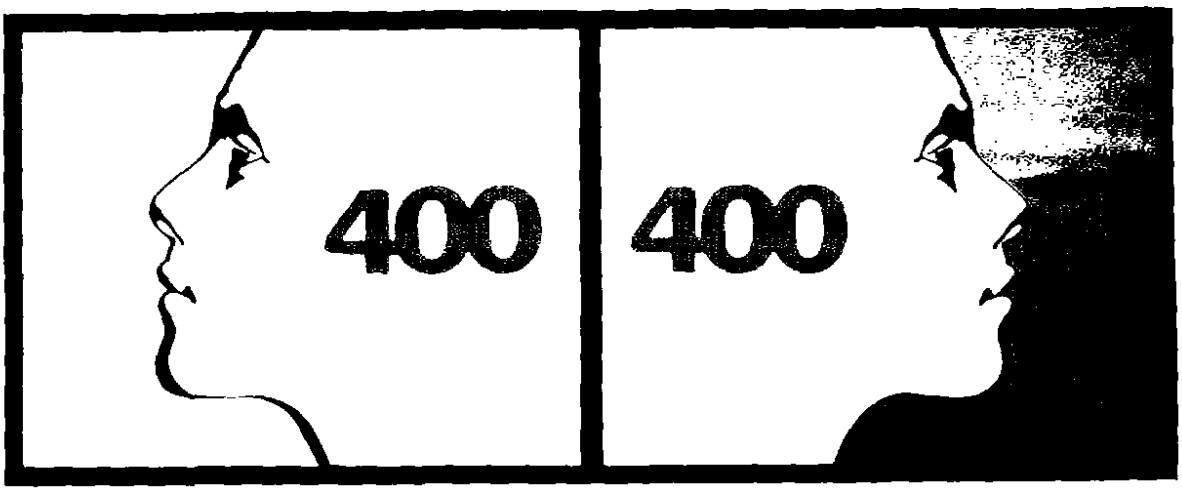
# Reflections on Patient Compliance

# Tagamet 400 mg b.i.d.
(cimetidine, SK&F)




A simplified regimen to promote patient compliance.

In a multicenter study of 583 patients from 9 European countries,* results for the b.i.d. dosage regimen compared favorably with those obtained with the q.i.d. schedule used in over 20,000,000 patients worldwide.

Rapid relief of both daytime and nighttime pain

Comparable healing rate in short-term therapy

Predictable safety profile

Easy dosage schedule to encourage patient compliance

*Data on file, Smith Kline & French Laboratories, International Medical Affairs January 1981

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# EDITOR'S WORDS

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By past conception, the Elixir Committee that is elected in that year would be responsible for reporting all the activities organized by various sectors of the Medical Society in that year. However, it was not until the very end of 1981 that our actual work began. So, in the first half of the year 1981, not much was done. The situation was further aggravated by the belated publication of Elixir 80, and we could ask for continuation of purchasement of advertising space only after the publication of Elixir 80, i.e. Nov., 81. We are now still waiting for the reply of some of these drug companies.

It is important that once a function is organized by the Medical Society, the organizer should write a report in the Elixir for the sake of completeness. However, there is often a delay or several months, not to mention the complete absence, of that piece of report. Similarly, articles supposed to be contributed by members of the Ex-co or from the various classes are often delayed.

The number of editors in the Committee is too small for any large project to be carried out, and we only aim to satisfy the minimum requirement of the Committee – to turn out Elixir 81. It is also worthwhile to mention that the number of students who are interested in essay writing and editing is decreasing.

If one understand the fact that most of the passages in this issue are written by representatives of the Medical Council only through lengthly and persistent persuasion, one would easily infer that contribution by ordinary members of the Medical Society will be very little. The reason is that each class has its own publication, and members of each class are more inclined to contribute to their own class bulletin than to the Cadueus or Elixir. Thus our role as official publication of the Medical Society has become less important than it should be.

Here, I would like to digress a little bit to make some comments on the Medical Society from the standpoint of a standing committee. I much appreciate the keen effort of organizers of various activities of the Medical Society who tend to arouse our alertness towards the problem of health care in Hong Kong. However, it is sorry to say that the number of participants in these activities is very small, and is ever decreasing. Take the Caduceus as example. One tends to see that the editorial board comprises about thirty to forty so-called editors. Taking into account of the majority of those who just have their names printed on the list of editors but have contributed nothing, the number of active participants in the Caduceus is extremely small.

The Christian Association and Catholic Society although are not part of the Medical Society, they have a considerable number of medical students as their members, many of whom pay more attention towards their own activities than to those of the Medical Society. Furthermore these often clash, both in time and in manpower. So, would it be possible for the Christian Association and Catholic Society to be incorporated into and become part of the Medial Society?

The Medic Choir has always been in an awkward position. We can only see them go for choir practice few days before any performance. Each Tuesday only a few turn up in the music room when there is no performance near. There is no official representative in the Medical Council and so the Medic Choir is not under any supervision, however little it might be.

There are many committees in the Medical Society that work in silence. The student representatives of the Library Committee and the representatives of the Library Committee and the representatives of various review boards are examples of these. No one ever care to take note of what they are dealing with, not to mention the poor participation. The others to be blamed are the committee members themselves, for they seldom make known to others what they are doing. Even the executive committee of the Medical Society has done nothing to remedy the situation, though making high-sounding statements during the campaign that they should strengthen the link between all members of the Society.

It is unfortunate to see that the enthusiastic attitude of students towards extracurricular activities, not to mention student politics, over the years is declining. Students of the 80's are less open-minded than those of the 70's, and we see a greater proportion of students more concern with their own than with others. The Medical students are no exception – but if we begin to think of the duty of doctors, that is, to care for the health of others, we would end up in a situation where there are more and more money-raging doctors who care only for themselves.

No one entering the Medical Society question the need to pay the membership fee. There are no laws saying that one should pay. In fact, one should think twice before payment, because being a member of the Medical Society, besides benefits to be gained, there are obligations to be fulfilled – we expect one to be an active participant.

# MESSAGE FROM DEAN OF FACULTY OF MEDICINE

Elixir is the annual record of the activities of the University of Hong Kong Medical Society as seen through the collective eye of the Editorial Board. This year (1981) the Board has departed from past practice by going to press on time – in fact, it has been suggested that it is the Dean who has held up publication by the late submission of his Message. If this is indeed so, I must offer my apologies and hope that the many times that I have arrived at functions on time (and found myself the only one present) will be evidence enough of the high regard I have for the Society.

The timely publication of Elixir allows one to reflect on the happenings of 1981 and, perhaps, worry a little about what is in store for us in 1982. The year 1981 was the second in which dental students were members of the Faculty of Medicine. This reflected in the activities of the Medical Society as reported in Elixir. Their presence has had a salutatory effect on the Society in that the activities of the Society have been broadened. In 1982, however, the new Faculty of Dentistry will come into being and, I presume, the HKU Dental Society will be taking over some of the activities hitherto performed by the Medical Society. The two years in which both medical and dental students have worked togerther will have helped to a bond that is bound to endure and I am sure that the two societies will find much scope for cooperation and friendly competition.

Over the past decade, the Society has broadened its outlook from an inward looking society catering to the needs of its members to one participating in community projects. This reaching outward, as reflected in the Society's concern for the disabled and the old in our community and its interest in social problems of the world as well as Hong Kong, is a sure sign that the Society has matured. However, students tend to approach social problems academically, as ones for study and discussion, rather than practically, as one that require action. It is here that the Society can offer its leadership. I should like to see fewer posters on the Bridge to the Pauline Chan Building discussing problems and more posters announcing field trips.

At the end of 1981 the newspapers announced that the two universities might be asked to increase their intake of medical students. As of January 1982, the Faculty of Medicine had not received official word but if we are asked to expand our intake I am sure that all concerned will enter into the project with enthusiasm. I have been asked by some students if there is indeed a shortage of doctors in Hong Kong. The use of Western standards for doctor/population ratios or hospital-bed/population ratios in Hong Kong may not be valid, they say, since a large proportion of population still prefers to herbalists. If this hypothesis is accepted then the answer to the question is: We do not know. We know neither the number of patients attending herbalists, nor the number of herbalists. However, we do know that there will be a shortage of doctors in the public sector since it is a simple matter to estimate the number of posts required to service the hospitals and clinics that are being planned and to match them against the number of local graduates that historically have chosen to remain in public service. So in addition to finding ways and means to persuade doctors to stay in public service, there is an urgent need to increase the production of doctors.

The year 1981 was the first year in which most applicants for entry to the Faculty of Medicine were inter-

viewed. While academic achievement still weighted heavily, performance at the interview influenced the results of 19 applications. This has led to the question of the fairness of the interview system. The argument goes something like this: A student from a disadvantaged faimily spends all his time and energy in his studies and achieves good results against great odds but he is then rejected on the grounds of poor performance at the interview. Thus, it is claimed, the disadvantaged student faces a double jeopardy and the system still favours those students from 'elite' schools that prepare them for the interview. It is apparent that the Admissions Tutor and his Committee is in a no win situation – no matter what we do we will be criticized – all we can do is to ensure that bias in the system is reduced to a minimum. We should also keep in mind that students from the 'elite' schools have just as much right to enter the Faculty. This year more than half the 136 HKAL students admitted took their "A" levels at seven schools, however these 136 students came from 57 schools scattered all over Hong Kong, Kowloon and the New Territories.

The year 1982 will see the completion of five full years of our new curriculum. The time is opportune for a review of what we have achieved and to attempt to set this against what we had hoped to achieve. It is obvious to me that the students should play a part in this review and I shall be seeking the cooperation of the Medical Society in this matter. The Faculty of Medicine has traditionally looked to the Medical Society for advice on student matters and I am sure that this tradition will continue.

Arnold C.L. Hsieh,
Dean, Faculty of Medicine.

Janurary 14 1982.
ACLH/ph

## MESSAGE FROM DEAN OF DENTAL STUDIES

As forecast in Elixir 80 the year 1981 was indeed a challenging one for Dental Studies. Looking back over such an eventful year one tends to wonder how so much was achieved in so short a time. Due to the failure of the building contractor to meet the planned deadlines it was necessary to commission and equip the Prince Philip Dental Hospital on a phased basis with all the attendant problems of such an operation. Nevertheless we are now occupying the whole building and equipment installation and desnagging are virtually complete. During March HRH The Duke of Edinburgh toured the hospital talking to both students and staff of all grades and staff of all grades and officially opened the Hospital. He was obviously very impressed with all he saw. Since that time we have been visited by many distinguished and informed colleagues, including over 200 members of the Hong Kong Dental Association, and the consensus view expressed is that Hong Kong now has one of the finest and best equipped dental teaching hospitals in the world.

During the year an Ordinance was passed which vested responsibility for managing the hospital in a statutory Board of Governors under the Chairmanship of the Hon. Lydia Dunn, OBE, JP.

Academic activity in the hospital increased in October '81 when Dental 85 entered the 2nd year of the BDS course. They have already begun to treat patients and appear to be enjoying themselves despite the rigours of the course. The second intake for the BDS course, Dental 86, joined us in October, are settling in well and making their presence felt in many ways. A contribution on the Prince Philip Dental Hospital by them appears elsewhere in this issue of Elixir.

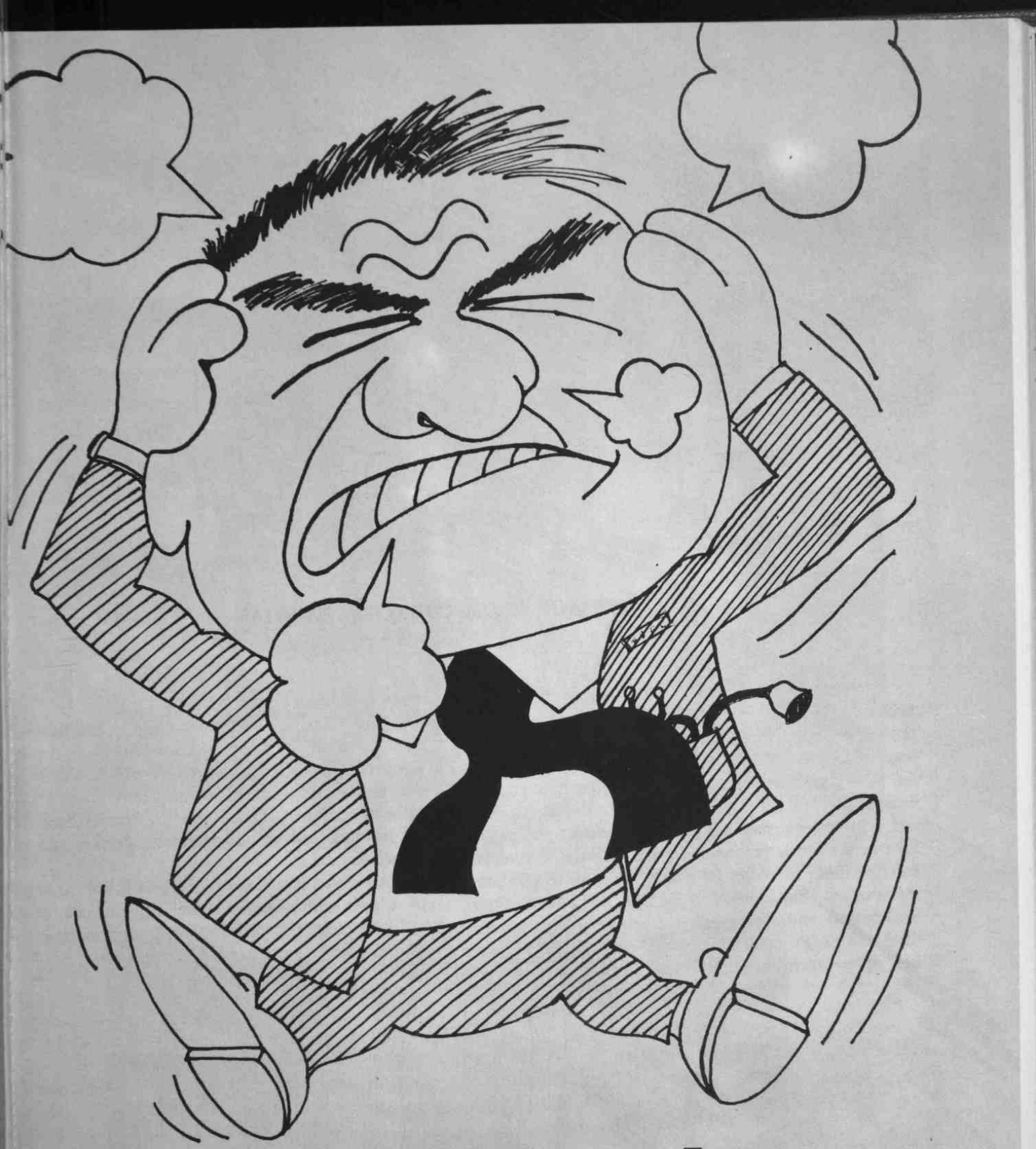
In December the first Hong Kong Dental Studies Ball was held at the new Holiday Inn, Harbour View and was rated an outstanding success.

During the year a number of new members of the academic staff took up their posts including, I am especially pleased to report, several colleagues of local origin. As I write the first group of 34 part-time lecturers is undertaking a three-day orientation course prior to participating in the clinical teaching programme. Thus Dental Studies HKU is forging firm links with the society it is designed to serve.

In December the Court of the University agreed that on the 1st July 1982 Dental Studies would become the Faculty of Dentistry of HKU. We are indebted to the Faculty of Medicine for having nurtured us and helped us and helped us in many ways during a period of very rapid development and growth. We are delighted that no less than eight departments in the Faculty of Medicine are to be represented on our new Faculty Board and trust that the bonds which have developed between us to date will be further strengthened in the years to come.

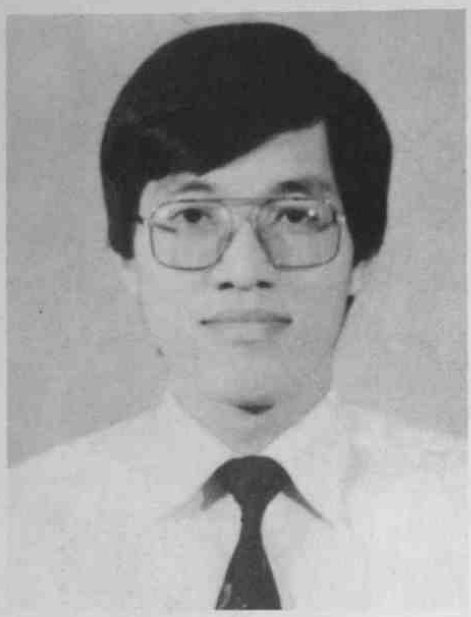
Geoffrey L. Howe
Dean of Dental Studies

21. 1. 81



# Frustrated with Med So Ex Co ?

EPORT/ACTIVITIES



## MESSAGE FROM COUNCIL CHAIRMAN

1981 has been another successful year for the Medical Society. Once again our fellow students have jointly produced a string of shining records. Simultaneously the Society actively pursued its goal of cultivating the character of our members thereby preparing themselves to be practitioners of honesty and integrity. The endeavours and achievements may act as encouragement and guidelines to the future professionals, and, perhaps, as stimulators for those to come. Of course, we have to attribute much of our achievements to the dedicated efforts of our predecessors and the unfailing support rendered by the Staff and the Profession. They have built a solid foundation upon which our Society can thrive consistently and continuously.

The Elixir serves as a record, or even more, monument, of the colourful life of the medical students It mirrors the activities, interests talents of our fellow students. It also provides a channel to bring the works and ideas of staff and students together. The Editorial Board no less than all the contributors, deserve our utmos gratitude.

A successful ending of a chapter is but the beginnin of a new and probably more difficult one. Shall w welcome the opening of this chapter by pledging to wor harder and serve better for our community.

*THE COUNCILLORS*

*HON. SECRETORY EX–CO CHAIRMAN PRESIDENT HON. TREASURER COUNCIL CHAIRMAN*

*The Agenda for today is . . . . . .*

*Dental Class Representatives*


請多多指教

*Let's proceed forward*

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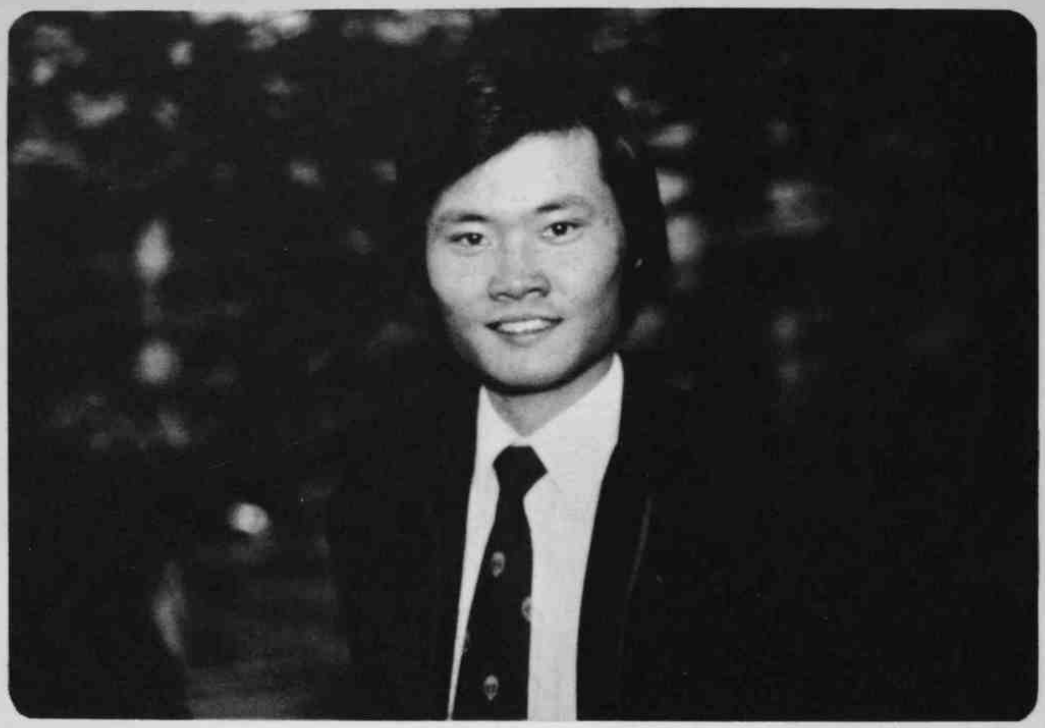


# 醫學會主席話當年

何兆煒

一九八一年香港醫療界中事件特別多的一年。在社會人士對現存醫療服務不滿的怨聲中，第一批中大醫學生開始了他們的課程，這無疑是香港醫療教育的一個里程碑。可是，正當大家還未能判斷這新醫學院的成立會對香港醫療服務帶來什麼影响的時候，中大學生會、中大校方及社會人士就已經對其收生政策、學制、及英國承認等問題展開了激烈的爭論，而這亦多少反映了普羅大衆對醫生的一些意見及期望。在醫療界內部，醫生與藥劑師今年在醫藥分家這問題上爭持不下；而隨著非英聯邦醫生移民來港的增加，政府加强了法例管制無牌行醫，引來非英聯邦醫生組織的反對，這兩件事件亦惹來許多公衆輿論的爭辯。在國際方面，聯合國訂今年爲國際傷殘年，「傷健一家」成了香港各醫療及非醫療團體的努力目標。

可是面對著這樣的外在形勢下，今年的醫學會卻是相對地沉寂。無可否認的是我們正踏入了一個轉接時期：舊的一班活躍份子離開了學生活動，而新的一羣還未可以承接上來，以致出現了各單位人手不足及活動不能廣泛推展的問題。面對著日益加重的功課壓力及個人主義的泛濫，我們嘗試提「擴闊胸懷，容納他人他事；培養公德，發揚精神；做個好醫生」的口號，可惜卻未能想出有效的落實方法去打破目前的僵局。

儘管今年未有出現任何新的突破，在會務們還是保持了一定水準的運行。在內務上，除常的文康福利事務外，我們今年舉辦了第一屆文辯論比賽，而體育活動方面，除舉辦了一屆會及兩次陸運會外，亦首次與羅富國師範學院生會合辦了第一屆「沙宣道挑戰盾」，希望通賽增加彼此的溝通與認識。此外，一度一度的項目——Gala Premiere——今年亦籌得了意外的好成績。

外務方面，我們曾在中大醫學院事件過程發資料册及以大字報形式向同學介紹事件發展，亦邀請了中大同學到來參加一個關於醫學教座談會。在醫藥分家問題上，健康委員會曾接關人士，並在啟思報導了整件事件的來龍去脈委會亦在十月尾成立了「非英聯邦醫生問題學組」，而啟思也有兩期分別以弱能人士及香港

生爲專題，引起同學對醫療問題的關注。

暑期內，我們恢復了舉辦健康展覽，今年的題「病向淺中醫」，嘗試從病徵入手向市民介紹常識。此外，一些同學又參與及協助了香港電辦的捐腎運動。我們亦協助了香港電台拍攝一「羣鏘集」，向市民介紹我們所接受的醫學教育年底的時候，我們與學護組織及理工學生會醫務系會有了初步接觸，預備明年二月間合作一廣「醫療隊伍」這概念的計劃，在幾個醫療界團體聯繫方面踏出了第一步。而在此之前，健亦在第二學期內成立了「輔助醫務人員工作學組」使同學對其他醫療單位有較透徹的了解。

在國際事務方面，醫學會今年舉辦了第四屆中學院交流團及第一次的北京醫學院專業交流團們的國際事務秘書亦被國際醫學生組織邀請加幹事會，成爲Assistant Secretary China 。

縱觀過去一年，「關心醫療界」似乎成了活動的核心，可是在活動推廣方面，各單位卻未能充分合作，以凝聚力量來克服人手不足的困難。針對這點，幹事會著重提倡醫學會的整體性觀念，加强內部調協及評議會功能，並以此作爲本年度檢討營的主題之一。雖然各單位之間一個良好的民主集中氣氛不能在一朝一夕建立起來，但對長遠的發展來看，我們確是有了好的開始。

對於活動手法的分析，一年的經驗告訴我們無需拘泥於未有一套完整的理論及實踐方法去帶動同學，而應該勇於把握時機，創造機會多方面去刺激同學思考，關心週圍的事物，週圍的人。透過文康體及認識性活動，我們希望在同學當中培養一種民主意識——對我們身處之醫學會以內及以外的人羣的關心、認同、投入、參與，而保持醫學會作爲一個富有年青理想的學生團體，在醫療界及社會中擔當積極的角色。

*Sports Secretory*

## Medic Sports

A. interfaculty competition 80–81

We succeeded in retaining the Omega Rose Bowl this year. Out of the twelve games we came:

first in Aquatics
first in Athletics
first in Lacrosse
first in Basketball
first in Softball
first in Squash
second in Tennis
second in Soccer
third in Volleyball
third in Hockey
fourth in Tabletennis
fifth in Badminton

Looking forward into next year, we have great confidence in retaining the Omega Rose Bowl again. We already have a good start by being the Inter-faculty aquatic champion in October.

B. Interyear Games

This year, we have incoperated students of Dentistry in the interyear games. The matches commenced in March and end in May. The results are as follows:

Ladies

| | Champion | first runner-up |
|---|---|---|
| Aquatics | 82 | 84 |
| Athletics | 85 | 84 |
| Basketball | 82 | 84 |
| Badminton | 84 | 82 |
| Tabletennis | 84 | dental |
| Volleyball | 85 | 82 |
| Tug-of-war | 82 | 82 |
| Champion | 84 | |
| First runner-up | 82 | |

Men

| | Champion | first runn |
|---|---|---|
| Aquatics | 83 | 84 |
| Athletics | 85 | 84 |
| Basketball | 83 | 82 |
| Badminton | 83 | 84 |
| Hockey | Dental 85 | 82 |
| Lacrosse | 84 | 82 |
| Soccer | 83 | 82 |
| Softball | 82 | 84 |
| Squash | 82 | 85 |
| Tabletennis | 83 | 85 |
| Tennis | 83 | 82 |
| Tug-of-war | 84 | 82 |
| Volley ball | 83 | 84 |
| Cross country | 84 | 85 |
| Champion | 83 | |
| First runner-up | 84 | |

| | Champion | first runn |
|---|---|---|
| Aquatics overall | 84 | 82 |
| Athletics overall | 85 | 84 |
| overall champion | 84 | |
| overall first runner-up | 82 | |

C. Awards

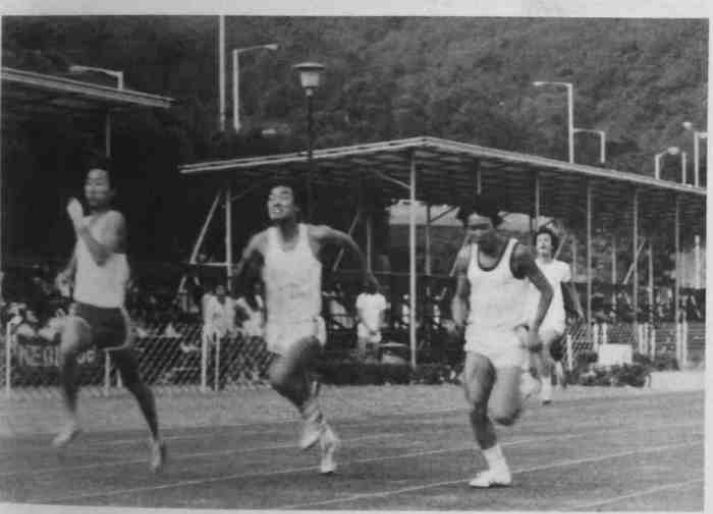
| | | |
|---|---|---|
| Sportsman | Leung Chi Wang | (82) |
| Sportswoman | Regina Ching | (84) |
| Most valuable players: | | |
| Aquatics | Iris Lau | (82) |
| | Hui Yau | (84) |
| Athletics | Lau Sau Wah | (84) |
| | Au Yui Kai | (83) |
| Badminton | Chin Sik Chung | (83) |
| Basketball | Ho Chin Ming | (81) |
| Hockey | Leung Chi Wang | (82) |
| Lacrosse | Ling Yu Yung | (Dental 85) |
| Soccer | Ying Yan Kai | (82) |
| Softball | Li Siu Man | (81) |
| Squash | David Lam | (82) |
| Table-tennis | Leung Kar Kai | (83) |
| Tennis | Richard Kwong | (83) |
| Volley ball | Chan Chor Man | (84) |

D. others

This year, we have organized friendly matches with Northcote College of Education. This is an annual competition for the Sassoon Road Shield. We hope that this will promote friendship between N.C.E. and our Faculty.

To conclude, I would like to thank the team captain of all the faculty teams, and those who has help to make the interfaculty and interyear sports a success.

Sports Secretary,
Leung Hing Tat.



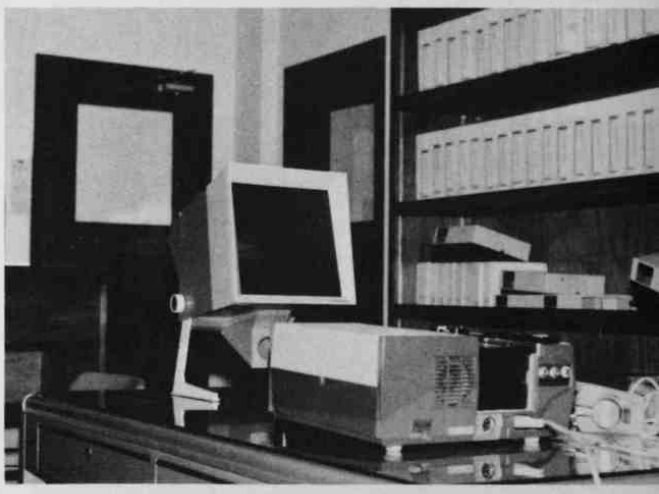
## THE LIBRARY COMMITTEE

The Library committee is a sub-committee of the Faculty Board. It is responsible for advising the Board of the Faculty on all library matters relating to the Faculty.

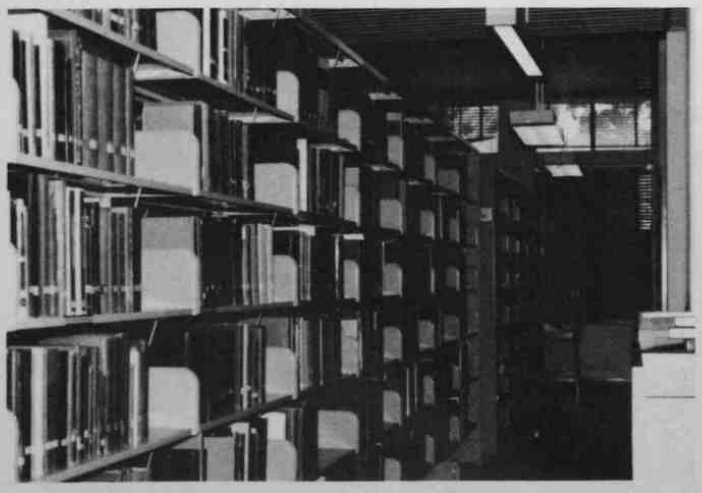
There are student representatives from different faculties and schools in the student consultative committee of the library. They are supposed to keep an informal means of communication between the library and students. They meet at least once a year. Our medical faculty has three student representatives (including one from dental studies) within this committee. Usually th discuss the use of various faciltiies in the library, openi hours and booking methods etc. in the committe Recently they are involved in a survey of current perio icals which would be considered for cancellation.

The members of the committee also receive libra bulletin from their own faculty and therefore can keep updated knowledge of the library matters concerni students.

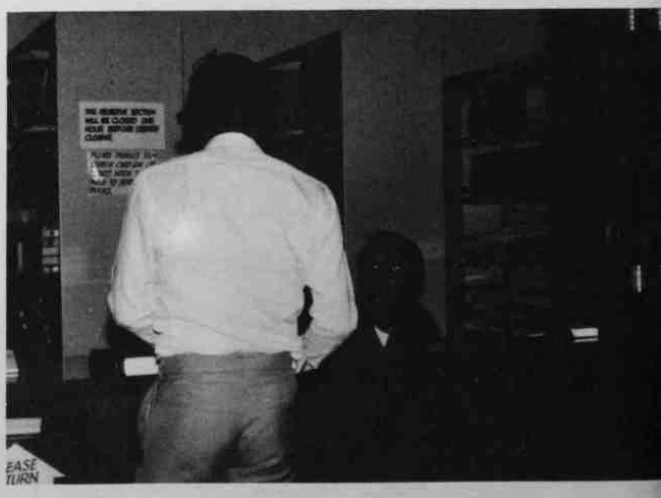
*1st floor reading room*



*Audio-visual aids*



*open shelves*



*reserve counter*

## THE MEDIC CHOIR

Since the establishment of the Medic Choir in 1977, it has maintained the primary aim of promoting interest in choir singing among medical students. This is partly achieved by regular weekly practice. The choir also provides a place for students of all years to meet and make friends. Moreover, a bit of singing can surely help to soothe the tense and hurried atmosphere in the Faculty.

Our choir has indeed demonstrated its abilities on occasions. In the Union Festival '81, our Choir for the third consecutive year came to be the first runner-up. We hope that through continued practice we can gain improvements in the future.

Last Christmas, under the arrangement of Medic 83, we joined them in Christmas Carolling at Tung Wah Hospital. It was our wish to bring to the unfortunately sick good tidings and comfort.

Nevertheless, our Choir is faced with its own problems. In order to arrange for students of all years to attend practice, we are left with no more than an hour of practice every week. The other problem is the lack of female voices in prportion to the male voices. This situation is self evident in the Medical Faculty which has a ratio of male students to female students of 6:1.

Much is left for improving our choir and progress can only be achieved through the support and advice of those represented by the Medic Choir – the Medical Students.

# CHRISTIANITY IN MEDIC

Christians exist in nearly every corner of the world. There is no exception in University of Hong Kong and in the Faculty of Medicine. The work 'Christian' means the one who follows Jesus Christ, and thus obeys Him. Being Christians, our aim in life is to glory God, lead others to know God, and love and help people. Being medical students, we should equip ourselves to be good doctors, both with academic knowledge and skill and compassion.

There are totally about 170 christians in the medical faculty. To be christians, we are eager to know and experience more about God. All our belief is based on the Bible. Thus studying the Bible is one of the important things we do. Some small cell groups are formed especially to study the Bible and discuss how to apply it in real life.

We are very eager to share the precious Grace of Salvation with our classmates. To know Him and to make Him known are of top priorities in our earthly lives. Parallel with this, we should love our classmates as we love ourselves. To share our belief with fellow students, gospel meetings are held, including talks, hymns sharing, slide showing and so on. Small groups of evangelistc Bible study groups are formed to study the Bible with our fellow students.

We emphasize the importance of fellowships l our brothers and sisters (Christians are in a same Some classes have regular meetings each week classes divide themselves into small groups and th groups that meet regularly. There may be Bible prayer, sharing of experience in God or hymns shar

There is also a faculty fellowship meeting month. Five years' Christans meet together. This orientate our attention to our responsibility in heal invite post-graduates to share their experience an point with us. (Of course, according to the Bible) talks and discussions are arranged; including:-

'The Biblical basis of healing'

'The application of the Biblical teaching on in actual situation'

'Mental healing'

'life and death'

Finally, we would like to share a golden Bibl with you, 'Salvation is found in no one el there is no other name (except Jesus Christ) heaven given to men by which we must be save

Faculty Fellowship Retreat Camp in Suen To Yuen (27–29th June 81), Fanling.

# WORK OF THE FACULTY BOARD MEMBERS

## REPORT OF STUDENT REPRESENTATIVES TO THE FACULTY BOARD 1980–81

### BEGINNING OUR WORK

The student representatives to the Board of Faculty of Medicine session 1980–1981 were elected on 25th February 1980. The campaign program was started a few weeks before the election and included discussions, preparation of pamphlets and visits to all calsses. Officially our work began in March.

### FACULTY BOARD MEETINGS

Faculty Board meetings were held once a month except during the summer vacation, when business was passed by circulation. During our term of office there were ten meetings and student members were present in all of them.

Although the student members were considered individual members of the Board not directly representing the student body, the opinions we expressed in the meetings were generally regarded as reflections of ideas of the majority of students and our comments and suggestions were accepted and considered seriously in all affairs concerning students.

Besides attending the formal Faculty Board meetings, we frequently visited the Dean, the sub-Dean, the Faculty Secretary and other members of the staff to discuss business of the meetings and related matters. Such informal discussions improved the understanding between the staff and students and avoided unnecessary conflicts in the meetings.

A major part of the business concerning students discussed in the meetings was related to the new cirriculum. New courses such as Behavioural Science, Human Sexuality and the Integrated Term were discussed frequently.

Other important issues were the change in admission policy, introduction of intercalated studies, determination of the dates of terms and changes in examination subjects and timetables.

Opinions of other fellow students on such issues were collected as far as possible before the meetings. When substantial information was required for the decision of some items surveys were conducted in the appropriate classes. Relevant information and decisions made in the meetings were publicized.

### SENATE MEETINGS

Senate meetings were also held once a month and the Student Senator was present in all meetings. Usually the business discussed in the meetings involved the University as a whole. There was co-operation with the executive committee of the Students' Union in some issues.

### CURRICULUM REVIEW

We participated in the cirriculum review organized by the Medical Society and studies were carried out on the Biochemistry course, the Integrated Term and Degree Examinations. These were related to the discussions in Faculty Board meetings and informal discussions with the staff.

### CO–OPERATION WITH MEDICAL SOCIETY

We participated in the Orientation Program and other issues such as the affairs of the medical school in the Chinese University. We were probably in a position to supply up to date information in such issues.

Other events related to student welfare would include the opening of the Pauline Chan Building, repair of facilities in the Faculty premises, and review of students who performed badly in examinations.

### SPECIAL ISSUES

**General Medical Council visit**

A delegation of the Overseas Committee of GMC visited the Faculty in April 1980 to reconsider the recognition of the M.B.,B.S. degree of our University.

We publicized the event and organized a forum to collect opinions from other students. A group of student representatives from all classes was formed and after much preparation we had a meeting with the GMC delegation. During the meeting many aspects of medical education and our cirriuclum were discussed.

In December we received the confirmation from GMC that the professional degrees will continue to be recognized for full and provisional registration in U.K.

**Universities and Polytechnic Grants Committee visit**

The Medical Subcommittee of UPGC visited the Faculty in January 1981 to discuss on the financial situation and expenditure of the Faculty.

We again formed a group of student representatives to meet the Subcommittee. The topics discussed in the meeting were financial assistance for medical students, student accomodation and transportation to outlying teaching hospitals for clinical students.

Improvements in these facilities may be provided in the next triennium of the University budget.

**PREVIEW**

Our term of office ended with the election of the new student members on 9th March 1981. Improvements in the work of Faculty Board Members in the future possible if there can be better communication with ot students, more initiative in starting projects other than routine work, and involvement of more students academic matters of the Faculty. We hope that the n members will more efficiently perform their role.

Prepared by
Ho Kau Chung Charles
(Student Senator and
Faculty Board Mem
1980–81)

# ORGANIZING COMMITTEE OF DENTAL SOCIETY

## Introduction

The separation of Dental Studies from the Faculty of Medicine is a foreseeable development in the near future. So a Organizing Committee is necessary to prepare for the establishment of the future Dental Society. Another important aim of this committee will be to discuss and consider, together with the Executive Committee of the Medical Society, all possible changes and difficulties arising from such development. Hopefully, all these can lead to future mutual understanding and better co-operation between the two Faculty-Societies and their fellow students.

At present, this Organizing Committee is provisionally responsible to two class committees of Dental '85 and '86. However, we think that all activities affecting or going to affect the Medical Society as a whole should be responsible to its Council and all other members. So we hope that this Organizing Committee can be recognized official by the Council as an ad hoc committee to deal with matters arising from the establishment of the future Dental Society.

## Present Progress

The first meeting was held on the 26th October, 1981. Six meetings have been held. A constitution drafting committee is formed within the Organizing Committee to draft the constitution for the Dental Society. Relationship with the Medical Society was discussed frequently. Staff Advisers and Student Advisers are agreed to be invited. A study programme is started to familiarize members with the present situations and structures of various students' bodies under the Students' Union, relevant information collected will be given to the constitution drafting committee for reference.

## Date of establishment of the Dental Society

The date was first proposed to be either September 1982 or December 1982. Later, after it is confirmed that the Faculty of Dentistry will be constitued in the very near future, the date was revised and agreed to be around mid-October 1982.

## Relationship between future Dental Society and Medical Society

The topic has been discussed frequently in the meetings of the Organizing Committee and with the Executive Committee of the Medical Society. The possibility of creating a new type of 'affiliated membership' in the Medical Society to promote relationship between first year Dental Students and the Medical Society has been discussed. No resolution is made at this stage. More thorough discussion will be necessary.

## Communication between Dental Students and Students' Union

Great physical barriers are involved. Anyway, a board exclusively for Union information will be allocated in the Prince Philip Dental Hospital very soon. A seat of official observer is now established in the Union Council. Four students to the Organizing Committee will be invited, three will be from the Medical Society and one from Union. Copies of informal progress report of the Organizing Committee will be sent to the Chairman of the Constitution Review Committee.

## Working Schedule

| | | |
|---|---|---|
| October | 1981 | O.C. starts working |
| January | 1982 | Official recognition of O.C. by the Council of Medical Society |
| March | 1982 | Constitution drafted |
| April—June | 1982 | Constitution discussed in the Council of Medical Society |
| | | Constitution discussed in Constitution Review Committee of Students' Union |
| | | Constitution discussed in Council of Students' Union for final approval |
| July | 1982 | O.C. technically dissolved under the Council of Medical Society |
| | | O.C. proposed to be under the Council of Students' Union |
| August—September | 1982 | Propose a cabinet for future Dental Society |
| October | 1982 | Open nomination |
| | | Election Campaign |
| | | General Meeting |
| | | General Polling |
| November | 1982 | Work finish |

In order to inform students of other Faculties about the establishment of a new faculty society, a series of propaganda programme is now under consideration. These

will include articles in the Undergrad, Caduceus, Union Bulletins and wall posters in the Main Campus; visits from other students' bodies may be arranged and invited to the Prince Philip Denal Hospital; and personal contacts maintained with different faculties societies. If possible an exhibition introducing the life of Dental Students and the Dental Curriculum may be held in the Main Campus.

**The Organizing Committee proposed**

| | | |
|---|---|---|
| Chairman | : Mr. Chan Sai Kwing | D'85 |
| Vice-Chairman | : Mr. Yuen Kwok Wah | D'86 |
| Gen. Secretary | : Mr. Wang Shi Chi | D'85 |
| Treasurer | : Mr. Ma Chun Kai | D'85 |
| Committee Members | : Mr. Chan Man | D'85 |
| | Mr. Chan Tat Man | D'85 |
| | Mr. Cheung Wan Leung | D'85 |
| | Mr. Ho Chi Wai | D'85 |
| | Ms. Lam Sin Yee | D'86 |
| | Mr. Lee Ho Chi | D |
| | Mr. Leung Siu Fai | D |
| | Mr. Leung Yin Hon | D |
| | Mr. Lo Chin Man | D |
| | Ms. Luk Wai Chi | D |
| | Ms. Tsang Chor Kwan | D |
| | Mr. Wan Shiu Yung | D |
| | Mr. Wong Chi Kwong | D |
| | Ms. Wong Woon Yee | D |
| | Mr. Yuen Fan Fai | D |
| | Ms. Yung Kam Ming | D |

The Organizing Committee is now only at the beg
ning of its work. Some of the plans may be modified lat
Regular progress reports will be sent to the Council fr
time to time.

Chan Sai Kw

# 迎新八二

馮健華

講起迎新，很多同學只會想到「迎新營」，其實「迎新營」只是衆多迎新項目中的一項。

早在四月初，迎新籌委成立後，籌備工作便展開。到了六月尾，在對MB的煎熬仍猶有餘悸的當兒，籌委便要馬不停蹄的預備迎新項目中的第一個——「中六同學日」（MATRICULANTS' DAY）。「中六同學日」的目的是向中六同學介紹醫學院及牙科學院——包括了課程，同學生活感受和收生制度等。今年的中六同學日是在七月四日，參加的中六同學超過二百人。

緊隨「中六同學日」的迎新項目是「學術性迎新」（Academic Orientation）。這項目是由港大學生會統籌而由各院系分工合作的，目的是向應屆港大入學試考生統一提供各院系的資料，重點是在收生政策和入學機會方面。內容包括了七月十三、十四兩天在陸佑堂的展覽和十七日的分組討論。

七月中至八月初是迎新工作較空閒的時間，但也是籌委落實計劃和籌備迎接新一年度的醫、牙科同學的各項活動的時候。

八月十八至二十的「迎新組長營」（Tutors' Camp）今年是在太古堂舉行。與往年一樣，學生輔導中心（Student Couselling Unit）對我們提供了很多意見和實際的協助，「迎新組長營」的目的有三個、第一是加深迎新組長之間的認識。第二是向組長介紹「迎新日」（Welcome Day）和「迎新營」（Fratern Camp）的各項活動程序。第三是加深個別組長對自己的認識——用意是使組長能夠更切身處地去幫助新同學解決他們的問題。今年參加的組長超過四十位。

跟著就是迎新的「戲肉」——八月廿七、廿八的牙科、醫科「迎新日」與九月一至三的「迎新營」。迎新日是迎新項目中第一個與新一年度的醫、牙科同學接觸的機會，也是「迎新營」的前奏。

今年的「迎新營」與去年一樣是在「烏溪沙青年新村」舉行。今年「迎新營」有頗大部分是放在新同學的聯誼和互相認識方面，而比較少接觸一些如認中關社等的較硬性的問題，就如在營中放的一套幻燈片的風格一樣——很生活化的介紹大學生活的各方面。

此外籌委還安排了買賣書的時間以方便新舊同學。

最後，值得一提的是今年的迎新是第一年有牙科同學參與籌劃和各項工作的，數日來的一起工作，可以算得上是合作無間、相處融洽，彼此之間沒有任何芥蒂、也不覺得是來自不同的學院的同學。在此謹希望即使在將來Dental Society成立以後，牙科和醫科的同學仍然能夠保持一貫的緊密聯繫，這不單是我一個人的心願，相信也是各位牙科、醫科同學的心願吧！


24


電影籌款——醫學會主要財政來源的活動——今年八月五日晚上九時三十分假利舞台戲院舉行放影「地獄戰」（A Rumor of War）共籌得款項四萬六千多元，所得款項將撥於醫學會之中大衛念醫醫學生貸款基金。

籌委會在第三學期初才正式成立及展開工作，這正是醫學院各班全面進入「緊張狀態」的時候，籌委們都努力工作，將爲數達五千多封的信件寄發各註冊西醫、牙醫及各同學家長，及大批派發廣告信寄往各大小商戶，以期收到良好效果。又七月初，各班同學分頭向各執業醫生、牙醫、講師、駐院醫生等推銷戲票及募捐，收入才達到上列數字，遠遠超過所定下的四萬元目標。

當晚酒會有二百多嘉賓到席。由籌委會主席陳漢明同學，及醫學會副會長霍泰輝醫生致辭，及由霍醫生向到席的「patrons」致送紀念品。

全院入席人數達八成以上。

節目在十一時三十分完滿結束。

# 醫學生節

黃聞强

猶記籌辦醫學生節之初，心情又是興奮又是焦慮。興奮是因爲這是一個考驗自己的機會，亦是一個帶給同學歡笑的機會，焦慮的是自己是否有能力把它辦得有聲有色。

但是，除了片刻歡笑之外，藉着醫學生節還可以帶給同學些什麼呢？提高班與班之間的感情，師生間的關係，對醫學院的歸屬感；這些聽起來總覺得有點空說，不過，自己如果眞的能在其中一方面裏做到一點成果，不就是很有意義的嗎？最後的決定是希望藉着醫學生攪好各班之間的感情。

但是，這又從何着手呢？首先從形式方面想，各班上堂時間的不同和繁密，使到醫學生節的節目只可以安排在午間和放學後舉行，而節目是要以比賽性質來吸引同學參加。這些規限似乎是沒有辦法解決的了，於是便從節目內容着手，在第一次與各班文康秘書開會時，大都認爲節目最好是不需要充分準備的，這樣才可以有較高參與率；在這個時候，才知道自己先前那「細小」的希望實是規限重重的！於是，自己便在節目時間的安排上盡量做到妥善，比賽的規則裏盡量詳盡和公平，力使整個醫學生節能沒有磨擦的情形下進行。

第四屆的醫學生節在舞獅的助威下終於開幕了，然後便是扯大纜「例牌頭盤」——。接着而是各型各類的比賽項目。在拘手瓜比賽裏，邪學請到了一位天生神力的講師助陣，替他們取部分分數而奪得冠軍。

班際康樂棋比賽是醫學院第一次舉辦的，當日數十位同學齊集Games Room，聚精會神賽的情形，煞是熱鬧。今年歌唱比賽的參與人常好，個人和小組各有三十餘之數，而水準普高；更難得的是我們能請到物理學系的馮戴雲担任評判，馮教授還向我們介紹了一些中西樂識。

隨着廿二號晚的音樂之夜，醫學生節終於了。細心想想，班與班之間的感情有否提高了想起同學們於遊戲日，爲了比賽規則的問題而兒吵起來的情形，確感到非常失望。

×××　　×××　　×××

總括而言各班內氣氛是提高了的，而同學以藉此機會發揮所長，但是班與班之間的感情沒有什麼提升。總希望同學們能明白到醫學生眞正意義，到明年醫學生節的時候能夠共同地破班與班的隔膜！


音樂之夜

# 九個月

英


還記得去年十二月左右，我班一羣志同道合的同學在一起，商量籌備健展八一的事宜。同學間的一股熱誠，就成了是次計劃的開始。但——

我們究竟有否肯定的目標呢？

健展已停辦了一年，前人的經驗，我們又能吸收多少呢？

悠長的九個月籌備工作，我們又憑甚麼來作支持呢？

在市民方面，我們實際能做到多少呢？

在醫學生方面，是次展覽又能做到甚麼呢？

在處理對內、對外的事上，我又要持守甚麼原則呢？

這一切，一切的問題就在這九個月裏不斷的盤旋在我腦海中，實在是一個不輕的考驗！

不論我們怎樣列出堂而皇之的目標，似乎「爲市民服務」這點是無可置疑的。但我們做到多少是無從曉得。

在籌備當中，最值得慶幸的是有一間藥廠全力贊助這次展覽，故此我們的工作量可以大大的減輕。但跟着便是場地問題了。我們怎能保證有最佳的日期來使用場地呢？曾經有同學建議藉着我們的Patron 的「勢力」來爭取「佳期」。但我們曾否思想過，這做法對其他申請者是否公平呢？這「手段」能否面對良心而無愧呢？

初時，表面上各方面的工作似乎都頗爲順一切都依足計劃而行，實在值得慶幸。然而·B·試過後，問題就來了。考試失手的要考，另一方面，又有不少同學要到外地旅行會裏餘下的人手頓顯疏落，工作上實在遭遇挈肘。急忙之間，唯有與副主席一起四出尋羅各方豪傑。

在往後工作過程當中，不斷發覺到自己及短處。與同學相處時，喜樂固然是有，但少誤會。有時眞是越走便懷疑自己的帶領能了最後，我只有反問自己，究竟是甚麼驅使付上這樣多時間來担負這個責任呢？（我不是個重担）是對社會貢獻之心呢？抑或是希自己要攴取甚麼呢？抑或是找機會在衆同學出自己的「才幹」呢？一時間連自己也想不有「忘記背後」便是。

從個人與同學間的合作之中，委實發覺的不少短處，亦更加認識到自己。有時，爲的進度連同學的辛勞及感受也忽略了，亦未一個大家合作的氣氛，實在有點遺憾！雖然學畢竟是同學，並非請來的工人，但很多時的工作壓力實在是無可避免。最寶貴的，是與同學坦誠相對，將心底的問題互相分担。

在對外方面，亦曾經歷不少問題。誠然展覽在Dem'tor的「訓練」上，實在奇乏無於展品及場刊的錯漏，也算不少。有時，回，也自覺在某些工作程序上是幹得馬虎一點嚴重的，是我們要向市民所負的責任。無可Dem'tor很多時是會有意無意之間「爆」錯這又怎可怪他們呢？因爲他們所接受的「訓在太少了。幸好連續數日都有高年級的同學助，否則情況可能不妙。

表面看來，這次展覽也屬不過不失。會多時，都是人頭湧湧，資料册亦一早售清，司署也要求再版。然而，這一切一切又代表呢？它究竟於市民有多少幫助呢？內中所傳息，又有多少是被市民所了解接受？有時也太大的期望，因爲就是勸自己的父親戒煙也，更何況……。

唉！罷了！畢竟人性軟弱。單是肉體得那又有何用呢？

# 捲土重來——健展八一

梁國齡

對症下藥展覽中協助畫格子，轉眼竟當「病向淺中醫」的籌委；白駒過隙的成張！

辦了一年，因此今屆的工作人員幾乎全新手；幸而我們獲得高班同學的積極支八二、八三都有相當多同學在籌委會台，協助我們這批毫無經驗，單憑拚勁的作。展覽期間，更有不少八一至八三的與講解；相信未到過今屆健展的同學，想像到多位四年級同學在版前對市民講高班同學以身作則，教導低班同學互助金科玉律；這般熱烈的參與，對籌委的語言所能表達。

內容方面，我們大胆地以病徵和病狀作提對市民的幫助，要比從個別病變著手要大前的難題包括了選材和龐大的工作量；選八二的同學肩負起了；而我們以人海攻勢量方面的阻礙；資料組工作人員竟多過三十位！今屆展覽總共動用人手之多，實已達到空前的地步。

展覽在九月十五日至十九日在大會堂舉行，由於事前宣傳積極，不久就出現排隊入場的景況。有些時候，場館內人山人海，眞有點吃不消！尤其各個有標本展出或有什麼東西量度的位置，更擠得水洩不通。很多觀衆更希望展覽延至九時，俾使遲點下班的市民能到場參觀。而籌委會出版的小册，很快便銷售一空，令負責賣書的同學，個個笑逐顏開！

展覽的成績固然令我們欣慰，但我卻更因今次展覽令我交得的朋友而高興；若不是這「一役」，我眞不能認識那末多盡責熱誠的同學。當然，我也從少部份同學中得到反面教材！雖然今次眞的十分疲累，我對健展八一的一切一切都很滿意。希望健展每年都繼續辦下去；當然也希望以後的工作人員和我一樣高興。

八一、九、廿三


# 幹事會改選

大學生是社會裏對他們期望很高的一羣，希望他們能貢獻自己的力量，爲社會服務，相信很多同學亦以服務人羣爲他們最終的理想。每個人都有自己的特質和角色，而大家亦知道在社會裏我們有多樣的角色，當我能肯定了服務人羣的意義後，最重要就是每個人自己找到最適當的方法和路向，在不同的角色裏去服務人羣。無可置疑，醫生對於我們來說會是一個極吃重的角色，但卻不能因此而否定其他角色的重要性。要在我們所有角色中都能夠把握而發揮到它的功能是一個大家的目標。而大學教育就可以協助我們向這個目標邁進。

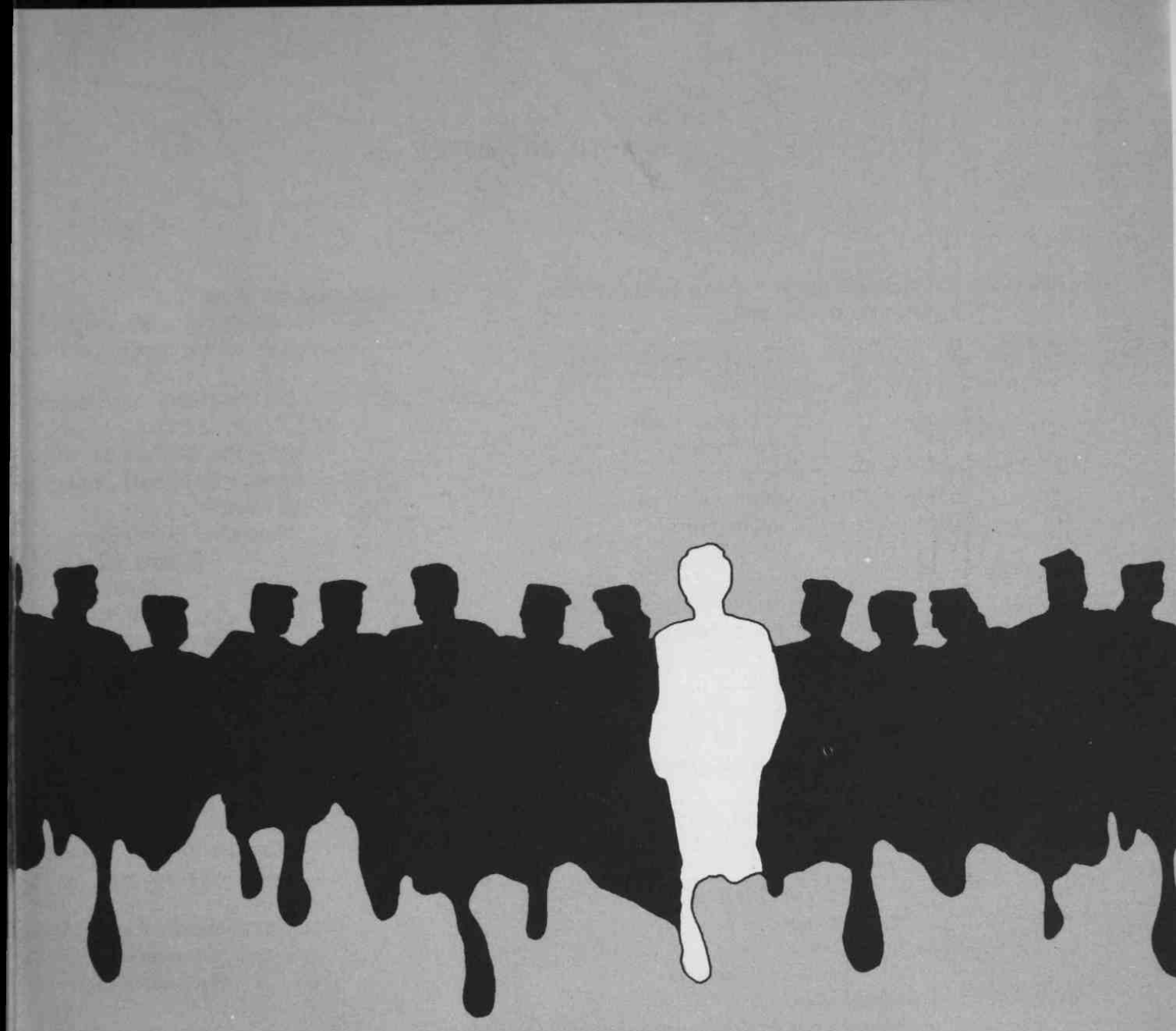
全面的大學教育包括了知識的傳授，個人性格上的培育和思想上的成長（和交流），醫學院只在知識的灌輸上下了功夫，而醫學會的角色就是去提供機會給同學參與各種活動，從而幫助個人性格成長，培養獨立思考，團結同學得到羣體的力量，爲大衆的福利而努力。

綜觀現今醫學會的情況，整體氣氛沉寂，平淡，整體結構的鬆散，再加上各常務委員會各自爲政，工作上不能一致和協調。醫學生由於環境和其他客觀因素，對社會其他事物都缺乏積極的參與。但另一方面我們覺得很多同學是不甘於現況的，他們對醫學會有很大的關心，有很高的要求，希望現況能有所改進；而一些也希望能付出自己的力量，爲使醫學會無論在方向運行上，工作上；對同學，對醫療界，對社會，都能走到更好的，更適合（同學的）境地裏。醫學會是大家的，它的發展，它的成敗，就往往決定於大家的關心和付出，大家個人的一點點支持，凝聚起來，就是信心的力量。

內閣名單

主席：馮健華（醫八四）
內務副主席：郭家麒（醫八五）
外務副主席：陳國齡（醫八五）
常務秘書：鍾錦文（醫八五）
國際事務秘書：王榮祥（醫八五）
體育秘書：黃玉庭（醫八六）
助理體育秘書：梁維遠（牙八六）
財務秘書：殷榮華（醫八五）
福利秘書：侯仕明（醫八六）
文康秘書：伍志然（醫八六）

馮健華



# TANDING COMMITTEES

# HEALTH COMMITTEE 81'

Approach: Our approach this year can be simplified with a 4 quadrant representation:

| Pracitce | Theory |
|---|---|
| Social Service | Study on health care theory |
| Health Education | Recent news on health care of Hong Kong |

Our planning is directed towards the goals laid out above and aim at a balance between study and practice.

Acutal programme:

2nd term:—Paramedical Worker Project
(12/1/81—14/2/81)

1. Occupational therapist, Physiotherapist, and radiographers
   - visit to students of Hong Kong polytechnic institute of Medical and Health Care.
   - visit to Sir David Trench Rehabilitation Centre.
2. Psychiatric Nurse
   - visit to Castle Peak Hospital
3. Ambulance Men
   - visit to Ma Tau Kok Ambulance Station
4. Medical Social Worker
   - a discussion with a Medical Social Worker from Queen Mary Hospital
5. Pharmacists
   - a visit to a Pharmacist, Mr. Raymond Poon
6. Published the report on Caduceus

3rd term:— Collection of information on recent proposal of division of labour between doctors and pharmacists
- informal discussions among students
- newspaper cutting
- visit to lecturers
- publishment of the report on Caduce

Summer Holiday 81: Wah Fu Health Education Proje
(25/7/81—22/8/81) A project f
giving Health Education to childr
between 8—14 year of age in W
Fu Estate

Programme: Games Day
First Aid and Hon
Safety
Dental Health
Anti-smoking

Content Quiz, drama, games, d
monstration, film show

Lectures given to community organizations:

- Tai Hang Tung resettlemer
  estate people's committee o
  Diabetes and Hypertension
  Common Diseases – common cold, epigastric pain and dia
  hoea
- Yee Chung social service group
  Demonstration on bloc
  pressure taking

1st term (81—82): Lectures on Health Care in Hong Kor
arranged by Health Committee.

Topic: Intorduction to health servi
in Hong Kong
Community Health in Hor
Kong.

Study group— a study on No
commonwealth docto
in Hong Kong

Social Service: Health Day organize
by 聖匠堂老人福利中心

School Health Education Proje
(Nov—Jan)


Can A Doctor Diagnose The Community Without A White Gown ?
Health officer
Assistant Health officer
Health Committee

# 八一年度啓思編委會工作報告

（因年中工作報告已在全民大會內通過，所以其中曾交待過的各項內容，在此只簡略重覆。）

× × ×

在這年內我們共出版了五期的啟思，其中第一、二、四期爲十二版，其餘的兩期則爲十六版。由於種種的因素使然，我們比年初的預算少出了一期。

報告事項：—

(一)啟思的流傳情況在今年內大致如前，即每期刊印四千五佰份，一千三百份分派各同學及講師等，另外的三千二佰分則寄發執業醫生。有鑒於後者所佔的比重頗大，所需費用（包括印刷及郵費）亦不少，我們不禁懷疑這是否「物有所值」？編委會經過內部討論後，在第四及五期啟思內，刊登了啟示一則，大意是「爲處理上的方便，要求各醫生讀者把聯絡地址連同條寄返醫學會」，作用有二：

一、粗略了解一下執業醫生們有否閱讀啟思，從而考慮維持或減少在他們中的流傳量，免除不必要的開支。

二、考慮在未來統一處理寄發工作

至於實際情況如何，乃有待來屆編委會作出決定。不過，啟思的流傳實應不時重新檢定，以避免產生積習浪費的現象。

(二)報紙的出版情況報告：

1. 重新採用整版的封面設計。
2. 校聞報導方面曾嘗試設立「校聞拾趣」一欄，以輕鬆手法報導校內見聞及活動。
3. 設立「服務專欄」，歡迎短篇的意見抒發、來論、提問及其他的服務，但反應頗爲冷淡。
4. 第一、二期沿用了分版方式，即專題、時事、校聞、醫療及綜合。第三期開始改用不分特定版面的出版方式，編委們按已定題目分組工作，但大體內容並無多大變動。兩種方法比較上以後者的彈性較大，工作興趣亦較高。

(三)編委會的其他活動：

1. 於年初時曾作了一次抽樣的問卷調查，同學對啟思的意見，並於其後舉行了一談會，向同學介紹啟思的工作及內部情
2. 迎新活動——九月初迎新茶聚及學期初輯工作簡介（附：今年加入啟思的新同十多位）
3. 十月中旬就醫學教育及雙語教學問題，了一次座談會，並邀請數位高年班同學短發言，氣氛頗爲融洽。

(四)回顧點滴：

1. 在轉庄時候所提出的「走向同學」及帶委以「服務同學爲辦報重點」等希望均實現。
2. 在「走向同學」一環上我們所下的工夫尤其是宣傳方面——未見充足，編委會學的隔膜及疏遠感仍存。
3. 編委們加入啟思，似乎都各有各的興趣望、及希冀，「服務」的概念頗爲模糊內我們一羣骨幹人物亦未能處處强調及「服務同學」的辦報精神。
4. 編委會在這年的出版方面，曾作了不少嘗試，但仍未能創出一個鮮明的、煥然的風格。希望來屆的編委們能有大一點子，作大刀闊斧的新改革嘗試。
5. 編委會初期（指在上學期初）人數頗多致「起步」時在的統籌、聯絡、溝通上現問題。
6. 今年啟思的出版時間分配得頗爲差勁，大概有二：—編委們的工作時間觀念不截稿日期往往形同虛設。
   —與印刷公司的默契及合作，以致經常有延誤及技術，不能依期出版等情形出
7. 同學的投稿情況仍是普遍冷淡。

(五)感想(一丁點兒)!

今年的啟思辦得怎樣?

感覺上似乎是毀多於譽。同學們仍是不大重視報紙的存在與否,有批評的亦多著眼於缺點上吧了!

願成績永遠是來年的較佳!

也對去年編委們的努力致謝!

啟思老總:(八一):

## 每期報紙簡介:-

第一期

專題爲「健康就是財富」,介紹勞工保險、醫療保險及保健等。其他的有Prof. Hsieh 有關課程的來稿及論兩巴加價、四人幫公審等文章。

第二期

「弱能人士在香港」——這期專題題目。內容爲探討香港的弱能人士在教育機會、康樂、住屋、工作、交通及康復上的種種問題。其他的有放射治療及時事等文章。

第三期

這期開始改用了不分特定版面的工作方式。比較大型的出版題目有:

(一)醫學生生活——「醫中一年」,以文藝筆觸,從「讀與樂」、「課餘時」、「住Hall」及「Mini-Hall 生涯」等各方面鈎劃出醫一同學的生活及感受。

——「Medic-Medic沙宣道」,集八三、八四、八五及Dental同學的來稿而成一小品式的醫學生生活翦影。

(二)「General Practice在香港」——介紹GP的執業情況,未來的普通科學系及藍新福醫生的訪問。

其他的包括有兩位在外國習醫的朋友的來稿及健委討論醫藥分家和醫療輔助人員工作研究報告。

·第四期

「蹺界」,是淺論青少年的犯罪及自殺問題的一個專題。其他的包括有「國內旅遊拉雜談」、「葵涌精神科醫院訪問」及邀約兩位其他院系的來稿談述「他們眼中的醫學生」。

·第五期

這一期報紙的內容頗爲充實,比較大型的題目有:

(一)遴選制度看今昔——綜論近年來醫學院收生制度的改變及在一年級同學中進行的問卷調查結果。

(二)醫學教育意見點滴——包括各學系講師的意見及座談會報告。

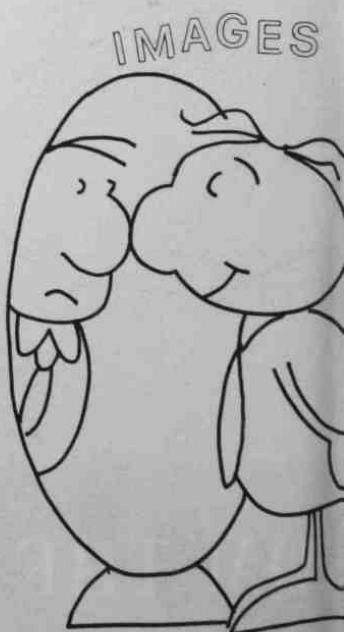
(三)精采來稿多篇。

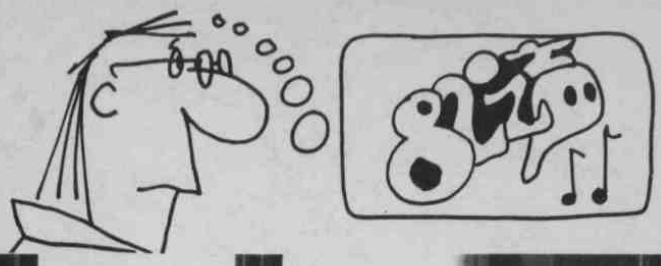





# ROM THE CLASSES

# 82





"

. . . . . The demands of life are much too manifold to let such a specialised training in school appear possible. . . . the school should always have its aim that the young man leave it as a harmonious personality, not as a specialist. This in my opinion is true in a certain sense even for technical schools, whose students will devote themselves to a quite definite profession. The development of general ability for independent thinking & judgement should always be placed foremost, not the acquisition of special knowledge.

– Albert Einstein –
Oct., 1936

"


八三滿天下

# 八五

於聖誕假期內到佛教般若老道老人院探訪。

郊遊樂—初冬時分

衛衛，八五齊心誓要立奇功，Interclass Atheletic
leet 勇奪男、女子及全場總冠軍

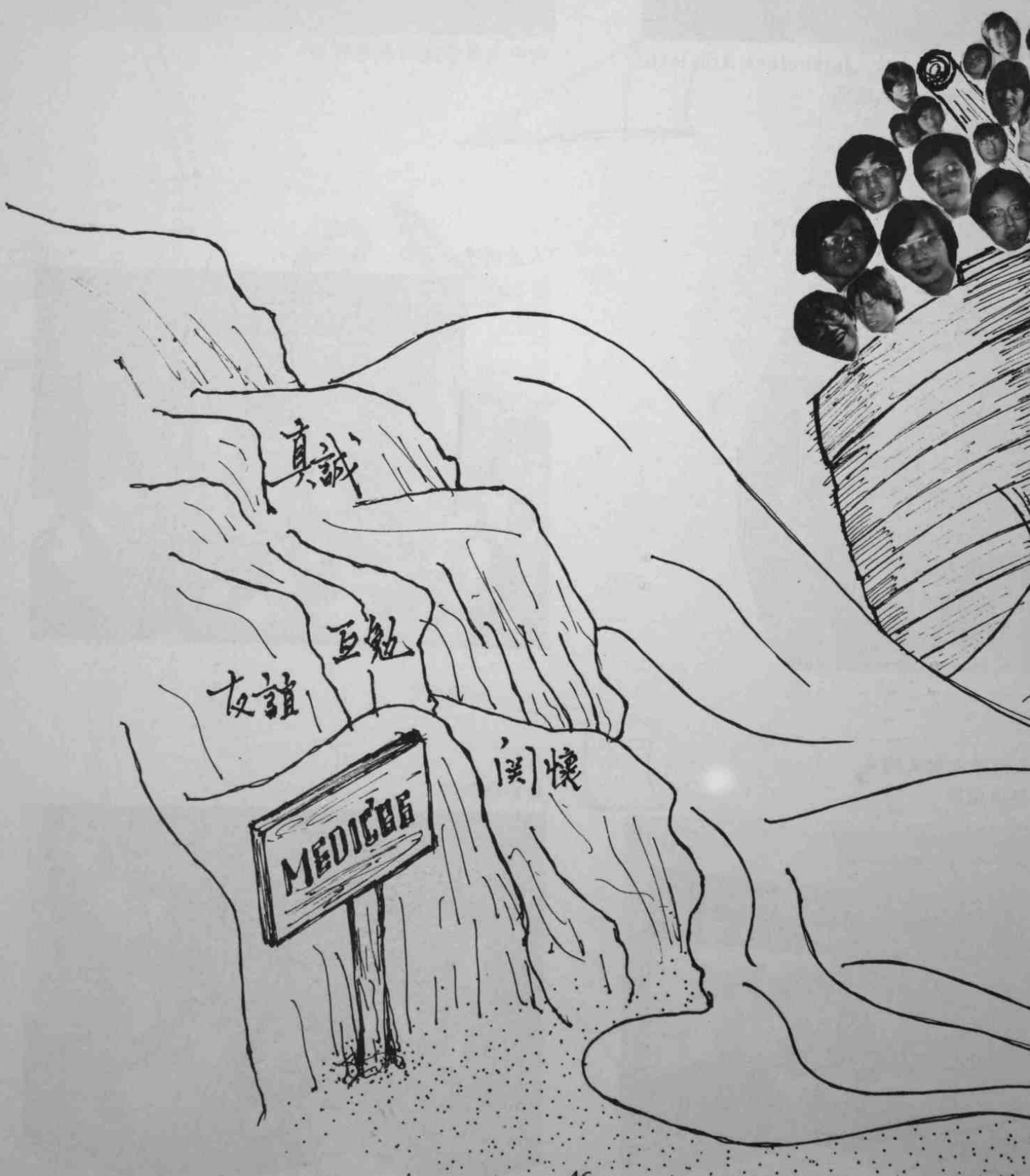
到中大醫學院作友好探訪

八五同學一家親，Term尾

講座：醫學生理想的轉變
醫生在社會的責任
老人醫療在香港

勇勇，八五同學有智又夠勇
學生節奪得總冠軍


聚餐樂融融


真誠
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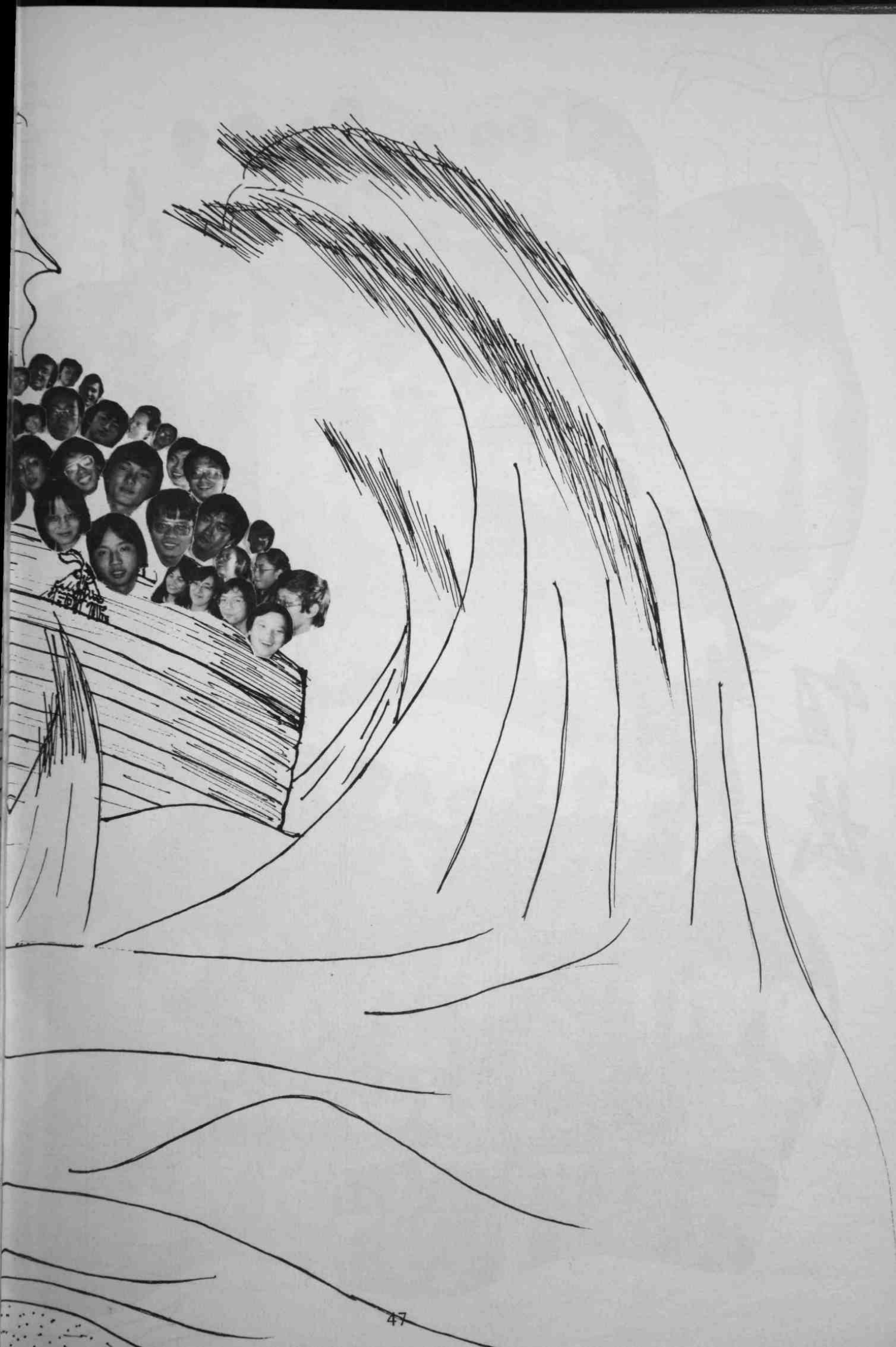


二年級
恒岳

# DENTAL 85

# 86

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# IDENTITY

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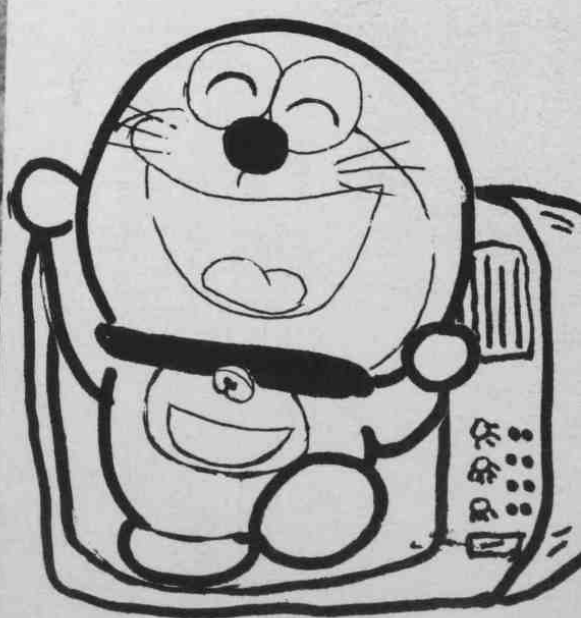
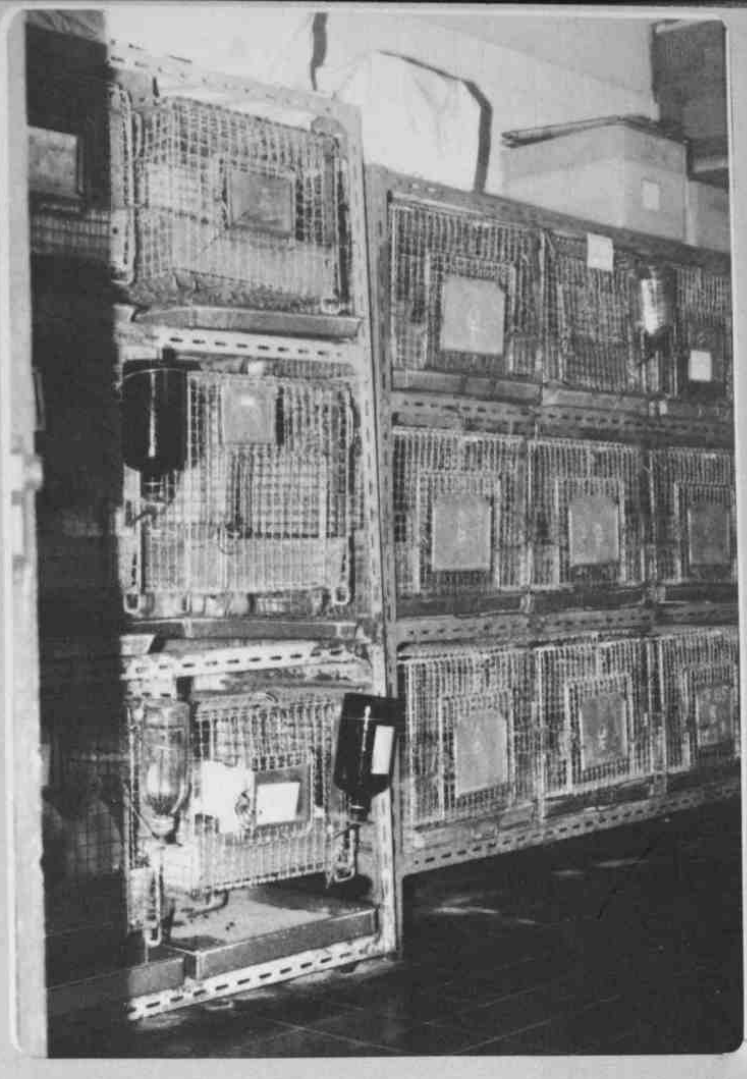
T.V.ROOM



拉鋤記書

# SOCIETY

# PHOTO




# DEPARTMENTAL SURVEY-PHARMACOLOGY

*Dr. C.W. Ogle*

Dr. C.W. Ogle graduated from the University of Malaya where he obtained his M.B.,B.S. degrees (with distinction in Obstetrics and Gynaecology) in 1958. After completing his Housemanship at the Singapore General Hospital, he worked for two years as a Medical Officer before joining the Department of Pharmacology at the University of Malaya at the end of 1960, as an Assistant Lecturer. He beame a Lecturer three years later. During his tenure as a Lecturer he was awarded a Riker International Research Fellowship which enabled him to carry out research at the Department of Pharmacology in the Medical Faculty of the University of Western Australia form 1964–1966. Dr. Ogle obtained his Ph.D. from this University. He came to Hong Kong in 1969 to take up a Senior Lectureship in Pharmacology at the University of Hong Kong. In 1976, he was promoted to a Readership.

On being asked his opinions of the present curriculum, Dr. Ogle said that as far as Pharmacology is concerned, its placement in the M.B.,B.S. teaching programme is acceptable. Ideally, the subject should be taught after the students have finished their preclinical course and obtained a reasonably comprehensive understanding of normal function to enable them to appreciate the actions of drugs at cellular or systemic levels. The present course of basic Medical Pharmacology should permit students to continue without any difficulty into Clinical Pharmacology where they will then learn details of drug actions and profiles when they focus upon individual patients.

He thinks that medical students here are basically like their counterparts elsewhere in commonwealth medical schools. However, Hong Kong students generally put too much emphasis on memorisation of facts without paying sufficient attention to rationalisation and understanding concepts. Happily, this tendency of studying blindly appears to be less nowadays, when compare to the time when Dr. Ogle first came to Hong Kong in 1969. More students now also tend to ask "why" and do not simply accept everything they are told by their teachers.

His current main field of interest is in the aetiology of experimentally induced gastric ulceration and of the effects of drugs on these lesions. Another avenue of interest is in researching into the pharmacological properties of Chinese herbal medicines. Because of the numerous preparations available, only selected medicines are investigated. Selection is based on the popularity of the preparation and on whether the claimed pharmacological properties could have important implications concerning public health. One such herbal preparation, Yunnan Pai Yao (claimed to possess haemostatic activity), continues to be studied.

Dr. Ogle has one son and two daughters. Two of his children have already started tertiary education in a university. He likes driving, playing chess, and classical music. His favourite sports are rugby, badmintton and judo. He won his school colours for rugby, and later played in the University of Malaya first XV and for a number of rugby clubs in Malaya and Singpaore.

*Dr. D.M.F. Li*

Dr. Li received his B.Sc. and Ph.D. degrees in Pharmacology from Monash University, Australia; and he continued his postdoctoral studies in Wales, U.K. In 1974, he returned to Hong Kong as a lecturer in the Department of Parmacology.

His main field of research is cardiovascular pharmacology, investigating the mechanisms of action of antihypertensive drugs as well as the physiological control of blood pressure. In recent years, he has become interested in the pharmacology of cannabis, and has contributed a chapter in the book "Cannabis and Health".

On asking for his advice to medical students, Dr. Li said that they should make more use of their textbooks, which will improve not only their comprehension of the subject, but also their skill in answering essay questions in examinations.

Dr. Li is happily married and has two sons. Besides his research work, he likes music, swimming and travelling.

*Dr. M. Y. Chan*

Dr. M.Y. Chan obtained her B.Sc degree in 1965 from University of Hong Kong. In 1970 she obtained her Ph.D from the University of California. Dr. Chan began to work in the Department of Pharmacology of University of Hong Kong from 1971.

The main field of interest of Dr. Chan's research is the interaction of central active drugs with adrenal corticosteroids.

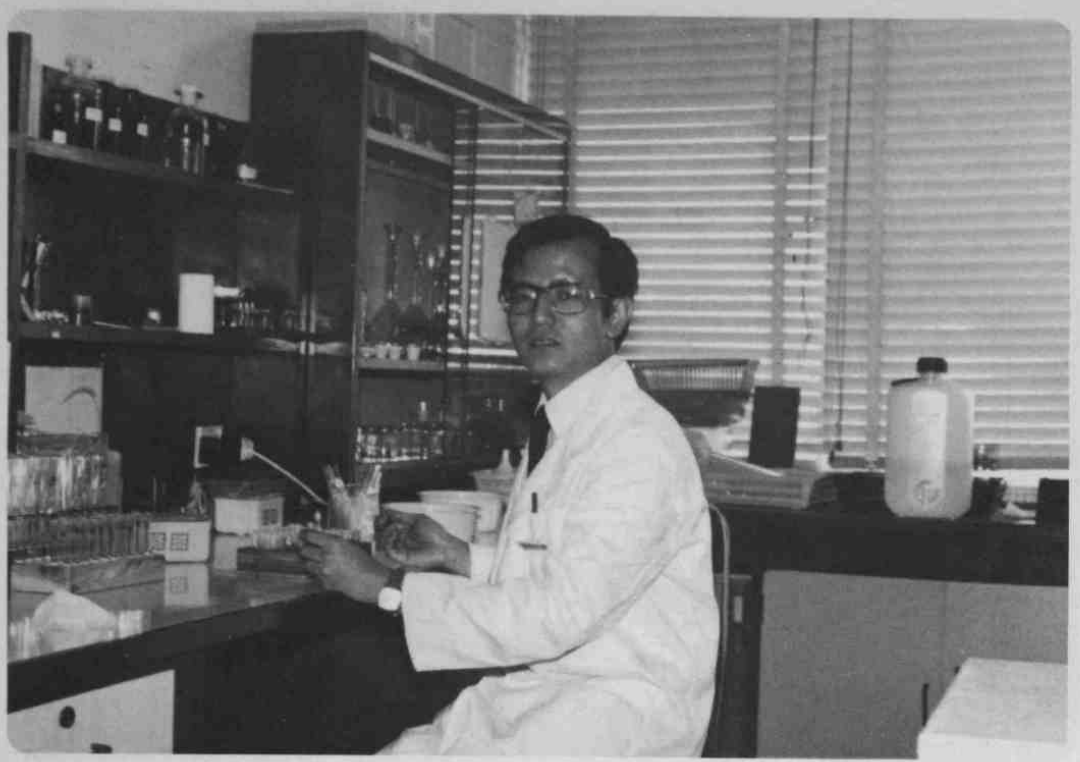
Dr. Chan expressed her astonishments in the reluctance of our medical students to read texbooks, since the ability to learn from books is the acknowledged basic requirement for a University students. As a result of learning from badly written and sometimes erroneous lecture notes, the communication skill of many of our medical students in examinations is poor. Hence, although our medical students are very deligent, the outcome in examination does not always match their efforts. Dr. Chan advised us to varify and amend the lecture notes with informations from textbooks and references before using these notes for revision.

During her holidays, Dr. Chan likes travelling abroad. In her free time, she likes to do some reading.

*Dr. G.M. Sein*

Dr. Sein was born in Burma and obtained his M.B.,B.S. degree from the University of Rangoon i 1964. He then served in the Defense Services (Army) Hospital after completion of his internship, and joine the Department of Pharmacology, Institute of Medicine, (Rangoon) in 1966. During that time he was als involved with the W.H.O. Campaign projects on the evaluation of drug therapy for T.B. and Trachoma. I 1969, he was awarded the Columbo Plan grant to continue his postgraduate studies at Guy's Hospit Medical School, University of London, from which he obtained his M. Phil degree in 1971. On his return t Burma, he served as a teaching staff in both the Rangoon Medical and Dental Institutes. De. Sein joined th Department of Pharmacology in 1979 as a temporary lecturer and was appointed lecturer in 1980 und Dental Studies.

His early research was on the effects of drugs on isoenzymes of LDH and cholinesterase. His preser research interest is on the effects of nitroimidazole compounds and hydantoin on immune system. Dr. Sei finds the teaching in HKU does not greatly differ from that of the previous institutes he has worked in. Th improvement of the Pharmacology course, as he pointed out, depends considerably on the feedback of th students, especially with the Dental course, which has only been introduced in recent years. His impressio of the first batch of dental students is that they are well motivated with a satisfactory overall performance



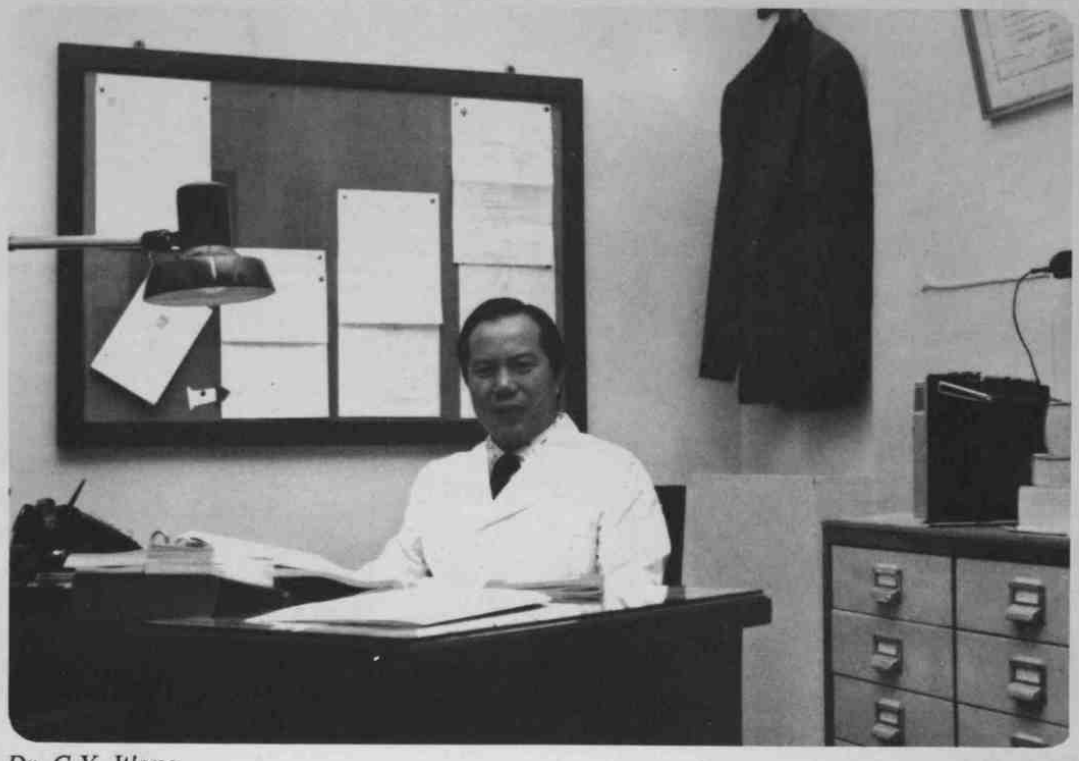
*Dr. S. Dai*

Dr Dai joined the Department of Pharmacology in 1970 as a demonstrator after he had completed medical training in Taiwan and worked as a medical officer in the United States. He was appointed lecturer and senior lecturer in 1974 and 1981 respectively. In 1974, he was awarded a Ph.D. degree in Pharmacology. He also obtained the Licentiate of the Medical Council of Hong Kong (L.M.C.H.K.) in 1980.

Dr. Dai is quite satisfied with the research and teaching work which he had been doing in the past ten years. His research interests include pathophysiology of gastric ulcer in relation to autonomic nervous system and histamine, types of histamine receptors in various organs, and the possible role of trace elements in the causation of certain experimentally induced diseases.

Dr. Dai has a son and a daughter. His hobbies are jogging and football. He is an active member of the Pharmacology staff soccer team. He also enjoys reading, especially classical Chinese novel such as 'The Water Margin' and 'The Romance of Three Kingdoms'.

He is keen at both teaching and research. He hopes he would have more opportunities to visit other research institutes for further studies. Finally, we wish him every success in future.

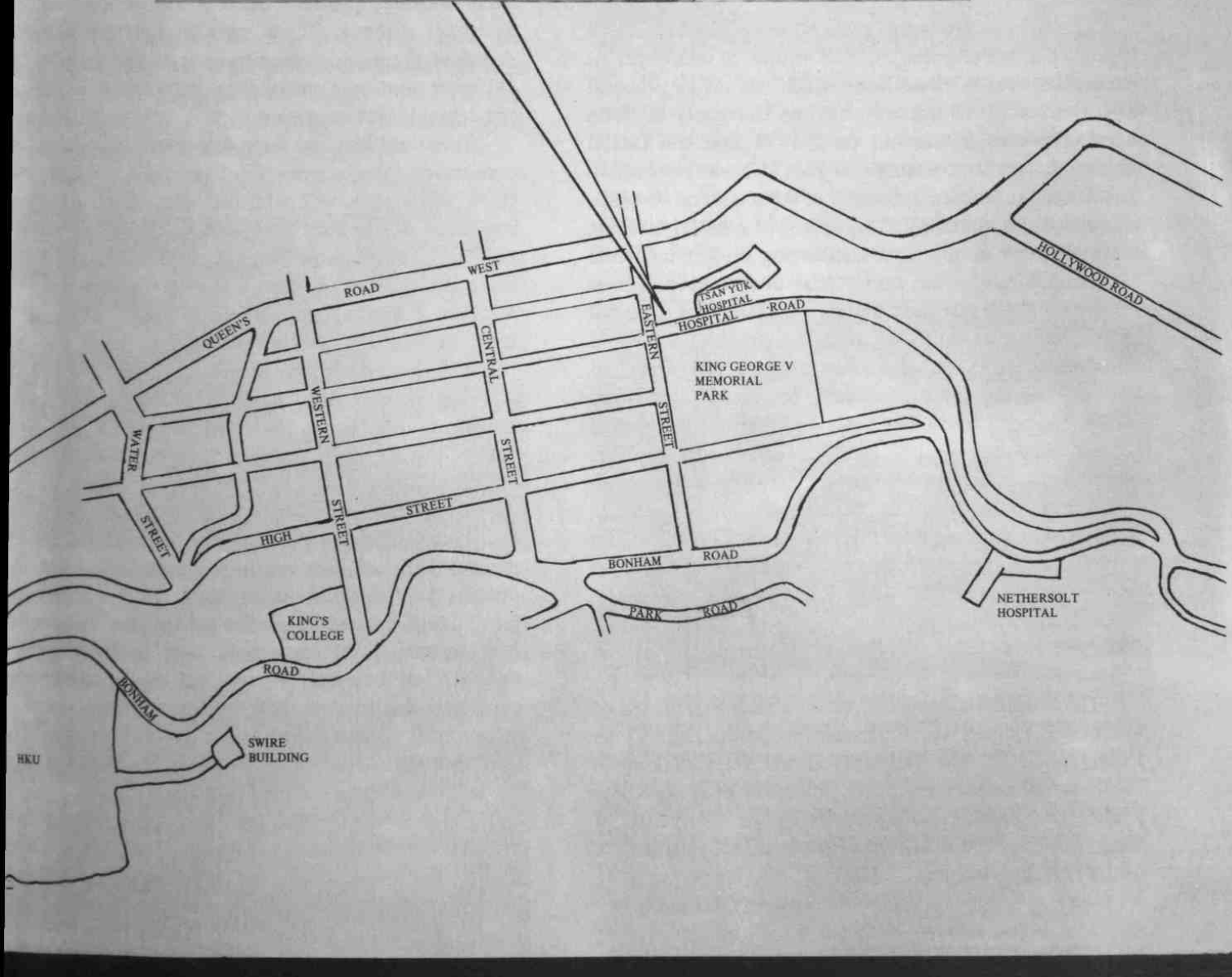


*Dr. C.Y. Wong*

Dr. Wong completed his secondary education at St. Paul's Co-educational College in 1950, and proceeded to attend the Medical School at the University of Ling-nan. This was an usual alternative many students intending to study medicine as the University of Hong Kong was only accepting very medical students at that time. After obtaining his M.B. degree in 1955, Dr. Wong continued to work teaching hospital in China.

In 1966, one year after the establishment of the Department of Pharmacology under the headshi Professor C.Y. Lin, Dr. Wong was appointed demonstrator in the Department. In 1973, he obtained Ph.D. in Pharmacology with his research on serotonin in the gastro-intestinal tract, and was appoin lecturer in the following year. In 1977, Dr. Wong sat for the registration examination and became a lice ate of the Medical Council of Hong Kong. He then had a brief study leave to refresh his clinical trainin Nethersole Hospital. Dr. Wong expressed that he has no intention of giving up teaching, as the registrat examination was merely a challenge from which he could obtain a sense of fulfillment. His present resea interests involve drugs acting on the central nervous system.

Dr. Wong is happily married and has a daughter. Though leisure time is not abundant Dr. Wong fi enjoyment in listening to classical music and in photography.


# RINCE PHILIP DENTAL HOSPITAL

# PRINCE PHILIP DENTAL HOSPITAL

## A GUIDED TOUR

### INTRODUCTION

Perhaps you have already heard or seen a lot of publicity concerning the Prince Philip Dental Hospital or perhaps you have been there for some reason or other. But are you aware of its actual structure and functions? Why was the Government willing to spend such an incredible amount of money to create this magnificent facility? What is inside this superb building and what role is it designed to play in society? We think that everyone will be interest in knowing the answers to such questions.

### BACKGROUND OF THE PROJECT

The story began in 1974 when the Legislative Council approved a white paper on the future development of medical services in Hong Kong which included a proposal to introduce dental education in the University of Hong Kong. However it was not until 1976 that the Dental Academic Advisory Committee (DAAC) was establshed. The DAAC submitted a number of reports some of which concerned the building and equipping of a dental teaching hospital. Such a huge and challenging project in dental education is rare in the world today due to the high costs involved and the relatively low priority accorded to dental health in developing countries. Even in developed countries existing dental schools tend to be refurnished and rehoused only infrequently. So the Prince Philip Dental Hospital symbolises both the significance accorded to dental public health by the Government and its determination to improve matters. It was not until mid-1978 that the actual construction commenced, and the building was finished during the latter half of 1980. The hospital was opened formally by H.R.H. the Duke of Edinburgh in March 1981.

### ADMINISTRATION

The hospital is administered by a statutory Board of Management under the Chairmanship of the Hon. Lydia Dunn, OBE, JP. The full-time clinical staff working in PPDH are all employees of the University of Hong Kong, whilst the students belong to either the University of Hong Kong, or the Insititute of Medical and Health Care of the H.K. Polytechnic.

### FUNCTION OF THE HOSPITAL

The Prince Philip Dental Hospital is purely a teaching hospital design to provide complete training facilities for dental undergraduates and para-dental students. It has no service role. Sohphisticated equipment is also provid the hospital for research purposes. Members of the ge public are invited to become patients for the purpos teaching programme. It must be emphasized tha hospital's resultant service contribution is but a product of the academic activity. Patients who are required for teaching purposes either because of nature of their dental problems or because sufficient of the same type are already registered are discharge cases of dental distress, essential emergency treatme provided before they are advised to seek treatment where and discharged.

The HKU students in PPDH are being trained become fully qualified dentists and leaders of de health care teams. There are also four grades of p dental workers undergoing training in parallel with th Different combinations of these para-dental workers f the dental health care team.

These student ancillary workers undertake a st core curriculum course which in theory could lea their certification as dental therapists. Each stage ca regarded as an individual course since each type ancillary has a viable role in their own right. De therapists are at present only being trained at MacLehose Dental Clinic in Happy Valley. The other types of ancillary are being trained in the Prince De Hospital and the HK Polytechnic.

Another and different group of Polytechnic stud are also present in the hospital are undertaking the th year course leading to the award of a Polytechnic Dipl in Dental Technology. To date they have spent two y in the Polytechnic and their final year in the hospital the course is shortly to be sandwiched. Another grou personnel trained here are the engineers who maintain dental equipment and operate the services of the hosp Since dental education has not existed previously in H Kong, much of the equipment found in the hospital not been seen here before, especially the sophisticated expensive facilities used for research purposes. Spe technicians are required to maintain these delic machines and have received in-service training in Prince Philip Dental Hospital.

The last but not the least aim of the hospital is prevention of oral disease and promotion of public de health. Talks, exhibitions and dental health campaigns held regularly. Statistical data on the oral health selected groups of the population is also being collec during the various teaching programmes in the hospi Before the establishment of the Prince Philip Den Hospital such data was lacking and so these studies sho prove to be invaluable in the drafting of dental hea education programmes in the future.

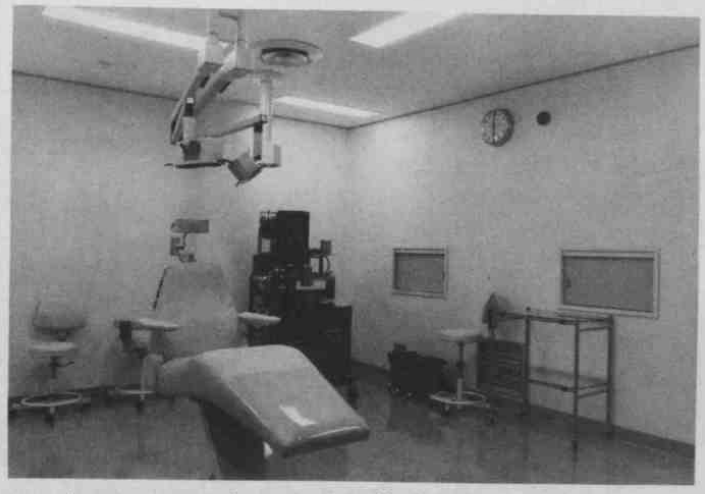
## DENTAL SURGERY FACILITIES

The building contains no less than 241 dental chairs, 142 of which are sited in student workplaces in the large open clinics in the Departments of Conservative Dentistry, Children's Dentistry & Orthodontics, Periodontology & Public Health and Prosthetic Dentistry.

All clinical workplaces are ergonomically designed and allow dental procedures to be performed with the patients either sitting up or in the supine position, by left or right handed operators working with or without assistance. A unique feature.

Every staff surgery in the building and every student workplace in the Department of Periodontology and Public Health, and the school of dental hygiene is equipped with an ultrasonic scaler fitted either in or on the cabinetry.

In order to ensure highest standard of patient care and safety, it was decided that general anaesthesia, with the exception of relative analgesia, would only be administered in premises especially designed for the purpose. The general anaesthesia suite comprises of waiting room, changing rooms, medical examination rooms, a scrub up instruction room, two operating theatres and a recovery room.



A two-way mirror is installed in one surgery in the Department of Children's Dentistry to facilitate observation by students of the management of difficult or uncooperative children. A 'panic' button is fitted at every clinical workplace to be used in emergencies to call the 'crash call' team who are equipped with 'walkie-talkie' radio.

Also, all departments have surgeries designed to provide access for handicapped persons either in wheelchairs or on stretchers.

## ORAL RADIOLOGY UNIT

The Oral Radiology Unit is situated on the first floor

adjacent to the Reception and Primary Care Unit. It contains a number of X-ray machines each serving a different purpose. The most common are the dental X-ray machines one of which is of the variable voltage type. Both types can produce a clear and detailed radiograph but the variable voltage machine is mainly used to produce the intra-oral films used in Periodontology. There are also two ortho-pantomograph machines which produce a picture of the whole of both upper and lower jaws on one film. The cephalostat is used to take lateral views of the skull for orthodontic purposes whilst the skull X-ray machine, which is uniqed in H.K. can be used to take a variety of views of the skull and jaws including tomograms and sialograms.

This unit is also equipped with automatic developing machines and day-light developers and is capable of providing all the many and varied types of oral radiographs. The main radiography unit is supplemented by the provision of seven satellite radiation-protected X-ray rooms in clinical areas, each of which contains a dental set and a daylight developer.

## TECHNOLOGY LABORATORIES

The main facilities for dental technology are housed together on the 4th floor in order to minimise noise and dirt nuisance and comprise two 24 place and one 106 place laboratories with supporting facilities. However, limited dental laboratory faciltities are also available in all the clinical departments to facilitate adjustmen modification of appliances. The technical laboratori equipped with workplaces of an advanced and mo design.

Two phantom head laboratories are provided o 6th floor in which dental students learn the prac techniques used in Conservative Dentistry.

## ANIMAL LABORATORY

This exceptionally fine animal facility, which is at ground level to minimise nuisance, has the capaci house marmosets in germ-free conditions for rese purposes.

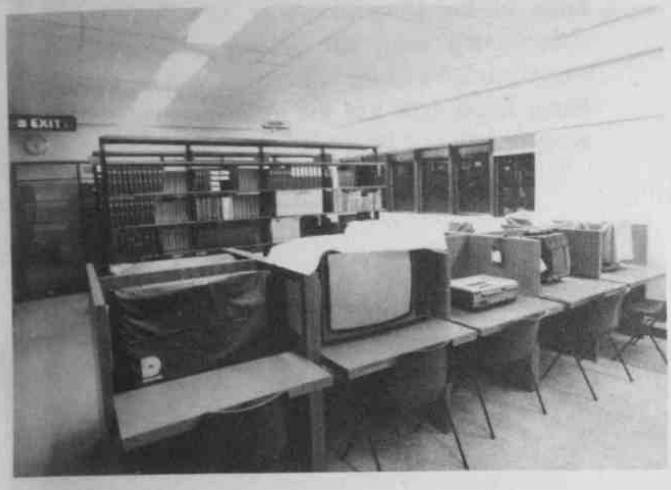
## OTHER LABORATORY UNITS

Other laboratories like pathology laboratories, those used for forensic odontology are designed to fu both teaching and research purposes. Expensive multi- research equipment is housed in laboratories on the floor, facilities for basic research being provided in te ing staff offices.

## LIBRARY

The dental Library has been develop from scratch despite the enormous problems which had to be o come, now houses an excellent collection of books journals, some of which are on mircofilm and mircrofi

Audio-visual teaching aids including two video cassette recorders, three caramate projectors, four microfiche readers and three microfilm readers are provided by the Library in parallel with photocopying services (including microfilm, photo-copying). The Library contains 70 carrels for the use of students.



## 'POSTGRADUATE' UNIT

The 'Postgraduate' Unit is situated on the ground and first floors and comprises a large lecture theatre seating 270 persons, a small lecture theatre seating 80 persons, three seminar rooms and office accommodation. These facilities are designed to be used for the teaching of both dental undergraduates and para-dental students and will also be used by post-graduates including both dental and medical practitioners. A large gallery suitable for exhibitions, and receptions is situated adjacent to the lecture theatres.

## DENTAL ILLUSTRATION UNIT

As the hospital is a teaching institution it houses a fine photographic unit sited on the first floor, which is equipped with modern and advanced facilities both for making and reproducing slides and other audio-visual aids for teaching purposes.

A graphic artist and her supporting staff occupy studios on the ground floor.

## CANTEEN

A canteen is situated on the 7th floor and is designed to cater for the needs of all the staff and students in the hospital when it is fully operational. Splendid kitchen facilities and a terrace are also provided.

## COMMON ROOMS

The three common rooms on the 7th floor provide facilities for both students and staff to relax and enjoy themselves.

## EXPANSION IN THE FUTURE

As the site is 100% occupied it would not be possible for additional floors to be added to the building, if needed, without disrupting activity within the building. Therefore the possibility of expansion of the hospital has been catered for by providing 33,928 sq. ft. of usable but unallocated space equipped with all main services on the 5th floor. Part of this is to be accommodate the Dental Data Processing Unit.

## CONCLUSION

Since its opening many distinguished and knowledge

visitors have toured the Prince Philip Dental Hospital. Without exception they have been very impressed and a typical comment is found in the Newsletter of the Hong Kong Dental Association for December 1981 which reads as follows:

> In lieu of the monthly scientific meeting, the December Meeting was in the form of a guided tour of the Prince Philip Dental Hospital. All together 270 persons attended (200 members and guests, 50 Dental Studies Staff). The Prince Philip Dental Hospital is really an ey opener and thanks to Dean Howe and the staff the Hospital, the visitors were very well intr duced to this colossal building. They we divided into groups led by the staff of Dent Studies after a buffet dinner to explore differe areas of the Hospital. After an exhaustive bu enlightening tour, the visitors were absolutel overwhelmed and the concensus opinion was th Hong Kong now has the most modern and be equipped Dental Hospital in the world."

VALEDICTORY

PUBLICATION

DEGREE CONGREGATION

SENATE

APPOINTMENT

HONOURS

PERSONALIA

COURT

# EXTRACT FROM GAZETTE
# VOL. XXXI No. 1-3 (Sept. - Dec., 1981)

## ONE HUNDRED AND THIRTEENTH DEGREE CONGREGATION

### DEGREE OF DOCTOR OF MEDICINE

Dr. Wong Kwok On 黃國安
Dr. Victor Yu Yu Hei 余宇熙

### DEGREE OF MASTER OF SURGERY

Dr. Lam Kam Hing 林鑑興
Dr. Leung Ping Chung 梁秉中
Dr. Stephen Lim Thuan Kiang 林傳駉

### DEGREE OF MASTER OF MEDICAL SCIENCES

Raymond Tsang Shiu Wah 曾肇華
Raymond Yuen Chuen Fong 袁泉芳

### DEGREE OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

*Honours List*

John Chan Kwok Cheung 陳國璋 (Distinctions in Physiology, Pharmacology, Pathology, Community Medicine and Obstetrics & Gynaecology)

1980

*Pass List*

(Miss) Cham Cho Lan 湛佐蘭
Chan Ping Yung 陳炳勇
Chan Wing Kay 陳永基
(Miss) Anne Fang Hang Sang 方幸生
Fu Yiu Kai 傅耀鍇
Ho Hok Fai 何鶴輝
Hung Chi Tim 熊志添
Kong Tak Kwan 江德坤
Arnold Kwok Kon Hung 郭冠雄
Lee Shue Kai 李樹溪
Lo Kuen Kong 盧乾剛
Lui Sing Heung 雷聲响
Poon Kai Ming 潘啓明
(Miss) Judy Siu Hing Mui 蕭璚梅
Henry Siu Kin Leung 蕭健樑
Donald Tang Lap Chiu 鄧立超
Gene Tsoi Wai Wang 蔡惠宏
(Miss) Francie Tung 董光光
Wong Chi Kin 黃志堅
Yu Wai Cho 余衛祖

*1981*

*Pass List*

Au Wah Cheong 區華昌
Beh Swan Lip 馬宣立
Warren Chak Chi Wah 翟賜華
Chan Chee Hung 陳熾鴻
(Miss) Patricia Chan Chee Ka 陳志嘉
Chan Chi Wai 陳志偉
Chan Ho Kit 陳浩傑
Chan Ka Yuen 陳家遠
Chan Kin Sang 陳健生
Chan Kwok Pui 陳國培
Chan Ming Houng 陳銘洪
Chan Wai Kam 陳偉金
Chan Wai Nang 陳偉能
(Miss) Diana Chan Wai Sze 陳偉思
Chan Yiu Kay 陳耀奇
Dickson Chan Yu Sang 陳雨生
(Miss) Jane Chang Kan 張勤
Chau Wing Kin 周永堅
Cheung Kin Ming 張建明
Cheung Kwok Leung 張國良
Cheung Pik To 張壁濤
Cheung Wai Lun 張偉麟
(Miss) Cheung Wai Yin 張慧賢
Blase Cheung Wing Lun 張榮麟
Cheung Ying Man 張應敏
(Miss) Margaret Chia Si-Chau 賈士秋
Chiang Chung Seung 蔣忠想
(Miss) Chiu Ling 趙玲
Chiu Yuen 趙源
Chong Lap Chun 莊立村
Simon Chow Liang 周亮
Chow Tsun Cheung 周俊昌 (Distinction Physiology)
Willie Chow Wai Hung 周偉雄
Patrick Chu Wai Man 朱偉文
Raymond Chu Wan 朱雲 (Distinction Physiology)
(Miss) Gloria Chua Wai Wai 蔡瑋瑋
Chui Tak Yi 徐德義
Kelvin Chung Kam Hung 鍾錦洪
Foo Bing Hung 傅秉鴻
Fu Kin Hang 傅健行
Fung Hong 馮康
Fung Ka Pak 馮家栢
Ha Shau Yin 夏修賢
Ho Chiu Ming 何昭明
Ho Shing Chee 何成枝
(Miss) Ho Wai Ching 何惠清
Hsu Yau Que 徐幼雀
Alvin Iu Chin Leuk 姚展略
(Miss) Pauline Kam Po Lin 甘寶蓮
Ko Wing Man 高永文
(Miss) Amy Kong Mang Yee 江孟儀
Bobby Kwan Ka Piu 關嘉驃

Kwan Wing Hong 關永康
Kwong Hon Cheung 鄺漢祥
Lai Kang Yiu 黎鏡堯
Lai Kwok Leung 黎國良
Lai Yiu Ming 黎耀明
(Miss) Barbara Lam Cheung Cheung 藍卓翔

(Distinctions in Pathology, Paediatrics and Medicine)
(Miss) Cindy Lam Lo Kuen 林露娟 (Distinctions in Physiology and Pharmacology)
Lam Sui Sang 林瑞生
(Miss) Vivian Lam 林詠榆
Lau Chu Pak 劉柱柏 (Distinction in Medicine)
Lau Fei Lung 劉飛龍
Law Chun Key 羅振基
(Miss) Judy Law Lai Chun 羅麗珍
Law Moon Yung 羅滿容 (Distinctions in Pathology and Surgery)
Law Tat Kuen 羅達權
Norman Lee Kam Kee 李錦基
Andrew Lee Ping Kwong 李炳光
(Miss) Belinda Leung Fung Ha 梁鳳霞
Peter Leung Fung Sun 梁逢申
Leung Sum Kin 梁深健
(Miss) Leung Yuet Foon 梁月歡
Li Chi Kong 李志光
Lo Chi Biu 盧志彪
Paul Look Chun Ngok 陸振岳
(Miss) Luk Sau Har 陸秀霞
Luk Wai Sing 陸偉成
Dannis Luk Yau Hei 陸有喜
(Miss) Ruby Lun Yok Wah 倫玉華
Mak Kong Ling 麥江寧
Mak Kwong Leung 麥廣亮
Man Chi Wai 文志衛
Edward Mark Fu Kwok 麥富國
(Miss) Jennie Ng Ching Wah 伍菁華
Ng Wai Cheong 吳維昌
Ng Wing Fung 吳榮豐
Ng Wun Siu 吳允紹
Ngai Wai Kit 倪偉傑
Dominic Sham Heung Wai 沈香威
Sham Man Wai 岑文惠
Sin Wai Chung 冼偉松
Anthony Sit Chun Yue 薛鎮宇
Alexander Siu Pui Sang 蕭沛生
Suen Ming Lai 孫名禮
Tam Chi Fai 譚志輝
Tam Wah 譚華
Tang Man Cheung 鄧文祥
(Miss) Tang Man Ching 鄧文貞
Tong Moon Tong 湯滿堂
Tsang Man Wo 曾文和
Tsang Sing Wing 曾醒榮
Tse Wang Sum 謝宏琛
Tse Ying Pui 謝英培
Victor Tse Yuet Fu 謝悅夫
Tsui Man Shan 崔文山 (Distinction in Physiology)
Stewart Tung Yuk 董煜
Jonathan Wai Heung On 衛向安
Wai Yuk Leung 韋玉良
Wan Tack Fan 尹德勛
Douglas Wong Kwan Keung 黃君強
Wong Kwong Pang 黃光鵬
William Wong Man On 黃民安
Yeung Chung Kwong 楊重光
Yeung Kai Cho 楊啓祖
Yeung Tok Fai 楊鐸輝 (Distinction in Medicine)
Yik Yu Hing 易餘璟
Andrew Yip Wai Chun 葉維晋
(Miss) Jennifer Yu Wai Ling 余惠玲
Yuen Kwok Yung 袁國勇 (Distinction in Medicine)
Michael Yuen Lai Fan 源禮藩
(Miss) Mary Yuen Yun Ping 阮潤萍
Yung Cho Yiu 翁祖耀

# FACULTY OF MEDICINE

*Appointments*

John Leong Chi Yan, M.B., B.S. (Hong Kong), F.R.C.S. (England) (Edinburgh), F.B.O.A., Senior Lecturer, appointed to the Chair of Orthopaedic Surgery from June 1, 1981.

Kenneth Chan Man Bun, B.Sc., Ph.D. (Hong Kong), Lecturer, appointed Senior Lecturer in Anatomy from June 1, 1981.

Soter Dai, M.B. (National Taiwan), Ph.D. (Hong Kong), L.M.C.H.K., Lecturer, appointed Senior Lecturer in Pharmacology from June 1, 1981.

Loh Tatt Tuck, M.Sc., Ph.D. (Western Australia), Dip.Sc. (Chung Chi College), Lecturer, appointed Senior Lecturer in Physiology from June 1, 1981.

Joseph Tam Wing On, B.Sc. (Chinese University of Hong Kong), Ph.D. (California), Lecturer, appointed Senior Lecturer in Biochemistry from June 1, 1981.

Susanna Wong Siu Chun, B.Sc., Ph.D. (Hong Kong), Lecturer, appointed Senior Lecturer in Biochemistry from June 1, 1981.

Loke Shee Loong, M.B., B.S. (Hong Kong), appointed Clinical Pathologist in the Hospital Pathology Services of the Department of Pathology from July 13, 1981.

Robin Wendell Evans, B.D.S. (Otago), appointed Lecturer in the Department of Periodontology and Public Health from September 1, 1981.

Ngai Sing Kin, C & G Final, Adv. Gen. Cert., Adv. Ortho. Cert., L.B.I.S.T., appointed Instructor Dental Technologist in the Dental Technology Unit of Dental Studies from September 1, 1981.

*Visiting Professor*

Professor Kwaan Hau Cheong, M.B.,B.S. (Hong Kong), M.D., F.R.C.P. (Edinburgh), F.A.C.P., Professor of Medicine and Director of the Hematology/Oncology and Thrombosis Research Laboratories, Veterans Administration Research Hospital, Northwestern University, Chicago, appointed the sixth K.P. Stephen Chang Visiting Professor in Medicine during his visit to Hong Kong from August 9 to 22, 1981.

Professor Doutor António Manuel Araújo Teixeira, Service de Patologia Cirúrgica – Cirurgia II Faculdade de Medicina do Porto, Hospit de S. Joao, Porto, Portugal, appointed the nint Kong Tak Yan Visiting Professor in Surgery fo one week from November 8, 1981.

*Resignations*

Dr. D.M. Scollard, Lecturer in Pathology from September 1, 1981.

Kathryn San, Instructor Hygienist in th Department of Periodontology and Publi Health, from July 24, 1981.

*Prizes*

The following prizes have been awarded:

*Belilios Medical Prize*: Lo Chung Mau

*Hong Kong University Alumni Prize*: Cindy Lam Lo Kuen

(Mrs.) Felice Mak-Lieh, M.D. (Santo Tomas) L.A.H. (Dublin), M.R.C.Psych., M.R.A.N.Z.C.P. Senior Lecturer, appointed Reader in Psychiatry from September 1, 1981.

Joana Ai Ho Cho Ieng, M.Sc. (McGill), M.B. Dip.Med. (Peking Medical College), Dip.Am Board, Clinical Pathologist, appointed Senio Clinical Pathologist in Pathology from Septem ber 1, 1981.

Choo Yew Cheong, M.B.,B.S. (Singapore) F.A.C.O.G., Lecturer, appointed Senior Lecturer in the Department of Obstetrics and Gynaecology from October 1, 1981.

Lai Ching Lung, M.B.,B.S. (Hong Kong) M.R.C.P. (United Kingdom), Lecturer, appointed Senior Lecturer in Medicine from September 1, 1981.

Ng Man Lun, M.B.,B.S. (Hong Kong), M.R.C. Psych., D.P.M. (England), M.R.A.N.Z.C.P., Lecturer, appointed Senior Lecturer in Psychiatry from September 1, 1981.

Ng Wing Ling, M.B.,B.S. (Hong Kong), M.R.C. Path., Lecturer, appointed Senior Lecturer in Pathology from September 1, 1981.

William Tam Yu Kay, M.B.,B.S. (Hong Kong) M.R.C.Psych., Lecturer, appointed Senior Lecturer in Psychiatry from September 1, 1981.

Grace Tang Wai King, M.B.,B.S. (Hong Kong) M.R.C.O.G., Lecturer, appointed Senior Lecturer in the Department of Obstetrics and

Gynaecology from October 1, 1981.

Chan Kwok Wah, M.B.,B.S. (Hong Kong), Clinical Pathologist, appointed Lecturer in Pathology from October 1, 1981.

Steven Chan Yue Wah, B.Sc. (Chinese University of Hong Kong), Ph.D. (Baylor), appointed Lecturer in the Department of Obstetrics and Gynaecology from September 1, 1981.

Chow Tak Wah, B.D.S., M.Sc. (London), L.D.S. R.C.S., appointed Lecturer in Conservative Dentistry from September 7, 1981.

Hui Pak Kwan, M.B.,B.S. (Hong Kong), Lecturer, appointed Clinical Pathologist in Pathology from October 1, 1981.

Lee Po Chin, M.B.,B.S. (Hong Kong), F.R.C.S. (Glasgow), appointed Lecturer in Orthopaedic Surgery from October 7, 1981.

Nina Grace Jablonski, B.A. (Bryn Mawr), Ph.D. (Washington), appointed Lecturer in Anatomy from September 12, 1981.

Lam Sui Yue, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in Pathology from October 7, 1981.

Irene Lui Oi Lin, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in Pathology from October 14, 1981.

John Ma Tao Che, B.A. (Oxon.), M.B.,B.S. (Middlesex), M.R.C.P. (London), appointed Lecturer in Medicine from October 1, 1981.

Alwin Pang Siu Wah, M.B.,B.S. (Hong Kong), Clinical Pathologist, appointed Lecturer in Pathology from October 1, 1981.

Pun Kin Kee, M.B.,B.S. (Hong Kong), appointed Lecturer in Medicine from September 7, 1981.

David Tay Kiong Chiu, B.Sc., Ph.D. (Flinders), appointed Lecturer in Anatomy from February 15, 1982.

Raymond Tsang Shiu Wah, B.Sc. (Nebraska), M.Med.Sc., Cert.Med.Sc. (Hong Kong), appointed Clinical Bacteriologist in Microbiology from November 1, 1981.

Philip Wong Hung Chung, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), appointed Lecturer in Medicine from October 1, 1981.

Paul Wu Tze Kuen, M.D. (Toronto), appointed Lecturer in the Department of Obstetrics and Gynaecology from October 1, 1981.

*Visiting Professors*

Professor Sidney B. Effer, M.D., F.R.C.S. (C), Professor and Chairman of the Department of Obstetrics and Gynaecology, University of British Columbia, appointed the third Aw Boon Haw Visiting Professor in the Department of Obstetrics and Gynaecology during his visit to Hong Kong in November 1981.

Dr. Thomas K.C. King, M.B.,Ch.B., M.D. (Edinburgh), F.R.C.P. (London), Department of Medicine, Division of Pulmonary Diseases, The New York Hospital Cornell Medical Center, appointed the second Mr. and Mrs. Wu Chung Visiting Professor in Medicine from October 31 to November 14, 1981.

*Resignations*

Dr. A. Koo, Senior Lecturer in Physiology, from September 30, 1981.

Dr. Anita M.C. Li, Senior Lecturer in Paediatrics, from October 7, 1981.

## JOHN LEONG CHI YAN,

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

Dr. J.C.Y. Leong, Senior Lecturer in Orthopaedic Surgery, has been appointed to the Chair of Orthopaedic Surgery from June 1, 1981.

Professor Leong graduated in 1965 with the degrees of Bachelor of Medicine and Bachelor of Surgery from this University. After serving as House-physician and House-surgeon in Queen Mary Hospital for a year, he joined the Department of Orthopaedic Surgery of the University as Assistant Lecturer. In 1967, he was promoted Lecturer, and in 1975, Senior Lecturer. From 1969 to 1972, he was also Honorary Registrar in the Department of Orthopaedic Surgery, Nuffield Orthopaedic Centre, Oxford. He was awarded Fellowships of the Royal College of Surgeons of Edinburgh and of England in 1969 and 1970 respectively. From 1978 to 1979, he was China Medical Board Fellow, and visited numerous orthopaedic centres in North America.

Professor Leong has been an invited speaker at various international symposia, and has been guest surgeon at hospitals in Guangzhou and Manila. In 1979, he was Visiting Professor of Orthopaedic Surgery at the University of California at San Francisco, and in 1980, Visiting Professor of Orthopaedic Surgery at the Osaka University Medical School. In 1981, he was appointed National Delegate for the XV World Congress of the Société Internationale de Chirurgie Orthopédique et de Traumatologie held in Rio de Janeiro in September.

Professor Leong is a member of many p fessional bodies, including the British Ortl paedic Association, the Western Pacific Ortl paedic Association, and the Société Inter tionale de Chirurgie Orthopédique et de Traur tologie. He has been President of the Hong Kc Orthopaedic Association, and is now t President of the Hong Kong Physiothera Association. He has contributed extensively academic literature in his field. Spinal proble and paediatric orthopaedics are his spec interests. His main areas of research into spi problems include degenerative conditions of t cervical and lumbar spine, acute and chro instability of the upper cervical spine, and sev spinal deformities in children and adults. far as paediatric orthopaedic problems a concerned, he is interested specially in neu muscular diseases. Professor Leong is al interested in adolescent idiopathic scoliosis. conjunction with the Department of Anatom he has studied the growth pattern of scolio patients and the abnormalities of paraspi muscles and muscle spindles in such patien In conjunction with the Department Mechanical Engineering and the Electron Services Unit, he has been engaged in sor bio-mechanical research centering around a stu of the visco-elastic behaviour of tissues und leg lengthening, and the design of an apparat that will allow lengthening and derotation a limb.

## PETER YEN KAI JEN, D.D.S. (West China Union), D.M.D. (Harvard)

Dr. P.K.J. Yen has been appointed Reader in Children's Dentistry and Orthodontics from September 1, 1981.

Dr. Yen was awarded the degree of Doctor of Dental Surgery by the West China Union University, Chengtu in 1947, the Diploma for Internship of the Forsyth Dental Infirmary for Children in 1950, the Certificate in Orthodontics in 1952, and the degree of Doctor of Dental Medicine by Harvard University in 1954. Thereafter, he worked almost continuously at the Harvard School of Dental Medicine and Boston Children's Hospital Medical Center, except two years (1962-64) when he was Visiting Profess at the National Taiwan University Medic School. From August 31, 1981 he was Associa Clinical Professor in Orthodontics at the Harva School of Dental Medicine and Senior Associa in Orthodontics at Boston Children's Hospit Medical Center. He has also many yea experience in private orthodontic practice a part-time basis.

Dr. Yen's main research interest is in crani facial growth. He has contributed extensive to learned journals and presented papers many professional and academic meetings.

## KARAM SINGER, M.B.,B.S., M.D. (Hong Kong), F.R.C.P. (Edinburgh), D.P.M. (England), F.R.C.Psych. (London), F.R.A.N.Z.C.P., F.A.P.A.

Professor K. Singer retired from the University on January 1, 1981 after a total of more than eleven years of service in the Department of Psychiatry, some of which was in a part-time capacity.

Professor Singer was educated at this University where he obtained the degrees of Bachelor of Medicine and Bachelor of Surgery in 1954. After pre-registration appointments for one year he became medical officer in the Government mental hospital. In 1956 he left for England and held training posts in psychiatry and general medicine in the London area, and attended postgraduate courses in London and Edinburgh.

On his return to Hong Kong in 1960, Professor Singer was appointed senior medical officer in the Government mental health service in 1960 and specialist in psychiatry in 1962. Concurrently he was assistant medical superintendent of Castle Peak Hospital in 1961, medical superintendent in 1967, and since 1969 he has been head of the Government mental health service. Professor Singer first joined the University as a part-time Lecturer in Psychiatry in 1969 and was appointed to the Chair in September 1972.

Professor Singer obtained the Diploma of Psychological Medicine in 1958. He became a Member of the Royal College of Physicians of Edinburgh in 1959, was elected a Fellow in 1972, and became a Foundation Fellow of the Royal College of Psychiatrists in 1972. He obtained his M.D. in 1972, was elected Member of the Royal Australian and New Zealand College of Psychiatrists in 1974 and Fellow in 1979. In 1974 he was elected Fellow of the American Psychiatric Association. In 1971 he was senior WHO fellow in psycholopharmacology in Denmark. He is also a member of the Committee of the World Psychiatric Association, and a Council member and Fellow of the International Association of Social Psychiatrists. He has served on the editorial board of *Social Psychiatry*.

Professor Singer published numerous research papers on the various aspects of mental illness. He has served on the editorial boards of *Social Science and Medicine* and the *International Journal of Social Psychiatry*.

## FELICE MAK-LIEH, M.D. (Santo Tomas), L.A.H. (Dublin), M.R.C.Psych., M.R.A.N.Z.C.P.

Dr. Felice Mak-Lieh, Senior Lecturer in Psychiatry, has been appointed Reader from September 1, 1981.

Dr. 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. In 1965, She went to Britain, and worked in various hospitals in London, Bournemouth and Oxford. In 1971, she joined the University of Hong Kong as Lecturer, and was promoted Senior Lecturer in 1978. In 1973, she was admitted to membership of the Royal College of Psychiatrists of the United Kingdom, and in 1978, to membership of the Royal Australian and New Zealand College of Psychiatrists.

Dr. 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 interests are on abortion, child abuse, suicides, and psychiatric and sexual disorders. Dr. Mak-Lieh is also active in community affairs: she was President of the Hong Kong Medical Women's Association in 1978, and is a member of the Committee for the Rehabilitation of the Mentally Ill and of the Occupational Therapy Board.

# PERSONALIA

Dr. R.M.W. Chau, Lecturer in Anatomy, was invited by the Chinese Anatomical Association to deliver a paper on 'Identification of transmembrane controlling system involving cytoskeleton from thermotropic "lacy" pattern of lipidprotein lateral separation in the plasma membrane of phagocytosing macrophages' at the National Conference of the Chinese Anatomical Association, held at Chengdu, Sichuan Province, People's Republic of China, from October 18 to 27, 1980.

Professor F.C.Y. Cheng attended the Third Biennial General Scientific Meeting of the Association of Surgeons of Southeast Asia in Jakarta from June 18 to 20, 1981. He presented four papers and chaired two scientific sessions, and was re-elected to the Council of the Association of Surgeons of Southeast Asia for another two years.

Professor R.W. Fearnhead was invited by the Nihon School of Dentistry at Matsudo, Japan, to speak on current topics of dental caries at an international symposium organized to commemorate their decennial anniversary. He also lectured, by invitation, at the Kyushu Dental College, Kokura, the Fukuoka Dental School, Tokyo Dental College, and Tsurumi Dental University on the subjects of enamel caries and dental education.

Dr. J.W.L. Kleevens, Reader in Community Medicine, has been admitted a Fellow of the Royal Society of Health of the United Kingdom.

Dr. Veronica M.S. Lam, Lecturer in Biochemistry, was selected to participate in the practical course on recombinant DNA technology held in Banares Hindu University, India, from February 2 to 22, 1981.

P.L. Lim, Lecturer in Microbiology, has been awarded the degree of Doctor of Philosophy by the University of Adelaide.

Professor F.P. Lisowski visited Kunming Medical College, the Institute of Zoology of the Academia Sinica and the Institute of National Minorities at Kunming, Yunnan Province, People's Republic of China, and delivered lectures on anatomical education, biological and applied anthropology as well as primatology from March 27 to April 11, 1981.

Professor Tan Sri G.B. Ong has been invited to deliver the Macewen Memorial Lecture during the session 1981-82 by the University Co the University of Glasgow.

Dr. K.F. So, Lecturer in Anatomy, att the Tenth Annual Meeting of the North A can Society for Neuroscience in Novembe in Cincinnati, U.S.A. and presented two p He also attended the Fourth European N science Meeting in September 1980 in Bri United Kingdom. Dr. So was elected a m of the International Brain Research Organi (IBRO). He has been appointed as an Hon Research Fellow in the Department of Ana and Embryology of the University Co University of London, for the year 198

Professor D. Todd has been elected t New York Academy of Sciences.

Professor S.C. Tso has been elected a F of the Royal Australasian College of Physi

Dr. Christina C.L. Wang, Senior Lectur Medicine, attended the Annual Conventi the Philippines Diabetes Association and P pines Society of Endocrinology and Metab held in Manila on January 25 and 26, 1981.

Professor J. Wong was appointed Vis Professor by the University of Sydney and invited to visit the Royal North Shore Hos from April 22 to May 2, 1981. He prese two papers entitled 'Surgical practice in H Kong – frustrations and rewards' and 'Hep cellular carcinoma – the place of surgery' taught a course in advanced surgery organ by the Royal Australasian College of Surge Professor Wong was elected to Active Mem ship of the James IV Association of Surg in October 1980.

The following attended the Fifteenth Wo Congress of the Société Internationale Chirurgie Orthopédique et de Traumatolo held in Rio de Janeiro from August 30 September 4, 1981:

Professor J.C.Y. Leong, as the National De gate for Hong Kong, presented a pa entitled 'Surgical treatment of scolio following poliomyelitis – a review fifty-five lumbar curves'.

Dr. S.P. Chow, Senior Lecturer in Orthop dic Surgery, delivered a paper entitl 'Microvascular anastomosis of arter around 0.2mm external diameter'.

The following attended the Third Annual Meeting of the Hong Kong Society of Neurosciences held in the Chinese University of Hong Kong on September 2 and 3, 1981:

Professor J.C.C. Hwang, was invited to give a lecture on the analysis of the vestibular system.

Dr. A. Koo, Senior Lecturer in Physiology, presented two papers entitled 'Noradrenaline activates presynaptic and postsynaptic alpha-adrenergic receptors in the rat uterine arterioles', and (with S.F. Pang) 'Brainstem stimulation produces a constrictor response in the rat liver microcirculation'.

Professor F.C.Y. Cheng was invited by the Chinese Medical Association (Macau) to attend a symposium on peptic ulcer disease held on August 30, 1981 in Macau, where he gave a lecture entitled 'Modern attitudes to the treatment of peptic ulcer'. Professor Cheng was invited by His Highness the Sultan of Brunei to visit B.S. Begawan from September 18 to 22, 1981, and to deliver a postgraduate lecture entitled 'Surgery of portal hypertension'. He also conducted postgraduate seminars and visited the new hospital site.

Dr. K.M. Cho, Lecturer in the Department of Obstetrics and Gynaecology, has passed the M.R.C.O.G. Part II Examination held in the United Kingdom.

Dr. R.J. Collins, Clinical Pathologist in the Hospital Pathology Services, has passed the Final Fellowship Examination of the Royal College of Pathologists of Australia.

Professor G.L. Howe has been elected to Honorary Membership of the American Dental Association. He attended, in his capacity as Vice-President, the Annual Scientific Meeting of the British Dental Association held in Newcastle-upon-Tyne from July 9 to 12, 1981. He also attended the Sixty-ninth World Dental Congress held in Rio de Janeiro from August 29 to September 14, 1981, at which he led the Hong Kong delegation in the General Assembly of the Federation Dentaire Internationale, and attended, as a member, meetings of the Commission of Dental Education and Practice. He chaired a meeting of Working Group One of the Commission and a symposium on surgical errors and their avoidance, and gave a lecture entitled 'The removal of mandibular third molars by the lateral trepanation technique'. In addition Professor Howe has been appointed Director of the Prince Philip Dental Hospital.

Dr. L.C.S. Hsu, Senior Lecturer in Orthopaedic Surgery, has been elected a Correspondent Member of the Scoliosis Research Society.

Professor J.C.C. Hwang has been appointed Visiting Professor in Physiology at the Hiroshima University School of Dentistry, Japan, from July 1981. He attended the Eighth International Congress of Pharmacology held in Tokyo from July 19 to 24, 1981 and presented a paper (with Dr. P.W.F. Poon) entitled 'Assessment of drug effects on the central nervous system by statistical analysis of neuronal spike trains'. Professor Hwang has been invited to speak at the Third Annual Conference on Engineering in Biology and Medicine in the session entitled 'Frontiers of computers in Medicine' held in Houston in September 1981.

Dr. J.W.L. Kleevens, Reader in Community Medicine, was admitted as a Member of the Faculty of Community Medicine by the Royal College of Physicians, United Kingdom. He was invited by the Regional Director for the Western Pacific World Health Organization to be a temporary adviser and to write a case-study for a conference on urban primary health care held in Manila from November 30 to December 4, 1981.

Dr. T.H. Lam, Lecturer in Community Medicine, has been awarded the degrees of Master of Science in Sociology and Master of Science in Occupational Medicine by the University of London.

Professor J.C.Y. Leong has been elected National Secretary of the Société Internationale de Chirurgie Orthopédique et de Traumatologie section of Hong Kong. He has also been re-elected President of the Hong Kong Physiotherapy Association for the year 1981–82.

Dr. S.T.K. Lim, Senior Lecturer in Surgery, attended the Third European Congress on Parenteral and Enteral Nutrition in Maastricht, the Netherlands from September 27 to 30, 1981. He also visited the University of Leiden,

the Netherlands, and Stanford University, where he gave, by invitation, a lecture entitled 'Cystoplasty using the gastrointestinal tract'.

Dr. K.D.K. Luk, Lecturer in Orthopaedic Surgery, has been elected Fellow of the Royal College of Physicians and Surgeons of Glasgow and Fellow of the Royal College of Surgeons of Edinburgh.

Dr. P.L. Nandi, Senior Lecturer in Surgery, attended by invitation the following Congresses: the Inaugural Congress of the Western Pacific Association of Critical Care Medicine held in Singapore on September 8 and 9, 1981 where he presented a paper entitled 'Postoperative cardiac intensive care in Hong Kong'; the Second ASEAN Congress of Anaesthesiologists held in Kuala Lumpur from September 11 to 13, 1981 where he presented a paper entitled 'Postoperative ventilation in children following cardiac surgery'; the Seventh Asia-Pacific Congress on diseases of the chest held in Hong Kong from November 1 to 5, 1981 where he presented two papers entitled 'Corrective surgery for tetralogy of Fallot in adolescents and adults' and 'Surgical treatment of recurrent spontaneous pneumothorax'. Dr. Nandi has been elected a member of the Thoracic Society of the United Kingdom.

Dr. W.S. O, Lecturer in Anatomy, attended the Task Force on Postcoital and Once-a-month Drugs Steering Committee meeting held at the World Health Organization, Geneva, from July 20 to 23, 1981.

Dr. C.W. Ogle, Reader in Pharmacology, has been appointed an External Examiner for a Doctor of Philosophy thesis in Pharmacology by the University of Melbourne. He also attended the Regional Symposium of the Collegium Internationale Neuropsychopharmacologicum (CINP) held in Hong Kong on October 9 and 10, 1981, and was invited to co-chair the workshop on neuropsychopharmacology of drug dependence.

Dr. W.H. Seto, Clinical Bacteriologist in Microbiology, has passed the final examinations of the Royal College of Physicians of the United Kingdom and Ireland and has been elected to membership in July 1981.

Professor D. Todd attended, by invitation, the Tercentenary Congress of the Royal College of Physicians of Edinburgh f September 6 to 11, 1981, and presente paper entitled 'Postgraduate medical educa in Hong Kong' at a symposium on the achi ments and needs of continuing postgradu medical education. On September 10, 1981 visited the Department of Gener.l Pract University of Edinburgh. Professor Todd an Examiner at the M.R.C.P. (United K dom) Part II Clinical and Oral Examinati held in Edinburgh from October 26 to 1981.

Profesor S.C. Tso was invited to atten symposium on regulation of erythropoi organized by the Department of Medici Jichi University, held in Nikko, Japan on J

Professor J. Wong attended the Th Biennial General Scientific Meeting of Association of Surgeons of Southeast Asia h in Jakarta from June 18 to 20, 1981. Honorary Secretary and Councillor, he atte ed two Council Meetings and was invited speak at a workshop on clinical research Southeast Asia. He was also invited by Indonesian Association of Surgeons to atte a clinical congress held in Semarang, Indones Professor Wong attended by invitation Conference on Gastrointestinal Cancer held Brisbane from July 14 to 17, 1981 and ga four lectures entitled 'Resection of liver metastatic cancer – indications, techniqu and results', 'The Hong Kong experience carcinoma of oesophagus', 'Manual oesophag anastomosis', and 'The obstructing carcino of the gastro-oesophageal junction'. Profess Wong was also invited by the Chinese Medi Association to attend the first Beijing Sy posium on Cardiothoracic Surgery held Beijing from September 20 to 24, 1981 whe he presented a paper entitled 'Carcinoma the oesophagus in Hong Kong'. After the me ing, he was invited to visit and lecture at t Zhongshan Hospital, Shanghai; the First Teac ing Hospital, Hangzhou; and the Guangdo Provincial People's Hospital, Guangzhou.

Dr. P.Y.D. Wong, Senior Lecturer in Physi logy, visited the National Research Institu for Family Planning in Beijing and the Fami Planning Research Institute of Jiangsu fro April 6 to 10 and April 11 to 14, 1981 respe

tively, as a temporary adviser to the World Health Organization on a United Nations Fund for Population Activities/China Project on research in family planning in China. He attended, by invitation, the Second International Congress of Andrology held in Tel Aviv from June 28 to 30, 1981 and presented a paper at the symposium on recent advances in the regulation of male fertility. Dr. Wong was also invited to participate in the Meeting of Experts organized by the World Health Organization's Task Force on methods for the regulation of male fertility, held in Tel Aviv, from July 1 to 5, 1981.

Dr. Vivian C.W. Wong Taam, Senior Lecturer in the Department of Obstetrics and Gynaecology, has been admitted to membership of the Asian Pacific Association for the study of the liver. She has also been appointed a member of the Editorial Board of *Medical Progress.*

Professor C.Y. Yeung has been elected Fellow of the Royal College of Physicians of Glasgow, and appointed Head of the Paediatric Unit at Grantham Hospital. He organized and chaired a workshop on developmental disorders in children held in Hong Kong on October 31, 1981.

# CONTRIBUTIONS

# 謹以此文獻給去年會協助助醫學會發展的同學，並特別獻給來屆十位幹事同學

## 「擴闊胸懷，容納他人他事，培養公德，發揚民主精神，，做個好醫生。」

這是八〇年幹事會內閣競選時所提的方向。

在御任的時候才來再嘗試解釋清楚一年前提出的東西，似乎時間顛倒了。

## 「擴闊胸懷，容納他人他事」

從自我擴展開去，嘗試關心愛護自身以外的人，去關心參與自身以外的事，把胸襟向着至眞、至善、至美開放。

智者求眞，仁者求善，勇者求美，我們追求智者、仁者、勇者的廣闊胸懷。

胸懷，是用來容納的。容納就是把一些人和事放在自己心裏。

每一個人都會關心他自己，懂得愛護自己，時刻的爲自己打算。

當我們將一件身外事，一個身外人與自己連在一起的時候，我們會以對自己最大的愛同樣加於這些人和事上。

人不是獨自爲生，人亦不是只爲自己而活。

最少，我們在自己的家生活。最少我們會將父母、兄弟姊妹放在心中，去關心，去愛護他們。

這就是「擴闊胸懷，容納他人他事」——我們的胸懷除裝納自己的東西外，還裝下了父母，家庭，並爲他們最大的幸福而盡最大的努力。

我們已踏出了擴闊的第一步。

問題是，我們還會再走多少步？

追求終身伴侶，找一個與自己原本毫無關係的人，他（她）的一切每時每刻都在自己心中迴蕩着，這是擴闊胸懷後的容納。

去關心，去愛護週圍的同學，朋友，大家爲創造快樂的羣體而共同努力。

去關切班會的發展，去參與醫學會的推支持學生會的運作，我們的胸懷愈納愈多。

繼續擴展開去，走入服務人羣的行列，推至一個公平的境地。

將國家人民的苦難，命運和成就與自己起，把民族的責任放在自己肩上。

留意世界各地的事情，把整個地球猶如中，與自己的心房共同跳躍。

對人類理性探求，尋找生命底哲義，信隨，從藝術反映人生，都是一些觸及人類本題，是人生所面對最廣遠，最深切，是永恒，超越時空的限制。

這就是「擴闊胸懷，容納他人他事」——我擴展開去，愛自身以外的人，做自身以外追求眞善美，每人盡量擴闊胸襟，直至無限

沒有人敢說他的胸懷已大至不能再大；人該說他的胸懷凝硬得不可擴展。

只要我們努力，我們胸懷容納的人，可己，多一個人，兩個、三個……以至千個、億個。

只要我們努力，我們所做的事，可以是兩件、三件……直至千件、萬件。

只要我們努力，我們可以向着至眞、至美逐步進發。

只要我們是向着無限進發，我們已可以愧，不管我們只是剛開始起步，還是已走得

## 「培養公德，發揚民主精神」

在人生的每一階段，我們都屬於一個個團體。

我們有解剖課中或病房床旁的學習小組有自己的班會，醫學會、學生會；我們有香社會；我們有中國這個國家；我們有地球這。

對於每一範疇的團體，我們都有一定的權利和義務。

「人人相善其羣」。「羣有以益我，而益羣，是我逋羣之負而不償也。」這是梁啓論公德」。

我們每一個都是團體的主人。班會是我

醫學會是我們的，香港是我們的，中國是我們的，世界是我們的。

主人便應有主人的風範。試想想你怎樣做你心愛底東西的主人。

主人有管理、改善、發展團體的權利和義務。

團體的發展要靠主人的努力。

這就是「民主」，「民」即我們，「民」「主」，就是「我們」做「主人」。

民做主一定要有兩個條件：

要有民可以去做主的制度。

要有民主動去做主的精神。

兩者缺一不可。

誰敢說醫學會的制度不民主，但有多少同學曾發揮民主精神去善用這個制度？

所以只有民可以做主的制度，民主的精神才能夠發揮。

只有民主動做主的時候，民主的制度才得以運行。

做主人是怎樣做的？

第一部是關心，瞭解團體的事情和發展——這是「知」。

第二步是就所知的事去思想，分析，提出批評和建議——這是「思」。

第三步是不單只「思」，自己更親自投入行動，實踐，去推行自己所想的——這是行。

知、思、行，這就是民主精神三步曲。

我們對班會要知、思、行。

我們對醫學會要知、思、行。

我們對醫學院和大學教育要知、思、行。「爭取權益」是其中的一部分。

我們對社會要知、思、行。「關心社會」是其中一部分。

我們對國家要知、思、行。「認識中國」是其中一部分。

我們對世界要知、思、行，「放眼世界」是其中一部分。

我們不單只是個人的實踐民主，我們亦聯結其他個體。很多事情非個人的力量所能達到，而且我們都在團體內共同生活。

這就是培養公德，發揚民主精神。

## 「做個好醫生」

做好醫生，是絕大部分醫學生的理想。

作爲一個醫學生團體，聯夥做好醫生，是必然的共同目標。

一個醫生如果能把「擴闊胸懷，容納他人他事；培養公德，發揚民主精神」發揮盡緻，他就會是個好學生。

我們最少要心懷病者，把他們的需要掛在心中。

我們要對社會和醫療制度鞭策，使服務能眞正切合人羣。

做好醫生，是醫學生表達「擴闊胸懷，容納他人他事；培養公德，發揚民主精神」的一個實踐方式。

## 爲什麼提這樣方向的口號？

這可以說是兩年大學生活體驗凝聚的成果。

至少這幾年來，大專學界的思想一直受學聯七五年提出的「放眼世界，認識中國，關心社會，爭取同學權益」所影響。只不過這一兩年加上「文康體福」這四個「極受歡迎」的字。

但從一年級開始，我一直對這樣的方向感到疑惑，它似乎欠缺很多？

參與校政，改善課程只是爲爭取權益？

爲甚麼要關心社會？

認識中國應抱甚麼態度？

關心同學包括在內嗎？

探討人生哲理，追求藝術的美善放在那裏？

找尋人類永恒本質應否是大學生目標之一？

我覺得這樣的一句口號既不完整包含人生應取的方向，又沒有解釋爲甚麼要「放認關爭」，更沒有說明應抱怎樣的態度？它也給人一種冷冰冰，與生活脫節的感覺。

我不滿意它作爲大學生的指標。

我要去尋求更眞切的方向。

回頭再看看一些已像投身「放認關爭」的人物。

他們可以走到總督府前靜坐，卻從未構想過自己擁有向學院提出改善課程的權利，只是逆來順受。

他們埋頭在自己的道路上走，其他方面卻顯得那樣貧乏。

他們可以「關懷」十億人民，卻忽略了週圍的

人的內心……

也看看那些「放認關爭」以外的同學。

「虔敬」的信徒只着眼別人的靈魂，他們的愛和勇氣比他們所信的是如何的局限。

大部分人都只關心最接近他們的愛侶，課本、小圈子、享樂、心胸是何等狹窄……

疏離的現象充滿整個校園：沉默的多數與沉默的多數疏離；沉默的多數與積極的少數疏離；積極的少數與積極的少數疏離。

整個校園是如何低沉，我們放下了多少應負的責任，我們的精神是多麼萎糜——但我們根本沒有放下作爲一個「人」底十字架的權利。

這一切一切都使我覺得非要尋找新的精神方向不可。

環顧全班，相信願意出來做幹事的不會多出於兩三個。

感覺上我不得不盡力使醫學會能發展下去。

但，如果我決定出來的時候，我可以爲同學做些甚麼？我要朝那個方向走？

我不願重拾學界所提的口號，因爲這既不全面，更不能針對同學普遍心態。

要建立一套理想的價值觀，先要擊破現存的那種自我、疏離的牢籠。要直接攻打人心。先要破，後才能立。

要訂明一個基本的取向，包括人生一切，並解釋其中意義。

要能聯結所有人，所有人都能投身其中。不管有沒有信仰，不管有沒有參與醫學會。

要針對全部每一個同學。

只關心自己的希望他能關心多一個人。

只關心班會的希望他能支持醫學會。

只關心醫療界的希望他能對香港整個社會關懷。

只談認識中國的希望他能眞正投入民族去。

要提出一個醫學會長期努力的方向，而以我們一屆的幹事會展開第一步。

於是，我提出了「擴闊胸懷，容納他人他事；培養公德，發揚民主精神；做個好醫生」。

我滿懷信心、希望。

## 這一年來

口號一提出的時候，不少同學都表示贊同[illegible]的精神，不少同學都覺得他們亦有同樣的取向。

但，大家都懷疑怎樣把口號落實。口號大空了，包含太廣，摸不着邊際。

口號眞是空泛嗎？

不！

如何去使各班同學主動接觸，融洽生活；[illegible]使沙宣道上下同歡樂，是醫學生節的目標——[illegible]容納他人。

檢討課程，正因爲我們有權利和義務對我們[illegible]接受的教育提出意見。

通過健委會和健康展覽，我們去接觸香港醫[illegible]界，去服務香港市民，負起作爲醫療界一分子的[illegible]色，這是民主的表現。

通過啓思，我們去分享其他同學的體悟和[illegible]，去探索日光之下各樣的事情，推廣我們的視域經驗。

搞好班會，讓我們創造一個活潑蓬勃的大家[illegible]

其實醫學會的一切活動，都可以是落實的好[illegible]式。

口號是點出了其中的精神和方向。

這不是舊瓶新酒，當我們能有新的精神面[illegible]，我們會幹得更起勁。我們也可以幹得更多。我[illegible]更會着重擴闊胸懷，公德民主，去找尋新的幹法[illegible]

太難做到嗎？當然。在一年內根本不能完成[illegible]但爲甚麼不以它爲長期目標，而在不同時空注重[illegible]同點？

只是個人修養嗎？不。他人他事，公德民主[illegible]全是面向外出的。

那麼，這一年來做得怎樣？

慚愧，整年竟是一事無成。

這一年來，絕少向同學解釋清楚其中的精神[illegible]明白表面的同學不少，但能眞正領會全部意義的[illegible]絕無僅有。

也許少在幹事會內部闡釋口號的內容，以至[illegible]事會不知怎樣把行動配合口號。

提出方向的我，更由於本身未能完成責任以[illegible]拖累幹事會的强力運作。

整年幹事會沒有甚麼顯明的行動去闡釋和實[illegible]所提的方向。我們錯失了不少良機。

整個醫學會也不曾給人一個鮮明的印象。

我們錯失了一年。內中的掙扎，痛苦非外人所能體會。

那麼，放棄了嗎？

不。至今我仍然頑強的相信「擴闊胸懷，容納他人他事；培養公德，發揚民主精神」是醫學會同學，以至整個學生界應走的方向。至少，它會是我人生的取向。

我們只是第一棒走慢了，但我們可以急起直追。

我們要做的，是去詳細闡釋和推廣其中的精神和意義，使全體同學一同投身。

我們需要有一隊勇敢强大的先鋒隊伍去實踐當中的意念，以行動顯明我們的理想。

我仍懷信心，希望。

## TO BE A MEDICAL STUDENT

Lam Lo Kuen

It had been five years since I laid my first step onto the ground of Medic centre. Looking back, a lot had happened, it had been a long time yet everything passed away as swiftly and time just slipped away without a word of warning.

If I am to be honest, these five years were not quite the colourful University life that I had dreamt of – studying made up majority of the life, but I still miss it.

There had been a lot of ups and downs, all the turmoils and tensions of examinations, all the late nights of studying, all the embarrassment of silly answers be intelligent questions, all the frustration of seeing human nature-selfishness, yet, I still go on and I like it. At times when my confidence was shaken and I wanted to quit, there was something that pushed me on – the massage in the medical profession.

Many people thought than it was a waste of time for a female to study Madicine, they even regarded it as a violation of nature. I felt sorry for these people because they still had not been liberated from the prison of the mind. Whatever road I had chosen, I was ready to pay the cost and it was worth it.

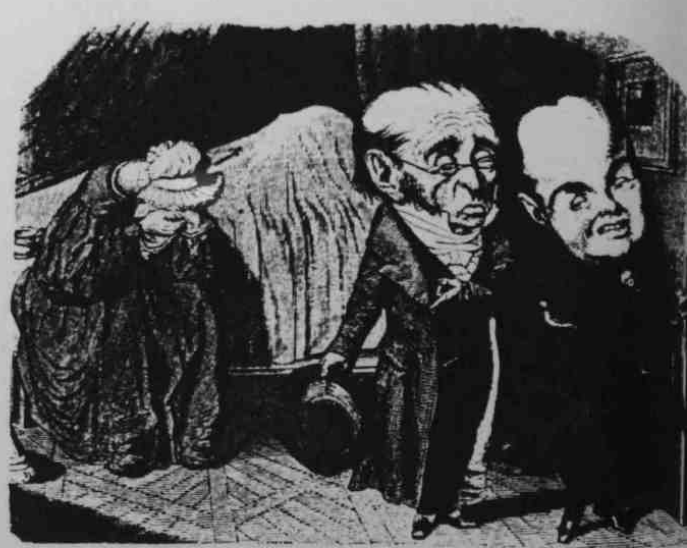
Many people regarded luck as the most important thing in order to pass through these five years. I agreed that it was important but it was not the most, the most important was still a master of one's own knowledge. If one knew one's stuff, one would be alright no matter how unlucky one was although one might not be able to get a distinction. I hope those who are studying for the degree take an advice from me – do not take chances.


## THE DOCTORS

By La Fontaine
Transl. James Michie

Dr It-can't-be-helped and Dr It-can
Met at the bedside of an ailing man.
The latter – though his colleague's grim prognosis
Was that the sufferer would soon be seeing
His ancestors – took a more hopeful view.
Opinions disagreeing
As to medicaments and doses
And Dr It-can't-be-helped's having prevailed,
Their patient failed
And paid mortality its due.

And so, considered either way,
Medical knowledge won the day.
'There,' said the first, 'he's dead –
Exactly as I prophesied!'
'If he'd trusted me,' the other replied,
'He'd still have years of life ahead



THE DOCTORS

# 眞人眞事　醫院內趣聞多

醫院，予人的感覺應該是嚴肅辦事的地方，因事關生死，稍有差池，後果不堪設想。因此醫生姑娘許多時都是冷冰冰。不過醫院亦會有許多充溫情的事件出現，特別是病癒的病人對姑娘的感，往往令人十分感動。

然而，醫院亦經常搞出不少令人啼笑皆非的烏事件。

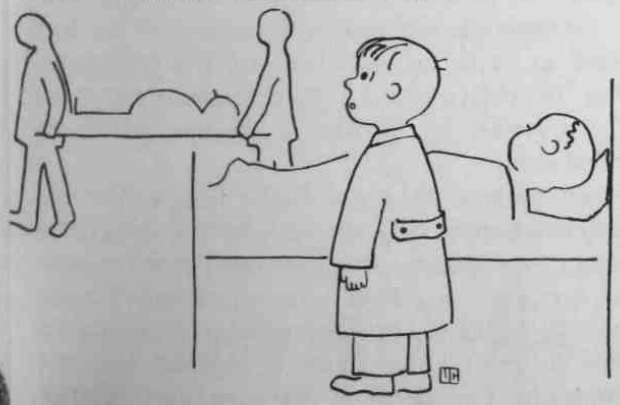
話說港島某大政府醫院，就曾發生過一宗冒牌生事件。一名男子不知那裏弄來一件醫生白袍，充醫生達半年之久而未被發覺。當正牌醫生巡視房時，「冒牌醫生」亦緊隨左右，由於他對病者常關懷，經常噓寒問暖，甚受病人愛戴。而醫院下員工亦對這位「醫生」亦十分好感。後來有人議將他升級，調進手術室，翻查檔案時，才揭發宗冒充事件。

另一宗「趣聞」亦在同一間醫院發生。某回，一名害怕做手術的病人被通知要開刀，他懷着極端沉重的心情對鄰榻的病友吐露今次必死無疑了。殊不知進入手術室後不夠數分鐘，他竟自動行出來。一只手托著一樽鹽水，樽口拖著的一條管子仍接到臂上的靜脉，另一手反手在背後執著遮得上來不得下的手術袍（病人在做大手術時，通常要脫光身子，換上手術袍，方便醫生開刀），非常狼狽走回自己的床子。駐病房的姑娘看見，連忙詢問發生何事。病人有氣無力地答道：「爲我進行手術的其中一個醫生，在試動一部手術用電鋸時，不愼切到手指，其他醫生現正爲他急救。並叫我先出去，好騰空手術枱。」姑娘們被弄得哭笑不分。

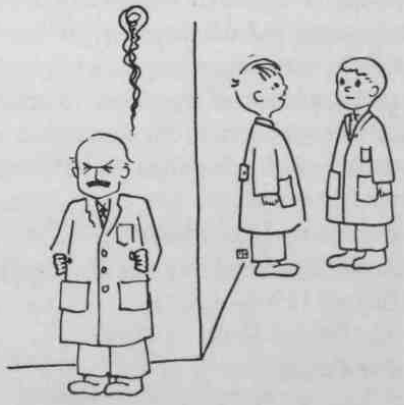
事實上，類似的趣事經常在該醫院內發生。病人唔病死都笑死。

·言·

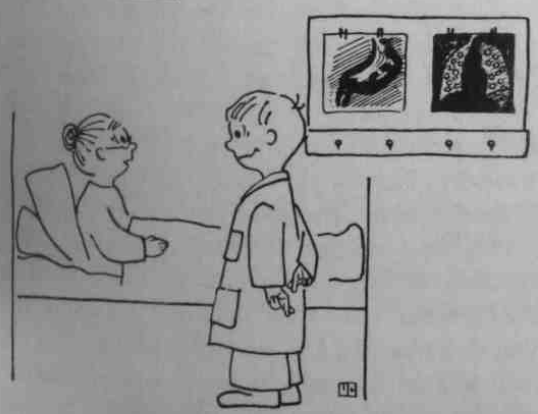
*Patient:* "Wonder where he's going_____."
*Student:* "Oh, to a private ward for better care, I suppose."



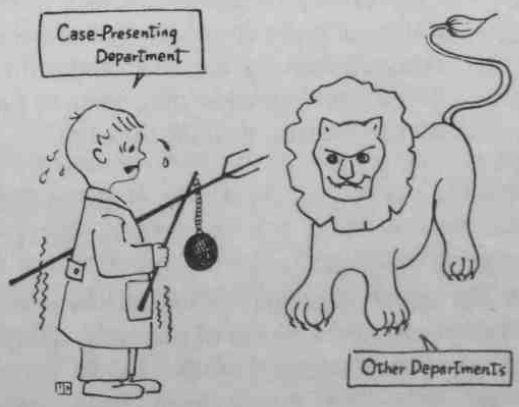
HERE-SAY KNOWLEDGE
*Student A:* "What do you think is the commonest cause of fever in our locality?"
*Student B:* "Splenectomy of course!"
*Teacher:* (My stomach aches ! !)



"WE OPERATE, GOD CURES."
*Patient:* "I will get better after surgery, won't I?"
*Surgeon:* "_____."



THE ARENA OF CLINICAL—PATHOLOGICAL CONFERENCE.



## PRESIDENTIAL ADDRESS

Dr. C. L. Lai

# E.F.G.H. : EINSTEIN, FLEMING, GALILEO HEPATITIS B

## INTRODUCTION

One may well wonder what connections Einstein, Fleming and Galileo have with hepatitis B. There are at least two links. Let us first take the more obvious connection, even though it is less relevant to our subsequent discussion. All three scientists have made world-changing discoveries; and the discovery of the hepatitis B virus around 1965 has been one of the most important discoveries in the medical world within the last two decades. Einstein changed our concept of the physical basis of the world with his Special and General Theories of Relatively; Fleming with penicillin, and Galileo with his scientific proof of the heliocentric (sun-centred) universe – all these discoveries were epoch making. In its way, the discovery of the hepatitis B virus particle was also epoch making.

The second link is more subtle and, to me, far more important. The three scientists chosen demonstrate very different methods of approach to scientific discoveries: Einstein's method was "intuitive" and "creative". Fleming's was accidental, and Galileo's was by meticulously accurate observation (against the suppression of the then all-powerful Church). I will confined my discussion mainly to tracing the development of our knowledge of the hepatitis B virus, digressing as we go along to see how the different methods of approach to science are or are not applicable to the saga of the hepatitis B virus.

The story of the hepatitis B virus can be roughly divided into five sections:

(1) Pre-history (Pre–1965)
(2) Accidental Discovery (1965–1968)
(3) History (1968–1981)
(4) The Present (1981–1982)
(5) The Future

(1) **Pre-history** (Pre–1965)

> "The history of humane learning is the history of highly intelligent but vain and obstinate men fighting tooth and nail to go on believing what they want to believe in the face of all the evidence."
>
> J. Mitchell
> "Half–Life" (1)

The above quotation is very provocative but it is unfortunately all too true in all too many cases of medical and scientific research. Luckily, people sometimes do change their view points when faced with genuine evidence, of which the breakthrough in the history of hepatitis B virus is a very good example.

Hepatitis B infection is described as early as Hippocrates' time as "endemic jaundice". The first written description is by Pope Zacharias in A.D. 751. In 1885, Lurman had already distinguished two types of viral hepatitis on clinical and epidemiological evidence: hepatitis A transmitted by the oral route and hepatitis B by the parenteral route.

The symptoms of hepatitis B infection are briefly as follows: (I) a prodromal period when the patient may have "flu"–like malaise, marked anorexia and nausea, mild fever and right upper abdominal ache; (ii) darkening of urine colour followed by jaundice with subsidence of the prodromal symptoms; (iii) complete recovery in about 90% of cases within 4–6 weeks with occasional deaths in fulminant infection. A small proportion of these symptomatic hepatitis B patients were known to progress to destruction and distortion of liver architecture leading to "post-necrotic cirrhosis".

There were other fragments of knowledge concerning liver diseases in Hong Kong before 1965. Post-necrotic cirrhosis was fairly common in Hong Kong but less than 10% had known preceding hepatitis B infection. The rest (over 90%) were labelled as "cryptogenic" (unknown in cause). Also cancer of the liver, the third commonest then in Hong Kong, was often associated histologically with post-necrotic cirrhosis (over 80%), but again very few were known to have hepatitis B infection or even preceding symptoms of cirrhosis. Thus hepatitis B virus infection, post-necrotic cirrhosis and cancer of the liver appeared to be partially inter-related, and yet isolated diseases. The chief obstacle to progress was, of course, the lack of a marker for hepatitis B infection and the unidentified virus.

When progress in any scientific field is slow, one often finds scientists circling round the field doing rather redundant experiments. This especially dangerous when human beings are the subject of the experiments. Thus for hepatitis B, the Willowbrook School for mentally retarded children in the United States of America had been experimenting from 1956 to 1967 on newly admitted children by innoculation of "purified" infected material from other children with hepatitis A and B (2). Their ethical justifications were, as expected, abundant : Firstly hepatitis was highly endemic in the school and most children would be infected sooner or later anyway. Secondly, informed consent was obtained from both parents of all subjects. Thirdly the subjects were supposedly free to withdraw from the study at any time (as if a mentally retarded child could rid himself of any infected material which had been innoculated into him already!). Very little mention was made about the possibility of mortality or long-term complications by inducing hepatitis. And what were their findings? – exactly the same as that described by Lurman eighty year ago (!), i.e. hepatitis A is transmitted orally; hepatitis B parenterally.

In my personal view, the Willowbrook studies

arguably marked the nadir of the hepatitis B saga. Not only was nothing really new discovered but the experimenters had apparently forgotten about the good old Hippocratic Oath:

> "I will follow that system of regimen which I consider for the benefit of my patients, and abstain from whatever is deleterious. I will give no deadly medicine to anyone if asked, nor suggest any such counsel."

Or to put it in more modern terms:

> "We have to cure ourselves of the itch for absolute knowledge and power."
>
> J. Bronowski
> "The Ascent of Man" (3)

**(2) Accidental Discovery, Truth and "Intuitive" Discovery (1965–1968)**

By 1965, with the connected an yet separate knowledge of hepatitis B infection, "cryptogenic" cirrhosis and cancer of the liver, what was necessary to crystallize a more coherent picture? – an accidental discovery of course!

> "Accidental discovery is entirely typical of the history of science."
>
> C.Sagan
> Cosmos" (4)

Here I will digress and take an almost identical example of accidental discovery from medical history to illustrate how accidental discoveries can be mixed blessings when compounded by human blindness.

In 1929, Alexander Fleming observed that the mould "penicillum notatum", an accidental contaminant in a bacterial culture plate, produced a substance which inhibited bacterial growth, and named the substance penicillin. However it was only in 1941 that Florey and Chain first used penicillin as an antibiotic for treating bacterial infections in man, thus revolutionizing the whole field of infectious diseases. The important thing to note here is the twelve year gap between the discovery and the use of penicillin, with the second World War acting as the final stimulus. So for twelve years, penicillin had been lying dormant while people were dying of treatable infections. It is indeed true what B. Brecht made Galileo say when asked by a monk:

> "Monk: Won't the truth prevail with us or us or without us?
> Galileo: No. No no. As much of the truth will prevail that we make prevail."
>
> B. Brecht
> "The Life of Galileo" (5)

And which is more ironically and pithily stated in J. Mitchell's "Half-Life" (1)

> "No one ever sees anything except what he wants to see."

This is the pitfall of accidental discoveries in science. Human nature has a great tendency to overlook or misinterprete the significance of accidental findings. If this sounds pessimistic, fortunately there is another way of arriving at scientific truths. For want of a better term, I will describe it as "intuitive" discovery. Einstein, another great 20th ceuntury discoverer, is the shining example of how such discoveries occur. It is worth spending a little effort to see what we can learn from him.

Einstein tried to see things anew. His only credo was: "God does not play dice with the world", or to put it in less mystical terms, he believed that there was a simple order governing the universal motions. By looking at the world from fresh viewpoints, he asked simple (by which I mean "fundamental") questions like "What happens to a person travelling at the speed of light?" This "simple" question abolished the concept of absolute time. From questions such as these, he expected and obtained simple by which I mean "mathematically simple") answers. These answers shattered the three-centuries old idea of Newtonian universe and created a new concept of the universe in relative space-time motion which was summed up by a few simple mathematical formulae. He is the supreme example of the creative/intuitive scientific genius whose

> "hallmark is that he has never lost the habit of asking simple questions – each of which led to a momentous discovery."
>
> A. Koestler
> "The Act of Creation" (6)

Do not despair because you cannot ask simple questions leading to momentous discoveries. I have highlighted Einstein not only because he is a genius and not only because he represents another way of approaching medical science. Not all of us are "geniuses", but all of us can and should always keep in mind another of Einstein's dictum's.:

> "We have great difficulties in represent-

ing the world of experience without the spectacle of the old-established conceptual interpretation."

It is the almost inborn inclination of man to see things in the established ways that has blocked the progress of science and made accidental discoveries a mixed blessing.

Reverting back to the history of hepatitis B, we will see the accidental discovery of the viral marker and the blunders which were made before hitting upon the truth that changed the whole aspect of liver diseases in the world and in Hong Kong.

In 1964, Professor Blumberg and his colleagues were studying "polymorphisms" of the serum proteins in man (7). "Polymorphism" is the variation of genotypes giving rise to variation in certain inherited biochemical traits. The simplest example is the ABO blood groups, with some of us possessing the genes for producing the A antigen, or the B antigen, or both antigens or no antigens. In multiply transfused patients, "isoantibodies" would be formed against certain minor "foreign" (polymorphic) proteins from other human beings.

In 1965, Blumberg discovered an antibody in multiply transfused leukaemic patients against an antigen from an Australian aborigine, the "Australia Antigen" (Au Ag) (9). He postulated that the Au Ag and its antibody may be of value in the early diagnosis of leukaemia and that the Au Ag may result from or precede the leukaemia. He mistook the Au Ag to be a marker for leukaemia.

By 1967, he found that Au Ag also occurred frequently in haemophilia patients and in hepatitis B patients (9). However, still unable (or unwilling) to see the tremendous significance of the Au Ag, he wrote: "The presence of the Au Ag in the haemophilia patient could be due to virus introduced during transfusion. **This, however, could not be the only explanation** since many transfused patients neither have the antigen nor antibody against it."

It remained for Prince in New York (10) and Okochi in Japan (1968) to definitely establish the Au Ag as detected in the incubation period of hepatitis B. The Au Ag was now finally and truly associated with the hepatitis B virus particle as a marker of hepatitis B infection.

(3) **History** (1968)1981)

"We had the experience but missed the meaning,
And approach to the meaning restores the experience
In a different form."

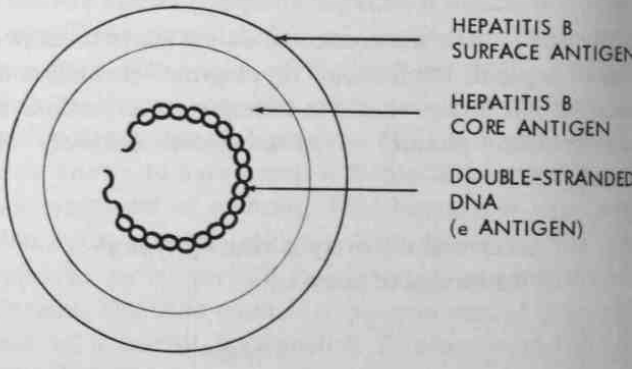
T.S. Eliot
"Four Quarters" (11)

A completely new epoch was made when the Au Ag was established as a hepatitis B viral marker. During t next decade, an avalanche of papers and new discoveri was made about hepatitis B.

Four questions immediately sprang up

(1) What exactly does the Australia Antigen present?
(2) What does the whole hepatitis B virus partic look like?
(3) How should the vrial particles be cultured?
(4) How does one develop sensitive methods for t detection of the virus and its markers?

After much research including electron microscop studies of infected blood, it was found that the Au Ag the surface of the virus particle (hepatitis B surfa antigen or HBsAg) and that the whole virus is a DN virus, with a core antigen, 2 strands of DNA, and a speci e antigen (e Ag) that, when present, means that patient more infectious. Figure 1 is a simplified diagram of th virus.




No tissue culture medium for the virus has bee discovered yet. However, the virus can now be transmitte to chimpanzees, a much more expensive but infinitel more ethical experimental model than the human being Rapid progression in the method of detection of th various antigens of the virus enable us to essay the seru HBsAg (1972), HBs antibody (1975), hepatitis B co antibody (1978) and e Ag (1980) by sensitive and specifi radioimmunoassays.

With these equipments to detect the hepatitis B viru we are ready to put together correctly the pieces of th hepatitis B jigsaw.

(A) Hepatitis B Infection. The majority of infecte cases are now known to be anicteric (i.e. not jaundiced) these would not be diagnosed clinically as hepatitis B (bu often as "flu"). These patients may, however, persist t have the virus with or without damage to the liver.

It is also found that, besides being transmitted by transfusions or needle-pricks, sexual transmission is very common. Hepatitis B is probably the commonest venereal disease in some parts of the world among promiscuous people (e.g. homosexuals). Also mothers with the e Ag

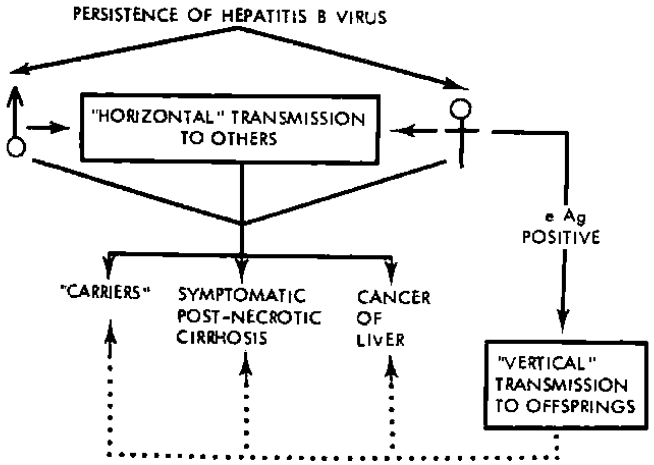
very often transmit the virus to their babies, either during or shortly after birth – so-called "vertical" transmission (12, 13) as against the usual adult-to-adult "horizontal" transmission.

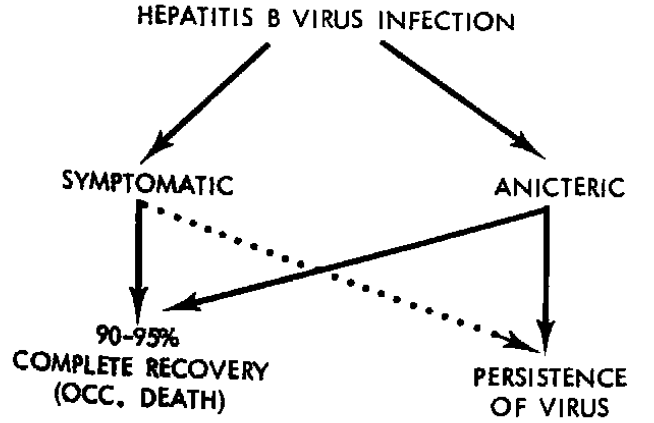
(B) "Cryptogenic" Cirrhosis. With sensitive markers, it is found that about 85% of these cases of cirrhosis with "unknown cause', are HBsAg positive (14), probably resulting frm anicteric hepatitis B infections.

(C) Cancer of the Liver. Again a large proportion are HBsAg positive – from 40% in Japan to 90% in Hong Kong and Taiwan (15, 16). Again most of these patients probably had previous anicteric infections.

It has been recently discovered that part of the DNA of the virus is actually incorporated into the host genome of the cancer cells (17). The latest report from Taiwan (November 1981), in a study of 22707 men, showed that hepatitis B carriers have an increased risk of developing cancer of the liver compared with non-carriers, the relative risk being 223 (18). So the hepatitis B virus probably plays a very important role in cancer of the liver.

There is, after all, a connected and comparatively simple order behind hepatitis B infection and the three major liver diseases in Hong Kong as summarized in Figures 2 & 3.




(4) **The Present (1981–1982)**

Major work is now being carried out to prevent infection by the virus or the persistence of the virus once a person is exposed.

(A) Passive immunization with hepatitis B immune globulin at 1 wk, 1mth and 6 mths after exposure gives up to 75% protection from infection of the virus (19).

(B) Active immunization with various vaccines are now being tried on groups of people at high risk of being infected.

Two vaccines made of purified HBsAg (without infectivity) have been launched in the States (20) and in France (21) giving over 90% protection. Newer vaccines, e.g. those consisting of polypeptides from the HBsAg (22) are being tried in chimpanzees.

(5) **The Future**

(A) Two immediate aims are apparent. Firstly the relative importance of vertical transmission versus horizontal transmission in causing the carrier state, symptomatic cirrhosis or cancer of the liver has to be determined. This is important as it determines which group of people should have priority for vaccination. Secondly, the best vaccine in terms of safety and efficacy must be found and mass-produced for wide-spread use.

(B) The ultimate aim in the control of hepatitis B is nothing less than GLOBAL ERADICATION. Smallpox has been almost completely eradicated; global eradication of hepatitis B would be a great step forward in the prevention of post-necrotic cirrhosis, and more importantly, of those cancers of the liver which are hepatitis B related.

With this happy picture of the eventual supprssion of hepatitis B infections, and possibly of cancers of the liver, I will end my discussion with a more optimistic quotation than the one I have used at the beginning:

> "Science is knowledge won through doubt."
>
> B. Brecht
> The Life of Galileo" (6)

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# A STUDY ON THE EARLY SYMPTOMS OF CARCINOMA OF THE ESOPHAGUS

(During the elective period in Gastrointestinal Surgery in February, 1982)

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Final Year Medical Student

Difficulty in swallowing is well recognized as the outstanding symptom of carcinoma of the oesophagus. It has also been stated that while dysphagia is the first symptom of oesophageal cancer in most cases, it is a late manifectation of this lethal disease, the early stage of which is usually silent.

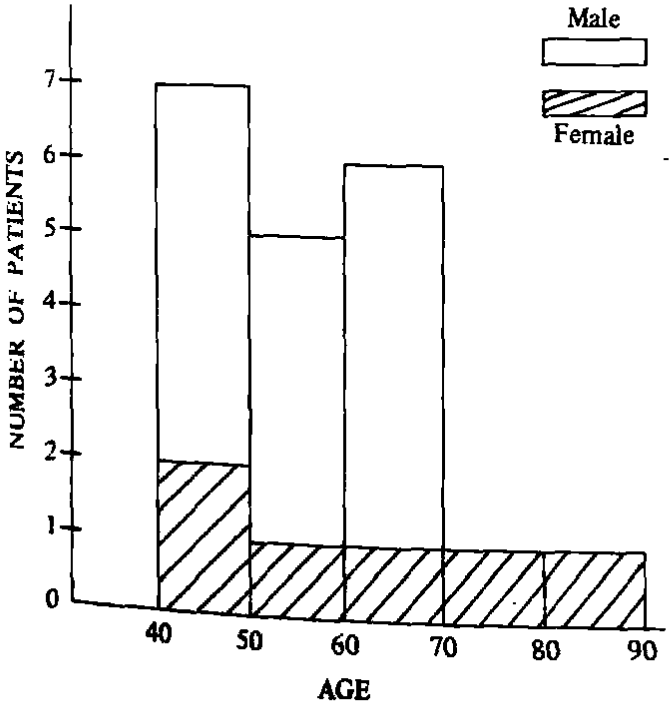
This study was undertaken to determine whether dysphagia is the first symptom of carcinoma of the oesophagus. Other symptoms occurring before dysphagia, which, if promptly investigated, could lead to an earlier diagnosis of oesophageal cancer, have also been sought.

## METHODS

All the patients with carcinoma of the oesophagus with histological confirmation admitted to University Surgical Unit and University Medical Unit of Queen Mary Hospital, Hong Kong were seen during the elective period. Detailed clinical histories were taken from all the new admissions with special reference on the early symptoms before the onset of dysphagia. The duration, intensity and character of these symptoms were all noted. Leading questions were not asked. Ample time was generously given to the patient during the interview to encourage the recall of the early symptoms. The results of barium swallow and histological report were also noted.

### A. PATIENTS

Twenty patients were interviewed, 14 were male and 6 were female. In the group of male patients, the oldest being 69, the youngest being 48, the mean age is 57.0 years. In the group of females, the oldest is 85, the youngest, 43 and their mean age 62.6 years. Their age and sex distribution are as follows.




### B. THE SYMPTOMS

(1) **DYSPHAGIA** All 20 patients complained of dysphagia on admission. This is probably the most alarming symptom to the patient and was taken as the chief complaint. However, on careful questioning, only 13 patients had this as their first symptom. The others just felt something else before dysphagia.

3 of the 20 patients complained that pain during swallowing was the cause of dysphagia rather than obstruction as in the other 17 patients. 2 patients located the pain under the sternum and 1 located it in the epigastrium. They lasted from ½ to 1 minute. One patient described the pain was so agonising that he kept rolling in bed and could be relieved by "lemon Concentrate" (檸檬精), type of soft drink marketed in town.

The duration of dysphagia of each patient is compared with their length of lesion on the barium swallow. No correlation can be found. Note is taken that only patients interviewed in Queen Mary Hospital are studied in this way. Tung Wah Hospital is a convalescent hospital and the barium swallow taken in Queen Mary Hospital will not be sent down to Tung Wah Hospital with the patient.

| Duration of Dysphagia of each patient (weeks) | Barium Swallow | |
|---|---|---|
| | Length (No. of vertebral bodies) | Partial Obstruction |
| 2 | 4 | + |
| 6 | 3 | + |
| 6 | 5 | + |
| 8 | 2 | – |
| 8 | 3 | – |
| 12 | 4 | + |
| 12 | 3 | + |
| 16 | 2 | – |
| 24 | n/a | n/a |
| 24 | n/a | n/a |

(2) **PAIN** 3 patient complaint of on and off aching which had on swallowing as their earliest symptom. The first patient felt this as a pressure on the lower sternum. Sometimes, it felt "itchy". He had been noticing this symptom for 20 weeks before the onset of dysphagia for solid diet.

The second complained of mild interscapular pain for 5 years before dysphagia. It has no reltaion to exertion and was used to be felt in the middle of the night. He denied any history of trauma. This particular patient also noticed weight loss for 15 lbs during the year before dysphagia and severe coughing for the past 3 years.

The last patient complained of ill-defined right sided

chest pain for 24 weeks before dysphagia. He had been seeing doctors for this symptom but it was just disregarded by doctors.

(3) **WEIGHT LOSS** One patient noticed loss of body weight as the first feature of her disease. She lost a little bit less than 10 lbs during the eight weeks before the onset of dysphagia.

Two more patients complained of weight loss not as the first symptom but a symptom before dysphagia. One presented with interscapular pain had subjective weight loss 1 year before dysphagia. The other presented with general malaise had lost 10 lbs in 12 weeks before dysphagia.

(4) **COUGH** A Chronic smoker, having chronic bronchitis noticed increased severity of his cough 2 weeks before dysphagia. He had been smoking 1 pack of cigarettes per day for the past 27 years.

The other patient with interscapular pain also noticed a cough for the past 3 years. He smoked 1 pack of cigarettes per day for 20 years. Chronic cough had not been his problem before.

(5) **GENERAL MALAISE** For 12 weeks before dysphagia, a woman noticed that she was not able to finish her office cleaning work in the time she used to need. Before, she woke up at 4 am and finished at 7 am. But later, she worked until 8:30 am when the office-workers arrived at work.

(6) **SORE THROAT** One patient complained of sore throat 6 weeks before dysphagia. He was then found to have carcinoma esophagus in the cervical region.

**Symptoms before dysphagia**

| Symptoms | No. of patients |
|---|---|
| Pain unrelated to swallowing | 2 |
| Weight Loss | 1 |
| Cough | 1 |
| Sore Throat | 1 |
| Pain unrelated to swallowing + Weight Loss + Cough | 1 |
| Weight Loss + General Malaise | 1 |

**Distribution of patients according to first symptoms**

| Symptoms | No. of Patients | % |
|---|---|---|
| Dysphagia (Obstruction) | 10 | 50 |
| Dysphagia (Pain) | 3 | 15 |
| Pain unrelated to swallowing | 3 | 15 |
| Weight Loss | 1 | 5 |
| General Malaise | 1 | 5 |
| Sore Throat | 1 | 5 |
| Cough | 1 | 5 |
| | 20 | 100 |

## DISCUSSION

While dysphagia was the chief complain of carcin of the oesophagus in all patients in this series, it wa first symptom in two-third of these. It has been obse that death from carcinoma of the oesophagus occurs months after the initial symptoms of dysphagia. So, quite a late symptom.

Pain unrelated to swallowing is found in 15 patients. It varies in site and duration. They varies chest pain to interscapular pain and from 20 weeks years.

The pathogensis of the back pain is not kn Various explanations of the pain have been advanced. I been suggested that dilatation of the oesophagus may rise to discomfort felt in the back. Persistent backache been ascribed to invasion of the periosteum of vertebral column although the prevertebral muscles aponeuroses are said to provide considerable resistanc spread in this direction.

Back pain has also been interpreted as evidenc intrathoracic infiltration, of spread into peri-oesopha tissues and as an indication of inoperable medias extension of the growth. It is possible, however, involvement of sympathetic afferents within the wa the oesophagus may lead to pain being referred to back, and that interscapular back pain does not neces ly indicate that carcinoma has spread widely beyond oesophagus.

Pain from carcinoma of the lower esophagus radiate to the epigastrium as in one of the patients.

Sore throat as an early symptom was very commo a series by Mannell and Plant (1979). These lesions vesiculopapules in the oropharynx, appearing as pimples with white tops". Only 1 patient in this se presented with sore throat. However, the throat was examined and recorded for comparion with Mann description before operation.

## CONCLUSION

Carcinoma of the oesophagus is a common diseas Hong Kong. The surgeons in Hong Kong have in a sh time developed their expertise in the field as demons ted by a number of successful treatment to the cancer.

Dysphagia, though a well recongized symptom carcinoma esophagus, is in a number of times, a manifestation of the disease. So, in order to achieve even better prospect for these patients, it is workthwh to know, if any, early symptoms of cancino oesophagus.

In this study, dysphagia is the frist symptom is t of cases. The other symptoms are interscapular p sternal pain, cough, weight loss and sore throat. Howe their significance is limited by the small sample of patie in study. It does suggest, however that a substan proportion of patients with carcinoma of oesophagus h antecedent symptoms prior to the onset of dysphag Whether these features will be of value in clinica diagnosing these patients earlier will require fut enquiry.

## ACKNOWLEDGEMENT

I wish to acknowledge my debt to Department of Surgery, Hong Kong University and in particular, to Dr. Harley Koo who has given me much guidance and encouragement in conducting the project.

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# AN INTER–DISCIPLINARY EVALUATION OF CLINICAL JUDGEMENT AS MOULDED BY CURRENT MEDICAL TRAINING

Lau Ho Li

## I. INTRODUCTION

It is often helpful to start with an elucidation of the titile.

The following discussions are concerned with an inter-disciplinary evaluation, meaning that the issue, clinical judgement as moulded by current medical training, is evaluated from different points of view, or perspectives.

"Clinical", according to **The Oxford English Dictionary**, means "of or pertaining to the sick-bed". "Judgement", my source indicates, means "opinion, discernment, understanding, good sense". Clinical judgement comprises "assessing", "making sense of", "arriving at an understanding of". It is a **professional activity** and is made in a **professional setting**. Thus, "clinical judgement is basically a sociological matter, referring to statements made about problems in professional-helpee situations" (Watson, 1980). The logic carries on for clinical judgement to change as professional factors (e.g. experience, status) develop. That is, many doctors "do not practice in the fashion in which they have been been trained" (Mechanic, 1978, p.422). But the present evaluation is only concerned with clinical judgement as moulded by medical training, and thus discussions of clinical judgement as influenced directly by the system of health care, the state, or others have not been included except when the influence exerts its effect through the process of medical training.

"Current medical training" refers to that kind of education received by medical students in the past decade or so in medical schools the curricula of which follow the traditional British model. It includes bed-side training, lectures, seminars, totorials, practicals, and bookwork.

## II. DISCUSSION

Certain basic concepts are useful in explaining as well as understanding the ensuing discussion.

**Perception** involves an "organism-environment transaction" in which the perceiver organizes his environment meaningfully. The exact nature of the stimuli or of sensations is not an adequate explanation of perception; we perceive things not as they really are, but as we construct them. Perception is **selective**. At any moment in time one **attends** to only part of the incoming sensory stimuli. What is perceived (in preference to what is not) depends upon the physical properties (intensity, size, contrast and movement) of the stimulus or stimuli, the perceiver's past experience, internal needs, expectancies and momentary interests (perceptual sets) (Mowbray and Rodger, 1967; Hilgard, Atkinson and Atkinson, 1979).

**Attitudes** are enduring organisations of perceptio motives and emotions centred upon something – person, a situation, an object or an insti-ution – a hence are dependent on one's past experiences. Attitud allow us to exploit patterns of past experience to de with present or future events. With a pre-formed set attitudes one tends to **stereotype** something as a memb of a group.

In order to make a balanced appraisal of clinic judgement, one should first evaluate the medical role a the influences on health, so that the scope of the possib problems presented to a doctor can be appreciated.

In the broades terms, the medical role resides in thr areas:

(1) prevention of disease by personal and no personal measures;
(2) care of the sick while they provide scope f investigation and treatment; and
(3) care of the sick who are not thought to requi active intervention (McKeown, 1976, p. 178).

However, only the second area commands medical intere and resources, although personal prevention by immuniz tion also shares a small part of the cake. The other are are largely neglected.

The traditional conceptual model that health depen primarily on personal intervention is not co cordant with past experience. The improvement of heal during the past three centuries was due essentially better nutrition, better hygiene and lowered birth-rate medical science and services made an important y limited contribution to the control of hazards throug immunization and therapy. It is probable that the sam influences are likely to be effective in future, but th relative importance of each is different: in developed, an many developing, countries personal behaviour relation to diet, exercise, alcohol, cigarette-smokin drugs, etc.) is now more influential.

"The literature indicates that clinical judgement m sometimes be adversely affected by clinical training (Watts, 1980). Thus, considering the relevant aspects medical training is a good starting point to assess clinic judgement as shaped by medical training.

### A. Medical curriculum

Although the exact curriculum varies from medic school to medical school, there are some common bas concepts among them:

(a) Medicine is thought to be concerned with inte vention in disease processes, predominantly b

investigation and treatment of established disease, but also by immunization against infections and, to a limited extent, by early recognition of disease through screening.

(b) The basic sciences are considered to be physics, chemistry and biology or, in some schools, mathematics.

(c) Medical education should begin with study of the structure and function of the body (anatomy, physiology and biochemistry), continue with study of disease processes (pathology and microbiology), and end with clinical instruction on selected patients of the types seen in a teaching hospital. (McKeown, 1976, pp. 127–128, slightly modified)

The following inadeqacies of the medical curriculum stem from the basic concepts directly or indirectly:

(1) Maguire and Rutter (1976) observed that "traditional methods of clinical training fall to equip medical students with adequate history-taking skills". They also found that, to one's surprise, that "senior medical students were more likely than inexperienced students to ask leading questions, avoid emotional aspects of cases, use medical jargon, and ignore important cues". That students lack basic history-taking skills had already been reported and evaluated by Anderson and his colleagues (1970) and Tapia (1972). These deficiencies in history taking are carried into the post-graduate years as supported by studies of the practice of paediatricians (Korsh, Gozzi and Francis, 1968), general practitioners (Goldberg and Blackwell, 1970), physicians (Maguire et. al., 1974) and surgeons (Maguire, 1976). It has been commented that the initial history is a fundamental aspect of clinical practice (Hampton et. al., 1975). And thus it is obvious that history taking directly affects clinical judgement, for the latter is nearly always based on the histroy.

(2) Medical educators seem, in general, to place little, if any, emphasis on monitoring students' attitude towards medicine (Maddison, 1978). This results in a "distressingly large minority of" students becoming "case-hardened little monsters, trade unionists in white coats." Thus, it goes without saying that these students' clinical judgement is greatly hampered and routinization of care, sometimes unjustified for each patient, results. Tuckett (1976) in his discussion on doctors and patients argued from a sociological point of view about conflicts in the doctor's role. He concluded with the remark that "the lip service that is [paid] to the 'scientific' basis of medicine, to universalism, affective neutrality, functional specificity, and collectivity orientation, serves, at least in part, as a smokescreen" (p.221). But would this situation be alleviated by an emphasis on the formation of a humanistic attitude towards medicine among students? Eichna (1980) thought so. I also think so.

(3) The fact that conditions under which disease occurs determine human health is not emphasized in medical training. In clinical teaching discussion is centred around investigation, diagnosis, pathogenesis, clinical manifestations (signs ans symbols) and treatment of disease. Little attention, however, is paid to disease origins. Thus the student would unwittingly focus his attention to how disease operates after its has occurred and hence how to manage, rather than why it occurs and how to modulate or prevent the conditions under which disease occurs.

(4) In general, the question concerning the effectiveness and risks of intervention is not discussed critically, and "doctors complete their education with only vague ideas about the credentials of many of the procedures they are expected to apply" (McKeown, 1976). In this way, graduates will limit their perception to what can be done to cure the patient (in other words, to intervene) without paying heed to the possible risks involved. One major hurdle here is, as Cochrane (1971) has emphasized, that the effectiveness of most clinical procedures has never been adequately assessed. However, what is not known, and even what is known, is not made explicit in clinical teaching. The strict adherence to what is taught is reflected in the study by Dobbs et. al. (1978), who concluded that had other prescribing methods of the drug digoxin been used, the outcome would have been different or better.

(5) Because of the undue emphasis on investigation and acute care, students are inevitably given the impression that the later needs of patients, less dramatic but equally important, are a secondary consideration which can usually be left to someone else. It results in the remarkable notion that diagnosis of a disease can be considered an end in itself; again it will certainly lead to inadequate clinical judgement.

(6) Clinical training ignores the concept that the data best remembered tend to be those that fit the hypothesis made (Elstein, 1979, p.22), and that facts may even be distorted on recall to something more consistent with a particular diagnosis (Higgins, 1980).

B. **Medical teaching staff**

Pappworth (1978) mentioned two causes of poor clinical teaching, which are attributable to the teaching staff:

(1) Domination of the medical schools by research workers, and

(2) Over-specialization by many clinicians (p.10).

He explained that the speicalist expert is often a person who is fastidious about his own speciality which may be of little, if any, importance **per se.** but makes blunders in other major areas of medicine. Moreover, doctor-patient relationship is rarely touched upon by these specialists or "superspecialists". Young graduates, following the teaching they have received, become superb technicians in certain selected aspects but largely miss other facets of the problems the patient presents them with, for the simple reason that they were not familiarized with these facets in the undergraduate years. It results in a dangerously biased clinical judgement.

C. **Intrinsic property of the medical profession**

The professionalisation of a medical student brings to him an important intrinsic property of the medical profession: the use of the medical vocabulary.

Pappworth (1978) in his book discussed in detail the medical vocabulary. He worte, "A prevalent cause of confusion in clinical medicine is the lack of agreement concerning the exact meaning of even commonly used words and phrases such as apex beat, secondary optic atrophy, exophthalmos . . . . " Many physicians . . . . delight in explaining hypothetical differences between terms which are generally considered to be synonymous" and "such an artificial distinction leads to errors in diagnostic logic ' (pp. 16–17), and hence clinical judgement.

The medical vocabulary is rich in neologisms (which are very often unjustified), jargons, romance descriptions (e.g. "swan-neck deformity", "rugger jersey spine") and eponyms, which confuse, if anything, doctors and students alike by hampering the communication between them and with patients. These terms are often communication-blockers in interviews with patients, as pointed out by Maguire and Rutter (1976). (Cf. discussion in A. (1).) A sound clinical judegement is in turn affected.

D. **Image of medicine projected at the teaching centre**

McKeown (1976, p.131) argued that "the really potent influence on students . . . . is the image of medicine which emerges from the range of activities and interests of the teaching centre". Students are exposed to a narrow selected range of "cases", and this conveys the wrong idea that these are the largest and most formidable problems by which medicine is now confronted. And the decision always to suspect physical illness – that i better to judge a well man sick than to judge a sick m healthy (Scheff, 1963) – will sometimes lead to disa in general practice, because patients may come for gnosis, advice, reassurance or to be simply "tempora dependent" (Thomas, 1974) for no clear reason. P chological disturbance is often a probable reason for, important component of, almost every problem t patients present the general practitioner with.

The models of clinical decision-making imparted the student vary both in character and in status. T surgeon's decision is characteristically goal-directed, ter and factual. The psychiartist's decision is tentati exploring and concerned with feelings and reactio Moreover, the former has hgher status (Higgins, 198 Thus, the student is exposed to different concept frameworks in different "cases" which have already be labelled for them. In the surgical ward, he **knows** that will be faced with "surgical" cases, and he will act a decide like a surgeon. In the psychiatric ward, he chang into a psychiartist. This illustrates a common feature clinical judgement as moulded by medical training: tha "case" is labelled or stigmatized, put into concre categories, and dealt with according to the model decision-making in that specialty. A holistic view seldom obtained.

In the teaching centre, every "case" is diagnosed a the student will carry with him the idea that everything sees is diagnosable in conventional terms. However, it often not true in general practice (College of Gene Practitioners, 1958). Young doctors have to see a proble within a medical frame of reference before they can ma use of what they know, although experienced docto tend to make less formal diagnoses as time goes on.

The problem of the frequently used word "case" a its inhuman connotations is particularly serious. Patien are invariably referred to as "cases". This is especial prominent in the so-called para-clinical subjects. To quo one example: "As with staphylococcal infections, cas and carriers of **strept. pyogenes** extensively contamina their clothing and the general environment . . . ." (Gillie 1978, p.81). Textbooks on clinical medicine seldom, ever, use "for **patients** suffering from . . . ." in place "for the **case** of . . . ." The effect of all these is t depersonalization of a very human subject: doctor-patie relationship. This often leads to a failure to understan the underlying problems of the patient, and in suc instances there is no such thing as clinical judgement speak of.

There is also the problem of relying heavily, if n solely, on tests and laboratory data. Eichna (1980) argue that careful history-taking and physical examinatio "have atrophied under the practice of reflexive orderin of tests". He strongly objected to what he calle "assembly-line medicine" which downgrades docto patient contact and hence appreciation of the re problem.

## III. OVERVIEW

The most salient inadequacy or limitation of current medical training is that it is not concerned with **all** the influences on health, both personal and non-personal, and that attention has not been extended to **all** types of patients and **all** phases of illness. Thus, medical students are brought up in an environment with a carefully controlled microclimate, which shapes the thought complex of them into one the input and output of which are highly stereotypic.

However, may I say that there is some sort of awareness amongst medical educators, otherwise no Behavioural Sciences courses will have been implemented. There are also hopeful changes in medical textbooks. In the 1980 edition of **Hutchison's Clinical Methods**, and extremely popular text, one can find right at the beginning, in the introductory paragraph, the following sentences, "In practice, of course, **patients** do not present with a diagnosis; they come with problems. The wise doctor does not think of himself as a diagnostician but rather as **someone who elucidates human problems**" (Italics mine.) These were absent in previous editions.

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# A STUDY OF THE UTILIZATION OF TRADITIONAL MEDICINE AND WESTERN MEDICINE IN A MODERN CHINESE SOCIETY, HONG KONG.

Winchell

## ABSTRACT

Chinese medicine ans Western medicine are the two major medical systems of Hong Kong. Although Western medicine achieves dominance in wealth and power, Chinese medicine still prevails. Western medicine is based upon science which most people accept whereas Chinese medicine is based upon Yin/Yang and the Five Elements Theories and is practised over thousands of years. In most cases, a typical Chinese would seek Chinese medical treatments for minor diseasis and Western medical treatments for more serious diseases. Each has its own merits and proper integration of the two can result in a 'Scientific Medicine' which we all look forward.

## I. INTRODUCTION

As the process of modernization continues in Hong Kong, people are more and more exposed to scientific and Western culture. Science is being treated as a universal acceptance and therefore it displaces much traditional beliefs of health and illness. But on the other hand, Chinese Traditional medicine has based its foundation on thousands of years of practices and its validity is not questionable. Therefore a dilemma exists in the people of Hong Kong about the decision to utilize which medicine. In his paper released in 1974, P.L. Lee claimed that Western medicine is more favourably evaluated and extensively utilized by the general public which I doubt very much.

In the following discussions, I shall first consider the peculiar situation of Hong Kong in which two medicines exists. Then I shall analyse the validity of the statement made by P.L. Lee that '. . . . Western medicine is more extensively utilized and facourably evaluated . . . .' Thereafter I shall study some traditional Chinese beliefs of health and illness and their implications on the process of seeking treatments to diseases. After this, I shall discuss the various constraints against utilization of Chinese medicine. Finally I shall project into the future and consider some prospects for the continuation and revivalism of traditional medicine in Hong Kong.

## II. PROFESSIONAL CO-EXISTENCE AND INEQUALTIY

In 1841, when Captain Charles Elliot negiotiated the preliminaries for the Sino-British teraty for the cession of Hong Kong island, one of his proclamations was:

'The Chinese will be secured in the free exercise of religious rite, ceremonaries and social interests. . . . .'

Since then, the statement has become the attitude of both the local Chinese and the Government. Chinese medicine, being considered as part of the tradition of the local population continued to exist and receive minimal intervention from the government.

However, the government's attitude, as described by P.L. Lee, is that it is 'supportive' towards Western medicine whereas towards Chinese medicine, its attitude is 'conditional tolerance'. The British colonization has brought to Hong Kong Western medicine and since then, Western medicine has dominated over Chinese medicine in many dimensions. Some of these are:

a. power– Western medicine has a greater power to control over both the social organization of medical care and technical content of medical work. The Hong Kong Medical Council which is responsible for legitimization and supervision of medical practices, has its members solely come from qualified Western-trained doctors. Chinese medical services are not recognized by the legal authority as duly qualified. Chinese medical practitioners are deprived of certain privileges, like the practice of surgery, issue of death certificates, treatment of eye diseases; possession of antibiotics and dangerous drugs etc., which the qualified Western trained doctors can. The profession of Chinese medicine is also prohibited by law to use any name or title to practice according to modern scientific methods.
b. Wealth– it is found that Western-trained doctors make more money than Chinese practitioners. Also, the government provides mich financial support to that aspect of medical and health care concerned with Western medicine, but none financial support is given to that of Chinese medicine.

## III. UTILIZATION OF CHINESE MEDICINE

In his report in 1974, P.L. Lee showed that most people prefer Western to Chinese services for the treatment of most diseases and it is only in some treatment of sprains and fractures that Chinese medicine is considered to be more effective (Table 1). His study also showed that Chinese practitioners are more likely to refer patients to Western-trained doctors than the latter refer patients to their counterparts. Hence he inferred that

**the services of the profession of Western medicine are more favourably evaluated and more extensively utilized by both the lay population and medical professions themselves, and in terms of social prestige, the professions Western medicine is superior to that of Chinese medicine.**

| | Western Better | Chinese Better | About the Same |
|---|---|---|---|
| (1) Tuberculosis | 91.2% | 1.4% | 7.4% |
| (2) Fever | 90.5 | 5.7 | 3.8 |
| (3) Heart diseases | 84.9 | 0.9 | 14.2 |
| (4) Stomach-ache | 84.3 | 3.4 | 12.3 |
| (5) Mental illness | 84.0 | 0.4 | 15.5 |
| (6) Skin diseases | 83.6 | 6.6 | 10.4 |
| (7) Throbbing and diarrhea | 78.3 | 13.4 | 8.3 |
| (8) Whooping cough | 76.9 | 14.0 | 9.1 |
| (9) Dysmenorrhea | 65.0 | 17.5 | 17.4 |
| (10) Anemia | 55.0 | 29.1 | 16.0 |
| (11) Measles | 47.9 | 47.0 | 9.1 |
| (12) Rheumatism | 24.2 | 54.1 | 21.7 |
| (13) Sprains and fractures | 8.2 | 86.5 | 5.3 |

Table 1. Evaluation by the Lay population of the effectiveness of treating specific types of diseases. (By P.L. Lee, 1974)

I am not much in favour of this, and here are some arguements I have to refute his perspectives.

In the beginning, P.L. Lee has not made a clear distinction between medical **services** and **medicine.** Medical services refer to those facilities provided in hospitals and clinics, either private or government runned and therefore they exclude the aspect of **self-medication** to which the medical services are intangible. In the previous section, I have described the dominance of Western medical services in wealth and power and it can be seen that this is due to the supportive attitude of the government. The Chinese medical services, because of the lack of government support only exist in form of simple private clinics and are absent in all hospitals.

To avoid confusion, I will be using the word 'medicine' to include all aspects of medical care, cure, treatment and remedy to diseases. Therefore 'medicine' includes medical services.

Although Western medicine holds the 'Orthodox' method of cure, ordinary people in Hong Kong have considerable knowledge of therapeutic practices and rituals of care. (Topley Marjorie) In 1970 it was stated in a Governement Information Service handout that 'although Western medicine . . . . is entirely acceptable . . . many still consult practitioners of Chinese . . . . medicine . . . That . . . . (it) . . . still retains a popular appeal is evidenced by the fact that 74 percent of patients other than emergencies, admitted to . . . . (a government hospital) . . . had been treated at some stage of their illness by practitioners of traditional medicine.' It was also stated that the 'most frequent practice . . . . is to have recourse to traditional medicine first and then if . . . . ineffective . . . . to turn to Western medicine. Sometimes . . . . (it) . . . . works in reverse.'

In a survey by Topley Majorie in 1973 on the medical students of Hong Kong University, it was found that out of 85 students, 31 went to traditional practitioners for fever; 22 for colds; 12 cough; for dislocation and fracture; 9 for influenza; 6 for headache; and 43 for miscellaneous complaints. Thus even in medical students who were much exposed to Western medicine, Chinese medicine was still being utilized to quite a large extent.

It is now well documented that there exists an illness iceberg in all modern societies in which only some illnessess are taken to the doctors whereas the rest are either unnoticed or are not taken to the doctors. Hence P.L. Lee's view could be critized on grounds that he only considered those diseases which are largely on top of the iceberg which medical intervention by doctors is necessary, without noticing those self-limiting diseases which self-medication constitutes a large part and are not taken to the doctors. (ref. Table 1)

To go on further, I have made a survey on the prevailance of Chinese medicine in the various mass media. The results showed that there are far more advertisements on Chinese drugs than on Western drugs. In Wah Kuo Yat Po ( 華僑日報 ) for example, there is a two to three pages column once every month on discussions of the uses of Chinese medicine. There is also a daily corner giving advices and answering letters from readers. There are also TV and radio programmes made on matters concerning Chinese medicine.

**Considering the above, one could positivity says that Chinese medicine still have its social support but it is only due to certain constraints that prevent its fullest utilization which I shall analyse later.** (Section V)

## IV. THE PROCESS OF SEEKING TREATMENT

To understand the process of seeking treatment to a disease in Hong Kong, one should hvae some ideas of the Hong Kong medical system.

## IV.1. The Hong Kong Medical System: a Brief Summary

This can be diagramatically represented as follows:

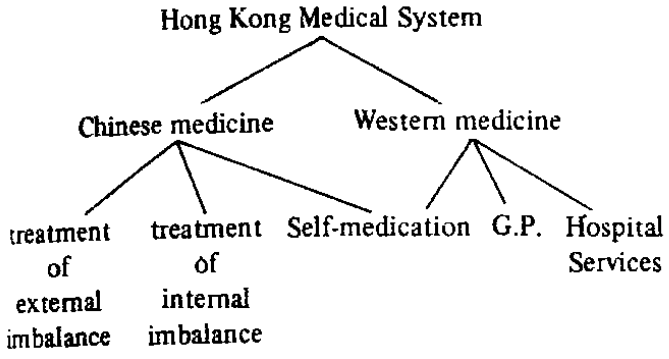



Fig. 1. The Hong Kong Medical System

Roughly speaking, treatment of external imbalance deals with the readjustment of the body with the external environment by matching the body systems with the almanac (通勝), geomantic compass (八卦), and the chasing away of the demons etc. Treatment of internal imbalance is concerned with the homeostasis of various organs of the body based on the theories of Yin/Yang and the Five Elements. The former has been largely given up by most Chinese, particularly the young generation, who see no scientific relationship between the almanac and the geomantic compass and the cause of their sickness. The later however, now formed the basis of the prevailing classical traditional practices of today. The theories worked in their own right, and have proved themselves valid for thousands of years of practices.

In Hong Kong, the number of registered Western-trained doctors is 3291. Of these 972 are in government hospitals, the rest are probably in private clinics and hospitals. (Hong Kong Annual Report 1980)

The number of Chinese traditional doctors cannot be exactly enumerated because of various factors. There is a lack of registration, a batch of part-time doctors and also an influx from mainland China from time to time. According to the Census and Statistics Department, the total number of Chinese practitioners of various kinds is about 8000 at present.

Hence we see that there is a dual medical care system in Hong Kong. In his survey in 1974, P.L. Lee has found that in the initial stage, people were most likely to be self-medicated (58%), rather than to seek help from Western-trained doctors (38%) or Chinese practitioners (4%). The percentage of self-medication might be more if Lee has considered those less serious and slef-limiting diseases. Also, the extraordinary powers of resistence to psychological stress of the Chinese may cause a further tendency to self-medicate (Priestley and Wright). Nevertheless, it is interesting to know which medicine people would prefer in the process of self-medication.

## IV. 2. Self-medication by the Public

There are suggestive evidences to show that Chinese medicine is utilized more during self-medication. Most people are ignorant about the effects of Western drugs and tablets; and because of their quick and profound actions, they have a strong deterrent effect on the use of these, for people are afraid of taking in a wrong drug which would demand immediate remedial actions. Some drugs also require a signed prescription from a registered doctor before one can purchase them.

On the other hand, Chinese herbs with the exception of some are easy to purchase without any signed prescription. People with some knowledge of Chinese medicine can even obtain their herbs form their gardens and hillsides. The effects of Chinese herbs are less profound and are slow in actions, and their side effects are minimal. knowledge of some drugs are widespread throughout the population as a community lore (e.g. Chrysthanmum tea) and people do not have any fear of taking these drugs as compared with Western drugs.

## IV. 3. The Dynamics of Seeking Treatment

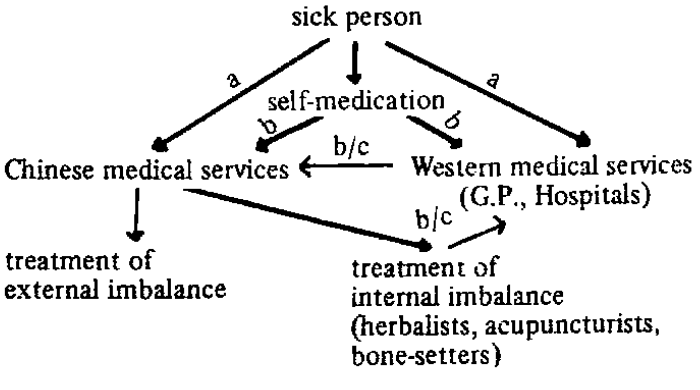
In his study in Kwun Tong, P.L. Lee has found that at the initial stage, most people were likely to self-medicate. Some would go to seek Western medical care straight away and very few would seek Traditional care. Later, when the treatment could not work, people who utilize Western medical care continue to do so, while those who self-medicate and those who utilize Chinese medical care revert to Western medical care.

But I have noted in the previous sections (III, IV 2) that it is mainly Chinese medicine that is utilized in the process of self-medication. Therefore it can be inferred that:

> **Initially, Chinese medicine is being utilized greatest; later, Western medicine is being utilized greatest.**

One further point to note is that when treatment by Western medicine has failed in the later stage, as in the case of terminal illness or incurable disease, one may revert back to Chinese medicine or utilize both at the same time.

The dynamics of seeking treatment can therefore be considered diagramatically as such:



a – initial stage

b – later stage

c – final stage

Fig. 2. The dynamics of seeking treatment

## V. CONSTRAINTS AGAINST UTILIZATION OF CHINESE MEDICINE

In the beginning, many Western-trained are skeptical of the practice of Chinese medicine. They say that Chinese medicine has no uniformity of standards and qualifications and some even question the theories of Yin and Yang and the Five Elements. Other selfish western-trained doctors may think that the revivalism of Chinese medicine might deprive them of some of their clients.

The government of Hong Kong, to some extent is not much in favour of the practice of Chinese medicine, for it might lead to cultural consciousness which in this British Colony is considered as undesirable. Accordingly it gives little support to Chinese medicine.

However, Chinese medicine has its own defects, many herbs and drugs are extremely rare and difficult to purchase. They are also expensive and difficult to prepare. Some require careful heating, and the relative proportion of each constituents is extremely important in each prescription. These, and many other procedures in preparation cause much incovenience and might contribute to the utilization of Western medicine instead of Chinese medicine.

In some portion of the population, Chinese medicine has become a deep-rooted experience in their medical and health care. These are mainly the older generations who have been using Chinese medicine for many years and they are reluctant to accept the scientific Western approach.

As a consequence of inequality of standards and qualifications among the Chinese practitioners, the lay populations is not guaranteed safe in utilizing it. Furthermore, the permittance of advertisement by Chinese practitioners has turned the system from professional to commercial. Some Chinese practitioners charge excessively. There is no body to control professional conduct and medical ethics. Subsequently, many people, particularly the young generation, has turned towards the Western medical services.

The study by P.L. Lee on Kwun Tong in 1971–72 has shown that western-trained doctor has a much better colleague network, and this allowed sharing of knowledge and experiences between themselves. However, the colleague network in Chinese Practitioners is extremely loose, and this makes Chinese medicine less prevailing.

Finally, the selfishness of many Chinese family must be critized. Some families are known to have speical cure to certain diseases, but they seldom make these known to outsiders, thus making many treatment of diseases by Chinese medicine unknown.

**As a result of the above various constraints, Chinese medicine comes to be utilized less than it should be.**

## VI. PROSPECTS OF CONTINUATION OF CHINESE MEDICINE

Some people may feel down-hearted to see Western medicine dominate over Chinese medicine. However I am optimistic about Chinese medicine and I dared to postulate that it will prosper for years to come for the following reasons:

a. There should have some degree of validity within Chinese medicine, for it has acquired empirical experiences of countless of people over thousands of years.
b. Many folk remedies are extremely successful in the treatment of minor diseases (taking in a bottle a Crysthanmum tea, is well known to all that the 'hot air' inside can be neutralized).
c. Because of the shortage of Western-trained doctors, folk remedies and traditional medicine can still take care of a large sector of the population.
d. Recent advances in the People's Republic of China in the use of Chinese medicine like acupuncture analgesia, bone fractures etc. have shown that Chinese medicine has its special power of treatment.

**Hence, Chinese medicine has its potential for further utilization.**

## VII. TOWARDS AN INTEGRATION OF AND WESTERN MEDICINE

So far, I have been using the word 'Western' medicine casually. In fact, the word 'Western' is a misnomer. As F.P. Lisowski in 'Glimpses of the History of Medicine' pointed out, it was the main branches of medicine – Chinese, India, Arabic and Persian that gave a large share of the medical learning that formed the foundation of the present 'Western' medicine. Scientific reasoning is in fact the basic approach of Western medicine.

People in Hong Kong tend to regard any medicine that is sceientific as 'Western' medicine. True to say, in a modernizing society like Hong Kong, science is most acceptable.

**Chinese medicine must therefore be made scientific, and then integrated with the prevailing Western medicine forming one medicine which I will call it as 'Scientific Medicine'.**

Hong Kong is in a good strategic position of doing this, for it is a place where East meets West. With its prevailing Western medical knowledge, combined with the local traditional medicine and also the many non-Commonwealth doctors from mainland China, there can be joint research for better integration. As suggested by P.L. Lee, a government recognized College of Chinese medicine and a Chinese Medical Council should be established. These two institutes would have control over training of students, registration and licencing of medical practitioners and ethics of medical practices. He went on to further suggest that the government should enforce a legal recognition of Chinese medical care, while the University with its academic status could confer the technical competence of Chinese medical practice and thus could contribute to its social legitimacy.

**A proper integration of the two medicines would enable a wider range of medical care. Each medicine could complement of supplement the other, thus resulting in a single but completely competent medical system.**

## VIII. SUMMARY AND CONCLUSION

Despite the process of modernization and the dominance of Western medicine in wealth and power, Chinese medicine still has much social support and still being utilized to quite a large extent. At present, becuase of the coexistence of two medical systems, people tend to roam about between the two medicines in the process of seeking treatments to diseases.

Chinese medicine is a large resource of medical and health care in Hong Kong. There are many unexplored fields which may open up new methods of cure; and it is only due to the many social constraints that prevent their 'booming'. Prospects of Chinese medicine is promising, and if the various methods of cure is made scientific, a more complete unifying medical system would emerge which could look after the health of a much greater number of people. This, I call it the 'Scientific Medicine'.

Space has not allowed a detailed discussion on the 'preventive' side of Chinese medicine. It would not be very appropriate to use the word 'medicine' for some Chinese habits and cultures. For example, Chinese Martial Arts or Kung Fu, morning walk (晨運) etc., serve to strengthen the body against diseases. Yet it would be quite desirable if these are also added to the 'Scientific Medicine'.

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### Simple dosage regimens

Zantac was specially developed for B.D. dosage. The recommended treatment course for duodenal ulcer and benign gastric ulcer, is one 150 mg tablet twice daily for four weeks.

For extended maintenance therapy, the dosage is just one tablet taken nightly.

In the management of reflux oesophagitis, one tablet twice daily, for up to eight weeks, is recommended.

### Highly specific action

Due to its innovatory molecular structure, Zantac does not cause problems with endocrine or gonadal function, or adverse effects on the central nervous system—even in elderly patients.

Similarly, as Zantac does not interfere with liver enzyme function, there are no unwanted effects on the metabolism of drugs such as diazepam and warfarin which may be prescribed concomitantly.

Zantac Injection ampoules are also available, containing 50 mg ranitidine in 5 ml for intravenous injection or infusion, for use in acute cases where oral therapy is inappropriate.

Glaxo

Zantac
RANITIDINE