版，眞是忙個不可開交。雖然工作程序頗爲公式化，但看到了新啟思面世，那種喜悅，卻非其他人可以體會得到。編委們拿着新啟思，由頭到尾翻一次，倒過來又翻一次，「這一版字太密了。」「這期專題太過資料性了。」「這一版如果有個漫畫會好看得多。」大家互相批評、砥勵一番後，又是充滿信心，開始下一期的工作，大家都在想：「下一期的水準一定要比今期高。」

自己從一年級開 始已是啟思人了。你若問我是否白白的把時間浪費在出版啟思，答案是否定的。一年級加入啟思，我認識了幾位「親密戰友」，又認識了一些關心師弟的啟思老柴；到了二年級，認識了一大羣充滿生氣的師弟師妹。

我慶幸我是啟思人！

啟思總編輯　吳兆强

健委

又是在最後一刻，才有人願意出來做健委。記得上年我是偶然，又可能是一時衝動，竟做了健委委員。鄭老總叫做寫一篇關於健委工作的回顧和展望，我覺得眞是一件很困難的事，我自知是一個不擅於寫文章的人。但理論上，不論是短是長，文總是要寫一些吧。

回顧過去一年的工作，我發覺和政綱所寫的是頗有出入。記得最初滿懷希望，以爲可以做到一些事出來，又爲着要給評議會一個好印象，所以把政綱寫得滿滿的，自己都相當滿意，開始時做得都算落力，到後來卻……。

關於健委的工作，我覺得一年與一年之間總是沒有多大的延續性。就好像起大廈一樣，每層都要自己起一座，所以一直都起得不太高。但如果上一屆只盡力起好地基，而下一屆才一層層的起上去，一定會更穩，更高的。我希望今年健委能全力做好一兩項活動和不要急於見到成果。能爲下一屆打好基礎已是很大的成果。

關於往年的健委工作，大致可分四類：

一、在推廣健康教育方面，我們和一些私人團體舉辦過一些健康常識的展覽，最大型要算和灣仔區議會，政務處和灣仔區內一些私人團體合辦的「灣仔健康週」了。

二、一些比較直接的服務——健康檢查，包括量血壓，驗尿糖等。

三、令同學認識醫療結構和制度，往年舉辦了和理工學院的醫療系訪問。

四、出健委通訊。

整體來看，往年的活動是比較被動，多數是外間的團體邀請醫學會協辦一些活動。另外，多數的活動，由於缺乏較高班的同學幫助，遇到不少困難。例如：在健康檢查時，市民會向同學問及一些醫學的問題，低班的同學往往不能作答，由於他們還未上臨床的科目。這也部份反映了醫學生和普通市民互相了解不夠，所以雙方的期望往往有所分歧。

關於探討醫療問題方面，由於往年幹事會成立了一個專責的醫療問題小組，所以健委會沒有做這方面的工作。但關於醫療制度的探討，我想是值得認眞的做一下。面對九七的轉變，除了香港本身的醫療制度外，中國大陸方面的醫療制度也是值得探討。

八五的健委政綱裏提到和一些社區一起舉辦健康教育的活動，我在政綱也有提過，可惜上年未能做到。我希望今年健委能看重這個計劃，把它做好。在未來的一年把這活動打好基礎，讓以後的健委把它發展，我想一定會成功的。在這活動裏，健委能夠處於主動的位置，健委應主動聯絡各社區的團體以建立起一個聯繫。這計劃能令健康教育的推廣更加廣泛，也能令醫學會的有限資源（人力及物力）發揮更有效的能力。因爲社區內的團體能供應部份的人力和物力，使醫學會的同學能把時間放於自己所長的工作方面，例如：展覽方面，醫學會主要負責資料的搜集和整理，其它方面可交由各社區做。

關於健委通訊方面，最後只出得一期，（原本預算出兩期），主要原因是缺乏足夠資料，另一方面，通訊的預算已佔了健委財政預算的三份二。有一值得考慮的意見是——由啓思闢出一角來給健委，以代替原本的通訊。

最後，我有一個提議給將來的健委，就是成立一個完整，有系統的資料庫，以方便將來健委活動的進行。

健委八四委員　馬德强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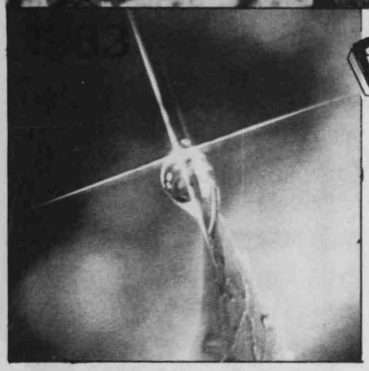


DEC

7

GENERAL POLLING

It's your responsibility

15

1ST COUNCIL MEETING

4TH MBBS EXAM

28

MEDIC CHRISTMAS PARTY

at Lok Yew Hall

1984

JAN

INTERYEAR ATHLETIC MEET

28

30

LUNAR NEW YEAR SOCIAL ACTIVITIES

FEB

1 – 16

CHINA FORTNIGHT

9 GENERAL POLLING FOR

- SENATES STUDENT REPRESENTATIVE
- FACULTY BOARD STUDENT REPRESENTATIVE

13 – 22 LAI CHING LUNG SHIELD CHINESE DEBATE COMPETITION

22 – 30

UNION FESTIVAL

27

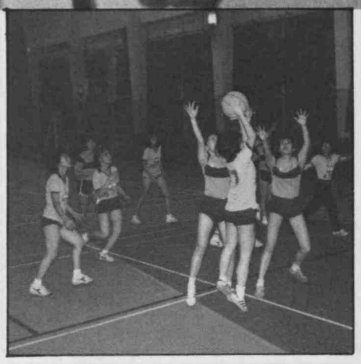
SECOND COUNCIL MEETING

MAR 1, 2

UNION FESTIVAL (CONTINUED)

APR 5 – 30

INTER-YEAR SPORTS COMPETITION



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FELICE LIEH-MAK SHIELD CURRENT AFFAIRS QUIZ

26

3RD COUNCIL MEETING

29

BLOOD DONATION DAY

30

PRESENTATION DAY

FINAL MBBS

MAY 7 – 10

FAMINE 900 FUND RAISING CAMPAIGN

- Exhibition
- Slide show
- Selling of "bread of love"
- Famine 900
-

JUN

1st, 2nd, 3rd MBBS EXAM

JUL 5

FIRST EMERGENCY COUNCIL MEETING

AUG

ORIENTATION 84

20 – 22
Tutor Camp (Old Hall)

24
WELCOME DAY FOR MEDIC '89 FRESHMEN

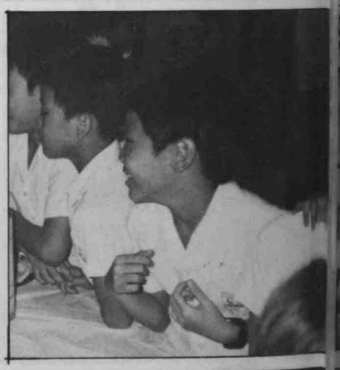
29 – 31 ORIENTATION CAMP 84 - [illegible]

SEP

1 Old books sale

1st edition !
1000 !
nth hands !?

14 – 16
HEALTH EXHIBITION "KNOW YOUR HEART AND LUNG"
at City Hall.



20
4TH COUNCIL MEETING

21 – 23
HEALTH EXHIBITION "KNOW YOUR HEART AND LUNG"
at Tsuen Wan Town Hall

21 – 26
ISSUE OF HONG KONG FUTURE EXHIBITION
by C.A.S.
in student lounge.

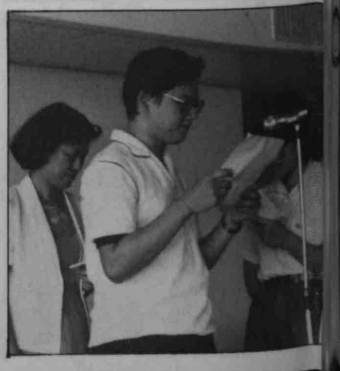
29 MATRICULANT'S DAY
in underground lecture theatre.

COMMENCEMENT OF NEW ACADEMIC YEAR

ACADEMIC ORIENTATION
in Fong Shu Chuen Amenities Centre

☑ Medic ☐ Law ☐ Engine
☐ Science ☐ Social ☐ Dental
☐ Archi. ☐ Arts

21/9 – 5/10
ORIENTATION [illegible]
FORTNIGHT



OCT 13
INTERYEAR
ATHLETIC MEET

20 INTERFAC.
AQUATIC MEET

22
2ND EMERGENCY
COUNCIL MEETING

30 – 31
5TH COUNCIL
MEETING

22 – 31
MEDIC FESTIVAL 84

NOV 1 MEDIC NITE

1 BLOOD DONATION
DAY

10 INTER FACULTY
ATHLETIC MEET
(heat)

15 6TH COUNCIL
MEETING
(last council)

17 INTER FACULTY
ATHLETIC MEET
(final)

21 ANNUAL
GENERAL
MEETING
(1st session)

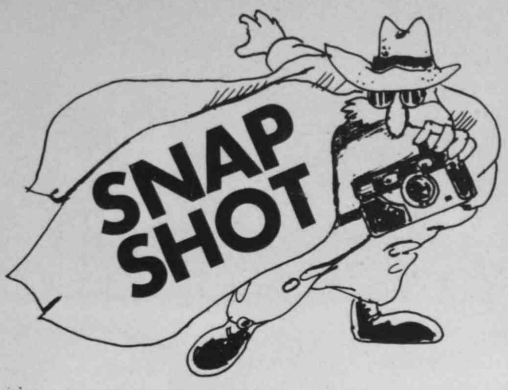
26 AGM
(2nd session)

27

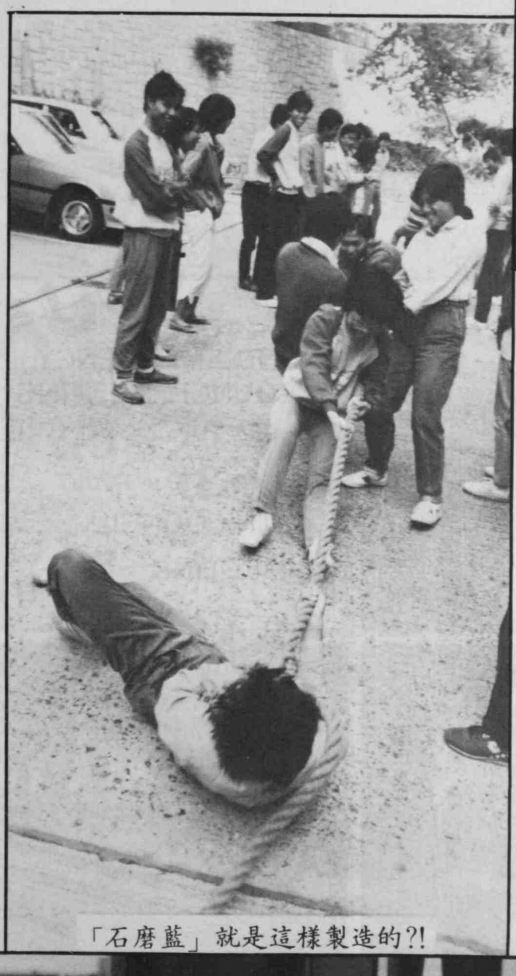
DEC
TIAL

4TH MBBS EXAM.

19 MEDIC CHRISTMAS PARTY

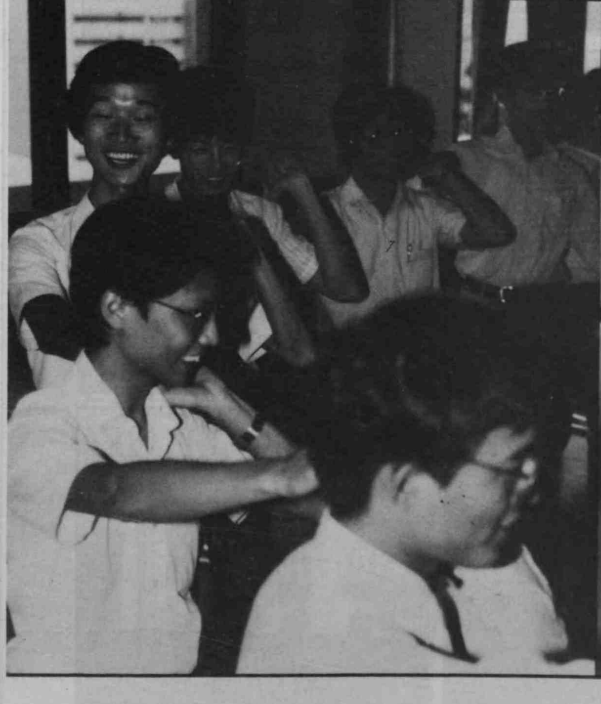


那裏來了三個小矮人？



「石磨藍」就是這樣製造的?!

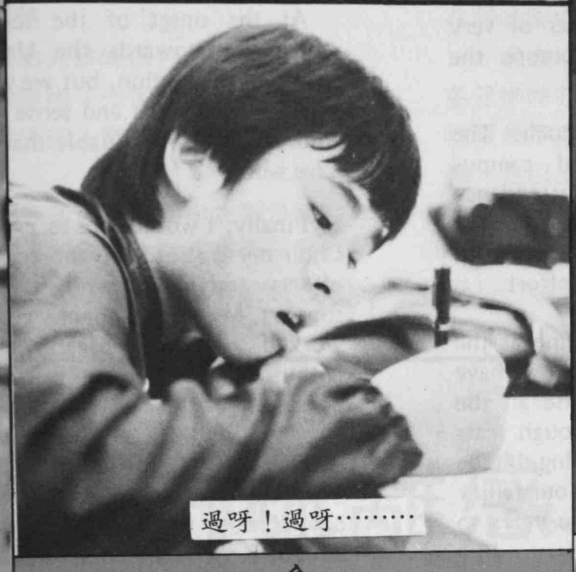
接着下來……哎喲，忘記了！



據說：衣服越少，喊Cheer的聲量越大，所以……

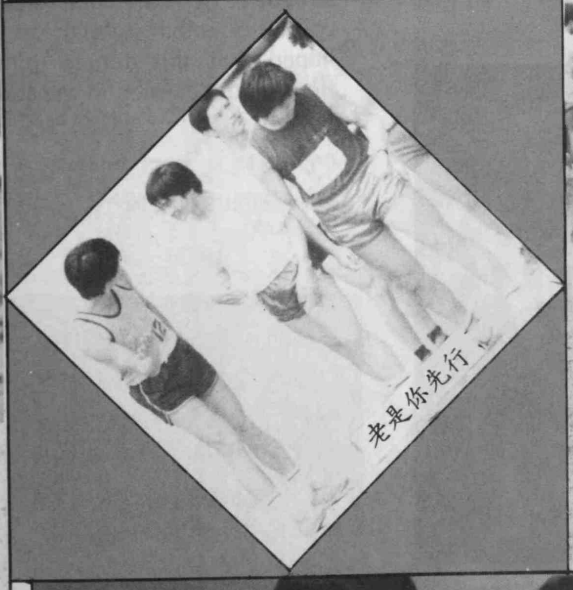
DEPARTMENT
OF ANATOMY?

DURING A
FULL-UP VIVA!



過呀！過呀……

邊個話我傻？



走先你先行

喂，你而家隻手係邊一種 Motion ？

「捉蟲？」

Medic Choir

The year 1983-84 has been a very remarkable year for the Medic Choir. A new committee for the administration of the Choir has been established for the first time. It was composed of a number of very enthusiastic members, who helped to promote the activities of the choir.

This year, our choir has expanded much. The attendance problem has always be-devilled campus choirs, but we are very proud to say that our attendance was constantly around 40-50 members each time – a very impressive number. I wish to take this opportunity to thank all our faithful members for their time & effort.

The choir rehearses every Tuesday lunchtime at the Pauline Chan music room. Owing to the fact that we have so many choir members, we have to mobilise all the tea-trolleys in the whole building to make enough seats for everybody. I personally find this very touching. I hope that this enthusiasm for the choir displayed by our fellow students will continue, if not increase, in the years to come.

Last year was a busy year for the choir. Our schedule began with the orientation performance in September. This showed to our new students that we did more than just study. In October, we took part in the Medic Festival. In November, we were invited to perform at the Dental Festival. The month of December was a special one. We had our first Annual Concert in the Student Lounge. Apart from our performance, we also invited the various class choirs to participate. I must confess that this is quite a challenging experience, but I think that it is a worthwhile event because it serves to promote musical activities within the faculty.

We celebrated our Christmas day with a carolling expedition to the Paediatric Department of the Queen Mary's Hospital. Apart from our professional skills, we could also bring joy and laughter to the patients. After all, "laughter is the best medicine." About 40 people were involved in the event.

At the onset of the second term, we began our preparation towards the Union Festival. We did not emerge as champion, but we were proud to have nurtured a very strong spirit and sense of belonging to our faculty. And this is more valuable than any prize which we could have won.

Finally, I would like to extend on behalf of the Medic Choir my gratitude to those who have contributed to our efforts and those who have given us their spiritual support. My special thanks go to the committee who has worked so hard in organizing the activities and all the enthusiastic members of our choir, who came to support us in spite of their heavy school work.

The Medic Choir has become more mature in this year. The members possess a quality of having initiative, cooperation, punctuality and a sense of belonging. The structure of our choir has already changed from a contest-oriented style to an interest-oriented one. It is hoped that this unique spirit of the Medic Choir will flourish and develop in the coming year.

The Conductor
Medic Choir (83-84)
Eric Chan Yan Kwong

Medic Choir Committee (1983-84)

Chairman: Chow Shun Ming, Simon (87)
Vice-Chairman: Poon Kin Hung (87)
Pianist: Chan Ka Lin, Irene (88)
Treasury: Chu Sai Man (88)
Coordinator: Lam Woon Yee, Polly (86)
Fung Ka Shun, Samuel (87)
Chu Chung Ming (87)
Lee King Chung (88)
Part Leaders: Lee Chee Ting, Julietta (87)
Lee Big Kau, Judy (87)
Fung Ka Shun, Samuel (87)
Chan Hing Sing (87)
Conductor: Chan Yan Kwong, Eric (87)

基督徒團契

基督徒佔醫學生總人數逾四分之一，因此，我們除團契外，也有門徒訓練的工作，以滿足不同的需要。這裏和大家談談團契的事情。

去年團契的目標是擴闊弟兄姊妹信仰的認識和對團契之投入意識。我們爲此共舉辦了七個祉會，第一學期佔其中的五個。初時每次參予的人數有二十多人，其後漸漸減少。

此外，我們在十一月間亦舉行了一連串之福音活動，信主的人數亦不少，在五月的畢業生歡送會中，我們在洋溢着弟兄姊妹的愛中，分享了畢業的寶貴經驗和他們對團契發展的一些看法。

在整個醫學院一起的祉會外，我們各班還有班團契或細胞小組。它們主要是爲了聯絡及推動每班的基督徒在神的愛中成長。

過去一年團契還未能清楚找到其在醫學院的角色；弟兄姊妹亦很難撥出時間參予，特別是在醫學院中還有性質差不多的工作在進行。因此，我們雖然有很好的動機，在以上種種原因和缺乏對信仰有深入反省的弟兄姊妹帶領下，團契的工作實在不太好。

未來的團契，我想是必須繼續摸索一條結合信仰和學科的路徑，這樣，我們才能更好地建立弟兄姊妹。■

醫學院裡的疏離感

● 人

前言：

我是醫學院二年班的同學。回想起過去一年在醫學院的學習和生活，令我留下最深刻的一個感受，要算是醫學院裏的「疏離感」（ Alienation ）——人與自我的疏離，人與人的疏離。「疏離感」不單是我的問題，而是每一個同學的問題。

甚麼是「疏離感」？

「疏離感」（ Alienation ）這個名詞，最先出現於黑格爾（ Hegll ）和馬克思（ Marx ）的著作中。他們處身於歐洲之工業革命時代（ division of labour ），深深看到工業革命帶給了工人很多問題。那時，工業走上了大量生產（ Mass production ）的路線，以分工（ division of labour ）的形式來生產。在這種生產過程中，工人失去了創造力，每天只是重複着一個被規定的動作。勞動再不是人的權利，而成爲最卑微的商品而出賣給資本家。這樣人便與自我疏離，因人的自我是有創造力的，但如今所活出來的，卻是只爲賺取不合理工資的一個假我。這就是馬克思的所謂「疏離感」。

繼馬克思後，近代有很多心理學家和社會學家，繼續研究「疏離感」的問題。最出色的要算是弗洛母（ Erich Fromm ）。弗洛母對「疏離感」，比馬克思有更新的觀念，「疏離感」再也不是工人階級的現象，資本家也同樣有這個問題。換言之，「疏離感」是現今整個人類社會的現象。

「疏離感」是整個社會結構和生活節奏的產物。目前整個人類社會結構和生活節奏，是以經濟利益爲大前提，人生存在的意義並不只是爲了經濟利益和物質享受，人不是受慾念主宰的動物，人生存有其更高更美的追求。但在生存在現今社會中，無奈要屈服於社會的洪流，難以避免受到社會化（ Socialisation ）。人失去了生存的更高追求，人再也不是人，只是用來售賣掏利的貨品。結果人與自我越來越隔絕，因爲那個自我是一個眞正的人，一個有更高更美的追求者。人所活出來的，只是假我（ Pseudo-self ），假我是社會化後，融合社會經濟利益的一個行爲表現。

人類不單是自我疏離，人與人之間也是疏離，因爲在現今社會結構下，人格降價，人再也不被當作人，人被當作可牟利的有血有氣的機器，人際關係只是機器的關係。

總括來說，人類自己建立了現今的社會結構，但卻成爲社會結構的奴隸，不能把眞我表現出來。這就是現今人類的「疏離感」。

醫學院的「疏離感」

從以上，我們可知道「疏離感」是「社會化」（ Socialisation ）的後果，「社會化」使人放棄自我以遷就整體經濟利益。換言之，當人跟隨週圍風氣而生活，但已不思想和反醒這種生活是否合乎或能發揮其自我的天性，他就已經和自我有了隔絕。在醫學院裏「社會化」的過程繼續進行。醫學院有其獨特的風氣和文化，這個文化對每一個同學都產生了熏化作用。醫學最顯著的風氣，要算是「攪」活動的風氣。你「攪」他也「攪」，一窩風兒人人都「攪」，於是大型、中型和小型的活動也隨之出現。幾乎每一個醫學生，一年內至少也曾參予過一個活動的籌辦，姑勿論他擔當的職位是大是小。而事實上，我曾遇見有一些同學，入到醫學院後，擔當了很多活動的籌辦，上了幾個「莊」，結果有百務纏身

，又要應付讀書，最後累得自己叫苦連天。但當我問他們從活動中得了些甚麼，他們竟答不出甚麼來；也有一些同學，在中學已是很積極地參予課外活動，入了醫學院後也是慣性地投入和參予，也有一些同學，在中學時不太多參予課外活動，入了大學便想嘗試「攪」活動，因爲不「攪」活動就不像一個大學生，又怕人把自己稱爲「潛水艇」，被同學「疼」死。由此可見很多同學「攪」活動，只是盲目跟風而已，看來有點糊里糊塗。但令人吃驚的是，他們在某些活動裏所付出的時間和精神極等浩大，但卻都是糊里糊塗地「攪」，不明白自己這樣做是爲了甚麼。但他們總不會承認自己是糊里糊塗，他們總會爲自己解釋說：「可透過這些活動，服務他人，這不是很有意義嗎？」但這解釋是否合乎事實呢？據我觀察，事實往往不然，健委的活動正是好例子。「健委康員會」經常舉辦身體檢查，其原本目的是服務大衆人羣，在頭幾次這類活動中，健委成員都很積極參予，因爲可以實習量血壓，正所謂熟能生巧，何樂而不爲，但當這類形活動經常地舉辦，同學漸漸厭倦了這種服務人羣的玩意，同學再也不如以往那麼積極參予了。

莫以爲我是反對任何課外活動的，事實上一些課外活動，如健委的身體檢查，確是頗有意義。我只是爲一些同學糊里糊塗地「攪」活動而可惜。現在，醫學院人人都「攪」，「攪」到天翻地覆，個個都忙過不停，於是出現了籌備好的活動無人參予的現象，累得籌委到處找人，甚至懇求人參予，也曾出現過有活動而無人出來「攪」，累得負責人到處找人幫手。醫學生便如此忙過不停，但有誰知道那麼忙是爲了甚麼呢？

以上所說的，都是醫學生的普通現象，當然並不是所有的醫學都是糊里糊塗的。但從以上我們可知大多數醫學生也是隨波逐流的一羣，缺少生活反醒。

醫學生不單受到大學文化所需求，更受到香港社會的風氣所感染。目前香港社會的結構，是建基於功利主義之上。在香港人的價值觀裏，最重要的是錢。物質主義（Materialistic），享樂主意便大行其道。甚麼「有酒今朝醉」，甚麼「想做就去做」，就成爲大衆市民的人生觀。但想深一層，他們「想做就去做」的「想」；是否眞的是眞正自己的想或意願了，這個「想」事實上卻只是假我的「想」，「社會化」（Socialisation）把他們的眞我變成假我（Pseudo-self）。生存在香港社會裏，人也迷失了眞我。眞我在人的內心裏被綑綁了，人不是眞正的自由人。弗洛母（Erich Fromm）對生存在現今功利主義社會下的人羣，有以下的看法：「人在自由民主社會裏，以爲自己有自由，但他們的自由只是被動自由（Passive freedom），因爲人類不能完全自由地選擇，只是在社會意識形態的規範下作其選擇，唯有人把眞我尋回，超越社會潮流的限際，才是眞正的自由。」弗洛母正說明現代人怎樣和自我疏離。

一羣隨波逐流的醫學生，生存在功利主義的香港，難免受其意識形態所熏陶，漸漸迷失自我，與自我極度疏離。

在醫學院裏，人與人也是疏離。有不少友誼的建立，是基於一種安全感，或也因爲以後可以彼此幫忙（其實可能是互相利用）。我也不會否認同學也有眞摯之情，但我對這並不樂觀，因爲他們老是隨波逐流。假若世界叫他放棄友情，他們必會遵從世界。高年級的同學，在此可能頗有同感，因爲病房常常會出現一些eager 佬，不顧公義，影響其他同學的學習。

總而言之，在醫學生中，同樣也有「疏離感」的問題——人與自我的疏離，人與人的疏離。

我怎樣面對「疏離感」？

當我發覺自己同樣也有「疏離感」的問題，我也與自我隔絕，我便嘗試解決這問題，找回我的眞我。

「存在主義」（existentialism）給我很大的啟發。「存在主義」興起於十九世紀末，它提倡找回存在的價值。人的存在價值，就是能尋回眞我，成爲「眞人」。生存在文明社會，人變成了「非眞人」。爲了成爲「眞人」，人要靠意志去選擇他的行爲，不停地自我超越，直致拾回眞我。但怎樣去認知眞我呢？認知眞我的方法是「直觀」，而不是感覺和概念，因感覺和概念都曾在「社會化」（Socialisation）的過程中扭曲了。但甚麼是「直觀」呢？「直觀」乃是整個人與整個實體的直接對合或直接感應。「存在主意」往往都是那麼抽象，那麼虛無漂渺。單是「直觀」這名詞已令人摸不着頭緒。每當看到不同存在主義者靠着他們之所以爲的「直觀」，而建立出來的一套人生觀和存在的方向，有着頗大的不同時，眞令人懷疑「存在主義」裏的所謂「直觀」，是否眞的使人重拾眞我。有些存在主義者所鼓吹的，是一種極强反社會和反世界的行爲，例如尼采（Nietzche）的哲學思想，深深影響了德國的納粹黨，以致發生了第二次世界大戰。這也使人對存在主義失卻了信心。而且存在主義使人成爲了孤島，和別人極度隔絕。對存在主義我最後的結論，是存在主義嘗試面對和解決「疏離感」的問題，但卻未能眞正導人尋回自我。

後來當我翻開聖經，終於仿然大晤。「神是照自己的形象造人，乃是照自己的形象造男造女。」（創：1：27）「因爲世人都犯了罪，虧欠了神的榮耀」（羅3：23）

我終於明白了，我要尋回的眞我，是有神的形象的自我。因爲罪的原因我便失卻了這個尊貴的形象。但神的形象是怎樣呢？

「沒有愛心的，就不認識神，因爲神就是愛。」

約・一4：8）

原來神的形象就是愛，我的眞我也是充滿愛的眞我。在功利主義的香港，我漸漸和這個充滿愛的眞我疏離，對於物質和享樂的追求，比對於愛的追求還大。遺留在心中的愛也是狹窄的，自私的。

從聖經，我認識了「疏離感」是罪的後果，因此，我也認識了我是罪人。我也深信，人靠着自己，永遠不能擺脫罪的綑綁，正如孔子也有云：「聖人都有錯」。但罪的後果乃是滅亡，因爲聖經這樣說：「罪的工價仍是死。」（羅・6：23）但耶穌的臨到世上，帶給了我們喜訊：「祂被掛在木頭上親身擔當了我們的罪，使我們既在罪上死，就得以在義上活。因祂受的鞭傷，你們便得了醫治。」（彼前・2：24）祂爲你我每個人的罪死在十字架上，用寶血洗淨我們一切的罪行，並且從死裏復活，賜我們勝過罪性、認識神、得着神、享受神的新生命。」

結論

在醫學院裏的這一年，我終於認識了神，從而我也找到人生方向和意義。我的人生方向，乃是要活出眞我——充滿愛的眞我。我要超越社會意識形態對我的影響，我決心不爲名利而生活，因爲這不是眞我所意願的生活方式。■

八四年十月

KATSO

「細胞小組」——個令人摸不着頭腦的名詞。這個名字的來由我不知道，但卻欽佩首先起用它的人。它代表着一班願意携手步於信仰旅程的人。裏面的每一個就是細胞的一個 Organelle，缺乏一個也影響到整個細胞的生存。

初時加入天主教同學的「細胞小組」眞感失望，經常出現的也不過那寥寥的十數人，整個醫學院七百五十人就只得這一小撮的天主教徒嗎？我不禁懷疑這細胞的生命力，起初甚至不敢承認自己是屬於它的。

經過一年的開Cell，在各師兄的「英明領導」下，我確感受益良多，他們對信仰的那份熱忱使我慚愧不堪。我們定了每星期一次聚會，整個Cell再分爲二，每個Sub-cell 都有一至四年級的同學參與，形式包括查經，信仰和生活分享等。除此之外，今年暑假更邀得一位神父每月一次與我們討論一些有關「醫學倫理」的問題，間中亦會一起去參與一些公開講座，而當然我們也會與整個 HKU 的KATSO保持緊密的聯繫。

但維持着這個細胞生存的不僅於每星期那個多鐘頭的相聚，而是在於生活的每一環節。有時在飯堂碰到一起吃飯，聊聊天，再找人請吃雪糕，其中的樂趣是不可言喻的。尤記得去年的團年飯，由五年級的「長者」帶領我們大踏步的由蒲飛路「操」到西環的「潮順記」飽餐一頓，再加上「長者」的一番「訓導」，使我們的新年更添色彩。

在這一個Cell裏，除了信仰的支持，我找到摯誠的友誼和親切的關懷，這個團體已成了我生活的一部份。

當八九的師弟妹進入醫學院時，我很希望能把我所得到的與他們分享。當然「傳統」的開Cell是不可或缺的，但我們亦嘗多些其他的活動，例如燒烤，聖誕聯歡等，爲的是希望藉以使大家能對這個細胞有着一份歸屬感。

但我不苛求每個人都要成爲Cell的Nucleus，不過一旦你認爲自己是屬於這個Cell時，你就會不自禁的去渴望它成長及活出眞正的生命，在此，再無 Nucleus 與 lysosome 之分了。

Theresa ■

天主，請看

祢給我的是何等樣的一個團體！

祢問我愛這個團體嗎？不，我不愛，因爲當它已是你的一部份時，已談不上愛與不愛了。可是也正因此，我不能不愛它。

我愛它，不是因爲它是一個十全十美的團體；正如祢愛我，並不因爲我好的緣故。

有人的地方，便會有缺點。

可是，那並不單只是一個「人」的團體，我知道，祢是常和我們在一起的。

當我們共同參與彌撒時，我是如何的感到祢臨在於我們當中——那是一個「屬於祢」的團體；

當我們在平安禮中互相握手祝福時，我是如何的感到我們是緊扣在一起的——那是一個「共融」的團體；

當我們開Cell時，那是一個分享的團體；

當我們一起聆聽醫學倫理時，那是一個「學習」的團體；

當我們一同吃團年飯時，那是一個——「吃飯」的團體；

（關神父說，若果是和和氣氣，快快樂樂地吃一頓飯，誰說吃飯不是一件神聖的事！）

可是，我知道，祢更願我們使它成爲一個「生活」的團體。

不過，祢愛我們，卻不會期望我們的什麼，

一切，只是我們自己的期望，只因我們付出過，

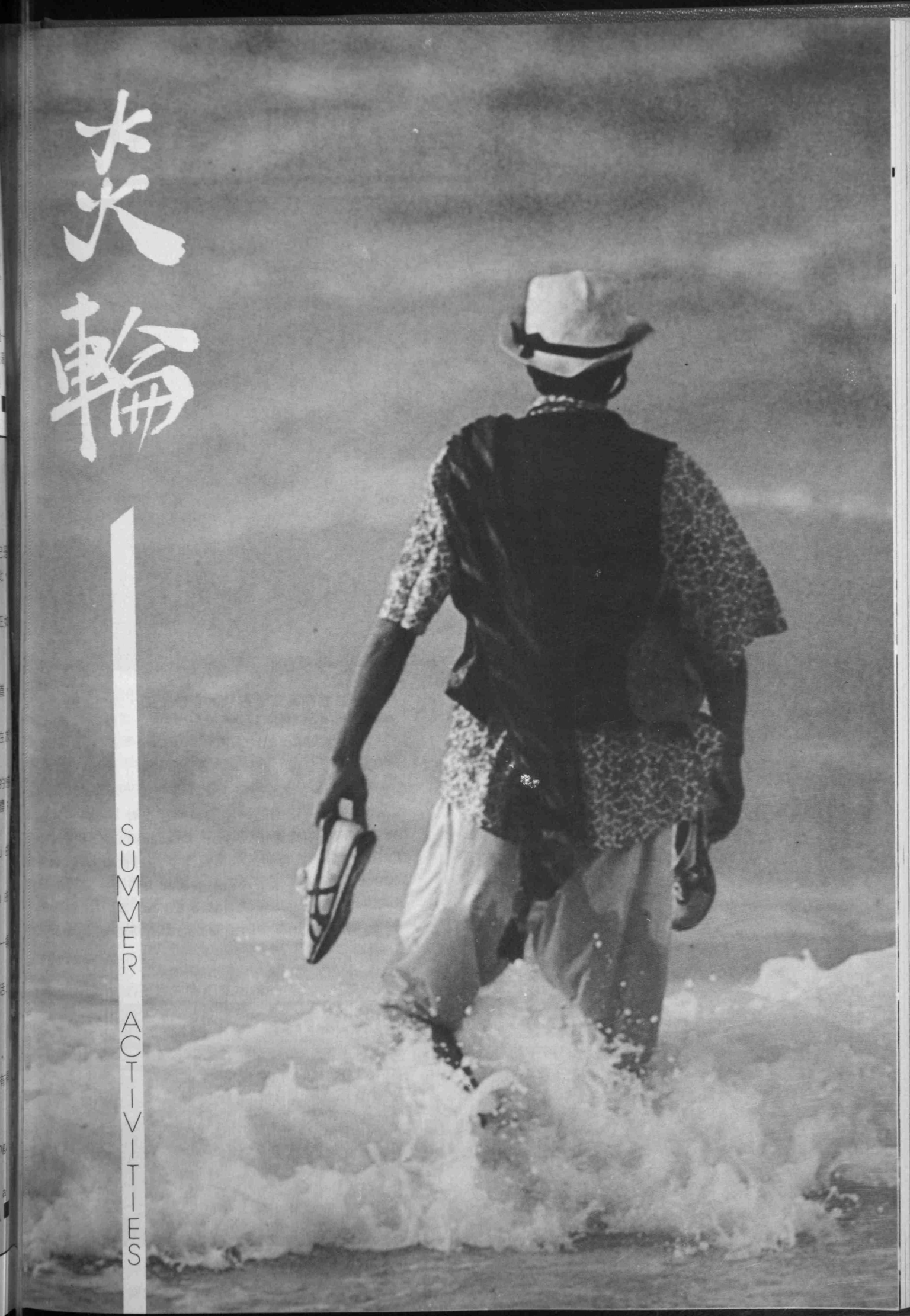
但，我已漸領會到，一切原是爲祢而作的，沒有得，也沒有失。

I have a song to sing,
If the world gets to konw and listen to the song,
That's lovely !
Otherwise, I will still sing the song, for I have a song to sing.

Rebecca ■

夏輪

SUMMER ACTIVITIES



電影首影晚會八四

目的

今年醫學會的籌款活動，仍以「電影首影晚會」的形式進行；是次活動的籌備自二月組成籌委開始，經逾半年的時間，於七月二十二日假座「香港大專會堂」舉行。

今年活動除主要爲醫學會活動及「杏雨貸款基金」籌款外，亦爲增進醫生、醫學生之間的聯繫和認識而提供一個文娛活動的目的。

籌備

籌備期間工作包括很多方面——聯絡廣告客戶及贊助人，試片及商討場地，向各界宣傳，出版場刊、海報和標貼等印刷品、策劃當日節目，和最重要的，是全港醫生探訪。

爲了盡量達到活動的目的，今年創新地舉辦了一次午間音樂會，更很榮幸地邀請到黃志昭教授，任麟孫博士和楊美博博士與同學一同表演，而當日反應可謂空前熱烈，整個陳蕉琴樓的Student Lounge 都擠滿了觀衆，不但達到宣傳之效，更製造了一次拉近師生距離的機會。

由於價錢及電影的原因，今年放棄了已經合作了數年的利舞台，而選擇了大專會堂，並另覓影片公司。雖然此舉好處在於能減低成本和取得更多的影片選擇，但是另一方面却失了電影院的宣傳幫助，同時未必能得到承諾一定公映。

售票

最值得一提的是，今年籌款在沒有「主力」售票同學的支持下，售票情況可謂「峯迴路轉」，令各籌委乍驚乍喜」，但有賴全部售票同學的特別賣力，入場券售賣的最後成績十分令人滿意，再加上各方捐款和廣告費，扣除開支後，共得款項爲 $ 61, 337. 55，比醫學會八三至八四年度預算中所須籌款活動所得的款項($55, 00)還要多。

Gala Premiere '84

首映晚會

當晚在電影放映之前，預備了茶叙，提供了各到會嘉賓和同學一個聚首一堂、互相溝通的機會。另一方面，今年的開幕典禮，更首次請得處理醫務衞生署長邱建江醫生蒞臨致詞。

選映的電影「Breaker Morant」 爲澳洲之製作，質素相當高，爲澳洲近年來最備受談論的電影作品，當晚觀衆反應亦算不錯。

今屆首映晚會場地選擇了大專會堂，的確提供了不少有利的因素，除了上述的低成本外，場地亦較爲適用，不但提供泊車位，更有足夠的地方供茶叙及開幕典禮之用，擁有了增强節目質素的潛質。但最美中不足的是可能由於交通比較不方便，而導致與會人數比以前減少了，觀衆出現零落的情況，惟望來屆如果亦選擇大專會堂時，可針對此點加以改善。

檢討和前瞻

近年醫生的支持似有漸見冷淡的情況，究其原因，可能因爲一方面電影首映所籌得款項，只有十分一被撥入杏雨貸款基金，似嫌太少，而另一方面是大家都不得不承認票價實在昂貴。

此外，醫學會的支出平均每年都有百份之十的增長，但電影籌款能否追得上這樣的膨漲，就有點「茫然」了。

以上都是醫學會籌款活動的一些隱憂。除了「電影首映晚會」有考慮改革的必要外，醫學會各執事同學每次擴大活動規模或數量前，都應予以三思。

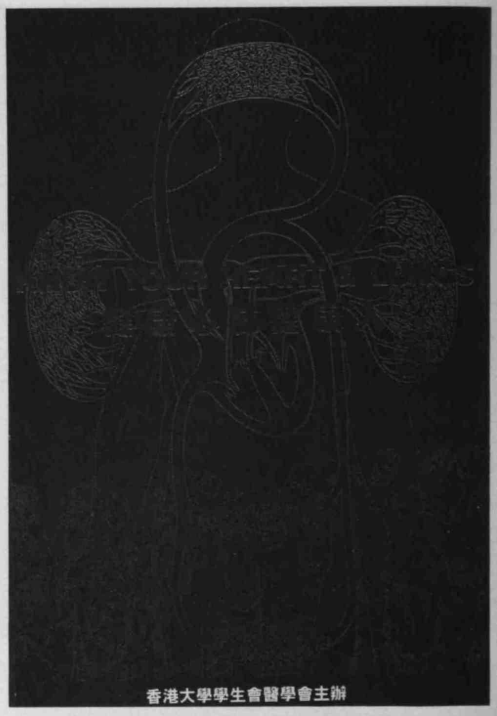
籌委會主席　郭文偉

*：經醫學會評議會議決，將所餘款項$6,337.55悉數撥入杏雨貸款基金。

健康展覽八四

健展從二月開始籌備，到九月中公開展覽，經歷超過七個月的工作，迄今已暫告一段落。

健康心肺？



今年的籌委，多數都是一年級的同學，所以籌委會成立的時候，倍覺朝氣洋溢，當然，其中亦有幾位是二年級的同學，他們亦頗活力充沛，加上他們的經驗，使今年遲了成立的籌委會，很快就上了軌道。

今年的籌備工作，比以往提早進行，例如資料搜集就大部份在考試前開始，而展覽板則在展覽前的兩星期已大概完成，這些都是籌委的衝勁及「搏命」。想起也矛盾，今年的展覽，我們强調要保持心肺健康，須定時作息，充足睡眠，適當運動，心境愉快，但細想我們的籌委，在忙碌的工作及功課的壓力下，又有誰能堅守這健康之道!?

力求新嘗試

今年籌委成立後，各方面的客觀環境都算理想，如財政方面早已無後顧之憂，又得到學術顧問醫生熱心的指導，及不少高班同學的幫助及支持，所以，我們希望能作多些新嘗試，例如與醫療視聽器材中心（Medical illustration Unit）合作，務求使今次展覽的設計水準提高，所以，今年的海報是由他們設計；而展板方面，他們亦給了我們不少的寶貴意見。在資料册方面，我們加上很多圖畫，力求把我們所傳遞的信息更生動及淺易地帶出來，在展板方面，爲了加深市民對一些病例的印象，我們採用了不少圖片，希望幫助他們牢記這些病例的預防及徵狀。在講解員訓練方面，我們亦嘗試把所有展板拍成幻燈，由大學醫療服務中心的負責人逐一詳細講解及介紹有關講解的技巧。

我們力求多些新嘗試，不是爲了要與以往的展覽有所不同，而是覺得醫學會有不少活動，都是每年舉辦的，它需要不斷的改進及創新，然後才有進步的。

Health Exhibition '84

努力的成果

整個展覽在中區大會堂及荃灣大會堂舉行，入場人數大約一萬，而其中佔了不少是學生。在中環大會堂時，最熱鬧的一個地方應算是放置人體模型及心肺標本（Specimen）的攤位，主要的原因可能是由於有不少高班同學的「押陣」，因爲參觀者在那裏問的問題非常廣泛，超越心肺的範圍，例如有人問：「我的左肚有痛，是不是有胆石？」，彷彿使人有門診部（OPD）的感覺。

由於在場的講解員並不充裕，所以不少同學很快就覺得聲音沙啞，雖然這樣，他們亦有不少的收獲，如遇上困難的問題時，他們可請教「大仙」，他們便會樂意地解答。

健展的前瞻

最近這幾年，有不少人提出有關健展是否值得每年舉行這個問題，主要的原因可歸立爲兩點。

第一，健康展覽無論在財政及負責人數方面，都是醫學院最大的一個活動。當然，推行健康的目的可以說是無可置疑的，但我們是否值得每年也花費這樣龐大的人力及物力呢？換句話說：如果把這些人力、金錢發展在另一些計劃，或兩三年舉行一次，以給醫學院的同學有一些休養生息的機會這不是更好嗎？

第二，健展其中一個主要目的是推廣健康教育，不錯，健康教育在香港一向都是比較缺乏，但近年來，我們可以見到有一個趨勢，以展覽形式的健康教育越來越多，就在去年，香港醫學會，骨科學會，中央健教組等也在暑假期間紛紛舉辦展覽，隨着展覽的數目增加，我們健展的入場人數也有下跌的跡象，如幾年前的「病向淺中醫」，只在中環大會堂一處舉辦，入場人數大約二萬，而今屆在兩處地方展覽，入場人數只不過一萬，有鑒於此，健展應否每年舉辦呢？

其實，以上的意見是值得考慮的，但是入場人數方面，我只當這是一個指標。我不覺得人數越多越好，最重要的是觀衆所得的多少。最近這兩年，人數顯然比以往的少，但是會場亦不時水洩不通，可能，人數少些，每一個入場者的得益還更大呢！

在這兩三年內，我覺得健展仍是可每年舉辦的。雖然，展覽近年來的數目有增加，但是我們要清晰一點，健康教育在香港仍是不足夠，而這幾年，健教可以說在進展中，如我們就滿足目前的情況，把健展停爲一兩年，這是不智的。

當然，幾年後的情況，我們不能很清楚，但在這兩三年內，我覺得醫學生仍應努力在推廣健康教育作出貢獻。或許幾年後，健教以展覽形式可能變得飽和，那時，我也覺得可考慮每兩年舉辦一次。

籌委會主席 郭文偉
彭文新

迎新八四

迎新八四結束了兩個多月、要我現在寫篇關於她的文章，眞不知從何寫起。不是因爲我忘記了所發生的相反地一切的事都深刻地印在心上，但發生的事實眞是太多太多了，而且內心的感受，有時不是言語所能形容的。

爲什麼我攪迎新八四

八四年一月，有人初步接觸我，希望我當迎新八四籌委主席，我當時一口拒絕了，因爲一年級的整個暑假我已完全給了迎新八三。我主動地參與了大部份迎新活動的策劃，雖然很辛苦，可是也很有滿足感。再做迎新八四，似乎對個人來說得益不大。而且我也很想利用一下二年級的暑假鬆馳一下身心，多些接觸大自然、擴闊自己的胸懷。但世事往往事與願違，最後仍然是經不起別人的苦苦哀求，答應了當迎新八四的主席。這內裏的原因，不是因爲有人「背鑊」，而是我覺得從迎新八二時的新鮮人身份和迎新八三時籌委和組長的角式中所得到的，大大充實了我的大學生生活，我和迎新，似乎有着不可磨滅的感情和關係。

迎新活動的籌備和經過

八四年二月，我開始接觸八七、八八的同學來當籌委，可能是因爲健展及電影首映籌款都招攬了很多人手，而且大部份八七的同學都想在暑假期間出外旅遊，籌委的人數比理想中少，但總算組成了一個二十多人的籌委會，並立即展開了工作。籌委會先後開了十多個會議，對於八四年迎新活動的項目、日期、主題、意義方面作出廣泛的討論。最後終於決定主題爲「計劃我前途、踏出第一步」，主要的意思是希望八九的同學在開課之前，首先能掌握一下未來所會遇到的難題、大學的生活、讀書和活動參與的態態度。這樣，對於他們（她們））日後切身處地時對於一些難題可以比較容易適應，而另一個背後的義意，則是希望新同學不單只關心自己的前途，也可關心一下香港的前途，畢竟醫生是不可以和社會脫離的。至於活動方面，則包括迎新營，組長營，歡迎日，賣舊書服務，迎新雙週，學術迎新，預科生日等。

Orientation '84

四月初，我們便開始了組長的招募，最初反應良好，但到最後因爲種種原因，組長的人數只剩下三十多人，加上十多個籌委，我們便知道在面前的是如何艱苦的一條路了。

MB過後，各籌委便開始大展拳脚了，又要準備給新同學的資料册，又要確定營期和人數，又要定下各項的程序細節，忙個不亦樂乎，加上不少籌委都出外旅遊，導致留在香港的人手奇短，個個人都日以繼夜地工作。好不容易到了八月中，大部分籌委都回來了，可是似乎很多工作仍未開始，最要命的是大學收生程序出了錯誤，大大地延遲了註册的日期，令到籌委都很担心迎新的程序是否要推遲，最後問題總算解決了，一切照原定計劃進行，但時間却買少見少。

八月廿日至廿三日在明原堂舉行的組長營但組長間能夠互相認識，而且了解迎彩四日至題和各項活動。但這目的是否能達到呢？出營後，便是整個籌劃迎新中最忙的幾天，因爲一切都在這幾天中落實，而其中拍幻燈佔去了大部份的人手和時間。八月二十四日，總算見到我們的主角——八九的同學了。歡迎日的程序雖然出了少少亂子，但整體仍是成功的。

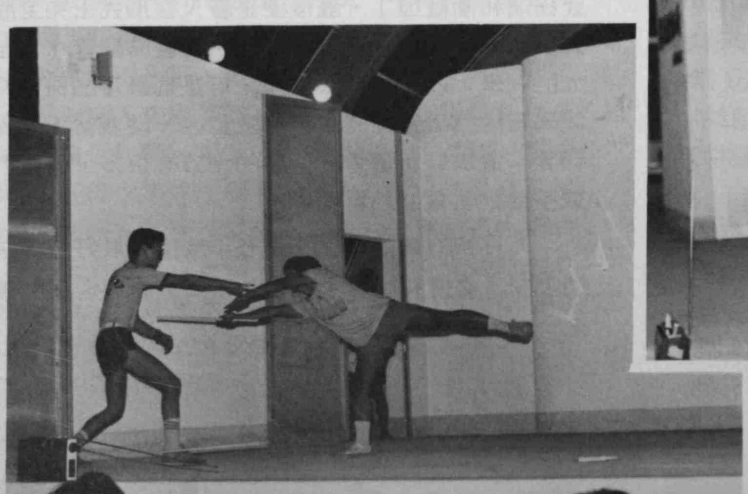
八月廿八日至三十一日、迎新的重頭戲——迎新營在西貢北潭涌戶外康樂營舉行。四日四夜中，我們嘗試通過遊戲、幻燈、討論、角式扮演等來達到迎新的目的。我的背後哲學是最初以組爲單位（如第一晚的集體遊戲），等組內熟悉了，便打破組的界限（如第二日的角式扮演和衝緩徑），最後便是新人在形式上完全脫離個人的活動（如籃球比賽、拔河、班會時間等）。至於八九的同學，最初太過被動了，可是到最後的班會時間，同學飛撲而出當臨時班會的主動性，使我留下了深刻的印象。這次迎新營中，不善的地方有很多，但我們希望或多或少能幫助到新同學。

九月初的賣舊書服務是歷年來攪得最好的一次，我們限制了書價和牌數，務求使新同學能以合理的價錢買到合用的課本。

八九開課後，迎新雙週便推出了。第一炮的高桌晚會，教師們都坐到學生的中間傾談，達到在醫學會的幾次聚餐中可說是很大的突破，可是其它的項目，似乎比較少人的留意了。

與迎新雙週同時舉行的有學術迎新八四和預科生日八四，這兩項不是針對八九班，相反不少八九同學都有幫手策劃這兩項爲想進入九零班的同學介紹醫學院的活動。

迎新八四至此便結束了。



迎新八四的評價

綜觀整個迎新，似乎和去年的迎新沒有多大分別。迎新似乎已走進了一個特定的模式，以往有的，現在都不可以沒有了。這是代表籌備的同學因循!!抑或迎新發展到現在已經成熟，各方面都發展得十全十美!!在籌委內部討論時，我們都有一個共同的信念，便是我們不一定要求突破，因循並不一定是壞事，相反來說，銳意，創新有時只會引來不良後果。雖然如此，我們仍然儘量做到最好。而且我們也回顧了整個迎新，得到了一些精神。

第一是組長的訓練。三日兩夜的組長營，有時不單不能達到效果，更可能令一部分有興趣的同學望而卻步，畢竟同學的時間是有限的，所以我們提議不再那麼依賴組長營，多幾次聚會加上一個二日一夜的宿營似乎是一個更理想的模式。

第二是重新考慮迎新營四日三夜的價值。四日三夜是希望同學有多些時間去接觸其他人，同時又不致因爲活動緊迫而太辛苦。但三日二夜，加上比較豐富的節目，是否能夠令迎新營的氣氛提高，而且可以在最高潮時結束，使同學留下一個美麗的回憶呢？

第三是迎新雙週。這一個活動舉辦了二年都並不成功，可能是籌備的同學都估計錯誤了。我們原是以爲多些空閒時間給新同學去熟習新環境是一件好事。但新同學都以爲迎新雙週一定有很多活動的了，結果事與願違，對迎新雙週便更加不看重了。再加上迎新營中的分組到了那時都不再存在，新同學缺乏了舊人的照顧和意見，更加妨礙了活動的推出。故此如果將現有的時間縮減，重點出擊，並且加强新人間的聯繫，一同參與，那麼「迎新週」便可以有聲有色了。

第四是預科生日和學術迎新脫離新籌委的範圍。迎新的項目，實在是太過繁複了，而預科生日和學術迎生一方面是比較獨立而且和當年迎新的服務對象是不同的，如果改由其他人負責，迎新籌委便可以有更多的時間去專注剩下的活動了。

除了上述之外，今年迎新仍有很多不足，最大的原因，是人手太過短缺了，導致一個人往往身兼數職，在某方面難免有所疏忽。迎新營中，現當的限制也令迎新大爲失色。集體遊戲，角式扮演，球賽等，如果能在較佳的時間或地點舉行，效果肯定會更理想，這可能導致迎新營總是攪不起氣氛的情形。至於籌委的經驗不足，可能也影响了一些活動的效果。組長們基於種種原因不能將籌委所計劃的切實執行，也影響了活動的質素。而新同學似乎靜默了一些，不能作出一些回應去刺激老柴去加把衝勁。但這一切都是不重要的。最重要的是籌委和組長們確實盡了他們的努力。

個人的感受

第三年參與迎新，所感受到的，又和前兩次不同了。今次我要和一班籌委一起工作、策劃整個迎新，不再是好像以往一般的針對一些單項活動。當主席並不是一件易事，也並不好受。迎新八三時，我可以親身感受到努力的成果，因爲我確實接觸了八八的同學，發到了迎新八四，我接觸八九同學的機會少了很多。我好像覺得和整個迎新活動的進行脫離了。但是從另一方面，我也得到了很多。和其他籌委一起工作時的快樂是難以形容的，但我卻時常都有一神感覺，好像是欠了他們什麼似的，因爲他們去迎新是實在搏得太盡了。我不可以忘記兩個營長，林華、堅叔的努力，不可以忘記 Ida 姐、怪獸、肥睿，Freddie 、熊貓、 Paul Chau 和陳澤霖的熱心參與，還有其他很多人的幫助，好像何伯，Clara，周Ming，肥明，鳥卒卒， Grace ，翁記，趙朗峯，韋兆輝其他組長。當然最重要的還是兩大支柱——Sidney 和標叔的鼎力支持。

迎新八四期間發生過的事，一幕幕在我腦海中顯現，好像通宵不眠的討論幻燈的內容，組長營中配音至凌晨五時，深夜十二時仍在中環拍攝夜景，迎新營中的「豬仔瓜籌委會」以至 reunion 後在中環碼頭談心等等。這一切都已成爲回憶，我會珍惜他們，現在迎新已成爲過去，滿足、失望、辛苦都會漸漸淡去，但是希望大家能記得我們一起捱過，一起承受過，或者一起失敗過。以後我們可以對其他人說，我們曾經付出過。

給八九

可能很多八九同學，就算入了迎新營也不知我是誰！但是你們現在都會認識了同班的同學和一些師兄師姐了吧？醫科是一個很狹窄的圈子，你可以很容易地一個人對什麼事不聞不問，終日醉心課本，但這樣只會使你更加孤獨，來吧？開啓自己，接觸多些人和事，使自己不是滿足於自我的小天地。光說是沒用，放大膽子，主動向你不悉識的同學說：「你是誰？」。

籌委會主席　曲廣建

系搜

DEPARTMENTAL SURVEY

What is Psychiatry

Most psychiatric textbooks defines the subject as the study, treatment and prevention of mental disorders. The Encyclopaedia Britannica defines psychiatry as a branch of medicine primarily concerned with disorders of thought, feelings and behaviour. I find all these definitions as being too simplistic and do not adequately describe all what the psychiatrist does or the intricacies of the subject.

The word "Psychiatry" was coined in 1808 by the German anatomist Johann Christian Reil, the discoverer of the "Island of Reil". By joining the Greek words "Psyche" (soul), "iatros" (physician), Reil conceived of a new kind of medical treatment in which the doctor makes use of his psyche as the agent of therapy. This approach was formulated at the time of the Romantic movement when the "Moral treatment" of the mentally ill was in ascendency. Before that time mental illness was considered the domain of philosophy; further back from early times to the middle ages the mentally ill were treated by sorcerers, medicine men and priests.

The realization in the 18th Century that the insane were not vicious but deranged, that they were in need of treatment and not punishment resulted in the proliferation of mad houses which catered to their needs. The rise in public concern for the mentally ill was coupled with the increase in professionalism among those who cared for them. As more physicians directed and staffed the institution, the specialty of psychiatry was born. Initially and in fact throughout much of the 19th Century, physicians who focussed their professional attention on the mentally ill were known as "alienists". It was not till a century and a half ago before psychiatry was incorporated into the over-all field of medicine.

In the 19th Century advances in biological research gave medicine a scientific basis and an intellectural acceptance. Since then tremendous technological advances have been made in medicine. Because of the inaccessibility of the brain, the ethical constraints on human experimentation and the inability to produce proper animal models of mental illness, psychiatry was not able to participate in the progress made by the other branches of medicine. In the search for etiology and treatment psychiatry became fragmented into various schools and multiple paradigms that compete with each other for scientific dominance, intellectual status and prestige. The different schools could be divided into 5 groups: 1) biological, 2) psychoanalytic, 3) interpersonal, 4) social, 5) behavioural-cognitive. The biological approach is mainly concerned with pharmacotherapy, genetic studies and CNS research. The psychoanalytic school deals with intensive, insight-orientated psychotherapy and psychoanalysis. The interpersonal school broadened the psychotherapeutic framework to include family and group therapies. Epidemiological studies and community mental health are the main concerns of the social approach. While the behaviour-cognitive approach deals with various forms of behaviour and cognitive therapies.

To understand the nature of scientific progress it is relevant to refer to Thomas Kuhn's book, "The Structure of Scientific Revolution". Kuhn suggested that the history

of a science is marked by revolutions. The essence of a scientific revolution is the emergence of a new paradigm which can provoke a significant restructuring of the ways in which the particular science defines its problems and directs its ways of looking at them. It has been claimed that psychiatry, because of its absence of a single dominant paradigm and the uncertainties regarding body-mind relationship, is still at a pre-paradigmatic level. To acceed to this point of view is to take Kuhn's idea of a paradigm in a very narrow sense; for there may be many competing schools of thoughts is psychiatry but it does not entail that one school should emerge as dominant. The paradigm of psychiatry is the general living systems theory. It is the only theory at present that is capable of providing a conceptual framework within which the contents of biological and social science can be logically integrated with the physical sciences. It serves to break down the firm boundaries of the different schools and reveal the orderly relationship between them. It does not only provide a new resolution to the mind-body dichotomy but also offer a new approach to etiology, diagnosis and treatment.

The general living system theory maintains that the universe contains a heirarchy of systems of increasing complexity. Each system is made up of matter-energy and bounded to other systems by information. By modifying J.G. Miller's proposal of 19 subsystems we can come up with 7 subsystems ranging from the simplest to the most complex: 1) cell, 2) organ, 3) organism, 4) group, 5) organization, 6) society, 7) supranational. As the system increase in complexity, information also become more complex; ranging from bioelectric pulse at a cellular level to the use of language at a group level. Each subsystem has boundaries that are semipermeable, thus allowing matter-energy and information to proceed in either direction. The various parts of the general system are differentiated and subserve special functions in relation to each other and the whole by some form of regulation that maintains homeostasis.

Having given a brief resume of the framework of the general living systems theory, I would now proceed to discuss its application in diagnosis, psychopathology and treatment.

The psychiatrist as a diagnosticism is like a system analyst trying to debug defects in the computer programme. Based on the general living system theory the diagnostic process involves the tracing of the routes of all the separate sorts of matter-energy and information transmission including input, output and feedbacks of the various subsystems. Then each sort of transmission and structure is analysed to determine whether the relevant variables are within normal range or is the loci of pathology. The various subsystems can also be tested to determine if they are in a state of normal homeostasis. If not the feedback systems can be tested to determine whether the adjustment process is functioning properly. Taking depression as an example we can classify it into: defects in information transmission due to serotonin deficiency, defects in the feedback system due to negative cognition, defects in the family homeostasis secondary to bereavement and so forth. Because the boundaries of the subsystems are semipermeable the diagnostic categories need not be mutually exclusive. For instance bereavement may also bring about a deficiency in serotonin in vulnerable individuals.

All levels of living systems, including cells, organs, group, society mediates a person's behaviours, feelings and thinking just as the various levels of living systems have comparable adjustment processes, so they have comparable pathologies.

Psychiatric disorders may be due to: lack of matter-energy input as in the case of pellagra or folic acid deficiency, excesses of matter-energy input as in the case of alcoholic abuse, inputs of inappropriate forms of matter-energy exemplified by lead poisoning, lack of information input as in sensory deprivation, excess of information input exemplified by the breakdown of executives who has been given too much responsibilities, input of maladaptive genetic information in the template exemplified by Huntington's Chorea, abnormalities in internal matter-energy process exemplified by depression in hypothyroidism and abnormalities in internal information processes as in schizophrenia. In a larger context we must also consider that people live in families and in society and pathology at these levels must also be identified. Recent advances in schizophrenia research can serve to illustrate this interrelationship; a high dopamine level in combination with abnormalities in perhaps another neurotransmitter causes abnormalities in internal information processing which responds to antipsychotic drugs but high expressed emotionality in family members may lead to a relapse of the illness. From a psychosomatic point of view excess of matter-energy and information input can produce diverse clinical conditions like: hypertension, peptic ulcer, coronary heart diseases which have been classified by Selye as diseases of adaptation. On another level biochemical abnormalities are not necessarily genetic or constitutional, because early experience can cause enduring chemical changes which may become genetically transmitted.

The application of the general system approach to treatment has highlighted the importance of involving the family not only in the treatment of emotionally disturbed youngsters but also in the management of chronic illness. It has also resulted in the growing prominence of consultation-liaison psychiatry within the medical community. Recent findings have shown that more than half of all hospitalized and medically ill patients manifest significant psychological dysfunction, either as a result of or in conjunction with medical illness; such dysfunction invariably detracts from the effectiveness of treatment. The winds of change has also blown in the opposite direction in psychiatry in the sense that psychoanalysts are now willing to use psychotropic drugs as an adjunct to psychotherapy. There is now a growing ecclecticism amongst psychiatrists who are willing and able to treat patients by approaching several subsystems. For example in the treatment of depression one may have to combine

antidepressants with cognitive-emotive and family therapy.

In dealing with complex or multivariate problems one can employ the mathematical model used in the physical science to introduce arbitrary simplification through techniques of analysis. The other is to accept the complexity as an irreducible element in the situation and to search for a paradigm that will enable us to accept it as a whole. The second alternative is psychiatry's only choice, to do less will only diminish our essence as "soul physicians". The acceptance of psychiatry's immense complexities may seem to be a curse in the short run but in the long run it will be psychiatry's glory.

Having dealt with the conceptual framework of psychiatry, I shall now proceed to mark out the domain of psychiatry. The outer boundaries of psychiatry include all people with psychiatric disorder but because of diagnostic problems these boundaries are unclear and changing. In the epidemiological survey by Srole in his "Midtown Manhattan Study" which was originally done in 1954 and repeated in 1964, he found that 31.7% of the people manifested mild psychiatric symptoms, 11.8% moderate and nearly 4% had serious symptoms. A psychiatric survey done by Shepherd in Britain revealed an overall prevalence rate for psychiatric disturbance of about 140 per 100,000 of the general population. Figures obtained from the four psychiatric case registers in Britain reported that in any one year 20 people per 1,000 make contact for the first time with specialized psychiatric service.

The biosocial and psychiatric survey done in Hong Kong in 1974 by Boydon found that 31.7% of people had mild symptoms, 11.8% had moderate symptoms and 3.7% had severe symptoms. This finding is in fact siimilar to that of Mid-town Manhattan, New York. Because of the ubiquity of psychiatric disorders, psychiatrists will be involved in treating children, adult and geriatric patients. Since patients do not live in a vacuum, the treatment of patients may also involve counselling families, relatives, teachers and employers. The psychiatrist may need to examine the mentally healthy at the request of the Courts, give expert opinion on the psychosocial management of patients who are physically ill.

Psychiatric services in Hong Kong have experienced a rapid rate of growth in terms of hospital beds and community facilities. There are at present 3,814 psychiatric beds and 1602 are in the pipeline. There are 11 outpatient clinics and in the future all polyclinics and general hospitals will include psychiatric facilities. The number of half-way houses will be increased and improvement in staffing standard have been approved. There are also provision for increasing the number of psychiatric community nurses. In 1985, 102 psychiatrists are required to provide for existing services.

Postgraduate training in psychiatry has also been formalized. A rotation scheme has been devised to enable trainees to be exposed to the various subspecialties. A trainees and a tutor's committee have been formed to plan and coordinate training. Formal lectures are being given weekly in which all trainees are given half day off to attend.

Finally I would like to say a few words about the attributes of an ideal psychiatrist. The good psychiatrist is intelligent, empathetic, has a sense of humour, and interested in others, sincere, mature but is also capable of further growth, able to handle ambiguities and has a scientific frame of mind.

Professor Felice Mak-Lieh
Head of Department

APPOINTMENTS

Lecturers

Chan Khim Yew, B.A. (Singapore), M.Phil. (Cantab), D.P.M., M.R.C.S., L.R.C.P. (London), M.R.C.Psych., as Lecturer in the Department of Psychiatry from December 3, 1984.

Pan Pey Chyou, M.B.,B.S. (Hong Kong), as Lecturer in the Department of Psychiatry from October 1, 1984.

Gabriel Yu Ka Kui, M.B.,B.S. (Hong Kong), M.R.C.Psych., appointed Lecturer in the Department of Psychiatry from February 5, 1984.

RESIGNATIONS

Lecturers

Dr. N.Y.T. Kung, Lecturer in the Department of Psychiatry from March 31, 1984.

HONORARY PROFESSORS

Professor Lin Tsung-yi, M.D. (Tokyo Imperial), D.Med.Sc. (Tokyo), Professor of Psychiatry, University of British Columbia appointed Honorary Professor in the Department of Psychiatry from November 5 to 16, 1984.

VISITING PROFESSORS

Professor Sir Martin Roth, M.A. (Cantab.), M.D. (London), Hon.Sc.D. (Dublin), F.R.C.P., F.R.C.Psych., Professor of Psychiatry, University of Cambridge, appointed the first S.Y. Mak Visiting Professor from April 8 to 22, 1984.

** The above material is extracted from the Gazette of University of Hong Kong*

The Department

PAST AND PRESENT OF THE DEPARTMENT

It had been a long-cherished hope of the Faculty of Medicine that a Department of Psychiatry would be established within the faculty. This hope was realized in 1970. (Before the establishment of the Department, Psychiatry was a unit of Internal Medicine)

By the end of 1972, there were one professor, one lecturer, two medical officers, one secretary and two to three honorary lecturers in the department. Since then, the department has embarked on expansion. In 1973, the department was moved to the New Clinical Building in Queen Mary Hospital. After the year 1977 when the new medical curriculum was implemented, the department was expanded by increasing the number of teaching staffs from three to eight – one professor, two senior lecturers, five lecturers and one clinical psychologist. Moreover, there are three technicians serving the department now as compared with only one before 1977. In 1984, another lecturer has joined the department.

The department has been engaging in research of various aspects in Psychiatry. The following lists shows the different research interest of her staffs:–

Prof. Mak-Lieh	– liaison psychiatry
Dr. M. L. Ng	– sexual disorders and psychotherapy
Dr. W. Y. K. Tam	– psychophysiology and psychopharmacology
Dr. K. Y. Chan	– forensic psychiatry
Dr. S. Y. Chung	– child and family psychiatry
Dr. S. L. Luk	– child and family psychiatry
Dr. P. C. Pan	– social psychiatry
Dr. G. K. K. Yu	– psychogeriatics
Dr. P. W. H. Lee	– medical psychology

Our Professor and Lecturers

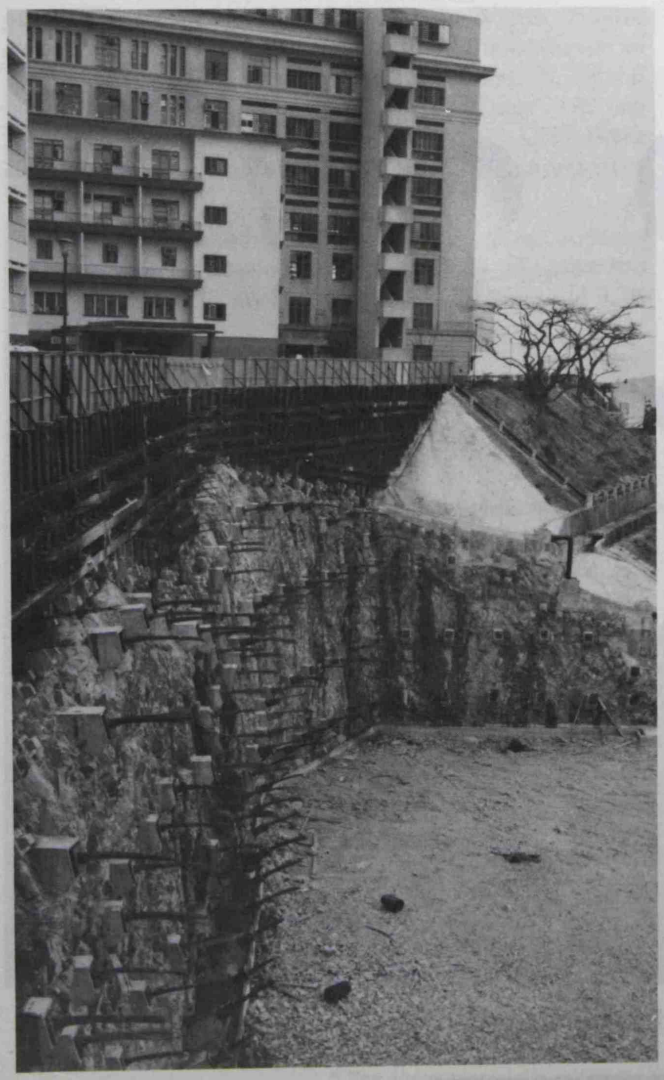
MR. CHAN KA-WAH *(Technician)*

MR. LO CHI-KEUNG *(Lab. attendant)*

MR. WONG WING SHU *(Technician)*

MISS HO YUEN-LING, WINNIE *(Secretary)*

MISS WONG WAI-CHUN, IVY *(Secretary)*



FUTURE DEVELOPMENT OF THE DEPARTMENT OF PSYCHIATRY

An enlightening prospect of a substantial expansion of the department can be expected after the completion of the Queen Mary Hospital extension. A new block will be built in the place of the present Queen Mary Hospital canteen. Out of the eight-storeyed block, six floors will be used by Psychiatry for six purposes:– observation for acute patients, patients treatment, child psychiatry, patients rehabilitation, teaching and research respectively. By that time, the number of hospital beds available for in-patients will be increased from 15 (now) to 84. ■

* The hospital extension was scheduled to be completed in 1987 but unfortunately the date might well be delayed due to various technical problems and repeated revision of the building plan.

Our Professors & Lecturers

Prof. Pow-Meng Yap

M.A.,M.D.(Cambridge)
D.P.M. (London)
F.R.C.P.(Edinburgh)
F.R.C.Psych.(London)

Dr. Yap was invited by the University to become the first professor and head of the newly established department. He assumed his appointment on June 24, 1971. Previously, he had been an honorary clinical lecturer in Psychiatry in the Faculty of Medicine during his appointment with the government. (Dr. Yap had taken up the post of specialist-in-charge of the High Street Mental Hospital in 1948, and became the first superintendent of Castle Peak Hospital when it was opened in 1961.)

Unfortunately, on November 29, 1971, news of the death of Professor Yap, which occurred suddenly while he was attending a conference in Mexico City, was received in the University. In the tragically short period of his office, he embarked on the planning, equipping and staffing of the new department and in organising the course of instruction. His death was really a great loss to the University in general and to the Faculty of Medicine in particular.

Prof. Karum Singer

M.B.,B.S.(H.K.), M.D.(H.K.),
F.R.C.P.(Edin), D.P.M.(Eng.),
F.R.C.Psych.(London),
F.R.A.N.Z.C.P., F.A.P.A.

Dr. Singer was appointed to the Chair of Psychiatry on September 5, 1972. Prof. Singer first joined the University as a part-time lecturer in Psychiatry in 1969 when he was the head of the Government Mental Health Service. He was the medical superintendent of Castle Peak Hospital in 1967-1970.

After a total of more than eleven years of service in the Department, Prof. Singer retired from the University on January 1, 1981. Now, Professor Singer is still an honorary clinical lecturer of the Department.

Prof. Felice Mak-Lieh

M.D.(Santo Tomas),
L.A.H.(Dublin),
M.R.C.Psych.
F.R.A.N.Z.C.P.

Prof. Mak-Lieh is the third professor of Psychiatry after the department was officially detached from the Internal Medicine in 1971. Prof. Mak-Lieh joined the department as lecturer on August 1, 1971 and was promoted to senior lecturer in 1978 and reader on September 1, 1981. Succeeding Prof. Singer, Prof. Mak-Lieh has been Head of the Department of Psychiatry since 1980. On August 1, 1983, the professorship was endowed on her.

Born in the Philippines, she spent her primary and secondary school years in a convent school in which she took part in a wide range of extracurricular activities. She exceled herself in debating, drama and volleyball.

Perhaps all teenagers have dreams of an ideal career and Prof. Mak-Lieh was no exception. Being a book fan, she had found the career as a writer very appealing but once being in contact with the subject of Biology in Form three, she made the determination to gear herself to the study of Medicine.

Prof. Mak-Lieh obtained her degree of Doctor of Medicine at the University Of Santo Tomas in the Philippines in 1964, and subsequently took up an appointment in the University of Santo Tomas Hospital before pursuing a course in neurology at the Institute of

Neurology. From 1965-1967, she was House Physician and House Surgeon in various hospitals in Manchester, Bournemouth, London and Oxford. By then, her adoration for exploring the mystery of brain was strong enough to give impectus for her specialization in psychiatry. Yale seemed to be her final goal where equipments and research prospects are one of the best in the world. However her affectional marriage to a civil engineer diverted her plan, from U.S.A. to H.K. From 1968 to 1969, she was medical officer in Psychiatry at the Castle Peak Hospital, Hong Kong. In 1971, Prof. Mak-Lieh joined the University.

Prof. Mak-Lieh was admitted to membership of Royal College of Psychiatrists of the United Kingdom in 1973 and of the Royal Australian and New Zealand College of Psychiatrists in 1978. In addition, she is affiliated to various professional organizations and learned societies. She has been a member of the Committee for the Rehabilitation of the Mentally Ill since 1980, of the Board of Occupational Therapists since 1980, and has been the Psychiatric Consultant of the Hong Kong Council of Women since 1982. She was the President of the Hong Kong Medical Women's Association, 1978-1980, Honorary Adviser to the Mental Health Association of Hong Kong, 1982-83, member of the Hong Kong Medical Association Ad Hoc Committee on Homosexuality, 1982, a Fellow of the World Association of Social Psychiatry, 1981, and a Member of the Committee on Psychiatric Education of the World Psychiatric Association, 1982-83. She was elected Fellow of the Royal Australian and New Zealand College of Psychiatrists in October, 1983. Currently, she was also the President of the Hong Kong Psychiatric Association, the Honorary Consultant to the Hong Kong Society for Mentally Handicapped Children.

Professor Mak-Lieh has a wide range of teaching, clinical and administrative experience. She has contributed extensively to professional journals and has attended numerous international conferences. Her current research are on an updating study in suicide done by the late Prof. P.M. Yap in 1954. The second project is a comprehensive study of chronic illness, with a special attention to its psychological and psychiatric aspects.

"A good psychiatrist should have a rigid doctrine on doctor-patient relationship. One should be empathatic and sympathetic but firm. To be effective, one cannot be both a doctor and a friend on a social basis with patients. Relationship with patients should be on a professional basis at all times". This is the fundamental rule she has abided by throughout her sixteen years of experience.

As one of the important figures in the University, she leads a laborious life. Literally, she has to divide her limited hours among teaching, patient consultation, research and administration of departmental affairs.

Thanks to the regularity of the consultations hours, she still has most of her evening intact for family affairs. Though she appears as a diligent professor at day, Professor Mak-Lieh prefers to adopt a wife-mother role at night and she emphatically reveals that she allows no mix-up of work and family. At present, her marriage is flourishing with three children: a boy and two girls aged from four to thirteen.

On Sunday, the family has fun on a yacht and every two or three years they go to Europe or Japan for a pleasant skiing holiday.

Through the years in Hong Kong, she has developed an intimate bond with it and thus holds an optimistic view of the Colony's future. Her husband has certain investments in Mainland China and this reinforces their faith in future stability.

The present Psychiatry Curriculum is inadequate and has lots of flaws. So her utmost ambition is to advocate an restructuring of the whole course. In fact, there has long been a concrete plan in her mind, just waiting for its realization.

a) Clerkship period should be longer
b) improvement in undergraduate training
c) increase teaching materials
d) improved postgraduate training
e) improvement in the teaching of psychotherapy
f) more beds for the psychiatric department
g) better research facilities for psychiatry

The public reconciliation of the importance of psychiatrical treatment to a healthy society certainly brings about the first step forward. By the end of 1987, the Queen Mary Hospital will have 84 beds in addition to the present 15 and a new building will be erected, six floors out of the total eight will be alloted to the Psychiatry Department.

Thus professor Mak-Lieh's long striving for a better Department of Psychiatry takes its effect. It's perhaps no exaggeration to attribute the entire success to her effort, and her contribution undoubtedly towers over many others in Hong Kong. ■

DR. M.L. NG

M.B.,B.S. H.K.; D.P.M. Eng.; M.R.C.Psych.; F.R.A.N.Z.C.P.

Dr. Ng graduated from H.K. Wah Yan College in 1965. He obtained the degree of M.B.B.S. at H.K.U. in 1971. After having been a houseman for one year, he decided to choose psychiatry as his specialty because he is interested in psychology and thinks that he can take care of the whole person besides the physical aspect of the patient. After serving as a medical officer for about seven months, he took up the post of lecturer in the University Psychiatry Unit.

Besides teaching, he also has to do research and to manage interesting psychiatric cases. He passed the two examinations in Britain in 1976 and 1977 and obtained the membership of the Royal Australian and New Zealand College in 1978. He was promoted senior lecturer in 1982. He has been doing research in sex therapy and psychotherapy as related to the Chinese and recently, music therapy. Now, he is also busy in running Sex-Education programmes for the Hong Kong Family Planning Association.

Dr. Ng has been the warden of clinical residence since 1974 as he is very interested in student affairs and helping them to solve problems with his knowledge of psychiatry. He said he likes to maintain a close relationship with students because it would make him feel much happier and younger.

Although Dr. Ng spent 8 years in a religious school, he has no religious beliefs. He has various hobbies. He is interested in chess, music, electronics and writing. He has been playing violin since he was young. He has two pianos at home, one of which is a grand, but his wife plays better with it.

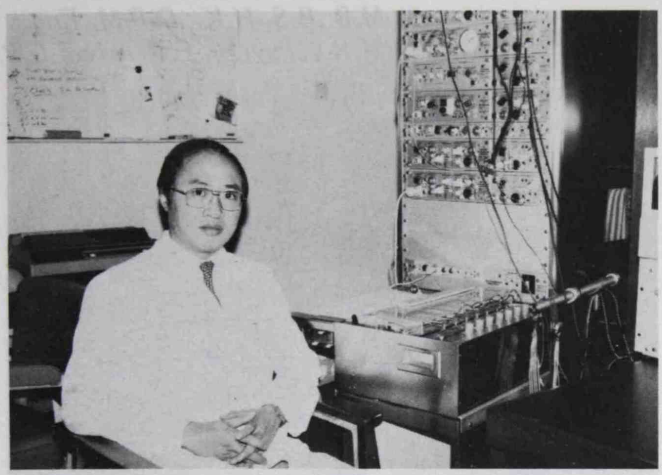
After graduation, he has written regular articles in the Caduceus for 2 or 3 years. He likes photography as well as being photographed in various costumes but transvestism is certainly not his favourite. Very interestingly, in memory of their marriage, he has taken wedding photos with his wife for as many as four times in twelve years. He is also very interested in computer and has been awarded several prizes for his programmes in some local computer journals.

Dr. Ng married in 1972. He has a son and a daughter. His son is studying in Pr. 4 at St. Louis School and his daughter is in Pr. 2 at St. Clare's. His wife is a Chinese from Vietnam. Besides piano playing, she is also very good at oil and water painting.

When asked about his view on the 1997 issue, he used a very vivid metaphor of describing China as a doctor who had a very poor past record. Although he said that his confidence in this remoulded doctor was not great, he would still work for the best and would remain in H.K. to contribute as much as condition allows. ■

DR. W. Y. K. TAM

M.B.,B.S.*H.K.*; Ph.D. *Lond.*; M.R.C.Psych.



Dr. Tam was born in Hong Kong with a Chinese nationality. Achieving a brilliant result in the HKCEE, he secured a place in the DBS secondary school. Under a pressure-free environment, he kept a balance between schoolwork and leisure. Though not a hard-cored enthusiast, he took part in many extracurricular activities, such as swimming, music and Chinese chess. He had a good command of Mathematics but he left it for Biology in the Sixth Form (At that time, Sixth Form Biology was a prerequisite for application to HKU Medicine Faculty). During his five years in the faculty, he developed an interest in Psychiatry. After graduation in 1972 and a year of internship, he joined the department of Psychiatry as a medical officer. He obtained his membership of the Royal College of Psychiatry in 1977 and received further training in general psychiatry and psychotherapy at the Institute of Psychiatry in London from 1977 to 1979. During this period, he also did research in the behavioural pharmacology of nicotine for which he received his PhD. He became senior lecturer in 1981.

Teaching, research and patient consultation are three aspects of his work. Though his patients take up a lot of his time, he still manages to be actively involved in research. His current interest is on schizophrenia: the influence of family, outcome as well as factors affecting the outcome. He is also looking at drug effects on human cognition using EEG spectrum analysis. He has recently carried out a comparative study on the views of medical students to psychiatry in Canada, New Zealand and HK.

Devoting nearly all his time to work, he remained as a bachelor until 1981 when he married a clinical psychologist who is also a lecturer in HKU. At present, he is enjoying his happy marriage with two children: a boy and a girl.

The couple's academic interest is not necessarily detrimental to their family fun. As Dr. Tam admits, the family spends a lot of time at home chatting casually. Though he has his study leave regularly, he has not yet arranged for a family tour abroad and he hopes it will come when the children grow older.

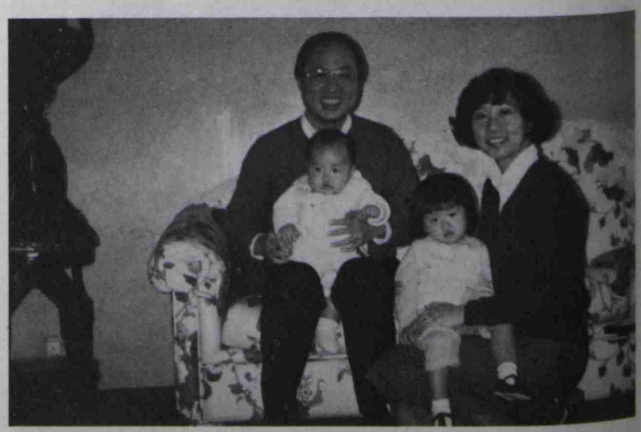
There is no drastic plan for the future. For Dr. Tam, finishing his research is foremost; now, he is certainly much happier since the recruitment of more staff helps his work a lot.

The work as a psychiatrist enables him to understand human existence in a more refined way. With examples of human weaknesses presented before his eyes, he has learnt the virtue of avoiding the futile self-deceiving behaviour in failure or despair, which he asserted, is a crucial deterrent to a free decent life.

"Being a psychiatrist is something more than being a doctor. In addition to being a scientist, he or she should possess patience and the capacity for concern and understanding as well as tolerance of ambiguity." Dr. Tam judges a good psychiatrist by the above standards and he is acclaimed to be gifted with more virtues than these.

"What's your view on the 1997 issue?"

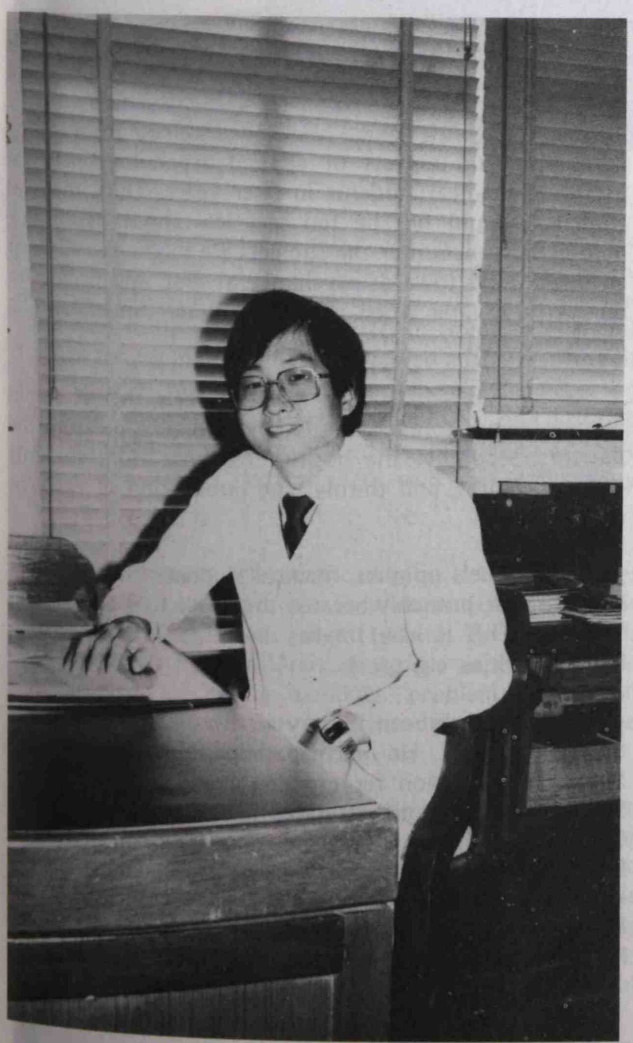
"Well, from conversation with my friends and reading of newspapers, I am led to the same worries as most of you. Of course, I fear the recurrence of madness in China, which I am sure, will affect Hong Kong profoundly. However, on the positive side, I am not allowing myself to be haunted by these worries and I will observe in the coming years the changes taking place in China. If everything is promising, why should I not stay? Hong Kong is my home." ■



Dr. S.Y. Chung

M.B.,B.S. *H.K.;* M.R.C. Psych.

Dr. Chung is an old boy of Kowloon Wah Yan College. He graduated in the University of Hong Kong as M.B.,B.S. in 1977. Having accomplished his housemanship in Queen Elizabeth Hospital, he joined the Psychiatric Department of Queen Mary Hospital as an M.O., and became a lecturer in psychiatry in 1980. In 1982, Dr. Chung went to England for further studies, and has just come back to Hong Kong this year.



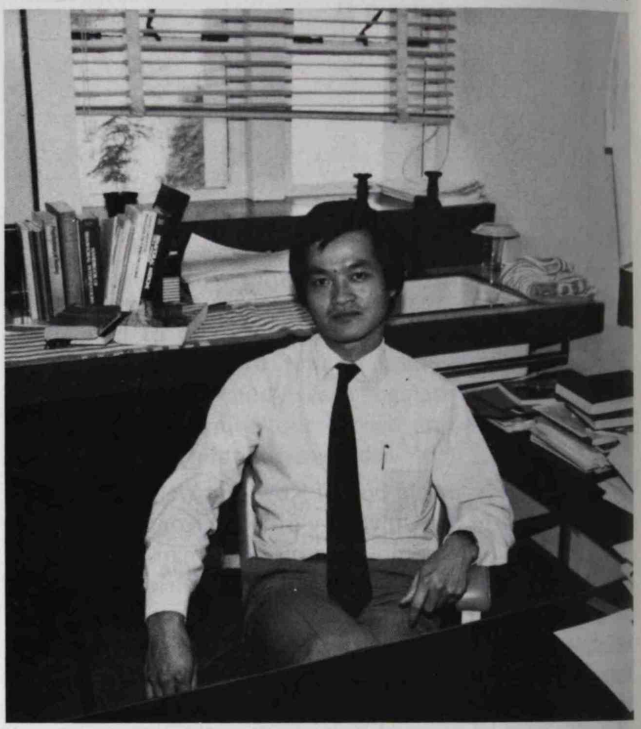
Dr. Chung had developed the interest in Psychiatry when he was still a 4th year medical student. He realises that a psychiatric doctor can treat a patient in a way that concerns with both physiological and psychological aspects. He derived part of his job satisfaction from being able to know more about the psychological, perhaps the spiritual, side of human being in the clinical work, which occupies most of his working hours. As a lecturer, he is also happy to see his students progressing in study. He thinks that medical students are hard-working, quite enthusiastic in psychiatry, but should ask more questions. But most of the medical students he meets are the fourth year students. Apart from being a doctor and lecturer, Dr. Chung also carries out some researches which involve child psychiatry and Cooley's anemia. And he is going to do a research on how to improve the interviewing technique of medical students.

Dr. Chung does not intend to leave Hong Kong after 1997, because Hong Kong is a more suitable place for him and a sense of origin is a dominant factor for his staying in Hong Kong after 1997. Moreover, he finds no reason that H.K. people should live in a more superior way than the people in Main-land China, so even some changes in life-style under the sovereignity of China are also acceptable.

Dr. Chung was married in 1979. His wife is an accountant, and he has an one year old boy now. In his spare time, he usually go shopping and swimming with his family. ■

Mr. P.W.H. Lee

M.Soc.Sc. *H.K.*



Mr. Lee received his secondary school education at Wah Yan College (H.K.). Thereafter he received his first degree in Social Sciences at HKU. After taking a 2-year full-time training course in Clinical Psychology, he joined the Correctional Services and worked in the Siu Lam Psychiatric Centre for one year. He returned to HKU in 1980 as an assistant lecturer in the Department of Psychiatry. 3 months later he was appointed lecturer. He took a one-year study leave to England in 1981. He was attached to the Institute of Psychiatry during that period, and had concentrated mainly on medical psychology, neuropsychology and working with adult neurotic patients. As present, he divides his time evenly among treating patients, conducting researches and teaching. Besides teaching 4th and 5th year students, Mr. Lee also gives lectures to 2nd year students on Behavioural Science.

Mr. Lee has a wide range of interests in his researches. In the past, he had conducted researches on the psychological state of leukemia children as well as on the adjustment of victims of industrial hand accidents two years after the occurrence of the accidents. His views on the development of medical psychology were also published in the Bulletin of Hong Kong Psychological Society. At present, he is engaged in a series of research projects on patients suffering from ankylosing spondylosis.

In Mr. Lee's opinion, being a lecturer in Clinical Psychology in the Department of Psychiatry is not as difficult as one might think. This is probably because, firstly, 4th year and 5th year students can usually realise the actual need of studying applied psychology and psychiatry, that is they realise that this may be of great use in later years, and secondly the interaction between lecturer and students is much better during the teaching of psychiatry because a lecturer would only have to face about 30 students. However, in order to arouse the interest of students, a lecturer in psychiatry would still have to put extra efforts in proving to students that psychiatry is an useful subject.

Also, Mr. Lee believes that though psychiatry is a soft discipline in the eyes of many people and therefore there might be some discrimination towards psychiatry in the medical field, the basic knowledge gained in studying psychiatry and aspects of applied psychology may be useful to medical students in later years. Thus, medical students should not be too sceptical about psychiatry before they encounter the subject. We might as well keep an open mind towards psychiatry at first, and decide on our attitude later when we have a better understanding about psychiatry.

As for job satisfaction, Mr. Lee feels that it comes mainly from 3 sources: firstly, the appreciation from the patients, secondly, the positive response from students during lectures, and thirdly, the publication of research papers.

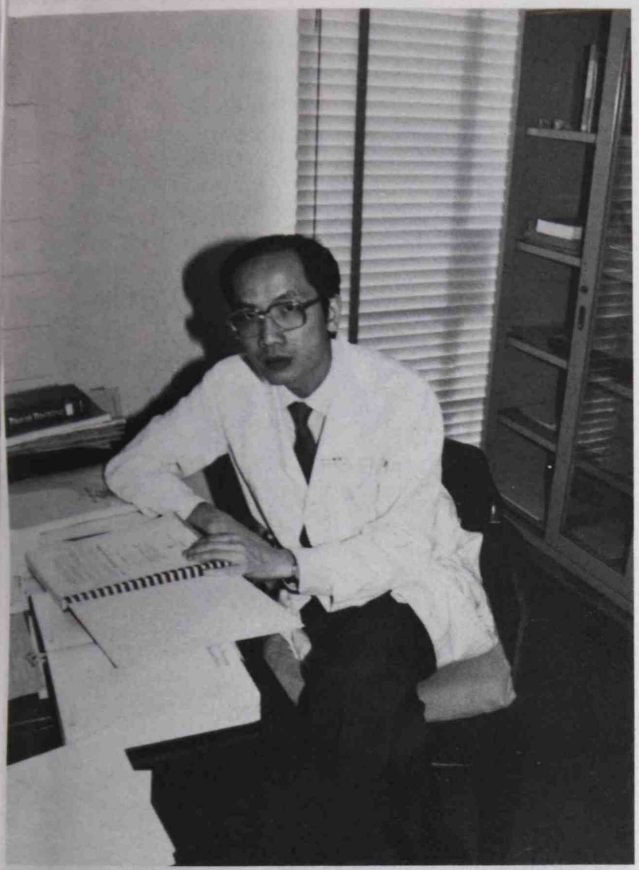
In Mr. Lee's opinion, medical students usually have a united spirit, probably because they have to spend 5 years together. This is what makes them perform so well in many activities, e.g. sports.

Mr. Lee had been a very active person during his university years. He participated in the Inter-faculty Squash Competition representing the Faculty of Social Sciences, and as an affiliated member of St. John's College, he participated in the Inter-hall Football Competition. He was also a committee member of the Psychology Society. At present, he is the Chairman of the Division of Clinical Psychology of the Hong Kong Psychological Society.

Mr. Lee enjoys playing squash, swimming and gathering with friends at leisure. ■

Dr. S.L. Luk

M.B.,B.S. *H.K.;* M.R.C. Psych.



Dr. Luk obtained his M.B.B.S. degree from University of Hong Kong in 1974. He then joined the psychiatric unit of H.K.U. as a medical officer. In 1979, he was appointed lecturer. One year later, he went to U.K. for further studies. At that time, he studied at the Institute of Psychiatry of Mosley Hospital and he concentrated on studying Child Psychiatry. He enjoyed very much during the two years in U.K. He learnt much in U.K. as there were many famous doctors there, and also made many friends.

Being a lecturer, the workload is quite heavy. Besides teaching, Dr. Luk often has to meet patients. Since his postgraduate studies is about Child Psychiatry, his patients are mainly children. A variety of problems are encountered, including conduct problem, emotional problem, psychosomatic problem, mentally retarded children and childhood autism.

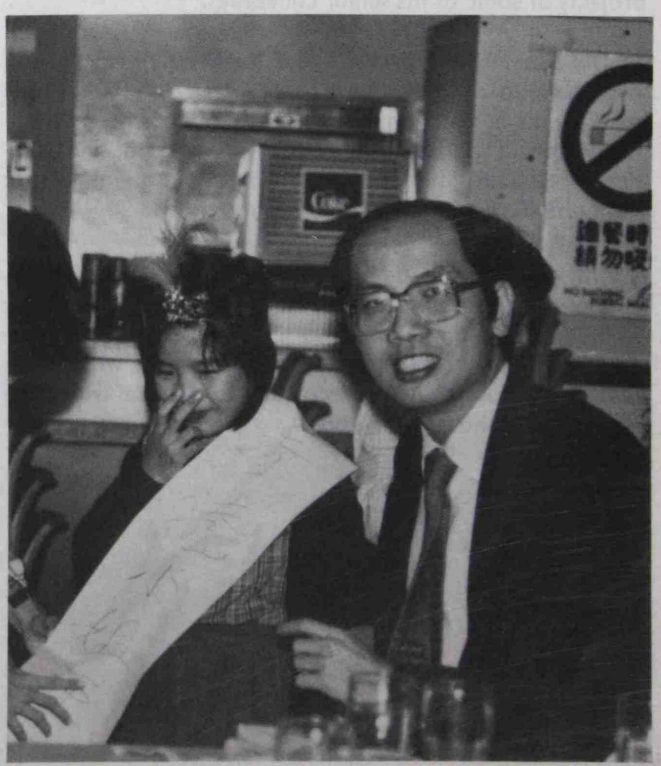
In his view, the methods of teaching in psychiatry have been much improved during the past ten years. For example, there is an introduction of tutorial groups, the use of television for teaching purpose. Besides, there are more chances to learn from practising doctors. These may arouse the students' interest in psychiatry. He also thinks that the teaching of behavioural sciences for medical students can help them to study psychiatry.

Dr. Luk is now doing research on hyperactive children and childhood autism. He hopes that the research will lead to better ways to help children who are suffering from these problems.

Regarding the fact that few medical students choose to specialise in psychiatry, Dr. Luk thinks that this is a common phenomenon throughout the world. Prospects and chances for further studies are the main factors that will affect the students' choice. Nevertheless, he thinks that medical students should expose themselves to this field as much as possible. In fact, working experience in this field can also help the practice in other fields.

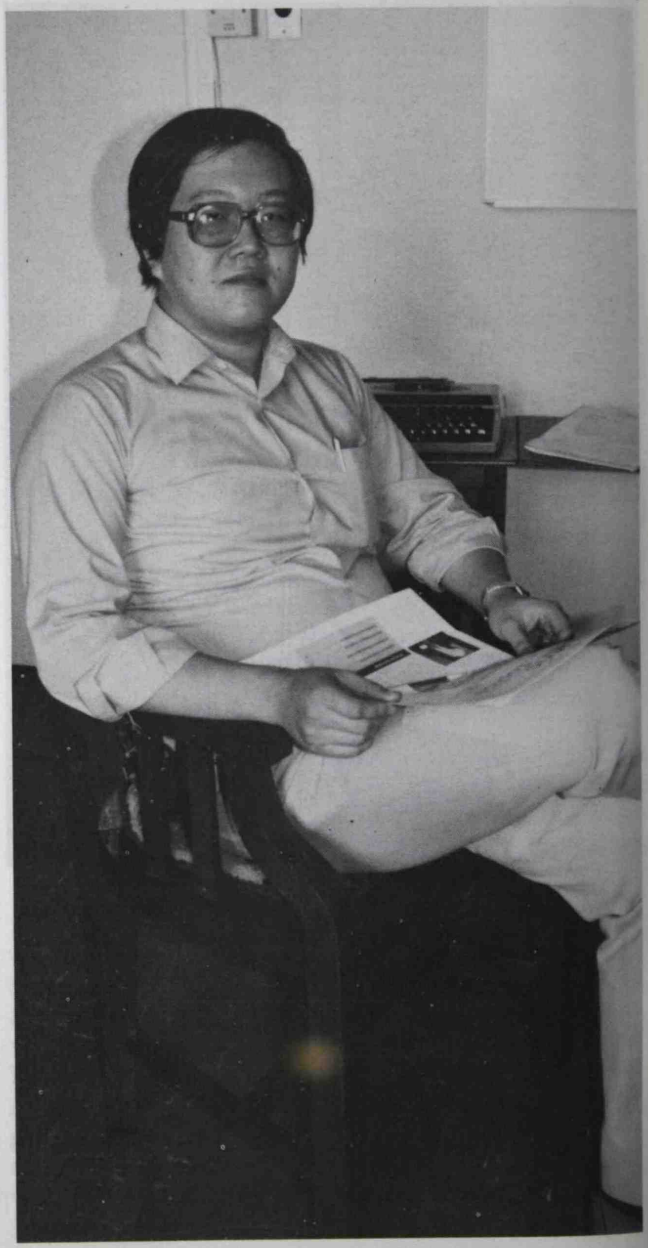
Dr. Luk was an old boy of King's College. When he was studying in secondary school, he liked playing football, basketball, volleyball and swimming. He was also good at chess and bridge. During his studies at H.K.U., he was a resident of Old Hall for 4 years. He also actively participated in the activities at Students' Union.

He is married and has two daughters. During leisure time, he usually spend the time with his family. He also enjoys swimming. ■



DR. P.C. PAN

M.B.,B.S. *H.K.* (from 1.10.1984)



Dr. Pan received his secondary education in Ying Wa College and matriculated in 1974. After taking the H.K.A.L. examination, he entered the Faculty of Medicine and graduated in 1979.

During his life as a medical student, Dr. Pan did not participate in many extracurricular activities but the Medic Choir because he lived far away from school. However, he was an editor of his school paper and a member of the school choir and the orchestra when he was in Ying Wah College.

On his graduation in 1979, he worked as a houseman in general medicine and general surgery. However, he was more interested in the Psychological aspects of human beings, and therefore determined to join the University Psychiatry Unit as a medical officer.

In 1982, he passed the first part of the examination of the Royal College of Psychiatrists in Britain. He became a lecturer of the department in October, 1984 and will take the second part of the examination in the near future. When asked about the risk of being a psychiatrist, he said that special precaution had to be undertaken to protect the personal safety of psychiatrists, and no serious accident had happened in Q. M. since he started his career.

Regarding his research interest, Dr. Pan is more interested in clinical work and has little experience in independent research. However, he has helped in research projects of some of his senior colleagues.

Dr. Pan married in 1981 and has 2 children – one is one year old and the other is three years old. His wife is working as a nurse in a special school for the multiple handicapped children. Although he is quite busy during his office hours, he finds no difficulties in maintaining a harmonious relationship with his family.

During his spare time, he often has to look after his children. Yet, he also enjoys reading books and magazines as well as thinking about and analysing the problems of the community. He dislikes certain magazines which take biased viewpoints on certain social and political issues. He likes to take photographs too.

When asked about his attitude towards 1997, Dr. Pan thought that the upper class would worry more about the future since these would mean a deprivation of their privileged status. When we look back on the history of modern China, the Sino-British Agreement cannot really ease our worries. The direction of progress adopted by the China's authority is correct, despite the many existing defects. Every Chinese would inevitably hope for the prosperity of our motherland.

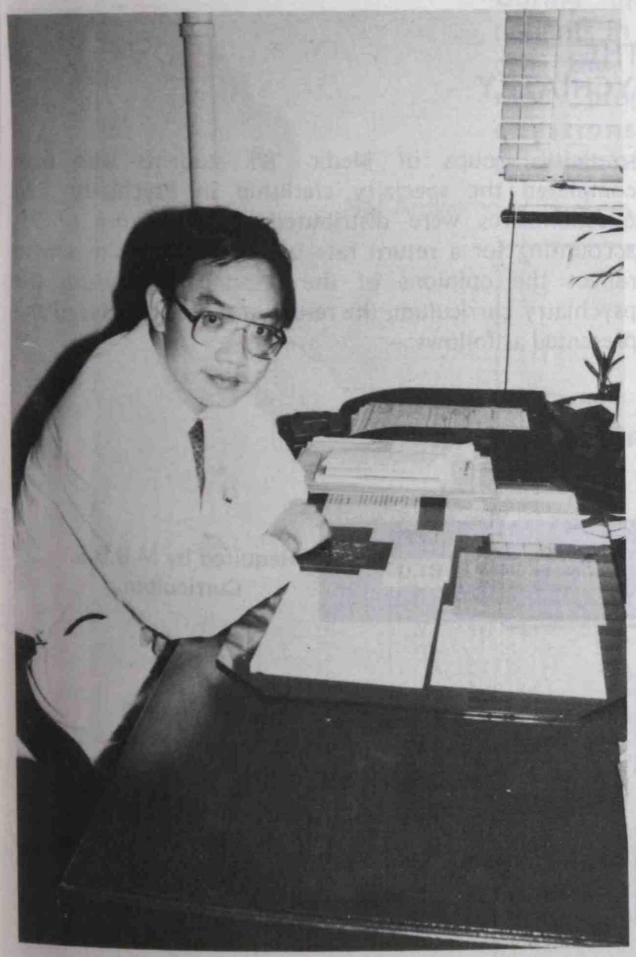
Lastly, he commented that the opportunity for further studies in psychiatry, is comparable to other specialties in terms of job satisfaction and prospect. ■

Dr. G.K.K. Yu

M.B.,B.S. *H.K.*; M.R.C.Psych.

Dr. Yu received his secondary education in Kowloon Wah Yan College and matriculated in 1972. After taking the H.K. A-Level examination, he was admitted into the Faculty of Medicine and then graduated in 1977.

Dr. Yu is quite active in his secondary school life; he has participated in the students' association and an altar boy in school. In university, he has lived in the Ricci Hall for five years, except for the brief interval during specialty clerkship and was the secretary of the Hall Association from 1973-1974. He enjoyed his life in the Ricci Hall and valued the friendship among his hallmates.



After internship, he worked in the casualty unit of Queen Elizabeth Hospital from July 1978 to February 1979. He later joined the Government Psychiatry Unit because he thought that the psychological and emotional aspects of the human body are as important as physical ones. In September 1981 and November 1982, he passed the Part I and Part II examination of the Royal College of Psychiatrists respectively. In February 1984, he became a lecturer in the University Psychiatric Unit. When asked about the risk of being a psychiatrist, he replied working with mental patients is not at all a problem since not all of them have violent behaviours.

Dr. Yu is interested in Psychogeriatics because very few people are working in this field and the psychological problems of old people are becoming more important. However, he thinks that limited time is left for research work because of the heavy work load in the unit.

Dr. Yu married in June 1980. His wife is a nurse in the Queen Mary Hospital. He said that his job as a doctor did not affect his family life since they understand quite well about their difficulties in work.

Dr. Yu spends his spare time in reading magazines and journals such as the Ming Pao Monthly. Times, The Economist and Scientific America. He is also interested in novels and movies.

Concerning the 1997 issue, Dr. Yu is quite optimistic and will stay as long as the situation in Hong Kong remain unchanged. He does not want to leave, unless this is inevitable. ■

The Curriculum

CURRICULUM OF PSYCHIATRY IN HKU

When Psychiatry was still a unit in Internal Medicine, there were only 6 lectures and 1 week for specialty clerkship in Psychiatry.

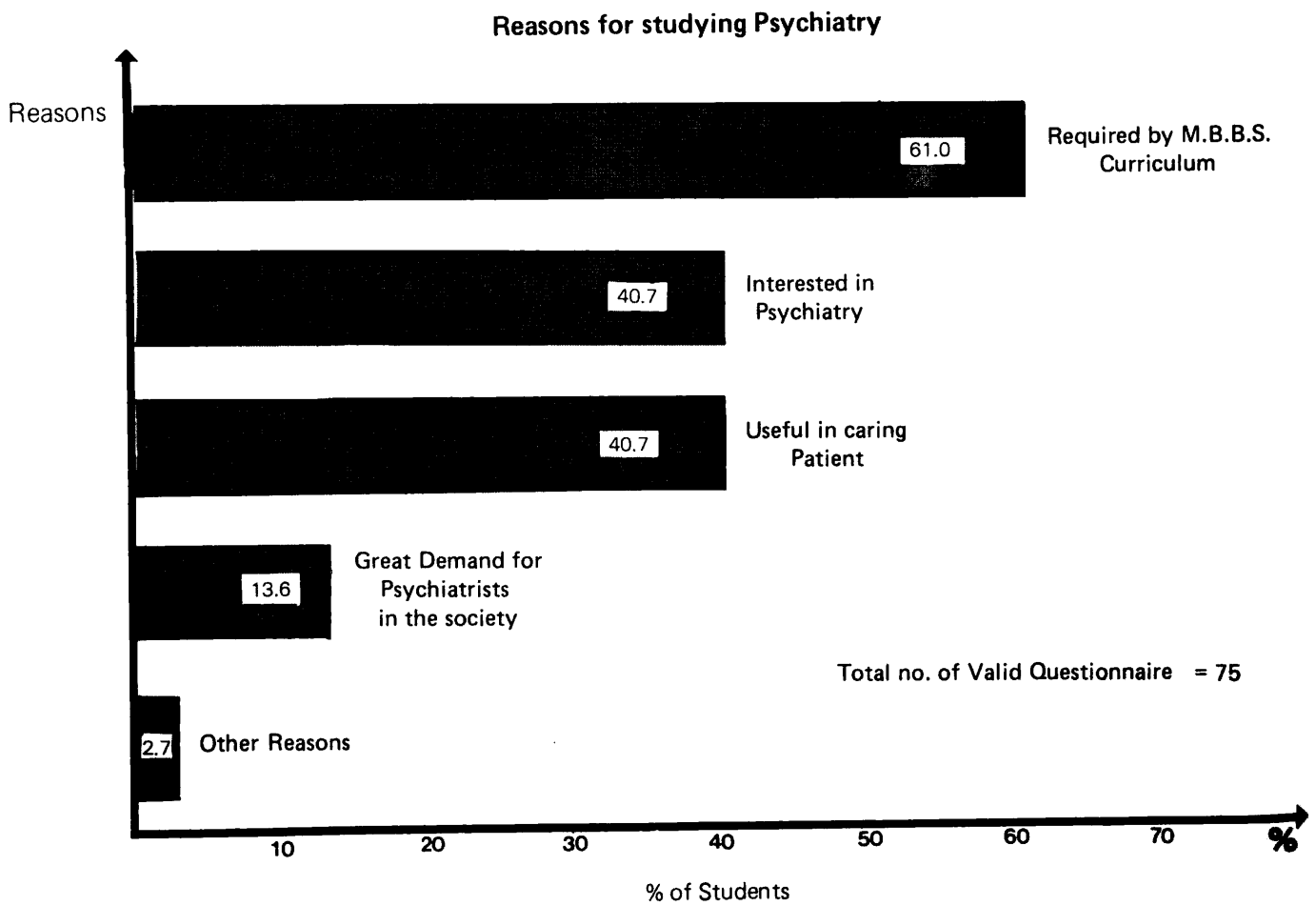
After the establishment of the Department of Psychiatry in 1970, the number of lectures were increased to 15 and the specialty clerkship spanned 2 weeks.

Since the introduction of the new medical curriculum in 1977, the teaching of Psychiatry was expanded to 32 formal lecturers in the fourth year. During the final year, the students are required to take specialty clerkship in Psychiatry which lasts for 10 weeks. The first nine weeks are shared with Gynaecology – 2½ days out of a week are devoted to video-watching of clerk cases conducted by three students of the specialty group and a mental patient and/or his/her family. Every student will take the clerk case in turn in order to obtain clinical experience. In addition, there are tutorials, clinical attachments, lectures and visits to United Christian Hospital and St. James' Centre. Then, the last one week will be spent on visits to Castle Peak Hospital before sitting for the class test of Psychiatry.

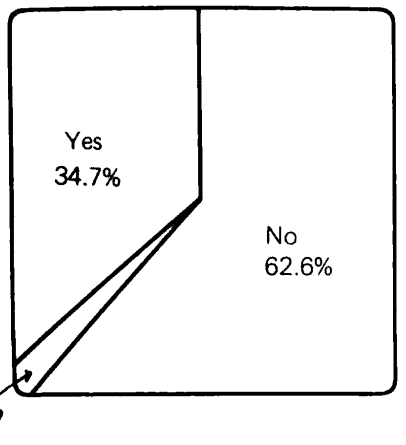
REVIEW OF THE CURRICULUM OF PSYCHIATRY

Mutual understanding and cooperation are indispensable for the improvement of the medical curriculum, making it more socially oriented and minimizing the wastage of resources. The survey conducted by Elixir '84 is aimed at facilitating the above-mentioned process.

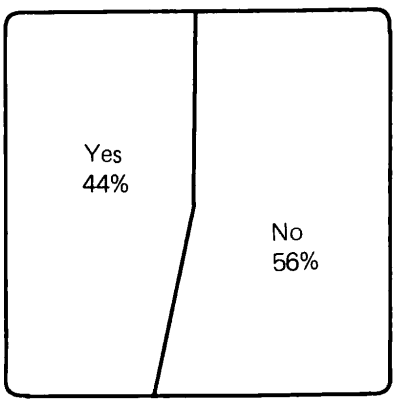
In Oct., 1984, questionnaires were set for the four specialty groups of Medic '85 students who have completed the specialty clerkship in Psychiatry. 120 questionnaires were distributed with a return of 75, accounting for a return rate of 67.5%. With the aim to reflect the opinions of the respondents towards the psychiatry curriculum, the resultant data are analyzed and presented as follows:–



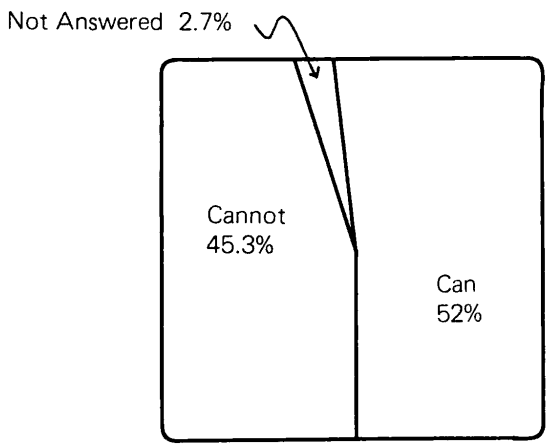
Do you think there are adequate psychiatric cases for teaching and study purpose in Q.M. hospital?



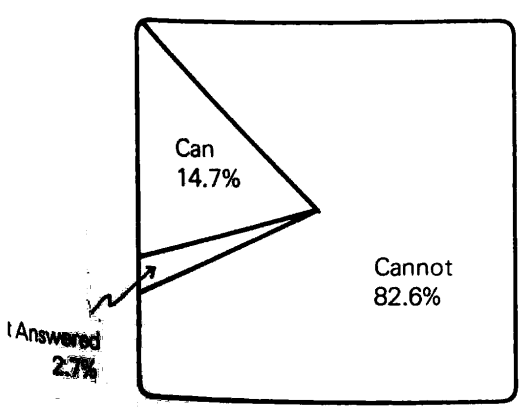
Do you think there are sufficient opportunities for interviewing psychiatric patients in Q.M.H.?



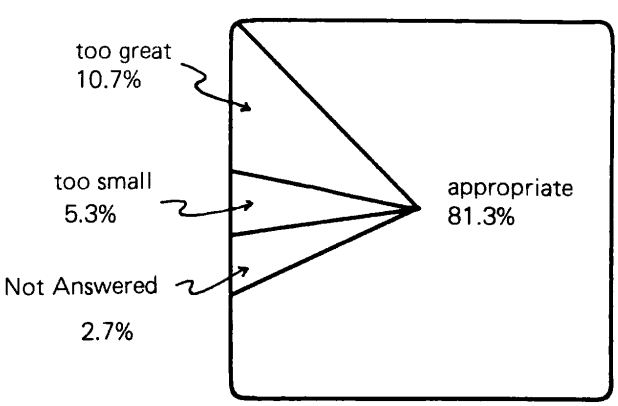
During interviews with the patients in specialty clerkship, can the interview students raise proper and relevant questions without the guidance of tutor?



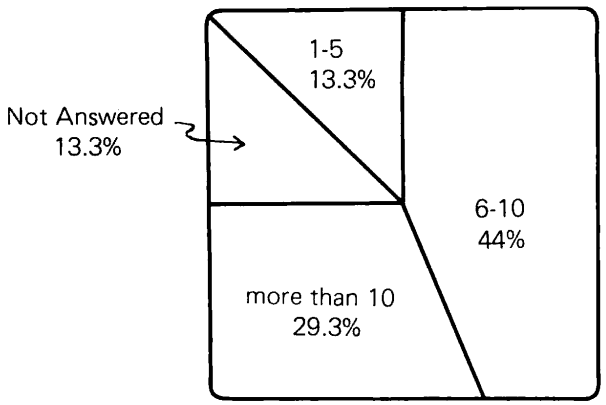
During video-watching in specialty clerkship, can you make the full use of the case watched without the guidance of tutor?



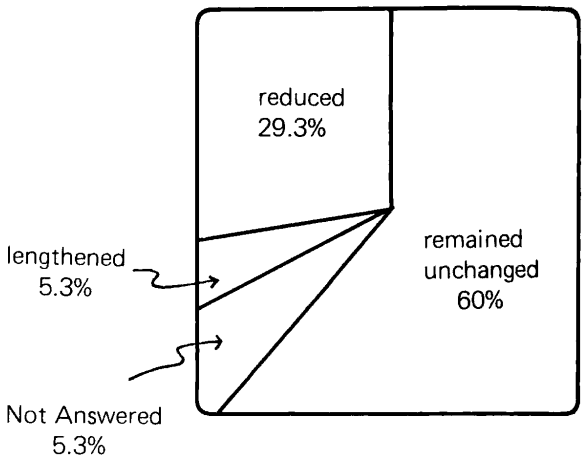
How do you consider the student-tutor ratio in Psychiatry study?



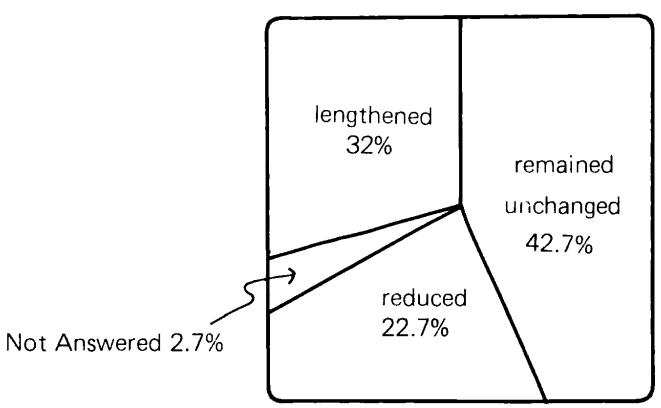
What is the optimal size in terms of no. of students for one tutorial group in video-watching?



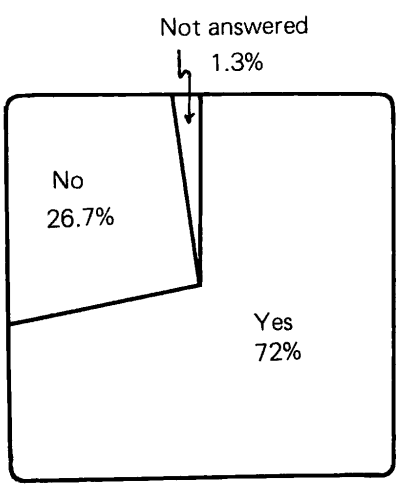
What change do you consider beneficial for students concerning the length of special clerkship?



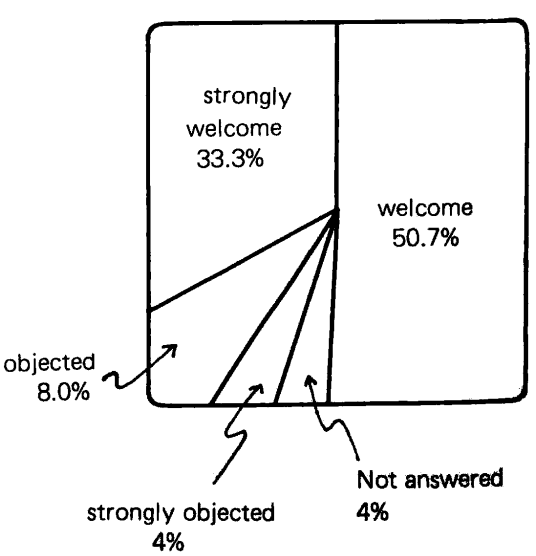
What change do you consider beneficial for students concerning the length of bed-side study in Castle Peak Hospital?



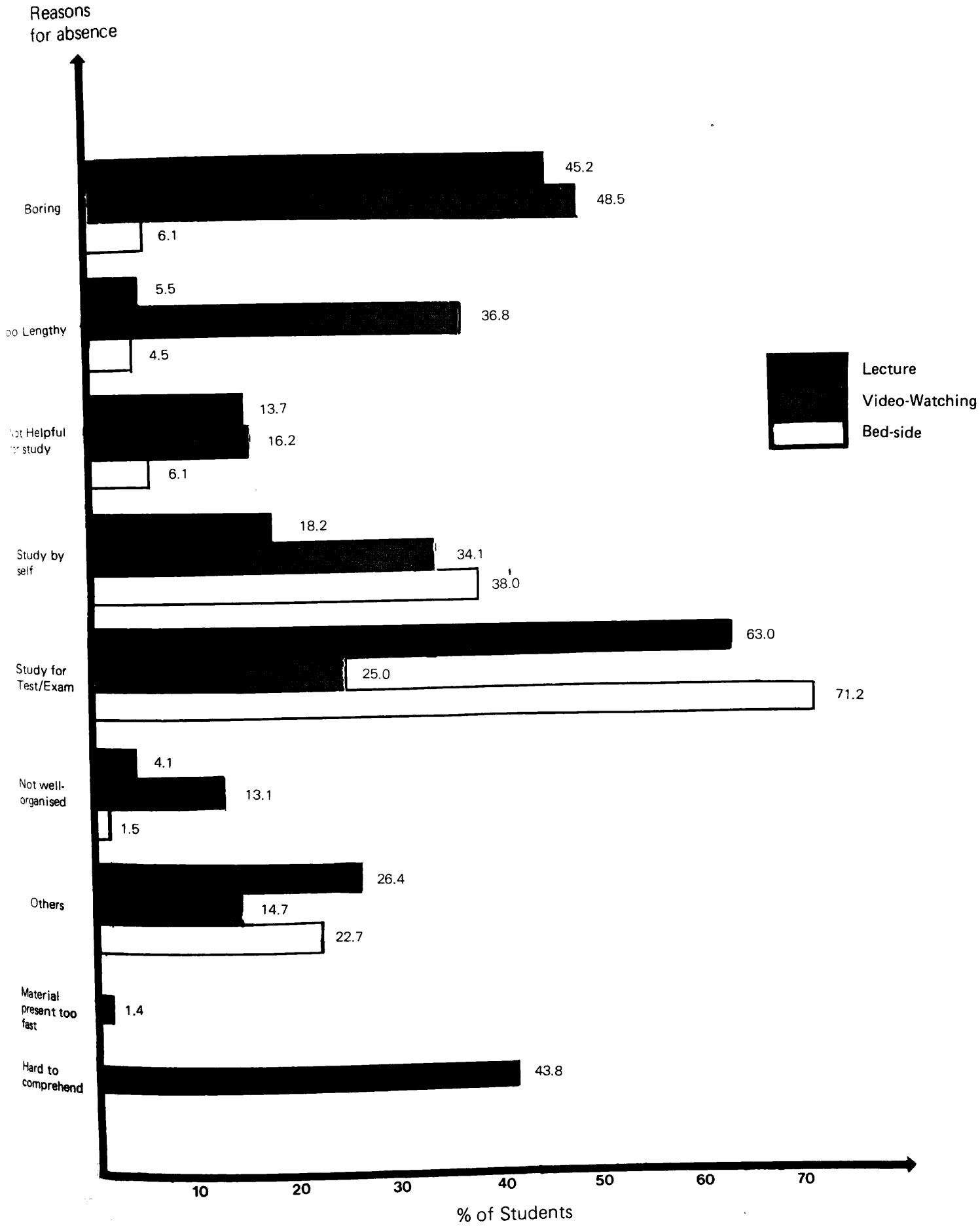
Do you welcome the use of Cantonese as teaching media in Psychiatry?



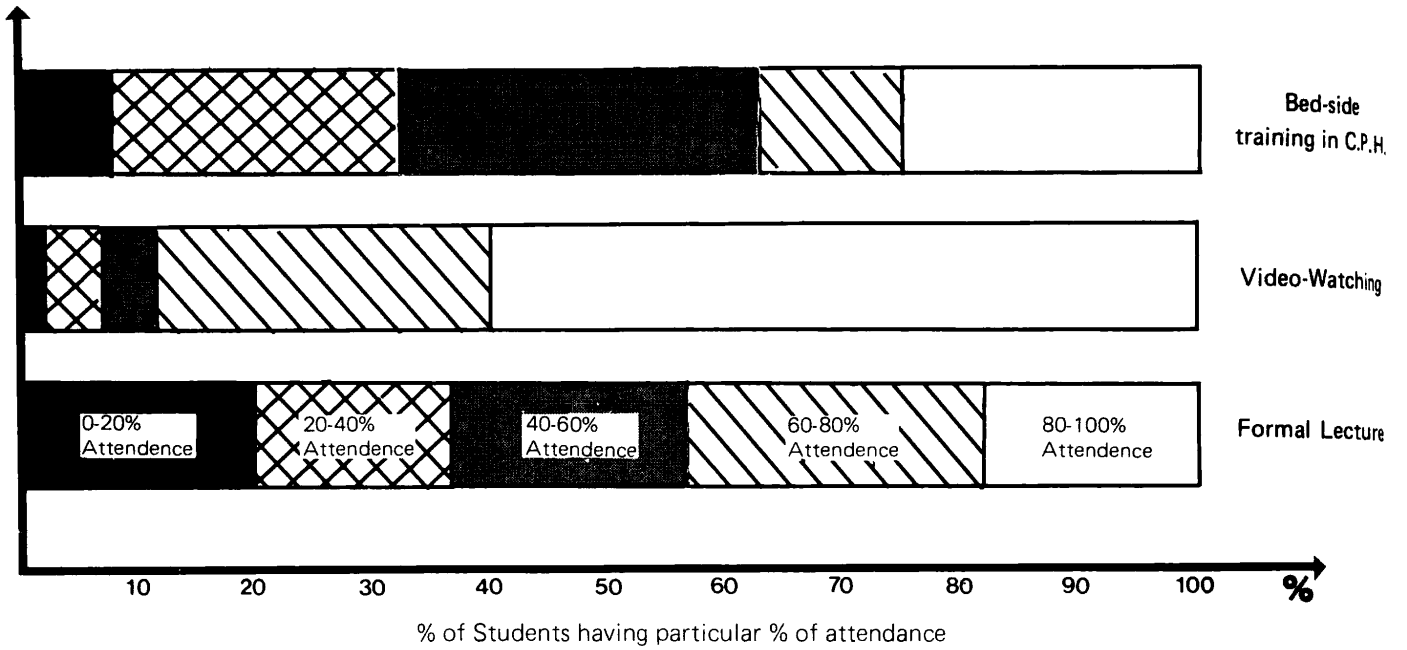
How do you value the integration of lectures into the specialty clerkship?



Reasons for absence in various Psychiatric training

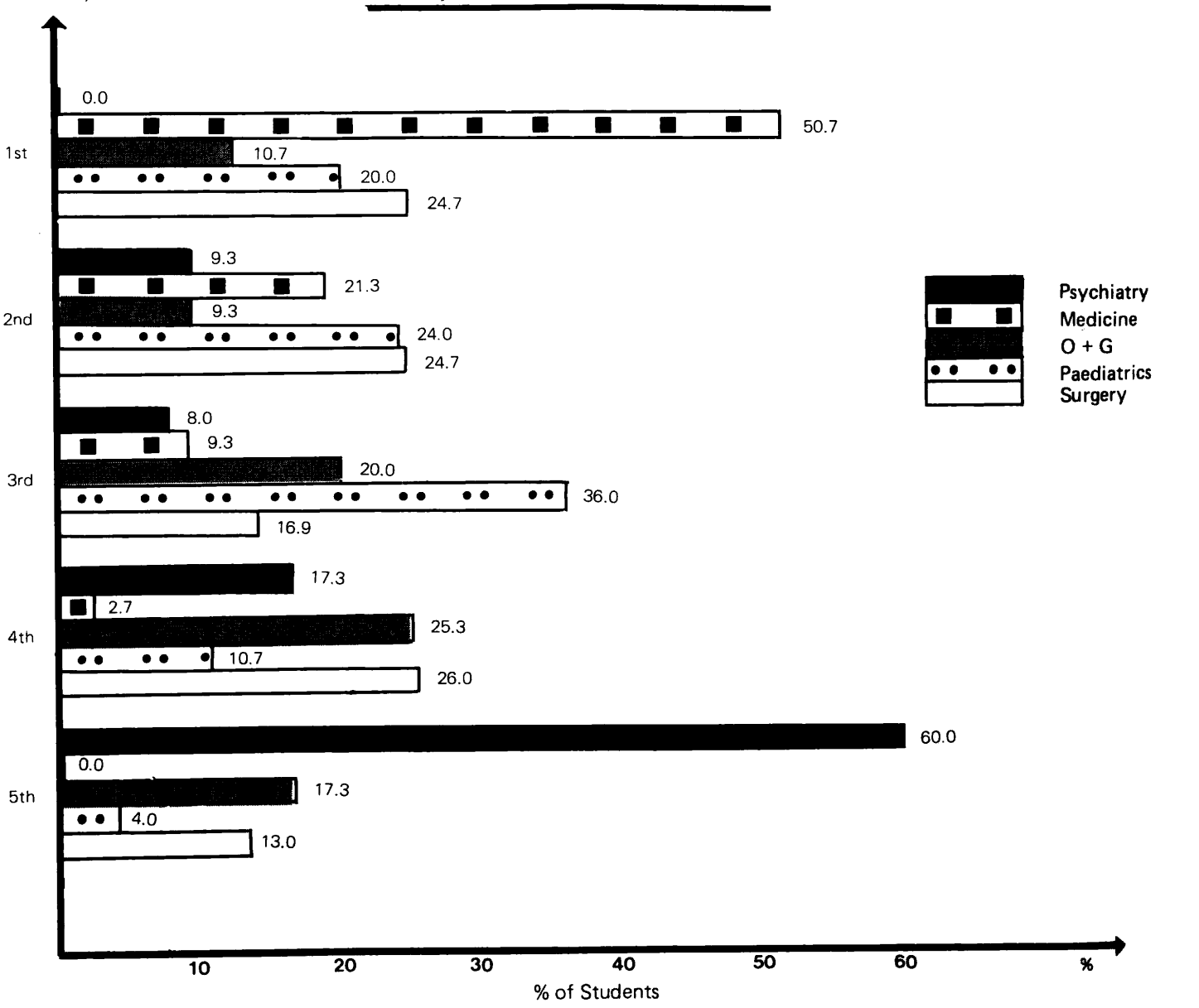


Percentage of Attendence

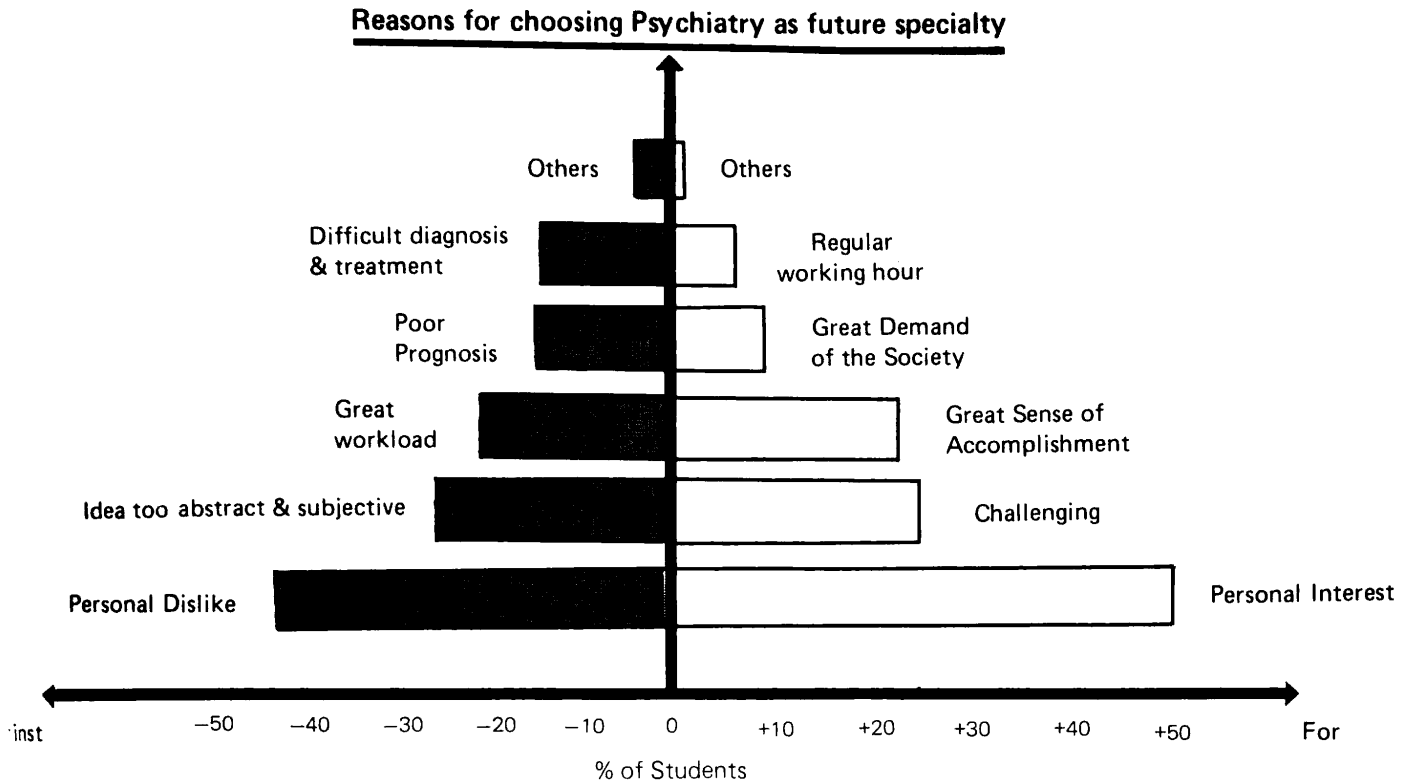


% of Students having particular % of attendance

Priority in choosing future specialties



% of Students



At present, the Department of Psychiatry is esperately short of ward space and hospital beds to ccommodate psychiatric patients for the purpose of linical teaching. Limited number of psychiatric patients re admitted to Queen Mary Hospital for treatment while large number are admitted to Kwai Chung Hospital or owloon Hospital. Doctors in Queen Mary Hospital are argely engaged in outpatient consultation and follow-up f patients after they are discharged. In order to provide dequate clinical exposure for students attending the pecialty clerkship, the Department resorted to video eaching instead of direct bedside teaching. Accordingly he formal lectures became a major part of the actual eaching process. Once the students found the lectures difficult to comprehend, they might rather devote the time for private study, especially when the class tests were near.

Every student has to attend an one-week period of clinical instruction in Castle Peak Hospital at the last week of the specialty clerkship for psychiatry. It is a valuable opportunity for the access to direct interaction with psychiatric patients. Nevertheless it had not much appeal for most of the students simply because the hospital is remote from the city centre. Since student accommodation is lacking at Castle Peak Hospital, many students found the journey very exhausting especially when there was a class test after the week's clinical instruction.

An extract from the report of 'Medical Education Review Committee (MERC), Medical Society, HKUSU (1981-1982)' of review on Psychiatry curriculum is quoted here to serve as a reference:—

(I) General Comments

1. **The General Lack of Interest in the Students:—**

Students in general show little interest in psychiatry. It may be due to the following reasons:

- Students do not see the importance of psychiatry in the caring of the patients. Furthermore it appears less scientific, less objective and less academic.
- The curriculum is badly arranged.
- Students find difficulties in comprehending psychological or psychiatric materials which appear abstract and difficult to be understood, especially when expressed in English which is not the daily spoken language of both the patients and the students.
- Psychiatry is not a part of the MBBS examination. Hence students may have less incentive to study.

2. **The Curriculum Itself:—**

As a whole, the curriculum is poorly arranged and cannot convey the importance of this subject or arouse the interest of the students.

- *Lectures* —

Lectures are given in the period of senior clerkship when the students have minimal idea of psychiatric illness and no exposure to psychiatric patients. Thus it is quite impossible for students to comprehend or benefit from the series of thirty to fourty lectures, not to say to develop any interest in the subject.

- *Bedside Teaching* —

One crucial handicap in the bedside teaching in Queen Mary Hospital is the limited number of patients available for teaching. This leads to very limited clinical exposure in terms of number of patients with direct contact and varieties of patients met.

Another serious problem is the format of teaching. The sessions of watching television are boring and cannot arouse the students' interest.

- *One Week Period in Castle Peak Hospital* —

Both the number and variety of patients in Castle Peak Hospital are numerous, particularly the chronic or florid cases, as compared to Queen Mary Hospital. Hence the clinical experience of the students are much enriched.

However, the visit is arranged only in the last week the clerkship when the pressure of the clerkship test may deter the students from turning up in the visits. Furthermore, after the beginning of a new clerkship, the students have no chance of following up the cases and no time to consolidate any interest enlightened during the visit.

(II) Suggestions

1. More emphasis and a proper prospective of the position and importance of psychiatry should be given.
2. Teaching of psychology in Behavourial sciences should be

improved and better co-ordinated with the Department of Psychiatry in order to prepare the students with a sound background knowledge in psychology.

3. Systemic lectures during the period of senior clerkship should be reduced or even abolished. Instead, they should be incorporated into case discussions during the clinical clerkship.
4. The number and variety of patients available for teaching should be increased. This is of crucial importance in arousing the students' interest.
5. The Castle Peak Hospital and Kwai Chung Hospital are good resources of patients for teaching. Arrangements to go there a once every week during the clerkship can be made.
6. Attachment to clinical staff in their management of patients during the initial diagnostic interviews, therapeutic interviews and the subsequent follow-up may enable the students to see the actual process of management which is an important stimulation during the study.
7. Assessment is best to be made at the end of the clerkship.

FUTURE DEVELOPMENT IN THE PSYCHIATRY CURRICULUM

In order to reflect the result of the questionnaire to the department and also to know the prospective changes in the curriculum, Elixir has arranged an interview in Nov., 1984. Five persons were invited to this interview:— Prof. Lieh-Mak and four senior students (2 fourth year and 2 final year students of who 2 are student members in this year Curriculum Review Committee). The finding of the interview is summarized as follows:—

The situation will become better after the completion of the Queen Mary Hospital extension. From then onwards, more psychiatric patients could be retained in Queen Mary Hospital for treatment so that it would be possible for the students to observe the same patient for some six weeks in his course. Once there was increased degree of direct clinical exposure, the formal lecture sessions would be condensed and the video session would also be reduced in consequence. The hospital extension was scheduled to be completed in 1987 but unfortunately the date might well be delayed because of various technical problems and repeated revision of the building plan.

In the near future, some changes would be implemented in order to achieve a better attendance at the clinical instruction session. In December 1984, the session at Castle Peak Hospital would be extended to alternate days over a two-week period instead of seven days in succession. In addition, there is a possibility that the venue for a fraction of the clinical instruction session might be conducted in United Christian Hospital in Kowloon.

Improvements were continually being proposed for the curriculum. These include an eight-week specialty clerkship solely for psychiatry to make the course more distinct and an integrated teaching by the Department of Psychiatry and Behavioural Science Unit in the second year of medical education to enhance the awareness of local clinical situation in the field of psychiatry. The class test may become part of the Medicine Paper. These proposals were under consideration, nevertheless it would be at least several years before any actual modifications could be effected. They are dependent partly on the future social trend of illness patterns and partly on the emphasis of UPGC in the allocation of funds.

In conclusion, the Department of Psychiatry is aware of the present shortcomings in the course, but with the limited resources now available, not much improvements could be made.

POSTGRADUATE TRAINING IN PSYCHIATRY

After completing the M.B.,B.S. course and one-year housemanship, a registered doctor can basically practise as a psychiatrist in Hong Kong. However, the practice requires a great deal of clinical experience. Thus, most of the prospective psychiatrists will like to further their training. Due to the lack of postgraduate training in Hong Kong, most doctors resort to pursue their training in foreign countries, mostly United Kingdom. With growing concern over the shortage of psychiatists, the Hong Kong Government has sent more doctors to sit for the postgraduate examination, e.g. Member of Royal College for Psychiatrists in United Kingdom.

Recently, a new training system is under consideration. It is suggested that over a three-year period, a prospective psychiatrist will have to work successively in six different specialties:— namely social psychiatry, psychogeriatrics, child and family psychiatry, forensic psychiatry and liaison psychiatry. This newly-proposed rotating system which will take place successively in various hospitals (Castle Peak Hospital, Kwai Chung Hospital, the Psychiatric Unit of Queen Mary Hospital, Kowloon Hospital, Prince of Wales Hospital) serves to increase the clinical experience of the doctors before sitting for the postgraduate examination.

At present, our Department has 2 trainees in Psychiatry. It is expected to have 4 trainees after the completion of the extension of Queen Mary Hospital in near future. ■

精神病？精神病！

精神病」與「精神病人」在一般人心目中都有着一種抗拒感。這篇文章主要就是對「精神病」，「香港精神科」等各方面作一個簡介，希望讀者能得到一個簡單而全面的認識；更希望這篇文章能喚起他們對這方面的興趣，日後自我探索，慢慢加深自己對這方面的體會。

全文大致可分爲以下幾部份：

一、精神病之概念
二、香港精神科制度之簡介
三、病人入住精神病院之主要途徑
四、在精神病院內工作小組之配合
五、香港現有之康復服務；並對「過渡期宿舍」作一簡介。

「八二年六月三日，一名精神病患者×××於元洲邨其寓所內無緣無故將其母親及妹妹刺斃，隨後×××走出寓所，在邨裏刺傷三名途人，並闖進一幼稚園內，刺傷數名三至四歲小童……。」

「一九八三年四月二十日，被告×××否認六項謀殺罪，但承認誤殺及十九項嚴重傷害他人身體的控罪，主控及法官以被告神智失常，同意減輕其刑事責任。」

以上一宗事件，相信在大家腦海中記憶猶新，及至日後公衆對精神病的看法，亦產生了莫大的影響。究竟絕大部份的精神病患者，是否一般人心目中那麼可怕的？

什麼是「精神病」？

提到精神病患者，你心目中會否有一個「衣衫襤褸，頭髮散亂，當街哭鬧，操刀斬人……」的形象浮現？其實甚麼是精神病，精神病又有甚麼病徵呢？

根據聯合國世界衞生組織（WORLD HEALTH ORGANISATION，WHO）的定義，任何心理上的失常，導致情緒，行爲或心智等方面的運作，對病者產生影響，均稱之爲精神病。

從治療的角度看，精神疾病可分爲以下幾種：

㈠ 重性精神病：如精神分裂症，燥狂抑鬱症等。
㈡ 神經官能症：如神經衰弱、焦慮症、癔病、慮病、强迫症等。
㈢ 病態人格：如偏執型、循環型、爆發型、性變態等。
㈣ 心身症：因情緒不平衡而呈身體病症的疾患，如胃潰瘍、高身壓、哮喘病等。
㈤ 器質性精神病：由身體其他器官疾病引起精神症狀的疾病，如羊癇症、顱腦損傷、甲狀腺病等。
㈥ 弱智：包括先天及後天引致的智力遲鈍。

若你認爲這些分類始終流於空泛，那麼我們說實在些吧。通常精神病人都會有或多或少的徵狀，使人（及醫生）知道他們「不正常」，普遍地，他們會因病而工作能力衰退，飲食及睡眠習慣失常，對家人及朋友的態度改變，思想異常，情緒不穩定等等。嚴重時病人更會有怪異行爲，喃喃自語，情緒難以控制及妄想與幻覺等症狀，甚至表現有自殺或暴力傾向。

滿街都是「神經」漢？

實際上，日常生活中遇到的精神病人，病況都是比較輕微的一種，就每年到精神科醫院及政府門診部接受治療的，均不下十多萬人，而且，諱疾忌醫的尚未計算在內，他們大多有正常工作，和一般人交談接觸，與常人無異。其實，依照以上定義，每年醫科考試前，便有不少醫學生經歷短時期的精神失常。

至於元洲邨事件中的病人，是屬於有暴力傾向的「精神分裂症」患者，他曾在七六年間於青山醫院接受治療，痊癒後出院，但仍有到油蔴地精神科診所就醫，直至七七年中爲止。自此之後他便不理會醫生的要求，拒絕繼續治療，後來其母向醫生報告病者的病況，醫生曾向她建議將病者再次送院接受治療，但爲其母拒絕。根據現行法例，醫生並無權力强迫已出院病人接受治療，或在未獲取其親屬同意及法庭的授權前將患者送入精神病院，正因這一點，終於演變成當日的悲劇。

從這個個案中，我們可以觀察到問題並不單獨產生在病者身上，而是在整過精神病醫療制度上。在以下的篇幅裏，我們就會對香港精神病服務作概括介紹，隨後再在精神病患者入院，接受治療，出院及康復等方面作進一步了解。

香港的精神科醫療制度

很久，很久以前……

本港的精神病治療服務，最早可追溯至一八九五年在政府中央醫院成立，位於西營盤的精神病人庇護所，直至一九二五年，此病院只有五名護士和十七名普通職工，一位中央醫院的醫官只在有需要時才到病房服務。由一八九五年至一九一二年，只有三十名病人入住該院。然而，當時精神病人普遍被認爲是家庭的恥辱，因此病人家屬寧可忍受照顧一名心理失常的人的種種不便，也不願將病人送往庇護所，事實上，當時確曾有些富裕家庭在自己的園子裏，建起小屋來收藏他們的患病家屬。

一九二五年，第一所精神病院在高街建成，但當時精神病院的最大作用，只限於在病人轉送至廣州的醫院治療前予以臨時照顧。

後來……

一九四九年，中華人民共和國成立後，再沒有精神病人被送到中國，本港的精神病治療服務也開始擴展，經過三十多年的發展，服務的種類和質數都比以前進步，而設備也完善得多了。現時本港的治療設施包括以下各種：

一、精神病院
二、精神科診所
三、心理健康中心
四、分區醫院精神科

精神病院（住院）

目前香港有五所精神病院，分別爲：

一、青山醫院　（病牀一千九百五十一張）
二、荔枝角醫院　（病牀三百二十四張）
三、葵涌醫院　（病牀一千三百二十六張）
四、小欖精神病治療中心　（病牀二百張，專供犯罪病人）
五、小欖醫院　（病牀二百張，專供嚴重患者）

現代的精神病院的新趨勢是要爲入院的病人即時提供快速而又精細的治療服務，使病人能夠在最短時間內康復離院，以免與外界脫節。而治療大致分爲幾方面，首先，葯物治療是不可或缺的、鎮靜劑、抗憂鬱劑等，均爲常用之葯物；其次，電療、心理治療、職業治療等也起了不少作用；而醫院內那富保護性的氣氛，對於病人康復亦有很大幫助。

上述的五間精神病院，除了小欖精神病治療中心外，均設有所謂開放病房，或「行街房」，即沒設門鎖裝備的病房。「不上鎖」的目的，不單是消除環境上的阻隔，更重要的是掃除了意味着病人被禁閉，被遺忘和葯石無靈的舊觀念。

精神科診所（門診）

精神科診所包括：

一、伊利沙伯醫院精神科診所
二、牛頭角精神康復中心
三、東九龍精神科診所
四、多間綜合性週日精神科診所

當病人離開精神病院後，院方都會爲病人繼續安排往診所接受治療，主要目的是希望能夠減低病人再次入院的危險，幫助病人保持健康狀況。一直以來，精神科診所只爲一些較輕微的精神錯亂病人服務，但較嚴重的精神病人也可往診所接受治療。

心理健康中心（日間醫院及門診）

這些中心包括：

一、香港精神病院
二、油蔴地精神科診所
三、南葵涌精神科診所
四、柴灣精神病中心
五、容鳳書東九龍健康中心

日間醫院治療是爲了部份不需要二十四小時留院治療的病人而設。這最大的好處，一來使病人能夠與家人保持緊密聯繫，可以晚上與家人一起生活，病人只需在日間往醫院接受治療；二則可以補救醫院牀位的不足。

分區醫院精神科（住院日間醫院及門診）

這包括：

一、九龍醫院精神科
二、瑪麗醫院精神科
三、聯合醫院精神科
四、威爾斯親王醫院精神科

在這裏、精神病人除了會在獨立的精神科部門接受治療外，可能亦會與其他內外科病人一同接受所需的治

精神病院一角

療，分區醫院精神科的設立，站在病者及其家人立場而言，都有好處：首先是醫院位於區內，方便病者家人前往探望；其次是病人能夠像院內其他病人一樣住院出院，病人的醫生亦同時能與院內的精神科醫生們緊密合作，在药物及其他治療方面，在分區醫院內均可提供。

以上的各種設施主要是由醫務衞生署的精神科所負責。普遍來說，本港的精神治療服務是和西方國家所提供的相似，但由於本港的精神病治療歷史只有短短三十多年，一切都有待進一步的發展。

而除了香港醫務衞生署和兩間大學的精神科外，還有數個政府部門，特別是社會福利署，和一些志願團體，都有提供協助。

人手方面

至八四年九月一日爲止，在精神科治療服務工作的專業人員（除瑪麗醫院精神科，威爾斯親王醫院精神科及聯合醫院精神科人員外），數目如下：

工作類別	人數
精神科醫生	七十六（其中二十三人持有精神科專業資格）
臨牀心理學家	九
社會工作者	二十九（及三名兼職）
職業治療員	五十二
護士（包括學生護士）	一千一百九十五

除了政府醫生之外，香港也有十多位執業精神科私家醫生，爲市民提供服務，雖然他們的服務對象通常偏向中上階層的人仕及較爲輕微的患者，然而，由於政府方面的人手缺乏，加上部份病人不喜歡到政府精神科求診，故此，私家醫生也在治療服務中扮演一定的角色。

入院

入院之途徑

在對香港精神病服務有一定的認識後，讓我們再進一步了解病人進入精神病院治療的途徑。

入院的病人可分爲自願與非自願兩種，自願入院的病人多數由醫生介紹到精神科門診部，輪候診治，如發現病情嚴重，便由醫生建議入院，他們入院只需經精神病院院長批准，無需任何醫生証明，而病人亦可隨時要求出院。（見附圖條例第三十條）

强迫病人入院的申請，以病人曾否犯罪來區分。如病人未有犯罪紀錄，則須由精神病人的家屬或兩名註册醫生申請，再經法庭或精神病院院長批准，才可作有限期羈留，時間通常不會超過一年，而羈留期只可延長一次；另一個途徑是由任何人提出正式通知，經太平紳士或法庭批准，送病人入院七日接受觀察。

至於非自願入院的病人，則通常是病發時由他人送院，但其中很多都不肯留院就醫，爲保障病人的人身自由起見，香港法例第一三六章精神健康條例就有規定强迫病人入院的守則。（見附圖）

如病人曾有犯罪紀錄的，則無需病人親屬或醫生申請，只要總督或法庭下令，便可把病人作無限期羈留。

入院程序的漏洞

縱觀整個入院條例，問題發生在如病人並無犯罪紀錄，而病人親屬又拒絕申請的話，醫生是不能强迫病人入院的，元洲邨事件便是這樣的一個例子，當時的主審法官就曾以條例並無授權醫生將有危險病人召回接受治療而表示可惜。

其後，於一九八三年五月發表的「曾有刑事暴力行爲或斷定有暴力傾向精神病康復者」研究小組報告書，就曾建議修訂入院條例，以便賦予有關公務人員權力，將精神錯亂人士送院觀察而無需得到病人家屬同意。另外，院長或精神科顧問醫生，亦應有權將那些獲暫試出院的病人召回醫院。報告書又建議有些病人必須在出院前接受特別評估及有權優先獲得善後護理服務，其中包括犯人，有暴力傾向或家庭環境不理想的病人。

報告書的建議，無疑保証了嚴重的精神病患者得到適當的住院和康復服務。那麼，病者在醫院內接受治療的過程又是怎樣的？

未有犯罪的病人入院

精神健康條例	申請人	所需醫生證明	批准入院者	羈留期	延長羈留期	出　院
第二十六條	病人親屬或指定的公務人員	毋需醫生證明	最高法院	無訂明限期	—	由最高法院批准
第三十條	病人	毋須醫生證明	精神病院院長	病人如擬出院可在七日前通知院方	—	由精神病院院長批准或病人自行要求出院
第三十一條	病人親屬或任何提出正式通知的人士	毋需醫生證明	地方法院法官、裁判司或太平紳士	七日	根據第三十二條的規定延長羈留期	如無延長羈留期，則於羈留期滿後出院
第三十二條	兩名註冊醫生	申請人簽署醫生證明書	地方法院法官	七日	只可延長羈留期一次	羈留期滿
第三十三條	病人配偶或親屬，如兩者皆不在，則由社會福利署署長代為申請	一名註冊醫生簽署醫生證明書	精神病院院長	十二個月	根據第三十四條的規定延長羈留期	由精神病院院長批准或羈留期滿出院
第三十四條	病人配偶或親屬，如兩者皆不在，則由社會福利署署長代為申請	精神病院院長提供的意見	精神病院院長	六個月	只可延長羈留期一次	由精神病院院長批准或羈留期滿出院
第三十六條	兩名註冊醫生	申請人簽署醫生證明書	地方法院法官	無訂明限期		由巡視精神病院人士、精神病院院長或地方法院法官批准

曾犯罪的病人入院

精神健康條例	下令入院	羈留期	暫准離院	轉解監獄	出　院
第四十五條	最高法院，地方法院或裁判司	由法官決定，或無訂明限期，其後再根據第三十六條的規定辦理	經總督同意可暫離醫院	入院令有效期間	在入院令有效期間，須經總督同意；期滿後則作爲第三十六條所指病人辦理
第五十一條	法庭或裁判司	十四日，期滿可延長四次，每次七日	—	—	羈留期滿
第五十二條	總　督	先在監獄服刑，其後再根據第三十六條的規定辦理	經總督同意可暫離醫院	刑期尚未屆滿時	刑期未滿時，須經總督同意；期滿後則作爲第三十六條所指病人辦理
第五十二A條	總　督	根據第四十五條的規定訂明期限	—	—	在入院令有效期間，須經總督同意
第五十三條	總　督	無訂明期限	—	如病人被判監禁，則於康復後轉解監獄	案件了結；如案件尚未了結，則根據入院令的規定辦理；羈留期滿
第五十四A條	法庭或裁判司	無訂明限期	—	—	經總督同意
第五十五條	監獄署署長或社會福利署署長（視個別情形而定）	十四日	—	—	羈留期滿
第七十六條	原訟庭	無訂明限期	如羈留在監獄署精神病治療中心，則須根據監獄條例第十二A條的規定辦理；如在精神病院者，則須經總督同意	羈留在精神病院者，在入院令有效期間，如無須再接受治療，得轉解監獄	先經總督同意

治療人員之整體合作

引子

「縛手縛脚的精神病人長髮披肩，一雙迷惘而散亂的目光凝視着窗邊的一絲毛塵。另外一邊，一個大吵大鬧的病人正從一盤熱水被轉浸入一盤冷水裏面……」以上的情景並非編劇們編做的精神病院的情形，而是眞眞確確在香港三十年代的高街精神病院的一角實景。當時除了將病人完全隔離於社會，囚進與世隔絕的四壁圍墻裏面之外，並沒有積極妥善的方法讓精神病人康復過來；說實話，當時只是把精神病患者推向更難復原的死胡同。

這樣的精神治療方法當然無法立足存在於現今的醫療服務之中。在今天的治療中，其中一項最被强調的就是各工作人員之整體合作。病人每方面都已有指定人員負責照顧，護理工作也週詳和有效得多了。

工作小組包括……

每一位精神病人由初入院接受治療，直至痊癒出院，繼續進行覆診，他們均接觸到不同種類的專業工作人員，其中包括了負責安排整套治療程序的精神科醫生，爲病人作出心理評估及進行心理治療的臨床心理學家、負起日常醫務護理工作的護士、輔助病人學習日常工作的職業治療員，以及解決病患者及其家人切身生活問題的社會工作者。

這般精細的分工對病人的康復無可置疑是全面的保証，也是給予病患者家人的一種有形幫助。醫務人員工作於這個整體工作之中，可以專注發揮自己岡位的功用，藉着與其他同事的通力合作，令病人儘早離開醫院，以免與外界脫節。

病人入院

當一個病人入院，首先與病人接觸的是醫生，經過診斷，瞭解了病人的情況後，醫生便會預備治療程序。如果病人情緒波動很大，那麼，護士的細心開解及護理便是不可缺少的了。經過了數天，當病人稍爲平靜下來，醫生便會着手進行治療的工作，這主要包括了葯物治療和電療。

初步診治

經過這些初步治療，比較穩定的病人會被送到「一般病房」（Informal Ward）。在這裏職業治療員會安排以工作爲主的治療程序，藉着這些機會使病人繼續做病前的工作，定時上班、吃飯、小休，適應常人的生活節拍。治療員會就病人的工作表現作出報告，提供病人對日常生活和工作的適應能力的資料，幫助醫生診症。此外，護士除了照料和觀察病人的健康和精神狀態，同樣也會向醫生報告病人的有關資料。

多方面的照顧

在適當的時候，醫生會約見病患者的家人，與他們一同討論病人的情況，使家人對其病情有所認識，也藉此向他們提出正確的態度，提醒他們當病人出院後要設法使病人恢復信心，重新工作及過正常的社交生活。如果病者的家人有需要，醫生會介紹醫務社會工作者幫助他們解決經濟上的問題，例如替他們申請公共援助等。在個別病案中，醫生有時要求社工查出病人的家庭背景及其他個人資料，以便了解其病因，得以對症下藥。

但是，藥物並不能完全治好病人心理的不平衡，所以臨牀心理學家會提供輔助性的治療工作，對病人進行個性評估，智商評估，心理治療和行爲糾正治療。

所以，在整個治療過程之中，各方面的工作是同時進行的，而且，隨着病人的不同需要，工作人員也設計不同的治療程序來幫助他們。

病人好轉後

當病人情緒穩定下來，病徵消除，身體健康回復正常後，醫生便會參考各方面的報告，考慮讓病人放假返回自己的居所住一段短時間，使他們習慣日常的生活，適應外界壓力和節奏。

當要決定病人是否可以出院時，院方會爲曾犯嚴重

病人正在接受職業治療

罪行或曾有暴力傾向的人作特別評估，而這類病人在出院後也會得到優先的善後護理服務。此外，在每個病人出院前，院方會安排他們到居處附近的精神科門診部作定期覆診；按個別情況，醫生也會爲部份病人安排出院後的精神科社康服務，藉此向其家人提供精神病知識，教導他們處理患者的正確方法，介紹各種醫療服務。

出院了

總括來說，各工作人員所給予的護理和康復服務是複雜而又互相緊連的（歸納見附表），他們務求從醫院裏面直到醫院外面的實際社會環境之中，病人都能得到全面的照料，希望病人能完全回歸社會，得到眞正的復原，重獲常人的健康生活。

病人出院後，社康護士和社會工作者會定期探訪他們。社康護士會繼續留意他們康復的進展；而社工則幫助解決病人起居遇到的困難，例如，一部份有需要的病人會被安排到「過渡期宿舍」居住或到「庇護工場」工作。

大部份病人通常出院程序

- 對病人作臨床評估並發覺病況已大有改善
- 從護士報告及職業治療員報告中得到支持
- 臨床心理醫生的報告（如情況有需要）
- 如有疑問向另一位較高級醫生諮詢
- 如有社會問題存在，與醫務社會工作員討論或個案交給他處理

出院後程序

- 門診診療所繼續提供醫療服務
- 如有社會問題，由醫務社會工作人員進行研究
- 如病人以往會有不依時前往接受善後治療的情況出現，則交由精神科社康護士處理
- 如沒有到門診診療所接受善後治療，醫生可將個案交給醫務社會工作人員或精神病社康護士處理

當你大病一場痊癒後，會感到如釋重負，你的朋友也會替你高興。同樣地，一個精神病人能夠回復正常，重過正常生活，也是藉得高興的事，然而，精神病並非一般傷風、感冒、當病人從精神病院返回社會後，他必須經過一段時間適應，才能眞正回歸社會。這段過渡期的處理，是決定病人能否完全康復的一個重要因素，亦是每個病人的必經之路。

在香港，復康服務大部份由志願團體提供，而政府則作財力上的支持，目前主要提供服務的團體包括：

一、香港心理衞生會
二、新生精神康復會
三、香港戒毒會　（註：只爲戒毒人仕提供服務。

這些團體和醫務衞生署及社會福利署緊密合作，負起協助病人重返社會的使命，現時他們提供的服務主要包括：康樂社、職業康復服務，庇護工場，社工士服務及過渡期宿舍（或稱中途宿舍）。

八四年初，新生精神康復會計劃在沙田新翠邨開設一所「過渡期宿舍」，引起該屋邨居民的嚴重抗議，部份區議員也加入反對行列，爭持良久，結果該計劃只有擱置。然而，究竟「過渡期宿舍」是甚麼呢？

設立目的

精神病人離開醫院後，將面對種種問題，其中之一，就是由於醫院太具保護性。當病人返回社會時，會難以適應，間接提高了病人復發的可能性，過渡期宿舍的設立，便是提供輔導，協助已痊癒的精神病人在最短時間內，重新踏入社會，接受正常和獨立的生活，以及建立自己的將來；同時，由於宿舍多設在屋邨，病人容易熟悉屋邨的環境，方便日後在公屋居住；此外，宿舍也照顧到一些在精神病院中留醫的病人，爲他們提供一些過渡式服務，使他們能夠逐漸適應院外生活。

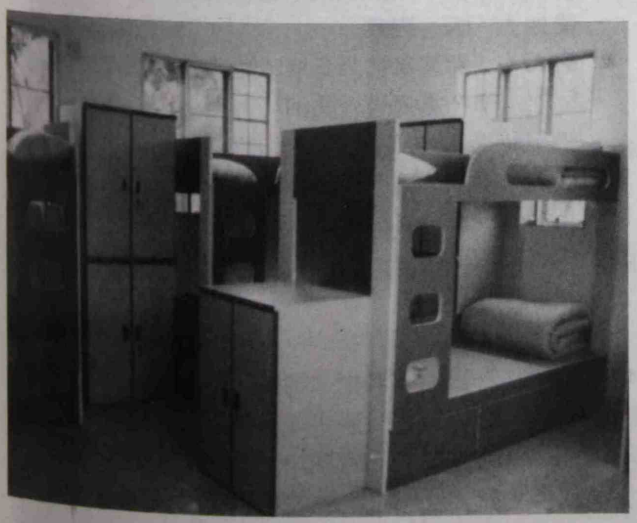
入住的條件

一般市民都有着一個錯誤的觀念，以爲任何離開醫院的精神病人，都可以入住過渡期宿舍，其實，所有宿舍裏的宿友，都必須具備一定的條件和要經過一系列的手續。宿友的來源主要有兩方面，大部份來自醫院，少數來自門診部。醫院方面首先會觀察病人的精況及照顧自己的能力，若兩方面都沒有問題，病人便會經主診醫生推薦往一所過渡期宿舍，然後再由主辦機構通過，成爲宿舍的宿友。除了基本上能夠照顧自己外，入住宿舍的病人必需無嚴重犯罪紀錄或反社會行爲，以及生理健康正常，如無傳染病或不良嗜好等；假若病人在以上各條件方面比較差，他們可能需要一段時間的試住，讓宿舍方面可以對他作一個詳細的觀察。

宿友＝囚犯？

過渡期宿舍並非禁固精神病人的監獄，病人可以自由離去，例如在他們自己找到適當的住所後。而通常病人都只會在宿途內居住半年左右，但如要重入宿舍，他們必需通過醫療社工作部的通過。在宿舍內，他們可以學習照顧自己，例如自己洗衫，輪流煮食等。宿舍方面也有提供康樂設施，例如康樂棋，乒乓球等，而且，經常會有些興趣小組成立，讓病人學習做一些手藝，還有，病人可以參與宿舍內的恒康社之活動。總而言之，病人在宿舍內可以得到足夠的康樂活動。

在宿舍內，職工扮演的角色是瞭解和可以幫助病人的朋友，例如他們會幫助病人申請公共援助和尋找工作等。同時，他們亦會照顧病人的日常生活，舉例來說，病人通常都不喜歡服藥，職工便替病人保管藥物，按時提醒他們服藥，或向他們解釋勸告，甚至嚴密監視等。



扶輪新生堂宿舍一角

新趨勢

隨着申請入住人數的增加，過渡期宿舍的需求愈來愈大。同時，近年來醫生和社會工作者推薦多些較爲健康和沒有嚴重病徵的病人入住，這些病人已離開了醫院一段時期，但因缺乏家人和社會上的支持，故讓他們居留在宿舍一個短時期，以便他們能夠重返社會，還有，由於政府近年對精神病人問題的關注，宿舍內的病人有更大的機會獲得恩恤徙置往公共屋邨，這對解決病人的居住問題，是一種有效的途徑。

總括來說，過渡期宿舍能夠幫助病人在離開醫院後去適應社會，以減低他們病發的機會，這個重要性已日漸受到重視。

附近居民之反應

就我們探訪的過渡期宿舍而言，在宿舍設立的初期，附近的居民也有多少不習慣，有時宿友會喜歡在他們住宅前徘徊或逗留，或高聲交談，當有居民對宿友的行動作出投訴時，宿舍方面便會對個別宿友勸告，通常問題都能容易地解決，慢慢地居民習慣了宿友的舉動，誤解與投訴也減少了。

結語

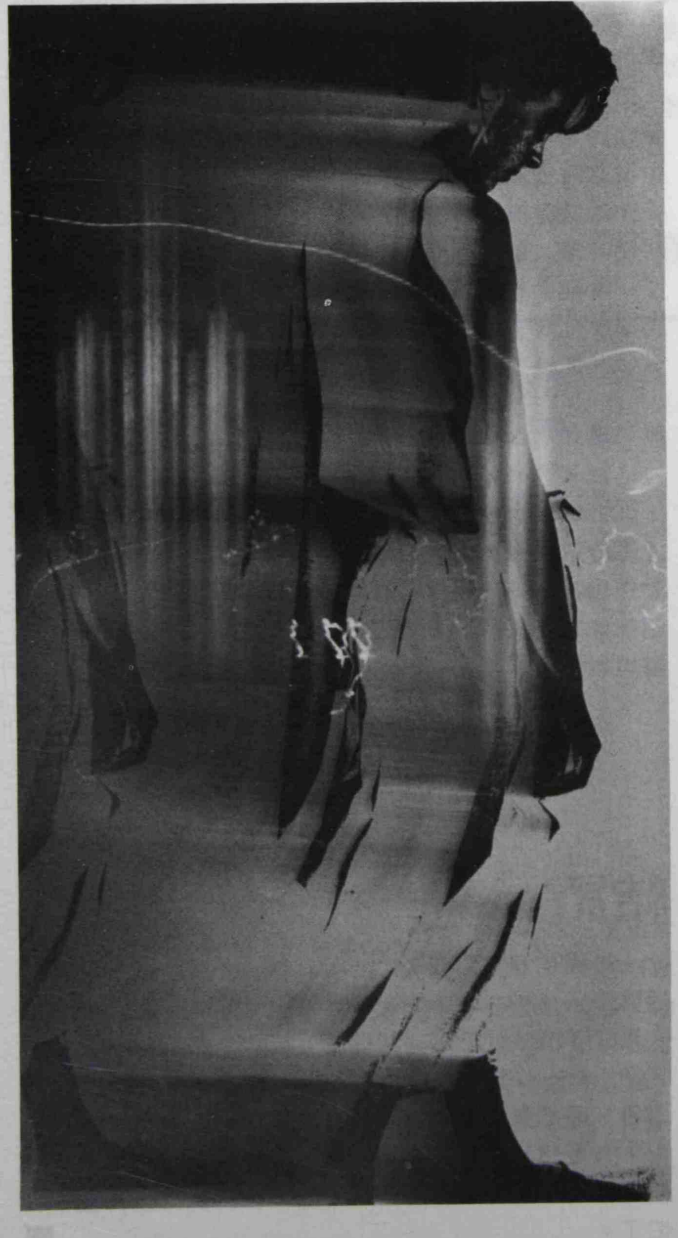
香港是個繁榮城市，正如其他大都會一樣，都市生活緊張，精神產生毛病是一個常見之現象，但又有多少人眞正了解精神病的背後問題？人們對精神病缺乏了解，便引起一切錯誤的估計和猜疑；正如人未見過鬼的眞面目，便把鬼想象得恐怖和「核突」。人們害怕精神病人，有否想到自己也有可能患上精神病？也許，你若肯去認識一下精神病的眞面目，便不會再覺得它神秘、可怕了。■

精神科醫生

有這樣一個諷刺醫生的笑話：

「外科醫生甚麼都不知，但無所不做。
內科醫生無所不知，但甚麼都不做。
病理學家甚麼都知，但已經太遲了。
……
至於精神科醫生，則甚麼都不知，也甚麼都不做。」

長久以來，人類始終未能充份掌握到神經系統功能及心理變化的奧秘，再加上社會因素的限制，精神科醫生在工作上往往遇到很多困擾，壓力及無奈。可是，他們絕不是「甚麼都不知，也甚麼都不做。」的。



精神科醫生的工作

精神科醫生的工作，主要是治療病人精神方面的病患。深入些說，他們是協助病人回復身體和精神上的平衡，使病人能夠重新投入社羣，成爲社會中的一份子。

在斷症前，精神科醫生首先要了解病人的情況，通常使用的方法是與病人建立良好關係，引導他們吐露出心中的不安或煩困，再與病人一起探討他們的病因，找出問題所在，然後作出適當的治療。

治療的方法大致可分爲「生理」和「心理」兩方面。生理方面是就病人的病情，施行直接治療，包括葯物治療，電盪治療等。心理方面，則是在精神上支持病人或幫助他了解自己，減少病人心理上所感到的孤獨和隔絕，使他們相信社會中是有人與他們站在一起，或讓他們找到問題的解決方法。

在整個治療過程中，精神科跟社會工作者，職業治療員，警隊，社會福利署等機構是有緊密聯繫的。故此，精神科可以說是一個治療小組的一部份，小組成員來自各方面，而精神科醫生則負起一個策劃，協調的角式。

精神科不易爲？

精神科醫生要整日面對心理上有問題的病人和環境因素的制肘，所受到的壓力和煩擾是着實不輕的。譬如在以下的情形下，一般醫生都會感到難以應付，而精神科醫生卻經常要在極短時間內想辦法解決。

㈠ **病人：「醫生，爲甚麼人有生、老、病、死？」**
醫生：「哎，因爲……」
病人：「那，爲何人又有富貴貧賤？」
醫生：「唔，因爲……」
病人：「那又爲何我是病人你是醫生？爲何春去秋來？爲何……爲何……」

精神科很多時都要涉及病人在哲學、人生、宗教、家庭等多方面的問題，倘若精神科醫生本身在這些人生問題上，也沒有一些穩定的觀點，而又摸索不到病人所要這樣問的心理原因，壓力便更大了。

× × ×

㈡ **病人：「醫生，我的遭遇是很悲慘的……」**
醫生：「唉！其實我也事事不如意才……」
病人：「那麼，我們不如一同自殺吧！」
醫生：「……」

有時醫生跟病人太接近，醫生的情緒亦可能受到病人的影響，產生抑鬱的現象或其他不良心理。故此，爲病人和自己的安全，即使在工作之餘，精神科醫生也比其他醫生更必要時常保持清醒。

× × ×

㈢ **醫生：「高先生，經過診斷後，我建議你到青山醫院休養數個月。」**

病人：「那你是說我有精神病？」

醫生：「可以這樣說。」

六呎餘高的病人霍然抓着醫生外衣領口，把他提上半天。

「究竟是我有精神病還是你有精神病？」

很少人可以泰然承認有精神病。有時醫生由於病人情況嚴重，打算强制將他收入病院，但又處理不得其法，不能在指出眞相時又兼顧各人的心理，便可能會引起病人或他的親人的强烈反應，鬧至僵局。

× × ×

㈣ **病人：「醫生，你能醫好我的夢遊病嗎？」**

醫生：「對不起，這個病症醫學上還未有合理解釋，我只能幫你……」

病人：「醫生，那你能幫我……嗎？」

醫生：「對不起，這個現象醫學上還未有紀錄，我只能……」

病人：「豈有此理，你是醫生，怎麼這又不知，那又不知，你是否不想醫我？你不負責任，我要投訴……」

許多精神病的成因仍然不大清楚，有些精神病亦沒有徹底治療的方法。因此，有時精神科醫生雖然深切了解病人的痛苦，也是愛莫能助。在這些情形下，他們不但要常常承受這些失敗的感覺，亦要替病人分担他那無助的痛苦，要接受他們的悲憤反應，只能給他們安慰和耐性的解釋。

× × ×

㈤ **醫生：「高先生，你以前有自殺傾向，現在已經完全痊癒，可隨時出院了。」**

數分鐘後，護士忽忙闖進。

護士：「不得了，高先生一出院便上天台跳下來死了！」

爲了病人康服設想，精神病醫生有時要替他作出一些責任重大的決定，例如對一些有自殺或暴力紀錄的病人，爲了能更有效治療他們，醫生必須盡量讓他們出院去適應正常生活環境。但即使是一個有經驗的精神科醫生，他不能担保他的決定百分之一百正確安全。每作一個類似的決定，都是一種精神負担，而萬一病人眞的因此出了事，心情也不易過。

× × ×

㈥ **醫生：「高先生，自你完全康復後，已有數年，…**

……

「……。」

病人：「對不起，我不認識你，你的名字是甚麼？」

做醫生其中的一個滿足，是在成功治癒病人後，病人所回報的稱讚和感謝，但精神科醫生卻未必能得到這些滿足。有些精神病人根本就不承認自己有病，「病」好了那肯多謝醫生？有些還會怪醫生曾經强他入院或仍然要他吃藥呢！

× × ×

除此之外，在香港，人手不足更大大加重了精神科醫生的工作量，舉例說，在青山醫院，某些時間內只有兩位醫生當值，卻要照顧數百名病人，工作量和壓力之大可想而知，據統計，精神科醫生的自殺率是普通人的六倍，由此可見，當精神科醫生絕不是一件容易的工作。

選擇精神科？

「做精神科醫生？我怕會變了做精神病醫生！」

普遍來說，選擇做精神科醫生的醫學生是比較少的，究其原因，首先，是由於精神科的內容：精神科研究範圍主要是人類的思想和感情，這都是一些比較抽象的問題，難如其他專科一樣，用一套簡單的系統去研究，於是，對於一些習慣了一般「狹義」科學研究的學生，精神科是很難掌握的。其次，當然是由於上述的壓力，限制和挫折感，而不選擇精神科了。

不過，那些任職精神科的醫生，除了少數因爲等候不到別的專科，而暫時選擇精神科外，大都有他們崇高的理想，對本身的職業充滿興趣。

他們認爲人的精神比肉體更爲重要，雖然藥物和手術能夠延長人的壽命，卻不能完全克服死亡，更不一定能提高生命的質素。他們要用精神科去幫助病人的精神生活，幫助他們過一個更積極的人生。……另一方面，在治療過程中，精神科醫生可以看到各階層人仕不同的個性和觀點，在幫助病人之中，不難使自己個性得到更成熟和穩定的發展，這亦可算是滿足感之一。

總之，若果你對人性和社會充滿好奇和興趣的話，那精神科對你絕對會是一件富於挑戰性和有意義的工作。 ■

精神科的迷惑

● 吳敏倫
香港大學醫學院精神學系高級講師

很多人對精神科的感受都很矛盾。心靈和肉體相輔相承，要給病人「整體」治療，沒有人能否認精神科的重要，但精神科所涉及的事，又往往看來很抽象，難以理解，甚至令人害怕。這些矛盾，容易使人對精神科產生不協調的反應，譬如一些醫生，口頭上關心精神問題，但遇到病人真有這方面的問題，即使是很輕微的，卻極力避免去處理它，找藉口說那不是精神問題或轉給另一醫生；另外一些，又過度關心精神方面的事，幾乎任何不尋常或醫治不好的病狀，都向精神方面去想，增加病人的煩惱。一般人對精神科的矛盾反應，就更爲極端，譬如一方面求更完善更多方面的精神科服務，另一方面卻常常訕笑精神病人甚至精神科醫生，對於一些服務的提議，又不肯出半分力量去接受或合作。

矛盾的根源，有理解上和感性上的。理解上的困難，似乎是由於我們對實質世界的習性。現世紀物質文明的發達，使我們自動薰陶於機械因果和單線發展的思想而忽略了它的局限。在醫生和醫學生方面來說，醫學院前的理科訓練，使他們更難於擺脫這習性，覺得精神科內容模稜兩可，自相矛盾和黑白不分，是無法理解和不「科學」的。這裏且不談精神問題應否完全用一個科學的態度去看，但即使是科學，一個研究科學的哲學家會告訴我們，眞正的科學，並不同於科學的唯物主義。前者是一種創造的藝術，利用科技去擴大人的感受，讓人更有餘暇去領略生命。它的作用，在向人提供行動的方向和機會，而不是建立一些一成不變的系統。那即是說，由科學建立出來的系統，應在替人服務，而不是人替這等系統服務。此所以譬如現代的物理學家，已不試圖以理論作爲對宇宙現象的最終闡釋，而能夠接受用極其相反的觀念如「粒」和「波」等來描述同一物理現象的不同可能性。愛因斯坦這樣說過：「要達到科學的最高層次，唯有犧牲它的內容。」這層次或許有人不認爲是最高，甚至會認爲它是最低，但任何科學，無疑都有這另一方面，只不過它不是我們通常所學，所熟習和應用的罷了。人的精神活動複雜，變化繁多，涉及的範圍也廣，所以研究的困難很大，精神科不能不常常進入這另一層次，使它看來與其他醫科大大不同。學習精神科的人，應該不以這些不同來視它爲不科學，反之，應利用這機會，去探討科學這另一境界，即使將來必能夠應用，也算是在科學上得到較全面的認識和經驗。

求知慾和對科學的興趣不一定能戰勝對精神科的恐懼。在意識上，很多人都說害怕接觸精神病者，因爲怕被精神病人傷害，或與他們接觸多了，自己也患上神經病。深究起來，這些理由很難成立。精神病者傷害他人的事，雖然時有所聞，但根據統計，比率並不較平常人多；至於精神影響，也不容易，要看本身的性格和與病者的關係，不如一般傳染病那樣簡單。其實世界上還有很多比與精神病人接觸更危險的職業，卻沒有這麼多人害怕。看來這個恐懼還有一些不自知的理由，人類應付大自然各類挑戰的最大倚杖，是他們的智慧和理性。面對精神病者，卻要面對人會喪失理性的這個可能，的確是可怕的。我們寧可看不見精神病者，或當他們是笑話，或當精神科醫生們都是無聊的或神經病的，也不願意去接受我們唯一的倚杖原來是這樣脆弱和會有喪失的一天。

另一個逃避精神科的理由，可能是美學上的。精神科理論告訴我們有關人類心理的運作方式，大都不是我們一般認爲是美好的。生物精神學使我們看來這樣無助；行爲主義把我們的心理描繪得與機器及其他動物等一般無異，失盡自由意志和人類的尊嚴；心理分析學更破壞了我們純潔的下一代的形象，告訴我們如何從孩提時代起，內心已深存憤懣，、攻擊、私慾和欺詐；存在主義又把我們的思想和靈性，過去和未來都視爲枷鎖……這一切一切，都把人的心靈勾劃出一個醜惡和可悲的面孔，都不是我們願意見和知道的，更不要說要去面對，分析和應用這些理論了。要解決這方面的困難，看來要重新考慮我們對美的標準。人是喜歡以爲美的，在美學上這已是一個根深蒂固的理論，此亦所以我們較接受孟子，不接受荀子。但何者爲「善」，何者爲「惡」，也可以視乎事物和觀察者的背景和角度，和事物發生的時間，未必有絕對的標準。我們精神科所描繪的人性爲醜，可能是在觀察時把自己過份代入了：「如果是我有這病人的思想和行爲，我是醜惡的，所以這行爲是醜惡的。」或者「如果他向我做出這行爲，我會覺得這行爲是醜惡的，所以行爲是醜惡的。」小心驗證這些推論，會發覺裏面存有邏輯上的錯誤，要避免這些因過份投入而引起的偏差，不是一件容易的事。關心則亂，但對我們週遭的人，對我們的病人（如果我們是醫生的話），我們又怎能不關心呢？什麼時候應該同情，什麼時候應該觀察，又什麼時候應該同情地觀察呢？你是一個微妙的問題，這是一個一直困擾着很多藝術家的問題。不過，無論如何，有一點可以肯定，我們不應因覺得一件事物放棄觀察，在觀察的時候，亦至少要有一些時間，能暫時放下個人的美醜標準。如果精神科裏面所說都有其眞理的話，又有什麼比眞理的追求更有價值？而「眞」又何嘗不是「美」的一個主要因素呢？行爲主義大師史基納，和比他早數十年的佛洛依德一樣，在發表了他的理論後，被攻擊得體無完膚，因爲他們的理論在很多人的眼中太灰暗，太醜惡了。對這些攻擊史基納回答過以下的一句話：

「濟慈（KEATS）對牛頓的分析彩虹大惑不解，但彩虹仍舊像往常一樣美，並且對許多人來說甚至變得更美。人並不因爲我們觀察他，談論他，並科學地分析他而改變。他在科學、政治、宗教、藝術和文學等的成就好像往常一樣。（這些及其他人性的表現），無論如海洋中的暴風雨，或秋天的落葉，或一個山峯，不管它們的來源如何，也不受科學分析的影響，一樣地備受仰慕。眞正改變的，是我們對理論題材要做些什麼的機會。」

系訪

MESSAGE FROM DEPARTMENTS

Anatomy

I am honoured to be asked to contribute this message to ELIXIR '84 even though I am such a recent arrival in Hong Kong. It cannot hope to be a comprehensive account of all our departmental activities, I have tried to write about events which may be of interest to all our students.

PERSONALIA

For this first contribution to ELIXIR I should perhaps introduce myself briefly. I have just arrived from Leeds in the United Kingdom where I was Senior Lecturer in Anatomy. I originally graduated from the University of Cambridge in Natural Sciences (Zoology) and I have, during the last 16 years, also held posts in Anatomy departments in the Universities of London and Birmingham. I am married, my wife Dr. Mo Weatherhead being a botanist now teaching and doing research in the Botany Department of this University.

The Department is exceedingly fortunate to have secured the services of Dr. Maria Hofmann as Part-time Lecturer in Anatomy. She too is a new arrival in Hong Kong and brings long experience of the teaching of Anatomy from her native Chile in South America. Most of our first year students will already have met her in the Dissecting Room.

Our warmest congratulations are due to Dr. Y.C. Wong on the occasion of this promotion to Reader in the Department.

DEVELOPMENTS

It is really too early in my career in Hong Kong to talk about the future of the Department of Anatomy since I am still learning about its many facets. I am trying initially to reorganise some of the research facilities in the department in order to accommodate my own research interests (see below) and to improve the facilities for my colleagues in general. Observant students on their way to the Dissecting Room may be aware of modifications to Research Laboratory 1 which is being developed as a general laboratory area for research in various aspects of cell and reproductive biology. Most students, however, will be unaware of the mortuary in the second basement floor. This is where cadavers are received, embalmed and stored. We are at present engaged in developing plans, for presentation to the University authorities, which will permit us to store cadavers in refrigerated units. It is hoped that this will improve the working conditions of our embalmers as well as improving the atmosphere in the Dissecting Room. I have other ideas for future developments but may be these should await future issues of ELIXIR!

RESEARCH

The Department has many research interests of which most medical students will be only dimly aware. I have chosen to write about just two areas which have, in their own separate ways, topical interest.

My own research is concerned with the hormonal regulation of melanogenesis in normal and malignant melanocytes. Most textbooks will tell you that melanin is synthesised from the amino-acid tyrosine through the action of the enzyme tyrosine hydroxylase. They are all out of date! We now know that at least one other enzyme, called dopachrome oxidoreductase, is involved. My own work predicted the existence of this enzyme and is now directed towards elucidation of the influences of various hormones, principally melanocyte-stimulating hormone from the pituitary and melatonin from the pineal, on its activity. I use as experimental systems the hair follicle melanocyte as well as malignantly transformed animal melanocytes – melanoma cells. Does this work have any clinical significance in addition to the intrinsic interest of the problem? Many of the intermediate metabolites in melanin biosynthesis are cytotoxic: if we could raise the levels of these metabolites artificially perhaps we may have a means for the specific autodestruction of melanoma cells – perhaps!

Some students may have read accounts in the newspapers of the part played by members of this department and their colleagues in the Faculty of Dentistry at Prince Philip Dental Hospital in identifying the victims of the tragic loss of the oil rig Glomar Java Sea which foundered in the South China Sea off Hainan in October 1983. Thirty one bodies, from a crew of 81, were eventually recovered in February/March 1984 and brought to Hong Kong for identification. The post-mortem examinations, conducted under the leadership of Dr. F. Ong (Chief Forensic Pathologist for Hong Kong) and Professor R.W. Fearnhead, relied heavily on dental evidence since the bodies were in an advanced state of decomposition. Nineteen bodies were identified un-equivocally; a further twenty five crew members were definitely excluded as being among the thirty one bodies; three bodies were identified in the "highly probable" category. Nine bodies, for which no dental records were available, were categorised as "consistent with" but "equivocal" identifications by the use of a super-imposition technique identifying cranial and dental landmarks. This technique differs from those employed elsewhere, being developed in Hong Kong, and relies on the matching of the anterior teeth visible in pre-mortem portraits with the anterior teeth which may be present in the skeletalised remains (see Interflow '84 for a further account). The appreciation of the Glomar Oil Company for these services rendered has been tangibly expressed by the donation of a Scanning Electron Microscope to the Prince Philip Dental Hospital. This work has also led to co-operation between our forensic odontologists and the Royal Hong Kong Police in the identification of human remains as well as to contributions on this theme to the Detective Training Programme.

CURRICULUM

Our first year students are part of an experiment in the teaching of gross anatomy. This year we have re-ordered the sequence of dissection so that study of the upper limb is followed by thorax and then head and neck. The idea is to follow structures through the axilla, shoulder and neck – transitional areas which often seem to be ill-understood when the conventional sequence of dissection is followed. Like all good scientists we should await the outcome of the experiment before drawing any conclusions.

I have arrived at a time when the medical curriculum in general is under review. We do not yet know how far reaching this review will be or what specific impact it will have on the teaching of gross anatomy, microanatomy, neuroanatomy etc. I am always happy to listen to students' suggestions on our departmental teaching patterns and methods: please don't all come at once!

An area of teaching to which I personally attach the greatest importance is the intercalated year leading to the B.Sc. in Medical Sciences. I have run such courses in departments in Leeds and Birmingham and I am totally convinced of their value, especially when the course comprises in large part a research project, with no formal lectures or practicals. Not all students will benefit from such a course but those who do undertake it will carry into their clinical years and into medicine in general an awareness of the methods, problems, frustrations and excitement of research. One extra year of study may seem like a lifetime to students urgently trying to obtain their M.B.,B.S. but in retrospect it will come to be seen as a very short time. Of the hundred or so students I have met during their intercalated year I know of only one who did not thoroughly enjoy the work: most find it to be a rewarding, intellectually stimulating experience.

PERSONAL MESSAGE

No visitor or newcomer to the University of Hong Kong can fail to be impressed by our cheerful and hard-working medical and dental students. Although you have a long and arduous road to travel in order to qualify in your chosen profession never, never forget that you are part of a University, a community of scholars with a unique and challenging responsibility for the furtherance of knowledge in all its forms, both personal and universal. Work hard to discharge this responsibility and in doing so enjoy yourselves.

Professor Brian Weatherhead

Head of Department

RESIGNATION

Lecturers

Dr. L.S. Jen, Lecturer in the Department of Anatomy, from July 1, 1984.

EXTERNAL EXAMINERS

Professor M. Berry, Guy's Hospital Medical School (Anatomy M.B., B.S., 1983-86).

Dr. A. D. Beynon, The University of Newcastle Upon Tyne (Anatomy, BDS, 1983-86).

APPOINTMENT

Professors

Brian Weatherhead, M.A. (Cantab.), Ph.D. (Birmingham), M.I.Biol., F.Z.S., as Professor of Anatomy from September 1, 1984.

Readers

Wong Yong Chuen, B.Sc. (Nanyang), M.Sc., Ph.D. (Western Ontario), Senior Lecturer, appointed Reader in the Department of Anatomy from June 1, 1984.

**The above material is extracted from the Gazette of University of Hong Kong*

BRIAN WEATHERHEAD

M.A. (Cantab.), Ph.D. (Birmingham), M.I.Biol., F.Z.S.

Dr. B. Weatherhead, Senior Lecturer in Anatomy at the University of Leeds, has been appointed to the Chair of Anatomy from September 1, 1984.

Professor Weatherhead graduated from the University of Cambridge with the degree of Bachelor of Arts in 1964 and the degree of Master of Arts in 1967. In 1968, he completed his Ph.D. studies in the Medical School of the University of Birmingham. His teaching career commenced at the University of London, where he undertook the reorganization of a course in histology and cell biology. In 1971, he took up a lectureship in neuroanatomy and neuroendocrinology at the University of Birmingham where he also helped conduct, on a part-time basis, courses in biological studies organized by the Oper University. In 1979, he took up appointment at the University of Leeds as Lecturer and was later promoted Senior Lecturer in Anatomy.

Professor Weatherhead holds memberships of various international learned societies. He is Scientific Fellow of the Zoological Society of London and member of the Institute of Biology. In addition, he is a member of the Anatomical Society of Great Britain and Ireland, the Society for Endocrinology, the European Society of Comparative Endocrinologists, the Brain Research Association, and a charter member of the International Pigment Cell Society. Professor Weatherhead has been an invited participant at various international conferences. In 1981, at the meeting of the British Association for Dermatology held in Cardiff, he presented an invited review lecture on 'MSH and mammalian melanogenesis', and in 1982, he was invited to present a cornerstone review entitled 'An overview of the hormonal control of melanogenesis' at the Fourth European Workshop on Melanin Pigmentation.

Professor Weatherhead's interests are essentially neuroendocrinological being especially concerned with the pars intermedia of the pituitary gland in a variety of species. His recent research activities include ultrastructure of the pituitary neuro-intermediate lobe, neuroendocrine control of secretory processes and neuroendocrine regulation of mammalian melanogenesis. These research activities are well recognized and have attracted support from various organizations, among them, the Royal Society, the Medical Research Council, the Science Research Council, the Agricultural Research Council, the Anatomical Society of Great Britain and Ireland, the National Institutes of Health of the United States and the Burroughs-Wellcome Trust. Professor Weatherhead has a long list of publications under his name and the results of his research findings have been widely published in international journals.

Professor Weatherhead is a member of the Scientific Advisory Board of *Anatomia, Histologia, Embryologia* and regularly receives requests from learned journals to referee papers, principally acting for the *Journal of Endocrinology*, and *General Comparative Endocrinology* as well as *Cell and Tissue Research, Neuroendocrinology* and the *Journal of Investigative Dermatology*. He has been invited on a number of occasions to referee grant applications to the United Kingdom Medical Research Council and the United States National Science Foundation.

WONG YONG CHUAN

B.Sc. (Nanyang), M.Sc., Ph.D. (Western Ontario)

Dr. Y.C. Wong, Senior Lecturer in Anatomy, has been appointed Reader from June 1, 1984.

Dr. Wong was educated at the Nanyang University in Singapore where he graduated with the degree of Bachelor of Science in 1966. He then furthered his studies at the University of Western Ontario in Canada and received the degrees of Master of Science in 1968 and Doctor of Philosophy in 1971.

While studying at Western Ontario, Dr. Wong also worked as Demonstrator in Anatomy until 1971 when he joined this University as Lecturer in Anatomy. He was promoted to Senior Lecturer in 1977. During his tenure at the University he had on many occasions held visiting appointments abroad. He was Honorary Lecturer at the Department of Anatomy of the University of Birmingham in 1974, Honorary Lecturer at the Department of Anatomy and Biology of the University of Chicago in 1977, and Visiting Lecturer at the human Morphology Unit of Flinders Medical Centre, Flinders University in 1981. In 1978, he was invited as a Visiting Professor to carry out collaborative research at the Department of Anatomy and Biology of the University of Chicago.

Apart from teaching medical and dental undergraduates, Dr. Wong has been taking part in organizing the Certificate in Medical Sciences postgraduate course ever since its inception in 1977, which has as its aim the training of preclinical teachers in the Southeast Asian region. In addition, Dr. Wong was heavily involved in the planning and setting up of the anatomy course for dental students before their first intake into the curriculum.

Dr. Wong holds memberships of many learned societies. He is a member of the Anatomical Society of the Great Britain and Ireland, the American Association of Anatomists, Canadian Association of Anatomists, the Society for the Study of Endocrinology, Metabolism and Reproduction and the Hong Kong Society of Neurosciences. Dr. Wong has been an invited participant at many international conferences. More recently, he attended the Ninety-Sixth Annual Meeting of the American Association of Anatomists held in Atlanta, Georgia in 1983 and the Third International Congress on Cell Biology held in Tokyo in 1984.

Dr. Wong's research interests were first broadly based which included the studies on the ultrastructural and functional aspects of muscle; various aspects of metaplasia and the urothelium structure, development and regeneration employing methods ranging from cytochemistry and tissue culture to electron microscopy. His current research interests centre on the study of the male sex organ system and reproductive biology. His research projects include: the structural and stereological studies of the effects of hormones on the accessory sex organs; the effects of gossypol and the cytochemical localization of various marker enzymes in these glands and the interaction between the glandular cells and the stromal tissue in the maintenance of the structural and functional integrity of these glands. He has published extensively in leading international journals in his field.

Biochemistry

Class of '89, would you like to know what the class of '59 thinks about Biochemistry? We recently had a visit from 4 distinguished members of that class who all said that biochemistry was of tremendous and increasing importance for their work in surgery and medicine. These were pleasant words for us to hear, but no mere pleasantries and we do wish that students will listen carefully to what the preceding generation has to say, rather than to young demagogues who have not yet had time to learn.

Just three Nobel prizes cover the whole of Science and Medicine. This year again, the prizes in both Chemistry and Medicine have been awarded for work in the field of Biochemistry, which has now been the typical pattern for over 40 years and is mentioned not by way of boasting but to emphasise to students how all-pervading the influence of chemical modes of thought has become in the study of biological and medical subjects: conversely too, how significant biological thinking and problems have become for those working in the physical sciences.

The biochemical research being done here has not reached quite that degree of world eimence; for one thing, our research budgets are ten to one hundred times less than in the award-winning laboratories of the world. Nonetheless, a look at the range of problems being studied at this moment in the Department of Biochemistry of Hong Kong University may show something of their significance and immediate practical relevance. In the field of so-called molecular biology we have groups working on the haemoglobin genes in thalassaemia, on collagen genes in inherited disorders, on causation of cancer and of the behaviour of genes during development. Other groups in the department work on parasitic diseases, liver and heart diseases, control of metabolism, nutrition, the blood coagulation system, and so on – the list seems endless.

TEACHING AND LEARNING

Students may be more interested in the teaching activities of the department than in research work but they should understand that it is the research work itself which makes the teaching worthwhile. There is absolutely no sense in learning off a few equations and phrases from a textbook which will be forgotten as soon as the examination is over and this is why our work has for many years past been directed towards developing understanding by students rather than forcing them to learn masses of material. Active participation is called for at every stage and it certainly is true that students who seek the comfort of knowing what to memorise and what can be left alone will have little help from us. As far as Biochemistry is concerned the most important work the student does is in small group tutorials (by way of active discussion with tutors), in projects and, beginning this year, with self-education systems either using audio visual aids or computers. Thinking is hard and if students find that being forced to think is uncomfortable, so be it. An athlete finds it uncomfortable to undergo hard physical training but he still undertakes it because he knows there is no other way to succeed. Our objective is training for life.

STAFF CHANGES

Students will be aware that a new lecturer, Dr. Kathryn S.E. Cheah brings to the department her highly valued expertise in work on gene structures. Perhaps not so many students know that our valued colleague Dr. Atkins, who left us in January 1984 to go to a new job in Cape Town, has since died following an accident. He is not being replaced at once because of the University's present financial difficulties and this leaves biochemistry even more short-handed than it was before. We hope the students will bear with us both in our loss and in our difficulties if we cannot provide as much personal attention as we wish.

Professor T.R.C. Boyde

Head of Department

RESIGNATION

Lecturers

Dr. D. Atkins, Lecturer in the Department of Biochemistry, from April 1, 1984. Died 2nd June, 1984.

EXTERNAL EXAMINER

Professor H. S. Bachelard, University of London (Biochemistry, 1983-86)

VISITING PROFESSORS:

J.C. Tsang, Illinois State University
C.I. Pogson, University of Manchester
J.W. Porteous, University of Aberdeen

**The above material is extracted from the Gazette of University of Hong Kong*

Community medicine

BRIEF HISTORY

The Department was established in 1950 and named the Department of Social Medicine. Dr. Sze Tsung Sing, a Hong Kong graduate was appointed to the Chair. When he left in 1952, the Director of Medical & Health Services was appointed to the Chair on a part-time basis. The first Director was Dr. K.C. Yeo who was succeeded by Dr. P.H. Teng in 1958 who changed the name of the Department into Preventive & Social Medicine. In 1970 a full-time Chair was re-established and the name of the Department was changed to Community Medicine.

Behavioural Sciences, previously taught by the Departments of Sociology and Psychology, was added to the Department in 1978.

LOCATION

The Department is situated in the Faculty's pre-clinical (Li Shu Fan) building, 4th floor, Sassoon Road, adjacent to the Faculty (Patrick Manson) building in which the Medical Library is also located.

DEFINING THE DISCIPLINE

The Department accepts the definition given by the Faculty of Community Medicine of the U.K.: "a branch of medicine which deals with populations or groups rather than individual patients ....."

Community Medicine studies disease, illness and health as phenomena of populations. Its descriptive and analytical instrument is the science of epidemiology and it is concerned with curative aspects of medicine as well as personal/mass preventive and rehabilitative measures, behavioural/anthropological aspects and the organisation/administration of medical and health facilities and (health) education programmes.

Community Medicine is concerned with the community's health and it deals with it from a medical professional platform.

In the context of activities of an academic department Community Medicine is mainly concerned with teaching and research. However, Community Medicine specialists may be engaged in curative, preventive or rehabilitative service with the underlying intention to study practical situations and to utilize these for the purpose of teaching.

SCOPE OF THE DEPARTMENTAL ACTIVITIES

To contribute to the body of knowledge of/about disease, illness and health as a population phenomenon in general, but with particular reference to Hong Kong, the Western Pacific and South East Asia Regions. To propagate this knowledge among students, professionals and the general public.

FUNCTIONS

The Department contains two methodological disciplines: epidemiology and medical anthropology, and two technical disciplines: occupational medicine and family health.

The Department has two main functions: 1. education

and training and 2. research

1. Education and training

Undergraduates (medical students)

The general objective is to put disease, illness and health in the broader perspective of the community.

First year: Medical Statistics (in the Calendar included under Behavioural Sciences). This course has only 10 official lecture hours assigned to it. In order to optimize the learning effect a special, partly self-teaching, method has been developed.

The course is described extensively in HEALTH STATISTICS, Ed. C.R. LOWE and S.K. LWANGA, International epidemiological Association/World Health Organisation, 1978, Oxford University Press, Oxford, New York, Toronto.

Third & Fourth year: Community Medicine

General introduction, epidemiology, social & cultural anthropological topics, personal preventive services including rehabilitative services, environmental services, social services, aspects of General Practice, organisation of Medical & Health Services in Hong Kong.

Practical work organised for small groups (10-12 students) include the following:

- Visits to institutions of community health and social welfare importance. They range from incinerator, abbatoirs etc. to School for the Blind, methadone treatment centre etc.
- Visits with the health visitor and medical social worker in the context of the TB-Control Programme of the Government Chest Service (as a part of the Senior Clerkship in Medicine).
- Summer Project: In the summer vacation term between the Third and the Fourth year the students are required to carry out a special field study of their own choice. Results of these studies are presented to the class and marked by a jury to determine a prize-winning team.

Fourth year: medical-social case work (together with the Department of Paediatrics).

The case of a paediatric patient is studied in relation to clinical, social and environmental factors. The students (in small groups) are required to search for factors predisposing to and provoking present illness, hindering recovery and full rehabilitation. Also the importance of the disease/illness is assessed in epidemiological terms. A visit to patient's home is organised and at a clinical conference the findings are presented and discussed. Finally a report is handed in.

2. Research

Our major fields of research at the moment are Cancer of the Lung, Occupational Diseases, Morbidity at the Household Level and Cardiovascular Diseases in Hong Kong.

Most projects are funded by the various HKU research grants committees, the HK Anti-Cancer Society, and the International Development Research Centre (Canada).

TEACHING STAFF

The nucleus of our permanent teaching staff is rather small: 1 Professor, 1 Senior Lecturer, and 3 Lecturers, but we have a substantial number (20-25) of part-time teachers, usually experts in Government positions and private medical practitioners.

In closing I should like to quote from two non-professional sources, one ancient and one modern, which represent a frame of thinking included in our "ideology".

"The superior physician helps
before the early budding of
the disease .....
The inferior physicial begins
to help when (the disease)
has already developed; he
helps when destruction has
already set in."

下工救其已成，救其已敗

上工救其萌芽

The Yellow Emperor's
Classic of Internal
Medicine
Chapter 26
200 BC

But before I treat a patient .....
I need to know a great deal more about him,
Than the patient himself can always tell me.
Indeed, it is often the case that my patients
Are only pieces of a total situation
Which I have to explore. The single patient
Who is ill by himself, is rather the exception.

T.S. ELIOT
The Cocktail Party

Professor J. W. L. Kleevens
Head of Department

APPOINTMENT

Senior Lecturer

Lam Tai Hing, M.B.,B.S. (Hong Kong), M.Sc., M.Sc.Occ.Med. (London), A.F.O.M.(R.C.P.) (London), M.R.S.H., F.A.C.O.M., Lecturer, as Senior Lecturer in the Department of Community Medicine from November 1, 1984.

EXTERNAL EXAMINERS

Professor S. Donnan, Professor of Community Medicine, Chinese University of Hong Kong, in Community Medicine, for the M.B.,B.S. Fourth Examination to be held in the academic year 1983-84 (re-appointed).

Professor S.R. Leeder, Professor of Community Medicine, University of Newcastle, New South Wales, in Community Medicine, for the M.B.,B.S. Fourth Examination, for a period of three years from 1984-85.

**The above material is extracted from the Gazette of University of Hong Kong*

Behavioural sciences

Deviants and Medical Education

Behavioural Sciences (BS) is, I think, considered as the ogre of the M.B.,B.S. course. Its subject matter is perceived as a monster, which, once released in to the tidy brains of second year students, runs amok completely oblivious to the neat categorizations inculcated by the HK education system generally and biosciences specifically. It is, like an energetic fish, difficult to grasp and then hold, always twisting free just when it appears subdued and controlled. It can be deceptively difficult to grasp.

BS makes no claims for panaceas, but it does demand recognition with credentials as compulsive as any subject and better than some subjects in medical education, if, that is, you take the time and effort to consider them.

BS is perceived as deviant in the institution of medical education. It does not conform to the apparent regularity of the biosciences anymore than planetary motion conforms to the laws of quantum electrodynamics. Different levels of conceptualization are required to comprehend BS's vital relevance to human functioning. The conceptual distances that separate the behavioural and biomedical sciences may, on some occasions, make BS seem irrelevant or, at very best, peripheral to the practice and principles of medicine, whilst at other times they may make us lose sight of the fact that vast distances separate parts from the whole, both empirically and conceptually.

Some may think that is a good thing. I tend to think it is not, for it leads to dismissive and over-simplistic attitudes that are dangerously misleading. Different, yes. But it depends on your point of view as to whether the microscopic or the macroscopic deserve more emphasis. Deviance is a state ascribed by the majority to the minority. It is not absolute but relative and deviance, like time, changes.

Staff

This last year has seen many changes in BS at HKU. John L. Anderson, the medical sociologist who established this course six years ago, left at the end of the last academic year. Initially, the Unit was in disarray as the emphasis of the course shifted. Mr. Y.H. Cheng was appointed as medical sociologist, beginning October 1984, so that, though we retained our complement of 1.5 psychologists and 1 sociologist, the balance of both the expertise and interests of the lecturing staff had altered considerably.

Additionally, two new demonstrators have joined the BSU; Ms. M. Shillinglaw and Ms. D. Nestel with their own interests and research ideas.

As in past years, this year's BS course will have some different components, yet it is envisaged that the course will change quite substantially within the next two academic years to reflect both the new balance of staff and the consideration of more applied models of BS.

Curriculum

Overshadowing the change in staffing is a substantial imminent change; the forthcoming curriculum review. This is an opportunity for all the courses within this M.B.,B.S. to look towards how we can improve the calibre of our graduates.

BS is no exception to this. However, it depends largely upon the institution of medical education, and more precisely, upon the more influential individuals who help to maintain medical education within HK as an institution, to what extent changes will be allowed to occur. Few deviants ever attain positions of power, though those that have have left their mark on history (usually a drastic change, as in Chile under Allende).

The changes that will occur, therefore, seem less likely to be between different segments of the course than within segments of the course.

If BS comes through into the new curriculum, it is hoped that it will not be limited to the second year, but that it may straddle the first to the third years, being both "preclinical and clinical" (if you like those terms). But, don't panic if you are a first year student, there won't be more BS. Hopefully, just the same amount, but allocated differently.

It is also hoped that BS will retain its reputation as a difficult subject, for it is. It requires not simple acquisition and regurgitation of facts (so-called), but an evasive skill called thinking, not readily located in the anterior cerebral cortex, or any other cerebral mass. It is not common sense, but uncommon sense. It pushes criticism and challenges unquestioning acceptance of "fact".

Prospect

It is almost certain that BS will continue to run loose in the brains of medical students, being chased by rigid categories which hope to neatly ensnare elusive "facts", for release at exam time. It will, like Mary Shelly's Frankenstein monster, be an source of fear and prejudice for students, arising from misunderstanding and novelty, from an unfamiliarity in knowing how to deal with it. However, we hope to locate BS more firmly within the broad conceptual space of health theory and knowledge so that one day the whole, like the Copernican universe, will be acknowledged as the norm and not the deviant.

Until then, BS will continue to be perceived as the deviant in medical education. Yet, times change. More and more doctors and students realise the synonymity between good medical practice, more coherent understanding of disease processes and what BS teaches. How soon before the deviant becomes the norm? I believe that the "monster" in the mind of medical students has already precipitated an evolution away from inflexible biomedicine towards a more realistic understanding of the issues of health and ill-health. Let us hope such evolution is encouraged and not discouraged.

Dr. R. Fielding
Head of Unit

APPOINTMENT

Lecturers

Cheng Yeung Hung, M.Sc. (London), Demonstrator, as Assistant Lecturer in the Behavioural Sciences Unit of the Department of Community Medicine from October 1, 1984.

RESIGNATION

J.L. Anderson, Lecturer in the Behavioural Sciences Unit of the Department of Community Medicine, from September 1, 1984.

HONORARY PROFESSORS

Professor Margot Jefferys, B.Sc.(Econ.) (London), Emeritus Professor of Medical Sociology, Bedford College, University of London, appointed Honorary Professor in the Behavioural Sciences Unit of the Department of Community Medicine from January 19 to February 11, 1984.

EXTERNAL EXAMINERS

Professor M. Jefferys, Emeritus Professor of Medical Sociology, Bedford College, University of London, in Behavioural Sciences, for the M.B.,B.S. degree examinations, for a period of three years from 1984-85.

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Medicine

1984 was an extraordinarily busy year. The challenges of teaching in a congested hospital and outpatients' clinic, coping with an ever increasing patient service with limited resources and carrying out research with inadequate technical support helped displace from our minds anxieties over the future of Hong Kong.

As one gets older, medical undergraduates appear to arrive younger on this scene. While the standard of spoken English seems to deteriorate year by year, that of Chinese is sound enough and in any event, overall performance in theory and clinical skills remains satisfactory. Despite the over-crowding, students appear to stay in the wards more and the assistant internship scheme is popular and successful. It is often difficult to teach when the wards are strewn with campbeds, and students are to be commended for their tolerance. Certainly I sometimes walk out in despair and telephone the medical superintendent who tries her best. Hopefully the situation will improve following the opening of the observation ward attached to the Accident and Emergency Department and the release of more beds for medical patients at the Tung Wah Hospital.

Teaching

With the return of lecturers after postgraduate training in the U.K. and Australia, teaching in most of the sub-specialties in medicine are now adequately covered. The recently introduced clinical pharmacology course has proved to be popular as taught by Dr. C.R. Kumana and when Dr. Henry Pan returns from Stanford University Medical School, the course will be further extended. Dr. Raymond W.S. Wong, Senior Medical Officer and Dr. CHAN Ka Ho returned in 1984 after spending a year in London, much to the relief of Dr. Anthony K.Y. Lee. Further, Dr. K.L. Wong will have completed his training in Sydney in early 1985 so clinical immunology and rheumatology will be well taught. Dr. Maxwell H.W. Tse has been appointed lecturer in general practice and is busy setting up a General Practice Unit at the Violet Peel Health Clinic, Harcourt Road. This is a temporary arrangement pending the building of more permanent premises on Ap Lei Chau. Neurology, which for many years was "under-manned", now has three teachers; Dr. C.Y. Huang and Dr. YU Yuk Ling have been joined by Dr. Edmund Woo who has just returned after 3 years postgraduate studies in Newcastle and New York.

Teaching was also augmented by Professor Barry G. Firkin, Lions Club of Tai Ping Shan Visiting Professor from Monash University who gave excellent sessions on medicine and in particular, haemostasis and thrombosis. In December, Professor John Turtle from University of Sydney came as Mr. & Mrs. Wu Chung Visiting Professor

and he proved most popular. The specialty clerks presented him with a handsome Chinese fan, a gesture which deeply touched him. A.J.S. McFadzean Lecturers included Professor A. John Camm and Dr. William Sircus who talked on "Cardiac Arrhythmias and Sudden Cardiac Death" and "Treating Peptic Ulcer: the State of the Art" respectively.

This Department's unit at the Tung Wah Hospital, established mainly for the teaching of dental students, continues to render invaluable service, particularly to patients with chronic renal failure and in 1984 a stroke unit was set up which meets a real need. Now patients from both the Tung Wah Hospital and Queen Mary Hospital with cerebral vascular disorders can be properly rehabilitated before going home. Medical students have commented favourably on the less hectic and relatively serene wards and outpatients clinics at Tung Wah Hospital and this should be more conducive towards studying patients. It is hoped that the medical cardiology unit at the Grantham Hospital will be opened to undergraduates for teaching purposes soon.

Students

The performances of the final M.B.B.S. candidates and that of the dental students were good and resulted in high pass rates at examinations. However, the graduates lost to teachers in the beer drinking contest at the graduation dinner.

Research

Most teachers continue to be active in research and about 50 papers appeared in international journals and over 40 abstracts or lectures were presented at international medical conferences in 1984. Some of three were based on collaborative research with other departments.

Prospect

Looking ahead, the curriculum changes which have been under discussion will be gradually implemented. General Practice teaching is scheduled to take place in the General Practice Unit as well as in different departments and in outpatients' clinics, both public and private. The Integrated Term will be replaced by regular integrated teaching throughout the entire year. There will be even greater emphasis on "small group teaching", with perhaps a reduction in the number of lectures. It is also hoped that more students will make use of the elective period to join in this department's research as well as clinical activities in the different sub-specialties.

Professor D. Todd
Head of Department

CLINICAL PHARMACOLOGY: A NEW HORIZON FOR PHARMACOLOGY AND THE PRACTICE OF MEDICINE

Two years ago, the University of Hong Kong, Faculty of Medicine introduced the relatively new discipline of Clinical Pharmacology into its curriculum. Clinical Pharmacology bridges the gulf between pharmacology (a basic science usually organised as a pre-clinical subject) and the practice of clinical medicine (often an art). Therefore, Clinical Pharmacology is presently an offshoot of the Department of Medicine and has close links with the Pharmacology Department. Though akin to what the medical students refer to traditionally as therapeutics, it differs from the latter in the following ways: a) It is not concerned with non-drug treatments (e.g. surgery, physiotherapy or psychotherapy); but it nevertheless attempts to provide a perspective on these. b) It is not confined to 'therapeutic' drug usage, as it also deals with deliberate overdosage and drug abuse. When dealing with so called 'therapeutic' drug use, it is concerned with good, bad and indifferent drug usage. c) It fosters an interest not only in how drugs affect the body's physiology (pharmacodynamics) but also in how the body handles the very same drugs over periods of time (pharmacokinetics); and thus it encompasses therapeutics and also helps to develop important means of studying patho-physiological processes. d) It makes no prejudgement as to the correctness or appropriateness of any form drug treatment, unless based on vigorous scientific evidence from clinical investigations carried out in patients to whom it is offered. Students can thus learn to appreciate that what was implied as beneficial drug treatment (since it would be considered under therapeutics) may actually be an unnecessary or even harmful intervention.

Whilst the status and identity of Clinical Pharmacology within a university medical centre might be unclear to some, its objectives are quite simple and include:

1) Dissemination of appropriate attitudes (rather than information) concerning the use of drugs in patients.

2) Fostering an understanding of clinically relevant pharmacokinetics and pharmacodynamics, thereby reinforcing and extending what was studied in Pharmacology.

3) Fostering the development of objective methods for drug evolution in patients (ie advisory and facilitating a role in the conduct of ethical and scientifically valid clinical trials).

4) The study of drug utilization within defined patient populations, with special consideration of the factors which influence drug prescribing in the context of costs, drug benefits and adverse effect.

5) By functioning as a teaching discipline it must bridge the information and credibility gap between

clinicians, basic scientists (microbiologists, pharmacologists and others), and the pharmaceutical industry.

At present, medical students of the University of Hong Kong are introduced to Clinical Pharmacology concepts in their third year, during their practical course in Pharmacology. The latter entails experimenting on volunteers (themselves, not patients); and learning the basic rules for conducting a clinical trial with drugs in intact humans. Most of the teaching in Clinical Pharmacology is directed towards clinical students in their penultimate year (senior clerks) and final year (specialty clerks). There is also a course of lectures for dental students. The senior clerks receive a series of about 10 lectures on various aspects of drug treatment in medicine. These have an emphasis on basic principles, and should prepare students to supplement their own further learning. The lectures are also matched so as to coincide (more or less) with the corresponding lectures in the clinical medicine course. The two courses should therefore supplement each other. When the students enter their specialty clerkship in medicine (during the final year), they attend about 7 small group (20-25 students) Clinical Pharmacology sessions. A series of important topics are discussed. At this stage the students can note the relevance of the issues which are considered to the drug being prescribed for the patients they are following in the wards. Being a relatively small group, the students are able to interact with the teacher and raise questions which concern them about the treatment of individual patients. Furthermore, at periodic intervals throughout the year there are therapeutic conferences (jointly offered by clinical specialists, the clinical pharmacologist and others), at which questions of topical interest are raised, debated and digested. These conferences have proved very successful with the students, the staff of the Departments of Medicine and of Pharmacology, as well as for doctors from elsewhere. All final year medical students and even senior clerks are encouraged to attend and participate no matter what their level of knowledge or ignorance!

The above mentioned educational activities in Clinical Pharmacology are intended to teach clinical students and doctors alike to appreciate the importance of drug prescribing for individual patients and the community. Hopefully, prescribers might even develop a concern for minimising the amount of drug usage. When reviewing the overall impact of Pharmacology and Clinical Pharmacology, upon the teaching of therapeutics, the following generalisations may be applicable, viz:

Pharmacology educates students about a) a drug's inherent features (kinetics, identity (class, generic and trade names) and expected effects on physiological processes including mechanisms of adverse actions (dynamics) and b) how subject characteristics such as mass, age, organ function and sex (including pregnant status and lactation) affect the former. Whilst, Clinical Pharmacology addresses itself more to c) aims of treatment, which include defining objectives, (priorities & costs), individualising therapy, and following up (monitoring) patients to assess any possible benefits &/or toxicity, and d) how the aims of treatment and the patients disease interact with the previously mentioned characteristics of the subject and the drug.

In a pragmatic sense, the only object of diagnosis is treatment; there being little point in distinguishing between various disorders using elaborate means, if the treatment to be offered remains the same. Moreover, of the various forms of treatment which can be employed, drug treatment is utilised most commonly and widely. Thus, although the skills required to make an appropriate diagnosis cannot be over emphasised, it is also apparent that using simple clinical assessment together with currently available laboratory facilities and electronic gadgetry, is making diagnosis much easier in the majority of patients. By contrast, there has been a tremendous increase in the availability of new drugs to treat old ailments, and deeper insight has been gained about all aspects of such treatment. This has resulted in claims and counter-claims being made about different drugs. Consequently, future doctors will be a large extent, be judged by how they make best use of drug therapy rather than for their diagnostic acumen. It is hoped that a proper balance of Pharmacology and Clinical Pharmacology will help to develop these necessary skills among students, and in so doing:–

1) achieve a sense of therapeutic responsibility so that at least as much attention is directed towards drug treatment as towards diagnosis,

2) foster an intense curiosity into how various drugs bring about their actions, and how physiological processes and disease states affect their handling,

and 3) promote cost consciousness, awareness of patient convenience, and concern to avoid adverse effects.

Dr. C.R. Kumana
Senior Lecturer

APPOINTMENTS

Professor

Lam Shiu Kum, M.B.,B.S., M.D. (Hong Kong), F.R.C.P. (Edinburgh) (London), Reader, as Professor in the Department of Medicine from September 1, 1984.

Reader

George Chan Man Kam, M.B.,B.S., M.D. (Hong Kong), M.R.C.P. (United Kingdom), Senior Lecturer, as Reader in the Department of Medicine from October 1, 1984.

Senior Lecturers

Lam Wah Kit, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), Lecturer, as Senior Lecturer in the Department of Medicine from October 1, 1984.

Yeung Choi Kit, M.B.,B.S. (Hong Kong), F.R.A.C.P., Lecturer, as Senior Lecturer in the Department of Medicine from October 1, 1984.

Lecturers

Maxwell Tse Hing Wah, M.B.,B.S. (Hong Kong), M.R.C.G.P., as Lecturer in the Department of Medicine from December 1, 1984.

Yu Yuk Ling, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), Honorary Lecturer, appointed Lecturer in the Department of Medicine from July 12, 1984.

Temporary Lecturers

Thomas Chan Yan Keung, M.B.,Ch.B. (Glasgow), as Temporary Lecturer in the Department of Medicine from November 1, 1984 to October 31, 1985.

Paul Cheng Ning Man, M.B.,B.Ch. (Wales), D.T.M.&H. (Liverpool), M.R.C.P. (United Kingdom), appointed Temporary Lecturer in the Department of Medicine from April 1 to September 30, 1984.

Chin Kim Fai, M.B.,B.S. (Hong Kong), F.R.A.C.P., appointed Temporary Lecturer in the Department of Medicine from January 16, 1984 to January 31, 1985.

RESIGNATIONS

Dr. D.K.F. Chin, Temporary Lecturer in the Department of Medicine, from August 31, 1984.

Dr. W.K.K. Hui, Lecturer in the Department of Medicine, from July 14, 1984.

VISITING PROFESSOR

Professor John Ross Turtle, M.B.,B.S., M.D. (Sydney), F.R.A.C.P., Associate Professor of Medicine, University of Sydney, and Head of the Department of Endocrinology, Royal Prince Alfred Hospital, Sydney, appointed the tenth Mr. and Mrs. Wu Chung Visiting Professor in Medicine during his visit to Hong Kong in December 1984.

EXTERNAL EXAMINERS

Professor D.J.C. Shearman, Professor of Medicine, University of Adelaide, in Medicine, for the M.B.,B.S. Final Examination to be held in April/May 1984.

**The above material is extracted from the Gazette of University of Hong Kong*

GEORGE CHAN MAN KAM

M.B., B.S., M.D. (Hong Kong), M.R.C.P. (United Kingdom)

Dr. George M.K. Chan, Senior Lecturer, has been appointed Reader in the Department of Medicine from October 1, 1984.

Dr. Chan received the degrees of Bachelor of Medicine and Bachelor of Surgery from the University of Hong Kong in 1972 with the Anderson Memorial Gold Medal. He was Medical Officer in the University's Department of Medicine at Queen Mary Hospital for a year and in 1974 he moved to the Hong Kong Sanatorium and Hospital. In July 1976 he went to London and at first worked at the Royal Northern Hospital and Whittington Hospital. In October 1976 he joined the Royal Free Hospital as a Registrar in the Department of Nephrology and Transplantation where he received his postgraduate training. In 1979 he was a Research Fellow and Honorary Lecturer. In 1981 he was promoted Senior Registrar. Since September 1982 he was a temporary Senior Lecturer and Honorary Consultant in the Royal Free School of Medicine until January 1983 when he joined the University of Hong Kong as Senior Lecturer in the Department of Medicine.

Dr. Chan obtained his membership of the Royal College of Physicians of the United Kingdom in 1976 and was awarded the degree of Doctor of Medicine by the University of Hong Kong in 1982. He has been a member of the International Society of Nephrology since 1980.

Dr. Chan has published extensively in international medical journals on various aspects of nephrology including dialysis and renal transplantation. He has also contributed to world literature in the field of lipid metabolism in renal diseases. Further, he has completed a textbook for renal registrars and medical students entitled *Integrated Systematic Nephrology*. Dr. Chan has been an invited speaker at various international symposia and conferences and he has given numerous public lectures and seminars, both locally and overseas. Since joining the University, Dr. Chan has re-organized the facilities for the treatment of renal failure patients and has collaborated with the Electronic Services Unit of the University in the research on peritoneal dialysis machines. His current research interest includes drug-induced nephrotoxicity. He was elected Chairman of Hong Kong Society of Nephrology in 1984.

LAM SHIU KUM

M.B., B.S., M.D. (Hong Kong), F.R.C.P. (Edinburgh) (London)

Dr. S.K. Lam, Reader in Medicine, has been appointed Professor on a personal basis from September 1, 1984.

Upon graduating from the University of Hong Kong in 1967, Professor Lam served in the Surgical and Medical Units of the Queen Mary Hospital until 1968 when he joined the Department of Medicine of the University as Assistant Lecturer. Thereafter, Professor Lam remained with the University, as Lecturer from 1969 to 1977, as Senior Lecturer from 1977 to 1980, and as Reader from 1980. Professor Lam was elected Member of the Royal College of Physicians of the United Kingdom in 1972, awarded the degree of Doctor of Medicine by the University of Hong Kong in 1975, and elected Fellow of the Royal Colleges of Physicians of Edinburgh and of London, and of the American College of Physicians in 1980, 1983 and 1984 respectively.

While on vocational leave from the University, Professor Lam was Honorary Medical Registrar and Clinical Research Fellow at the Gastrointestinal Unit of the Western General Hospital, Edinburgh from 1971 to 1973. In 1978-79, Professor Lam was Visiting Scientist at the Center for Ulcer Research and Education (CURE), UCLA School of Medicine, Los Angeles. Since 1982, Professor Lam has been Affiliated Investigator with CURE.

Professor LAM is affiliated to numerous academic societies. He is a member of the British Society of Gastroenterology, a member of the American Gastroenterological Association, a fellow and trustee of the International Academy of Proctology, a member of the Asian Pacific Association for the Study of the Liver, the President of the Hong Kong Society of Gastroenterology, and Ethical Committee Member of the Organisation Mondiale de Gastro-Enterologie.

Professor Lam has contributed extensively to literature in his field and has been Reviewer, Honorary Adviser, Associate Editor, and Editor to a number of leading international journals. He has been invited on numerous occasions to speak at international meetings and academic societies, and to conduct seminars and deliver lectures at overseas universities. The emphasis of his present research is on peptic ulcer, its aetiology, genetic and pathophysiologic heterogeneity, and its treatment, on the physiology and pathophysiology of gastrointestinal hormones, and on diagnostic and therapeutic gastrointestinal endoscopy.

Microbiology

FORWARD

Medicine has evolved before our eyes to a field which now embraces a multitude of disciplines. The ever increasing complexity of each makes it impossible for a mortal soul to master all of them and bring them to bear in practice, or, as they should be practised. The headlong rush to establish ever more subspecialties causes many to lose sight of the virtue of total patient care once provided by the family general practitioners. Failure to coordinate the various efforts in the management of patients compromises the quality of patient care. It also results directly in the sky rocketing cost of health care. All these cause much soul searching within the profession and establishment of independent national and international bodies to review health care provision.

Today, it is indeed equally important, to develop effective interphasing between different disciplines, as it is to develop individual disciplines. This responsibility rests squarely with tertiary institutions. Rightly or wrongly, Microbiology, Pathology and Pharmacology are referred to as "Paraclinical" subjects in our curriculum. Viewed within the confines of microbiology the discipline, this term carries a connotation of passiveness which misrepresents the subject. For whether seen from a historic or current perspective or looking to the future, there is nothing passive about the subject. Rather, in microbiology one perceives vitality and sustained excitement in its development. One might, however, interpret "Para" as a statement of commitment to effective interphasing between different disciplines, then, that is indeed a goal we aspire to. It is an area of activity that is intellectually rewarding and it is also an area to which we devote much of our effort.

Effective interphasing or interdisciplinary cooperation requires an attitude of mind that governs our approach. This is exemplified by our current work on childhood diarrhoea. Joint effort with the Paediatric department and the Kwun Tong Community health programme allows us to mount a study so comprehensive in its scope that it promises to contribute to the management and control of childhood diarrhoea. Results of the hospital study to date, which will be described below, have, I believe, substantially enhanced our understanding of this important childhood disease. At the same time, it also illustrates the importance of organizing our effort, (especially in the relative isolation of Hong Kong), between different disciplines towards a common goal.

THE DEVIL WE DON'T KNOW

Let me first admit that laboratory diagnosis is fallable, to the extent that about 50% of the specimens we received in one year did not yield a positive identification (Fig. 1). The reasons for this are several:

First, routinely, a positive isolation only refers to one of the several conventional pathogens and in one case, some less conventional ones such as enterotoxigenic E. coli (ETEC) and rotavirus which we only recently included in our routine procedure as a special

investigation. There are many which can, given the right circumstances, cause diarrhoea especially in a infants, but reliable method to identify them is not available. Enteropathogenic E. coli (EPEC) is a case in point; while certain strains of E. coli are "enteropathogenic", a diagnosis of EPEC is only made with supporting epidemiological evidence. Therefore we are unable to confirm diagnosis of sporadic diarrhoeas caused by such organisms because of a lack of supporting epidemiologic evidence.

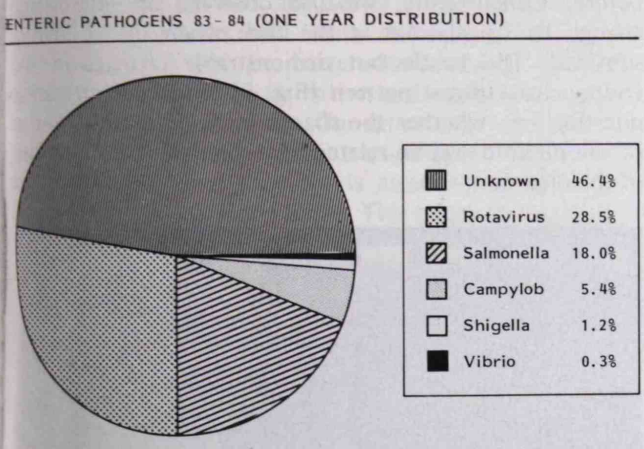

Figure 1. Relative prevalence of enteric pathogens identified from diarrhoeal patients in the paediatric wards of Queen Mary Hospital between May 1983 and June 1984.

Second, there are many viral agents which can be the cause of diarrhoea but, for which there is no simple method of detection that is appropriate for routine investigation. Calici virus, astrovirus and others depend on direct observation by electronmicroscopy (Fig. 2) which is not amenable to large scale routine operation. Adenovirus is a frequent cause of diarrhoea, but method for its routine identification is only just being developed.

Third, the causes of diarrhoea are changing with time. Many organisms that cause diarrhoea today, such as ETEC and campylobacter, were not known yesterday, and I expect there are some which cause diarrhoea today which will not be known for sometime until they become so prevalent that our attention is drawn to them.

Finally, among the 50% or so of the cases that have no known aetiology, some could be of a non-infectious origin. The contribution of the laboratory to management of acute diarrhoeas is, therefore, minimal, because under the present circumstances, a negative result cannot be taken to mean a non-infectious cause. On the contrary, there is a high probability that it is caused by less conventional agents such as mentioned earlier.

Herein lies the main fallability of laboratory investigation of diarrhoea and, hence, it points to the need for a concerted effort at further development of investigating method. The introduction of rotavirus identification to our routine operation has made an impact because this agent accounts for about half of all the known causes of infantile diarrhoea in QMH. In a negative sense, our effort at studying ETEC also has important contribution for, we learn as a result, ETEC is not likely to be a significant causal agent of the disease in Hong Kong, at least for now.

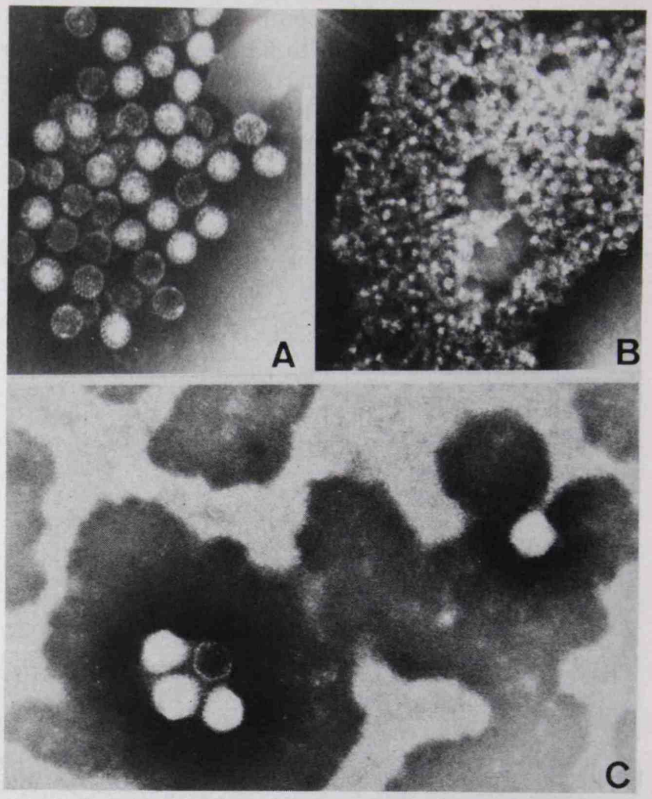

Figure 2. Electromicrographs of some viruses associated with diarrhoea. (a) Rotavirus (b) Small round viruses (c) Adenovirus.

THE DEVIL WE KNOW

Having admitted our fallability, I should like to return to the devil that we know. I shall start with the premise that infants are one of the most susceptible subjects to infectious agents. As such, they provide a sensitive index for us to gauge the nature of the community of diarrhoeal agents prevalent in Hong Kong. It is a reasonable assumption that the microbial community is influenced by the community of man and certainly by the environment that we share. I should like to share my thoughts with you as regards how they may be related to one another.

Salmonellosis

Salmonellosis is a food borne disease which has been, endemic here for a very long time. Its epidemiology in Hong Kong differs from Salmonellosis elsewhere in that there is a larger family of these organisms here. The latest count about 2 years ago indicated that there are at least 64 different species of Salmonellae prevalent in Hong Kong. Such a large variety of prevalent salmonella species may be accounted for, in part at least, by the fact that Hong Kong depends on much of its food supply being

imported from all over the world. While this makes Hong Kong a centre of gastronomic excellence, it also results in continuous introduction of large variety of Salmonellae.

A clever piece of detective work documented convincingly one such incident. The event began in 1973 when there was a sudden outbreak of Salmonellosis caused by S. johannesburg with 63 cases recorded in the paediatric wards for that year. The case number increased further to 124 and 118 in the years 1975 and 1976, respectively. Thereafter, it declined, as rapidly as it had started (Fig. 3).

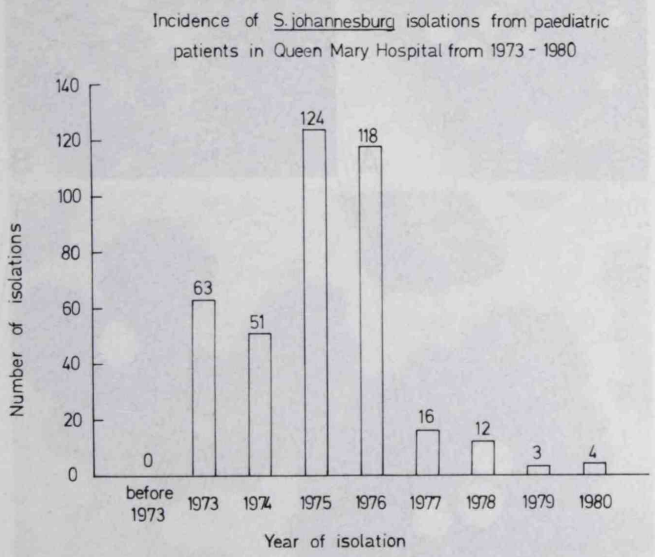

Figure 3. Isolation of Salmonella johannesbury in the paediatric wards of Queen Mary Hospital between 1973 and 1980.

The organism isolated during this period carried an extra-chromosomal element (plasmid) of about 140 megadalton in size (Fig. 4). By compatibility tests using a battery of standard plasmids, this plasmid was found to belong to the FIme group and the plasmid also carried on it multiples of antibiotics resistant genes. All these pointed to the fact that the epidemic was caused by a clone of bacteria, (bacteria that originate from the same parent). This conclusion was confirmed when the endonuclease digest pattern indicated that FIme plasmids from all isolates of S. johannesburg have a similar nucleotide sequence (Fig. 5).

This organism had not been seen in Hong Kong prior to 1973 but the same organism that harbored the same plasmid had been prevalent in South Africa prior to that year. It was therefore reasonable to suspect that the organism may have originated from South Africa via imports of meat and dairy products. We obtained a number of strains of this bacteria from South Africa and our contention was supported by the finding that the same endonuclease digest patterns were obtained with the plasmids from Hong Kong and South African isolates alike.

Now we are in a position to piece together this information: We believe that the organism was introduced for the first time to Hong Kong about 1973. It became established here as a new member of our microbial community. The organism must have been quite virulent as was evident from the protracted epidemic it caused. It must also have become widely disseminated because the epidemic was colony wide.

Something happened to the organism towards the end of the epidemic. For although the organism still persists today, we have,for the past 6 years, only encountered it sporadically. It seems that it has become less virulent than before. Concurrently, we also observed an interesting change to its plasmid at the time when the epidemic subsided. The subtle but demonstrable changes in its endonuclease digest pattern (Fig. 5) raised an intriguing question i.e., whether the change in nucleotide sequence of the plasmid may be related to the apparent attenuation of the organism.

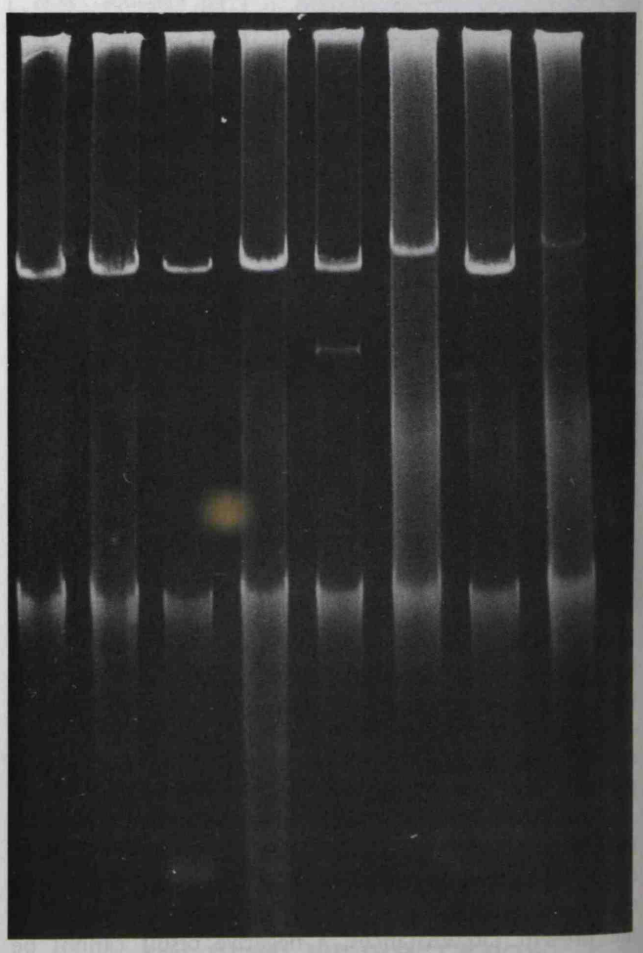

Figure 4. FIMe plasmid occurring in clinical isolates of Salmonella johannesburg. Note the consistent presence of FIMe plasmid (corresponding to the 140 mega dalton band) in all clinical isolates.

Campylobacterosis

Poultry farming is big business here, a substantial proportion of chickens consumed here are produced in the New Territories. With liberal use of antibiotics in animal

feeds, we have overcome a major difficulty of the industry related to bacterial diseases. Together with vaccination, this has made production become much more efficient than that by traditional methods. Poultry farming can now be carried out in very little space, a commodity Hong Kong is lacking. But this production method also promotes transmission of certain bacteria, Campylobacter being the foremost among them.

There is an insatiable demand for chicken here and we have many nice chicken dishes. An especially favoured dish is poached chicken. The secret in making this dish is not to over-cook the bird. Many will further advise that the bird must not be frozen before-hand and that injections, presumably vaccination and antibitoics, tend to spoil the flavour somewhat. Our rational self will warn us that all these contribute to transmission of Campylobacter. Indeed, this organism is assuming an increasing prevalence in Hong Kong today. This brings me to a point about the life of a microbiologist in Hong Kong. He is forever torn between his rational self and his gourmet inclination, and more often than not, he gives in to the latter when a dish of poached chicken is brought before him.

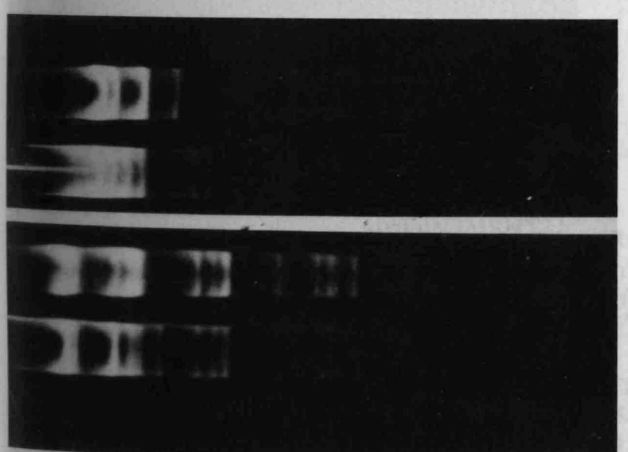

Figure 5. Analysis of the nucleotide sequence of FIMe plasmids by endonuclease digestion. FIMe plasmids obtained at the beginning and towards the end of the outbreak of gastroenteritis due to S. johannesburg were exhaustively digested with the endonucleases, HINII (left panel) or E COR I (right panel). The resulting fragments were electrophoresed in agarose gel. The electrophoretic patterns compare the resulting fragments of FIMe plasmids isolated at the beginning (left lane) or towards the end (right lane) of the epidemic.

ETEC

It was not so long ago that water restriction was a way of life here. But this problem has been solved by construction of large reservoirs and by piping water from across the border. We also have an efficient water treatment system and this has contributed to the control of water borne diseases. Cholera, for example, has not been seen here for some time now. Many might not be aware of it, but our water works department has recently passed yet another acid test:

My colleagues here have tried for the past 2 years to look for toxigenic strains of E. coli amongst infants and children with diarrhoea. They used in their investigation, probes made up of recombinant DNA of the genes that encode for the toxins – the heat labile toxin and heat stable toxins (Fig. 6). Of the 600 or so of the diarrhoeas with E. coli as the predominant organism cultured from the stools of these patients only 4 were attributed to ETEC. This is to be contrasted with our neighboring Southeast Asian countries. In rural areas of Thailand, a substantial proportion of infantile diarrhoea is caused by toxigenic E. coli. It was further shown that these organisms are readily found in the water. The incidence of diarrhoea in our neighboring Guangzhou is also higher than Hong Kong. Although at a rate of about 5%, diarrhoea caused by ETEC is not as serious as it is in Thailand.

ETEC might be considered as a modern index of microbial contamination of water supply. As a result of our investigation, the Hong Kong water supply is given a clean bill of health; water direct from the tap is most likely safe to drink.

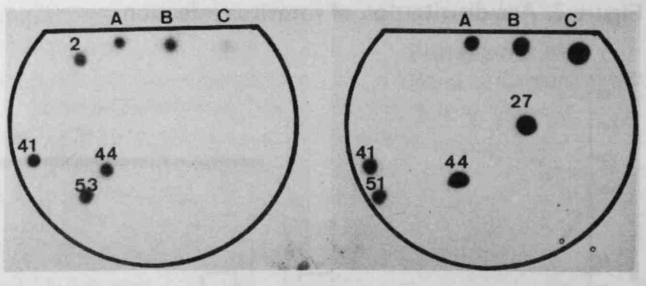

Figure 6. Direct detection of enterotoxigenic E. coli by nucleic acid hybridization using labelled recombinant DNA of the heat labile toxin (LT) gene. Presence of ETEC was revealed as darkened spots.

Rotavirus

Rotavirus is the most common of all the diarrhoeal agents of infancy and childhood. The large majority of the affected patients were less than one year of age (Fig. 7). The infection showed a marked seasonal distribution, being typically the most prevalent during the winter months. But the infection persisted throughout the remaining seasons, and there was one outbreak occurring in the summer (Fig. 8).

An additional feature worthy of note was that rotavirus was the most common nosocomial agent complicating diarrhoeas caused initially by bacterial or other agents. This resulted in a more protracted and severe form of the disease. Complication of diarrhoeas was documented in one group of patients who yielded in succession two or more enteric pathogens during a single episode. In 14 of them, rotavirus was the subsequent pathogen identified, preceded by bacterial agents (Salmonella or campylobacter), whereas rotavirus was the primary pathogen identified in the remaining 4 patients whose conditions were complicated by bacterial pathogens during their hospitalization. There was another

group of 25 patients who did not yield a positive identification of an enteric pathogen until 3 or more days after symptomatic onset of diarrhoea. The pathogen subsequently identified in 22 of these patients was rotavirus. The remaining 3 patients subsequently gave a positive identification of bacterial agents. Presumably the pathogens identified later in the course of the disease were acquired nosocomially.

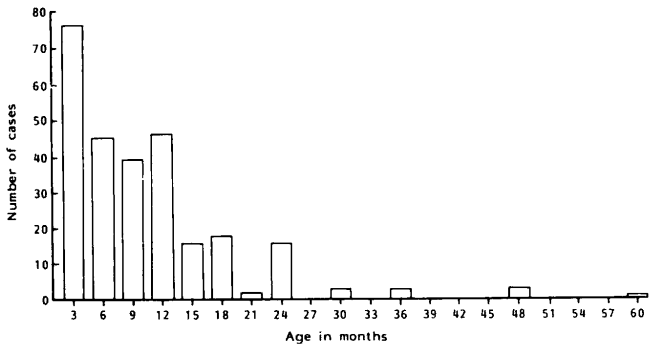

Figure 7. Age distribution of rotavirus infection.

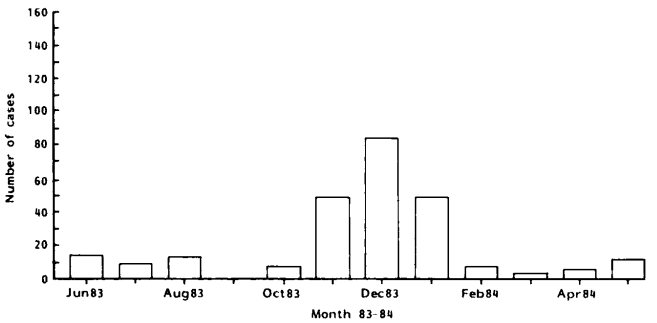

Figure 8. Seasonal prevalence of rotavirus infection.

The above described observation were significant in that a substantial proportion of diarrhoeas seen in QMH were complicated by further infections with other enteric pathogens especially rotavirus. This did not only further aggravate their condition but also resulted in increased cost in caring for these patients. It is also apparent that measures which had already been instituted in the hospital were reasonably effective in containing the spread of bacterial pathogens so that there were only a few documented cases of complication due to bacterial agents. The same measures however were not as effective in the case of rotavirus. It might be speculated therefore that the mode of transmission of this agent is either more efficient than, or is different from, transmission of bacterial agents. Similar difficulty is also encountered in other institutes around the world and this is not a unique problem to Hong Kong. Even the strictest of isolation measures seems to fail in containing the spread of rotavirus infection in hospitals. The efficiency with which the virus is spread among patients makes one wonder therefore, whether, in addition to the oral-fecal route, the virus might also be transmitted via the respiratory route.

The genome of rotavirus comprises of 11 segments of double stranded RNA varying in sizes between 2.5 to 0.2 x 10^6 dalton. The segments are readily resolved by electrophoresis in polyacrylamide gel. Combined with silver staining which is capable of detecting as low as 10 ng of the viral RNA, it is possible to analyze the viral genomes extracted directly from stool specimens according to the size distribution of its genomic segments (Fig. 9). By this approach, it became apparent that the populations of rotavirus prevalent in this and also other communities are genetically extremely diverse. A total of 14 genetic variants, referred to as electropherotypes were detected over a period of 12 months beginning May 1983. One of the electropherotypes was by far the most preponderant accounting for over 80% of all the virus seen during this period. The remaining electropherotypes seemed to be detected in succession, with each persisting for only a short period of time so that only a few electropherotypes were prevalent at any given instant during the period of study.

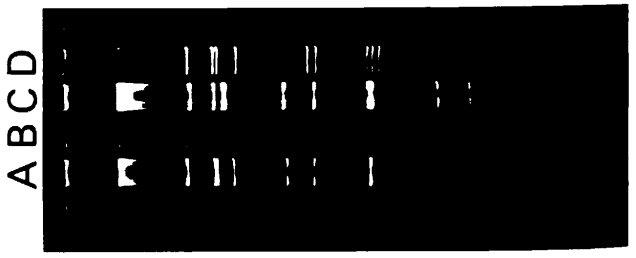

Figure 9. Polyacrylamide gel electrophoresis of rotavirus genomes extracted direct from stool specimens. Note the difference between the different rotaviruses with respect to the size distribution of their genomic segments.

The continuously changing virus population is a special feature of rotavirus infection which requires in the first instance mechanisms to generate the genetic diversity amongst the virus. For viruses with segmented genomes as are rotaviruses, the most important of the mechanisms is probably by reassortment and recombination between the genomes of prevalent viruses. The resulting variants may, in turn, interact similarly with other viruses to produce yet other variants, and so on. Such a progressive course of events may thus be expected to give rise to a succession of electropherotypes as was indeed observed. It was further observed that one of the patients was simultaneously excreting two different electropherotypes for 5 days during a diarrhoeal episode, both of which were the prevalent electropherotypes at that time. This suggested that opportunities for different viruses to interact in nature is not insignificant, but detailed genetic analysis is required to elucidate the relatedness between the genomes of the different electropherotypes.

Other mechanisms might also operate in Nature to generate genetic diversity amongst the virus population. This was apparent from an additional genomic segment detected repeatedly in the electropherotic patterns obtained with stool specimens of one patient, which was

otherwise the same as one of the prevalent electropherotypes at the time. Repeated detection of the additional segment from stool specimens obtained over 5 days during the diarrhoeal episode made it unlikely that this was an experimental artifact. There was also no evidence for the patient being mixedly infected with different viruses prior to the appearance of the additional segment. It would therefore appear that the virus might have undergone minor changes in its RNA sequence which is known to alter electrophoretic migration of the affected segment. But such changes are expected to affect the virus population randomly and hence it could not adequately account for the apparently ordered appearance of the different electropherotypes during the 12-month period of observation.

The frequency of detection of an electropherotype is a reflection on the size of the virus population in the community or its ability to cause disease or a combination of both. The results showed that this varies substantially for the different electropherotypes. This together with the waxing and waning of the different electropherotypes suggested the existence of forces that modulate the virus populations in our community. The nature of such forces remains obscure but it is not unreasonable to expect that different virus populations may mutually interfere with one another. Environmental, and climatic factors and the immune status of the human population no doubt also contribute to the dynamics of the virus population here. The key to understanding the natural history of rotavirus infection and its control lies in a better understanding of each of these factors, their relative contribution to the dynamics of the virus population, and the interplay between them in regulating the virus population in our community. Such is a difficult task, its resolution promises to challenge our resourcefulness.

ACKNOWLEDGEMENT

I am grateful to my colleagues and students for stimulating discussions and providing the data from their work.

Professor M.H. Ng
Head of Department

APPOINTMENT

Clinical Bacteriologist

Raymond Yung Wai Hung, B.A. (Minnesota), M.B.,B.S. (Hong Kong), as Clinical Bacteriologist in the department of Microbiology from August 1, 1984.

EXTERNAL EXAMINERS

Professor I. Phillips, University of London (Microbiology, 1981-84)

Professor J.D. Williams, The London Hospital Medical College, University of London (1985-87)

**The above material is extracted from the Gazette of University of Hong Kong*

Obstetrics & gynaecology

Teaching

"All doctors should be able to detect an enlarged uterus, a big adnexal mass or an abnormal cervix. Gynaecological examination skill can only develop by knowing how one should perform the examination and by examining as many patients as possible. It is felt that establishing a teaching unit in Kwong Wah Hospital will improve our teaching facilities and will make available more patients for the students to see. Consequently, since September 1984, our department has been engaging itself in preparation to make the Kwong Wah obstetric and gynaecology unit a subsidiary university teaching unit.

"It is suggested that there will be shortening of the time allocated in the specialty clerkship of the M.B.B.S. course for practical obstetrics. One of the reasons is to make way for the inclusion of other subjects such as general practice in the ever-expanding curriculum. However, it should be stressed that practical obstetrics is still a part of the essential training of an undergraduate.

Interflow

"Throughout the year, there has been frequent academic interflow with other universities and various health institutions. A prominent increase of academic interaction with China has been witnessed. Due to the opening of China, there has been tremendous increase of visits by Chinese academics to our department. At the same time, the Department staffs have made many visits to China. The visit to Kun Ming Medical School has proved to be very fruitful.

Research

"It is an undeniable fact that financial support from the University for research purposes is very limited – less than one third of that being applied. Other sources of subsidy such as that from the World Health Organization have to be sought in order to upkeep a high standard of research work.

Personal message

"Genuine interest is a prerequisite of this demanding profession. Being self-demanding as well as non-complacent are two of the most indispensable qualities to be a successful doctor. The level of social consciousness of doctors is also very important as the doctor must be aware of the environmental and social factors in order to treat the patients successfully.

"The overshadowing uncertainty over the future of Hong Kong has unavoidably exerted its undermining effect on the medical profession. It is of paramount importance to the development of health care system in Hong Kong that experienced doctors would stay and work in Hong Kong."

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* The above passage is extracted from the interview with Professor Ma, Head of Department of Obstetrics and Gynaecology.

APPOINTMENT

Senior Lecturers

Joseph Woo Sai Kit, M.B.,B.S. (Hong Kong), M.R.C.O.G., Honorary Clinical Lecturer, as Senior Lecturer in the Department of Obstetrics and Gynaecology from December 28, 1984.

Lecturers

Macor Wan Chun Wai, M.B.,B.S. (Hong Kong), appointed Lecturer in the Department of Obstetrics and Gynaecology from February 3, 1984.

Dr. Hextan Ngan Yuen Sheung, M.B.,B.S. (Hong Kong), M.R.C.O.G., appointed lecturer from January 9, 1985.

EXTERNAL EXAMINERS

Professor R. W. Beard, St. Mary's Hospital Medical School (Obstetrics and Gynaecology, December 1983).

*Professor N. A. Beischer, University of Melbourne (Obstetrics and Gynaecology, April/May 1984).

RESIGNATION

Lecturers

Dr. J.C.R.M. MacHenry, Lecturer in the Department of Obstetrics and Gynaecology, from January 29, 1984.

Mr. J.B. Lawson, M.A.;M.B., B.Chin., F.R.C.O.G. Consultant, Newcastle General & Princess Mary Maternity Hospitals, Director of Postgraduate Studies, Royal College of Obstetricians & Gynaecologists was invited to deliver the Tenth Daphne W.C. Chun Lecture during his visit to Hong Kong December 17-20, 1984.

**The above material is extracted from the Gazette of University of Hong Kong*

Orthopaedic surgery

The Department of Orthopaedic Surgery has continued its long-established tradition of being very active in clinical and basic research. Despite the obvious disadvantage of a relatively small number of University teachers in this Department, the staff (including University and Government) are extremely active in academic research. A very serious start has been made in the direction of research in biomechanics, in association with the Department of Mechanical Engineering. Although such activities have commenced way back in the early '70s, last year saw the establishment of a formal Working Group between the two Departments with regular meetings to monitor progress. Some 12 people are directly involved in this. In fact, a proposal has been made from the two Departments to the Vice-Chancellor to set up a Bioengineering Unit based in the Department of Mechanical Engineering. Several internationally reputable bioengineers from Britain have visited Hong Kong in the last two years under the sponsorship of the British Council. The Vice-Chancellor appears to be receptive to the formation of the Unit in principle, but unfortunately implementation is not possible in the present economic climate.

Research into microvascular techniques in orthopaedic surgery has continued to be a major component of basic research in this Department. Our facilities serve not only our own staff, but research workers from other hospitals. In clinical research, a big step forward has been made by computerizing the storage of research data of patients.

by **Professor J.C.Y. Leong**
Head of Department

(**Abstract**) Some of the original papers published from the department (in the academic year 1984-85).

LONG-TERM RESULTS OF LUMBAR INTERVERTEBRAL DISC PROLAPSE

J.C.Y. LEONG, FRCS, FRCSE, S.Y. CHUN, FRCSE, W.J. GRANGE, MA, FRCS, and D. FANG, M Ch ORTH FRCSE

A series of 40 patients is presented at least ten years following anterior spinal fusion for intervertebral disc prolapse. The proportion of patients who had complete relief or only isolated transient symptoms at the five-year review (67.5%) showed only a very slight fall over the years (65.0%). The union rate was shown to improve with time. There was no clear evidence that anterior spinal fusion led to accelerated degeneration of adjacent intervertebral discs. The significance of posterior extension of the fusion is discussed. [Key words: lumbar disc prolapse, anterior lumbar fusion, long-term results]

Reprinted from SPINE, Vol. 8, No. 7, pp 793-799, 1983

EXPERIENCE OF POSTERIOR SURGERY IN ATLANTO-AXIAL INSTABILITY

P. C. LEE, FRCS (GLAS),* S. Y. CHUN, FRCSE,† and J. C. Y. LEONG, FRCS, FRCSE*

Twenty patients with atlanto-axial instability treated by posterior spinal fusion were reviewed. Patients with atlanto-axial instability due to congenital causes usually presented late with chronic myelopathy and treatment in these patients was associated with poor surgical results. Atlanto-axial fusion for fracture non-unions offers immediate stability, reliability, few complications, and good range of neck movement after surgery. Occipito-cervical fusion is indicated whenever atlanto-axial fusion is surgically not feasible. [Key words: atlantoaxial instability, etilogy, myelopathy, posterior fusion, outcome]

Reprinted from SPINE, Vol. 9, No. 3, pp 231-239, 1984.

TUBERCULOSIS OF THE UPPER CERVICAL SPINE

D. FANG, J. C. Y. LEONG, HARRY S. Y. FANG

From the Department of Orthopaedic Surgery, University of Hong Kong

Six patients, aged between 3 and 51 years, with tuberculosis of the upper cervical spine were studied. Prominent features of the disease included pain and stiffness, paralysis, swelling of the retropharyngeal soft tissue, osteolytic erosions, and atlanto-axial subluxation. Cure was obtained with antibiotics, transoral decompression and C1-2 fusion.

Reprinted from JBJS, Vol. 65-B, No. 1, pp. 47-50, Jan. 1983

TUBERCULOSIS OF THE LOWER CERVICAL SPINE (C2 TO C7)

A REPORT ON 40 CASES

L. C. S. HSU, J. C. Y. LEONG

From the University of Hong Kong

Forty patients with tuberculosis of the lower cervical spine (second to seventh cervical vertebrae) have been reviewed. Pain and stiffness were important and dominant symptoms. Two types of disease were recognised. In children under 10 years old involvement was extensive and diffuse with the formation of large abscesses. In patients over 10 the disease was localised and produced less pus, but was associated with a much higher incidence of Pott's paraplegia. The overall incidence of cord compression was 42.5 per cent (17 out of 40); 13 of the 16 patients with the "adult" type of disease had this complication. The commonest method of treatment was with antituberculous drugs, anterior excision of diseased bone and grafting. This regime rapidly relieved pain, compressive respiratory symptoms due to abscesses and Pott's paraplegia. It also corrected kyphotic deformities from an average of 25.5 degrees to 5.4 degrees.

Reprinted from JBJS Vol. 66-B, No. 1 pp. 1-5, Jan., 1984

LAMBRINUDI TRIPLE ARTHRODESIS FOR CORRECTION OF SEVERE RIGID DROP-FOOT

S. C. TANG, J. C. Y. LEONG, L. C. S. HSU

From the University of Hong Kong

The results of 10 patients with severe rigid drop-foot corrected by the Lambrinudi triple arthrodesis were studied. The average amount of correction was 47 degrees, as evaluated from standing radiographs taken before and after operation. Radiological features of osteoarthritis and of flattening of the talus were common, but the feet were painless when reviewed at an average of 70 months later. A satisfactory range of movement was obtained at the ankle joint.

Reprinted from JBJS Vol. 66-B, No. 1, pp 66-70, January, 1984.

EXPERIMENTAL MICROARTERIAL GRAFTS: FREEZE-DRIED ALLOGRAFTS VERSUS AUTOGRAFTS

S. P. CHOW, Y. C. SO and C. W. CHAN

Department of Orthopaedic Surgery and the Department of Pathology, University of Hong Kong

Summary — A segment of the femoral artery from a Sprague-Dawley rat was removed and freeze-dried. It was then used as a graft for a defect in the femoral artery of another rat. The femoral artery on the other side of this recipient rat had a similar grafting procedure using a segment of its own femoral artery, thus acting as a control. The patency rate, histopathology and scanning electron microscopy studies showed that freeze-dried allografts behave in the same way as autografts in this experimental model. They were easy to preserve, readily available on rehydration and were somewhat easier to handle because of their mild rigidity.

Reprinted from British Journal of Plastic Surgery 36, pp 345-347, 1983

MYCOBACTERIUM MARINUM INFECTION OF THE HAND INVOLVING DEEP STRUCTURES

Five patients with Mycobacterium marinum infection of the hand involving deep structures were seen recently. Four of them were fishermen. Hydrocortisone injection or simple incision and drainage led to worsening of the infection. The clinical presentation, operative finding, and histopathologic and microbiologic features were quite similar in all five patients. Extensive debridement and therapy with ethambutol and rifampin led to satisfactory results in four patients while biopsy and therapy in the fifth patient seemed to offer another form of acceptable treatment. (J HAND SURG 8:568-73, 1983.)

Reprinted from The Journal of Hand Surgery, Vol. 8 No. 5, pp. 568-572, Sept., 1983

APPOINTMENTS

Reader

Chow Shew Ping, M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh), Senior Lecturer, as Reader in the Department of Orthopaedic Surgery from October 1, 1984.

Senior Lecturer

Louis Hsu Che Shek, M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh), F.A.C.S., Senior Lecturer, as Reader in the Department of Orthopaedic Surgery from October 1, 1984.

Lecturer

Pun Wai Ki, M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh) (Glasgow), appointed Lecturer in the Department of Orthopaedic Surgery from July 1, 1984.

**The above material is extracted from the Gazette of University of Hong Kong*

CHOW SHEW PING

M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh)

Dr. S.P. Chow, Senior Lecturer in the Department of Orthopaedic Surgery, has been appointed Reader from October 1, 1984.

After graduating from the University of Hong Kong with the degrees of Bachelor of Medicine and Bachelor of Surgery in 1968, Dr. Chow was House Officer first at the Ruttonjee Sanatorium and later at Queen Mary Hospital. In 1969 he went abroad to Canada for a year. On his return to Hong Kong, he joined the government and worked at its various departments until 1973 when he took up appointment as Lecturer in the Department of Orthopaedic Surgery of the University. In 1980 he was promoted Senior Lecturer. During the period from 1976 to 1980, Dr. Chow furthered his orthopaedic training in London, Edinburgh, the United States, and West Germany.

Dr. Chow was elected a Fellow of the Royal College of Surgery of Edinburgh in 1974. In addition, he holds memberships of many professional societies. He is a member of the Societé Internationale de Chirurgie Orthopaedique et de Traumatologie, British Society for Surgery of the Hand, British Orthopaedic Association, the Western Pacific Orthopaedic Association, the Hong Kong Branch of the British Medical Association, Hong Kong Surgical Society, and Hong Kong Orthopaedic Association. He was president of the Hong Kong Orthopaedic Association for 1983 and 1984, and is the Secretary-General of the Hand Section of Western Pacific Orthopaedic Association.

Dr. Chow's current research interests centre on hand surgery and microsurgery. He is also involved in othe;research projects which include treatment of hip fracture, the study of fat macroglobules after trauma, and of the use of bankbone for spinal fusion, and of the use of bankbone for spinal fusion. Dr. Chow has published extensively in leading international journals in his field.

Dr. Chow has held surgery demonstrations at renowned hospitals and has been an invited participant at many international conferences. More recently in 1982 he was a guest speaker at the Annual Meeting of the Japanese Society of Hand Surgery in Tokyo. In 1983 and 1984, he was a faculty member of the Instructional Course Lecture on Hand Surgery in Kuala Lumpur, Singapore, and Indonesia. Dr. Chow is also active in community services. In 1980, he was a voluntary doctor to a Vietnamese Refugee Camp at Shamshuipo, Hong Kong and in 1982, under the CARE-MEDICO programme, he was Voluntary Visiting Specialist at Dacca and Bangladash where he undertook teaching and operation duties at postgraduate institutions and in rural areas for a month.

LOUIS HSU CHE SHEK

M.B., B.S. (Hong Kong), F.R.C.S. (Edinburgh), F.A.C.S.

Dr. Louis C.S. Hsu, Senior Lecturer in the Department of Orthopaedic Surgery, has been appointed Reader from October 1, 1984.

Upon graduating from the University of Hong Kong in 1968 with the degrees of Bachelor of Medicine and Bachelor of Surgery, Dr. Hsu was House Surgeon in Queen Mary Hospital and later House Physician in Queen Elizabeth Hospital. In July 1969 he was Medical Officer at the Duchess of Kent Children's Hospital. Dr. Hsu's academic career began in 1971 when he became Lecturer in the Department of Orthopaedic Surgery of the University of Hong Kong. In 1975 he went abroad and was Senior House Officer and Registrar in Princess Margaret Rose Orthopaedic Hospital and in Western General Hospital, Edinburgh. He returned to Hong Kong in 1976 and was promoted Senior Lecturer in the Department of Orthopaedic Surgery in 1977. Dr. Hsu is concurrently Consultant Orthopaedic Surgeon and Medical Director of Duchess of Kent Children's Hospital, Honorary Orthopaedic Consultant of Queen Mary Hospital and Consultant Orthopaedic Surgeon of various spastic centres and schools for the physically handicapped.

Dr. Hsu was elected Fellow of the Royal College of Surgeons of Edinburgh in 1975 and Fellow of the American College of Surgeons in 1982. In addition he is affiliated to various professional organizations and learned societies: the British Orthopaedic Association, Scoliosis Research Society, U.S.A., British Scoliosis Society, Societé Internationale de Chirurgie Orthopaedique et de Traumatologie, Western Pacific Orthopaedic Association, International Cerebral Palsy Society, and the Hong Kong Orthopaedic Association. He has been the Honorary Secretary of the Hong Kong Society for Rehabilitation since 1980.

Dr. Hsu's clinical and research interests centre on the management of spinal deformities, anky-losing spondylitis, neuromuscular problems in children, cerebral palsy and congenital anomalies. His ongoing research project includes a study into the pathogenesis of idiopathic scoliosis. Dr. Hsu has contributed extensively to academic journals in his field. He took active part in international conferences where he delivered academic papers by invitation and, on various occasions, he was guest surgeon in Japan, China and other Southeast Asian countries where he demonstrated the techniques of anterior spinal fusion and decompression and of halo-pelvic traction.

Dr. Hsu is a distinguished sportsman. In 1966, he was Hong Kong's lawn tennis representative at the Fifth Asian Games in Bangkok and in 1968, he was Sportsman of the Year of both the Hong Kong University Medical Society and the University's Ricci Hall Students' Association. In 1971 and 1972, he was Hong Kong's representative at the Davis Cup Championship Competitions.

Paediatrics

THE DEPARTMENT OF PAEDIATRICS – IT'S ONLY KID'S STUFF ("小兒科" 啦)

Introduction

In response to the editor's request to write an article on the recent development of our department, I wish to begin with a favorite story a former professor of medicine used to tell over and over again. The story went like this. There was a very famous knighted British doctor who had three physician-sons seeking for his advice on their career development. He suggested that the brightest of the three should do internal medicine, the less endowed surgery, and the least intelligent to go into a surgical sub-specialty, viz. obstetrics and gynaecology. Apparently paediatrics was not even considered worthy for his sons! This story pretty well sums up the traditional thinking that medicine comprises only of internal medicine and surgery and any other disciplines are but "sub-specialties". Paediatrics is only "kid's stuff", just like the popular slenderous remark " 小兒科啦 " in Hong Kong these days!

Paediatricians often failed to make their colleagues in other disciplines understand the special physical and emotional needs of the growing children. Their proposals to improve health care facilities for children are often met with unfavourable consideration or are put on a low priority for implementation. As a result many found it necessary to break away from the general medical team by setting up children's hospitals and special child care institutes simply to get the proper things done. The treatment received by our Department of Paediatrics has not deviated too much from tradition, although we have been a little luckier in the past few years.

Historic Background

The Department of Paediatrics was established in 1962 with its first founding professor C. Elaine Field after having been a small sub-division within the Department of Medicine for a number of years. A formal 10-week block paediatric clerkship was introduced in 1963 to the undergraduate curriculum and paediatrics has become a final MBBS examination subject since 1964.

By necessity, the department began as a heavily service-oriented clinical unit. It inherited two small general wards for in-patient accommodation. It had to utilize an open corridor space for seminar teaching and as a small laboratory. A few years later, a proper laboratory was established to provide various micro-tests on small children which the hospital was not servicing. This was followed by additional space for offices and other functional areas in the new Clinical Building allotted to the department.

Over a period of the 9 years following Professor Field's retirement in 1971, there had been 4 changes of headship for the department before my appointment in September 1980. It is conceivable that the frequent changes were not particularly conducive to growth and progress of the department.

Clinical Services

During the past few years, the department has established a range of acute tertiary paediatic services, including neonatal medicine, intensive care paediatrics and paediatric cardiology.

We have organised a team of doctors to provide neonatal care to all the babies at Tsan Yuk and Queen Mary hospitals. With the support of the Government, we have started a new neonatal laboratory service for small infants in 1982. These activities together with continued co-operation with the obstetricians have resulted in our neonatal survival rate comparable to most modern neonatal centres.

We have also established the first general paediatric intensive care unit in Hong Kong and have completed two training courses for paediatric intensive care nurses. Since 1982, the department has also become fully responsible for the paediatric cardiology services of the newly organised cardiology centre at Grantham Hospital, which offers a full range of investigatory and therapeutic procedures including open heart surgery for children in Hong Kong.

The department is currently providing a number of specialties-services including neurology, developmental paediatrics, haematology/oncology, endocrinology, nephrology and respirology besides acute tertiary care facilities as mentioned earlier. Plans are completed for a new Children's Wing at Queen Mary Hospital and a new Developmental Paediatric Centre at the Duchess of Kent Hospital. These projects will be completed by 1987/88 if proceeding on schedule.

Educational Programs

During the past few years, a number of attempts have been made to enrich the undergraduate teaching program. Firstly, students are assigned to Queen Elizabeth and Princess Margaret Hospitals for regular bed-side teaching. This has proven to be a highly valuable experience and I am particularly grateful to all the Government paediatric consultants for their devoted commitment in this teaching program. Secondly, we have implemented teaching at MCH and UCH community health project to ensure that our teaching is not only hospital-based. Thirdly, we have also enforced a compulsory 2-weeks residence program.

The format of post-graduate training in paediatrics has followed mainly the British system, namely by in-services apprenticeship-type training. Trainees spend an average of 3 years in the clinical unit before writing the M.R.C.P. (U.K.) examination. Having obtained the qualification, they then move on to a specialty or vocational training of their choice. During the past 4 years, 10 members (2 lecturers + 8 MOs) have obtained the MRCPs and 2 have additional training in specialty subjects; 7 other members (5 lecturers, 2 MOs) have had specialty training overseas, including 2 in neonatology, and one each in nephrology, intensive care, respirology, cardiology and developmental paediatrics. Several senior staff also have had sabbatic experience in other centres.

Research and Other Academic Activities

Ever since its inception, the department has placed much emphasis to study various local child health problems. Neonatal jaundice is one of the many examples which has attracted intensive interests and has generated quite a few publications from members of the department. A book on the normal growth and development of local children published by Professor C. Elaine Field and Dr. F. Baber has become a classic reference in Hong Kong. It has continued to arouse much research into related areas, both within and outside the department.

It is gratifying to note that the research productivity of the department has increased significantly during the past couple of years.

Conclusion

I have given an account of some of the background history and the changes which have led to the present development of our department. I hope that members of the medical society can cultivate a spirit to promote the various development of paediatric services for the betterment of child health in Hong Kong. It is no longer just "kid's stuff", for "to-day's child health is to-morrow's wealth".

Professor C.Y. Yeung
Head of Department

APPOINTMENTS

Reader

(Mrs.) Chan-Lui Wai Ying, M.B.,B.S., M.D. (Hong Kong), D.C.H. (London), F.R.C.P. (Edinburgh) (London), Senior Lecturer, as Reader in the Department of Paediatrics from October 1, 1984.

Senior Lecturer

Anita Li Ming Cheng, B.A. (Erskine), M.B.,B.S. (Hong Kong), D.C.H. (London), F.R.C.P. (Edinburgh), Honorary Clinical Lecturer, as Senior Lecturer in the Department of Paediatrics from July 1, 1984.

Lecturers

Alfred Tam Yat Cheung, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), appointed Lecturer in the Department of Paediatrics from July 1, 1984.

Edwin Yu Chau Leung, M.B.,B.S. (Hong Kong), D.C.H. (London), M.R.C.P. (United Kingdom), Honorary Lecturer, appointed Lecturer in the Department of Paediatrics from July 1, 1984.

RESIGNATIONS

Senior Lecturer

Dr. P.M.P. Yuen, Senior Lecturer in the Department of Paediatrics, from May 1, 1984.

Lecturers

Dr. Flora Baber, Lecturer in the Department of Paediatrics, from February 29, 1984.

Dr. T.F. Fok, Lecturer in the Department of Paediatrics, from April 3, 1984.

VISITING PROFESSORS

Professor C. Chantler, Professor of Paediatrics, Guy's Hospital Medical School, University of London, in Paediatrics, for the Final M.B.,B.S. Examination to be held in April/May 1985.

Professor Alvin Zipursky, M.D. (Toronto), Professor of Paediatrics, University of Toronto, and Director of the Division of Haematology/Oncology, Hospital for Sick Children, Toronto, appointed the second Wyeth Visiting Professor in Paediatrics from March 4, to 14, 1984.

Professor R. Berhman, Case Western Reserve University.

Professor N. Butler, University of Bristol.
Professor J. Chan, Medical College of Virginia.
Professor C. Chantler, Guy's Hospital, London.
Professor J.U. Crichton, University of British Columbia.
Professor Dahlqvist, University of Lund.
Professor R.J. Desnick, Mount Sinai School of Medicine.
Professor P.A. Imbach, Lansanne Children's Hospital, Switzerland.
Professor Eric Stroud, King's College, London.
Professor B.F. Anthony, UCLA School of Medicine.
Professor H.G. Jing, Shanghai First Medical College.

Professor A. Zipursky, Hospital for Sick Children, Canada.
Professor Richard Bethman, Case Western Reserve University.

EXTERNAL EXAMINER

Professor F. Cockborn, Samson Gemmell Professor of Child Health, University of Glasgow, in Paediatrics, for the Final M.B.,B.S. Examination to be held in May 1984.

**The above material is extracted from the Gazette of University of Hong Kong*

CHAN-LUI WAI YING

M.B.,B.S., M.D. (Hong Kong), D.C.H. (London), F.R.C.P. (Edinburgh) (London)

Dr. W.Y. Chan-Lui, Senior Lecturer, has been appointed Reader in the Department of Paediatrics from October 1, 1984.

Dr. Chan-Lui graduated in 1963 with the degrees of Bachelor of Medicine and Bachelor of Surgery. After a year of internship, in 1964 she was Medical Officer at Sai Ying Pun Infectious Hospital and later transferred to the University's Department of Paediatrics at Queen Mary Hospital. In 1967 she went abroad and for two years, she was Senior House Officer and Registrar at various hospitals in Scotland, among them: the Royal Alexandra Infirmary, Paisley, the Royal Infirmary, Glasgow, the Royal Edinburgh Hospital, and the Royal Hospital for Sick Children, Edinburgh. In 1969, Dr. Chan-Lui went to the United States and was Honorary Clinical Fellow at the Department of Child Neurology, Children's Hospital, Washington, D.C. Dr. Chan-Lui joined the Department of Paediatrics of the University of Hong Kong in 1969 and was promoted Senior Lecturer in 1976.

In January 1974, while on leave from the University, Dr. Chan-Lui, under a China Medical Board Fellowship, was attached to the University of Kentucky as Honorary Clinical Fellow at its Department of Neurology and, in August, to the Department of Medical Neurology of the National Institute of Neurological Diseases and Stroke, National Institute of Health, Bethesda, Maryland. More recently, in 1983, Dr. Chan-Lui was visiting Associate Professor of Child Neurology at the Albert Einstein College of Medicine, Yeshiva University, New York and at the Hospital for Sick Children, Toronto.

Dr. Chan-Lui was awarded the Diploma in Child Health in 1967 and was elected Fellow of the Royal College of Physicians of Edinburgh in 1978 and of London in 1983. In 1980, she was awarded the degree of Doctor of Medicine by the University of Hong Kong.

Dr. Chan-Lui holds memberships of various professional organizations, among these: the International Child Neurology Association, the International Cerebral Palsy Society, the Asian and Oceanian Association of Child Neurology, the Japanese Society of Child Neurology, the Spastic Association of Hong Kong, the Hong Kong Neurological Society and the Hong Kong Paediatric Society.

Dr. Chan-Lui has contributed extensively to academic literature in her field, her papers being published in refereed international journals, such as *Archives of Diasese in Childhood, Developmental Medicine and Child Neurology, Journal of Neurology, Neurosurgery and Psychiatry, Neuropediatrics, Brain and Development, Canadian Journal of Neuroscience* and *Australian Paediatric Journal*. She is an editor of *Mother and Child, Medical Progress*, and *Spastics* in Hong Kong. She has been an invited participant at numerous international and local seminars and symposia where she delivered invited papers.

Dr. Chan-Lui has been actively involved in academic and community services and holds numerous honorary appointments. She is Paediatric Consultant to the Heep Hong Club for Handicapped Children,the Apleichau Preschool Centre for Handicapped Children, the J.F. Kennedy School, thyKo Fook Iu Memorial School, Paediatric Consultant and Programme Director of the Child Development and Habilitation Centre, Duchess of Kent Hospital and Director of the Cerebral Palsy Multi-Professional Programme at David Trench Rehabilitation Centre, Adviser to the Hong Kng Association of Occupational Therapists, and Honorary Consultant in Paediatrics to the Medical and Health Department of the Hong Kong Government.

Pathology

One meaning of the word 'elixir' is a medication to prolong life (長生不老約); the term is now used in the more general sense of a tonic. Medical science has not yet developed on elixir to prolong life, although average lifespan in modern society is increasing due to the many incremental improvements in hygiene, nutrition, medical care and so forth. A few years ago there was much interest in the notion that a primary factor in ageing was the deterioration in the immune system. One of the most dramatic illustrations of this is the gradual involution of the thymus gland from puberty onwards, but it is relatively late in life that a decline in number and function of thymus dependent lymphocytes (T cells) can be detected. Nevertheless it is a fair assumption that this decline is, in part, responsible for the increase in incidence of neoplasms in old age, as well as the increased susceptibility to infectious diseases. In the Immunology section of the Department of Pathology a good deal of effort has been put into developing laboratory techniques which will tell us how effectively cells of the immune system (lymphocytes and phagoeytic cells) are functioning. Several years ago we completed a study which showed a significant decline in monocyte function with ageing. Other techniques, which we use to assess immune function routinely, could be applied to the investigation of ageing in this community.

As mentioned above, ageing is accompanied by an increased incidence of neoplasms. The study of carcinogenesis is one of the principal research interests in the Histopathology section of our department. In this kind of research work animal models are essential, and it is necessary to use these models to determine how various environmental factors interact in carcinogenesis (promotors, inducers etc.) as well as the influence of genetic factors. Here is another area where the research activities of the Department could be directed towards a major medical problem of ageing. We hope that the extended Pathology Building (to be finished by the end of 1986) will provide better facilities for carrying out animal experimentation of this kind. Another hope that we have is to establish fund to allow prominent academics to visit the Department and to contribute expertise and experience to cancer research. Whether this can be made reality or whether it is a mere pipe-dream remains to be seen.

Dr. J.W.M. Lawton
Head of Department

APPOINTMENTS

Reader

(Mrs.) Faith Ho Wat Chi Suk, M.B.,B.S., M.D. (Hong Kong), D.Obst. R.C.O.G., M.R.C.Path., Senior Clinical Pathologist, appointed Reader in the Department of Pathology from May 1, 1984.

Senior Clinical Pathologist

Pauline Mildred Emerson, M.B.,B.S., M.D., Dip. Biochem. (London), M.A. (Oxon.), M.R.C.S., L.R.C.P. (London), F.R.C.Path., as Temporary Senior Clinical Pathologist in the Hospital Pathology Services from November 1, 1984 to August 31, 1985.

Clinical Pathologists

Raymond Chu Wan, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in the Hospital Pathology Services from June 18, 1984.

Lin Che Kit, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in the Hospital Pathology Services from July 1, 1984.

Lloyd Neil Denmark, B.Sc., M.B.,B.S. (London), appointed Clinical Pathologist in the Hospital Pathology Services from May 1, 1984.

RESIGNATIONS

Clinical Pathologists

Dr. P.K. Hui, Clinical Pathologist in the Hospital Pathology Services, from June 17, 1984.

Scientific Officer

R. Joyce, Scientific Officer in the Hospital Pathology Services, from April 7, 1984.

EXTERNAL EXAMINER

Professor J.R. Anderson, University of Glasgow (Pathology, 1981-84).

**The above material is extracted from the Gazette of University of Hong Kong*

FAITH HO CHI SUK

M.B.,B.S., M.D.(Hong Kong), D.Obst., R.C.O.G., M.R.C.Path.

Dr. Faith C.S. Ho, Senior Clinical Pathologist in the Hospital Pathology Services, has been appointed Reader in the Department of Pathology from May 1, 1984.

Dr. Ho received the degrees of Bachelor of Medicine and Bachelor of Surgery with Honours in 1963 from the University of Hong Kong. After working for a year as House Officer in Queen Mary Hospital and in Tsan Yuk Hospital and for half a year in the University Department of Medicine and in Alice Ho Miu Ling Nethersole Hospital, she went to London in 1966, where she became first Post-registration House Officer in Medicine in the South London Hospital for Women, then President Pathologist at St. Thomas's Hospital. In 1969, Dr. Ho returned to Hong Kong and joined the University as Temporary Lecturer in Pathology. In 1971 she was Clinical Pathologist and a year later Lecturer in Pathology. In 1974, Dr. Ho underwent further postgraduate training at the Department of Pathology, University of Glasgow at the Western Infirmary and, in 1976, was awarded a K.P. Stephen Chang travel grant to study electron-microscopy of lymphomas at the Westminister Hospital and Medical School in London. In November 1977, she was promoted Senior Clinical Pathologist.

Dr. Ho obtained the Diploma of Obstetrics of the Royal College of Obstetricians and Gynaecologists in 1968, was elected to membership of the Royal College of Pathologists in 1974, and was awarded the degree of Doctor of Medicine by the University of Hong Kong in 1983.

Dr. Ho holds memberships of various professional societies, among these: the New York Academy of Sciences, the International Society of Haematology, the Hong Kong Pathology Society, and is Founding Member and past Chairman of the Hong Kong Society of Haematology.

Dr. Ho's research interests centre around the pathology, electron-microscopic study and immunohistochemical typing of malignant lymphomas and leukaemias, the application of immunohistochemical techniques at the electron microscopic level, and other aspects of haematopathology. On these areas, Dr. Ho has contributed a long series of articles to leading international journals.

Pharmacology

In the past year, as in the three previous to that, the Department of Pharmacology has actively sought to improve upon its teaching effectiveness. Feedback from regular staff-student consultative meetings has played an important role in moulding teaching strategies. The main thrust of the course has been emphasis on pharmacology which is relevant to professional needs. The rapid advance of knowledge and increasing information in this discipline has made it necessary to be selective, and for much material of mere academic interest to be discarded. Principles and only essential details are, therefore, focused upon so as to enable the student to problem-solve effectively. This type of sound basic background is complemented by more details being added on later when the student moves into Clinical Pharmacology and Therapeutics, and when he deals with individual patients with particular disease patterns.

Student performance has been reasonably satisfactory over the years, with the usual fluctuations in failures in the 3rd M.B., B.S. Examination. The past year saw an extremely good pass rate and it is hoped that this level of achievement will be maintained. It is gratifying to note that, because of changes in teaching strategies, there is a general tendency for students to show a better understanding of principles and to problem-solve more efficiently, rather than to depend purely on rote. We hope that this trend will become more prominent with future groups. The Department is also involved in teaching B.D.S. undergraduates, as well as postgraduates reading for the Cert. Med. Sc. or carrying out Special Studies. There were three Cert. Med. Sc. candidates (one from China and two from Indonesia) in the 1983/84 academic year. Currently, there are two Cert. Med. Sc. candidates (both from the Philippines) and one (from Taiwan) doing Special Studies; another postgraduate (from China) is expected to arrive later on in the year to do Special Studies.

Where research is concerned, there has been a significant increase in postgraduate students working for higher degrees in pharmacology in the past year. There are currently six higher degree candidates (two for M.Phil. and four for Ph.D.), with one about to submit his thesis for examination. The major areas of on-going research by staff members in the Pharmacology Department are in CNS drugs, opiates and addiction, gastric pharmacology, immunopharmacology, cardiovascular pharmacology and respiratory pharmacology. Certain aspects of Chinese herbal medicines continue to be investigated. Collaborative research is also being conducted with other departments in the Medical Faculty.

Due to current financial constraints being experienced in the University and the freezing of one teaching post in this Department, we are unable to embark upon significant expansion programmes. Our main focus is, therefore, on the consolidation of existing teaching and research activities. We will also continue with our policy of striving to improve our teaching effectiveness through awareness of current trends in pharmacology requirements for professional needs and through guidance from feedback by students and by teaching staff from the clinical departments. Due to the limited hours allocated to Pharmacology in the present M.B., B.S. and B.D.S. curricula, it is, unfortunately, not possible to have closer contact (in the form of tutorial sessions) with students. However, all students are always welcome to approach staff members for discussions whenever they have problems.

Professor C.W. Ogle
Head of Department

APPOINTMENT

Lecturers

Cho Chi Hin, B.Pharm. (National Defense Medical Center, Taiwan), Ph.D. (Hong Kong), appointed Lecturer in the Department of Pharmacology from May 14, 1984.

RESIGNATION

Lecturers

Dr. D.M.F. Li, Lecturer in the Department of Pharmacology, from January 8, 1984.

VISITING PROFESSORS

Professor P.H. Joubert, Department of Pharmacology & Therapeutics, Medical University of Southern Africa, Republic of South Africa. (Jan-Mar., 1984)

EXTERNAL EXAMINER

Professor P. Turner, University of London (Pharmacology, 1982-85).

**The above material is extracted from the Gazette of University of Hong Kong*

Physiology

TEACHING

The Department of Physiology fosters the educational practice of small group teachings. Although labour intensive and time consuming, the Department has made every effort to subdivide large classes into small groups for tutorials & practicals to promote more personal staff-student relations. There is continual effort to try to reduce formal didactic lectures to allow time for informal discussions.

RESEARCH

Research in the Department of Physiology continues to strengthen, despite limited financial support. Research interests range from basic cellular physiology to cognitive functions of the human brain. Each year there are ample opportunities for both undergraduate & postgraduate students to become involved in various areas of research such as hematology, comparative physiology, biophysics of muscle, reproductive functions, endocrines & metabolism, neurophysiology of vision, audition, vestibular function and control of movements. New advances have also been made in the understanding of the function of nose as well as the pineal gland in our laboratories. Pioneering work on information processing and computer based biomedical research has also progressed in strides in recent years.

In addition to teaching & research responsibilities, many of us in the Department also serve as advisers and consultants to numerous outside and international bodies. We are involved in research grant committees, journal referees and serve as advisers & consultants to Hospitals & the World Health Organization etc. Frequent lecture tours to the People's Republic of China, together with visits by Chinese physiologists to Hong Kong, have helped to forge stronger & closer links with Chinese academic and research institutions.

TEACHERS

August 1984 saw the arrival of a new lecturer in the Department, the Australian neurophysiologist Dr. Ray Muir. A graduate of Melbourne and Monash Universities, Dr. Muir spent three years in the University Laboratory of Physiology in Oxford and over four years with the Medical Faculty of Erasmus University, Rotterdam before coming to Hong Kong. His research interests include the central neural control of skilled hand and finger movements.

In autumn, we were also honoured by the presence of Visiting Professor K.L. Chow, who for the past seventeen years, has served as Professor Of Neurology at Standard Medical Centre, U.S.A. Professor Chow was with us to collaborate in research on the functional connections of retinal ganglion cells.

Visits and exchanges between Hong Kong and overseas physiological institutes and attendance by our staff at international meetings and conferences are helping to put the Department of Physiology and the University of Hong Kong "on the map" in the world of physiological science.

All teachers of the Department of Physiology have an "open-door" policy for students. We welcome students to drop in anytime to have a friendly chat to discuss their academic problems, tennis elbows or 1997.

Professor J.C.C. Hwang
Head of Department

APPOINTMENTS

Senior Lecturers

Pang Shiu Fun, B.Sc. (Chinese University of Hong Kong), M.A. (California), Ph.D. (Pittsburgh), Lecturer, as Senior Lecturer in the Department of Physiology from August 1, 1984.

Wong Tuck Ming, B.Sc. (Chinese University of Hong Kong), M.Sc., Ph.D. (Hong Kong), Lecturer, as Senior Lecturer in the Department of Physiology from August 1, 1984.

Lecturer

Raymond Barry Muir, B.E. (Melbourne), Ph.D. (Monash), M.I.E.E.E., as Lecturer in the Department of Physiology from August 24, 1984.

HONORARY PROFESSORS

Professor Yoshio Nakamura, M.D., Ph.D. (Tokyo), Department of Physiology, School of Dentistry, Tokyo Medical and Dental University, appointed Honorary Professor in the Department of Physiology from September 4 to 10, 1984.

VISITNG PROFESSORS

Professor K.L. Chow, Professor of Neurology, Stanford University Medical Schoo, U.S.A.

Professor R.J. Reiter, Professor of Neuroscience, Department of Cellular and Structural Biology, The University of Texas Health Science Center at San Antonio, U.S.A.

Professor W.E. Grill, Professor of Department of Physiology & Biophysics & Medicine (Neurology), Chairman of Department of Physiology & Biophysics, University of Washington School of Medicine Seattle, U.S.A.

EXTERNAL EXAMINERS

Professor K. W. Cross, University of London (Physiology, 1982-85).

Professor S.M. Hilton, Professor of Physiology, University of Birmingham, in Physiology, for the B.Sc.(Biomedical Sciences) and M.Med.Sc. degrees, for the academic year 1983-84.

**The above material is extracted from the Gazette of University of Hong Kong*

Surgery

With the rapid progress in surgical science, tremendous challenges face a university surgeon who wishes to keep abreast with new discoveries, offer a high standard of patient care, engage in research pursuits of quality, and carry out his teaching activities conscientiously. To cope with these tasks, the Department of Surgery was reorganised in 1982 into eight teams of surgical specialties, namely hepatobiliary surgery, gastrointestinal surgery, head and neck and vascular surgery, colorectal and endocrine surgery, urological surgery, paediatric surgery, neurosurgery and cardiothoracic surgery. Surgeons with special interest and who have had periods of training in certain specialties are grouped together. By matching patients and surgeons in this way we hope to provide the best patient care possible and to carry out in-depth teaching, training, and research in the specialty.

In order to expose our undergraduates to different categories of surgical patients and to overcome the limitation of space in the wards in Queen Mary Hospital, the Department of Surgery has now established teaching units in Queen Elizabeth Hospital, Kwong Wah Hospital, Tung Wah Hospital and The Grantham Hospital.

Teaching for the Introductory and Junior Clerks are conducted mainly in the Queen Mary Hospital and the Tung Wah Hospital. Senior Clerks spend most of their training period in Queen Elizabeth Hospital and Kwong Wah Hospital. The Specialty Clerks are attached to the various teams in Queen Mary Hospital and The Grantham Hospital where the different subspecialties instructions are given. Each year about 50 students in the Specialty Clerkships join the Department to work as Assistant Interns. This offers an opportunity for students to work as member of the surgical team, and experience is gained through practical work in the wards.

In spite of a large commitment to patient care, members of the department have engaged in substantial surgical research. The main emphasis is on surgical problems common in this part of the world, such as recurrent pyogenic cholangitis, carcinoma of the liver, peptic ulcerations, head and neck cancers, oesophageal and urological cancers, and basic research in tumour immunology and cholelithiasis.

In a few years' time, the new extension to the Queen Mary Hospital will be completed, and this will provide relief to the overcrowded working conditions in the wards. Also, with the establishment of the new chairs in anaesthesiology, otorhinolaryngology, diagnostic radiology, and radiotherapy in the Department of Surgery, teaching for the undergraduates will be improved.

Professor John Wong
Head of Department

APPOINTMENTS

Professor

Ulf Carl Goesta Engzell, Med.Lic., M.D., Docent. (Karolinska Institute), Senior Lecturer, as Professor of Otorhinolaryngology in the Department of Surgery from December 1, 1984.

Reader

Htut Saing, M.B.,B.S. (Rangoon), F.R.C.S. (Edinburgh), F.A.A.P., Senior Lecturer, as Reader in the Department of Surgery from July 1, 1984.

Senior Lecturers

Philip George Reasbeck, M.A., M.B.,B.Chir. (Cantab), M.R.C.P. (United Kingdom), F.R.C.S. (England), F.R.A.C.S., appointed Senior Lecturer in the Department of Surgery from June 1, 1984.

William Ignace Wei, M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh), F.A.C.S., Lecturer, as Senior Lecturer in the Department of Surgery from December 1, 1984.

Lecturers

Joseph Lee Man Ho, M.B.,B.S. (Hong Kong), F.R.C.S. (Glasgow), appointed Lecturer in the Department of Surgery from January 1, 1984.

Paul Tam Kwong Hang, M.B.,B.S. (Hong Kong), F.R.C.S. (Edinburgh) (Glasgow) (Ireland), as Lecturer in the Department of Surgery from December 24, 1984.

RESIGNATIONS

Senior Lecturer

Dr. P.G. Reasbeck, Senior Lecturer in the Department Surgery, from August 31, 1984.

Lecturer

Dr. N.W. Lee, Lecturer in the Department of Surgery, fro April 10, 1984.

VISITING PROFESSOR

Professor James Yao See Tao, M.D. (National Taiwan), Ph.D (London), F.A.C.S., Professor of Surgery, Northwestern University Medical School, Chicago, appointed Visiting Professo in the Department of Surgery from December 27, 1983 to Januar 8, 1984.

EXTERNAL EXAMINER

Professor P. J. Morris, University of Oxford (Surgery 1983-84).

Research Associate

Zoltan Lett, M.D. (Czechoslovakia), F.F.A. R.C.S. (England (Ireland), F.F.A.R.A.C.S., D.A. (England), R.C.P.S. (Ireland) formerly Reader in the Department of Surgery until his retiremen in June 1983, has been appointed Research Associate in th Department of Surgery from January 1, 1984.

* *The above material is extracted from the Gazette of University of Hong Kong*

HTUT SAING

M.B.,B.S. (Rangoon), F.R.C.S. (Edinburgh), F.A.A.P.

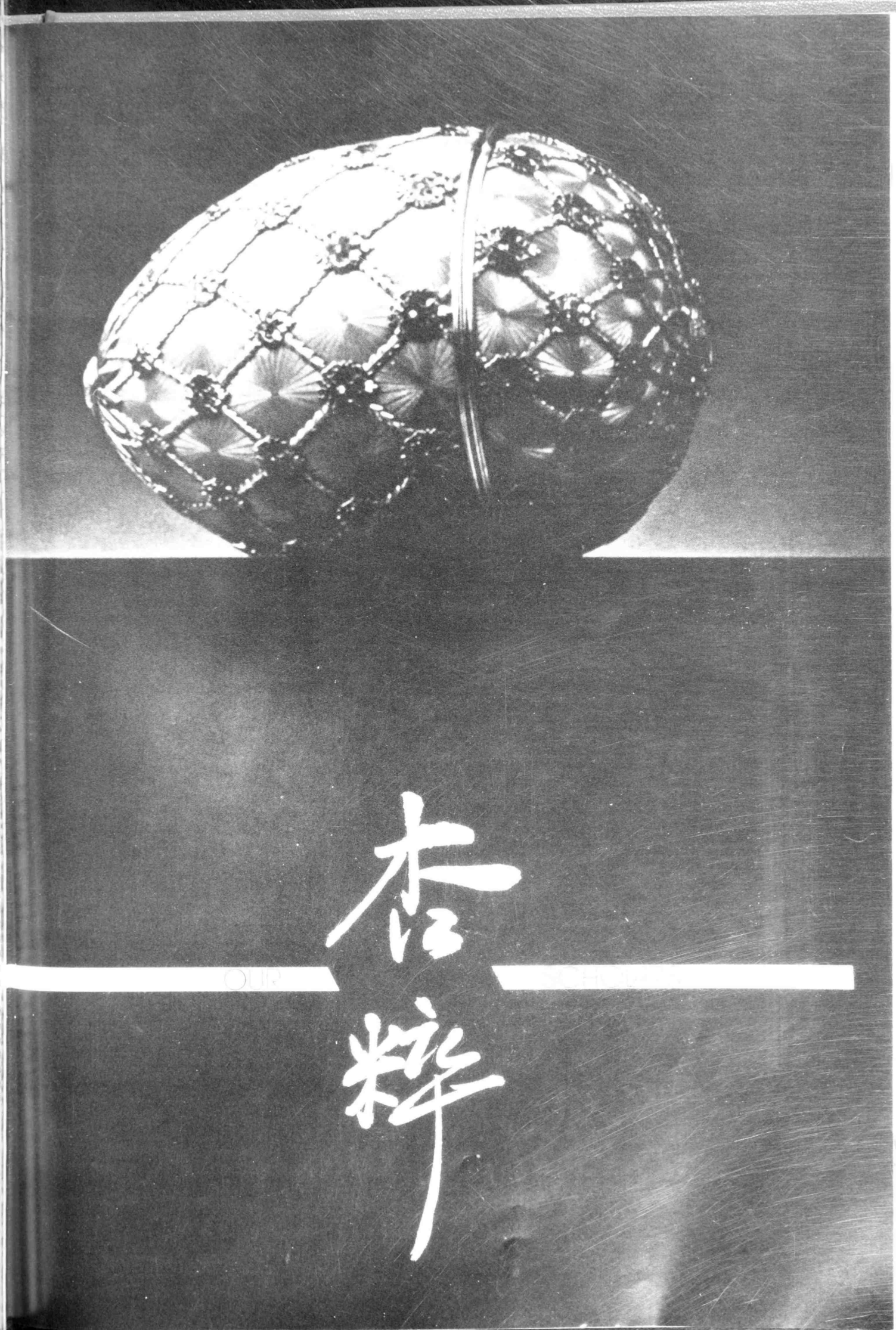
Dr. H. Saing, Senior Lecturer in the Department of Surgery, has been appointed Reader from July 1, 1984.

Upon graduating from the University of Rangoon, Burma in 1960 with the degrees of Bachelor of Medicine and Bachelor of Surgery, Dr. Saing worked for a year as House Surgeon in Rangoon General Hospital where he became Surgical Registrar in 1961. From 1965 to 1979, he served at the Rangoon Children's Hospital, first as Assistant Surgeon, then as Consultant Paediatric Surgeon and, since 1978, headed the Department of Paediatric Surgery. From 1969 to 1979, Dr. Saing was concurrently Lecturer in Surgery at the University of Rangoon and Lecturer in Surgical Paediatrics at the School of Child Health, Rangoon. Dr. Saing was Colombo Plan Scholar in 1968 and 1969, during which he received further training in paediatric surgery in Sheffield Children's Hospital, United Kingdom. In 1972, on being awarded the Canadian International Development Agency (CIDA) Scholarship, he underwent further training at the Montreal Children's Hospital, Canada as Surgical Fellow cum Chief Resident. Dr. Saing took up appointment at the University of Hong Kong in 1979 as Senior Lecturer in charge of the Division of Paediatric Surgery. He is concurrently Consultant Surgeon of both the Queen Mary Hospital and the Duchess of Kent Children's Hospital.

Dr. Saing was elected Fellow of the Royal College of Surgeons of Edinburgh in 1969 and Fellow of the American Academy of Pediatrics in 1974. In addition he is affiliated to a number of learned societies: the British Association of Paediatric Surgeons Société Internationale de Chirurgie, the Association of Surgeons of Southeast Asia, the Hong Kong Surgical Society and the Hong Kong Paediatric Society. He is also an Executive Committee Member of the Society for the Relief of Disabled Children.

Dr. Saing's clinical and research interests centre on biliary atresia, choledochal cysts, necrotising enterocolitis and splenectomy in thalassaemias. His ongoing studies include congenital duodenal obstruction, neonatal intestinal obstruction intussusception, childhood hydronephrosis, hypoglycaemia in newborn and infants, surgical ascariasis and conjoined Siamese twins. Dr. Saing contributed extensively to academic journals in his field and he took active part in international conferences of paediatric surgeons.

Besides academic pursuits, Dr. Saing is also active in sports. He is at present a member of the Royal Hong Kong Yacht Club, and Vice-President of both the Hong Kong Students' Rowing Club and Hong Kong University Rowing Club. Back in his school days, he was recipient of the Depelchin Gold Medal which was awarded for character, studies and games by St. Joseph's College, Darjeeling India. He was also winner of Burma's Sportsman of the Yea Award in 1958.


杏粹

Our prize-winners

John Anderson Gold Medal	Leung Wing Hung
John Anderson Gold Medal	Fan Yiu Wah
(proxime accessit)	Poon Ming See
Belilios Medical Prizes	Chan Tsz Yeung
	Ho Kin Ming
Chan Kai Ming Prize	Leung Wing Hung
Digby Memorial Gold Medal in Surgery	Leung Yiu Cheong
C. P. Fong Gold Medal in Medicine	Fan Yiu Wah
	Wong Cheuk Kit
C. P. Fong Gold Medal in Pathology	Yik Ping Yin
R. M. Gibson Gold Medal in Paediatrics	Leung Wing Hung
Ho Fook Prize	Raymond Cheung Tak Fai
Hong Kong Medical Association Price	Dr. Jao-Yiu Sung
Hong Kong Pathology Society Prize	Ng Woon Leung
Hong Kong University Alumni Prize	Fung Kin Wah
C. T. Huang Gold Medal in Microbiology	Lung Hin Fai
Dr. Mary Hui Ling Li Memorial Prize	Chan Kwok Wah
Gordon King Prize in Obstetrics and Gynaecology	Leung Wing Hung
Li Shu Fan Medical Foundation Prize in Biochemistry	Lam Chi Ming
Li Shu Fan Medical Foundation Prize in Pharmacology	Ho Kin Ming
Li Shu Fan Medical Foundation Prize In Physiology*	Miranda Chan Chi Mui
	Edmond Ma Shiu Kwan
Sir Patrick Manson Gold Medal	Chan Tai Kwong
Janet McClure Kilborn Prize in Physiology and Biochemistry	Miranda Chan Chi Mui
	Kathy Lee Lai Fun
Mun Gold Medal and Prize in Psychiatry	So Ka Yee
Nesta and John Gray Medal in Surgery	Leung Yiu Cheong
Ng Li Hing Prize in Anatomy	Lo Chung Yau
	Wong Siu Shan
3M Far East Prizes	Raymond Cheung Tak Fai
	Lam Chi Ming
	Chow Yu Fat
	Ng Woon Leung
Yuan Ai-Ti Gold Medal in Behavioural Sciences	Ng Woon Leung

Our academics

DOCTOR OF MEDICINE

Dr. Wu Pui Chee 胡沛之

DOCTOR OF PHILOSOPHY

Mr. Chan Dit Hung, Samuel 陳秩雄 (Biochemistry)
Mr. Ha Kwok Kuen 夏國權 (Pathology)
Mr. Lee Kin Sing 李建成 (Biochemistry)
Mr. Lee Wai Ming, Will 利偉明 (Physiology)

MASTER OF PHILOSOPHY

Mr. Chan Boon Lak 陳本力 (Biochemistry)
Mr. Lau Kin Dick, Samuel 劉健德 (Anatomy)
Miss Tse Yuet Ha, Susanna 謝月霞 (Physiology)

MASTER OF MEDICAL SCIENCES

*Dr. Abellana, Jocelyn A.
*Dr. Quisumbing, Teresita Lambo

BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

1984

Honours List

Mr. Leung Wing Hung 梁永雄 (Distinctions in Anatomy, Microbiology, Pathology, Surgery, Obstetrics & Gynaecology, and Paediatrics)

1983

Mr. Au Ka Kui 區家駒
Mr. Au Yiu Kai 歐耀佳
Mr. Chan Fook Chuen 陳福全
Mr. Chan Yuen Sang 陳源生
Mr. Chau Wing Shun 周永信
Mr. Cheung Fu Keung 張富强
Mr. Chiang Shu Yin 蔣樹人
Miss Choi Suk Mui, Annie 蔡淑梅
Mr. Chung Kit Keung 鍾傑强
Mr. Chung Ling Hung 鍾嶺雄
Mr. Lau Hon Kong, Eddie 劉漢岡
Mr. Lee Sing 李誠
Mr. Leung Yun Sum 梁潤森
Mr. Loo Ka Tai 盧稼泰
Mr. Ng Chun Bor 吳進坡
Mr. Seto Lan Ki, Patrick 司徒立奇
Mr. Wat Chi Sum 屈志森
Mr. Wong Yiu Wah 黃耀華
[redacted] Yuen Wing Sheung, Rose 阮詠霜

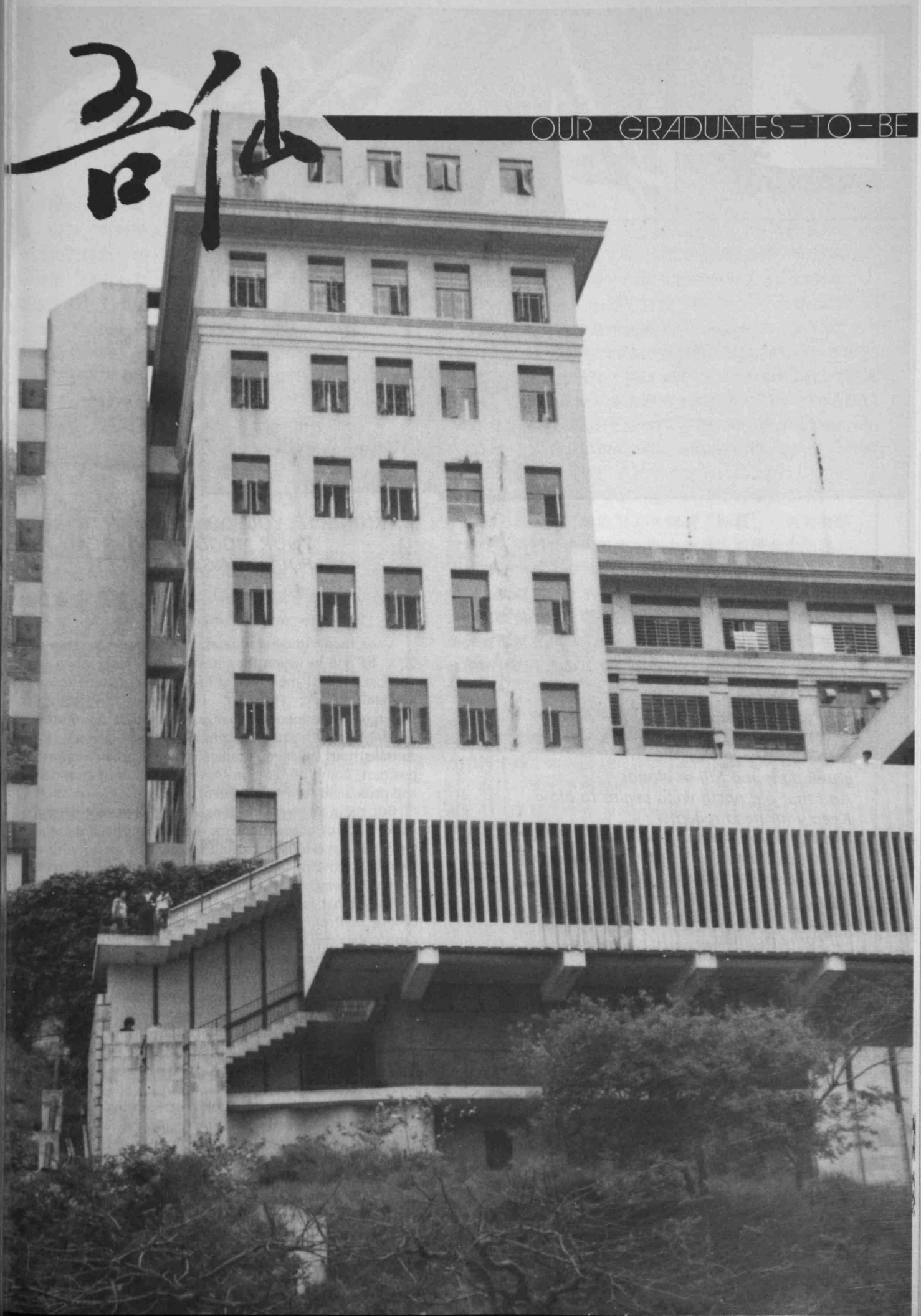
1984

Mr. Au Lap Keung 區立强
Mr. Au Ting Wah 區鼎華
Mr. Au Wai Choy 區偉才
Mr. Au Yeung Kar Wai, Alexander 歐陽嘉偉
Mr. Chan Chor Man 陳楚文
Mr. Chan Chung Sum, Sammy 陳從心
Mr. Chan Hok Chin, Eddy 陳學前
Mr. Chan Shek Chi 陳碩志 (Distinction in Pharmacology)
Miss Chan Wai Kuen, Edith 陳惠娟
Mr. Chan Yuk Tat, Eric 陳育達
Mr. Chang Chun Chau 鄭鎮秋
Mr. Chang Yu Lin 張煜麟
Mr. Chau Wan Yeung 周允揚
Mr. Cheng Kar Keung 鄭家强
Mr. Cheng Wing Keung, Stephen 鄭永强 (Distinctions in Anatomy, Physiology, and Obstetrics & Gynaecology)
Mr. Cheung Yiu Cheung 張耀璋
Miss Ching Cheuk Tuen, Regina 程卓端
Mr. Chiu Hok Ming 趙鶴鳴
Mr. Chiu Kay, Clayton 趙琦
Miss Chiu Kit Yee, Sherlianne 趙潔儀 (Distinction in Pharmacology)
Mr. Choi Koon Shing, Andrew 蔡冠誠
Mr. Chow Cheuk Fai 周卓輝
Miss Chow Chung Yee, Patricia 鄒重儀

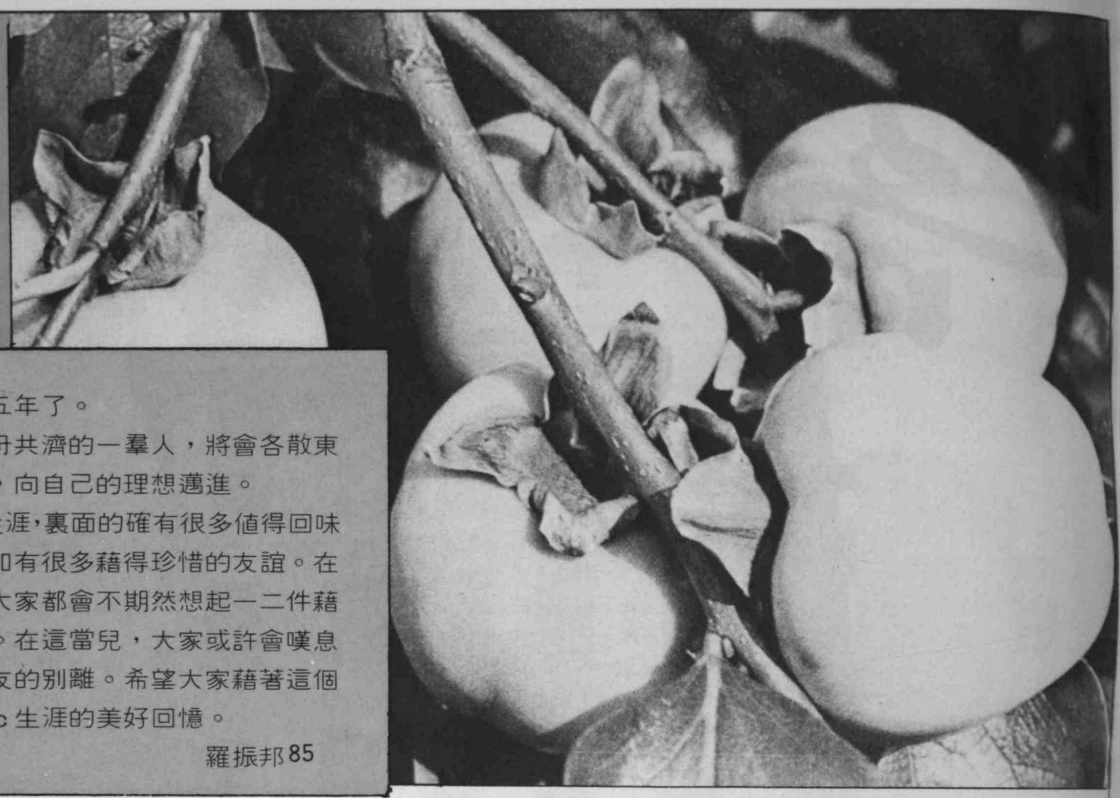
Mr. Chow Wing Cheong 周永昌
Mr. Chow Yuk Yin 周育賢
Mr. Chum Pak Ying, Norman 覃佰英
Mr. Fan Tak Wing 范德穎
Mr. Fan Yiu Wah 范耀華 (Distinctions in Pathology and Medicine)
Miss Fan Yun Sun, Susan 范瑩孫
Mr. Fok Lai Sing 霍禮成
Mr. Fu Yiu Tung 傅耀彤
Mr. Fung Chi Wing 馮志榮
Mr. Fung Kin Wah 馮健華 (Distinction in Pathology)
Miss Fung Siu Ling, Amy 馮小玲
Miss Ho Chui Fong, Mimi 何翠芳
Mr. Ho Tai Wai, David 何大偉
Mr. Ho Ting Pong 何定邦
Miss Ho Wai Chu, Judy 何惠珠
Mr. Hui Yau 許由
Mr. Ip Ki Kwan, Steven 葉祺焜
Mr. Kao Hing Kee, Frederick 高興基
Mr. Khoo Robin 邱羅濱
Mr. Ku Kwok Wai 顧國偉
Mr. Kung Yu Yat 龔羽一
Mr. Kwan Tze Hoi 關子凱
Mr. Kwong Ngai Shan 鄺毅山
Mr. Lai Chi Wai 黎志偉
Mr. Lai Chi Wing 黎志榮
Mr. Lai Moon Sing 黎滿勝
Mr. Lam Chun Kit 林俊傑
Mr. Lam Ka Hing, Kenneth 林家慶
Mr. Lam Lai Kun 林禮根
Mr. Lam Shun Chiu 林順潮
Mr. Lam Ting Wa, Jodis 林廷華
Mr. Lam Tsun Ngai 林俊毅
Mr. Lam Tsz Ping 林子平
Mr. Lam Yuk Sing 林鏸成
Mr. Lau Ho Lim 劉浩濂
Mr. Lau Ip Tim 劉業添
Miss Lau Sau Wah 劉修華
Mr. Lau Yiu Nam 劉耀南
Mr. Lau Yue Ting 劉汝亭
Mr. Law Hing Fai 羅慶輝
Mr. Lee, Joseph 李約瑟 (Distinction in Microbiology)
Mr. Lee Kai Cheung, Stephen
Mr. Lee Kai Man, Joseph 李啓文
Miss Lee Shuk Han 李淑嫻
Mr. Lee Wai Ying, Elvis 利維英
Mr. Lee Yuen Lun 李淵綸
Mr. Leong Heng Tat 梁慶達
Mr. Leung Chung Cheung 梁頌璋
Mr. Leung Chung Shan 梁仲山
Mr. Leung Chung Ying 李啓祥
Mr. Leung Kin Kay 梁健基
Mr. Leung Kwok Ling, Ares 梁國齡
Mr. Leung Siu Kui, Dominic 梁少駒
Mr. Leung Wai Hung, Andy 梁偉雄
Mr. Leung Wai Suen 梁偉宣
Mr. Leung Wai Tong 梁惠棠
Mr. Leung Yiu Cheong 梁耀昌 (Distinction in Surgery)
Mr. Li Kai Ming 李啓明
Mr. Lie Kwok Wai, Albert 李國維
Mr. Lin, Michael 練紹忻
Mr. Lo Man Kam, Johnny 盧文錦
Miss Luk Wai Fan 陸慧芬
Mr. Ma Kwok Man 馬國文
Mr. Mak Chi Wai 麥志維
Miss Mak Man Lai 麥文麗
Mr. Mak Sze Yuen 麥思源
Mr. Moy Man Cho 梅文藻
Mr. Ng Kwok Keung 吳國强
Mr. Ng Kwok Keung, Daniel 吳國强
Mr. Ngan Hung Kin, Henry 顏孔健
Mr. Pak Po Kuen 白寶權
Miss Poon Ming See, Angela 潘明施 (Distinctions in Biochemistry, Pathology, Pharmacology, and Community Medicine)
Mr. Sham Yiu Cheung 岑耀祥
Mr. Shek Chun Chiu 石俊超
Mr. Shing Ming Kong 成明光
Mr. Sitt Wing Hung, Edward 薛穎雄
Miss So Ka Yee 蘇嘉儀
Mr. So Wing Shum 蘇永順
Mr. Sun Joo Ming, Andrew 沈祖明
Mr. Sun Wai Ho 孫偉浩
Miss Tai Tak Hing, Patricia 戴德卿 (Distinction in Behavioural Sciences)
Mr. Tam Ka Hung, Christopher 譚嘉雄
Mr. Tang Lok Sang, Gordon 鄧樂生
Mr. Tang Pak Sang 鄧柏生 (Distinctions in Behavioural Sciences and Pharmacology)
Miss Tang Yuet Kiu, Rebecca 鄧悅翹
Mr. Tong Chi Tak 唐志德
Mr. Tong, Leon George 唐力安
Mr. Tong Wai Nung 湯偉能
Mr. Tsang Cheung Fung 曾祥風
Mr. Tsang Ngai Chong 曾艾壯
Miss Tse Man Wah, Doris 謝文華
Mr. Tse Po Shu, Patrick 謝寶樹
Miss Tse Tao Yan, Agnes 謝道欣
Mr. Tseng Hing Chuen, George 曾慶泉
Miss Tsoi Lan Ching 蔡蘭貞
Mr. Tsui Kwok Biu 徐國標
Mr. Wai Sing Hang 衛承鏗
Mr. Wan Koon Yat 尹貫一
Mr. Wong Cheuk Kit 黃卓傑 (Distinctions in Medicine and Paediatrics)
Mr. Wong Chi Keung 黃志强
Mr. Wong Fook Kwang, Philip 黃福鋐
Mr. Wong Kwong Wai, Raimond 黃光偉
Mr. Wong Man Shun, George 黃文遜
Mr. Wong Shu Fai 黃樹輝
Miss Wong Wai Yu, Amelia 黃惠瑜 (Distinction in Pathology)
Mr. Yiu Gar Chung, Michael 姚家聰
Mr. Yuen Siu Tsan 袁兆燦
Mr. Yung Tak Cheung 翁德璋

高仙

OUR GRADUATES-TO-BE



GRADUATE 畢



花開花落，轉眼間便是五年了。

畢業以後，曾經是同舟共濟的一羣人，將會各散東西，各自追求自己的目標，向自己的理想邁進。

回想這五年的Medic生涯，裏面的確有很多值得回味的物事。五年的同窗，更加有很多藉得珍惜的友誼。在畢業的歡樂氣氛中，相信大家都會不期然想起一二件藉得懷念的事物和一些朋友。在這當兒，大家或許會嘆息學生生涯之不再，惋惜朋友的別離。希望大家藉著這個專題，能保留一點點Medic生涯的美好回憶。

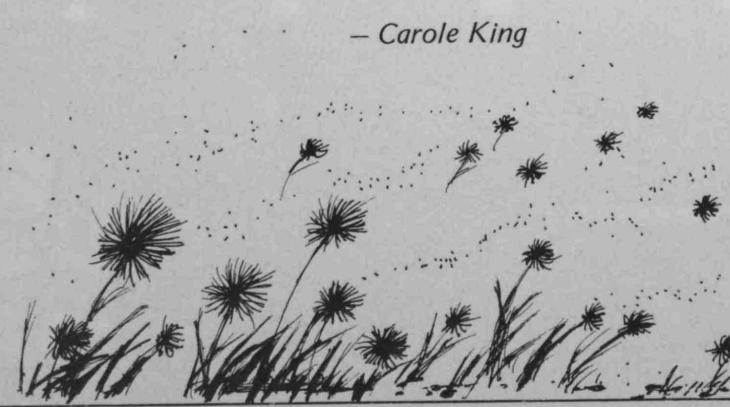
羅振邦85

You just call out my name
and you know wherever I am
I'll come running
to see you again
Winter, spring, summer or fall
All you have to do is call
And I'll be there
You've got a friend

If the sky above you
grows dark and full of clouds
And that old north wind begins to blow
Keep your head together
and call my name out loud
Soon you'll hear me knocking at your door

You just call out my name
and you know wherever I am
I'll come running.....

— Carole King



WARNING: *IF YOU DON'T WANT TO RUIN YOUR MOOD, DON'T READ THE FOLLOWING PASSPAGE!*

● **DIM**

For many undergraduates, the second year seems to be one in which they have already established (and stabilized) their way of life and the attitude towards academic work. However, I can see my attitudes undergoing tremendous change in the past few months, starting from last Christmas. I have always been conscientious, placing academic work at an important position, doing things in my 'own' way, full of confidence and pride, and feeling in control of myself.

But these are mere illusions. Though I cannot deny the importance of academic work, I have sacrificed more and more time previously allotted to them to spend with my friends. I am afraid that one day we won't be able to chat in the old way, or we cannot find anything to say to one another. What is more fearful is that these are totally out of my control. Getting good results in tests and exams cannot give me a slightest feeling of happiness, this I have experienced. Ironically, when I look back on the times I spent with old friends, nostalgia and melancholy are the emotions that overwhelm me. The past is the past; and no one can relieve the enjoyable moments in his life. Perhaps I should look into the future optimistically. Obviously, one can attempt to make friends with the people you see and work with every day. It is easier said than done. Acquaintances are commonplace; but friends with mutual understanding and appreciation are becoming increasingly rare, especially when one grows older. The sadness of solitude seems inevitable.

11:00 p.m. February 21, 1982

GRADUA畢

我看八五班女孩子

其實，本班的女孩子，大都是非常平凡沒有什麼可談之處，但是，有幾種女孩子，卻並不平凡，阿叔希望在下面將她們略爲分類，以供各位同學參攷！

第一類是「碌士」型，她們Motor area 裏的「手板」特別發達，而她們也活像一部打字機，上課時的每一句說話，每一下舉動，都給他們記錄得一清二楚。而且教副打字機還常常在一起對Notes，所以，她們也爲我們男仕造福了不少，因爲，她們有時也肯借自己的Notes給我們這些「莘莘」學子來影印。

第二類型是「pseudo騰雞」型，此派的掌門人腋下挾着兩個「丁」，仍然周圍唱自己好「騰」，騰什麼？騰拿不到「丁」也。還記得在 I st MB 之後，她問道：「死啦，撰鐘，如Physio「丁丫」「丁」唔到，會唔會Supple，留班㗎？」頓時使小弟目瞪口呆，說不出話來欷脹乎！

第三類型是女强人型，她們遲早都要揪「老沙」（沙士比亞）出來鬥垮鬥臭，因爲「老沙」說「女人，你的名字是弱者（Women，Thy name is weakness）她們恨不得跳上講台大聲疾呼：「男人，你的名字是弱者」每逢有任何男同學企圖或意圖表示女性能力比男性低，她們會大聲疾呼地否認。醫學會，幹事會，班會裏滿是她們的足跡。

另一類型當然就是「拖手仔」型。這類型的女孩子，和其他的女孩子，並無什麼分別，她們喜歡過些祇羨鴛鴦不羨仙的生活，而此類型的同學，普遍野心較低現。

講完分類之後，又要講講小弟最新發現的定律Thomas Law of Transformation，原來，女孩子們是不會老是一類型的，有時候，她們會由一類型變到另一類型，有些顯見例子，如三變四一變四等，都比較常見，而照小弟愚見，大部份的女孩子遲早（也希望早些）都會變成第四類型，其實，相夫教子，始終都是女孩子的天職，正如Anderson所說：“Women is taking an Expressive role”。■

我看八五班男孩子

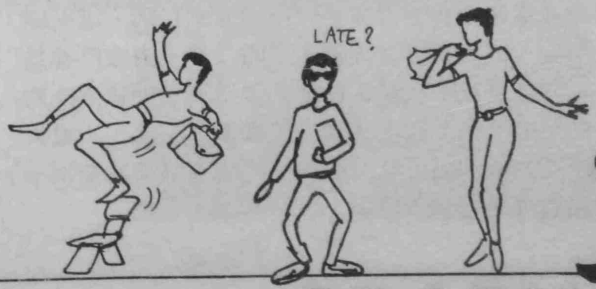
看罷上一期「思林」的主題後，突發一念，爲什麼有「八五女同學」的專題，而不寫「八五男孩子」呢？根據聯合國的人權宣言，男女是應該平等的，所以我們實不應只爲女性作專題，而不爲男性寫特稿。所以，今期我也湊湊熱鬧，寫寫「八五男同學」，以調劑繁忙的功課。

其實，「八五男同學」亦可分爲多類型的。第一類爲「最男性化型」的。何解？蓋通常人們形容男仕比較喜歡Generalise 男仕是最勇敢的。君不見每逢在「病理學大樓演講廳」下課時，例必有一人奮不顧身，飛身撲出，連跳數行只有三寸厚的椅背，率先搶閘而出。初時，全班例必嘩然，其後已「見怪不怪，其怪自敗」。特此奉勸此君一句—「今老矣，當一切保重身體爲重」。

另一類人屬「無我型」。何謂「無我」？無我者即忘我也，所謂「心中無我，腦中無我，而世界亦無我」。練得此功者，非等閒之輩，非有深厚之面皮不可。此類人上堂遲到時，不但沒有放輕脚步，行入「第一影樓」更且大搖大擺，「啲嗱，啲嗱」地發出聲響。此類人如非練得無我神功，焉能達成忘我於此世界上之地步。如果不是面皮深厚，又怎能受着「橫眉冷眼」而仍面不改容？

「姐手姐脚」通常是用來形容男仕「女人型」的。但我卻在此說一句，這generalisation 是錯的。汝等看，我們班中最「女人型」的男仕，他在醫學會內的一舉一動，幹勁冲天（這點我絕對佩服），絕不拖泥帶水。最重要的，當然是他有 testosterone（只是想當然耳）。然則他爲什麼被列入這列之內呢？理由有二。其一，他自認自己是半個女人。通常女人均比較謙虛，喜歡報少數的。憑這種假設，我相信這自認半個女人的男孩子，實質有四分三爲女人矣。其二，此君經常扮演女人，騷首弄姿，嗲聲嗲氣嗲男仔，非令男同學Shivering，誓不罷休。啊喲，不好，他是官，我是民，他報復是向我使出那招嗲功，我必肉麻死無疑，還是不說爲妙。

其實，我班的男孩子又豈止此三類。不過限於篇幅，就此收筆，如有機會，再詳加訴說罷。■



沒寄出的信

劍鳴

強：

你看此信的時候可能會有點兒吃驚，但這話我可不能不說——你可感覺到我們走在一起的時候總有一點異樣的感覺嗎？其實這感覺在我心中已存在了許久許久，祇是我拿不起勇氣對你說，現在我再抵抗不了內心的交戰，靈魂深處教我呼喚着你的名字……強…強！

我想在你的腦海裏，將永遠抹不掉我這個女醫學生的形象。記得我曾問你喜歡我什麼嗎？你說喜歡我的面龐，胖圓的臉蛋上鑲着那一雙晶瑩汪亮的眼珠子，盈盈笑語使你如沐清風，忘卻俗世間的瑣屑煩惱；可是接下來的，我可不大願意聽了；或者是你的語氣告訴我這是誨氣的說話吧。你說欣賞我堅強不屈的性格，任勞任怨的精神，還有那過人的工作能力，隨着攤開了雙手，向我扮了個鬼臉，顯出一副無可奈何的樣子，此刻我的心如鉛的沉重，直向黑暗深淵裏墮下去，因爲我明白到這是你對我無言的控訴。

你問我爲什麼總是那樣忙碌？那麼若即若離？難道上了醫科人就失去感情，那和原始的動物又有何分別？我們的感情彷如撒在曠野上的種子，在你空閒的日子裏，彷彿像得到雨露的滋潤，生機蓬勃茁長起來；假若你忙了，這曠就像給蓋上了冰霜，冷冷的你忍心叫這種子躲在泥土深處，不再披出頭來。

强，我想解釋，但我看這是無補於事的。强，你知道嘛？我祇是一個普通的女醫學生。女孩子唸了醫科自會給糖種鬼魅一般的困難束縛着，我也沒有例外；有時我想掙脫，但現實終究將我扯回來，再繫上討厭的枷鎖；我也曾發誓要摒棄感情的煩惱，狠狠地唸書！但可惜我和失敗結上了緣份，又或者這就是我跟你的緣份吧……！

强，我承認愛我的人需要付出很大的代價，這是絕對不公平的，但我又可有什麼法子呢？我知道我們都是硬性子，很多時互不相讓，但此刻我是衷心期望你能夠付出一點兒的耐性；或者終有一天忍耐熬不住了，繼來的暴風雨冲走我們的一切，但我仍作出這懇切的要求。

你願意接納這請求嗎？

莉 冬夜

給另一個生命

● 一個生命

翔，和你初次見面，是在解剖實驗室的一角。那時我們被安排在同一「枱」裏。經過這麼的一年半載，如今我們已成爲好同學，也是別人眼中的「死黨」。

由於是同「枱」的關係，我們經常接觸，也試過無數次共晉午餐。當初，我們一「枱」人圍在一起，除了功課也不知有什麼可說。然而因着你的爽直，這使人尷尬的沉靜終於給你打破。話匣子打開，你就滔滔不絕，還會間中說笑，令被沉重擔子壓迫的我們豁然開朗，事實上除了「弗事」，還在什麼更廉宜的調劑品呢？

去年第二學期，在某一次的會議上，我驚訝你也成爲其中一個委員。平常輕佻浮躁的你，這時變得認眞起來。你毫不隱瞞地把自己對事物的意見和立場表明出來，使我十分欣賞。一向我以爲你是摸不着邊際的，扯了大半大還拉不到自己身上。別人（包括我）也是如此，可能這使大家容易好過些吧，而我也不敢希冀有什麼進展。然而，經過那次會議，我發覺我們不單止可以表面上時常在一起，原來也可以互相交流！

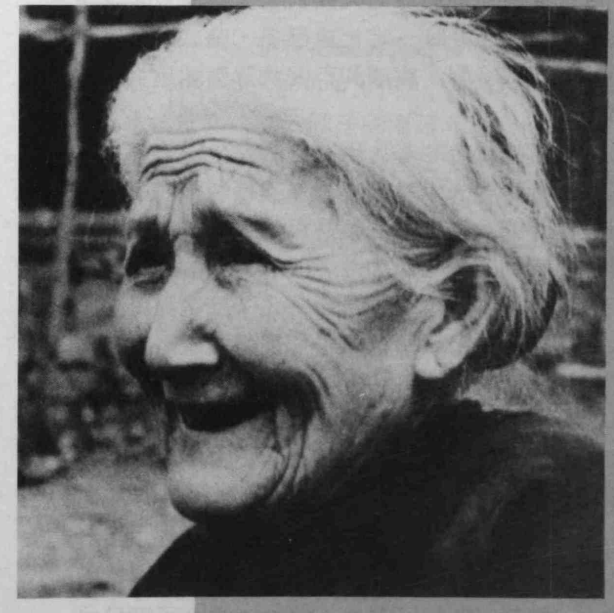
翔，我最珍惜的，還是那大考前的一夜。那一晚，當人們還挑燈夜讀的時候，你突然獨身來找我。原來表面看來堅强無比的你，內心是如此需要別人的瞭解和安慰。你朋友雖多，卻無從表白自己的情緒和感受。我既驚且喜，以往我們涉及的都只是「身外物」，眞正生命與生命的接觸這還是第一次呢。事後我也有點懊悔，如果我早些把「心內物」與你分享，你可能很早就把感受告訴我。

翔，可別要這麼快便高興起來，友誼的階梯還有更高的一級。那天晚上，雖然說了很多平常不會說的話，但有很多你當時腦海中所想到的，卻被你吞了下去！翔，下一回當我們再傾談時，請你不要隱瞞任何東西。情緒沒有好壞之分，坦然面對自己與別人是成長的必經之路，就讓我們剖白自己，走在這成長之路！ ■

有意義的探訪
十軟弱的我

● 熹

一個白髮蒼蒼的老人，年齡和自己相差不下三、四十年，他不認識你，你同樣不認識他。這樣的要互相溝通，殊不容易。但沉寂始終是要打破的。不知從何說起嗎？最簡單還是問問姓名，年紀，職業……交換資料一番。想不到打破的沉寂可以那麼快地復原！腦子不斷地打轉，卻轉不出什麼話題來。交運的遇著些開朗的亞伯亞婆，還可以讓他（她）高談闊論地想當年。要是對方是一個多愁善感的，鬱鬱地呆坐在你對面，那就糟糕了！往事不堪回首？近況流離潦倒？家庭妻離子散？這些問題都太敏感了。心中不斷地盤算，一面要找話題，一面又怕會觸起他們的傷心事，到時對著你抱頭痛哭，問你黏頂！我們來到老人院探訪，總希望會給他們帶來一些歡樂，既不是來考驗自己的應變能力，又不是來研究老人心理，又何必勾起他們的傷心事呢？正是最需要你的關懷一羣，你又束手無策，奈何！但事有黑白，或許你一時的不愼，卻可爲他們舒發了多年的悶氣呢？



其實老人的生活亦不是壞透的。一年當中總會有很多善長贈送衣服，日用品，食物等等。在物質上對老人是足夠有餘的。但是，這亦止於物質供應而已。老人家始終是雖要別人關懷的。關懷的基礎就是感情。而在一次探訪中所建立的感情未免太兒戲了。但又有多少人能夠長期地和這寂寞的一羣建立友誼，開解、慰藉他們呢？

有時我眞懷疑探訪的意義。意義——好像抽的名詞。我們又是否有意義的事才做呢？常聽到有人說：「在大學短短數年，不好好地幹一番大業未免太沒有意義了。」我很欣賞這些人的魄力。但軟弱的我，幹不出大事，又是否「枉此生」呢？我眞希望有人能告訴我。但人類的野心和進步已爲自己帶來了不少苦惱。因此，我不求精密的頭腦，只希望自己所做的事能夠爲自己、爲別人帶來快樂、溫暖和愛，那就足夠了。 ■

有感

● 文仔

從聖誕節的老人院探訪、班會舉辦的「八五話老人」和Behavioval Science Project 當中，自己得到很多認識老人問題的機會；而在每次與老人家傾談的時候，話題都一定會涉及大家對人生意義的看法。

自己爲什麼會特別重視老人家對人生的意見呢？第一是因爲他們的人生經驗一定比自己多，第二就是因爲他們大多都會比較冷靜、客觀和不受物質引誘地去思索人生的問題。

但是，在會接觸過的老人中、無論是生活無憂或是凄凉無依的，他們對人生意義的看法都是消極的：人只爲生存而勞碌。究竟生存的意義是爲什麼呢？

自己頓然感到問題的迫切性，既然人生的問題到自己年老時一定會遇到，現在早早解決了不就是更實際嗎？在未找到答案前，自己所做的一切都好像沒有意義似的。

其實，身爲醫學生可說是非常幸福；我們不用爲未來的職業和肩負家庭重担而憂愁，再加上大學教育所提倡的培養獨立思考，這種種條件提供給我們一生中不可多求的機會去解決自己的基本問題。

有些同學會覺得只要懷著現時的一片善心和盡量讀好書，將來一定可以做個好醫生；但是，大家可知自己的善心是多麼的脆弱嗎？社會的疾痛和不平我們都只滿足於知道，而又有多少位同學肯犧牲時間去參與改革的工作呢？如果現時大家都不肯犧牲一些的時間去追求人生意義和服務社會，我們怎能有資格去担保將來肯獻身社會和追尋眞理呢？

進了大學後，發覺到自己需要在各方面的問題有本身的立場和意見，因而認清培養獨立思考的重要性，使能在種種事情有自我的看法，不會盲從附和不受潮流所支配。

「醫學院就好像一副機器，它能將不同心態和類型的中學生經過加工後，產生出一班同一心態和類型的醫生。」一位醫學院講師曾這樣說過。我們還會無動於中嗎？我們有否多閱讀醫科以外的書本呢？我們有否誠懇開放自己，容納他人他事呢？

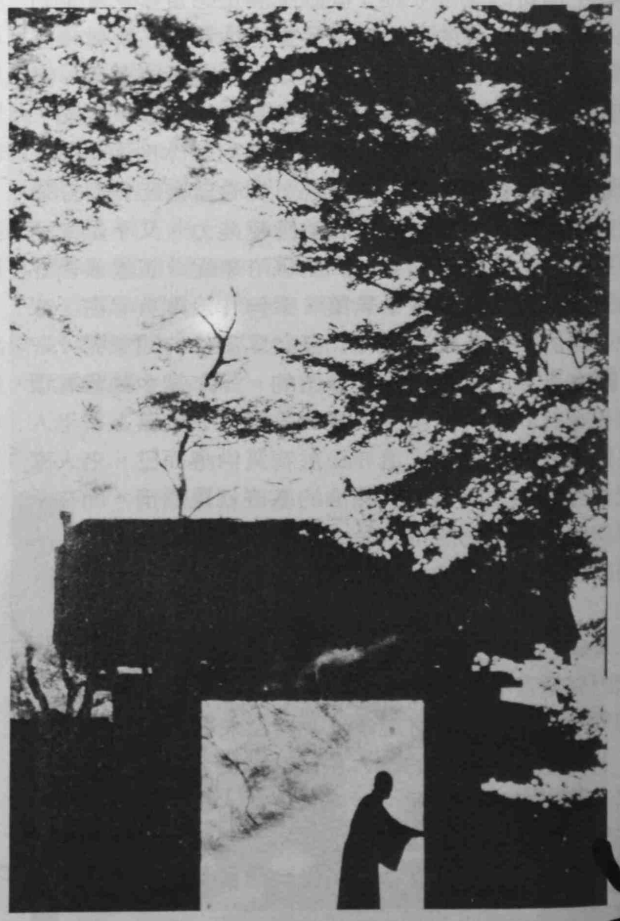
培養獨立思考就是追尋眞理所必要的。在云云的宗教信仰中，都有各自的一套眞理，如果要逐個研究可眞是不可能的。

自己曾經在基督教裏追求眞理，但是發覺到基督徒對上帝的信是理性和感性並重的，而自己在感性的接觸中始終提不起信心。

自己又曾從人本的角度去看人生的問題，「愛」好像給了自己的一個答案，只要盡能力去愛別人，那不是很好的嗎？至少自己良心會舒服些。但是，自己的良知是從那裏來的呢？萬物眞的沒有主宰嗎？

雖然自己的追尋仍然沒有結果，但是總覺得積極地去面對人生問題才是正確的。

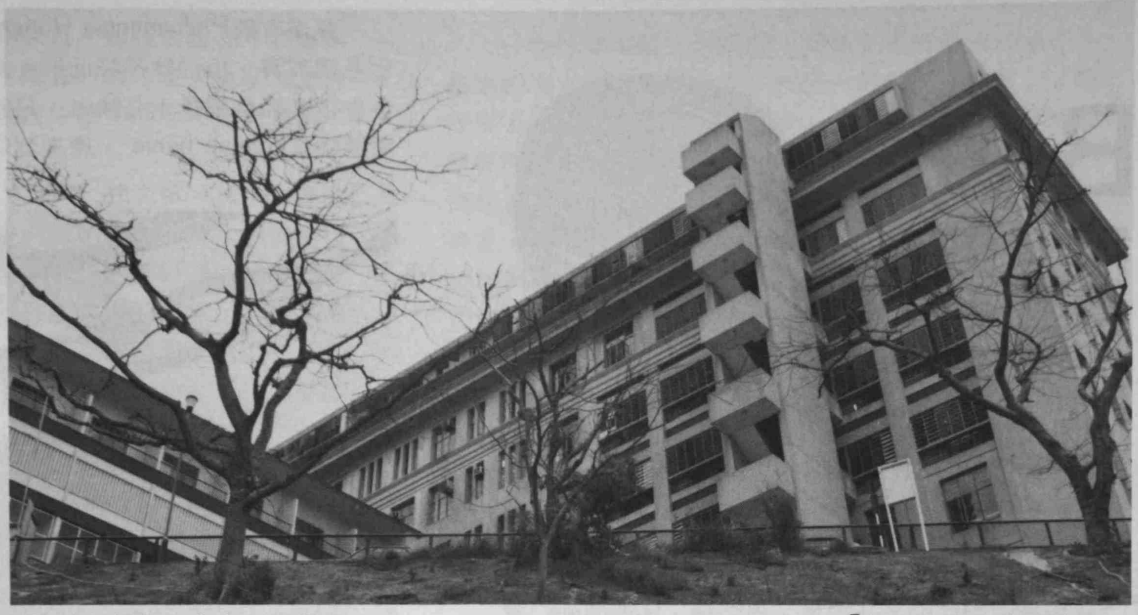
以上所說的都是自己的一點表白，希望提出來後可以使大家更加關注和討論人生的問題。 ■



GRADUA

繆思

● 斯眸



每當需要到創作時，腦子便一片空白。本來已經是個感之不切，思之不深，行之不動的人，這兩年多的醫學生涯，更使我僅有的感覺、知覺，隨着虛度的光陰汩漸消失，變得麻木。回憶似乎很多，因爲這裏是我失憶，困惑的地方，也是我重獲滿足，信心的地方。

由預科那所學校到瑪麗的一段石板路，留下我不少的足印，更記下我不太成熟的理想和心願。初初踏上沙宣道，足下嘎然有聲，心中磋蹉滿志，每次當我昂首看上去「宏偉」的瑪麗時，心中總盼望「自由」在那裏出入的日子，連上Growth那陣子，也期待拿起白袍上瑪麗做 Measurement 的那一天；抱着「不求止於善，求致於善」的心態，日子也過得挺快樂，人際間的相處，工作上的磨練，使我學到很多書本外的東西，當然不是無代價的了。日開日落，在陳蕉琴樓內也見過兩度最絢麗、燦爛的夕陽和晚霞；記得杜鵑花開得最燦爛時，我也會隔着圖書館厚厚的玻璃靜心欣賞。

現在，每天（星期一至星期日）也會拿着白袍在瑪麗「出出入入」。瑪麗是個充滿矛盾的地方。第一次跟導師像穿花蝴蝶般穿插於各病房間，有一種跟旅行團遊覽地方的感覺，也是這第一次，我遇上了一個迷糊的病人，張手伸向我叫着：「醫生，我很痛，給我一點點止痛藥！」只記得那時和同組的同學交了個尷尬的眼色；除此，我們可以做到些什麼？

初初上病房學習，無疑是一個刺激的經驗，也難怪每天早上九時四十五分左右，有D2對出嘈吵和喧嘩，那些聲音使我想起中學時小息等待下一節課的時刻，不是嗎？可能在我們許多人下意識裏，瑪麗是所課室，而忘記了它也是所醫院。

每次做 Physical Examination 都沒法避免做第一個，因爲不熟書，不想做錯。又明知病人千萬個不願意，你又怎會想做第廿個去Palpate他脾臟的學生呢？親手檢查是會學到多些技巧的；但不做的話，病人會好過些；那麼，做還是不做？這是個太常見也是很實際的問題。

不想例行公事式的同一句：「阿伯，痛不痛？痛便出聲！」以前我會認爲若不是出於內心，只是it's said in the book，我寧可不說。到現在可能是我不太可以控制到面部肌肉，弄成表情僵化，但更可怕是自己的感覺也麻木了。

回到宿舍，也帶回了一般濃厚的醫院味。很自然地，上了三年班，也就成爲堂友的健康顧問。每有傷風，喉嚨痛，也會走來問：「醫生，用不用去看 Clinic ？」「吃幾片Panadol 夠嗎？」沒有驕傲，有的只是感到自己的無助與無知。有時會後悔clerkship test 後爲什麼玩足幾天，不去讀多兩回patho，又或者爲了去遠足而拋棄了pharma。

平常的日子，也會把握每個機會，與堂友練習Stethoscope, ophthalmoscopic exam.，教教他們 elicit knee jerk, 也會給他們帶來一陣子的雀躍。

還記得暑假的某一晚上，爸要我用他新買的血壓計替他量血壓。爸患有糖尿病，平時已不懂得給他食飯上的advice，量起血壓來，就更加手忙脚亂，只有由姐姐代勞。最後換來爸爸一句：「讀了兩年醫科，連血壓都不懂很度！」當時非常慚愧，令到爸爸失望是我料想不到的。

……

或者，今晚應該是 leukemia， anaemia 而不是綠格子。但感謝思林編委的催促，讓我檢討上 ward 以來的感受，不至於在無窮的醫學文字知識中迷失。就讓沙宣道上和煦的陽光和清涼的晚風洗滌我滿面蓬垢，朝着迎新紀念册上一位堂友的勉勵而努力：

「只有一個請求：
做一個好醫生，體恤貧黎，
醫身、醫心、醫靈魂。」 ■

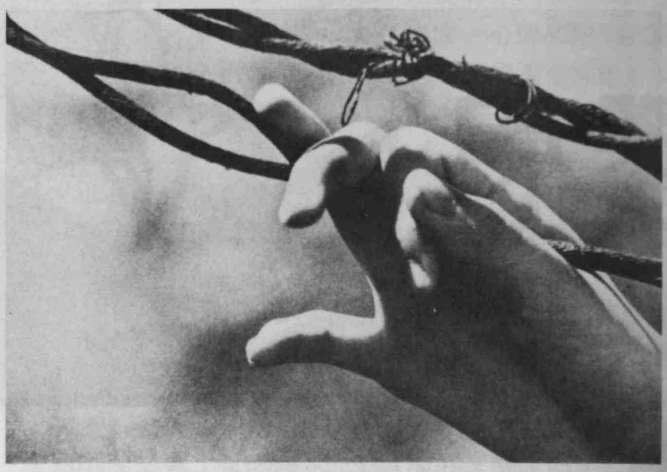
B仔隨筆

與舊朋友在一起時，不多不少定有牢騷要發。亞寶對我說她已對U的生活厭倦，說同學，Hallmates 都很「假」，找不到眞的友情，又說功課辛苦，大家都在「死讀書」。不錯，或許這就是她對U完全沒有歸屬感的原因。唉，當大家都傾向個人主義的時候，又有誰會眞正的有時間，有心情去付出眞的感情？所以我對她說：「我不會怪任何人，因爲我不知自己是否妳說的其中一個。」當然她明白我的是「反話」，因爲我們都關心對方，欣賞對方。或許有一天，她要出嫁的時候，我會有幸做她新郎的伴郎呢！

很興幸自己有一羣好朋友。雖然他們有不同的個性，對事物看法不同，但他們尊重我，了解我；而我也尊重他們的性格和見解，張仔對朋友的態度一向「冇所謂」，也即是「君子之交淡如水」。但在我看來，他比很多人更重友情。與他同行，可以說是幸事。但畢竟這樣的朋友，又有多少？

自己欣賞「蜀山」的地方很多，但最重視的卻是徐克的魄力及他那種「玩戲」的導演手法，黑色幽默加上浪漫愛情和中國民間神話的神秘色彩構成了「蜀山」吸引我的地方。當然，那些羅拔貝勒Star Wars 的特技構思卻是吸引其他觀衆的主要原因。

有沒有聽Philharmonia Hungarria 的演奏？個人覺得它名過於實，但仍然不枉此行。其實 Art's Festival 之中有很多節目都是十分精彩，只可惜背上的功課繁重，壓着兩條Sciatic nerve ，連走到City Hall購票也覺得疼了。



如果大家不知道甚麼叫「緊張」、「全神貫注」、「一頭煙」、「速度寫字」及「與時間賽跑」的話，請留意Dr. Ogle 的Lecture 因爲全部字眼都在Lecture 中被通過的illustrated 如果大家想同時做到抄notes, fussy，玩「井」，讀Lecture Notes or General Singer 和發「白日夢」的話，請上Kleevens主講的「Community Medicine」Lecture 。

在回家的巴士上，看出窗外煙雨濛濛的淺水灣。雨水如淚般流下窗前，濺濕了我的外套，心中的一陣傷感，腦海中的一串往事，正好配合了如淚的雨，爲這該殺的天氣再增寒威。我問雨點可否把我心中愁洗得一乾二淨？

人心惶惶個多月，Medicine終於放榜。Good Pass的有一個人，但Failure List 卻有十多個人的名字。眞的是一將功成萬骨枯，有人快樂有人愁。一個人的快樂和十多個人的痛苦，實是一個很大的諷刺。自己很幸運，在榜中無名一畢竟不受人注意（無論 ' Distinction viva ' 或 'pull up viva' ），總比受人注意好些。但自己也曾細想；如果自己是其中一個failed students 那時又如何？

看看日曆不經不覺新年又近。對我來說新年其實與平日並無不同，除了看多一兩套好戲，見見舊朋友之外，剩下的少許時間只可用在家中陪Daddy。至於讀書，我也不敢去想了。

看到上期「思林」中 WTWK 的文章，其中提及的心境，自己也曾感受。夢中的自己在萬里黃沙的撒哈拉，那火紅的太陽在背後追趕。每次看到綠洲的時候，夢境即完；雖然沒有「醒來一身如寄」的感覺，但總不能再次入睡。起身推窗外望，一輪明月照着沈睡的大海，如歌如泣的濤聲湧進耳內。那時自己就會有「莊生夢醒迷蝴蝶，世事何知假與眞」的感覺。

那個外國人問我對香港前途的意見。我說：「我不可以代表任何香港人作答；因爲我不懂政治，對行政管理，權力架構，官僚主義，政客游說等都不感興趣，但我卻覺得只要是對香港人有利的，能令我們安居的話，誰去統治香港也不重要。我會identity自己是香港人，但也不會忘記香港人也是中國人的其中一種，正如北京人、蘇州人或台灣人，流着中華民族的血。那夜，我幫他找到他下塌的 hotel 時，對他說：「希望你不要多謝我，只要知道有很多香港人仍然是熱心助人的就足夠了。不要將他們當作崇洋，他們只是對遠方來的朋友盡地主之誼。」

不知是那首英文歌的歌詞：「但英雄的負担實在太大，而我們也不能成爲英雄；因爲英雄無淚。」（……And too much for heroes, we could never be heroes, because heroes don't cry ）。

不錯，我曾經哭過，而且不只一次，我也不能成爲，更不想成爲英雄，但請不要以爲我軟弱，因爲我可以說此誰都堅强，只不過我有太多的感情，而太多感情的人往往會被人傷害。

三年的Medic 生涯，令自己改變了不少。入「U」之前，自己是個傻頭小子，現雖然已更深近視，思想也更成熟，但仍然保持了入「U」前那種對生命的態度。或許這就是「江山易改，品性難移」朋友說：「你變了很多，看來愈來愈Qid 。」但他並不明白，這只是我對生命的熱愛的結果。難道思想複雜就是成熟的表現？如果是眞的，那麼我情願一生不成熟。雖然自己不是Christian，但基督所說：「讓孩子進入天國」，我卻萬分同意。

分組所發生的一切問題，彷彿已隨時間而冲淡了。直到出稿之時，大勢已定。自己一向「好管閒事」，所以有不時詢問同學他們組「組」的情形，知道每組的形勢已明朗。總算不負Class comnartter 的期望，大亂的情形並沒有出現。雖然不敢否定同學之間有「心病」的存在，但至少 it has not manifest itself 。自己一向對分組興趣不大，因爲相信「緣份是由天註定」。不過最後能和 I st year 同枱的朋友一起，實在不錯。

一向欣賞別人的新潮衣服和那種我行我素，敢作敢爲的精神。那天見到Winnie「紫色組合」的裝束，不禁耳目一新。有時眞的希望自己的 friends 也可以這樣，其實這也是娛樂之一呢！但話得說回來，如果上Ward見病人，則必須裝束整潔，不是提倡「扮嘢」，而是對病人尊敬的表現。

所以說上Ward 看病，是眞實人性的表現。有些平時讀書很「叻」的同學，上Ward 可能手震脚震。有些平時滿口醫德，Behavioural Scieme Principles 不絕的人，上 Ward 時可能爲了要elicite one minor physical sign，而令病人吃飯時間也要延遲。反之，有些平時Fussy，玩世不恭的人，上Ward 對病人卻正氣凜然，呵護備至。或許這就是面具。

Everybody has some masks, and who knows what his real face is like ?

不是提倡「四書」思想，但自己很讚成先「修身」然後才「齊家」、「治國」，而「平天下」則是最終的目的。可能少時受儒家思想薰陶，始終認爲「天下爲公，世界大同」是可以達到及應該達到的。但是這會是何時的事？即使是小小的一個Medical Society 內也紛爭不絕（如血書事件及最近的大字報事件等），又怎能希望美蘇中日等强國停止冷戰？

Are we waiting for something great, like a nuclear war to bring all these disputes to an end ?

Something that I can think of ....

● Anonymous

The clinical years started like the first few notes of Beethovan's Fifth Symphony – simple but grandiose, straight-forward and yet profound. There were no special memories or rituals of any breath-taking intricacies; however, the greetings from the professors, the symbolism of the stethoscope, the acquisition of a Harrison and a Bailey & Love and the legitimate access to wards and patients all but proclaimed unmistakenly the commencement of a new era in our lives.

As the Introductory Clerkship proceeded, not unlike the development of the Fate Symphony, it gradually unfolded its hidden mystery and unraveled its complexity and intricacy. Moreover, the tempo quickened. Many were bewildered. Some were better off in their sense of rhythm and managed to keep in pace with the accelerad. For the others, they were just always lagging some bars behind. Fortunately, the first clerkship was a rather short one. Before our memory gets blurred up, it is indeed a good idea to pause for a while now, organizing our thoughts and experience during the first eight weeks.

If you asked me to summarise the Introductory Clerkship in one word, I would choose CHANGE. Indeed, life has always been a process of continuous change but the Introductory Clerkship, being a transition between the preclinical and clinical years, emphatically highlighted this fact of change.

The Change in Self-perception

We all want to grow mature, not just physically but also in our intellect, temperament, personality and our relations with our family, friends and colleagues. We all want to have our own goals and try our best efforts to actualise them in the socio-economic-political context that we are located. In the preclinical years, the hundred and fifty of us kept experimenting our different approaches. Some soon settled down with a first priority of academic pursuit, while many others continued to expose themselves to different aspects of life by getting involved in extracurricular activities – Medso, Union and even those outside the campus. But what happens when we step into the wards? The professors told us that we are being trained to become doctors with professional acumen i.e. with not only clinical knowledge but also observational power, deductional ability and relational skills (with the patients and colleagues). What a Change! The direction given is simply too clear compared to that in the preclinical years. This is the first time I really grasp the meaning of being a professional, after hearing about it so many times in the past. It is not just a matter of five years for a degree and a year for the internship. It is a lifelong process requiring stamina, perserverance and single-mindness. Suddenly I see myself nakedly unprepared. I am exhilarated by the aspiration and at the same time I am perplexed. It seems that I have to quit some previous undertakings. Indeed it appears that I have to change my life-style. No more T-shirts, jeans and plimsolls. It is precisely a re-moulding! The role of university student is fading, unnoticed, with the unawarded creeping in of the concept of professional trainee. What a minute! What is really meant by professional devotion or singlemindness? It is definitely not narrow-mindness. I will fight hard to prevent professionalization from depriving me of the opportunity of balanced development and maturation. Nevertheless I know it is a tough game.

The Change in Inter-personal relationship

'What are you studying now?'
'Medicine.'
'Which year are you in now?'
'Third year.'
'Oh, really! We are soon having another doctor! Which specialty are you going to take? Mrs. Wong's son is now a Paediatrician. Nowadays people pay so much attention to their children and he is bound to make a fortune. By the way, I have an ache of the right shoulder. Does that mean any thing serious? Yes, what do you think about 1997? You professionals don't really need to worry, do you? You guys can go anywhere you like. Have you got a girl-friend...? What a stupid question! No doctor needs to really worry....'

Does the above conversation sound familiar to you? It may be a bit exaggerated but it does reflect a fact – the status of a doctor or even a medical student can make it very difficult for one to live out, speak out or work out one's genuine self when he or she interacts with others. The stereo-type is pretty deep-rooted in people's mind. They are simply not expecting to find anything else in you. Maybe this is another exaggeration. But, haven't you one time or twice felt lucky or flattered on hearing these words? I have. Actually, besides this danger of building up false image of oneself, there is a greater challenge – superficiality. Think about our interaction with the patients. Think about the conversation among ourselves. Are they not filled with jargons, or connected with medical subjects? Even our jokes are getting pro-fessionalised! We may be in the same teaching group throughout the four clerkships but what we know of each other may be nothing more than the standard of clinical knowledge or behaviour in the wards.

The Change in Methodology of Learning

Gone are the days of burrowing all the time in the library. The motto 'We take wards to make laboratories' finally makes sense to us. Reading through all the texts and notes is not only impossible but also it gives no guaranty to success while even some of your embarrassing mistakes or humiliating comments from your tutor may bear invaluable impact on the progression of your learning. Someone has said that the clinical years can either consolidate one's self-confidence or aspiration or do the completely opposite. Indeed, I have already seen people euthusiastically seize every opportunity to learn, asking intelligent question and admitting ignorance with courage and gentility, whereas others have consciously or unconsciously make their presence at a bedside session in hush-hush business, satisfying at being a passive on-looker rather than allowing oneself directly confront the clinical problem. Moreover the evil spirit of following mass direction still possess many of us. Read what others read. Others go to wards three times more than I do and I will feel uncomfortable... I really appreciate those colleagues who have managed to develop their own approach of learning, integrating the ready-made information in handouts, self-gathered data from reading relevant references and texts and their clinical experience. Finally I cannot but admire those who have overcome the conditioned reflex of recording down everything they perceive and manage to sit back calmly (cool man!) and listen. As for those who have developed a new habit of colouring, I honestly have no comment. (I am one of them).

The Change of Value System

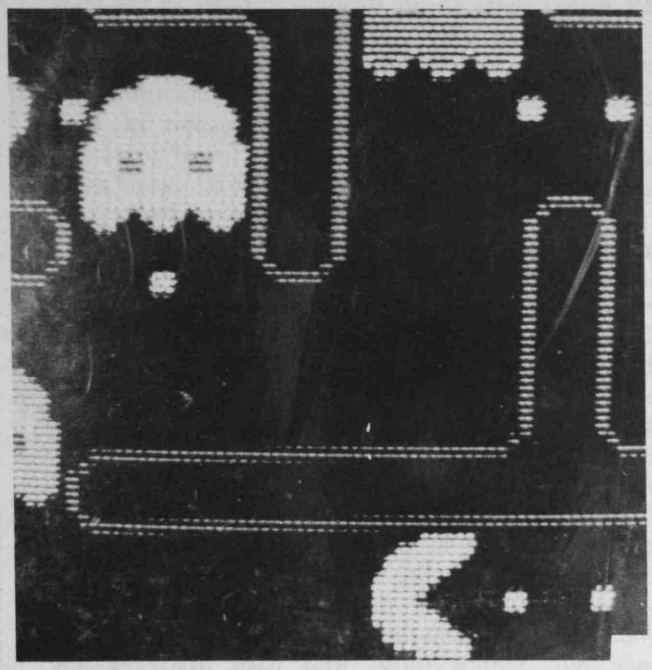
Finally, there are a few words on how we judge and choose. Someone has said that as time is limited and energy is exhaustible the cost we invested must be justified by the benefit we medical students are pragmatic. Go to the panel discussion and give opinion! Attend that gathering to uphold the spirit!? Set example for the juniors!? Idealism!? Meaning of life!? Sit there to listen to that guy 'salivating'!? No fooling around! Be more relevant!

Have we really come to this stage? (T_4, N_3, M_1)

Not a Conclusion

The above paragraphs are nothing but some re-collection of thoughts during the Introductory Clerkship. They are not put forward as any kind of argument. You may take this as a kind of gasing off. I feel better after writing these down. This certainly help myself to know where I stard now and thus help go ahead too. But some may think in other ways. So why don't you scribble some lines as well?

打機十二則



歐陽嘉俊

1. 子曰：學而時習之，不亦說乎？有新機玩者，不亦樂乎？零分而不慍，不亦君子乎？
2. 子曰：機三百，一言以蔽之，皆搵笨也。
3. 子曰：吾打機所貫多矣，三十元而立，四十元而不惑，五十元而知天命，六十元而耳順，七十元而從心所欲耳。
4. 子入中心，每事問。或曰：孰謂此人高手乎？曰：是禮也。
5. 子曰：知者食鬼，勇者賽車。勇者動，知者靜。知者樂，勇者撞。
6. 子曰：機不「正」，不打。
7. 季路問食鬼。子曰：「未能食人，焉能食鬼？」曰：「敢問死。」子曰：「行得慢，必死矣。」
8. 子曰：吾嘗終日不食，終夜不寢，以思無益，不如多打也。
9. 孔子曰：君子有三戒。少分時，血氣未定，戒之在莽。及其壯也，血氣方剛，戒之在鬥。及其高分也，血氣既衰，戒之有貪。
10. 孔子曰：君子有三畏，畏中炮，畏撞山，畏夠鐘。
11. 子曰：生而叻打機者，上也；學而叻者，次也；困而學之，又其次也，因而不學，下下矣。
12. 子張問打機於孔子。子曰：能行五者，爲精矣。請問之。曰：避、誘、困、食、射。避則自保，誘則搶攻，困則必勝，食則取分，射則重重有獎矣。■

唸病人的名字

劍鳴

朋友，當你詢問病歷的時候，有否唸上病人的名字？你忙亂中拿起一張X光片，詫異地發現肺的頂部滿是白點，但病徵裏挑來挑去也找不出半點呼吸系統毛病，焦急的你精靈的眼珠子往上一瞟，不禁失聲大笑——你沒唸上病人的名字！

病人的器官仿如一粒粒的珍珠子，我們左檢右查，看這顆有沒有瑕疵，那顆有沒有斑點，最後把它們無缺完整地串起來，無疑這是對每一個醫師的最基本要求，但你覺得這足夠嗎？

作爲一個將要成爲醫生的人，一個直接與病人性命打交道的人，你有否時刻感到一種沉甸甸的使命感和責任感？愛心永不會建築在金錢的渴求上，溫暖的它更害怕日以繼夜地躲在冰冷的圖書館裏，病人是象牙塔外的一羣，要了解他們就得要跳出這象牙塔，體會他們的生活，那你或可察覺到更令人痛心的不是他們身患的頑疾，而是他們背後的無知和貧窮。■

張寶賢　李錫光　梁國賢　張明智　李劍雄　殷榮華　李偉强　樊志偉

郭昶熹　黃文强　譚國權　黃榮祥　唐嘉麟　吳炳榮　周佐治　黃國成

鍾子光　社榮基　周少芬　周婉玲　崔綺玲　溫淑瓊　莊瑞芬

林勇行　林國基　莫鎮安　古志坤　黃德興　姜宜港

林楚明　蔡寶英　沈瑞楓　MR. ROBINSON（Elective Student）　黃志强

林子顥　任德光　莫俊强　林蓋世　鄧珮儀　呂智麗　鄧維敏　何碧頤醫生

邱振中　吳福康　沈兆華　張偉强　鄺仕量　衞浩賢　楊日明

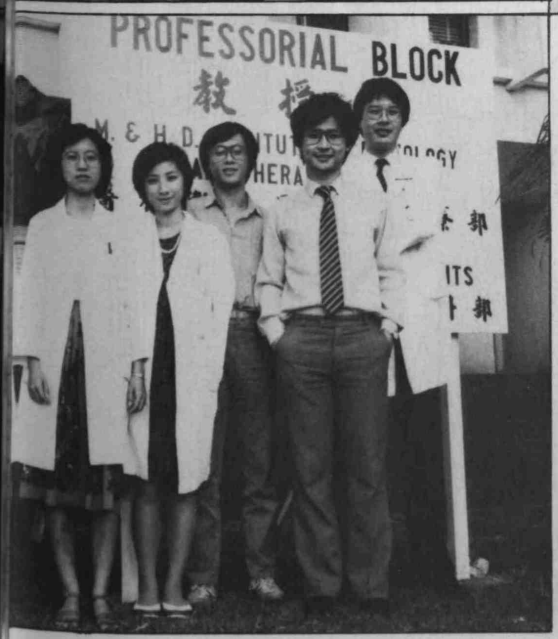
姚銘廣　黃建成　余嘉輝

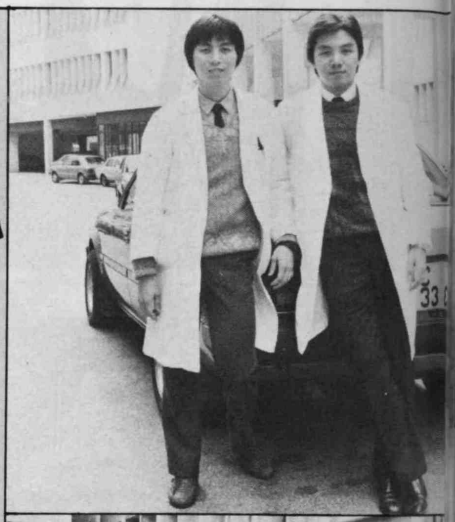
葉大偉　簡志亮　余立基

周志平　梁遂安　余則文　游子覺　賴偉明

徐成之　林展輝　徐有成　羅振邦

張雅賢　陳杏霖　謝達成　陳穎宜　關彥華

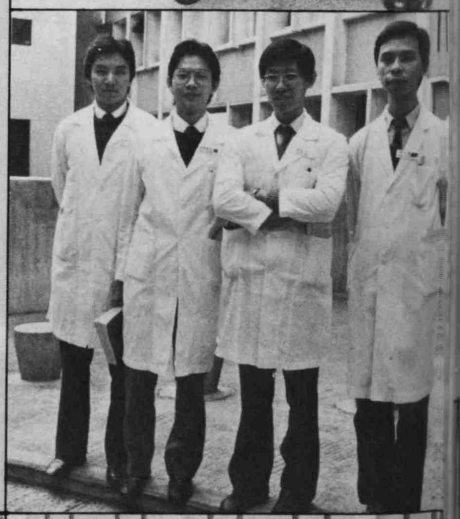




陳鑑添　陳至權　凌志堅　盧寵茂　董文忠　陳楚英　蔡德康　黃漢文　吳德亮

劉智敏　陳俊銘　尹耀基　劉子亮　何偉權　盧礎文　歐陽嘉俊　梁道偉

廖惠玲　陳漢宜　李志勇　秦富强　盧國輝　曹志彬　陳至正



蔡照榮　陳碼健　張保平　周日新　張金源　鄭鎮光

陳德茂　余俊豪　周鶴平　陳國超　吳　奎　莫仲威　梁自基

張光宇　林焯森　曾偉基　郭家麒　葉兆輝　陳偉光　麥孟津　譚劍明　譚聖栢

張敏華　鄭明麗　黃世芬　朱麗珍　陳國齡　林文英　張國明

林貞華　伍華山　區兆基　鄭嘉艮　鍾錦文
張敏芳　陳漢明　周美仙　周偉浩　姜宜港

缺席：
張國明
霍兆榮
鄺駿子
林正財
林漢文
林兆强
林　燦
林慧文
劉蓮嬌
梁漢輝

缺席：
莫健英
沈偉翹
謝俊恩
徐炳添
黃雅信
黃榮光

胡廣森　　何振銘　胡志和　劉植輝　郭健華　鄭嘉艮


OUR CLASSES
同窗錄

Sports News

曾經當過班委快三年了，要不是 Integrated Term 比較清閒，恐怕還沒有機會反省靜思一下。

頭兩年總帶點摸索的味兒，挫折是不少了，當然也有得意的時刻。往事不消提，倒想拿今年的感受談談一下。對我而言，3rd year 才是體驗最深刻的一年。

可曾記得學期初班代表的提名一再押後？至今我仍然相信八六同學並非對班會工作失興趣，只是不像二年級那時有這麼多同學垂青班代一職而已。事實上，當財仔和 Peter Pang 「挺身而出」後，整個班委會很快便組成了。與以往兩年一樣，它有十五個成員；所不同的，是已經三年級了，人人都對功課認真得多，而且有了兩屆班會的經驗，同學對當班委也再不會抱太多幻想，所以這十四位（自己當然不算）肯在投票前便應允參與班會工作的同學，更令我欽佩。

在差不多一年的光景裏，財仔給了我最大的支持和鼓勵。當初情商他出任班代，是因爲他對八六的一份熱誠（以往他不算是搞活動那班人的圈子裏，但仍不減對班的參與），和他對工作認真的態度。和他「拍檔」後，更讓我體會到他的組織力，和對事物的中肯剖析。他對其他班委的關懷，往往彌補了我的粗心大意。也不只一次，他「深明大義」的勸導，馴服了我偏激狹隘的思維。

責任繁重的 Social Sec. 一職，總覺得難當了 Peter Pang 獨個兒承担。但「亞茂」憑無比的衝勁，和一貫的輕鬆手法，爲我們增添了不少歡樂的回憶。 Medic Festival 的輝煌成績固然不在話下，如果不是 Peter Pang 的熱心，又會有誰去組織我們在 Lecture Theatre 慶祝聖誕，或者把 Notice board 佈置得美侖美奐？更遑論在聖士提反灣來一次創新的「燒烤十打邊爐」。如果沒有他時時提點，恐怕我也不能持續地利用「早晨音樂」去祝賀同窗的生辰。

「情人雄」和「亞畢」是天生一對的 Sports Sec. 他們的熱心帶導，加上參賽同學的努力，八六班終於可以一嚐班際總冠軍的滋味（當然還有男子組冠軍和女子組亞軍）。在沒有比賽的日子，他們也不甘賦閒，主動與八八舉行友誼賽，訂造球衣，有助其他班委等，都證明他倆是難得的好 Sports Sec. 尤其 Albert 做了一年 Med. Soc. IVC 後，還不遺餘力地爲八六服務，更令我敬佩！

Welfare Sec. 和 Academic Sec. ，一向給人的印象是默默工作，但我們四位「學術及福利秘書」——譚老板， Potella，關公和莊子，一卻爲這份職務帶來了點點生氣！老板和繼芬固然合作無間，再加上關公的盡責和莊子的經驗，爲大家帶來了班會紙和課本，替同學們印筆記，試卷，也幫助財仔和我們Department交涉。自己也曾當過 Welfare Sec. ，使我更體會到他們工作的辛勞，相信大家和我一樣，定會感激他們對八六班的付予。

今年的「財務秘書」也不再默默耕耘。單從 Individual Account 電腦化便可知一二了。Gordon一絲不苟的數口，亞熙的 Computer Program，還有余國雄的多方相助，有他們三人分担繁瑣的工作，班會的帳目定會有條不紊！

在我担任班刊主編的兩年裏，編委會幾乎成了班會中的班會。今年，Al-bud 一向享有的獨立和自主，當然繼續維持下去（沒有「出版自由」，班刊又怎能發揮它的功用？）。卓芹，梃生，Dora這三位富編輯經驗的同學一起負責，避免了風格的個人化。編委會也添了不少新成員（和他們引進的新意念）。在課程繁重的 3rd year 仍能（至少）出版兩期「杏蕾」，成績算是不錯了！

數風雲人物，當然少不了管理 Lecture Theatre 的鄭先生，沒有他的義務相助，我們恐怕無福欣賞到以「雙重投射」放映的三套幻燈！（可記得『幻彩八六』、『洋紫荊』和『生活的點滴』？）還有當我們不只一次用 Theatre 開會時，便得花掉不少鄭先生的寶貴時間。還有他每每替我們檢回失物，協助我們播放「早晨音樂」，還有……每位八六同學實應向他道謝一聲！

劉天驥

醫科八七

一年的回顧

「八面玲瓏，七竅皆通，八七英勇，大顯威風！」“three Cheers for '87, Hip, Hip, Hurrah” 八三年十一月「醫學生節八三」的音樂晚會上，87的喝采聲在陸祐堂內飄揚。經過了個多月的 Honey Moon term，透過一連串的文康體福活動，同學們能夠達到彼此之間進一步的了解。雖然87最後未能贏得醫學生節的總冠軍，但從參與的人數和熱烈的程度，卻可以看出同學的團結，後來聖誕聚會和87好友營都得到不少同學的支持，同時，87也擁有了自己的班刊—「杏仁」，使同學們多了一個交流的園地。總括來說， 1st term 的文康體福活動都能充份發揮了加强同學認識和班內團結的功能。

Second term 功課壓力大增， Behavioural Science 的 Project，加上新科目如 pathology , microbiology ，與 First term 的賦閒成爲强烈對比，到了 Third term ，同學又要拾回放下了整整一個學期的 Neurobiology , human growth 再加上 pharmacology，學業一點兒也不能放鬆。雖然如此，87的同學仍然參與多項活動，好像班際的運動比賽中，87不但鼎力支持，而且更於多項目中掄元，與此同時，班會內一羣熱心的同學也在努力爲訂購課本和儀器而工作，使其他同學能在三年級開課前作充份準備，實在功不可沒。

二年級的 M. B. 是漫長的，而結果當然有幸有不幸，87同學也在這裏顯露出互助互愛的精神， Distinction Viva的同學，都花了大部份時間，爲不幸的同學準備 Pull-up Viva 時的策略，他們的熱誠使人欽佩。M.B. 過過後，大部份同學都出外旅遊，因爲這已是五年內最後一個可以暫時擱下功課的長假了。兩個月的時間忽忽而逝，同學又要收拾起心情準備九月份的 Pharmacology Class Test 了。

上了三年級，便開始了醫學生生涯的一個新歷程。上 Ward 的體驗，大大刺激了同學學習的興趣，可是，87是不會爲此而變成 150 條書蟲的。不錯，87一貫的學術風氣是很濃厚，但這根本就是成爲醫生的必要條件。況且，87的同學根本就在很多方面都很活躍，只是地點不在沙宣道這裏罷了。

150個人來自不同的地方，興趣不同，體驗不同，要有一致的見解或活動的參與是不可能的。但當在八四年十月份的班際運動會中，同學熱心支持並創下佳績，及在十一月份的醫學生節中鋒芒大露，勇奪總冠軍時，我不禁對87充滿信心，相信每一個同學都好像我一樣爲能夠身在87而感到自豪，正如在醫學生節八四所高唱的：“ALL THE WAY WE ARE 87 GUYS”

曲廣運

攝影

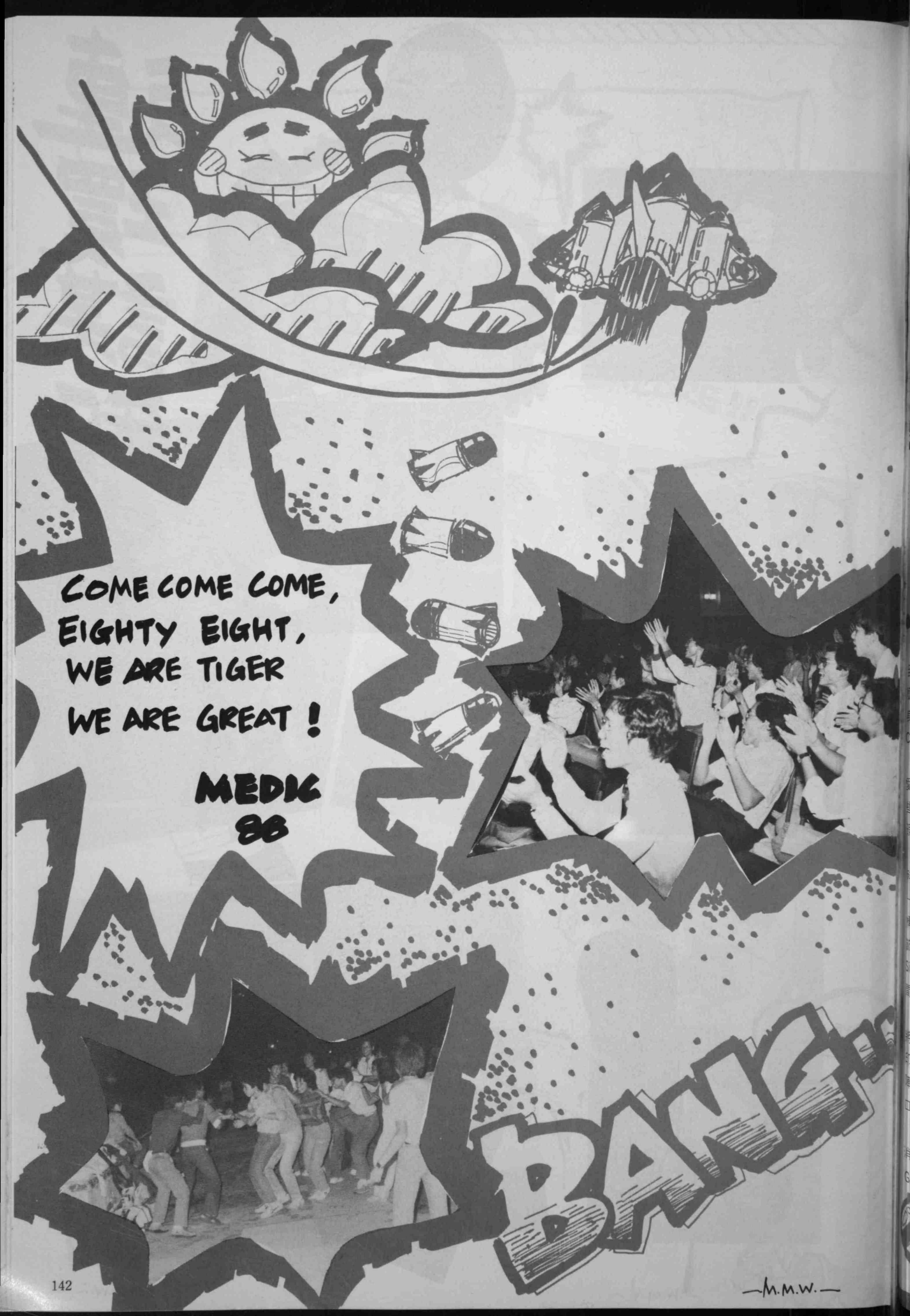
— M.M.W. —

WE ARE 87 GUYS

ENCORE !
ENCORE !!

~ M.M.W. ~

連環謀殺案


COME COME COME,
EIGHTY EIGHT,
WE ARE TIGER
WE ARE GREAT !
MEDIC
88
BANG!
—M.M.W.—

八八。88

八四年一月三日，步入另一個階段……

無論你中學成績多驕人， A-L 多出衆，你都得面對這第一個考驗— first term test 。也許是由於醫科的教學方式與學習環境都與中學時代截然不同，又或者是由於大學生活實在太迷人了——下午沒課上嗎？可以舐著一個甜筒走上 Student Lounge ，聽一會兒點唱，然後去「拉記」鋤一陣報紙；悶了嗎？可以去 games room 玩一陣康樂棋，然後找人 fuzzy 一番；還嫌悶嗎？可以去 Canteen tea 一陣，東拉西扯地聊一番，然後到了六點，衝進 T.V. Room 同 Boo Bee 講聲 hello。怎麼，認爲以上的生活太頹廢了嗎？沒關係，只要你肯飛身撲出， Med. Soc.， Class Com.，啓思、杏雨同 Health Com 等等永遠會向你微笑招手，拉你進去，陪他們一起「衝嘢」，一起通宵，眞眞正正做個爲人民服務，關社愛國的大學生—以致幾乎半班的同學慘遭滑鐵盧，還有些就如此地無言地捐出了他們的第一次（「我從小學到現在才第一次肥㗎！」）有趣乎？

眼見班內的鋤書氣氛漸濃，但是 first year 乃五年醫科之基業，豈可如此虛渡？於是班會便處心積慮地搞了一個 Intertable Competition 藉著 dissecting table 這個架構，以激發同枱團結的精神與參與班內活動的熱忱。其節目內容包括各項遊戲， dissecting table 清潔比賽與 Singing Competition，可慰的是大家尚算投入，而各枱之間亦能衝破障礙，讓「大圈子」的精神繼續成長。

踏入 third term，人人自危。而班會亦投大家所好，將以前的 mass games 同點唱變成影印 past paper 同影印 transparency ，果然反映熱烈。到了杜鵑花開時，一陣騰風由 main campus 吹至 Medic ，各人都拼著最後一口氣，盡最後一分人事……

在緊張的「 Viva week 」過後，八八就似乎自Medic 消失了。只剩下一批人在 Med. Soc. 房同啓思房衝 Gala，然後換了一批衝 Health Exhibition 同 Orientation

，還有小貓數隻在拉記…… Medic 是靜靜的。

人大了，能做的能玩的都多了，所以這個近乎三個月的暑假似乎一點都不冗長。一轉幕就到了第二年。

啊！這個被師兄形容爲「終日無所適事」的 honey moon term 終於給我們等到了。整個八八班都是熱哄哄的。「不如去置富飲茶啦。」「一陣去睇乜嘢戲啊？」「唔知 City Hall 今個月有乜嘢節目呢？」「 Main Campus 下午有 talk 同埋 film show……」但是亦有些人是懶洋洋的。睡得晚了就多睡一會兒，不是「較脚」，而是因爲“ Lectures are not compulsory ”，但是就連那 compulsory 的 practical 也塲面冷淸，tutor 幾乎多過學生！

不要說我誇張，因爲更加誇張的還在後頭。班會搞了個名爲「秋之狂歡」，實爲大拼盤之節目，內容包括 Pauline Chan 之攤位遊戲， Sports Centre 之踢毽、排球及羽毛球大賽，還有扯大纜、 Cross country 、天才表演、點唱、自助晚餐……

你們還可以想到其他什麼節目嗎？總沒有了吧！?可是我們仍然不滿於此，還搞了一次踩 roller；兩次的保齡球大賽；更於 first term最後一日，八八夜總會正式開幕，當晚的舞會歌舞昇平，極風花雪月之娛；於 term break ，又搞了一個 Class camp ……總之各適其適，只要大家有時間，肯投入，這個 honeymoon term 就是你的！

無可否認，每次參與活動的都是同一班稔熟的面孔。可是這樣也好，有一班基本的捧場客總比沒有的好。但是其他同學呢？是遊戲不合胃口？是無法投入？還是「丁」的吸引力或者「肥」的恐懼感太大了？每個人在 first year 時都是這個大家庭陌生的一份子，熟落與否，投入與否完全是視自己而定。而且你我並不是身邊擦過的陌路人，而是五年的同窗，日後的同儕，能多一份認同感，投入感與歸屬感不是更好嗎？而且搞嘢的熱忱，與同學的參與有著絕對的關係。你們多一分參與，我們多一分熱忱，好嗎？

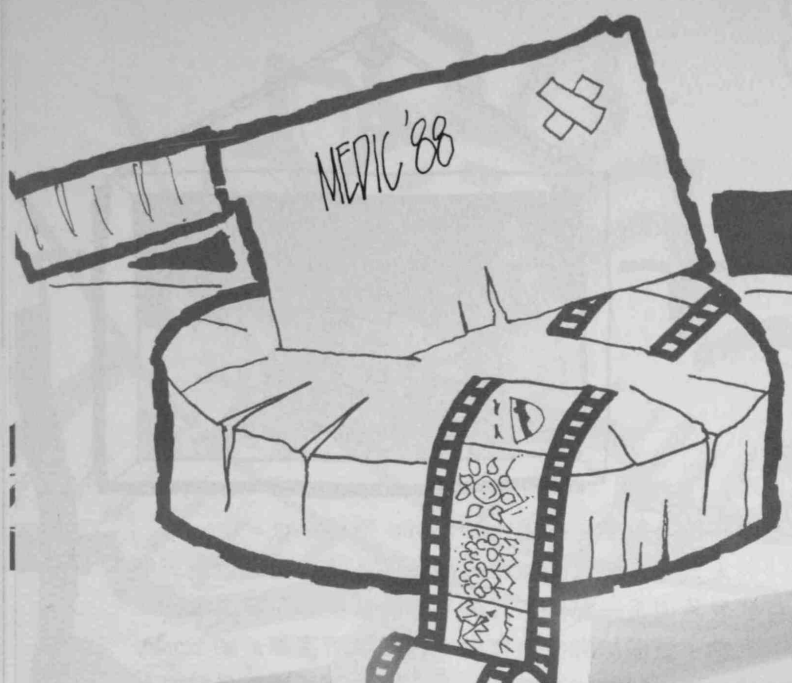
不過回顧過去年餘，一個個人變了一羣人，一羣羣人變了八八班。同學業已日漸相熟，table 或其他的 group function 都已成爲我們日常生活的點滴，假以時日，我相信八八班定會在同窗數載的情誼下更加團結。所以讓我滿懷信心地說一句：「明年的 Medic Festival 大家等著瞧吧！」

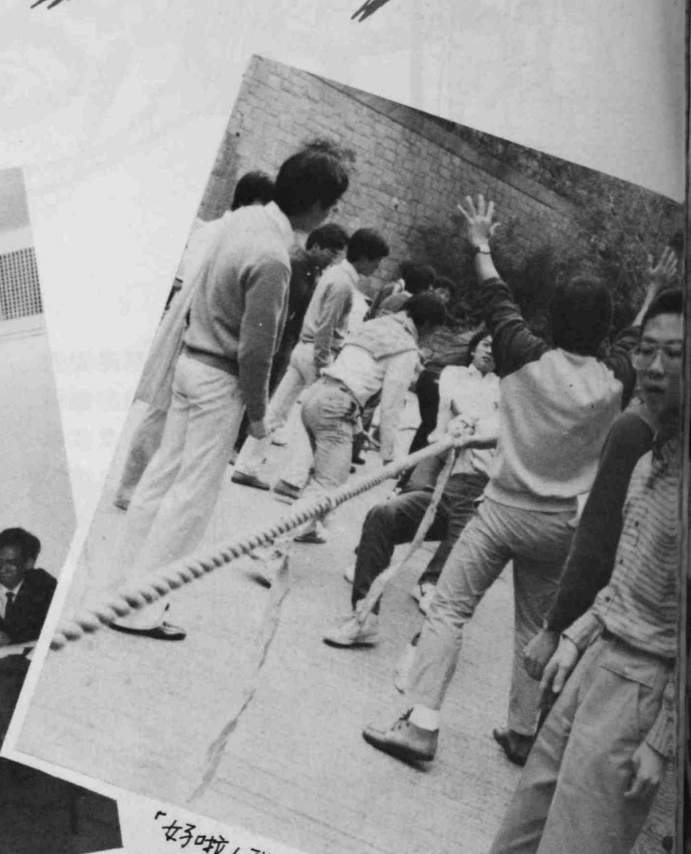
We are tiger, we are great !!

周靜德

剪影

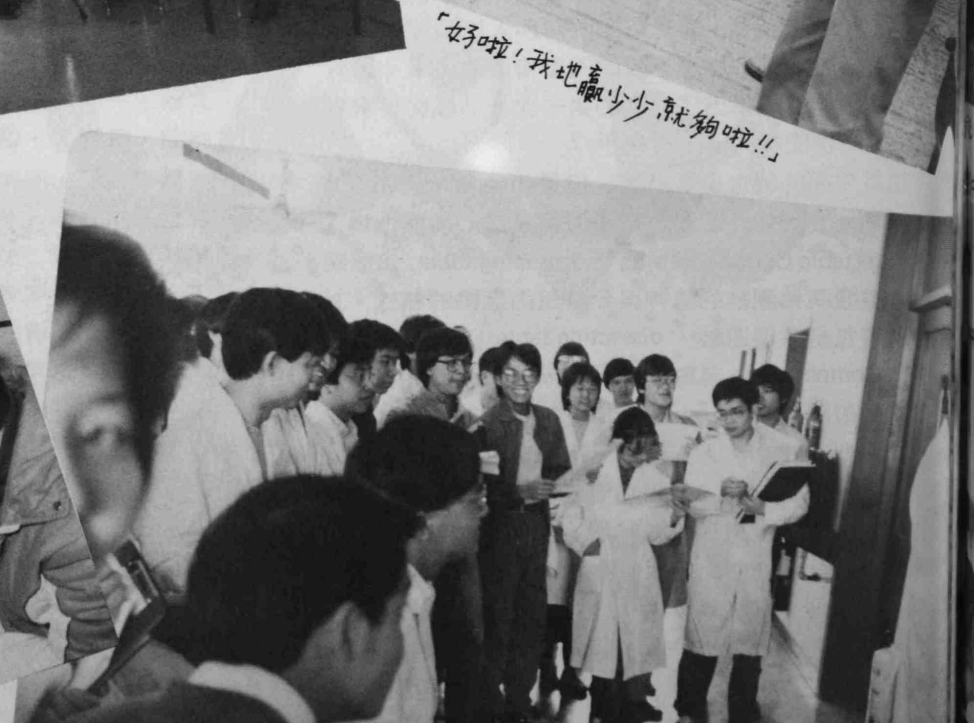
M.M.W.





「好啦！我地贏少少就夠啦!!」

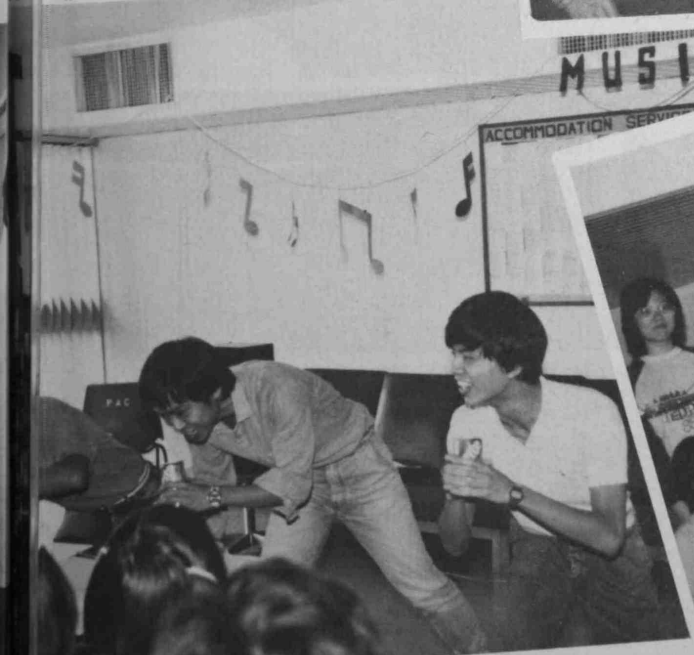
買定離手——開!!



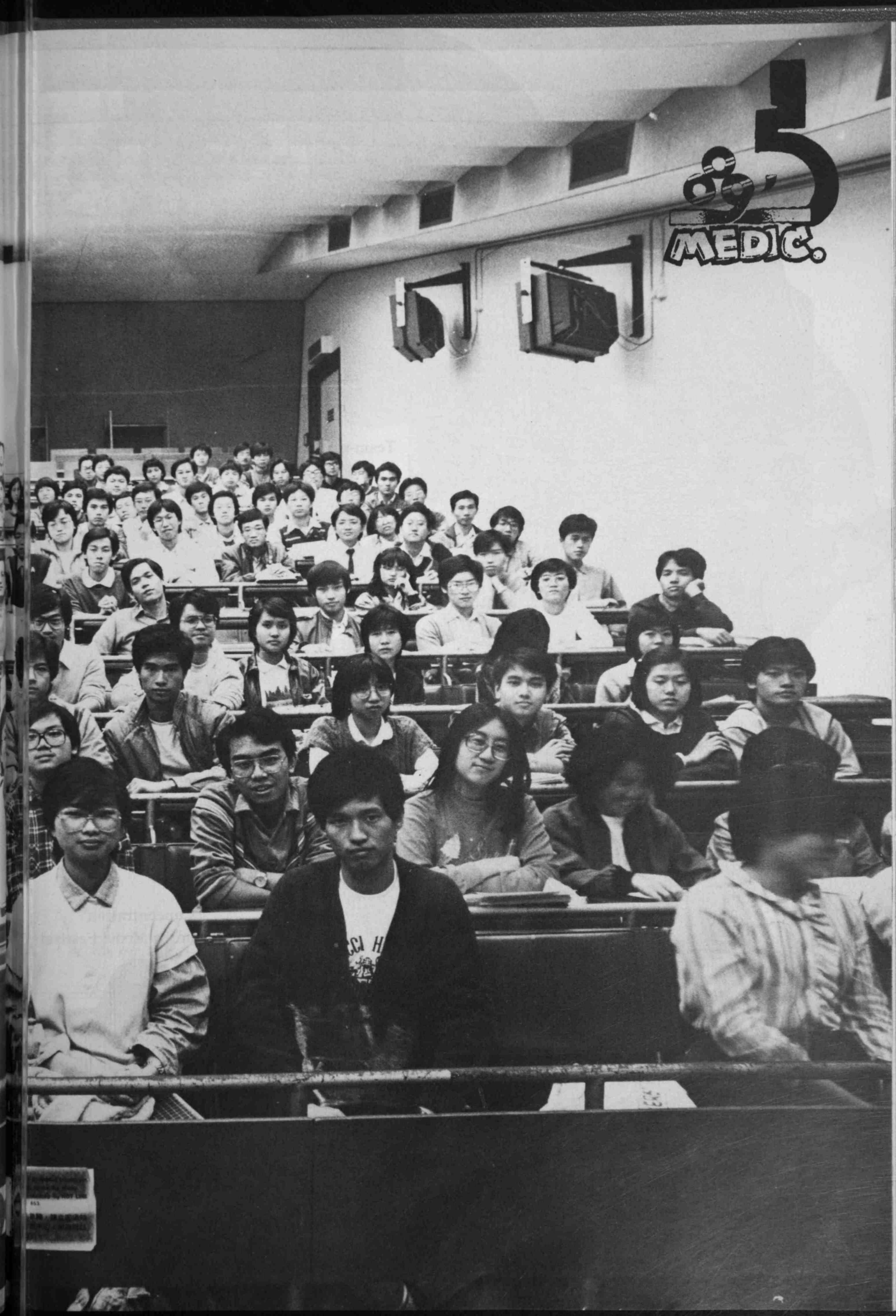
「CHEERS!」

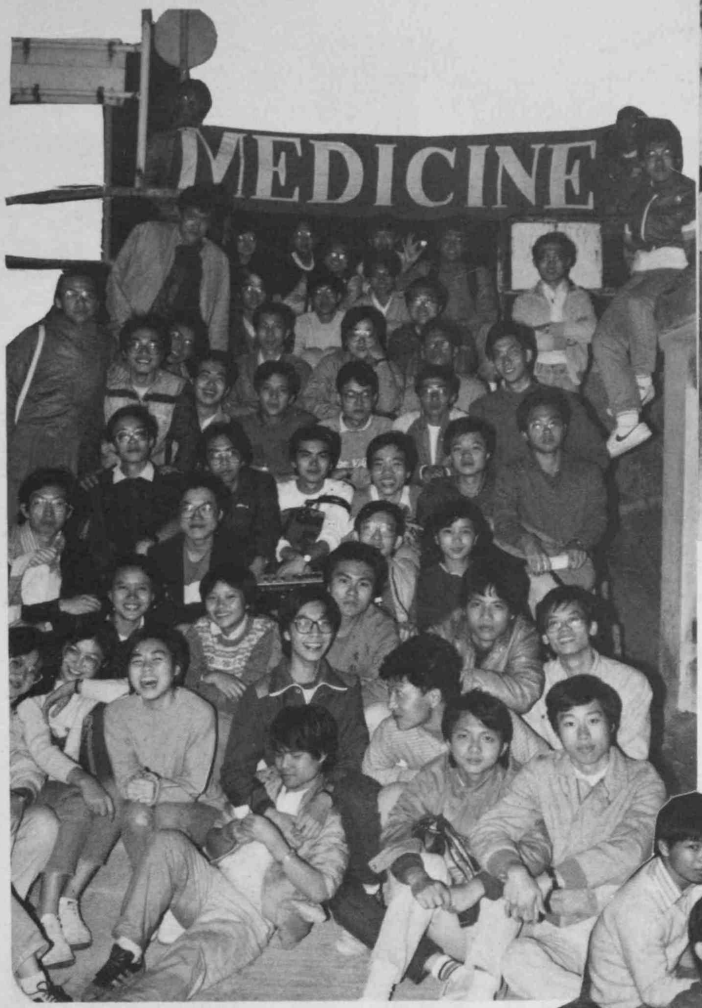
台該二十三碗雲吞麵!!!」

-,顯赫一時的「小-猫隊」



ARE TIGER OR WE ARE CATS !?

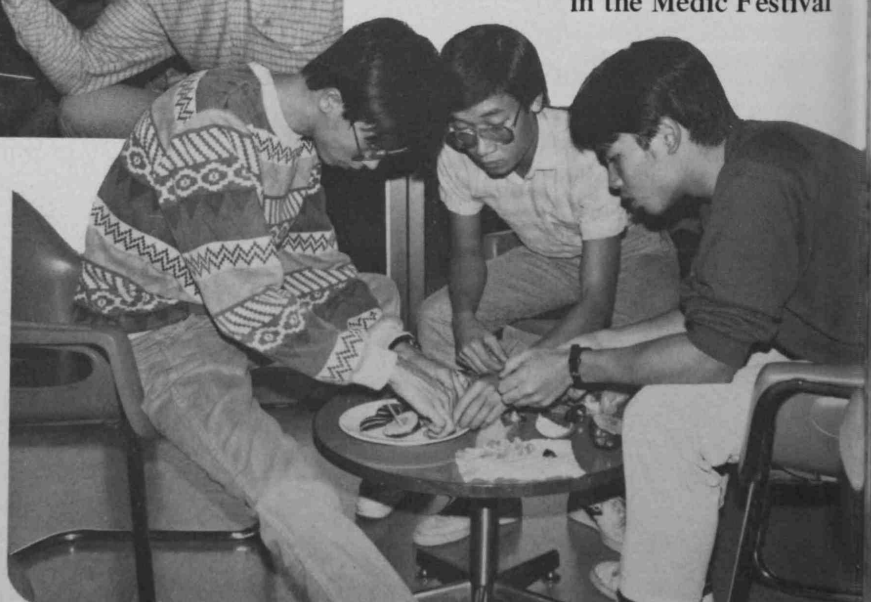

85
MEDIC.



Team-mate of the interyear Athletic Meet

赤柱 BBQ

'Concentration'
in the Medic Festival



心願　（曲：爸爸的鋼琴）

麥銘維89'

(1)夜已深，從窗邊觀瞻街裡似沒有人；
現今，埋頭書本堆中的我莫愧於心，
只想努力爲人，日後救助病人，
不管書本多厚，仍然勤力認眞!!
（副）成爲好醫生，唔信命運，只想謹愼；
他朝的我必須救護病人！
時時要盡力，常常去盡力，顯出本份！
要發揮醫生的愛心去拯救那黑暗!!!
(2)夜更深，聯想起，他朝一個個病人，
用愛心，祈求可將諸般苦痛盡變歡欣!!
不管崎嶇徑，亦繼續前行；
雖則身心飢渴，但願仍能盡愛心!!

學年初　原曲："IQ"博士

姚偉廉' 89

Nikon Micro稱得上十分之高超，
印度嚟嘅骷髏骨、會嚇你一跳，
Lang-man 同細 Clin好重要，
儭目無盡升，荷包的轟炸
奸商日日也偷笑（水魚嚟喇）。
①人人齊坐課室裏，D位猛話細
尤其是在中間裏，實在無「乜」計，
只有學成飛天本領先至入得去。
②時時勤力去拉記，根本無「訂」企
浮浮沉沉書室裏，重未學識笑
An-at-tomy 嘅 terms 想記都記不了。
（Anatomy）　FINE

SOCIETY PHOTO
1984

OUR 古村 CAMPUS

薄扶林文娛中心

文娛中心的行政

薄扶林文娛中心，設於陳蕉琴樓和部份白文遜樓，是我們醫學生必到的地方，經理梁戴海鷺女士除了負責文娛中心外，還負責見習醫學生宿舍及教職員休息室／餐室的工作。梁太除協助同學及屬會舉辦學術和康樂活動，管理文娛設施，使同學適當地運用外，並且作爲同學與校方的橋樑，保持密切的聯繫，徵詢同學意見。每年更有定時的Consultation Meeting，和醫學會同學、學生會幹事及膳食主任商討各項設施的需求和應用。個別同學也經常和梁太聯絡，或透過Booking office的工作人員，反映同學的要求、意見。

由梁太直接管轄的有十多位工作人員，其中負責文娛中心的佔七位。但實際工作時，卻不只此數，往往和宿舍及教職員室的員工合作。靈活的調動人手，既可節省開支也可發揮爲同學服務的最大功效。教職員室擴建工作完成後，人手會陸續增加。

文娛中心的應用情形

文娛中心成立於1980年五月，在這數年中，同學在設施的應用有着顯著的增加。以下的統計，是據陳蕉琴樓方面經 Booking 借用設施的情形，而不包括白文遜樓方面與個別同學的應用：

a. 場地的應用

80年初期，只有約 300 人經 Booking 借用地方，舉辦活動。

至去年（83年）人數已增數倍，最少的一個月也有一千人；

在十月份更達四千人之衆。其中以Discussion Room的應用人數最高。83年達七千人。增幅則以 Student Lounge 最大，是80年初期的十倍。主要由於同學多辦了大型活動之故，如音樂會，展覽等。

同學中，以醫科班會最多，其次順序是醫學會，合唱團，牙醫班會，杏雨等等。

活動項目在82及83年，約有2000個，其中65%用作開會，20%音樂會和宗教同學聚會，其餘順序是座談會，展覽，辯論，茶聚，賣書等等。

d. 文娛用具的應用

中心設有各項文娛用具，包括棋類，乒乓球、電視、鋼琴等；音响器材及影視器材也經常供同學借用。此外Booking office還有借閱雜誌的服務，而學生休息室更有多份報紙，讓同學隨意閱讀。

據84年 6 — 7 月間同學借閱雜誌的統計：明報週刊讀者佔了66%，突破10%，至於九十年代，明報月刊，time ，選擇等則比較少人借閱。據梁太表示，和醫學會幹事討論後，決定在85年更換部份雜誌及報章，以迎合同學的興趣及需要。

經濟情形

經濟來源主要是大學，其餘則直接或間接獲校內、校外人仕捐款及捐贈各項文娛設施如樂器、影視器材等。梁太每年需準備翌年的財政預算，通常提交的預算都會被通過。

設施的增添和文娛中心未來的發展

最近增設的飲水器（Drinking Fountain）使同學得到很大的方便。而一個供醫學會儲物之用的大櫃，也正在建造中，以緩和醫學會辦公室的擠迫情形。至於醫學會辦公室的擴建計劃，校方正在處理中。此外，一部新型的洗衣機，短期內可替同學服務，以取代那部棄置多時的壞機。

在未來數年內，大學計劃於沙宣道增設文娛中心，添置各項設施，也同時增建宿舍，屆時將有一座或兩座可容 600 人的舍堂，現時的宿舍將擴大50%，而餐廳的擴建也包括在計劃中。

工作方面

梁太認爲大部份同學都很有責任感，尤其在借用文娛設施方面。而員工亦能以服務同學爲己任，彼此互相尊重及合作。祇是由於大機構之故，部門分立，偶然要處理一些急切的事項，而要受制於程序，則感美中不足。不過對於在大學會任學生會幹事工作的梁太來說，能常常和同學在一起，處理學生活動及文娛設施，實在是一件很感親切的工作。此外由於同時須管理學生宿舍及教職員休息室／餐室，使接觸面更廣，而工作也更充實了。

陳蕉琴樓飯堂

陳蕉琴樓內的飯堂

與醫學生最息息相關的地方，相信很多人都會想起陳蕉琴樓內的飯堂，爲了加深對它的了解，我們特地訪問了大學膳食組的張準先生。

張先生的工作是執行大學對膳食組制定的政策和負責膳食組的營運。除陳蕉琴樓外，工作範圍還包括了方樹泉中心，菲臘牙科醫院，和幾間大學管理舍堂等共有七間不同形式的飯堂及餐廳，在他之下有近百名全職員工，而在陳蕉琴樓內就有十四位。

工作上的困難

近年來各學系的擴展造成職員的數目增加，再加上整個醫學院的發展，對飯堂的服務需求大大增加，因此造成使用陳蕉琴樓餐廳的人數較以往來說有急劇的增加，現時飯堂內約有 300 個座位，但在每日的午飯時間則要供應約 900 人的膳食，因此設備的不足是工作上的困難之一。

在大學的膳食系統（Catering System）下，大學把一個建成的飯堂連同各種必須的設施移交膳食組。此後，每一個飯堂便要財政獨立，大學在營運上不做任何津貼，就是水、電費也要自行支付。在財政上，飯堂經營的目的，就是要得到飯堂收支平衡，既不希望賺錢，也不可虧本。賺了超過一定範圍的錢（約營業額的 5 %）便要解釋，虧了本則一定要自付。很多同學都以爲飯堂的服務是大學的一種福利，因此對膳食服務的收費認爲應該是非常廉宜的。可是，由於大學對膳食服務並沒有採取‘津貼’的政策，因此雖然膳食組已儘量保持合理的食物價格，但長遠來看，膳食服務一定會受到社會上物價及通脹的影響。例如近日由於美元急升和通脹，令飯堂於1984年下半年度及1985年上出現相當大的虧蝕。爲了要使下半年財政年度的收支平衡，惟有把食物的價錢提高約二至七角。

張先生是很尊重醫學會的意見，亦以此作爲大多數同學的代表。醫學會大致上也沒有反對是次加價，而生意也沒有顯著地受加價影响。

外來人士使用飯堂雖是飯堂擠迫的部份原因，但這問題很難處理。對膳食組的員工而言，大學與非大學人士是很難分辨的，曾試過在購票時查學生証，但這不但引起學生反感，更會減慢效率，做成擠塞，而且大學的職員是無職員証的。此外，外來人士對整個膳食系統的經濟情況是有幫助和貢獻的，最終受益的還是大學生們，但膳食組的員工卻沒有好處，因他們全是固定的月薪制，並不因生意額加大而有‘花紅’。

至於投訴的處理方面，假如接到投訴後，膳食組會要求該員工作出合理解釋，如無法做出合理解釋，則會以口頭或書面作出警告，但由於膳食組員工和我們的教育及工作背景不同，在溝通上往往比較直接，這點希望大家能瞭解。

Catercng System 未來的發展

1985年大學除了會在West Amenities Centre 建一設備比較完善的飯堂外，同時會在Sandy Bay建一小食店。在長遠的發展計劃中還會擴充現有之陳蕉琴樓飯堂，以應付未來醫學院之發展。如飯堂能夠擴充，則在厨房設備上會打算增加一些能做中式叉燒的爐和提供售賣西餅服務。

本身有商業管理碩士及營養學碩士學位，曾在數間大學唸書，畢業後幹過酒店工作的張先生，覺得大學的Catering System 在香港是一項新的工作，對他本人則是一大挑戰，雖然自信對學生有一定的了解，但由於學生的心態及對膳食的需求都並不完全一樣，他相信還有許多地方是膳食組要學習，同時也有許多困難是他們在將來需要努力去克服的。■

醫學院圖書館

圖書館相信是醫學生們最熟識的地方 —— 溫習的地方，尋書的地方，嚴肅清靜但不宜睡覺的地方!

圖書館共有十二位職員，包括副館長 —— Miss Morgan，一位高級助理，五位助理及四位初級助理，負責不同的工作。工作大致可分爲集體及個別工作。集體工作包括借書、還書、影印、收錢等，而個別工作則包括目錄整理，維持影印服務，訂購新的醫學雜誌及通知圖書館有關醫科新書的資料等。近一兩年來，圖書館更增加了一堂教導醫科及牙科學生如何正確使用目錄（Catalogue ）和找尋醫學雜誌，相信很多一、二年級的同學也已參加過了。

經濟情況

圖書館的主要經濟來源是Library Book fund和China Medical Board Endowment Fund.後者有經常的捐款予以醫科圖書館，而Miss Morgan則是安排理用此款的委員之一，因此要盡力爲我們的圖書館爭取金錢以添置更多新書。由於財政方面的限制，圖書館對錢財的運用要格外小心。

未來發展

圖書館現在推行目錄電腦化的計劃，以增加將來同學使用圖書館的效率，但由於此非一朝一夕可做到，故相信還需數年才能推行。

給同學的話

圖書館近來的主要問題是館內的刊物和雜誌常被撕去若干頁，雖然並不常發生，但也值得憂慮。此外，圖書館亦希望同學切勿違法地影印書籍和雜誌，法例的標準是每人每次不可印超過一本書的十分一，而每本雜誌則不可多於一篇文，在英、美等地，已有圖書館因類似事件而受出版商起訴。

總括來說，Miss Morgan認爲醫學生都有責任感和自律，但希望我們更能爲他人設想，在圖書館裏保持肅靜及愛護書本，如有任何關於使用圖書館的問題，她很歡迎大家和她討論。■

實驗室動物中心

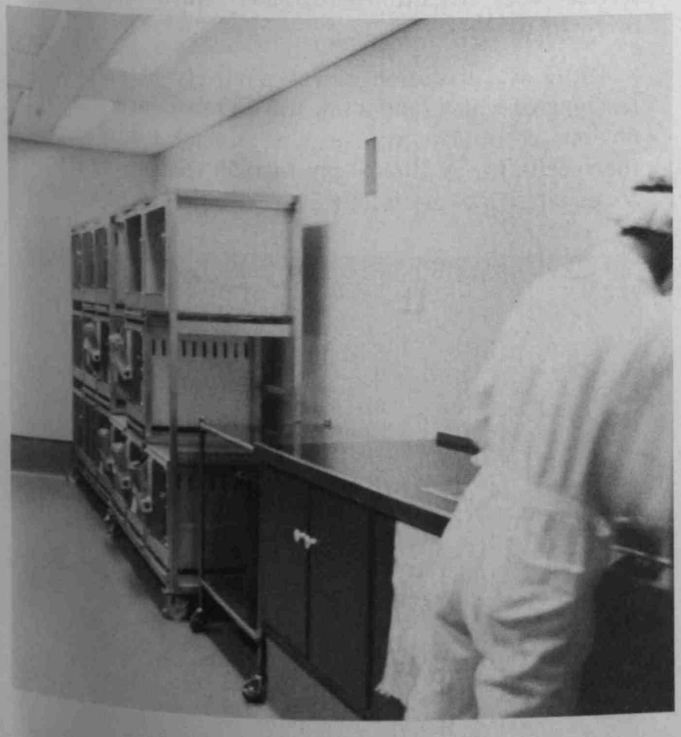
實驗室動物中心座落於沙宣道陳蕙琴樓隔鄰，雖然只是咫尺之近，但我們對它的認識卻不多。最近我們訪問了自1978年以來已在中心工作的主任 Dr. E.J. Moore ，從而使我們對這中心有進一步的了解。

中心歷史

在一九七九年之前，中心在李樹芬樓的地牢設有一所動物屋飼養動物以供實驗之用。1979年，牙醫學院正式成立，加上各臨床前（ Pre-clinical ）學系需要更多的地方作實驗及教學之用，因此中心便遷往現址。

經濟情況

中心的經費主要透過醫學院由 Development and General Purpose Committee （ D.G.P.C. ）資助。此外，由於要保持常用品種動物的供應，中心飼養動物的數目是稍高於需求的，而這些剩餘的動物的數目便可售予各中學作爲解剖之用，從而得取少量額外收入。



中心工作

中心的工作目的是飼養健康的動物以供實驗及教學用途。在醫學院內，葯理及生理系對動物的需求最大。

現時，中心內有二十七位職工；他們的工作包括繁殖及飼養動物、檢察動物健康、維修設備及文書工作等。由於中心爲香港同類型中的第一所，所以開始時的技術人員都要接受在職訓練。兩年前，香港理工學院設立了Animal Technology 的文憑課程，而大部份的專門課堂，都是由中心內的高級技術人員所教授。

中心內設有手術室，X 一光室和癌症實驗室。現在已有研究生到中心進行動物實驗及接受使用設備訓練。

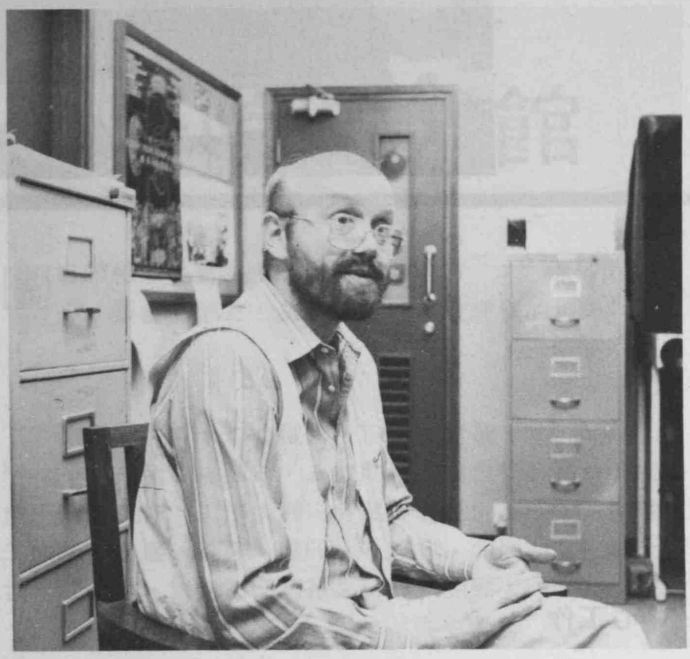
工作上的困難

中心的工作量不斷增加，尤以在培殖突變體（ mutant ）及特別品種方面的工作爲甚，而集郡（ Colony ）的數目更由五個增至現在的十八個。雖然工作量使管理上出現困難，但經驗豐富的中心職工現時仍可應付得來。不過新品種動物的需求日益增加確實令人覺得中心有擴充的需要，但就目前的經濟狀況而言，設立一所分開的中央繁殖中心（Central Breeding Unit）的可能性不高。

給同學的話

Dr. Moore 勸喻同學們盡量善待動物，這更能減少牠們在實驗中的緊張，以免影響實驗的結果。 ■

M.I.U.



The Medical Illustration Unit has been in existence for some four years now and was formally established as a Unit within the Faculty of Medicine in March, 1983. The Unit is situated on the ground floor of the Pauline Chan Building, 10 Sassoon Road, Pokfulam.

Medical illustration is the term currently given to a multi-discipliary profession which embraces photography, graphics, typography, film, television and video recording. The end product of any particular discipline may be used for documentation, teaching, publication or research. Many medical illustration departments, even in large teaching hospitals do not provide such a comprehensive range of services as has just been suggested.

THE WORK

It has been fully recognised by the MIU that all clinical departments have special and particular photographic needs related to their service and research functions. The resources of the MIU have been concentrated on providing a Faculty-wide service in the areas of graphics, reprography, specialised photography, film and television.

The MIU is responsible for the five Medical Faculty lecture theatres (3 in the Li Shu Fan Building and 2 in the Clinical Building) in terms of routine maintenance checks, unlocking in the mornings and the following services: projection services; (C.C.T.V.) and video recording. There are two Laboratory Assistants looking after the Lecture Theatres and when necessary the Office Assistant can be involved forming a team of three. This service is co-ordinated by the clerk who also helps with the preparation of typed slides and the typing on graphics for publication.

I have just mentioned four members of my staff and I think this would be a good time to list my staff establishment before explaning in more details what we all do in more detail.

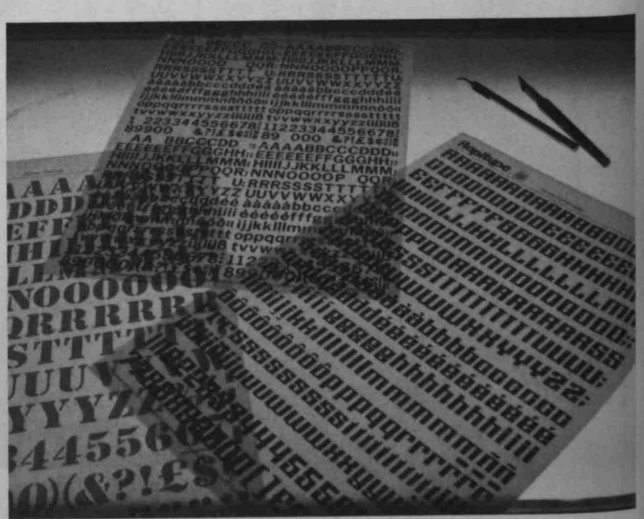
Head of Unit, who is also the Medical Artist; Audio Visual Officer II, who in the case of the MIU is the Medical Photographer; there are two technicians (Graphic Artist & Graphic Assistant) and as I mentioned in the previous paragraph, one Laboratory Assistant (Lecture theatre attendant), the other lecture theatre attendant is on loan from Centre for Media Resources, an Office Assistant and last but by no means least of all, the Clerk II.

The MIU seeks to offer a service, that is primarily provided for educational purposes, and which includes the service of the two Artists, Graphic Assistant and the one Photographer. Clearly with only one photographer there is and will be, need from time to time for the MIU to seek assistance from the other photographic units within departments of the Faculty and the Centre for Media Resources.

Photography

Photography of the patient, although normally a basic function of a medical illustration department, has been traditionally undertaken by the Department of Pathology as has the routine service for the photography of pathological specimens. The Department of Orthopaedic Surgery and Pathology are recognised as second and third photographic units and offer a back up photographic service with regard reprography when the MIU is overloaded.

Pictorial illustration serves a variety of purposes in teaching of which only a few will be mentioned. The most obvious purpose of course is to produce a substitute for the real thing. A clinical photograph enables the teacher to demonstrate the visible signs of disease. This realism



can be extended to any internal lesion which can be reached by photographic instrumentation to the microscopic appearances of cellular structures, pathological organisms, and movement recorded on film or video tape. This type of illustration is used to assist the students to recognise real things, but it does not necessarily help him to understand them. For that, interpretation of the visual information is needed.

Every day the Medical Illustrator struggles with the problem of translating a wide range of complex information into pictures which can be understood by a whole spectrum of intellect from the lay public to the trained scientist.

Reprography

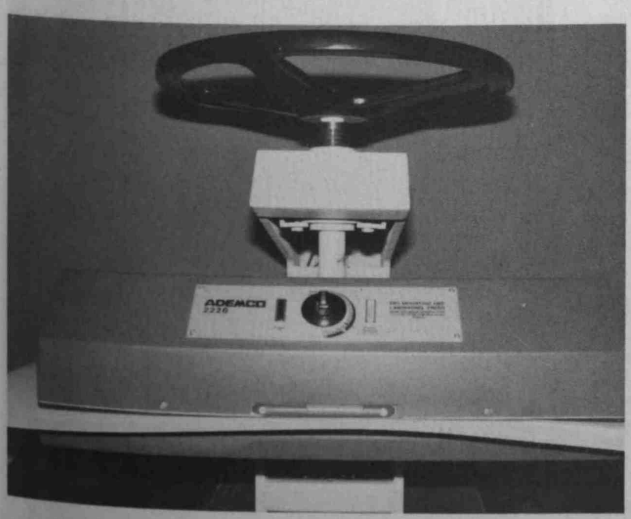
The reputation of a medical illustration department may well depend on its efficiency and willingness within the area of photographic copying. Diagrams, graphs, charts, illustrations, X-rays and colour transparencies arrive daily, some for ultimate publication and many more for lecture slides and results are usually required by a specific date.

Medical art and graphics

Much of the artwork photographed in the Unit is produced by the Medical Artist, Graphic Artist and Graphic Design Assistant. In order to cope with an ever increasing demand for artwork, we standardise as much as possible on size and layout using the quickest methods available, whilst maintaining quality.

During the last year we have assisted in the preparation of two major exhibitions: "Your Mind and Your Health" organised by the University Health Service and "Know Your Heart and Lungs" organised by the Medical Society, Hong Kong University Students Union.

The Medical Artist is also trained in the presentation of facts. He can advise on when a pie chart is better than a table, and can help to sort out data, whether it is for a professor, doctor, technician, student or whoever. The



Artist can be as selective in his presentation of a visual as he wishes to be while the photographer includes both the wanted and often unwanted. Drawings of surgical procedures, for example, will surely always be more instructive and specific than photographs. Where film and television is undertaken the artist produces titles and diagrams as well as the more complicated cells used in the production of animation sequences.

Television

Probably the greatest recent impact on medical illustration departments has been television. Teaching programmes are produced and presented in cassette form so that they may be replayed at will on any compatible video playback equipment.

There is a steady demand for video recording, and C.C.T.V. although we are limited due to the lack of equipment. In conjunction with the Department of Obstetrics and Gynaecology we have helped in the production of a film on emergency childbirth.

Video recordings of gaits, tremors and restricting palsies are made for documentation or teaching purposes on a regular bases. We do not have any editing facilities but can call up the CMR for that service.

THE FUTURE

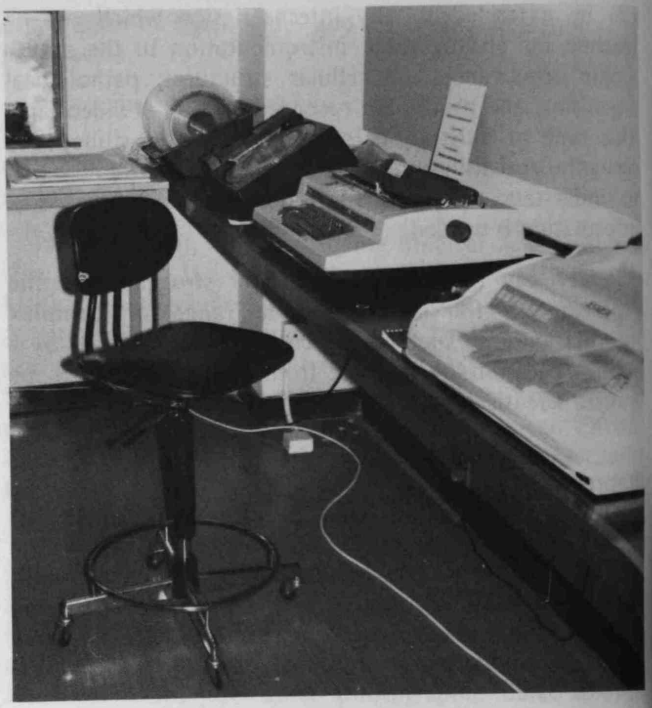
The amount of graphic work produced in universities, medical schools, large postgraduate teaching hospitals and research institutes is staggering. It is essentially a labour intensive industry since the bulk of this material is produced by hand with the support of simple mechanical

aids such as typewriters/composers, headliners, letraset etc.

This represents a considerable expenditure on staff at a time when the financial resources of the Universities are being severly cut back. At the same time however, the demand for medical illustration services is increasing substantially as research output and scientific advance continues to accelerate. Consequently there is a desperate need to find ways of increasing output which involve a reduced or static expenditure of resources on manpower.

Computer graphics may be one way of achieving a solution to this dilemma. The computer industry is at last realising that the ability of their equipment to produce pictures is important for sales. Areas such as engineering and design, picture processing and graphic art are all potential outlets; with the American space programme spuring them on.

For a relatively small investment one can enter the world of computer graphics and eventually recover that investment in terms of small material costs, low labour costs and increased productivity. This is the direction towards which medical art will be turning.



CONCLUSION

To conclude this short introduction to medical illustration and the MIU in particular, I would like to say that it is a prime function of medical illustrators of all disciplines to channel new techniques of their separate specialities into medical application.

The breadth and efficiency of the Medical Illustration Unit is directional to the stimuli fed into it by its medical colleagues. ■


NIKE
NIKE
SPORTS MEDICINE

體育在醫學院

在功課繁重的醫學院內能看見體育運動的發展是一件可喜的事。每個學年中，不但有基本的班際賽及院際賽，還包括了不少友誼性質的賽事。

杏雨作爲一本醫學院年刊，理應只報導當年（84年）內所舉行的活動，但由於班際及院賽均橫跨了兩個年頭，所以爲了使讀者能有一個貫徹的資料報導，在餘下篇幅中我們輯錄了83至84年度班際賽〔水運（30／9／83），陸運（14／4／84）及球賽（5／4／84至30／4／84〕及院際賽〔83年10月至84年12月〕的詳情及成績。當然，在進行中的84至85年度班際賽及院際賽也會提及。除了報導性的文章之外，我們還會探討一下體育運動在醫學院所起的作用，同學們的態度及以後的展望。而資料更是通過過去三屆體育秘書的訪問得來，確實有他們的獨到的看法。

爲甚麼搞體育？爲甚麼參與運動？

統籌體育活動並不是一件容易的事，試想想全院七百多人的運動比賽及以外事宜都要落在兩位體育秘書身上便可知其中之困難了。很多人也許對體育活動在本院的推動的困難，目的及現況等等缺乏了一個清晰的概念。由於體育秘書是最了解以上一切一切的人，所以特地訪問了三位體育秘書黃玉庭，曲廣運和姜建鈞，和他們探討了體育在醫學院的問題。以下是綜合了他們三人的意見而寫成的。

目的：

體育活動醫學院並不是爲搞活動而搞的。雖然要找出一個公認的目的是不可能的事，但如果可以知道體育秘書的目的，我們也許可以明白一下我們所參與一切一切活動的背後動機，從而作出比較。

贏取比賽，贏得亞米加玫瑰盃也許是一個不能被沒殺的動機。但是只爲勝利而比賽的心態卻不是值得鼓勵的。在班際賽中，勝負是不應被看重的，團結各班及增進友誼是不二的大前題，一年一次的比賽，雖不能期望有甚麼很大增強作用，但至少也達到了一定的促進程度。而另一值得高興的是醫學院的比賽出席率已是全港大之冠，足見醫學院的團結精神是可喜的。而沒有體育比賽，那可以見到這令人振奮的友誼表現呢？另一個更基本的意念便是由醫學院去提供更多的活動機會給各同學。因爲除了一些住Hall和S.A.屬會的會員外，大部份醫學生都是只參與班或學院所安排的活動的，沒有體育秘書的推動，相信同學在五年中眞是難得到何世光夫人體育館一次。

困難：

在大學裏搞活動，都不免會遇到一連串的困難。而體育活動在醫學院裏推行，更是阻力重重。參加人數少是主要因素。除了功課的壓力，其他認知性的活動也奪去了不少有潛質的運動員。所以每年的班際比賽中都有「拉失」的現象，尤以球賽爲甚。一隊球隊往往需要十人以上才可成軍，而在每班找到足夠的人數並不是想象中般容易。以院際比賽爲例，有時比賽是緊貼在課堂之後，有些被安排在授課時間之中，所以，那可以要求同學參與呢？班際的球賽的主要賽程都在三、四月間，M.B.試相距不足兩月？一些平時有玩的同學也會因「騰」考試而放棄一年一次的班際盛會。要改善出席率，最好是把比賽提前至一二月在Term Test 後舉行。

體育秘書本身也面對不少工作難題。首先是預訂場地方面。因爲大學場地有限，更有各S.A.屬會，宿舍等要使用，所以形成了搶場的情況，而不少班內舉行的練習及比賽也因而被迫取銷。第二個困難就是學院和各班體育秘書的聯絡。如果班體育秘書是缺乏自發性的，該班就很難有足夠和妥善的體育活動安排，因爲院體育秘書是不會替班搞活動和訓練的。

現況展望：

[illegible]曾經雄霸院際賽，屢奪Omega Rose Bowl。但去年卻失去了冠軍名銜。不少同學爲此而憂慮，恐怕醫學院的水準不能再如往昔般超羣。但是如果知道各隊員已盡全力，失敗也不是值得介懷的事。有人歸咎失敗原因是少了一班高水準的「明星」運動員。這些運動員無疑是表現出衆樣樣皆能，曾爲本院取了不少分數，如今他們畢業了，自然令人懷念。可能87、88和89班是少了這些「明星」但普遍水準也不至大幅下降，起碼於在今年的院際賽也有不少新人的冒起，現時總成績也在領導地位，極有機會奪得今年的冠軍。所以憂慮是不實際的。其實Omega Rose Bowl之所以易手，是和其他院系體育水準的提高有關係的。現時可以威脅醫學院的已不只工程學院，還有社會學院，此消彼長，所以相信以後勝負的關鍵是只在於一兩場比賽，而另一方面因爲比賽是單淘汰制的，所以幸運也佔了很大的比重。而醫學院能做的事只有增加同學的參與精神，鼓吹班內運動，及加强訓練。但是也要維持同學對運動的自發性，不可强無意識的參與。現時體育發展在本院的情況是不錯的，份量很適中，唯一要改善的便是與班體育秘書的聯絡，加强各同學參與運動的機會。而訓練方面，相信仍然要依靠S.A.及Hall，因爲强加訓練，在時間和安排上是不可行的，而在認知，時事等各類形活動充斥之下，我們不能將體育放在唯一的大前題，而抹煞了同學參與其他活動的機會。■

今年的體育活動，分爲院際及班際比賽，各項活動的報告如下：

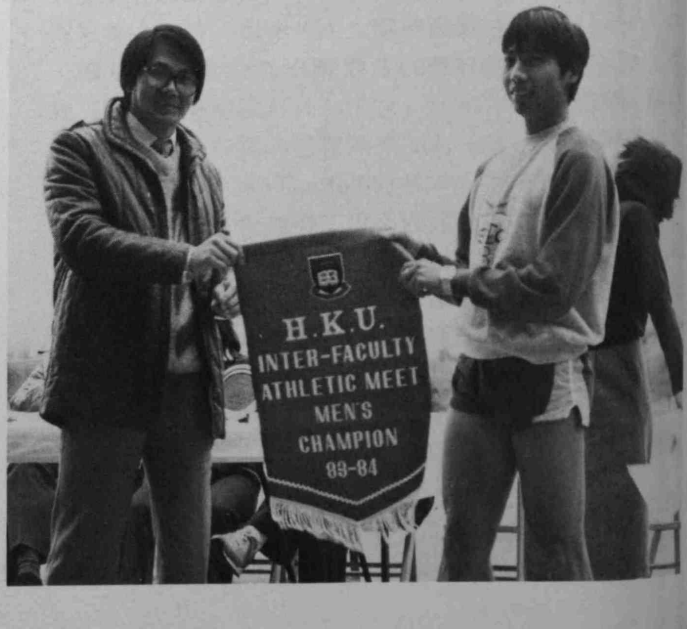
（甲）院際運動比賽（亞水加玫瑰杯）
（八三至八四年度）

八三至八四年度共有十二項院際運動比賽，除陸運及水運外，皆不分男女組別。所有比賽在第一、第二個學期內舉行。結果醫學院得季軍。

各項比賽成績如下：

		成績	隊長	最佳表現隊員（MIP）
水運	男子	亞軍	陳惠倫 (87)	—
	女子	冠軍	方榮生 (86)	沈孝欣 (88)
	全場	冠軍		
陸運	男子	冠軍	盧寵猷 (87)	—
	女子	季軍	—	—
	全場	亞軍		
羽毛球		—	廖家傑 (87)	—
籃　球		—	周鶴平 (85)	莫毅成 (86)
足　球		季軍	葉錦洪 (87)	—
曲棍球		—	陳德明 (88)	潘兆康 (85)
壁　球		季軍	黃玉庭 (86)	梁慶達 (84)
乒乓球		亞軍	黃兆文 (86)	黃兆文 (86)
網　球		冠軍	關治邦 (86)	龐寶星 (87)
排　球		亞軍	林鑑華 (87)	高德全 (86)
壘　球		殿軍	魏志文 (86)	—

全年最佳男運動員：高德全 (86)
　　關治邦 (86)
全年最佳女運動員：沈孝欣 (88)



(乙) 班際運動比賽 (八三至八四年度)

八三至八四年度的班際運動比賽共有二十一項：男子組佔十三項，女子組佔八項。其中水運會於八三年九月三十日在港大體育中心泳池舉行；而陸運會則於八四年四月十四日於九龍仔運動場舉行。其他比賽項目，則在第二至第三學期舉行。至四月三十日結束，並於當日舉行頒獎日。

I 時間：5／4至30／4

II 項目：男子組—水運、陸運、羽毛球、籃球、越野賽、曲棍球、足球、壘球、壁球、乒乓球、網球、拔河、排球。

女子組—水運、陸運、羽毛球、籃球、越野賽、乒乓球、拔河、排球。

III 地點：體育中心泳池 — 水運（30／9／83）

九龍仔運動場 — 陸運（14／4／84）

體育中心 — 羽毛球、籃球、壁球、排球

大口環球場 — 曲棍球、足球、壘球

西苑網球場 — 網球

醫學院 — 乒乓球、拔河

IV 賽制：除水運、陸運、越野賽及男子組拔河外，其餘皆採單淘汰制。賽例以院制比賽爲依歸。

V 結果：男子組冠軍 ： 86班 陳棟光獎座

女子組冠軍 ：：88班 廖獻貞盾

總冠軍 ： 86班 鄭志仁盾

水運總冠軍 ： 86班 Gibson's Cup

陸運總冠軍 ： 88班 President's Cup

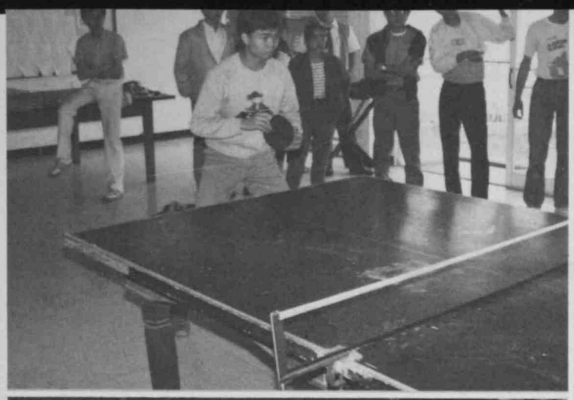
1983－84年度班際運動會成績

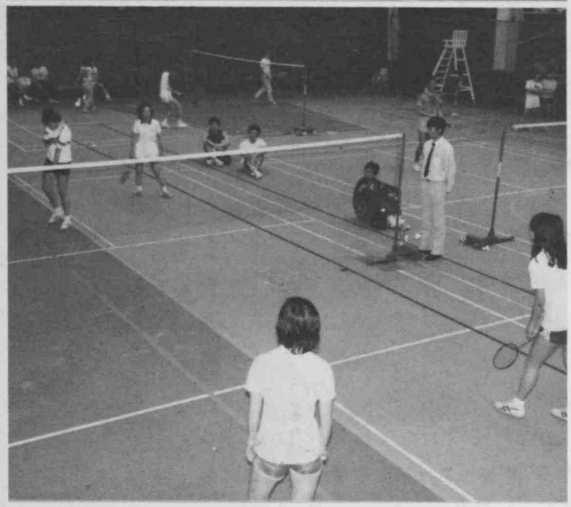
班級	男子					女子				
項目	84	85	86	87	88	84	85	86	87	88
水運	4	18	12	8	6	4	6	18	8	12
陸運	—	—	18	8	12	—	—	12	8	18
越野賽	—	3	4	9	3	—	—	4	6	9
足球	—	3	6	9	3	—	—	—	—	—
籃球	—	9	3	6	3	—	3	9	3	6
乒乓球	—	3	9	3	6	—	6	9	3	3
排球	—	6	9	3	3	—	3	3	9	6
網球	—	—	7½	7½	3	—	—	—	—	—
羽毛球	—	6	9	3	3	—	3	6	9	3
曲棍球	—	7½	7½	3	3	—	—	—	—	—
軟式棒球	—	—	9	6	3	—	—	—	—	—
壁球	—	3	3	9	6	—	—	—	—	—
拔河	—	9	6	3	4	—	6	3	3	9
總分	4	67½	102½	77½	61	4	27	65	49	66

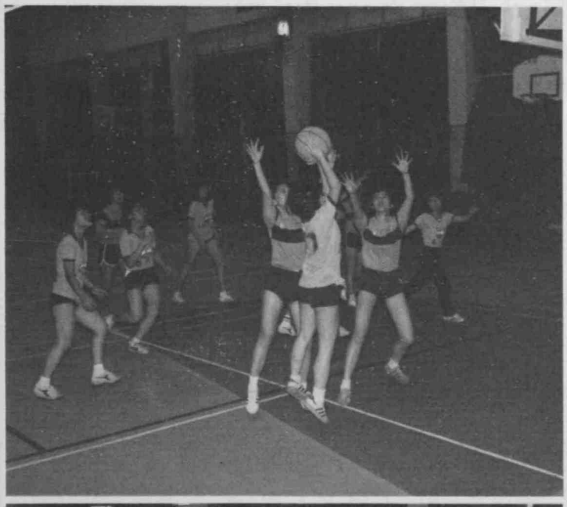
男子總冠軍 ： 八六

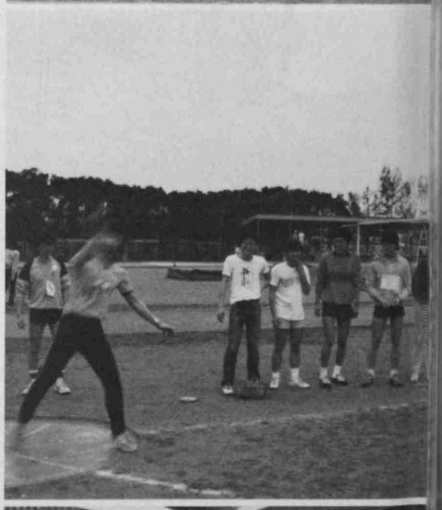
女子總冠軍 ： 八八

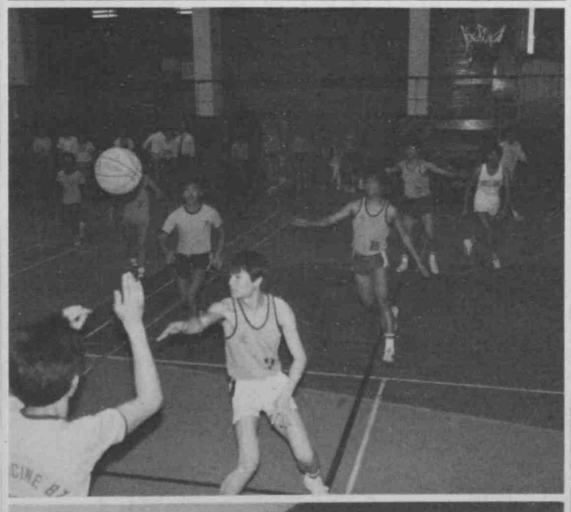
全年總冠軍 ： 八六



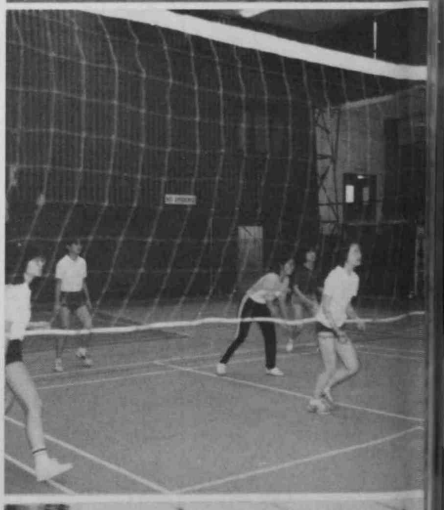







MEDICINE


H K U
MEDICINE
INTER YEAR
AQUATIC MEET
MEN'S
CHAMPION
83-84
MEDICINE
INTER YEAR
ATHLETIC MEET
MEN'S
CHAMPION
83-84



八四至八五年度

八四至八五年度之院際比賽亦已於十月初開始，男子組共十一項；女子組則有五項，其中籃球、壁球及羽毛球屬友誼賽性質，成績將不會計算在亞米加玫瑰杯內。

比賽項目如下：

		成績	隊長
水運	男子	亞軍	莊裕開（88）
	女子	冠軍	沈孝欣（88）
	全場	冠軍	
籃球	男女	／	趙學民（88）
	女子	／	邱逸華（88）
排球		冠軍	岑旭華（89）
陸運	男子	冠軍	姜建鈞（88）
	女子	冠軍	邱逸華（88）
	全場	冠軍	
乒乓球		／	鄭建明（88）
網球		冠軍	龐寶星（87）
足球		冠軍	葉錦洪（87）

將於八五年舉行

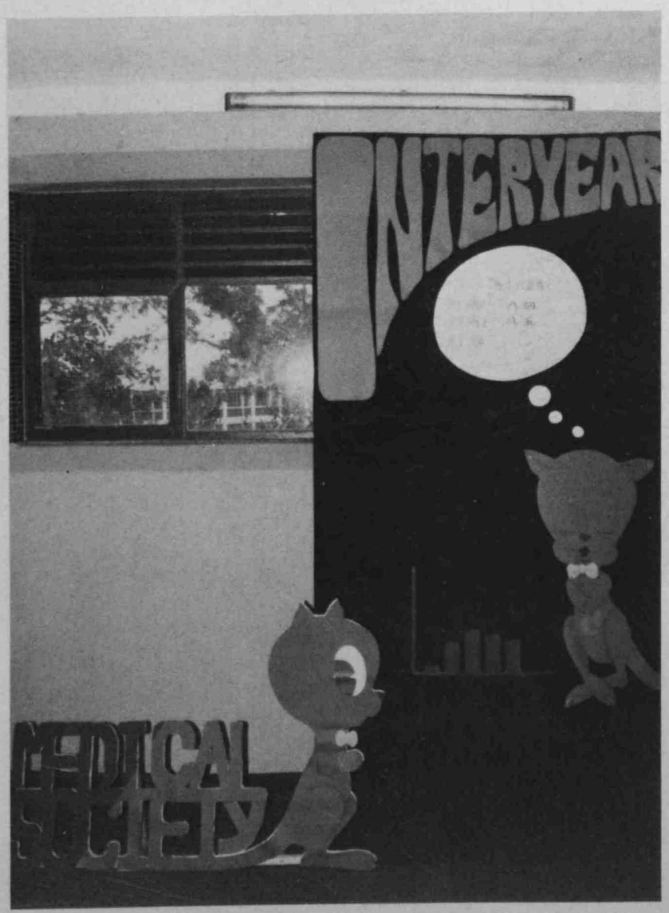
羽毛球	男子		鄭志文（89）
	女子	季軍	張秀儀（87）
曲棍球			何百昌（87）
壁球	男子		盧寵猷（87）
	女子		林婉瑜（88）
壘球			

I 陸運：

時間：13／10／84　2:00pm－6:00pm
地點：九龍仔運動場
成績：男子組冠軍：87　女子組冠軍：88
亞軍：88　亞軍：87
總冠軍（President's Cup）：88

意見：

(1)由於香港仔運動場已分配給教育司署各學校，未能公開租用，故在九龍仔運動場舉行。
(2)由於當日有太多同學欲乘校巴，故有部分須自行乘車前往。
希望以後能預先確定每班乘車人數。
(3)當日田賽項目進行極之緩慢，以使比賽至六時才能結束；最好能在比賽前於每項田賽找一位負責人，使比賽能順利進行。
(4)由於當日是inter-hall aquatic meet heats，所以有不少first year 同學未能參加，（但除此別無他日）。
(5)參賽人數共一百二十人之多（五班）顯示這段時間舉行非常適合。
(6)雖然比賽至六時才結束，但仍舉行頒獎。



II水運：

時間：28／9／84　6:00pm－8:30pm
地點：Stanley Smith Swimming Pool
成績：男子組冠軍：85　女子組冠軍：86
亞軍：88　亞軍：88
總冠軍（Gibson's Cup）：86

意見：

(1)由於比賽在九月尾舉行，距離開學祇一個星期，所以報名時間較短。
(2)泳式及起點因沒專人負責裁判，故引起些少混亂及投訴，來年希望能邀請有經驗人仕（如Swimming Club）協助。
(3)由於時間短促，故未能於比賽後頒獎。

(丙)其他活動

㊀ 足毽比賽
本於二月中舉行，但由於參賽隊伍太少而取消。

㊁ 與中大醫學院作籃球比賽

在八四年十一月三日，醫學院男女子籃球隊曾到中文大學與其醫學院的籃球隊作一友誼比賽，並於賽後互相傾談，交流經驗。

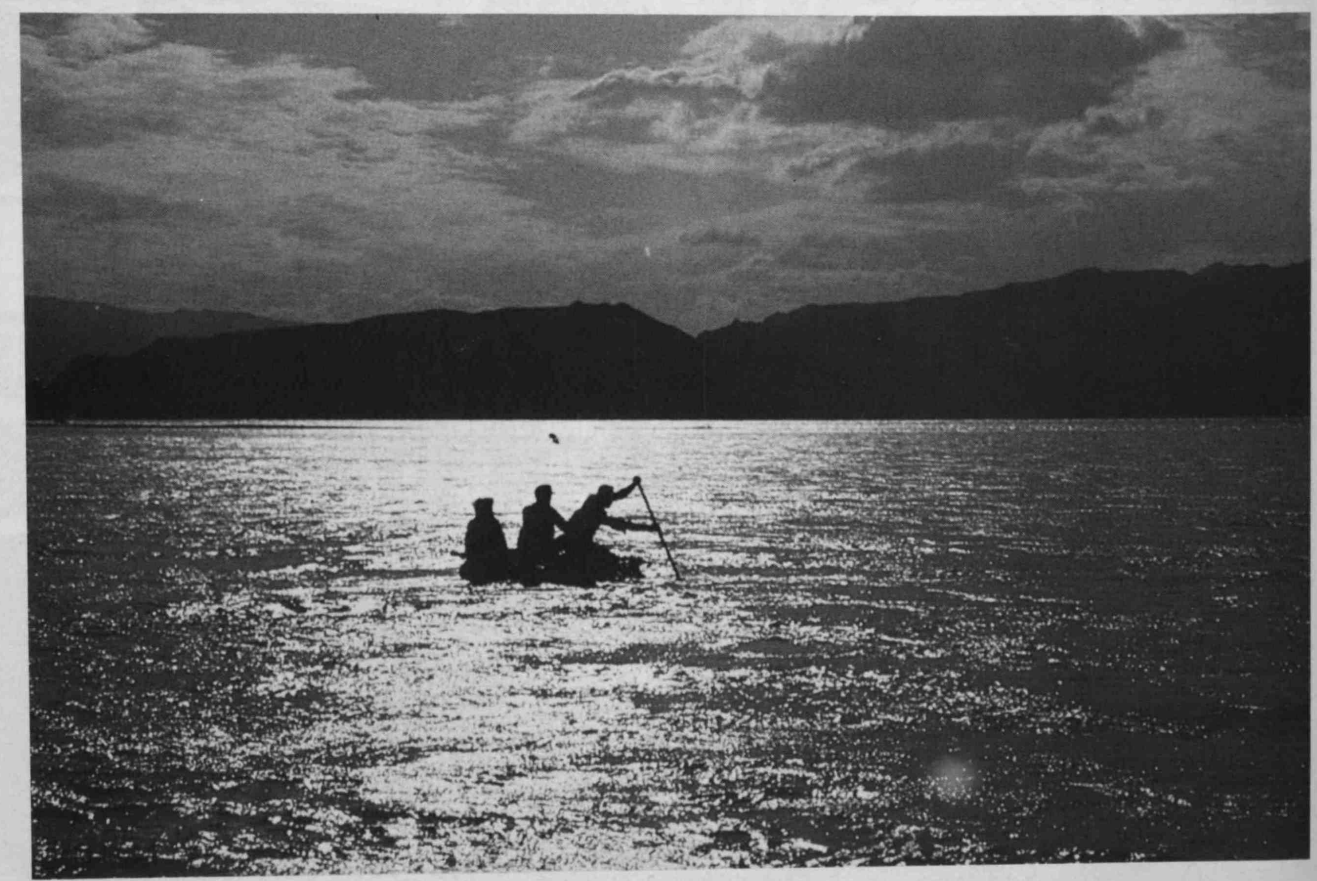
(丁)頒獎日爲八四年四月三十日，於陳蕉琴樓學生休息室學行。內容包括頒發八三至八四學年內的各項獎項（由文康秘書舉辦）。其中獎項已於前段紀錄。


國杏
ANHCNI SCIDEN

醫療訓練在中國

「……話說天山矮佬受了中州大俠華劍峯一記絕命神掌，吐血數斗，全身經脈盡斷，本道必死無疑，幸好神醫閻王敵及時趕到，以一粒九轉回魂丹保住性命，再以天羅金針大法，在他身上十八個大穴施針，加上靈芝再續膏，終於爲矮佬駁回全身經脈，得以恢復原來武功……」

中國武俠小說裏的大夫，醫術出神入化，可以說到了「有醫生，無死人」的階段，相信大家身爲醫學生，都會羨慕不已。不過如此「高明」的中國醫術，恐怕經已失傳，否則有一科「武俠小說醫學大全」，就不用再學甚麼Medicine, Surgery 。然而，現代中國內地醫生所接受的訓練，則是有根有據，亦是我們想介紹給大家的。



黃河—這裏是否中國醫學的起源呢？

醫療服務結構

因爲中國與香港的醫療服務結構不同，要了解中國醫生的訓練，首先應從其醫療制度入手。現今中國大陸的醫療制度，是從一九四九年中華人民共和國成立開始。一九五〇年，在「全國醫療服務大會」中，有關方面定了四大原則：

㈠依靠羣衆大量把健康護理普及和伸展力
㈡ 疾病預防放在第一位
㈢ 利用所有人力及醫葯資源（中西醫結合）
㈣ 健康運動要與其他運動配合（尤其農業發展）

由於當時的醫療設備簡陋，中國又是個人口衆多的農業國家，加上共產主義强調勞動力的重要性，以上原則是可以理解的。隨後數十年，這些原則基本上沒有改變，政策則由衞生部計劃及切實執行。

醫療三級制

現在全國的醫療服務架構，是一個金字塔式的轉送制度，由保健人員，保健站及醫院三個層面組成，通常稱爲「醫學三級制」。在農村裏，最基層的保健人員是赤脚醫生（Barefoot Doctor），接生員及衞生員，他們於生產大隊及大隊中，提供預防及初級醫療服務；比較嚴重的疾病，病人會轉送上第二層，即公社衞生院，公社衛生院的醫療人員主要是醫士（Assistant Doctor ）和中醫士。最後，最嚴重的病人會轉到最高層，即縣級醫院，由高等醫學院畢業的醫師（Doctor）處理。

城市中的結構也差不多，第一層是工廠及街道紅十

字站的紅十字保健工人（Red Cross Health Worker）和街坊、里巷工作人員（Neighbourhood, Lane health Worker），性質上與赤脚醫生相似，提供初級醫療，較嚴重的患者轉送地區醫院，最嚴重的轉送市級醫院或專科醫院。

這個制度，除了文革十年外，一直沒有重大改變，它針對了高級醫療人員的缺乏，使服務地方化，非專業化，因爲有了底層的過濾，高層單位可以更有效地發揮作用。

而另一方面，爲了適應整個制度，中國的醫學教育，亦作了相當程度的配合。

醫學教育

現行的醫學教育制度，由初等、中等、高等以及畢業後教育組成。

初等醫學教育

初等醫學教育的任務是培養城鄉初級衛生保健人員主要是農村不脫產（半農半醫）的衛生人員，如赤脚醫生，接生員等。培訓工作主要於公社衛生院，縣級醫院和縣級衛生學校進行。學生一般只有小學或初中程度，經過3個月至半年的初訓，學會幾十種常見疾病的治療和預防，然後便回生產大隊服務。以後，會有多次復訓，逐漸增加他們的醫學基本知識，提高實際工作能力，凡是達相當於中等衛生學校水準，經當地衛生行政部門評定的，可以授予鄉村醫生的稱號。

赤脚醫生

中等醫學教育

中等醫學教育的主要任務是培養各類中級醫葯衛生人員，例如醫士、中醫士、衛生醫士、婦幼醫士、口腔醫士、放射醫士、護士、助產士、葯劑士、中葯士及檢驗士等。這一任務由中等醫葯學校負責完成。中等醫葯學校一般招收初中畢業或具有同等學歷的青年，報考學生必須通過國家統一入學考試，由學校擇優錄取，學習年限爲三至四年。各專業的教學計劃，教學大綱和教材，均由衛生部制訂和編印出版。學生畢業後，由國家分配工作。

高等醫學教育

高等醫學教育的主要任務是培養醫師，中醫師，衛生醫師，口腔醫師，葯師，中葯醫師等高級醫葯衛生人才。這任務由高等醫葯院校負責。（詳情將於以下篇介紹。）此外，高等醫學教育還包括業餘教育、函授教育和夜間大學等。

畢業後訓練

畢業後訓練是爲接受完高等和中等醫學教育的人提供進一步深造機會的教育制度，目前大致上分爲兩類：

㈠ 研究生教育：研究生分碩士和博士研究生兩種，主要目的是培養高等醫葯院校畢業生成爲醫科研究人員和醫學院校教師，制度與外國研究院類似。

㈡ 進修教育：這是爲在職高、中級醫葯衛生人員提供進一步的學習機會。一般來說，進修內容必須與所從事的專業互相一致，學生可選擇在職或離職兩種訓練方式。體制方面則採取中央、省、縣三級管理。

高等醫學教育

概況

中國幅員廣闊，人口衆多，各省各縣，都有其獨特的環境限制與需要。雖然上文所述的「醫療三級制」差不多是全國性，但在醫療人員的訓練方面，各地方都有多少出入，以下我們嘗試把高等醫學院校的情況介紹給大家。

中國內地一九八二年共有高等醫學院校 118 間，分類如下：

醫學院校	71間
中醫學校	23間
葯學院	2間
醫學專科學校	22間

在以後篇幅，我們將把焦點放在「醫學院校」。

「醫學院校」所訓練的是西醫師，除了北京首都醫科大學爲八五制外，其他多數爲五年制，也有少數爲六年制。

國內共有五間被稱爲重點醫學院的醫學院校，其設備、師資以至學生成績等方面均較一般爲優勝。它們分別爲中國首都醫科大學、北京醫學院、上海第一醫學院、中山醫學院和四川醫學院。

教學計劃

「教學計劃」乃衞生部所制定，是各學校培育人才和組織教學活動的重要依據。然而，各院校情形有異，需要也不同，所以這計劃只是指導性文件，各校可根據實際情況，對課程設置、教學時間和課程進度安排等方面作適當的調整，以作靈活的運用。

入學資格

在香港，要進入港大讀醫科，必須通過「高級程度會考」，或具同等學歷。在國內，情況也差不多。自從七七年起，每年夏季，有志於修讀大學的高中畢業生均要參加一次由教育部負責的全國統考，並填寫申請表，列明其志願。學校方面則根據考生是次考試之成績、中學時之表現、老師的評價等，以評定其德、智、體三方面的水準，擇優錄取。考生是否被取錄，通常不會受其居住地區所限制，亦即是說，基本上，住在北京的學生也可報考上海的大學。

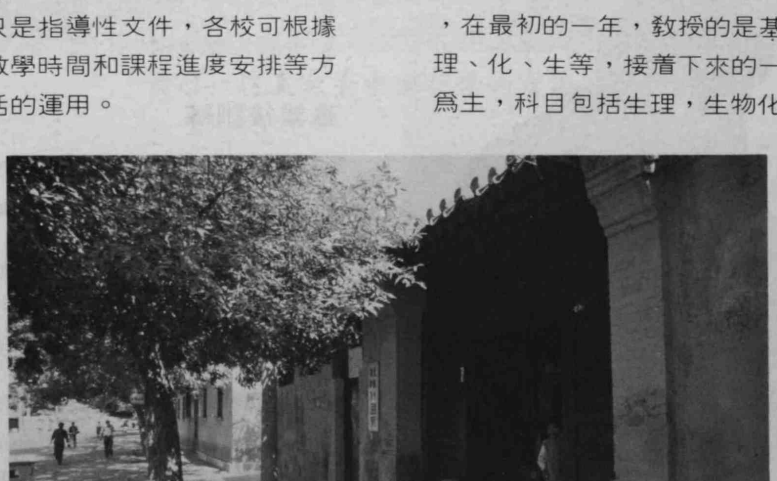
競爭情況於每間醫學院均不同，招生總數，每年也有別，這要視乎國家之需要和各醫學院所能容納的人數來作決定。八二年，全國的招生人數則爲29,486人。

教學形式與課程

國內的醫學院，除了沒有導修課（ tutorials ）外，上課形式與香港的差不多，大致可分爲大課（ Lecture ）、實驗（ Experiment ）和上醫院實習。

醫學院大多爲五年制，每年分兩個學期。這五年（即 259 週）中，時間大致分配如下：
數學 192 週，考試16週，入學教育及畢業教育 2 週，勞動和軍訓 8 週，假期39週，機動 2 週。

然而，每間醫學院的實際時間分配與課程都有多少出入，但就以上海第一醫學院（一所六年制院校）爲例，在最初的一年，教授的是基本科學，科目包括數學、理、化、生等，接着下來的一年半，則以基本醫學知識爲主，科目包括生理，生物化學、解剖學等。以後的兩



中國的一些醫院有着很傳統的外觀，而它的醫學教育亦保留了傳統醫術的傳授。

三半，學生要學習微生物學、药理學等，及其臨床科目包括婦產科、兒科、內、外科、皮膚、神經及精神科等

最後一年，學生會被派到縣級或以上的醫院裏，進行畢業實習，這以內、外、婦產及兒科爲主，但也有安排一部份時間在其他臨牀學科進行學習。

除此之外，醫學院的科目也包括中醫和政治。每間院校的學生，都會在其中一個學期裏學習一些關於中药和針灸的基本概念，學生於畢業後通常都已懂得一般中药的應用。政治也是國內頗爲重視的科目，每週約有半天政治教育，主要學習國內外形勢和黨的路線、方針、政策等。

教材

現在國內醫學院所用的教材主要在蘇聯教材的基礎上，加以演變、組織而編寫出來。文革時期，雖然各地方院校的教材水準參差不齊，但七七年後，衛生部開始再次編撰新的教材，頒發給全國醫學院作爲參考。校方則可根據自己的實際情況與特點，自行編訂教材靈活運用。

除教科書外，國內醫學院在最近數年來，也開始大力發展輔助教學工具和設備，這包括標本、模型、掛圖、幻燈片、電影和錄影帶等等，但其數量與其他先進國家比較，仍有一段相當的距離。

語言媒介

國內的醫學院，一向採用中文教學，課本以中文爲主，授課也用普通話。然而，自七九年以來，已先後有十所院校陸續開辦了五種不同言語（英、日、法、俄、德）的外語醫學班，部份或全部課程採用外文版教材，在其他很多院校也設有英文課。這些改變，都是爲了提高學生的外語水平，適應四個現代化建設和開展國際學術交流的需要。

考試

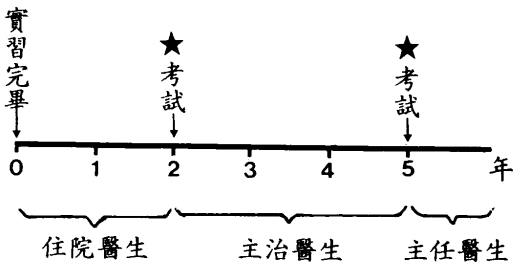
爲檢查教學效果，衡量學生的水平和提高教學質素，除了平時的測驗外，各學生在每學期完畢時均有一次考試，在學年終結的考試合格才可升級，而這些考試的安排和方法，則由學校自行決定。

自從八二年起，每年來自全國十多間有名的醫學院的應屆畢業生，均參加一次由衛生部負責的全國統考。這統考的目的，是要衡量這些醫科畢業生的水準，爲未來釐定課程時有所參考，這考試之形式爲多項選擇題，科目則包括內科、外科、婦產科、兒科及有關的基礎醫學和預防醫學知識。

畢業生之出路

醫學生畢業後的出路，大致可分爲數類：到外國進修（極少數有此機會），繼續做研究工作（即前文所述的「研究生」）、或到縣級醫院／市級醫院當醫師。畢業生有權選擇其志願，但最終還是由政府指派工作。

現在全國主要城市的醫療單位均已定下培養醫生的五年計劃，這種提升制度可表示如下：



（★經醫院評定水準）

其他

現今中國政府對醫療訓練算是頗爲重視，就讀在醫學院的學生均無需繳交學費，一切需要應用的儀器也由國家供應，而成績優異的學生更可獲得獎學金。通常學校都附設有宿舍給學生居住。

除了訓練國內學生外，中國也有派學生出洋學習，另一方面，某些醫學院也有少數外國學生，他們多來自第三世界國家。

結語

中國是一個高度政治化的國家，所以醫療政策也隨着政治、經濟方面而改變。近幾年來，國內較爲着重把醫療變得專業化，積極加强高級醫務人員的訓練；此外，受到經濟發展的影響，在一些較爲開放的地區，私家醫生和私家醫院也開始出現。

中國最終的目標就是不斷提高醫療服務的水準，保障全國人民的健康。

不斷的嘗試，不斷從過去中吸取經驗，希望……

中國農村的醫療網

● 陳俊賢

註：港大醫學會於1984年12月舉辦廣州交流團，其間參觀從化縣農村醫療網。（本文部份資料則取自廣東省從化縣衛生局。）

中國人口接近十億，其中八成以上居於鄉郊，故農村的醫療衛生一直是政府關注的問題。

從化縣轄屬廣東省，距廣州市大約六十公里，是一個中型的縣份。從化縣面積二千平方公里，總人口373,200 人。全縣分爲13個區， 5個鎮和 130個鄉。（註：區相當於以前的公社，鄉相當於以前的生產大隊）1983年全縣人平均收入爲 400元，在全省內是屬於中等水平。

衛生技術人員

鄉縣的衛生技術人員分三級：高級衛生技術人員乃受過五年訓練的醫生，佔25％；中級衛生技術人員乃受過三年訓練的衛生醫生、醫士、護士和助產士，佔49％；初級衛生人員包括鄉村醫生和赤脚醫生，接受起碼半年的訓練，佔26％。

我們經常聽聞的赤脚醫生，是一些不脫離生產的農民，多數是小學程度。他們接受六個月的基本訓練，工作包括：初級醫療服務、配藥、衛生督導、食水檢查，還提供衛生教育、免疫、傳染病控制，孕婦及嬰兒保健等。

現在估計中國大約有一百萬名赤脚醫生，可是這個數目在不斷下降。原因有三：一、很多赤脚醫生都接受複訓，然後參加省統考，合格者發給「鄉村醫生」証書。二、中國政府現在着重訓練中、上級之衛技之員，減少赤脚醫生的培訓。三，由於中國近年之經濟改革，很多赤脚醫生都棄醫務農，從而賺取更多的酬勞。

三級醫療網

從化縣醫療衛生機構，分爲縣、區、鄉三級。縣級醫療機構包括：縣醫院、衛生防疫站、婦幼保健所、藥品檢驗所和衛生學校。區有區衛生院，鄉有鄉衛生所。三級的關係是：各有分工，逐級指導，上下支援。這是一個轉送制度，即是說當下級機構遇有複雜疑難的病症時，便會轉送到上級機構處理。

1983年，從化縣有縣屬衛生單位 7個、區衛生院14個，鄉衛生所 121間、衛生分所 122間，平均每2000人有醫生一名。

縣醫院

這是一所綜合性醫院，有醫務人員 210人，設有內、外、婦、兒、傳染、五官、牙科、中醫、藥劑、放射、檢驗、病理等科室。全院病床 248張，門診每日平均800 人次，住院病人每年5500人次。

縣醫院在縣中作醫療技術指導之工作，接受各區、鄉的疑難病人和危重病人的會診和搶救。縣醫院也爲各區、鄉各醫療人員舉辦進修班，爲期半年至一年，不斷提高縣中衛技人員的技術水平。

縣衛生防疫站

工作人員32人，主要是通過三級醫療網管理及紀錄縣內的傳染病。區、鄉發現任何傳染病都要立刻報告上來。防疫站又負責疫苗之分配，殺蟲滅鼠，以及注意勞動衛生、環境衛生、食品衛生等。目前從化縣已控制了虐疾、線蟲病，其他傳染病也大幅度下降。

縣婦幼保健所

縣婦幼保健所是縣裏婦女和學齡前兒童保健的技術指導中心。它對縣內危害婦幼的疾病進行普查工作，更提供婦幼保健的一般服務，例如：定期檢查、兒童缺點矯治，計劃生育及優生工作的指導。一般婦幼健康的宣傳教育都是由它負責。

1983年，從化縣的新生嬰兒死亡率爲 8.4 ‰。產婦死亡率爲0.20‰。而產婦嬰兒死亡率爲40‰。於發展中國家是算不錯。

縣藥品檢驗所

它是負責縣內藥廠所製的藥品質量監督。無論是西藥，中藥或其他化學物品，它都會作定期抽樣本檢驗，合格率平均超過80%。

縣衛生學校

縣衛生學校負責培訓初、中級人員。1976年前，它以培訓赤脚醫生爲主。現在它主要培訓中級衛技人員，包括護士及衛生醫士。中級課程入學資格爲高中畢業，課程爲期三年，包括解剖、生化、生理、藥理、內外科、兒科、中醫等二十四個學科。三年課程後，學生參加全國統考，合格者頒發畢業証書。

衛校會視乎需要而舉辦赤脚醫生進修班，爲期半年，完成課程者參加全省統考，合格者頒發「鄉村醫生」証書。

衛校訓練出來的衛技人員，大部份都調派本縣各單位服務。衛校現有教職員24人，學生130 人。

艮口區衛生院

艮口是從化縣十三個區之一，人口二萬六千人，分八個鄉一個鎮。區內有一個區衛生院和九間鄉衛生所。

艮口區衛生院設有外、婦、內、兒科及醫技科室。一般外科手術、搶救、計劃生育手術都可以應付。它有病床42張，平均每天門診66人次。

區衛生院除了提供一般醫療服務外，還負責全區的衛生指導、衛生統計、防疫及婦幼保健的工作，提高鄉衛生所的服務和赤脚醫生技術水平也是區衛生院任務之一，它經常舉辦赤醫研習班和講座，使赤醫對一些經常發生的疾病有更深入了解。它更經常派醫療人員到鄉衛生所，整頓工作程序和添置設備。通過對赤脚醫生的培訓和整頓，提高了鄉衛生所的治愈率，使送來區衛生院就診的病人逐年減少。

艮明鄉衛生所

艮明鄉人口3700人，是一個中型的鄉份。鄉衛生所就是農村醫療網最基層的設施。衛生所有三個鄉村醫生，包括一名女接生員。衛生所的設備和部份藥物的費用是由政府資助的，但經常性的開支則由鄉村醫生自己負擔，而他們的收入就是病人付的診金，通常是0.10元至0.20元。

衛生所是24小時服務的，病人隨到隨診（每日平均30人次），特別情況下醫生也會出診。鄉衛生所有西藥74種、中草藥120種。一般的急救、常見病、消毒、產前檢查、接生的工作，鄉村醫生都可以應付。唯有10%以下的疑難病重者，則須轉送上區衛生院或縣醫院。

此外，鄉村醫生還兼營防疫、婦幼保健、計劃生育指導、中草藥採集等工作。

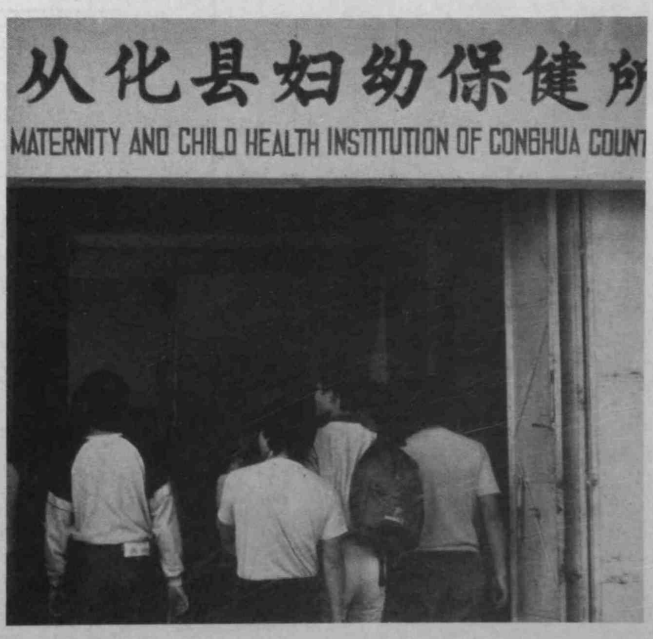
農村醫療收費

中國的醫療收費分公費醫療、勞保醫療、合作醫療和自費醫療四種。公費醫療制度，是保障國家機關幹部人員健康的一種免費醫療制度，一切醫療費用由國家支付。凡鐵路、航運及工礦企業單位的工人則享有集體勞動保險的權利。

在農村，合作醫療原本是最重要的一種醫療收費制度，生產大隊每年將農產的利潤集中，部份撥入福利金，其中部份用於合作醫療，除了福利金之外，農民還得按月繳付規定的金額。合作醫療於是提供了農民到鄉衛生所、區衛生院以至縣醫院的醫療費用。

最近的經濟改革

一九八〇年起，中國在農業經濟上起了重大的改革。生產大隊瓦解，土地分成小塊，實行責任制：定額的產品由國家以廉價收購，其餘的農民則可以高價賣出，利潤歸己有。經濟改革對醫療服務起了很大的影響，原來的合作醫療面臨瓦解。農民富有起來，對醫療水平的要求提高，他們願意自掏腰包看有高級技術水平的醫生



，譬如有病時寧願直接去縣醫院求醫。

很多赤脚醫生索性棄醫務農，因爲收入比較多，餘下的赤醫大都採取病人自費的制度。有些大隊乾脆把衛生所包給赤醫，而赤醫就要自己維持衛生所的收支平行。雖然政府有制度定診病的收費，但有些赤醫卻大大提高醫藥費，增加病人的負擔。

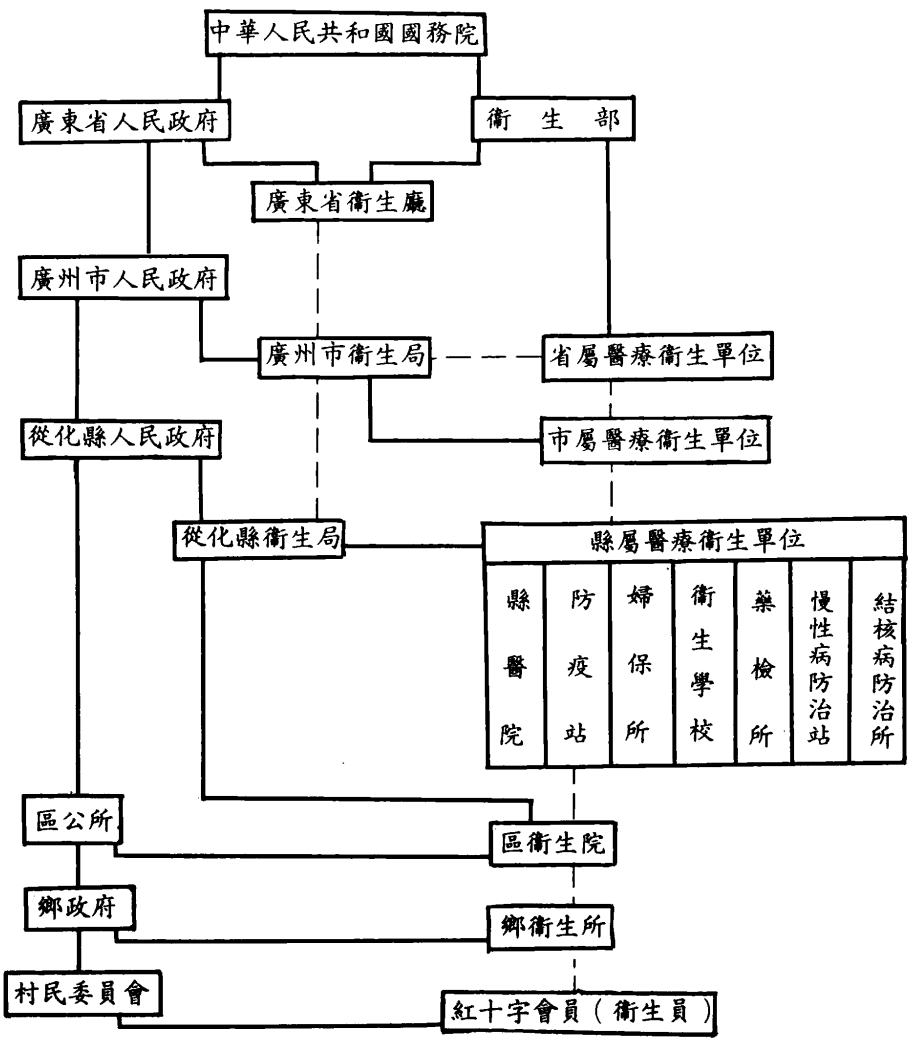
結語

要達到世界衛生組織「2000年人人享受衛生保健」的目標，就有賴各發展中國家設立一個有效而普及的初級醫療制度。中國的農村醫療制度和「赤脚醫生」是一個獨特的嘗試，可供其他國家參照。從化縣本身便是世界衛生組織的一個模範初級衛生保健中心，過去曾爲世界各國舉辦講習班和參觀團。

不過當一個國家經濟發展，人民生活水平提高時，當局就必須重新檢討原有的醫療制度。現在中國裏傳染病減少了，衛生和食水改善了，當今的問題是如何預防和對付慢性病患，如何面對環境污染，如何應付對高質素及高技術的醫療的需求。

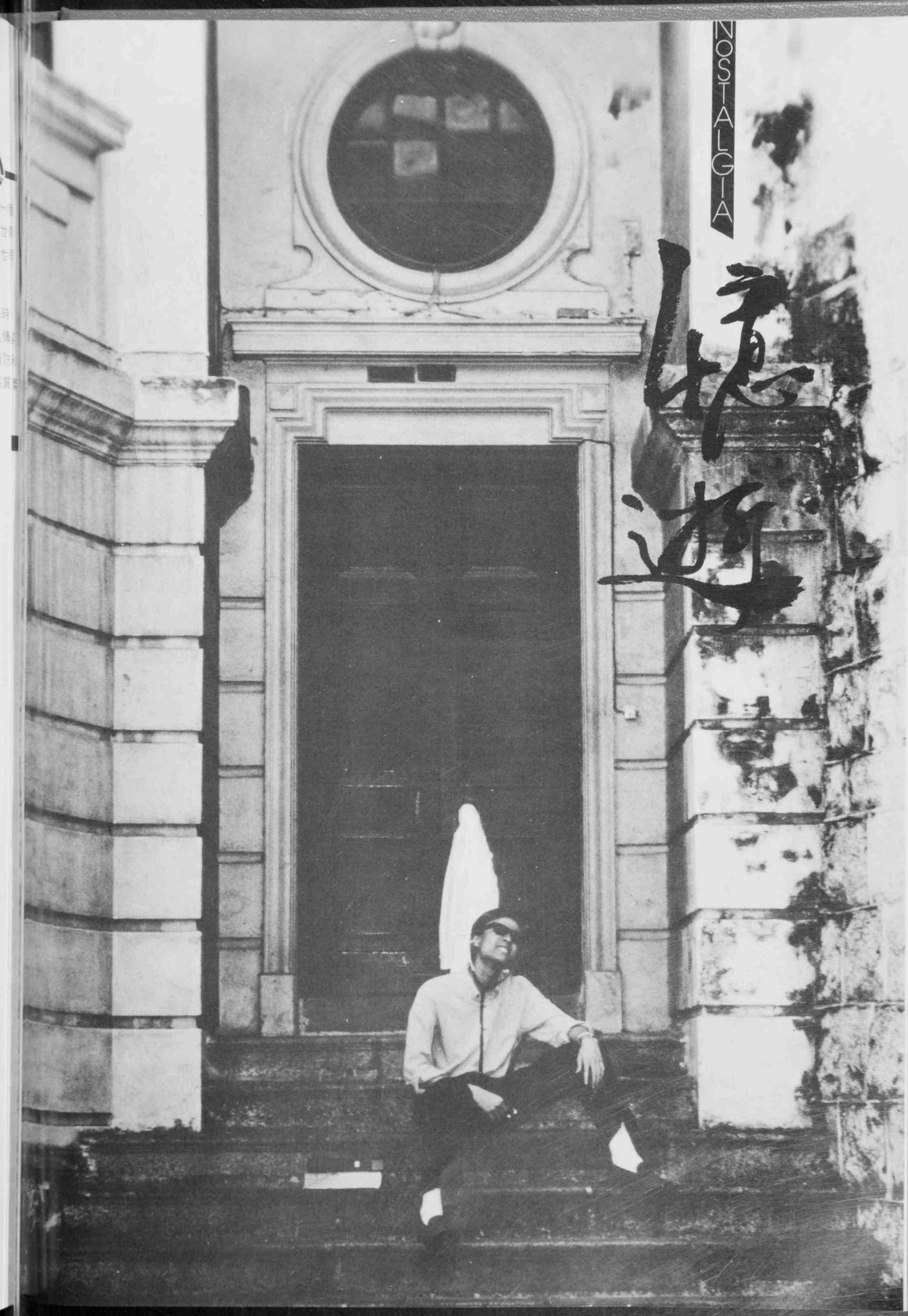
我們且看中國未來數年醫療事業的發展。

中國行政管理和衛生業務管理關係示意圖



NOSTIALGIA

懷舊




四月十五日
初一春分・十六清明
二月大廿六
本 THIS MONTH 月
下 NEXT MONTH 月
MAY 五月
星期一
13
TUESDA
八月十三日
初六大暑・廿
AUGUST 八月
八月十四日
初六大暑・廿一立秋
APRIL
1
星期一
廿一立秋
六月小廿二
二月大十二

五月廿一日
初二小滿・十八芒種
23
THIS MONTH 月
MAY
四月小初四
NEXT MONTH 月
JUNE
S M T W T F S
21
APRIL
THIS MONTH 月

WOMEN —

It has long been a well-recognised fact that the behaviour of women is related to their physico-chemical properties. This is borne out by the results of a recent research which is the joint effort of Prof. smeller, M.D., F.R.O.G. and Dr. Wolff, M.D. of the University of Utopia. The following report is the outcome of their work and proves to be of immense value to those who wish to have a better knowledge of the fair sex.

In the conduction of the research, only purified specimens of the age group between fifteen and forty-five are employed as objects of investigation, because the reactions and behaviours of individuals outside that age group are regarded to be far from typical. This is not to be taken as discriminative selection when we take into consideration the fact that chemical compounds which have been stored for too long are not used in chemical experiments in order to prevent any untoward reactions interfering with the results of the experiment.

A chemical analysis*

• Anonymous

Woman as an element :-

Symbol: ♀

Atomic Number: 107

Atomic Weight:

Unknown. This is due to the fact that most women keep their body weights as well as their age a secret. Even though they may reveal it to those conducting the research, the figures give nare far from the truth hence they are not included in this official report.

Occurrence:

Women may be found where their counterpart element, men, are present. They are usually under the common names of "Miss" or "Mrs.", depending on their status, that is, whether they occur alone or in combination with a man as a couple. However, the two names are interchangeable, for a woman may change from a "Miss" to a "Mrs." and then reverts back to a "Miss" again in no time and with no trouble at all. This illustrates an important feature of the element we are dealing with, that is, versatility, which makes the behaviour of woman so complicated and unpredictable.

Electric Charges:

A woman carries a negative charge and will attract the positively charged man by an electrostatic force the magnitude of which will be directly proportional to the magnitude of negative charge. The physical law that unlike charges will repel each other explains very aptfully why women cannot stay together peacefully for any period of time.

Valency:

The normal valency of woman is one. That is to say, a woman will combine reversibly with a man to constitute a couple. However, this is not always the case, for women, like nitrogen and phosphorus, may have more than one valency. This is due to its capability of forming hydrogen bonds. As it is well known that the hydrogen bond is mainly due to electrostatic attraction and is a very versatile type of chemical bondage, a woman may be linked loosely to more than one man at the same time, thus exhibiting a polyvalency of covalent nature.

pH;

The reaction of a woman is always to the acid side. This may be due to their high vinegar (acetic acid content).

Melting-point:

The melting-point of women is very low indeed and on melting, tears are formed. This is an advantage to women themselves and they also make use of this fact as one of their most powerful weapons.

Boiling-point:

The boiling-point of women ranks amongst the lowest of all the elements found on earth, and very often they boil with explosive force. Owing to their extreme volatility and inflammability, women should always be HANDLED WITH CARE, otherwise one will easily be singed or even inflicted with a burn of the first degree. However, one may make use of the physical law that the boiling-point will be elevated by the addition of exogenous solutes such as money or jewels to stop a woman from boiling.

Spectrum:

Woman is well known for her spectacular spectroscopic changes. When a woman is angry, she will turn red and may attain a purplish hue when the condition is severe. The most fantastic changes occur when a woman is placed beside a more refined specimen. Then she would undergo all the colour changes one can possibly observe in the visible spectrum, i.e. from red to green and then purple, and lastly returning to green.

Radioactivity:

There are several radioactive isotopes which may be found. When the atomic configuration reaches 36-22-36 or higher, they begin to emit-rays. However, the half-life of their radioactivity is not long and varies between five to ten years.

Chemical Affinity:

Woman has a strong affinity for the precious metals such as silver, gold and platinum, but she reacts most vigorously with the very common element, carbon, not the amorphous form, charcoal, but the crystalline allotrope, diamond.

Conclusion:

Broadly speaking, woman is a very dangerous element to handle and when one is determined to tackle her one should exercise the utmost care and should arm oneself with a detailed knowledge of her properties and with such accessories as diamonds and jewels etc. Without woman, there would be much less trouble in this world but without this source of trouble, what is the fun of living? ■

* *The article is extracted from Elixir '63 (No. 2, P46-48)*

「萬般皆下品！？唯有讀醫高！？」*

● 陳嘉富

近日，不斷聽到社會人仕談及香港非常缺乏醫生，雖加上從外地聘來的，亦不敷應用。於是有人認爲政府應增加醫官的薪金，或是畢業生的服務應硬性延長，又或應以獎學金來鼓勵醫學生參加政府醫院。以上任何一點，均指出社會實在需要更多醫生，應付醫療問題；祇從海外聘取並非治本的辦法；既然醫生的需求是這樣急切，我們醫學生實無須顧慮到職業問題。這想法也許是太自私，但這確實給予我們很大的「安全感」。

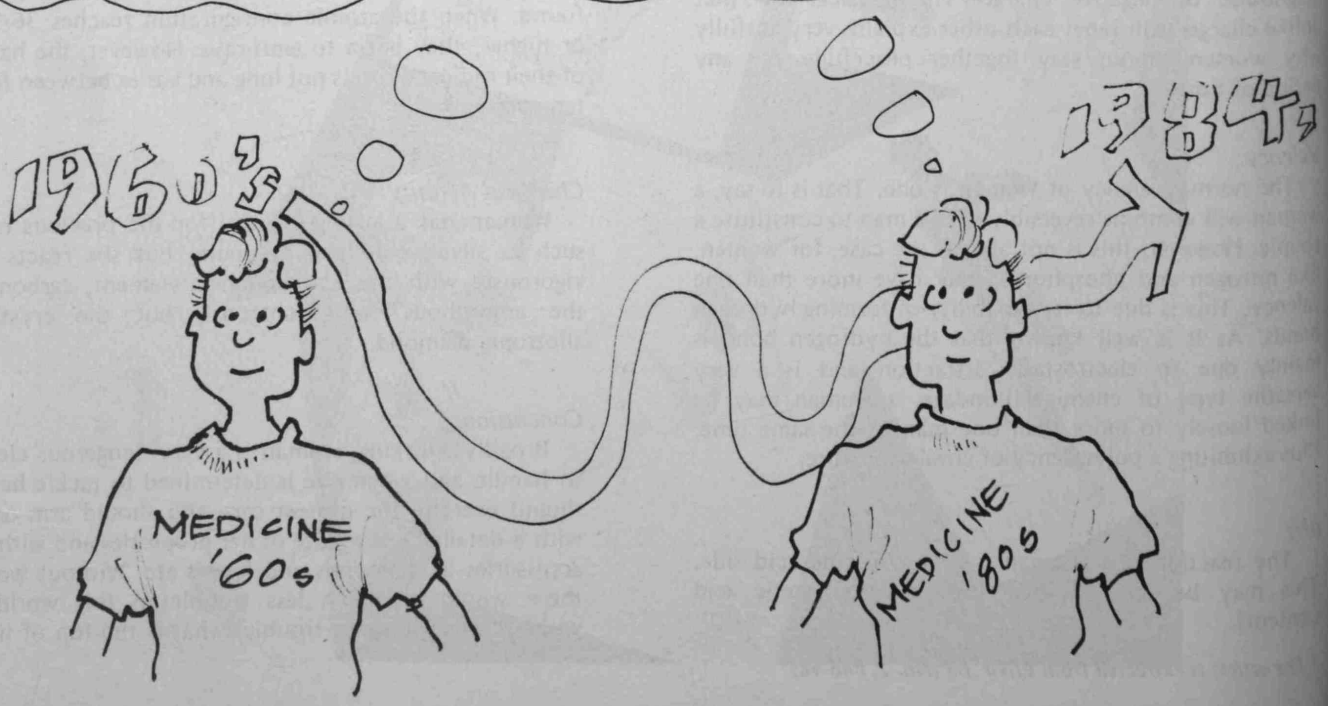
大家都知道，醫生的生活是最安穩不過，一經政府承認，少有要爲生活担憂的。若不設立私家醫務所，亦很容易在政府醫院謀一位置；生活有了保障，醫生便可以安心工作了，在閒暇時，還可以旅行、散心、或玩哥爾夫球，調劑千篇一律的日常生活。在財富方面，一個私家醫生不比大商家差，在地位方面，醫生最受人稱譽的；這並不言過其實，醫生用學識來賺取診金，若用本利算式來計，幾乎是一本萬利，單舉一個例子，稅務局估計某一醫生在幾年來，瞞稅超過二百萬，如此推算，他的收入比普通大商家要多幾倍呢！醫生除擁有財富外，還到處受人尊敬，他們的財富是以正當途徑得來，而醫治病人又是一件救人的工作，所以能獲得普遍的崇敬。

社會人仕既尊敬醫生，也同樣尊敬醫學生，而且政府很重視我們，因爲我們是醫院的「接班人」，由此我們可以得到很大的信心來完成學業。嘗有人以此爲笑語：「當讀到第四年的時候，就可以購定藥箱了」，這話是言之過早，但可見醫學生的前途是明朗的，祇要考試沒有問題，志願一定能達到。

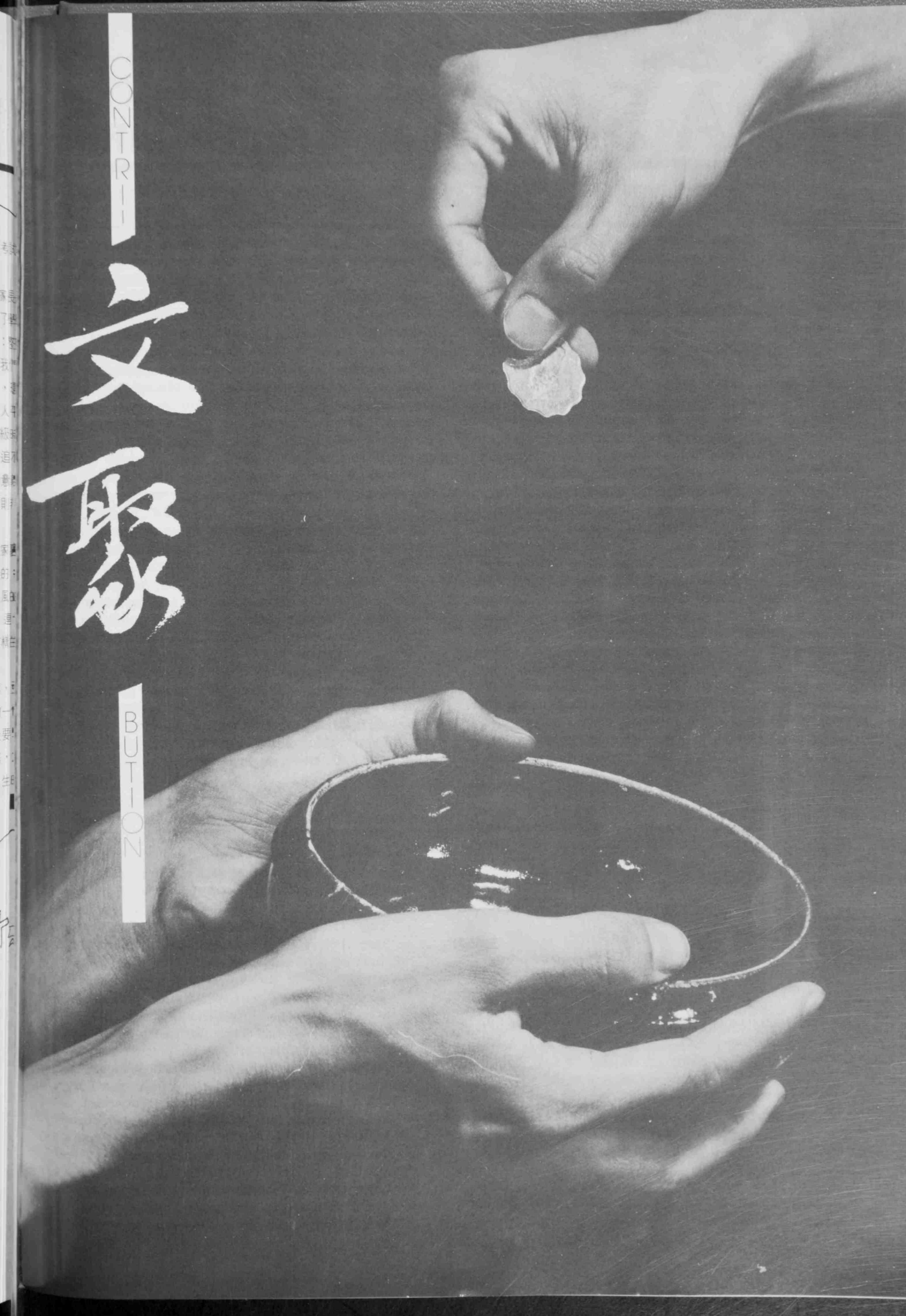
我們的各樣好處，可使外人非常羨慕。連一般家長的心理，都很希望兒女能成爲醫生，若有兒子考取了學位，便比中獎券還歡喜。但我們的生活卻並不輕鬆：整天都担心考試不及格，而這樣的心理最難受，因爲我們在考試上缺乏安全感。晝讀夜讀，亦一樣會「肥」，環顧其他學系，有的祇要幾晚通宵便可應付過去；別人平時隨處遊玩，我們卻是在圖書館裏「啃書」；高年級時，連假期也少得可憐，功課繁緊，稍爲放鬆，即有追不上的感覺，確實體驗到「學如不及，猶恐失之」的意義，苦處是不是爲外人道的，若問誰是最苦的學生，則非「醫」莫屬了。

不過，醫學生的辛勤又並非完全沒有報酬。在家裏，讀醫的兒子是寵兒；在路上，醫學生是昂首闊步的；想想打着醫學會呔在學生會的走廊上走，是何等威風的事；事實上，高年級的無不帶着一副威嚴的面孔，連低年級的看見了也要生畏，當然後者亦渴望將來有這樣的一日。

美好的遠境，給我們很大的鼓舞，明確的目標，免去我們多餘的焦慮，深自慶幸我們已成爲醫學院的一份子。誠然，我們明白財富與地位不是最重要的，最要緊的是能夠做一個有用的人。我們要盡力爲社會服務，爲人羣謀幸福，不要變成一副賺錢的機器，失落了人生的意義。■



*以上文章原載於杏雨六九第一期中文部份第七頁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BUTION

On A Slow Boat From China

● PROFESSOR YUET-WAI KAN

Professor Y.W. Kan is one of the most distinguished graduates of the University of Hong Kong. He entered the University from Wah Yan College and qualified M.B.B.S.(Hons.) in 1958 with distinctions in Social Medicine, Medicine, Surgery, Obstetrics & Gynaecology. Following internship and one year as Assistant Lecturer in the University Department of Medicine, Queen Mary Hospital he left for postgraduate training in Haematology and Medicine in the U.S.A., studying at Harvard Medical School, Massachusetts Institute of Technology, McGill University and University of Pennsylvania. He returned to Harvard Medical School as Assistant Professor in 1970 and joined the University of California, San Francisco in 1972 as Associate Professor of Medicine and Chief, Haematology Service, San Francisco General Hospital. He became full professor there in 1977, and in 1979 was also appointed a professor of Biochemistry and Biophysics in the same University. Since 1976 he has been an investigator of the Howard Hughes Medical Institute Laboratory for the Study of Human Genetic Diseases and in 1983, was appointed Louis K. Diamond Professor of Haematology and Head of the Division of Genetic and Molecular Haematology at the University of California, San Francisco. His teaching and research career has been brilliant. His contributions to the understanding of the molecular biochemistry and genetics of sickle cell anaemia and thalassaemia and the application of molecular and recombinant DNA techniques to the prenatal diagnosis of these conditions have established him as one of the leading medical scientists today. Honours he has received include the National Institute of Health Research Career Development Award (1975); Dameshek Award, American Society of Haematology (1979); Stratton Lecture Award, International Society of Haematology (1980); Litchfield Lectureship, University of Oxford (1980); the Harvey Lecturer at the Harvey Society, New York (1980-1981). He was K.P. Stephen Chang visiting Professor at this University in 1982. In 1984, he was recipient of the Gairdner Foundation International Award which recognizes "outstanding contributions in the field of medical science". In the same year, he was recipient of the Lita Annenberg Hazen Award for excellence in clinical research: this annual award is to a physician whose "investigative studies have changed the medical profession's perception and treatment of disease".

In 1980, he was awarded the D.Sc.(H.K.) which is the highest scientific degree awarded by this University. In 1981 he received the M.D.(Honoris Causa), University of Cagliari, Italy and the D.Sc.(Honoris Causa), Chinese University of Hong Kong. In the same year, he was elected F.R.S. (Fellow of the Royal Society) London and is the first Chinese scientist so honoured. In recognition of his distinguished contributions in medicine, he was elected F.R.C.P.(London) in 1983.

"On a Slow Boat from China" is a heart-warming and stimulating account of Professor Kan's career to date. It is related with modesty, sincerity and humanity. The single-mindedness with which he was dedicated his life to research and seeking scientific truth for the betterment of mankind should be an inspiration to us all.

Professor D. Todd
Head Department of Medicine
University of Hong Kong

The Lita Annenberg Hazen award is given annually for excellence in clinical research. It is indeed a great honor to follow in the footsteps of such distinguished previous recipients as Jesse Roth, the late Henry Kunkel, Aaron Lerner, Michael Brown, Joseph Goldstein, and Robert Lefkowitz. Rather than using this opportunity to present yet another scientific review, which I try to avoid doing as often as possible, I thought I would share instead some personal experiences along the road to the development of prenatal diagnosis for sickle cell anemia and thalassemia. In doing so, I will be able to acknowledge many of the colleagues who have been instrumental in helping me during the course of my career.

My decision to go into medicine was a simple one. I was the youngest of 14 children. Some of my brothers had already gone on to become successful businessmen and lawyers, but none were physicians. My father said to me one day, "You are going to be a doctor," and I made up my mind. After finishing medical school at the University of Hong Kong. I took a different route from other graduates. At that time, most would go to Great Britain to obtain additional training, sit for one of the examinations given by the Royal Colleges, and then return to Hong Kong. Through the urging of my teacher and good friend, David Todd, I decided to visit the United States before going to England. Much to my surprise and that of everyone in Hong Kong, I never left.

My first exposure to research was in Frank Gardner's laboratory at the Peter Bent Brigham Hospital where I was a fellow in hematology. The Brigham, then under the direction of George Thorn, was an exciting experience for me and opened my eyes to the possibilities of academic medicine in this country. I decided to get additional research training in Vernon Ingram's laboratory at the Massachusetts Institute of Technology, where I studied the structure of hemoglobin. In addition to providing the impetus for my scientific training, Boston also changed my life dramatically for I met Alvera Li mauro. We married and I then went to work with the late Louis Lowenstein in Montreal. During this second fellowship, a resident in pediatrics asked me to see an infant with hydrops fetalis. I remembered several years earlier reading

a paper by Lie-Injo Luan Eng from Indonesia in which she described such a syndrome caused by homozygous α thalassemia.[1] Studying this patient profoundly affected the direction of my research.

The opportunity of studying thalassemia arose when David Nathan, whom I knew from the Peter Bent Brigham days, asked me to join him. He had moved to the Children's Hospital Medical Center in Boston, one year before Louis K. Diamond retired. Dr. Diamond, whom I first met when I arrived in Boston, has continued to be a source of support and inspiration throughout my career. I began studying the different thalassemia syndromes using protein synthesis analysis. We defined the various α thalassemia phenotypes by globin chain analysis. I became interested in the synthesis of the different types of globin during the newborn period. When Alvera went into the delivery room for the birth of our second child, Debbie, I handed the obstetrician a heparinized tube and asked for some cord blood. Thereafter, a pediatric resident came to the house once a month to draw Debbie's blood. She served as the normal control for a study that was later published, and I still regret not acknowledging her in the paper.[2]

The next logical step was to study globin synthesis during fetal development. Several papers had been published describing the synthesis of adult hemoglobin in the fetus. I was intrigued by the idea of using globin chain analysis to detect and quantitate adult hemoglobin synthesis in the fetus and the possibility of applying this method to prenatal diagnosis of sickle cell anemia and thalassemia. Indeed, just before I left Boston in 1972, we successfully detected the presence of sickle hemoglobin in a sample of fetal blood using an assay that required only microliters of fetal blood.[3]

In late 1971, Stephen B. Shohet asked me to look at a position at the University of California in San Francisco. Steve was a friend and associate from David Nathan's laboratory who had just moved to UCSF. The decision to leave Boston was not an easy one as life was comfortable there. I was in a good hematology division, my research was progressing reasonably well, and I did not have to worry about getting grants (David Nathan did!). However, I felt it was time to start out on my own.

In 1972 I moved to San Francisco and assumed the position of Chief of Hematology at the San Francisco General Hospital, one of the three teaching hospitals of the medical school. Fortunately, I was able to persuade Andrée Dozy, who had come to Boston after many productive years with Titus Huisman in Augusta, Georgia, to move to San Francisco with me. I concentrated my research in two areas: development of a prenatal test for sickle cell anemia and thalassemia, and study of the molecular mechanism of thalassemia.

Although the work in Boston had demonstrated the theoretical feasibility of analyzing fetal blood for prenatal diagnosis, the actual technique for obtaining the blood was not yet available. Soon after arriving in San Francisco I attended a meeting on genetic diseases and ran into Carlo Valenti, an obstetrician from Downstate University in Brooklyn. Carlo had made important contributions in the development of prenatal diagnosis and was one of the first to perform amniocentesis for Down's syndrome. He asked me to come to Brooklyn and we designed an experimental protocol to see if fetal blood could be obtained by placental puncture. Altogether I spent five weeks in Brooklyn. The results were exciting – from the outset we had a high rate of success with the fetal blood sampling procedure.[4] Back in San Francisco I was fortunate to meet Mitchell Golbus, an obstetrician who was interested in developmental genetics and prenatal diagnosis. He set up the fetal blood sampling procedure as a method for prenatal diagnosis.

Soon after Mickey and I began working together, I received a call from a couple in Peoria, Illinois who had obtained my name from Carlo Valenti. They were of Italian background and had first contacted Carlo enquiring about the possibility of a prenatal test for β thalassemia for the child they were expecting. They already had one child affected by homozygous β thalassemia and knew first-hand the terrible emotional and economic burden the disease causes. Carlo was about to move to Italy and referred them to me. At that time no one knew whether or not it was possible to detect the β thalassemia phenotype in the fetus, although we strongly suspected it was. I explained the experimental nature of the procedure to the parents, but they were insistent about undergoing the test. They flew to San Francisco and as luck would have it, Mickey obtained fetal blood with the first sample. Fraction collectors were notorious for failing at critical moments, so I stayed up all night watching each tube being collected. The results indicated that about half the normal amount of β-globin chains were being synthesized in the fetal blood. The most reasonable diagnosis was β thalassemia trait, but without any previous experience we could not be sure. I remember sitting up yet another night worrying about what to say to the parents, because I know how patients often follow the physician's advice, depending on how he expresses his opinion. About 2 o'clock in the morning, I called Hong Kong and had a long chat with David Todd about this, not that he (or anyone else at that time) could have given me any scientific answers, but just to make myself feel better. The next morning I told the parents that based on the findings, our most reasonable guess was that the child did not have homozygous β thalassemia. They decided to continue with the pregnancy and the diagnosis was confirmed at birth.[5] The parents were so happy that they took out an advertisement in a Peoria newspaper to thank everybody. And rightly so, because this was the first successful prenatal diagnosis for a hemoglobin disorder.

The next series of interesting experiences in connection with prenatal diagnosis arose from my collaboration with Antonio Cao of the 2nd Pediatric Clinic of the University of Cagliari in Sardinia, Italy. Carlo Valenti first introduced me to Antonio at a meeting in Vienna in 1973. Thalassemia is a major health problem in Sardinia and hundreds of children with homozygous βthalassemia were being seen at Antonio's clinic. The first time I visited

Sardinia in 1974 I was impressed by the number of children being transfused each day. Antonio, who is one of the most knowledgeable and energetic pediatricians I have ever met, was extremely interested in the idea of prenatal diagnosis and decided to send someone to my laboratory to learn the techniques. However, before all the logistics had been worked out, some Sardinian couples had already caught wind of the possibility of prenatal diagnosis and decided to come to San Francisco for the test. Practically none of the mothers spoke English; indeed many had never before been out of Sardinia. I had to meet them at the San Francisco airport and drive them to the hospital. On several occasions the women missed their plane connections in New York and arrived at 2 o'clock in the morning. I became very familiar with the Italian word "stanca" (tired). One woman whose test was scheduled for the next day came in on one of the delayed planes after traveling for more than 24 hours, and fell asleep during the fetal blood sampling procedure. That was the smoothest test we ever performed! Altogether, about 30 women flew to San Francisco for the test before the procedure was set up in Sardinia.[6] Antonio's clinic is now one of the most advanced prenatal diagnosis centers for thalassemia. The first mother tested in San Francisco named her son after me. Imagine an Italian boy called Ignazio Yuet!

I was also interested in the molecular mechanisms responsible for the thalassemia syndromes and these studies lead to the next phase of development – the use of DNA analysis for prenatal diagnosis. Not long before I moved to San Francisco, David Baltimore and Howard Temin discovered reverse transcriptase[7,8] which opened up a new technology for studying thalassemia at the nucleic acid level. I had no formal training in biochemistry, apart from the rudiments I learned in medical school; to me DNA was that stuff in the nucleus. I was extremely fortunate in San Francisco to obtain the help of Harold Varmus, Mike Bishop and one of their postdoctoral fellows, John Taylor, who assisted Andrée Dozy and me in setting up nucleic acid analysis for thalassemia.

Alpha thalassemia had interested me ever since I saw the first hydropic infant in Montreal. We already knew that no α-globin chains are synthesized in fetuses affected by the homozygous form of the disease. We used nucleic acid hybridization to determine whether the α-globin genes are present or absent in the genome of such infants. The answer came back loud and clear – the α-globin genes are deleted from the chromosome.[9] This was the first time ever that gene deletion had been demonstrated as the cause of human disease. We further showed that in hemoglobin-H disease, one of the four copies of the α-globin gene remains,[10] confirming the hypothesis put forward by Herman Lehmann that the α-globin structural genes are duplicated.[11] Our findings also paved the way for applying DNA technology to the diagnosis of the thalassemia syndromes. Instead of relying on fetal blood analysis, we could now study DNA obtained from amniotic fluid cells, which are fetal in origin. This was a major improvement, since amniocentesis is a much easier and safer procedure than fetal blood sampling. We performed our first test using DNA analysis on a Chinese woman and correctly predicted that the fetus was heterozygous for α thalassemia.[12]

In the mid 70s the art of recombinant DNA was born. Being at the University of California San Francisco was an advantage since the discovery resulted from a collaboration between Herbert Boyer of our university and Stanley Cohen of Stanford.[13] The technique added an entirely new dimension to the study of the hemoglobinopathies and thalassemia. For the first time, we could define the human genome in molecular terms, and also use the technique to directly detect human diseases. We studied the different types of α thalassemia and again confirmed that the α-globin genes are deleted. We were also able to prove Lehmann's hypothesis[14] that in black α thalassemia only one out of two α-globin genes on each chromosome is deleted, and therefore this population does not experience the severe form of the disease.[15]

As so often happens in research, the next dramatic discovery arose almost by accident. Andrée was gene mapping a number of DNA samples from patients with α thalassemia using a mixed cDNA probe with sequences homologous to the α- and β-globin genes. On one of the digestions with the restriction enzyme *Hpal*, she noticed a band out of place in a sample from a patient who also happened to have sickle cell anemia. Further analysis showed that the abnormal band originated from the β-globin structural gene. But it was clear from the nucleotide sequence that the DNA at the six position of the β chain, the site of the sickle mutation, was not the recognition site for the enzyme *Hpal*. Further mapping showed that the abnormal fragment was caused by a mutation of the DNA flanking the β-globin structural genes. As we studied more cases, it became apparent that the loss of this site was frequently linked to the sickle mutation.[16] This discovery led to a new method of genetic analysis using restriction site polymorphism as linkage analysis. We went on to demonstrate that the sickle mutation was detectable in about 70% of the American black population. The sickle genes from West Africa carried the mutation that abolishes the *Hpal* site, whereas the genes from East Africa, Saudi Arabia, and India did not.[17] These findings strongly suggested multiple origins for the sickle mutation in world populations. Thus, DNA polymorphism could also be an important tool for studying genetics and evolution.

This discovery also had great implications for prenatal diagnosis. Rather than relying on fetal blood, which had to be obtained through a complicated and often risky procedure, prenatal diagnosis could be achieved analyzing fetal DNA obtained by amniocentesis.[18] Although the *Hpal* test for sickle cell anemia was superceded by a more direct method of analysis using the enzymes ***Mst II***.[19] The principle of restriction site polymorphism has proved useful in a wide variety of other genetic diseases for which direct analysis is not possible. In addition, random DNA probes are being generated to search for unknown disease

loci by linkage analysis. The latest success in this regard was James Gusella's discovery of a DNA probe linked to the Huntington's chorea locus.[20]

A number of events have been pivotal in formulating my career. Through the encouragement of David Todd, I decided to take up hematology and come to America. My choice of Brigham was fortunate both scientifically and personally. The chance finding of a patient with α thalassemia stimulated my interest in thalassemia research, which was made possible by David Nathan's offer of a position. My long association with Andrée Dozy whose diligence and meticulous work are legend has been responsible for many of these results. The move to San Francisco in 1972 forced me to rethink my approach to research because I was out trying to make it on my own in the cold world. The move happened to coincide with the advances in DNA technology which were taking place all around the San Francisco bay area at that time. In 1976 I became an investigator with the Howard Hughes Medical Institute, and this appointment has given me additional time and resources for my research work. The continued support of Louis K. Diamond, first in Boston and then in San Francisco, has also been instrumental. The University of California recently established an L.K. Diamond chair in hematology, and I was honored with the appointment. Of course I should not forget to mention the contribution of my wife Alvera, not only because of her support and encouragement, but because she strongly influenced my decision to stay in this country. ■

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Requests for reprints should be addressed to Yuet-wai Kan, M.D.,F.R.S., Louis K. Diamond Professor of Haematology, U426, San Francisco, CA 94143

HEALTH CARE AND MEDICAL EDUCATION: THE DILEMMA AND THE WAY FORWARD

● F.P. Lisowski
Department of Anatomy
University of Tasmania
Hobart, Tasmania, Australia

Introduction

This paper is concerned with the broader considerations of medical education and health care. At the outset one has to remember that these two issues are interrelated and have been influenced by historic and socioeconomic developments. Certain major features stand out. Medical education is part of the whole health care spectrum and health care is of national importance.

Health Care

In western countries, and this includes Japan, health care is facing a crisis. The costs are rising steeply and the actual health benefits are static or even declining. Many developing countries, anxiously copying the most advanced medical technology, are on the verge of bankruptcy and are unable to solve even the barest health problems.

These are profound issues that concern all those involved in the development of health care.

If one examines data for 1971 to 1972 on the physical health pattern of 22 western countries, and in this Japan is also included, one finds some rather disquieting features (Maxwell, 1975). According to different criteria of health – infant mortality, maternal mortality, mortality in the middle-aged, etc. – one finds that the first seven countries were in this order: Sweden, the Netherlands, Norway, Switzerland, Denmark, Japan and England. The 21st country was U.S.A. and the last Portugal. Each of the first seven countries had a lower concentration of doctors in 1970 than the U.S.A. (Maxwell, 1975). And yet U.S.A. spends relatively more on health than any other country.

In 1932 the Committee on the Costs of Medical Care produced a report on the American situation which documented the great disparity in medical care according to income. Visits to the physician, hospitalization, dental care, etc. were all strongly related to family income. And this is a situation that has not changed much over the years. The report implied an important principle: the sale of medical care as a commodity distributes that care to those who can pay for it rather than on the basis of need.

It has been found in America that the poor at all ages receive less care relative to their need for medical care. The disparity between need and what is received is especially great for children (Andersen, Kravits and Anderson, 1975). Another finding is that physicians generally do not locate their offices in poor or minority communities (Salber, 1976). It has to be noted that as of 1971 some 35.5 million people of America were officially defined as poor (Cambridge Research Institute, 1976). Approximately 25 million people lack health insurance of any kind, and 40 per cent of infants and young children are not even fully vaccinated (Himmelstein and Woolhandler, 1984).

One also finds that some of the work done by hospitals could have been done as effectively or almost as effectively outside hospital, and certainly more cheaply; and that some of what is done in hospitals today is of little or no proven benefit. In the last two or three decades the health expenditure has increased unjustifiably high – and on the whole unfruitfully – on the hospital side with far less available for the community. To take only one example, an American congressional report estimated that in 1974 approximately 2.4 million unnecessary operations were performed in that country, resulting in 11,900 avoidable deaths and a cost of US$3.9 billion (House Committee on Interstate and Foreign Commerce, 1976).

The pharmaceutical drug scene in western countries is also one of deep concern, the ever increasing use of powerful drugs.

American hospitals take in some 30 million patients a year and of these approximately 6 million hospital in-patients, one-fifth suffer an adverse drug reaction (Bradshaw, 1978). A 1974 estimate gave 60,000 as the very minimum likely number of deaths in U.S. hospitals due to pharmaceutical drugs (Talley and Laventurier, 1977). For comparative purposes the mortality rate for motor vehicle accidents was c. 50,000. And in England there are almost 3000 deaths a year due to drugs – overdosage or adverse side effects (Leading article, *British Medical Journal*, 1976).

The total number of prescriptions for drugs in the period 1964 to 1974 increased by 50 per cent in U.S.A. by 200 per cent in France and by 25 per cent in the U.K. (Gould, 1974).

To take another example, antidepressive drugs are used widely in the west to relieve tension and anxiety: in England alone some 45 million prescriptions were issued in 1973 (Office of Health Economics, 1975), and 144 million prescriptions for such drugs were issued in U.S.A. in 1972 (Blackwell, 1973). And there has been a considerable increase since then.

Lack of knowledge and sophistication in the proper therapeutic use of drugs is one of the great deficiencies of the average American physician (Koch-Weser, 1973). And this situation applies also to other western countries. Over prescription-over use of pharmaceutical drugs is rampant (Bliss, 1976).

The situation with regard to modern high technology drugs is quite serious. We know little about the delayed adverse drug effects, i.e. those that might develop months or years after a drug is stopped (Bradshaw, 1978). It was in this way that thalidomide and its effects, tetracycline tooth staining, delayed aplastic anaemia due to chloramphenicol were missed. Similarly the use of certain estrogens for menopausal symptoms, which became very prevalent in the 1960s, has shown that there is an increase in the risk of cancer of the uterus by 5 to 14 times (Editorial, *New England Journal of Medicine*, 1975). We now know that in certain cases where mothers have taken certain types of estrogen containing contraceptive pills their daughters have developed vaginal carcinoma at the ages of 20 to 27 years.

From these and other studies it is evident that the people of the western world generally are over dependent on pharmaceutical drugs and that now to a great extent their lives are managed with such drugs. And it is the pharmaceutical companies, the media, the doctors and other agencies who are to blame for this situation. One has to note that for as long as this situation continues for so long one can expect millions of adverse drug reactions a year and tens of thousands of deaths. Western civilization has become soaked in its drug technology, and it is hard to see a way out of this situation.

A major contradiction in western countries is that the health services like to deal with only the top 10 per cent of the health pyramid. Medical education is such that it teaches the new professionals to favour the highest technology, and medical research and development is such that it likes to generate only the highest technology. Resource distribution in the medical sector is such that 80 to 90 percent of the resources go to meet 10 to 15 per cent of the health problems. Health research has focused on the narrowly technical components of disease rather than on the broader economic and physical environments so central to the population's health status. Technological medicine has made doctors dependent on capital-intensive commodities, ones that require substantial capital investments. The interests of doctors, hospitals, research scientists and medical industrial corporations all coincide in the promotion of expensive medical technology. They have built a profitable symbiotic relationship based on the commodity system of medical care.

Once a service or product is developed, the major medical interest groups determine its market. The growth of clinical laboratory testing illustrates the effectiveness of these market forces. Vast numbers of tests are undertaken that are unnecessary. The cost of this type of service and other medical technology in a commodity medical care system is enormous and rising at essentially geometric rates. In America medical technology is estimated to account for half the increase in costs of hospital care from 1965 to 1974, a period in which hospital expenditures tripled (U.S. Congress, 1976).

One can build more and more hospitals and fill them with more and more expensive machines. As a result people believe that they need not bother too much about taking responsibility for preserving their own health and that when something goes wrong the "wonderful" hospital will put it right. But that just is not so.

Life expectancy in western countries has either failed to increase or else increased only a little in the last 20 or so years. In fact for certain sections of the people in certain countries it actually decreased. According to World Health Organization (1974) figures life expectancy has dropped in 15 out of 25 western countries. Such a drop in life expectancy must always be taken seriously, especially if it is not just a small, temporary drop affecting merely one or two countries.

The causes for this mortality situation are cardiovascular and cerebrovascular diseases, certain cancers and respiratory diseases and accidents. And the factors mostly involved in the causes of these conditions are: tobacco, air pollution, too much food of the wrong type (especially saturated fats, fibre-deficient sugar and white flour; cancer-producing foods, e.g. certain food additives), cancer-producing chemicals at the place of work or in the home, lack of exercise, the automobile, stress of life and alcohol. These causative factors are characteristic features of the western way of life. It is the life-style of that society that is inimicable to health.

How do western doctors respond to the variety of lethal or disabling diseases? By treating them at a late stage and usually in hospital by high-technology means and on the whole with very little success. Hospital medicine, although it has not yet reached a counter-productive stage, is nonetheless relatively powerless to deal with this flood of new conditions.

The contributions of the academic departments of medicine to the understanding of disease are established

and real, and they have helped to make possible the deployment of the discoveries of modern medical science, both in relation to treatment and in diagnosis. However, one must face the fact that these departments have not been responsible for, nor even seriously involved in, any of the discoveries in therapeutics or preventive medicine (Platt, 1967). Those who have been responsible for the major advances in these fields in the west have been non-clinical scientists, engineers, teachers, farmers, public health authorities, and so on.

Historical epidemiological evidence overwhelmingly supports the conclusion that medical science has played a relatively small role in reducing morbidity and mortality. McKeown (1965, 1971) has shown convincingly that improved health and the great decline in Western Europe's total death rate from the eighteenth century to the present were due to four factors. First, nutrition improved because food supplies increased. Second, environmental sanitation measures were instituted, such as the cleaning up of the filth of the urban areas and providing uncontaminated water supplies. These measures were well underway by the middle of the nineteenth century, before either the concept of specific causes of disease or the germ theory was widely accepted. Third, these improvements in the standard of living caused a substantial increase in population, which would have overrun the gains in health if birth rates and family size had not soon sharply declined. Fourth, specific preventive and therapeutic medical measures gradually introduced in the twentieth century slightly accelerated the already substantial decline in mortality and also improved physical health. While science and technology greatly extended advances in agriculture, hygiene and birth control, the contribution of medical science to the overall reduction in death rates and improved health was relatively quite small in spite of the larger number of doctors. In the great majority of cases the toll of the major killing diseases of the nineteenth century declined dramatically before the discovery of medical cures and even immunization.

To a very large extent the improvements in the general living and working conditions as well as sanitation came about as a result of labour struggles and social reform movements. It is these improvements that are most responsible for the improved health status (Rosen, 1958; Dubos, 1959).

When one looks at the situation today, one finds that the physical and social environments are just as important in determining disease and death rates as they were historically. Infant death rates are still strongly influenced by environmental or socioeconomic factors. A person who is poor or belongs to a minority is more likely to die at every age. It is well known that environmental and occupational pollutants are major determinants of disease and death rates. To cite one example, according to American health officials, epidemiological evidence demonstrates that possibly 40 per cent of all cancer cases are caused by occupational carcinogens, the most neglected area of environmental cancer research (Epstein, 1974). Accidents and occupational diseases are on the increase. Genetic pathology due to physical, chemical and biological agents are becoming more manifest. Social relations – the ways in which individuals relate to one another in society – also have a broad and dramatic impact on how healthy people are and how long they live. The stresses of living in modern western society have a deleterious effect.

The warning is there, global standards of health and wellbeing are declining: life expectancy, after reaching a peak, is now again decreasing; cancer rates are rising; cardiovascular diseases are rampant; alcohol, tobacco, drugs and traffic accidents nowadays kill more people than did all the epidemics together in earlier centuries; and the aged are overwhelmed with diagnostic technology, but their psychosocial and mental wellbeing is left largely unattended and uncared for. As a consequence of the present high technological pitch of diagnostics and therapeutics, the very attempt to diagnose and treat one disease may produce another. As many as 20 per cent of hospital admissions are reported to fall into this category in certain parts of the developed world. All this gives rise to a widespread feeling of unease about today's health care.

Furthermore, our western high-technology society has made it possible for humans in a number of ways to destroy or, at least, decimate the species, and indeed threaten all life on earth. This capacity, like the inactivity in the face of known causes of disease, is a characteristic never seen before in humanity. We must look for hope to those, whether or not medically qualified, who see the need to create a new society, of which health will be an integral part, and who will search for the philosophy needed for the establishment of such a society.

One is now faced with the limits of medicine and the importance of dealing with the total socioeconomic and physical environment. A completely new pattern of disease is emerging which calls for a different type of approach. A preventive, grass-roots approach is needed, just as it produced most of the real improvements in health in the past. There has to be a devolution of health care – right down to the ordinary people – and of prevention (Mahler, 1975). The people should be made more responsible for maintenance of their health, and for alterations of the environment and to their life-style that will improve health. There has to be a shift of emphasis away from expensive hospital-centred medicine towards prevention. In this new strategy health workers analyze the different factors that contribute to a health problem and, then, with the people affected develop social as well as medical-technical strategies for changing them (Brown and Margo, 1978). Individually oriented curative medicine is obviously needed because human beings are not

perfectly adapted to any physical or social environment. But health care should do more than apply a bandage to the wounds created by disharmony between people and environment.

When comprehensive primary medical care is distributed throughout the population it contributes to improving the general health level of that population. But when combined with social reforms – particularly ones that will eliminate inequalities, brutalities and the destruction of the physical environment – good technical medical care and supportive personal and social services can reduce the burden of disease an individual, a family, or a society must bear. Concomitant with this realisation there has to be the necessary training of doctors and other health workers to face these problems and the necessary education of society to work towards the goal of health for all and the maintenance and improvement of health.

These reforms in medicine must be tied to broader social change. If programmes to educate health workers are to serve the health needs of developing countries, the people of those countries must not let the interests of foreign nations or the interests of their own medical professionals determine the purpose and character of their programmes. Those who plan, develop and teach in the field of health care must consciously examine both the material interests that shape their programmes and the social, political and economic consequences of medical policies and practices. They must ensure that medical programmes contribute to, and do not detract from, the goals of improving the health of the people (Brown, 1979).

Medical Education

In the past the aim of medical education was to produce a "complete" doctor, that is, someone who is able to deal with general clinical cases. With the enormous advance in medical science, however, it has become quite clear that no single person can cope with every type of health care problem. Specialization in the various areas of medicine is therefore needed and a team approach in all matters appertaining to health care. It was during the 1950s that a good deal of rethinking and discussion about medical education took place. Various countries set up commissions that enquired into the matter and made suggestions for improvement which were put into operation during the 1960s and early 1970s. It has to be noted, however, that all these new schemes operate within the existing socioeconomic systems in the different countries. Thus while there have been changes in the educational approach in medicine, there has been very little change in the actual health care delivery, and the isolation of medical education from national health care continues.

A thoughtful observer of western medical schools will be troubled by the regularity with which the whole educational system of these schools is isolated from the health service systems of the countries concerned. In many countries these schools and faculties are indeed the proverbial "ivory towers" which prepare their students for some high, obscure, ill-defined and allegedly international "academic standards" and for dimly perceived requirements of the twenty-first century, largely forgetting or even ignoring the pressing health needs of today's and tomorrow's society (statement by the Director General, World Health Organization, 1976).

Most of the world's medical colleges prepare doctors, not to care for the *health* of people, but instead for medical practice that is blind to anything but *disease* and the technology for dealing with it; a technology involving astronomical and ever-increasing costs, directed towards fewer and fewer people who are often selected not so much by wealth as by medical technology itself, and frequently focused on persons in the final stages of life. They prepare doctors to deal with rare cases which are hardly ever encountered, rather than with the common health problems of the community; for cure rather than for care. They tend to forget that technical solutions must respond to social demands, not dictate them. Medical practice has become almost synonymous with curative medicine and doctors are trained predominantly to look at episodes of diseases, paying little or no heed to the whole person, and to his or her interaction with society and its environment.

Many medical schools prepare their graduates for medical practice in which the "best" health care is assumed to be that by which everything known to medicine is applied to every individual, by the highest trained medical scientist, in the most specialized institutions. But "quality" under this assumption can lead to a dangerous situation on the basis of which health interventions become more limited and costly and medical education becomes insensitive to the health needs and problems of the community, being oriented instead towards expensive technology whose efficiency and effectiveness are conspicuously decreasing.

An examination of the medical curricula shows that they do not take into account the stages of development of medical students. Learning and maturation are slow during the first two years because of the crowded curriculum, didactic teaching, too many lectures, little problem solving and no responsibility for learning. Thus students develop a negative attitude toward the sciences. The striking acceleration in maturation and learning that occurs in the early clinical period results from the stimulus of contact with patients and with community health problems. Here the knowledge gained during the

first two years is used and especially acceptance of responsibility for learning. The slower pace in the subsequent years reflects the students' reduced sense of responsibility as "consultants" for patients and their lack of interest in community health, lower standards of accomplishment and diverted attention. The real concern of students in western countries in the final year is internship hunting and moving to a new location.

Medical college staff extrapolate to all the curricular years students' abilities as observed at the time of initial contact. The basic medical science staff underrate ability and potential and resort to pedantry. The clinical staff overrate the capabilities of first and second-year students, advocate activities for which they are not ready and overload them. The results are curricula and teaching methods that are unsuited to the students.

It is evident even from this brief overview why a growing dissatisfaction is discernible with health care in general and with medical education in particular. Society, which after all foots the bill for all that happens in health, expects us to prepare doctors to fulfil a social purpose in response to the health needs and demands of the community which they are going to serve. The medical school is an integral part of society, an instrument which should prepare for work *in* and *for* society.

To this end one must first examine carefully the conditions that graduates will face when they leave medical school, and arrange an educational programme which prepares them for that role. To do this, one has to ask a few searching questions:

1. Do the graduates think and behave in terms of "health" rather than of "disease"? That is to say, do they apply techniques of prevention and health promotion and not only those of cure and rehabilitation?
2. Do the graduates think and behave in terms of family and community, rather than in terms of the individual sick patient?
3. Do the graduates think and behave in terms of membership of a health team consisting of doctors, nurses and other health workers as well as social scientists and others?
4. Do the graduates think and behave in terms of making the best and most effective use of the financial and material resources available?
5. Do the graduates think and behave in terms of their country's patterns of health and disease, and the relevant priorities?

Therefore in planning medical education, the following principles (adapted from Eichna, 1983) for designing undergraduate curricula ought to be considered:

1. Health care of the community and patient care are the purpose of medical college education. They come first.
2. Students come second, not first. Students orientated curricula result in doctor-orientated, maldistributed practice of medicine and neglect of community health.
3. Curricula are for students, not for the staff. The staff often devise curricula suited more to their own knowledge, experience and interests than to those of the students.
4. Medicine cannot be learned in the total time allotted to the undergraduate medical curriculum.
5. Medical schools do not produce doctors. They impart a core of concepts, information, and skills on which doctors base their future self-education.
6. Patients, society, and the future practice of medicine are best served by a broad education in basic medical sciences, clinical disciplines and skills, and the socio-economic aspects of medicine. Otherwise doctors will be narrowly focused and will overuse tests, procedures, consultants, and medications, thereby increasing the cost of medical care.
7. Specialization comes after broad-based learning, during the hospital residency and postgraduate work. This is the postgraduate stage.
8. The content of instruction and time for learning need to be in balance. Otherwise memorization and forgetting replace learning.
9. Thinking, problem solving, questioning, doubting, self-instruction, and a sense of responsibility for learning through personal participation are fundamental to learning.
10. Knowledge is best gained in a sequential manner with previously acquired information and concepts, not in unrelated segments without the requisite background knowledge.
11. Basic medical sciences are medicine just as much as clinical medicine is.
12. Clinical medicine is a science that combines basic medical sciences with clinical skill and not a trade learned through apprenticeship.
13. The study of the clinical, sociological, economic and community aspects of medicine is meaningful when students have responsibility for patients, understand their community and have adequate background knowledge – not before.
14. Elective studies require background knowledge; they are not substitutes for comprehensive core learning.
15. The personal principles and values that are essential in a doctor are not automatically present in students; they need to be developed. Patient care and the health of society ultimately depend on these attributes.
16. Inculcation of medical ethics must have priority. Access to patients is not a right but a privilege that students must earn by first acquiring a knowledge of the biological and behavioural sciences.

The success or failure of a curriculum depends on how students are evaluated – i.e., on examinations. The

examinations determine how students study, what they learn, and their attitudes toward learning. Evaluation procedures should test factual knowledge (not simply recognition of facts), generation of information and concepts from within, problem solving, and writing. They should also incorporate the evaluation of preceptors and oral examinations. If all these principles are not implemented, the curricula will fail medical college education.

Translation of these principles of curriculum into courses; determination of the content of courses; and allotment of time to lectures, seminars, laboratories, and self-instruction are functions of each medical college. The curriculum should be structured, but in itself not restrictive. The way in which a structured curriculum is implemented determines its relative rigidity or flexibility.

Medical science is no more than the body of knowledge which is always being added to by scientists, through controlled and reproducible observations, which in turn must ultimately affect medical education. When considering the relationships between the various subjects within the medical curriculum, one has to be quite clear that none of their contents or relationships are enduring and that none of them are sacred. What one attempts is the best possible arrangement of a body of available knowledge in order to further the best possible medical education at any one phase in our history. One must be flexible and courageous in initiating change, one must try to do it as logically as possible. While stressing one's own subject one must at all times be conscious of the greater unity of the whole, for medicine is a natural as well as social science, in the sense that it is concerned with human beings and is directed more immediately towards human welfare than any other natural science.

It has to be realised that medical education must deal with the particular needs and realities of a country, and that it has to be tailored to those needs and the particular situation, and that it must be part of the health care system of the country.

Medicine has to remain flexible and adaptable, and incorporate the new advances made in the medical and other sciences. Those responsible for the medical curriculum should always be ready to try new ways in education but they must be related to the overall health care system. Furthermore, wise decisions for today cannot be safely taken unless one realizes that those same decisions determine the shape of tomorrow and possibly the day after. This realization may not lead to the right decisions, but it might help to obviate some of the worse. This emphasizes the importance of detailed and careful planning.

Medical education helps to shape a nation's culture, substantially determines its health resources and, especially in developing countries, consumes a significant portion of national income. Developing countries need modern medical science – developed to meet their needs for basic medical care, sanitation programmes and public health measures for all their people (Abel-Smith and Leiserson, 1978).

Health for All

Doctors and other health workers tend to adapt to the existing health system even when they are trained for quite different tasks. Therefore, the health system will have to be changed first and then the doctors should be trained to operate within that system (statement by World Health Organization). A proper health care system is one which is accessible to all members of the community, and in which major decisions concerning health are taken and implemented by the community. It is a system in which the doctor is only *one* component of a team whose every member does what he or she has been trained for and which is oriented towards identifying and solving the priority health problems of the community. A system which clearly recognizes that the enjoyment of the highest attainable standard of health is not only an individual human right but, over and above that, a community goal. And in defining these goals four key sets of factors are involved (World Health Organization): political, social, economic and technical, and it is the business of medical education to make the student aware of the role and importance of all four. It is political and economic decisions that determine the conditions under which people live or die.

Health care and medical education cannot be dissociated. Medical education, the development of health care manpower, is only one integral element of the development of health services. "Health care manpower" has neither meaning nor purpose in isolation, it is solely an instrument for effecting health care.

Given an integrated development of health services and health manpower, the activities of individual medical schools should be defined by health manpower plans based on the overall national health policies and plans. These in turn, are an intimate part of the national overall policies and plans that each society must set for itself in the light of its social, economic and political aspirations and its own needs and resources.

Health manpower plans define not only the numbers and categories of health personnel to be trained, but also indicate the knowledge, skills, attitude, and area and level of competence needed to carry out the tasks of each.

Health personnel trained to understand a problem, to exercise judgement, to take a decision and to continue learning throughout their lives will be able to serve society usefully both upon their graduation and 30 to 40 years later, that is, well into the twenty-first century.

Rapid advances in knowledge and technology and changing societal thinking suggest that in the future medicine will be quite different from the way it is today. With modern science and technology preventive health care and the promotion of health will predominate. Community health, and diagnostic and therapeutic decisions will probably be computerized, with decisions ultimately made by panels of experts in various fields and local clinics determining patient care. However, the principles of curriculum will still apply, even if the methods of implementation differ.

It follows therefore that health care manpower must be trained in terms of the health services within which it will operate. It follows too, that the health services will develop according to the type of manpower available to them. No country can any longer afford the haphazard growth of health services, with its attendant waste of human and financial resources that one has seen in the past. Those services must be carefully planned, and the success of the planning will depend in large measure on developing manpower appropriately fitted to every stage in the development of the health services. National or local health conditions will dictate the particular needs and demands that the health service must meet. The final decisions as regards the health service must be made by society rather than by the professionals concerned.

The achievements of China in health care of the nation have been enormous and have made her much admired by the outside world and in particular by medical specialists. While ensuring that the quantity of health care personnel is steadily increasing, she is also concerned with their quality. Having started with practically nothing, China has succeeded in establishing a basic health care network throughout the country. It is now a matter of building up on this base. There can be no blind copying from other countries. China must make things foreign serve the needs of her country, and see that the priorities are right, there has to be a careful balance.

Health care is a team effort of the people, of doctors, assistant physicians, rural doctors, health assistants, nurses, technicians, health authorities, medical teachers and other health workers. All have to work together. The important aim of medical education is to raise the level of health care of the people throughout the country, both rural and urban, for their wellbeing and for progress in agriculture and industry.

The ultimate goal of economic development is to improve the wellbeing of people. Industrialisation, agricultural development, irrigation of land, the terracing of land and the training of engineers are but a means toward that end. Improving the health of people is fundamental to improving their wellbeing. And health, as the World Health Organization states is: "a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity".

There are two ways to view the relation between health and development. One sees health as a prerequisite for development. The other sees health as a concomitant of development. Both views are mutually supportive.

Human energy is the fuel that drives development, the source not only of physical work and other economic activity but also of hope for the future, social awareness and the ability to absorb and apply new knowledge, all of which are essential to development. Genuine measures to improve health are likely to contribute to general socioeconomic advance. The critical amount of human energy in question is the amount required to initiate social and economic development. Just as health promotes development, so development tends to promote health. Health is a fundamental human right. The true goal of development – the wellbeing of people – can be achieved only by way of an approach to development that is oriented to the needs of people.

The equitable distribution of health resources is basic to raising the general standard of health in any country. For a country with limited funds it is essential to allocate those funds preferentially to the most deprived people. This implies proper choices not only among geographic and demographic sectors but also among forms and techniques of health care. Thus well-organized community health-delivery systems are required, with people and health workers interacting and with links to and from more central health facilities. This means developing a broadly based pyramidal health system, in which as many services as possible are provided as near people's homes as possible but in which each level of care is closely supported by a higher level to which patients can be referred. Appropriate technology is crucial to the success of any health system. It demands scientifically sound materials and methods that are socially acceptable in a particular context, directed against relevant health problems and effectively delivered; by affordable systems, where they are most needed.

Although medicine can discover and adapt treatments for numerous pathological conditions, it is still resourceless in the face of the most common ailments – malnutrition, malaria, tuberculosis, gastroenteritis, cancer, heart disease. These conditions require action on their causes, rather than symptoms. But it is precisely at this threshold – the causes of disease – that the whole medical approach stops. It is at this threshold that economic and political choices begin. These choices are not and never can be in the province of medicine. In reality they depend on the values that are at the basis of our society. ■

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* Professor F.P. Lisowski was once the head of Department of Anatomy, University of Hong Kong (1969 to 1983)

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奔向自由

● 盧子健

八年前，我在《啓思》以「石天」的筆名，發表了一篇文章，題爲「理想、事業、職業——一個對醫療缺乏興趣的醫學生的自白」。事後，我沒有聽過什麼反應，只有一個同學對我說：「那篇文章不像是你寫的。」另一個則說：「你即使眞的這樣想，也不必要寫出來，對你沒有什麼好處嘛！」

一年半後，我作出放棄醫科的選擇。我當時找過楊紫芝教授，她是忙得很的人，只有抽時間在大清早巡房後見我。她見面後劈頭的第一句是：「什麼原因？」跟着，她翻查了一下手中有關我的資料檔案，再說：「你的成績不是太差呀！英文也不像有問題。」

其後不久，我又見到另一位教授，她對我說：「你將來可能會爲這個決定後悔。」

到了今天，我還沒有感到後悔。

我對心理學和心理分析沒有什麼研究，但非常欣賞佛洛姆的《逃避自由》。不錯，世界上有不少人曾經爲自由戰鬥和犧牲，但有更多人逃避自由，把自己依附在集體、在組織之上。

心靈上自由是一種痛苦的經驗，因爲自己要向所作出的決定負上一切的責任。在中學時，在選擇文科或理科的問題上，任憑我選擇的話，實在不容易作出決定。幸而成績較好的都選擇理科，自己幸而是其中一份子，於是可不假思索地作出決定。

入大學時，個人的思想開始成熟了，曾經爲進入醫學院還是社會科學學院思考了好一段日子，終於又是環境戰勝了自我。在社會和家庭的期望下，我選擇了醫科。

放棄醫科，是我第一次眞正自由地作出的重要抉擇，那個過程是痛苦的，作出抉擇後的感受卻是痛快的。

「醫生有什麼不好？」這個問題根本上就是問錯了？眞正重要的問題是：我爲什麼要做醫生？我們隨時可找着醫科學生來問：工程師有什麼不好？律師有什麼不好？小販有什麼不好？的士司機有什麼不好？工廠工人有什麼不好？……

這個社會原來就存在一大堆既成的觀念和價值，把人來分等分級。「醫生有什麼不好？」這個問題的背後，其實隱藏着一個深刻的成見：醫生比很多其他的職業好。這一類價值俯拾皆是，例如發了達的人泰半是「成功」的；民主較易在受過「高等」教育的人之間推行；薪酬是一個人對社會所作「貢獻」的反映……又有多少人曾經深思過這些觀念有多合理？

香港是一個「自由」的社會。但，在觀念上、在價值上、在意識形態上，我們是否完全自由呢？到了今天，還有人對我當年放棄醫科感到興趣，不是很說明問題嗎？

我還記得，大約三年前，醫學會的一些同學約了我去談談與醫科「告別」的感受和個人理想。我作了開場白後，有一位同學頗爲失望地說：「你放棄醫科，好像也沒有什麼特別原因啊！」她可能期待我轟轟烈烈地談一番抱負，可惜我坦白的說：「原因是我沒有興趣。」

「逃避自由」，本是個人心靈的活動，但反映到社會上，卻變成集體的一種壓力。要逃避這種壓力，正是痛苦和掙扎的來源。很多人會依附另一種更「崇高」的理想，來擺脫原有的社會上的集體意識的壓力。這樣做的危險是，由一個集體的牢籠，逃避到另一個。

當年火紅的學生運動，相信引導過不少人進行過這樣的心靈活動。他們鄙棄香港社會現成的價值觀，因而積極找尋另一套來代替。眞正的探索是痛苦的，比較不那麼痛苦的方法是：接受另一套現成的價值。

一個人長期活在某種價值參準架構（REFERENCE FRAME）內，是安樂的。一個人由一個參準架構跳到另一個，會有一次痛苦經歷，但不會多。只有當一個人要不斷地修正自己的參準架構，才是最痛苦的一回事。

倘若我說：我找到了比醫生更爲重要的工作，所以離開醫科。這只能是自欺欺人的講法。我只不過鑽進另一個既成的觀念世界內，戴上有色眼鏡去觀察其他人。

所以，我只能講一個平凡的答案：對醫科沒有興趣。我想這個平凡的答案，也有它不平凡的一面。

我不知道其他的醫科生怎麼想，也從來不會鼓勵他們放棄醫科。這個決定只有由他們自己來作。不過，作爲一個旁觀者和批評者，我可在這裏提幾點看法。

第一，我們首先要破除醫生的「地位」和「重要性」的成見。醫療本來就是一個集體服務。沒有了護士、麻醉師、物理放射員、實驗室化驗師、藥劑師、醫院裏的服務人員，及其他的後勤工作如消毒、運輸、製藥等，這個社會的醫療還能搞下去嗎？爲什麼醫生被看成是醫療行業的代表呢？推而廣之，這個社會的前進，是靠各行各業的活動而存在的。「地位」和「重要性」憑什麼來量度呢？

第二，要問個人對醫療這個行業是否眞的有興趣有投入感。只有樂業，才能把自己的本行做好。勉強當一個醫生，對人無利，於己無益。當然，倘若有人只把當醫生看成一種手段，只是用來「發財擺采」，我倒沒有什麼意見。不過，我會建議他考慮一下做其他生意的可能性。

第三，放棄醫科不代表你一無所有。做學生的，還很年輕，要在生命中做一個轉變，完全不是大問題。只要想得通自己幹什麼，咬緊牙根的拚一拚，總會闖出一條路來！當你一步步實踐你想走的路，那種痛快的感受是難以形容的。

寫到這裏，也應該收筆了。收筆前只想講：我放棄醫科，不表示對那幾年生活完全沒有懷念。我還很懷念曾經合伙居住了一年多的同學，希望他們看到這篇文章；也很感謝他們曾經多次幫我「過關」。

此外，我也很懷念一些曾經一齊在學生會或其他社會運動中工作的醫科同學。他們對社會的關懷，使我對他們的事業寄予很多希望。

我還記得楊紫芝教授手裏原原的文件夾，裝着有關我諸多問題的資料，就讓這篇文章成爲最新的一份文件。

一九八五年四月　於倫敦

能醫不自醫

● 郭家麒

你聽過有人用計時炸彈去形容一樣公共服務嗎？在大概二三年前，筆者就看過一篇文章用計時炸彈來比喻香港的醫療服務。引用這個比喻，是因爲該文作者認爲當時的醫醫療服務已到了一個不能容忍的情況，當時正值爭取興建東區醫院運動進行得如火如荼之際。

過去兩年，各方面的注意力都集中在香港前途問題上，到了最近，政府宣佈委托一間顧問機構檢討本港的醫療服務，寫在此時，本文希望能對現時醫療服務作一個初步探討引起更多的討論。。

談到醫療服務，我希望先談醫療服務的質素，然後來討論一些影響醫療服務質素的原因，去找一個完全客觀而又全面的評估標準是不容易的，由於醫療服務是一項祇有支出而沒有盈利的服務，從來就沒有人嘗試向病人做市場調查，去了解病人對醫療服務的評價，事實上，從設計到執行以至評估整個醫療服務，當局在表面上或實際上，是甚少以接受服務的市民之意見作爲主要的參考。

醫療服務的質與量

評估一項服務的足與不足，大致上可用質與量這兩個指標，究竟質和量是指甚麼呢？現在就先來了解甚麼是「量」，筆者稱爲「量」的，就是指一些可以具體地寫出來或計算到的指標，如果有人翻開醫務衞生處的年報，佔了年報超過三份二的圖表及統計數字，就是我所指的量了。

以下就是一些例子：

本港現時有註册西醫約四千人，平均每一千三百人有一個醫生，總病床數目，截至一九八三年，是二萬三千張，平均每百人有四點三張病床，一九八三年，醫療總支出約三十億，佔政府總支出的百份之七點一六。

這類數字，對於評價醫療服務是一些有效的指標，一般輿論，都會以這些數字作爲主要的參考，例如病床數字及醫生數字，就是長久以來，一般輿論要求政府改善醫療服務的一些指標。

但對於一個門診部或醫院裏的病人，這些數字又有甚麼意思呢，舉個例子：如果閣下所住的病床是在補助醫院而並非政府醫院，你所得到的資助祇是政府醫院的一半，或教學醫院的三份一，病人住在醫院的病床，可能祇是一張帆布床，甚至是一張放在厠所外的椅，另一個明顯的例子，一間建於六十年代的精神病院原本的設計是容納少過一千名病人，但現在這間被稱爲全港最大的精神病院長期住着一千九百多名病人，但這些病床是計算在剛才所說的統計數字之內。又例如政府門診服務，從年報中可以看到八三年有四十四萬多的門診次數，這個數字相信會佔全港門診服務，（包括政府、補助及私家門診）中重要的一部份，但事實上，不少門診病人須要輪候幾小時才見到當值醫生。而病人並沒有門診記錄，當值醫生亦無法得知病人以往病歷，這些例子都指出一點，單靠一些統計數字，並不能準確地代表醫療服務的水準。

但從服務量來說，本港距離目標尚有一大段路，在一九七三年的醫務發展委員會報告書已指出，香港要在八二年達到每千人有五點五張病床，但這個目標，在九零年之前相信亦不會達到，其他如精神科、老人科、眼科、耳鼻喉等專科服務亦是非常不足，各種醫護人員的人手，例如醫生、護士、物理治療員、職業治療員等，還是十分缺乏。

剛才說過，單從量方面去評價醫療服務並不足夠，醫療服務的質素亦是非常重要，提起服務質素，不期然就想起官方發言人每當被問起醫療服務時，就會拿出一些數字，去說明本港的醫療健康的高水平，例如初生嬰兒死亡率、產婦死亡率、肺結核發病率等等，這些數字自從六十年代到現在是下降了很多，本港現時的初生嬰兒及產婦死亡率比起一些西方國家還要低，而本港的衞生水準亦是非常高。但這些數字祇是冰山的尖頂，我們不能憑此去評定整體服務水準，香港並沒有向接受公費醫療的市民作過調查，亦無有系統地收集過市民的意見，但筆者從親身接觸所得，不少病人是對醫療服務不滿意，我亦無法理解病人怎能忍受現時不少公立醫院房內像戰地醫院的情景，無論官方怎樣强調本港的良好醫療服務，也沒法令人信服本港的醫療服務已達到滿意的水平。

醫療制度與醫療服務

醫療服務的好壞，是直接維繫於制度的完善與否，而醫療制度本身是一個非常複雜的系統，筆者打算祇從政策制定，政策本身及政策執行三方面去檢討這個問題。

醫療政策

有人曾經提出過，香港根本就沒有一個完善醫療政策，有的祇是頭痛醫頭，脚痛醫脚的工作政策，但筆者認爲政府是有一個政策，就是所謂危機介入政策（CRISIS INTERVENTION）意思就是當某部份的服務呈現不足或受到外界壓力的時候，便着手改善那部份的服務，比較明顯的就是第二線的醫療服務（主要是指住院服務），在這個政策下，當然並不會把服務質素提高至一個高水平，說到這裏，我想分析政府怎樣對待醫療服務，大家都知道，政府的醫療服務是幾乎由政府全面資助的，換言之，這是一項祇有支出的服務，而與其他

社會服務一樣，政府祇是希望把服務的水準調至一個僅可接受的水平，而在這個政策之下，在這個制度下的，醫護人員以及病人，都是處於一種張力之下，醫護人員被迫要接受一個過高的工作量，而病人祇能接受到一個低水平的服務，事實上，這樣的服務在多數情況下是不會危害到病人的安危，但他們祇能沉默地接受這些次等的服務。

政策的制定

與其他的公共政策一樣，醫療政策的主要決定，是落在少數的政府高層官員手中，如掌生殺大權的財政科官員，而一些諮詢組織，如醫務發展委員會，祇是替政府訂下一些廣泛而並不能實現的指標，另一點使人失望的，是在整個決策過程中，受到直接影響的市民及基層的醫護人員，最沒法發揮其影響力，在積極提倡民主參與的今日，的確是一個莫大的諷刺。

政府可以擴大醫務發展委員會，委任更多的市民及基層醫護人員，或由一些醫護人員公會推舉代表進入該委員會，以其能收集更多有代表性之意見，另一方面，政府亦應對醫療政策作定期的檢討，把醫務處及發展委員會的意見交予公衆討論，令公衆有機會對醫療服務提出意見。而對部份急待解決的問題，如解決醫院床位及濫用急症室等，可成立有醫護人員代表的專責小組，長期個別問題可在短期內得以改善。

政策的執行

現時的醫療服務，是透過醫務衞生處的協調統籌，由基層的醫護人員負責實際工作，由於資源有限及人手不足，大部份的醫護人員都是長期在沉重的工作壓力下工作，而工作環境又並不理想，部份在政府醫院工作的醫生，連一張像樣的辦公枱也沒有，不少醫生需要經常超時工作，而一個值班護士可能在夜更時要照顧多過二十個病人。這樣的工作條件，不但使部份人工作仕氣低落，更直接降低了對病人的服務質素。

另外，加上晉升及進修機會並不多，例如一個註册護士可能工作超過十年亦未能獲升至二級護士長，亦導致部份人離職，故此每年都有不少醫生轉往私家執業。

筆者認爲，政府應着手改善醫護人員的工作條件，如改善人手不足的情況，提供更多的晉升機會，及設立更完善的人專管理制度。以期令醫療服務得以提高。

政府動用大量金錢、去聘用顧問機構去檢討現時醫療服務、當然是有意思去改善不足之處，但醫療制度內的各個問題，並不是祇靠一羣從外地請來的專家一年研究就可以解決，教育顧問團報告書就是一個啓示，很多意見早在報告書發表之前已有人提出，但到了報告書正式爲建議，政府仍遲遲未予執行。

本港現時的醫療服務是急需改善，一個更完善的制度，一個能滙集各方面意見的政策制定過程，及一個更加向市民負責的態度，是本港醫療服務所需要。

結語

醫療制度本身十分繁複，筆者並沒有能力一一把各個問題拿出來討論，但我希望此篇文章能引起讀者興趣去關注這個問題，更加希望能帶起更多人的意見。 ■

註：危機介入（ Crisis Intervention ）原本是用於社會工作學，筆者借用此詞，並不是指社工學中之意義，祇是用作形容醫療政策的被動性。

「香港的醫療服務」是否亦需要送往「急症室」呢？

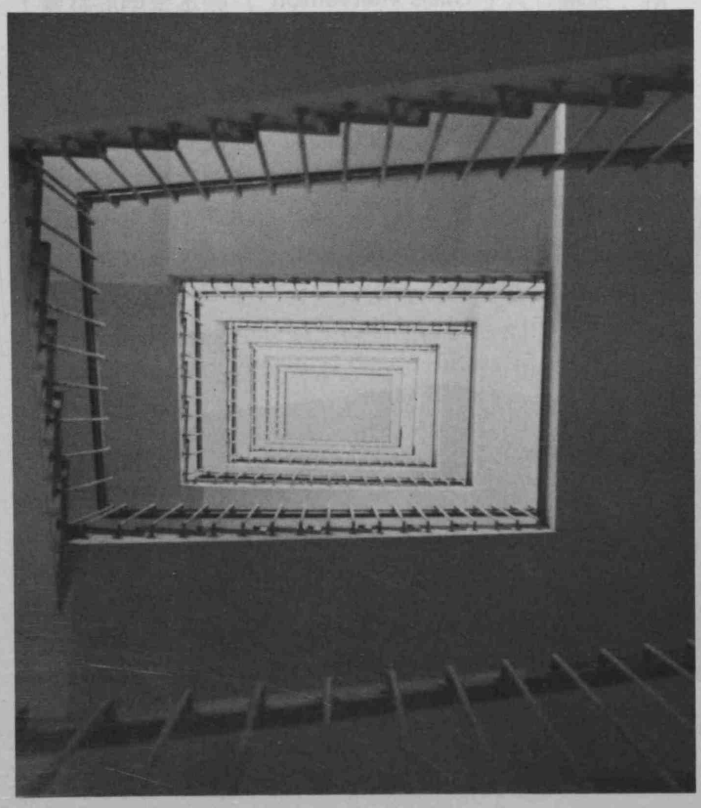
無題

● 名

「叮叮…叮…叮…」朦朦朧朧地硬把眼睛張開，第一件想起要做的事，便是看看鬧鐘。啊！已經是八時許，匆忙了一輪，趕到醫學院，便開始了一天的生活。

不知不覺間，開學到現在已經有兩個多月了。回想去年這個時候，或許已決定了將來所走的路，記得塡入學申請表時，面對港大十數個院系，一時之間眞的不知如何抉擇，前思後想，結果還是塡上了醫學院，選擇讀醫的原因委實在多得很：服務社會、父母的期望、對學科的興趣、爲金錢、地位、工作的意義、挑戰性……腦子總是一大堆的念頭，當時只顧着如何做好自己的工作，未想到有一天眞的會入到醫學院，現在卻覺得是應該重新思索一下將來的計劃及人生的目標的問題，或許也不算太遲吧！

某天的中午，終於收到了醫學院的錄取信，高興了一會兒後，心中卻又覺得不是味兒，入到港大，固之然感到喜悅，但一想起被拒錄取的同學及朋友的心情和情況時，自己又無能爲力，總是覺得有點難過。對他們的境況，我是十分了解的，因爲自己也曾經歷過，當我接到第一次考HKAL的成績時，心中湧起的感受，或者大家是不會明白的，自己不斷的在責備自己不用功讀書，無故地荒廢了兩年的學業，但這也給我帶來了教訓，在社會中一年的工作實踐，令我看到更加多的事物，接觸更加多的人物，從中我亦慢慢地改變，感到除了讀書之外，有很多事情是等着自己去做的。



我第一次眞正地深入認識到大學，也許就是在迎新日和迎新營中，當時的確又興奮又新鮮，也結交了不少同學，同學們相處之間亦甚爲融洽，迎新中最印象深刻的要算是那套幻燈片了，帶來了不少冲擊，能引起同學們在一些嚴肅問題上作思考，但片中的內容太過低調，每每只是環繞着一些醫學生將來所面對的挫折、困難與無奈，又指出很多醫學生沒有理想，只會追求名利，難道醫科生涯中眞的連一點點快樂時光也沒有嗎？我聽聞不少同學對幻燈片有所微言，縱然衆同學們應該正視這些問題，但如果表達手法能改變及盡量避免消極的態度，是更加可以引起同學們的興趣的。

正式開學後，總是種種新鮮事物也要嘗嘗，其實一向被人形容爲生活刻板的醫學系，雖不及大學本部，但也不乏多姿多采的活動。沒錯，功課上是忙了一點，但仍然是可以抽一些空餘時間來消遣或培養一些個人興趣的，而且入了Mini，嘗到了集體生活的滋味，可說是一種新體驗。

以前曾經聽人說過，大學生是在「庇護」下生活的一羣，現在親身經歷下，確是覺得這個說法一點也沒有說錯及誇張，只要讀書，萬事也不要我們來勞心，又享有種種的福利，例如grant & loan 等等，我們這一羣實在十分幸福，難怪這麼多人千方百計也要考進大學。

和我在外工作的一年生活相比，大學生活的確是更多姿采，兩者的相距實在是很遠很遠，回想起過去的事，更加使我覺得必須珍惜及好好利用在大學中的數年時間，以免虛耗光陰，現在就起步吧！■

迎新

● 隆

不知不覺間，第一個學期又將近結束了。大學生活，又或者是醫學生生涯，着實有苦有樂。當然，作爲一個一年級學生，在現階段來評估醫科生涯，未免來得早了一些；然而，至目前爲止，醫學生的生活卻絕不如在迎新期裏所想像的那末無奈，失意！

還記得在應考高級程度會考之前，曾經看過香港考試局的年報，作爲「前車可鑑」之用。閑餘之際，也曾翻閱過其他非報考的科目的報告。印象比較深刻的是中文科的一欄。文中指出是年作文題的題目是試作一篇關於野火會的記敍文。考生們一見之下，大有機不可失之感，於是立即大做文章，以求驚世駭俗矣：郊野遇險，驚心動魄；惜別知交，聞者心酸；又或是懷舊追憶，感慨萬千……。諸如此類者，層出不窮。再往下看，考生們苦矣！報告指出，題目是希望考生們能描述一個野火會的過程，與及其中的樂趣。難道野火會一定是毫無趣味可言嗎？是年考生們大有自作聰明，以致離題萬丈之感。

迎新活動中的幾套幻燈片集，給我一個甚爲特別的感覺：與是年考生作文之表現，大有「異曲同工」之歎，在迎新營中的三部幻燈片集，便是一例。個人以爲，片集中主題頗不正確，且消極低調，甚難接受及不能引起共鳴。內容不外乎是圍繞着醫學生涯的種種挫折：諸如課程繁重、刻板，缺乏人格培養之訓導，以致將來對待病人時冷酷麻木，又或是醫學生面臨之種種壓力，社會責任等等……。至於迎新雙週的另一套幻燈片，概云是八七班迎新時的一套，亦大同小異，仍是那些甚麼醫生對社會作不出甚麼改革、貢獻等等。

不錯，以上種種問題的確值得我們三思，尤其是一些對醫療制度及醫科生涯有着較爲深切的認識的高年級同學。不過，將這些複雜的問題，一股腦兒的堆在一羣剛踏進這圈子，對醫療制度及醫學生涯只有較爲片面認識的新生們，又有甚麼意義呢！又何苦在他們剛踏出第一步時，便要在他們心上種一根刺？

說句實話，學生們在預科班時選修學系時，多半對自己將來的理想，未有太大的認識，基本上都是採取學術興趣作爲原則來選修學系。一旦取錄後，很多時還對自己所作出的抉擇未有太大的信心，滿以爲在迎新營中能得到高年級同學們的支持和鼓勵作爲倚傍，誰不知一腔熱誠和盼望，都被迎新營中的幻燈片打消得無影無踪，着實令人感到沮喪！試想想，自己還在狐疑之際，考慮着有沒有選擇錯誤時，便已感到前路一片荆棘，但卻又無從退避，那裏還有原氣去面對漫長的道路！整個人就是那樣地無依、沮喪。

或者，試圖去想像醫科生涯是一種活在伊甸園般的生活是幼稚了一點，但總不成醫科生涯當眞是那般無奈，灰死的罷？難道我們毫不嚮往那無盡的學問，同學間眞摯的友情，與及羣體生活的樂趣？

不錯，我們有必要去讓新生們知道他們將來要走的道路，會遇到的困難、挫折及要肩負的責任，但帶出問題的手法，卻有待商榷。歷來的迎新作風，似乎未免過於急進及偏激，且有嘩衆之嫌。這樣徒然令那些狐疑之衆失去信心，令他們日後需要負出更大的勇氣來面對將來罷了。

我以爲迎新的目標應當是鼓勵新生們好好的計劃將來。謹此希望日後的迎新活動能採取一個較爲積極及活潑的手法來給予他們一些信心和鼓勵，不致令絢爛的醫學生涯，老就早在新的一羣中，留下一個灰沉沉的陰影。

沙地灣

● 待

上病房已差不多一年，自己似乎已很久很久從Medic Centre中消失。但我始終沒有忘記在沙宣道脚的那個老朋友——「沙地灣」它的夕陽，和海浪；它的淒涼，和沉默寡言都深深地把我吸引住。它沒有半點的濃粧艷抹，亦沒有密得令人不見天日的「森林」，更沒有繁囂的人羣。是，一切是寧靜，優悠，間中路過的人面上總也會帶着一切閑靜的神容。中午時份會有一羣天眞無知的小孩子在海邊嬉戲。騰地給這個沉鬱的老者帶來一股生氣。我喜歡看着他們在石上東跳西跳，我喜歡看他們在石堆中拚勁地向下掘（相信是在掘沙蟲吧。）因爲他們令我感到年青，感到無憂無慮。有時候我亦喜歡從陳蕉琴樓露台上眺望它，看看它如何在大海的冲擊下仍能堅强地站立；我亦會靜心地聆聽它向大海的聲聲怒吼。它雖然是一個老者，但它卻比我還堅强百倍，還勇敢萬倍。昨年開始它身旁出現了一件小擺設——那個正在興建中的港大運動場和看台。我喜歡這個停了工的地盤。那個看台孤清地站着，呆望着面前一片破爛的黃土。啊，是多凄清的呀！但它從沒有發半點的怨言，它只是默默地站着，堅守着自己的本份。我仰慕它，我尊敬它。

已完全忘記何時交上這個朋友。但這一點也不重要，我只知道這多年來我的快樂和憂愁都與它分享了。一年班的時候我間中亦會跑下去探望它一下，但我與它眞正的溝通是二年級那年才開始的。那時候我被工作和朋友的問題壓得死去活來。我孤立，我有苦無路訴。假若我不是男孩子的話，我定會抱頭痛哭一頓。就是在痛苦中我重新發現這個慈祥的老者！幸好得到班中一位同學的幫助和鼓勵，與我一起讀書，那我才不致在考試中垮倒。還清楚記得那個聖誕假期的一切。在晨早的寒風中，我們會在老者身邊跑步。耳邊不時傳來海浪冲打石頭的聲響，好像是大海向我發出的警告。但我亦不害怕一點也不畏懼，我只知道我要往前跑。大抵Medic的人就都是這樣的吧——不顧一切而前跑。要跨過一切考試和測驗，其他的東西一概可以不理。間中我們亦會沿着身旁的石灘走往遠處的鋼綫灣。那是我與這漫長石灘的初次見面。海浪不斷地冲擊着它，而途中亦會出現一些直揸雲霄的峭壁，替這本來平易近人的它平添了不少艱險。很多時我們要手脚並用才能攀過。途中我會在石堆中呆坐下來，對着茫茫的大海，看着那些辛勤地趕着出海捕魚的漁船發愁。我開始感受到「沙地灣」這位老者的情懷，我開始墮進它的思想領域。我的腦海給它淨化了！整個嚴寒的聖誕就是在讀書和老者的關懷中渡過。終於，考試順利過了，我仍能保持不敗之身。我眞的很想向他們（老者及她）說一聲多謝。但我始終沒有這樣做，因爲我相信眞摯的感謝是不須用言語來表達的。

對我來說這石灘充滿着智慧和挑戰。我喜愛在大石之間奔跳。每次當我從石灘的一端跑往另一端都是這樣的刺激和充滿挑戰。除了要在崎嶇的石堆東跳西跳外，有時更要涉水而過，或在高懸空中的峭壁上攀爬。危險是有的，但我卻從沒有害怕過。縱然崖下是大海一片，縱然崖上就連立足的地方也不大，但我對自己的能力始終是充滿信心，爬石不單只是一種體力的表現經過詳細的考慮和估量。在舉步之前還要考慮，到跟着的途徑和假若出問題時的應變動作。因此我深深愛上這運動。

這個石灘對我來說是如此的有趣，因此我喜歡與人一起分享這份情趣，特別是那些要好的朋友。還很清楚記得那次與妹妹趕往海邊看日落的一切。那時太陽已開始下山，眼看天邊要給落日的餘暉染得通紅，心中當然是異常的焦急。於是我們便決定跑步下去。爲了要加高難度，於是我們選擇了沙宣道盡頭的那條山徑。路是艱難異常，但是爲了趕時間也只得拚命往下衝吧。她看來已進步很多。雖然她仍然保持着一貫的作風——經常發出高聲的驚叫（其實她驚叫並不是因爲害怕，這只是她的作風，嘿，倒是個怪孩子），但從她的步姿看來她已放胆了很多。也許我給她多次的訓練已凑效吧！好不容

才找到一塊合適的巨石坐下來，那時太陽只有兩吋就下山了！總算欣賞到一次美麗的日落，當時心中忽然想起那首「落霞與孤鶩齊飛，秋水共長天一色」的詩句。雖然這不是秋天，可是那時的環境卻要比詩中的意境令人陶醉萬倍呢！太陽俏俏地消失在遠處山巒之間，蔚藍色的天空開始變得灰黑，當是回家的時候了。入黑後在石灘上走動是件很危險的事，因此，雖然我們興致仍濃也只得帶着無奈的脚步向「沙地灣」球場走去。途中我們經過一處石壁。由於水漲的關係，我們平日走的路都給海浪殘忍地吞噬了。在無計可施之下，我惟有沿着那高高筆直的石牆爬過去。但她……她爬不過呢！正在傍徨之際，偶然抬起頭來，看見天邊的海鷗也趕忙返家了。那時我眞恨不得我也像他們一樣長着翅膀，她等我可以背她飛過這「難關」。呀，就是這樣給了我啟示：背她過來！我留意到下面近水的石堆給巨浪冲擊數次之後總會露出頭來數秒鐘。於是是我看準時機跳下去那佈滿青苔的石上，然後跑過把她從壁上背過來。幸好我的時間觀念還算不錯，大家都沒有弄濕衣服鞋襪。

還有一次我們一班人一起下去，又是走這條路徑。可能我已有經驗，因此今次難度似度低了很多。雖然那個石壁光了我們許多時間，但我們全都過了，而且還是獨自爬過。她不再須要我背負。我雖少了一個笑她的題材，但是我心底卻是開心的。

這次我們也不顧得天晚要回家這回事。跑到老者身邊後，我們仍興致勃勃。海邊蓋有一個高高的竹棚雄視着兇湧的大海。它倒也有十多尺高。高傲地站立在石堆之上，像看不起一切似的。我生平最討厭那些高傲，那種被睛長在頭頂上的東西，因此我決定要爬到它頭頂之上，要把它踏在我脚跟之下。於是我們一班人便浩浩蕩蕩地攀爬上去。它看來很不高興我們這樣對它無禮，竟瑟瑟地在發抖，像是要警告我們它隨時有能力把我們摔下來。但我們這班人就是天不怕地不怕的那類人，那時心中就只有一句話：話之佢！我終於站到它頭頂之上，聽着滾滾不息的巨浪在黑暗中怒吼和遠處的幾點燈光，心中頓時一片茫然，腦子也是一片迷惘。甚麼才是我人生中的明燈呢？是蓮？是主？是……人爬到高不可攀的地方又怎樣呢？像我一樣只得一片茫然？千千萬萬的問號在心中徘徊不息，一向「活潑」和「頑皮」的我也只得呆站着。我感到渺小。難道我生來就只是這滄海的一隻棋子？

看來我要飛越大海的志願始終沒有褪減。看見巨浪不斷在張牙舞爪，心中眞是異常的憤怒。我急不及待要向它發出警告。不知是巧合還是老天爺的安排，海灘遠處懶洋洋地臥着一把長梯。我努力地把它搬過來，架在海中的一塊石上，然後一步一步地走到海的中心。管他是巨浪滔天，管他四週是漆黑一片，我一點也不關心。我只要告訴那討厭的大海不要再不斷欺凌弱小。

我不單喜愛老者給我驚心動魂的經歷，我也喜歡靜下來，欣賞一下它的寧靜。我特別喜愛傍晚時與我小的妹妹一起走下來，在這與世無爭，遠離功利的環境下談天說地。她不像姊姊那樣有探險精神，因爲我們很少走石壁那邊。但這一點也不要緊，因爲老者寧靜的一面亦是這樣的迷人。在夕陽之下，海面都給染得金光燜燜，海浪的聲音顯得特別可愛溫柔。在這環境之下眞教人有一份遠離塵世，超然脫俗之感。也不知我們在這環境之下渡過了多少個小時，談過多少件令人快樂或沮喪的東西。已不記得是何時了，一天她在海邊發現老者的「棺材」——一塊平坦得怪異的大石，看來這個棺材倒不算小呢？七尺乘三尺雖然遠遠不及老者的壯大，但對渺小的我來說，它已是大得可憐的一幅棺材了！我們喜歡坐在它之上，遙望着滔滔不停地滾流着的大海。有時候海浪還會湧到棺材邊來，像是要把我們的脚弄濕才罷休。但我們不怕，我們一點也不担心。

近日來心情一直欠佳，煩悶得很。最近那次找老者談天時，由於自己疲乏不堪，竟然在棺材上睡着了。唉，大吉利是！醒來時發覺老者沒有給我任何智慧，只是我手臂上給烈日曬得通紅了。那時眞有一份給拋棄之感——老者離我而去了！但漸漸手臂上的古銅色腿去了，使我猛然悟到老者始終是疼着我。它其實給了我一個嶄新的啟示——一切東西都只是短暫的！我不能接受這種消極的看法，但我亦不能否定它。是嗎？一切是短暫的嗎？老者，求求你坦白地告訴我吧。

八四年四月二十七日

＊本文原載於八六班之班刊「杏源」

昆明講學後記

● 譚智媛
香港大學醫學院高級講師

「五百里滇池奔來眼底，披襟岸幘喜茫茫空闊無邊，看東驤神駿西煮靈儀北走蜒蜿南翔縞素，高人韻士何妨選勝登臨，趁蟹嶼螺洲梳裹就風鬟霧鬢，更萍天葦地點綴些翠羽丹霞，莫辜負四圍香稻萬頃晴沙九夏芙蓉三春楊柳

數千年往事注到心頭，把酒凌虛嘆滾滾英雄誰在，想漢習樓船唐標鐵柱宋揮五斧元跨革囊，偉烈豐功費盡移山心力，盡珠簾畫棟卷不及暮雨朝雲，便斷碣殘碑都付與蒼烟落照，只贏得幾杵疏鐘半江漁火兩行秋雁一枕清霜」

破天荒以普通話授課

這是著名的古今第一長聯，是乾隆年間自號「美樹梅花一布衣」的孫髯所題，後爲張樹望書刻，掛在昆明市的大觀樓門楹。令人神往的詞句，加强我親臨滇池欣賞香稻睛沙的慾望。這次昆明之遊，山川奇氣，盡覽無遺，雖感不到騷人墨客的灑脫，卻捉摸到大夫學者的脈博。

歷史悠久的美國醫學授華會（China Medical Board）從1981年開始改變援助的方式，以部分獎學金頒贈給中國醫生來香港大學醫學院進修臨床或科研的新知；去年昆明醫學院派了一位教授到港大婦產科學系工作半年，主修圍產學、超聲波素描和產前診斷諮詢等；回國以後，學以致用之餘，她覺得當地的醫生會對若干醫學新觀點發生興趣，因此便安排這次港大婦產科講學團前往昆明醫學院訪問。

過去幾年，系內同事到國內參觀、開會、講學數不在少，但都是以英文或廣東話講解，這次我們破天荒嘗試以普通話授課，全部教材包括幻燈片和講義都譯成中文 備課時更翻查了不少中國出版的醫學書和雜誌，力求瞭解現今國內婦產科的水平。擬好講稿後，又到大學語文中心補習普通話，準備工夫花的時間比較平常到外國講課和演說要多出好幾倍；系內同事，上上下下均忙着協助翻譯，抄寫和製作教材，光是幻燈片，我們這個團共五位講者便帶去四百多張，可能是個破紀錄的數目。

忙中偷閒遊踪遍春城

昆明機場周圍一片碧綠，不負春城的盛名！我喜歡這些小規模的機場，一下機便看見接機的朋友在欄杆外招手，洋溢着親切感。候機室當稱得上是窗明几靜，可是洗手間內的厠所坐板和門扉都不翼而飛……。機上乘客，大多是旅行團，海關「同志」讓他們先過，我們反正一離開香港，便把平日的緊張生活方式拋諸腦後，所以有的是時間，坐下來享受一下「樂聞」（Walkman）傳來的輕音樂，也很寫意。

我帶去的一個電火鍋，海關人員從來沒見過。「是用來做飯的嗎？」「我想可以吧！」「是用來煮菜的嗎？」「也可以嘛！」「是用來燒水的嗎？」「也可以！」他拿出來檢示，險些兒把玻璃蓋子掉在地上。仔細鑑賞一番之後，細閱打稅表，沒有電火鍋一欄，請示上司，也不得要領，苦思無計，相對無言，關卡大堂已空空如也，外邊同團的和接機的人都等得十分焦急。我請他課以最高稅項，他說不行。後來問明鍋子原價約一百塊人民幣，他沉吟大半天，又與其他關員再三商量，完稅三十塊，「聞判」如釋重負，不過如何把拆開的包裝重新整理？

經東風路到翠湖濱館，市容整齊清潔，路旁兩排銀樺樹，羙煞一行香港來客。常聞「春城無處不飛花」，但畢竟是10月天時，街道上已看不到多少花，有點令人失望。不過橫弄裏古舊的庭園卻別具韻味，而一些早期的建築物，如博物館和歌劇院等，宏偉壯觀，反映着從前法國文化對當地的影響。

翠湖賓館環境優美，原來預訂的房間竟告「客滿」，只剩下一間四個人共用的房間給我們。安頓停妥，晚飯四餸一湯，雲南菜相當好吃，看見別人桌上的烤鴨、沙鍋魚，令人食指大動，可惜加菜必須預早安排，只有「住口」。

回房間準備講詞，可是四個人擠在書桌燈前實在不行，興起遣興的主意，穿過時光隧道，到賓館那家陳設完全是六十年代模樣的咖啡室，聽保羅安卡的「噢！家璐！」和「在老橡樹上掛上黃絲帶」，舊日的歌曲，舊日的閑情，我想起了從前唸大學時的日子！

星期天大清早起程到西山，登龍門，遊筇竹寺五百羅漢塑像，泛舟滇池，遠眺「睡美人」長髮垂湖畔蕩輕波之貌，綺麗風光，令人心往神馳，深慶不枉此行。

白魚口工人療養院，主治肺病，病人可能患肺結核或其他工業引起的肺病，得到國家的優待，在這風景如畫的湖濱康復休息，也算是「禍福參半」罷。療養院門前練劍的工人戴着墨黑的太陽眼鏡，想起看守機場的同志和登西山的遊人，也戴着相同的眼鏡，這種時尚正橫掃昆明哩。

岸邊看到摩登釣魚郎的奇景，不少人坐着汽車輪胎，浮到綠水波中垂釣，有「萍香波暖泛雲津，漁樵樵歌曲水濱」的樂趣麼？

人到中年仍力求上進

講學程序分三天進行，五個團員平均每人有三小時的課，另加三小時的分組討論，內容差不多是婦產科主要科目的濃縮體，包括計劃生育、腫瘤學、高危妊娠和超聲波素描等。

不知是內容吸引還是我們有「號召力」，報名學員超出一百五十位，這是進修班前所未見的。他們是從四川、廣西和雲南三省來的主診和主任醫生，背景和水準相當參差，有些在公社醫院或縣級醫院工作，有些在城市或醫學院附屬醫院任教，他們接觸的病例和醫院的設備頗有差距，與香港比較更難比擬。我們講學要照顧全面，須由淺入深，務求所有學員都能明白，而又要不讓水準高者覺得沉悶，所以必須穿插若干新鮮資料以資討論。

帶着患得患失的心情踏上講壇，心情緊張主要是憂慮普通話不流利，辭不達意。第一課完畢，反應不錯，知道人家總算聽懂自己的蹩腳普通話。放下心頭大石。看出席的醫生，不再是清一色的六十歲以上的高層人士，代之是許許多多的中年醫生，這是可喜的現象。我不否定老前輩的經驗可貴，可是要提高中國醫療水平，不是一朝一夕的工夫，提携新的一代，利用他們的衝勁和魄力，我想會事半功倍些。

當前急務需保母嬰健康

我們未到昆明以前，已知道中國農村婦幼保健的問題，這些問題和世界其他的發展中國家大同小異，基本是人民知識水平低，農村的「傳統接生」（Traditional Birth Attendant）從未受過基本的訓練，孕婦不知產前護理的重要性，產前、產後或生產期間出了亂子，非到臨危不召醫生，加上交通不便利，到達醫院時可能已返魂無術。因此，要減低圍產死亡率和母親死亡率，一定要從基本教育開始。

我在1981年世界母嬰健康協會第一屆世界會議中發表了「母親死亡之原因及其預防之方針」，是針對發展中的農業社會，文中所提及的三大方針，——教育母親、教育醫護人員（包括傳統接生）和改進醫療設施（包括孕婦求助和轉送之組織）——在中國農村應考慮按步實行，相信對減低孕婦、胎兒、新生兒的死亡率和發病率，也會起一定的作用。

此次講學的目的可分兩部分，第一是把醫學新發展作綜合報導；第二是討論如何選擇經濟實用的處理方法，實施於缺乏設備和條件較差的環境。

在分組討論時，我們特別強調後者，可是有些在邊疆或小數民族地區工作的醫生，認爲實行我所提議的三點也很有困難，如果要向文盲推行健康教育，要教導傳統接生員關於基本處理孕婦與新生兒的無菌技術，要提供最簡單接生用的消毒器材，需要增加經費和訓練健教人才，沒有領導屢的支持，根本無從入手。我很同情他們面對的難題，自上而下的官僚制度的隔膜和阻力，在任何社會制度下也會遇到，要改進醫療服務，基本動力一定源於醫護人員，透過適當的途徑，使領導或統治階層明白到此等改進對社會整體的影響，如果減低發病率可減低國家經濟的負担，政治家也會洗耳恭聽。

再者，幾個世界性的組織都備有經費資助改進母嬰健康，如世界衛生組織、世界家庭健康聯會及世界母嬰健康協會等，我認爲中國醫療界，有關單位應該積極與這些組織緊密聯絡，謀求達到世界衛生組織的理想——「到二十世紀末全世界人民健康」（Health for all by the year 2000）。

午睡陋習何日根除

昆明醫學院內教學用的視聽設備非常完善，三課室一共可容納九百人左右，有閉路電視設備，講者在一間課室授課，其他兩間課室也可以觀察得到。中央控制室可控制電燈、窗簾和電視的位置等，負責組織這次講學，安排時間表、派發講義等的效率也很不錯：惟是每天下午兩點鐘開始的那一課，對習慣午睡的國內醫生們，是極嚴峻的考驗。「蓬隆」一聲傳來，一個熟睡的學員跌倒地上，我想她一定是忘記了像其他勉强保持清醒的學員般，事先灌上幾杯上海特產的「咖啡茶」，這種含咖啡因極高的易溶茶磚，內有咖啡、茶和糖，味道既濃又提神又利尿，喝了便很難合上眼睛打其瞌睡。

醫院裏處理病人的方法，當然有很多有待商榷和可以改進的地方，本文不擬深入討論。至於醫護人員認眞的工作態度、樂於學習和助人的精神，香港的同行倒應向他們借鏡。

靜脈輸液系統潛伏危機

附一醫院婦產科內有羊水細胞培植化驗設備，亦有超聲波診斷單位，後者雖然成立不到一年，診斷的工作有條不紊，效果和水準也算不錯，證明國內的醫生到香港學習，並不需要太長時間的摸索，便能有所得益，如

果所學的科技可以立刻應用，便可以刺激系內外各同事們的興趣，開始學習研究，間接帶動整體進步的齒輪。參加這次講座有些主任醫生也去參觀附屬醫院，他們對這個婦產科超聲波的設備和診斷的效果，覺得非常驚異並讚賞不已。無論他們的單位有沒有類同的設備，我相信他們回到自己的工作崗位後，其對產前診斷水準的要求，必定提高，成爲現代化的催化劑。

話得說回來，現代化當然是重要，但在講求最新儀器和科技時，先要衡量其對病人、單位與社會的先後重要性，以防止本末倒置的情況出現。觀察國內醫院，最令人詫異的地方，是近乎原始的靜脈輸液系統，滴注的液體放置在開口的玻璃瓶，只有一塊紗布蓋上，液體滴注完畢便從瓶口再加進去，空氣中或手指上的微菌隨時都可以滲入，間接輸入血液裏，可引致血中毒，是非常危險的事。在香港或其他先進國家，全部用封密口的瓶，有些是用完一次便棄置，節儉些的話，玻璃瓶用完後，大可經消毒後再用。這些密封的系統，比較國內通用的開口系統安全得多，符合基本無菌原則；在經濟方面，如果用循環消毒的玻璃瓶，開始時要添置瓶子的費用，使用時要消毒瓶子的費用，在中國現在的經濟環境，如果可以花幾塊美元購買診斷儀器，當然可以負担得起玻璃瓶和消毒的費用。奇怪的是中國近幾年來不乏出洋留學的醫生，爲甚麼他們不覺得開口瓶極不妥善？可能是他們只看到先進國家用的膠瓶和輸液膠管全部是用完便掉的，覺得太浪費和不合中國的環境，便沒有考慮採用。

香港十多年前也不是用可棄置的輸液系統，現在也有些醫院還採用循環消毒的輸液瓶和膠管，但全部是封口的，如果國內的醫生到香港觀察，應該要看看設備不太完善的醫院，那麼便可以洞悉蛻變中的各階段，從而選擇適合自己單位的醫療設施。

以上例子，反映出中國現代化全速進行時，處處只從大處着眼，結果招致「陰溝翻船」，因小失大的不必要困阻。其次，這「小事」也顯出香港對中國四化的重要性，單純在人才訓練方面，除了上例可參攷香港發展中各階段所結集的經驗以外，被派來港的人也不需要花費太多時間學習英文（或其他外文），和適應外國的生活環境與方式，學習情緒和效率一定比較高，而且香港人的辦事和行醫態度，和中國的比較近，對中國的實際情況，港人較外國人也多些理解，因此能夠互相切磋，掌握一些在中國可行的科技，更可以把我們在香港現代化出錯的經驗轉告他們，那麼人才和經費都不會浪費。美國醫學援華會近年來資助國內醫生來港學習的方針，對中國是一喜訊，也反映出他們的遠見。

願在中國除三害

在昆明觀光，少不了到大觀樓和金殿，但天不造美，連日毛毛細雨，大觀樓不准登臨，菊花展也是開到荼蘼的尾聲，金殿三天門也走不過，敗興而返，在小書店發現小畫家卜鏑的童畫詩情集，和三國演義連環圖的精裝本，成爲送給家裏孩子的紀念品。

到石林一天，天剛放晴，途中在一市集休息，當見掛狗頭賣香肉的地方，大小石林都是謀殺菲林的地方，本地人比我們更甚，他們用名貴的日本照相機、長焦鏡頭和廣角鏡，式式俱備，還有即時冲菲林的服務，湖邊賣工藝品的少數民族也學得幾句廣東話，生意興旺。

在餞別的晚餐中，我們每一個人都收到一份意外的禮物，包括紀錄一週來一切活動的相片册，這代表我們兩間大學婦產科合作的開端，他們有很多可作研究的資料，加上我們研究的儀器和經驗，相輔相成，如果有適當的交流和訓練，也是可行之法。

踏上歸途，全團所帶的手信，除工藝品、書本等外，還有汽鍋和三十公斤的宣威火腿！從機艙俯瞰祖國的錦綉山河，耳邊飄來「龍的家鄉」和「我是中國人」的歌曲，想起要達到「全民健康」的艱巨工作，頗有感觸。如果容我擦阿拉丁神燈——允我三個願望，我願在中國除三害——抽煙、吐痰和不衞生的厠所！

*本文轉載自香港《信報財經月刊》第八卷第九期（一九八四年十二月）