

ELIXIR

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Summer 1970

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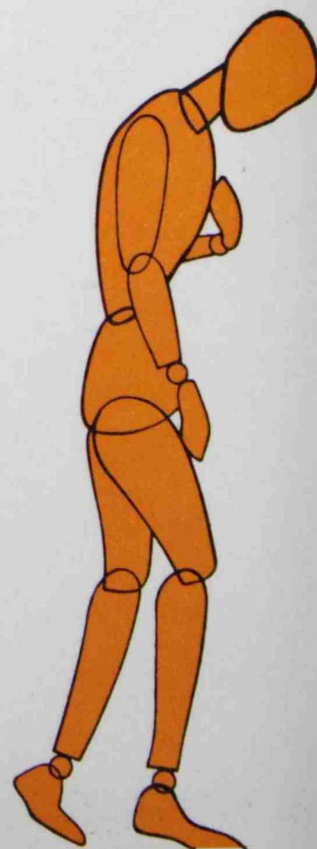


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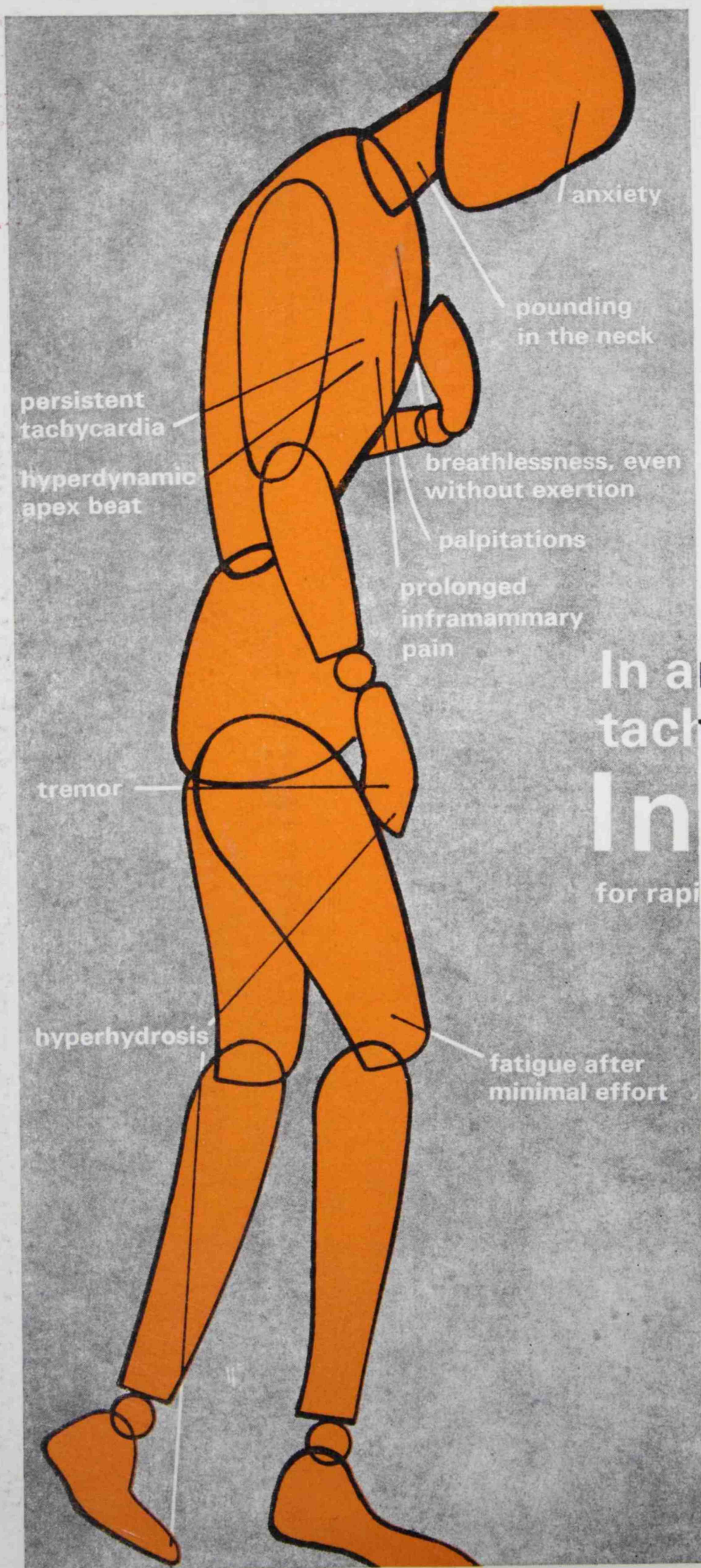
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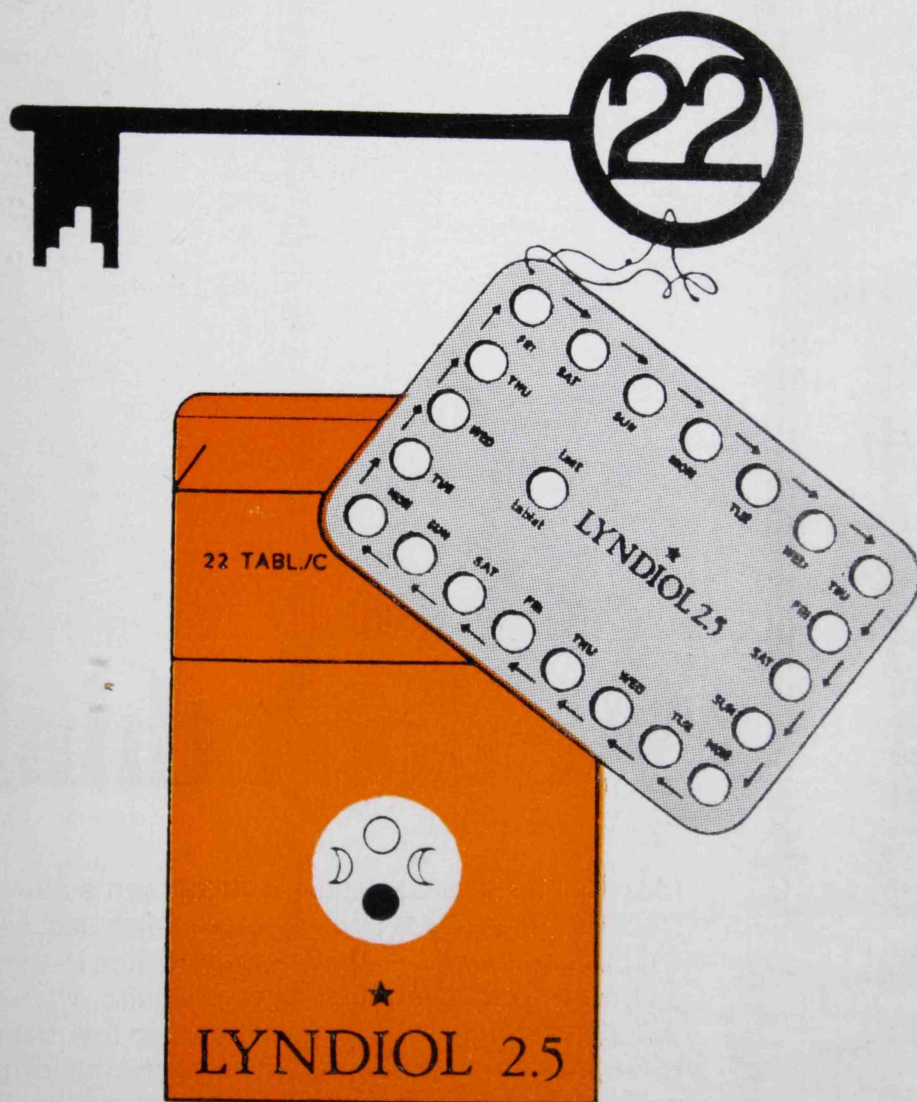
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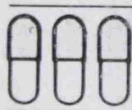
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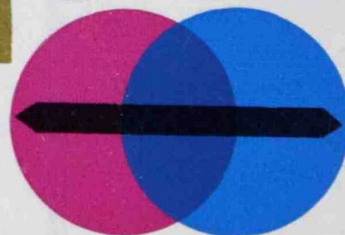
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Dunlop E.: Paper, presented at the Symposium on Psychopharmacology, sponsored by the Academy of Psychosomatic Medicine, Freeport, Dec. 8-9, 1968.

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Dorfman, W.: Editorial, Psychosomatics, Volume X Number 3 Section II; May-June, 1969.



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Foreword

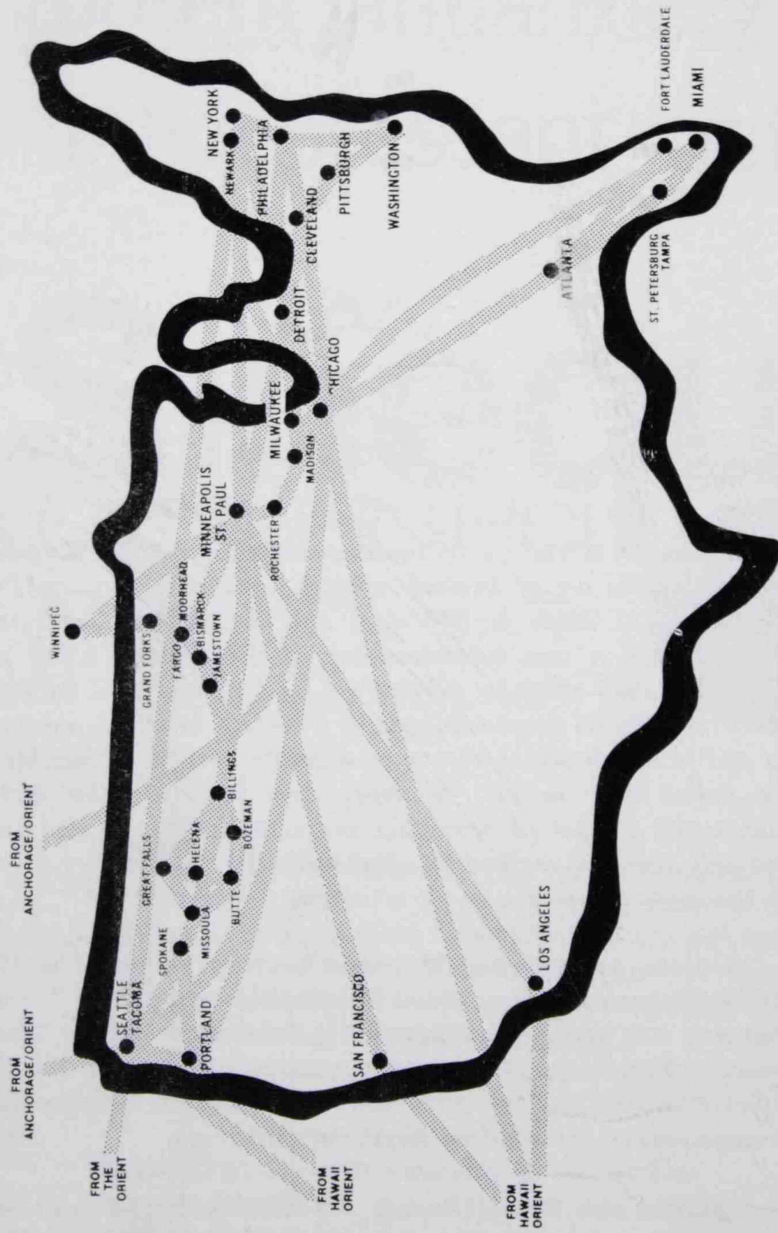
Although a variety of motives have inspired us to take up this training in the art of healing, what is certain is that, once in it, we shall have to abide by its rules and disciplines. It is meet then that we seek a true understanding of the nature of the profession which we shall soon be joining, of its greatness and its responsibilities, especially its responsibilities in a society in which we are brought up and in which our service is so urgently needed. Thus Mr. Stephen Ng points out, in his "Students And Society", the lack among students of a sense of belonging and responsibility to our own people and this our native land, a deplorable fact which yet is the order of the day.

On the same theme Dr. Aldrich writes in his "The Physician's Public Image and His Social Responsibility in 1985," tracing the changing role of the physician through the ages. In his "Professional Secrecy, Yesterday, today and tomorrow," Dr. Robb dwells on the difficult subject of the preservation of absolute secrecy in various circumstances—the modern physician's dilemma.

Also in this issue, "Puffing the Magic Dragon" will take us to look at the serious problem of drug addiction in Hong Kong from its different aspects.

Our readers may have noticed a change in the contents of the recent issues of Elixir. This change is purposed to parallel the appearance of our sister publication, the Caduceus, who has undertaken the job of reporting the activities and daily gaieties around the Medic Centre.

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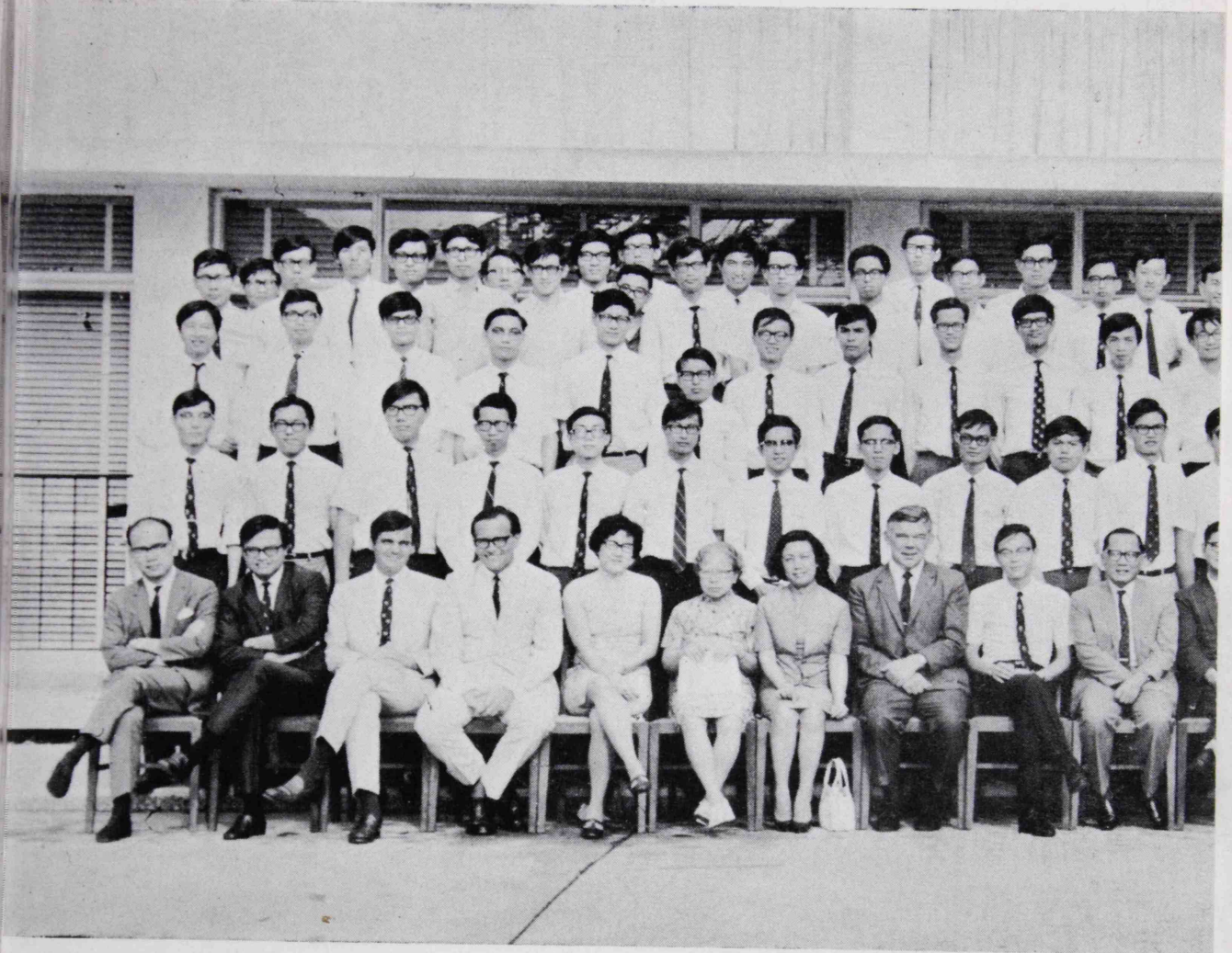
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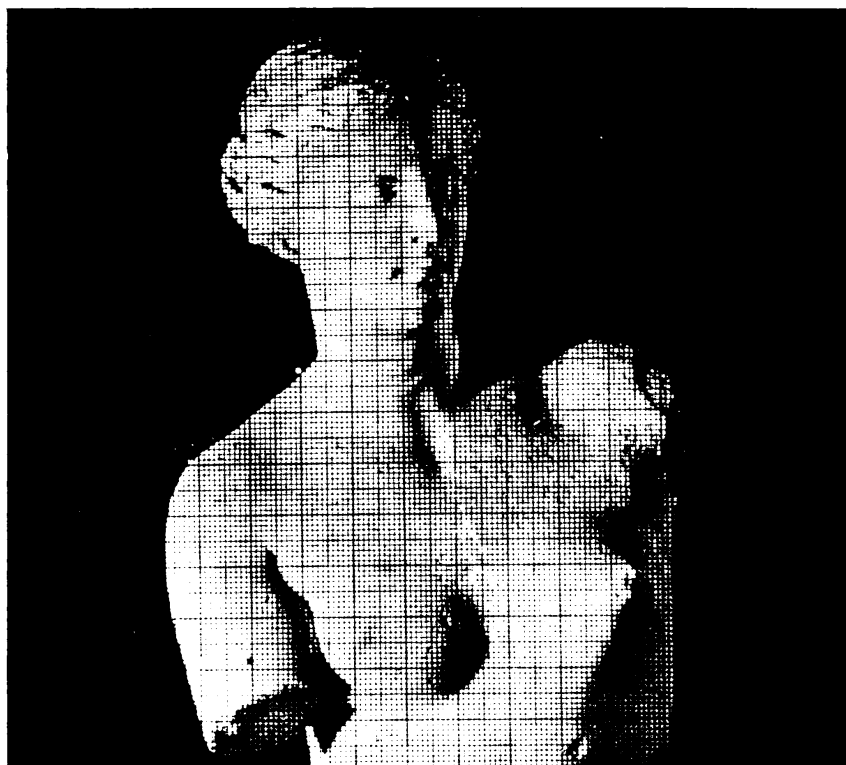
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PRESIDENTIAL ADDRESS



28th May, 1970

PET, PEST AND PESTILENCE

Infections Transmitted from dog to man

C. T. Huang, M.B., Ph.D., M.R.C. Path.

Introduction

Pets are animals tamed and kept as favourites or treated with fondness. Many animals are kept as pets, and all of them can in one way or another transmit some microbial diseases to man. For instance, the parrot and budgerigar are reservoirs of Psittacosis, the monkey carries *Shigella* and *Entamoeba histolytica*, the tortoise which is sometimes kept as pet may be infected with *Salmonella* and *Arizona* groups of bacteria. The cat is just as intimate a pet for man as is the dog. The reason that I select the dog for my topic is not that I am sentimental about him nor is it that I hate him. It happens this is the year of the dog in the lunar calendar and there are many more dog lovers than lovers of any other pets.

The association of dog with man is long. Dog has become domesticated since the time of savage cave-men. The dog has adopted himself quite readily to purposes of economic usefulness to man. Dogs are natural hunters, assisting man to procure food supply. They were trained to protect property as guard dogs and watch dogs or tended flocks and herds in agricultural communities. They were hitched and harnessed, pulling wagon or sled, for animal baiting and for entertainment. They were pitted to fight each other or to race in the canidrome. The flesh of the dog in the time past was used for food by the American Indians and still is by some Chinese people.

An important modern role for dogs is as companions and household pets. The dog enjoys a more intimate contact with man than any other animals, sharing not only his dwelling, but sometimes even his bed. It was suggested that there is a correlation between the emotional manifesta-

tion of the dog and his owner. Many dogs have become a mirror image of their masters' emotion, and if the master does not adjust well to society, neither does the dog. The intimate contact of dog with mankind poses a great problem in the control of infectious diseases. The two major diseases in which the dog is the important source are rabies and hydatid disease. These are so well known, they need no exemplification. But there are still many others which are less familiar or recognised. I take this opportunity to describe some of them.

Parasitic Diseases

Dogs are infected with a large number of animal parasites, and more than a score of them may infect man. Dogs are important reservoirs of these diseases and are important in passing the parasites back to the intermediate hosts so the life-cycle of the parasites can be perpetuated in nature.

Leishmania donovani, *L. tropica* and *L. braziliensis*, the agents of kala-azar, cutaneous leishmaniasis and espundia respectively, have reservoir in canine hosts. The dogs constitute important sources for infection of the sandfly which is the vector of the haemoflagellates. The reservoir hosts for *Trypanosoma cruzi* include dogs and cats. From them the agent is readily picked up by the blood sucking bugs and are inoculated into unsuspecting human beings.

Schistosoma japonicum, *Clonorchis sinensis* and *Paragonimus westermani*, the common trematodes of the Far East, have been recorded from dogs. Dogs are important in passing the parasites back to snails, the first intermediate hosts of these parasites.

That dog plays an important role in the tapeworm *Echinococcus granulosus* infection is very well known in countries where livestock constitute the chief national in-

come. The hydatid worm reaches maturity in the intestine of the dog and its wild relatives. Eggs are discharged in dog's faeces which form the source of infection of hydatid cyst in sheep and other herbivorous animals and man. Dog's faeces may contaminate food, drinks, play objects or mess kits and lead to human infection.

Dipylidium caninum, a relatively uncommon human parasite, is acquired from accidental swallowing of the fleas of the dog which harbour the cysticercoid stage of the worm. Dog also serves as reservoir host of the broad tapeworm, *Dibothriocephalus latus*, but man is usually the indirect source of his own infection.

Ancylostomum caninum, *A. ceylanicum* and *A. braziliense* are the hookworms of dogs and cats. They may be occasional intestinal parasites of man. However, they often produce cutaneous manifestation in man referred to as "creeping eruption". This is due to the fact that the infective larvae of these hookworms are incapable of reaching the peripheral blood vessels on penetrating the skin, but continue to live for weeks or months in serpiginous tunnels they set up in the skin.

"Visceral larva migrans" is a very much more serious disease than "creeping eruption". It is acquired by swallowing the fertile eggs of a very common round worm of the dog called *Toxacara canis* or of the cat called *T. cati*. The disease occurs in children. The adults of these parasites are commonly found in the intestines of puppies or kittens and are therefore a potential danger in the households. When the mature eggs of toxacara are swallowed, the emergent larvae pass through the intestinal wall and are carried to various organs and tissues of man, notably the liver, brain and orbit of the eye where they lodge. The infection may cause a prolonged febrile illness with enlargement of the liver or may present as monocular blindness due to granuloma surrounding a larva in the eye. Usually there is considerable eosinophilia.

Toxacara "larva migrans" is world wide in distribution. A survey shows that one in five dogs and cats in the London area carries the adult toxacara (1). All dogs, whether poodle or alsatian, are hosts of *T. canis*. Moreover, signs of infection are

uncommon in animals and they are usually not noticeable to the owner.

Strongyloides stercoralis is occasionally found in dogs, which possibly obtain their infection from human sources. From our record, there is increasing evidence of strongyloidiasis in Hong Kong in recent years. *Gnathostomum spinigerum* of feline and canine hosts with common habitat in the oesophagus, may produce subcutaneous abscesses and at time tunnel in man. *Thelazia callipaeda*, the conjunctival worm of dog, has on occasion been recovered from human conjunctiva. Increasing interest has also developed in recent years in immature stages of filarial worms not well developed in the human host. *Dirofilaria conjunctivae*, which is likely a dog parasite and transmitted by mosquitoes, can cause subcutaneous tumours in the orbital regions or the conjunctiva of man. *D. immitis*, whose habitat is the heart chambers of the dog, may infect the subcutaneous tissue on the head, trunk and forearm of man.

Bacterial Diseases

Dogs are equally susceptible to the human and bovine types of *Mycobacterium tuberculosis*. They have a high resistance to avian tubercle bacillus, however. Tuberculosis in dog produces few symptoms that are characteristic and as a consequence the disease is seldom recognised while the animal is living. The disease frequently affects the lungs where the lesions undergo necrosis with extension of the bacilli into the larger respiratory channels. Tuberculous tracheitis may also occur. Consequently, the tuberculous dog is a potential danger to human beings and especially to children who frequently fondle and play with their canine pets in an intimate manner.

The frequency of infection of dogs with the human type of tubercle bacilli is about three times as great as the frequency of infection with the bovine type. The disparity in the incidence is not that dogs are more resistant to the bovine type. It is because there is a greater opportunity for exposure to infectious material containing tubercle bacilli of the human type.

Scott (2) investigated into the probable source of exposure of a hundred tuber-

culous dogs and found that 51 had lived in restaurants or cafés where human sputum was at all times present on the floor; and 28 had lived in intimate contact with sick persons. Few if any of the dogs were diagnosed as tuberculous during life. The potential hazard for human beings of such seedbeds of the infection is obvious.

The public health aspect of tuberculosis in dogs is worthy of consideration. The possibility of transmission of infection from a tuberculous dog to man certainly exist, although few such instances have been reported. In tuberculous dogs having pulmonary lesions in which there is bronchogenic spread or exudative tuberculous pneumonitis, countless numbers of tubercle bacilli find egress with the respiratory excretions mixed with the saliva. Many of the organisms are undoubtedly swallowed and eliminated with the faeces. In severe destructive tuberculosis of the kidneys, tuberculous bacilliuria is probably common. These facts constitute sufficient reasons that a tuberculous dog should be destroyed.

Dogs carries many salmonella serotypes as does the cat. Bruner and Moran (3) reported the isolation of 2,788 cultures of salmonellas from 32 animals species other than man and fowls. They found the majority of strains from swine (2,119 strains) with the dog second on the list (103 strains). A dog may carry as many as five different serotypes of salmonellas in its faeces of a dog does not substantiate the etiological role of that serotype in causing illness in dog. However, many of the isolates from dogs, for instance *S. paratyphi B*, *S. choleraesuis* and *S. typhimurium*, are well established human pathogens.

Dogs are assuming increasingly important place in epidemiology of leptospirosis especially the disease due to *Leptospira canicola*. There is no doubt that the habit of dogs associated with micturition and sexual aggressiveness lead to the spread of leptospirosis by direct contact with urine. The intimate relationship of man and dog has led to many cases of canicola fever, because urban dog population show high morbidity rates. In a number of surveys, antibodies to *Lept. canicola* have been found in 20-40% of urban dogs. The clinical manifestation of leptospirosis in man and animals are protean, varying from inappar-

ent infection to fever with malaise and meningismus to severe renal and icterohaemolytic disease. The symptoms can mimic influenza, infectious gastroenteritis and various etiologically undefined syndromes.

Experimentally, dogs are highly susceptible to the streptococcus of Scarlet fever and diphtherial toxin and culture. Reports have been made from time to time concerning infection of dogs in contact with human cases of Scarlet fever or diphtheria, but all lack bacteriological proofs.

Pasteurella septica causes haemorrhagic septicaemia in a wide variety of animals. In man it has been isolated from cases of appendix abscess, pyoarthritis of the knee, puerperal fever and septicaemia. In the past years three cases of *Past. septica* infection were reported in Hong Kong (4). Though none of these patients had been bitten by dog, yet many of the infections with this organism had a history of dog bites. Smith (5) showed that more than 50% of dogs he had examined harboured *Past. septica* in the throat, though the organism rarely causes disease in this animal. According to one survey of 436 cases of local sepsis in man related to animal bites, all but five resulted from wound inflicted by dogs or cats (6). Wound infection with *Past. septica* is characterised by a prolonged course, slow healing, and a tendency to underlying bone necrosis.

The local tissue necrosis which occurred in the cases may leave the patient with an ugly scar. For this reason, dog and cat bites should not be treated lightly, especially in the case of children who are liable to be bitten about the face. *Past. septica* infection resulted from dog bite were reported twice as often as those following cat bite and scratches. It was estimated that more than 600,000 Americans were bitten by dogs every year.

Virus Diseases

The relationship of dog bite and the virus disease rabies is universally recognised. Rabies has long been a serious affliction of the dog, but there are other animal hosts of the virus which perhaps are equally if not more important in the perpetuation of the disease. Because of its close association with man, the dog is still the most

usual source of rabies in man. Rigid control by licensing and inoculation of dogs and efficacy of active and passive immunization after exposure, rabies in humans in the United States has decreased from an average of 22 cases per year between 1946 — 1950 to only one or two cases per year since 1963 (7). Rabies in domestic animals has diminished similarly. In 1946, for example, there were more than 8,000 cases of rabies in dogs in the same country as compared with 296 cases in 1968. Although the likelihood of man's being exposed to rabies by dog has decreased greatly, the bites by dogs and cats continue to be responsible for the overwhelming majority of antirabies treatment. Wild animals are the most important source of rabies for man and domestic animals today.

The chief reservoir of the virus of mumps is man himself. Other animals, however, may be a factor in the dissemination of the disease from time to time. Apart from monkeys and cats, the dogs may also acquire the disease. Morris, Blount and McCown (8) demonstrated the presence of complement fixing antibodies of mumps virus in the sera of normal dogs and suggested the possible susceptibility of this animal to mumps. Noice, Bolin and Eveleth (9) reported two instances of mumps in dogs. A six month dachshund was allowed the freedom of the sickroom even the bed during the illness and convalescence of the patient with mumps. The dog became ill with swollen parotid glands, difficulty in swallowing and mumps virus was isolated in its saliva. After a few days, the animal died. The second case was that a Boston terrier of three months old. This animal likewise was allowed free contact with the family when there were three cases of mumps. The dog became ill with usual symptoms including mumps virus in the saliva and a positive complement fixation test. After 14 days the animal recovered.

Man is the chief reservoir of measles. The role of animals in the spread of this disease has not been considered of importance. But a possible relationship between canine distemper and measles virus was suggested by Adams (10). Skaggs (11) has shown that the viruses of the two diseases

share antigenic components and stimulate closely related antibodies. Similar clinical syndromes and histological changes occur in the respective hosts. Enders (12) and his colleagues infected 48 dogs with measles virus. Fever was present in 50% of the animals while coryza and rash occurred in 28%. There was viraemia for 2-8 days following the inoculation. The virus was isolated and passed to a second group of pups where it produced similar effects. Warren et al (13) found that dogs infected with measles virus uniformly developed subclinical infection with subsequent appearance of antibodies for both measles and distemper. Results of investigations to determine whether measles infection in man is associated with canine distemper in dog and whether canine distemper vaccine will provide protection against measles are lacking.

Fungus Diseases

The dog shares with other animals responsibility for transmitting fungus diseases to man. Blastomycosis is found chiefly in dogs, rarely in other animals. Histoplasmosis has been found in 38% of dogs tested. Actinomycosis and cryptococcosis though rare, are sometimes isolated from dogs. Of all fungus infections, ringworm is most common. The dog being afflicted with several of the dermatophytes.

70-80% of human infection with dermatophytes which involved the exposed parts of the body in rural areas are acquired from animals. *Microsporum canis* does not cause epidemic of dermatomycosis in man, but usually affects one or more members of a family or others living in close association. Dogs and cats have been proven as sources of human microsporum infection numerous times. In several countries it is the major cause of tinea capitis.

Conclusion

There is no doubt that elimination of stray dogs and strict adherence to a policy of tethering or confining all owned dogs would lead to a drastic reduction of both canine and human infections. In some cases such as rabies an effective vaccine serves to curb the infection in dogs, but in others, especially parasitic diseases, vac-

cine has no value at all. For example, the major importance in preventing "visceral larva migrans" in man lies entirely in the control of the worms in dogs with appropriate treatment, improved hygienic standard of quarters and great care in handling or fondling of the animals by both adults and children. Thus, the transference of the helminth's eggs from the hair coat of the animal to hand and mouth of man could be prevented. People, particularly children, should not eat from the same utensils used

by their canine or feline pets and should not share their beds with them. Cats usually bury their faeces poses a less important problem than the dogs in fouling playgrounds, parks, streets and other public places where toddlers and children have access. The danger to public health from infected dog is a very real one. Hygienic control of the dog population is much more difficult than it sounds because of the exaggerated sentimental value of the dog especially in the esteem part of the society.

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* * * *

One of the first duties of the physician is to educate the public not to take medicine.

—Sir William Osler

Souvenir Presentations

May 28 1970

DR. H. E. VON ERTFELDA,
*Orthopaedic Surgery returning
to the United States ▼*



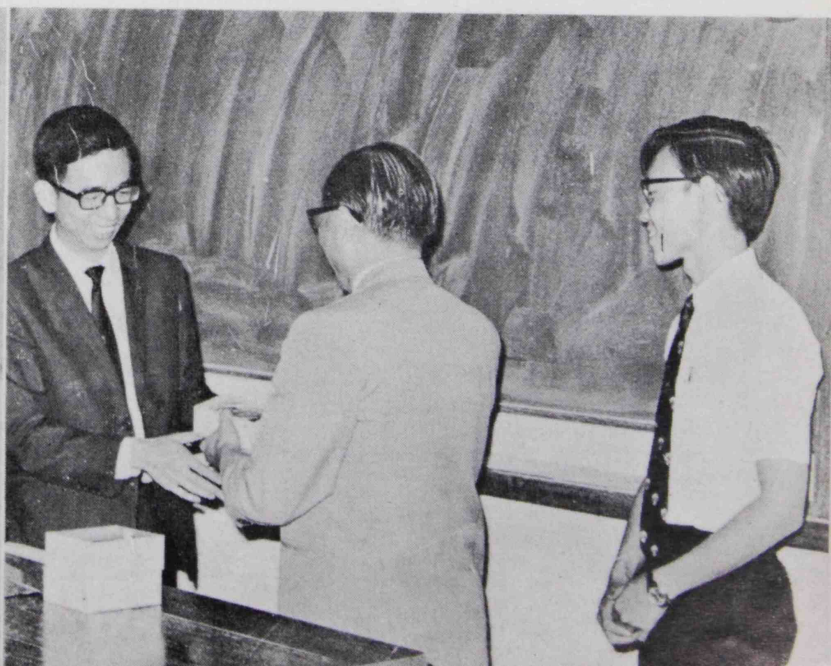
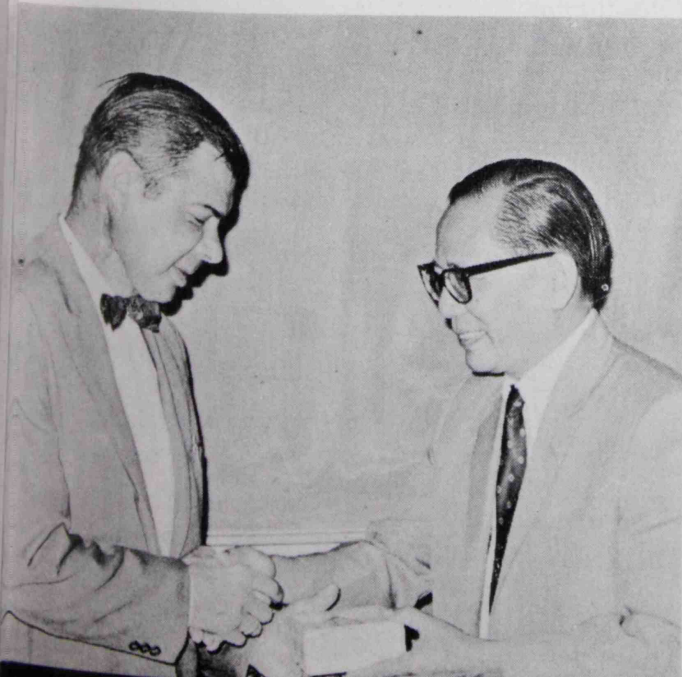
PROFESSOR LIN, *Pharmacology,
on retirement*



P. O'BRIEN, *Orthopaedic
Surgery, also returning to the*

DR. CHIU, *Pathologist, leaving us for further
▼ studies in the States*

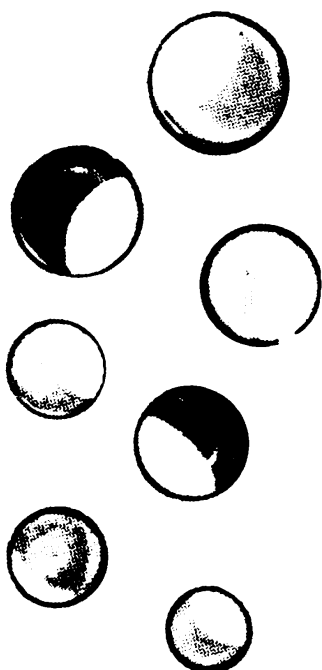
DR. C. C. GRUHZIT, *Pharmacology, going
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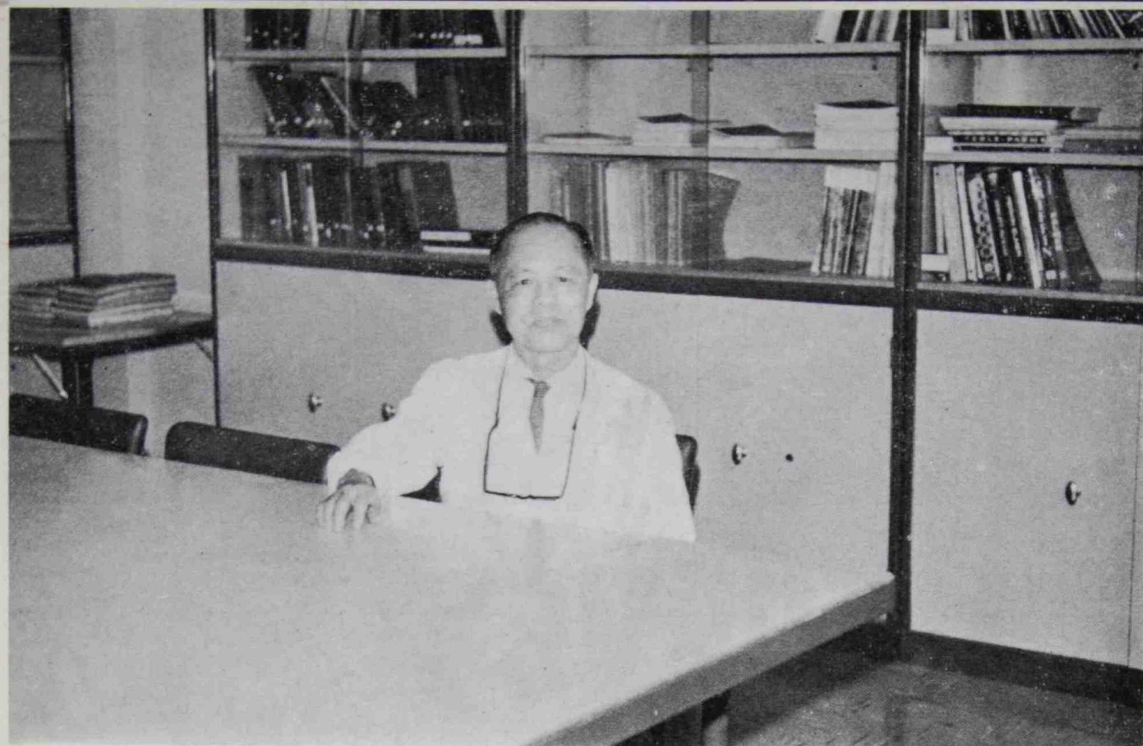
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PHARMACOLOGY



Message from the Professor

Professor Lin is always interested in the youths as he wishes to share with them his valuable experiences which he has gained over the years. His messages to the youths are:—

1. The richness of life is in giving.
2. In a competitive world like ours, if one expects to achieve something, one must make a special effort.
3. Strengthen your body and mind by means of physical exercise, spiritual grace and live artistically with a great deal of sense of humour.

XX

THE DEPARTMENT OF PHARMACOLOGY

I. The Young Department

The pharmacology Department came into being in 1965 as it was felt that the rapidly expanding field of drugs could no longer be accommodated within the Department of Physiology. Its importance in medical training deserved a department of its own. A doctor should be well grounded with his drugs just like a painter with the colours.

At its establishment, Professor Lin was virtually the only staff. The heavy task of building the department fell on him alone. He had to prepare the syllabus, train technicians, set up practical work, recruit staff and furnish the laboratory.

After 4½ years, the department has grown into its present size and shape with three lecturers, four technicians, one departmental secretary and a full size practical laboratory which is shared with the Physiology Department.

II. Practicals in the Department

The most striking feature of the department is the many home-made apparatus provided for the practical class and a special effort made by the staff to stimulate the students' interest in Pharmacology. Each student performs his or her experiment independently with a set of apparatus. One can even sip a cup of tea complacently

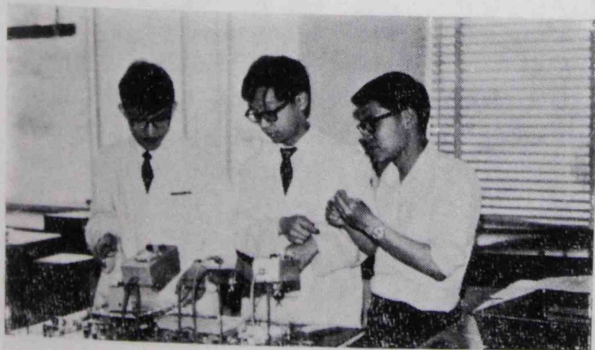


Our Professor in action

while the department-made new paper-ink recorder keeps a faithful record of the experimental results. We are certainly grateful to the department for changing what would be a tedious experiment into an enjoyable experience.

As the building up of a new department takes up so much of his time, Professor Lin is not able to do much research work. He has however, devoted all his time whole-heartedly to improving the teaching particularly the practical work and demonstration in pharmacology during the last four years. His department was the first in our University to use closed-circuit television to aid in the demonstration of interesting experiments to a whole class of 120 students in the lecture theatre in October 1967. He told us that from his experience it is from doing experiments that one is often inspired and attracted to scientific work.

He also told us of an instance which had changed the career for his life. He



had first intended to study medicine and so he obtained admission in 1926 to a pre-medical course at Yenching University, Peking with the aim of doing medicine in the well known Peking Union Medical College. One day in 1927 the Biological Society invited Professor Robert K. S. Lim (Honorary D. Sc. Hong Kong, 1961), head of the department of Physiology, Peking Union Medical College to give a lecture on gastric function. As a member of the audience, he was fascinated and inspired by Professor Lim's lecture as he brought with him four dogs, with oesophagus fistula, Pavlov's and Heidenhain's pouches respectively to demonstrate in the lecture, the effect of sham-feeding, psychic and gastric factors on the secretion of gastric juice. He later went to see Professor Lim and on his advice changed his plan to study Physiology instead of Medicine.

In order to stimulate student's interest in a scientific approach to medical problems Professor Lin tries hard to provide us with as adequate supply of apparatus and material as possible for the practical work. In his recent attempt to provide each student with a paper-ink recorder in place of the old time smoked-paper kymograph, he was able to build us at low cost with simple parts and local material in his department's workshop. The last and the present classes of pharmacology students are using them. They prove to be a good substitute of the much expensive imported products. The April issue of Far East Medical Journal carried a full description of this marvellous device as Professor Lin wishes to share his experience with other teachers and research workers. This is just an example of a host of ingenious devices designed by his department. For example, even a small box for keeping a guinea pig still and comfortable during the experiment is specially improvised by his department.

III. The Prospects

However, the department is still like a child groping his way. It is far from perfection. Professor Lin, who will leave us on retirement in September, gives it his blessing and hopes that it will continue to develop under the new Professor Michael Roberts into a fruitful department.



Dr. Clive W. Ogle

Dr. Ogle was born and educated in Penang, in North Malaya. He entered the University of Malaya (the present University of Singapore) to study Medicine in 1952. In 1958, he graduated with distinctions in Obstetrics and Gynaecology. After serving his Housemanship in Singapore General Hospital, he became a Medical Officer in the Casualty and Out-patient Departments, and later a Prison Medical Officer.

As his curiosity challenged him to investigate further the drugs employed in treating patients, Dr. Ogle joined the Department of Pharmacology in the University of Singapore as an assistant lecturer at the end of 1960. In 1964, he was made lecturer and was in the service of the University of Singapore up to Feb. 1969 when he came over to Hongkong as a Senior Lecturer in Pharmacology.

During 1964 — 1966, under the Riker International Research Fellowship, Dr. Ogle continued his research in the University of Western Australia. His work on renal pharmacology with particular reference to the action of hormones from the posterior pituitary gland led to the award of a Ph. D. His present research interests continue in this field.

Dr. Ogle is a democratic person. He regards the students as his equals and enjoys discussions with them. He is an active man. Besides being a member of the University Library Committee, he is also a member of the Government Pharmacy and Poisons Board.

Dr. Ogle is a happy father of three children. Motoring is his hobby. During holidays, he takes his family out for drives. As Hongkong is small and unfamiliar to him, he contents himself by taking his family to swimming instead. He is a judo enthusiast, having reached the brown belt stage. Unfortunately, due to injuries, he has given up active practice of this sport.

Dr. C. T. Chang



Dr. Chang was born and brought up in Burma. He studied in an Anglo-Chinese school. In 1958, he graduated from the University of Rangoon with M.B. B.S. Teaching in a pre-clinical Department attracted few but Dr. Chang felt inclined to it. He realized the meaningfulness and importance of the task in preparing the students for clinical training. So he joined the Department of Pharmacology in the University of Mandalay as a demonstrator and assistant lecturer.

In 1961, Dr. Chang pursued his post-graduate work in Sydney where he was awarded his Ph. D. He returned to his teaching as a lecturer in the University of Malaya until his departure for Hongkong three years ago.

Dr. Chang enjoys teaching. Personally, he regards a teacher as a friend to the students. Nothing delights him more than a mutual understanding and co-operation between teachers and students in their pursuit of knowledge.

Dr. Chang is a proud father of five children. He spends his holidays happily with his family. With the little time left to himself, he does a little gardening. "It is a wonderful experience to see one's efforts blossom into flowers," he says.

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How pharmacology has evolved to be a separate discipline in the medical curriculum

The subject of pharmacology was originally meant to embrace all knowledge concerning the supply (*materia medica*), action and use (therapeutics) of drugs in medicine. In the early days, since there was very little knowledge of the action of drugs available, the subject which included in fact, only the supply and use of drugs on patients was taught by physicians in the medical school. Later some physiologists undertook to teach some aspects of experimental pharmacology in the physiology course to the medical students. Not until recently, has there been established an independent Department of Pharmacology in every medical school and pharmacology is now being made a separate discipline in the medical curriculum.

The scope of pharmacology has nowadays been narrowed down to the actions only and separated from the supply and the use of drugs in the treatment of disease in contradiction with its original definition to cover an overall knowledge of drugs.

The evidences for this narrowing and separation are found in the following practices: (1) many chairs established in medical schools in Europe and North America since the early period of the present century were named Chair of Pharmacology and Therapeutics; (2) many text-books written on this subject were named with a title separating the action from the supply and uses of drugs and adopting PHARMACOLOGY to cover the action of drugs such as seen in the following examples:— Hale-White's — *Materia Medica, Pharmacology and Therapeutics* (1892); A.J. Clark — *Applied Pharmacology* (1923); Goodman and Gilman — *The Pharmacological basis of Medical Practice* (1941); Lawrence — *Clinical Pharmacology* (1963) and Galbraith, Matthias and King — *Practical Therapeutics* (1962); (3) In commercial

literature introducing a new drug, there is always a sub-section of Pharmacology which gives information on the basic action of the drug obtained from experimental investigation on animals and (4) Pharmacy or *Materia Medica* has become a professional subject and is no longer taught in medical schools.

In my opinion, the reasons which have brought about this change are:—

(1) In the early days before the 18th century, most of the drugs used in medicine were obtained from the plants and minerals. There were very little information of their actions on the cells and tissues of the body. Medical students were taught the supply and what ever action of drugs by the physicians along with their uses in the treatment of disease. There was no need for the knowledge of drug to be split into several subjects.

(2) An important advance was then made in the mid-18th century in the development of Pharmacology as a separate discipline and it was due to the influence of Oswald Schmiedeberg (1838-1921) in Strasbourg Germany. He was a pupil of Rudolph Buchheim (1820-1879) who maintained laboratories in his own home, made contribution on the actions of atropine and ergot and became the first Professor of Pharmacology at Dorpat in 1846 in Tartu. He was a most vigorous research worker and a stimulating teacher in Pharmacology. The outstanding contribution from his research work prompted the University of Strasbourg to create a special Chair of Pharmacology for him in 1872 and his stimulating teaching attracted pupils from many countries to come to Germany to study with him. In consequence, there were over thirty Chairs of Pharmacology in universities over the world occupied by his pupils. Among the most prominent were John Jacob Abel who was appointed as the

first Professor of Pharmacology in the U.S.A. in the University of Michigan in 1891; Arthur R. Cushny (1868-1926) was appointed first Professor of Pharmacology in the United Kingdom in the University College of London in 1905 and later he moved to Edinburgh (1918); Torald Sallmann was appointed first Professor of Pharmacology in the University of Western Reserve Medical School, Cleveland, U.S.A. and Hans Horst Meyer was appointed first Professor of Pharmacology in the University of Marburg in Vienna, Austria.

Schmiedeberg emphasised experimental investigation and introduced many experimental methods to demonstrate the mode of action of drugs on animals. He also laid down a new definition for pharmacology which reads as follows:— "Pharmacology is an experimental science which has as its purpose the study of changes brought about by chemical agents on living organisms be it for therapeutic uses or not". In other words, Pharmacology is meant to be a discipline dealing with the action only and separated from the therapeutic use of drugs.

One can easily imagine the tremendous stimulating effect of this new spirit of pharmacology, spread and amplified by so many of his students who held chairs of pharmacology throughout the important medical schools of the world, to the research activity on drug actions undertaken by workers in this field. In fact one can justly say, that the tremendous amount of new information concerning the mode of action of natural and synthetic drugs now in our hands are the results of research work led mostly by Schmiedeberg's followers in the present century.

(3) Along with the rapid development in both physiology, biochemistry and pharmaceutical chemistry which has taken place during the last two decades, a great leap has also been made in our understanding of the mode of action of drugs. These advances not only provide a rational basis for their use in the treatment of diseases but also stimulate the synthesis of many new, more effective and more selective drugs. As a result, a new horizon has for their use in the treatment of diseases

with drugs and the clinicians are now provided and facilitated by a big number of therapeutic agents which were not available in the last century for the treatment of organic, infectious, neoplastic and mental diseases.

Under the influence of these developments most people in medical schools began to realize that it was not enough to teach the students just how to use drugs for treatment and that it would be profitable if they be taught the basic action of drugs before they do the clinical subjects. However, the physicians and physiologists found that they would not be able to cope with this new development on the action of drugs unless they gave up their original fields of interest and devoted their full time to it. In short it was the general contention that the subject of pharmacology be allowed to branch out from medicine and physiology and be established in its own right as a separate and new discipline in the medical curriculum. In fact, such a move is probably more than justified and is rather belated in the case of the Department of Pharmacology in the University of Hong Kong which was established only in October 1965, when one looks back at the University of Michigan and the University College of London which had in each a Department of Pharmacology established in 1891 and 1905 respectively.

(4) The last and obvious reason is perhaps a general one and that is whenever a certain field of knowledge grows it tends to breed specialization. The early examples are in the science subjects. Biology was split into botany and zoology and chemistry was split into three departments of physical, organic and inorganic chemistry in both the Universities of Oxford and Cambridge since the early part of this century.

In the medical schools, there were similar examples of one department branching out from another such as Physiology came out of Anatomy and later Biochemistry came out of Physiology; Microbiology came out of Pathology; Orthopaedics came out of Surgery and Paediatrics came out of Medicine to become a separate discipline for each one of them.

by Professor Robert C. Y. Lin, Department of Pharmacology.

Professional Secrecy—

YESTERDAY,

TODAY

AND TOMORROW

by Douglas F. Robb, M.R.C.S., L.R.C.P.

— Senior Assistant Secretary of The Medical Defence Union

So much has been written on the subject of professional secrecy in the world of medical practice that it may be thought that all that is worth saying about it has already been said. In the last year or two, however, we have been provided with evidence which suggests that the wind of change may be blowing as effectively in this sphere as it has in others. Lord Moran's publication¹ in 1965 of his intimate disclosures about Sir Winston Churchill may well prove to have been an act of great significance; not so much because they provided a detailed and vivid account of the various sicknesses and of the deterioration, physical and mental, of his illustrious patient, as because for the first time in the history of modern medical practice a doctor deliberately, voluntarily, and openly contravened one of the accepted requirements of his professional creed. Now doctors find themselves faced with yet further disrespect for the same requirement in that section of the Regulations drawn up under the Abortion Act 1967 which permits the Chief Medical Officer of the Ministry of Health, to whom notification of a termination of pregnancy under the Act must be made, to disclose information about it to the Director of Public Prosecutions or to the police. Where, then, does the duty of a doctor to preserve absolutely his patient's confidences stand now? On what is it based? What legal protection does it enjoy? Where does its future lie?

Hippocratic Oath

The starting point for most writings on professional secrecy seems to be the Hippocratic Oath. Although there is now considerable doubt in the minds of some authorities as to whether this testament in the form in which it is generally reproduced is properly attributable to Hippocrates, it has, over the centuries through which it has been regarded as setting a standard of professional behaviour, acquired the significance of Holy Writ. As to its authenticity, Professor Kudlien² of the University of Kiel, referring to the edition of the works of Hippocrates which was published in 100 A.D. and from which all modern versions stem has written:—

"There is, however, no evidence, external or internal, that the oath which is buried in this somewhat diffuse mass of traditional documentation was actually put together by Hippocrates or belongs in the collection at all."

But from whatever source it sprang and for whatever audience it was intended, (Ludwig Edelstein suggests that it represented in the first place an undertaking entered into by a limited group of doctors whose philosophy was distinct from that of other practitioners) it cannot be disputed that in its sonorous phrases are contained the essentials of ethical medical conduct.

The part of the Oath which relates to the subject of this essay consists of one sentence only

"Whatever, in connexion with my professional practice or not in connexion with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such be kept secret."

After the end of the Second World War, in the course of which there were many examples of an appalling rejection by doctors of the principles which had been instilled into them during their formative years, the World Medical Association was founded. As one of its first acts it produced the Declaration of Geneva which stated in modern and dignified terms the ideals to which all doctors should subscribe, and which included the assurance "I will respect the secrets which are confided in me". From this Declaration in general terms there followed a more detailed statement of the essential ethical requirements made of a doctor in peace and war alike. In this International Code of Medical Ethics there is included the simple but unequivocal sentence.

"A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him."

This view of a doctor's duty of secrecy regarding his knowledge of a patient, stated perhaps for the first time in the Hippocratic Oath (for though there were other and possibly earlier codes of medical conduct they were nothing like so comprehensive) and confirmed some 2000 years later in these two Declarations, is, of course, supported by the General Medical Council which includes in its list of offences which may give rise to disciplinary action the improper disclosure of information obtained in confidence from a patient. Although as yet no medical practitioner has ever been arraigned before the Council's disciplinary committee on such a charge, it is known that the preliminary Penal

Cases Committee, which sits in camera, has more than once had to consider allegations of this nature against a doctor.

Reasons for Professional Secrecy

(1) Mutual trust between doctors and patients.

It is dangerously easy to conclude that this duty of secrecy is based purely on traditional and ethical grounds; and indeed so often is the Hippocratic Oath referred to in this connection that it seems that there are many, patients and doctors alike, who hold this belief. A moment's thought will show that this is not the case. Hippocrates himself — if, as is by no means certain, he ever existed as such a person — stressed its importance for a sound reason. The basis of all doctor/patient relationships is mutual trust. The doctor relies on his patient to describe truthfully and fully his symptoms and history; the patient will only do so completely and frankly if he knows that what he says and what the doctor learns about him will be, and will remain, in confidence. Clegg,³ writing on professional ethics, said:—

"The doctor's consulting-room should be as sacrosanct as the priest's confessional. The whole of the art and the science of medicine is based on the intimate personal relationship between patient and doctor, and to this it always returns, however scientific medicine becomes and whatever the great and undeniable benefits society receives from the application of social and preventive medicine. That, I believe, is why we should examine with profound scepticism any special pleading that professional secrecy is becoming outmoded."

(2) Legal Obligation

A further reason why a doctor must maintain strict secrecy about his patient's confidential disclosures is that he is under a legal obligation to do so. There is no doubt that between patient and doctor there exists a contractual relationship, and that one of the implied terms of this contract is the assurance of secrecy. This obtains in precisely the same degree whether the relationship is one which is dependent on the National Health Service Acts or whether it is based on payment by the patient of a fee. It is in this respect that the doctor faces one of his greatest difficulties, for while there is no doubt of the existence of this requirement, there is equally no doubt that it is not absolute. Indeed, as will be considered later in this essay, there are various occasions on which a doctor is positively compelled to provide certain information about a patient despite his implied promise to that patient not to do so.

No legal action based on a breach of the doctor's contractual duty to respect his patient's confidence has ever been heard in the English courts. Judicial comments have however been made from time to time which throw some light on the subject. There are certain classic cases which come to be quoted in this context. That of the Appeal in *Tournier v. National Provincial and Union Bank of England* (1924)⁴ is of importance because of the remarks made by Lord Justice Scrutton.

"It is curious that there is so little authority as to the duty to keep customers' or clients' affairs secret, either by banks, Counsel, solicitors or doctors. The absence of authority appears to be greatly to the credit of English professional men, who have given so little excuse for its discussion."

He then went on to observe that the obligation of secrecy rests upon a term implied into the contract between, in that particular case, the customer and the bank, and continued:—

"The Court will only imply terms which must necessarily have been in the contemplation of the parties in making the contract. Applying this principle to such knowledge of life as a judge is allowed to have, I have no doubt that it is an implied term of a banker's contract with his customer that the banker shall not disclose the account, or transactions relating thereto, of his customer except in certain circumstances. This duty equally applies in certain circumstances. This duty equally applies in certain other confidential relations, such as Counsel or Solicitor and client, or doctor and patient. The circumstances in which disclosure is allowed are sometimes difficult to state, especially in the case of a medical man; and I do not propose to do more than indicate the exceptions material to the present case."

A point of additional significance lies in the fact that the majority of the Court in this case held that **all** the information which a banker receives about a customer's affairs, whether from the customer or some other source, he receives "in the character of that customer's banker". The same principle must surely apply to the doctor; and thus any information which he obtains about a patient, whether from the patient himself, from some other party, or in the course of his examination of the patient, he receives "in the character" of that patient's doctor and is equally to be regarded as confidential.

To the other cases which are usually quoted as providing evidence of this implied duty, imposed on a doctor by virtue of his contract with his patient, only a brief reference need be made. *Kitson v. Playfair* (1896)⁵ was an action for slander instituted as a result of an indiscreet comment made by Dr. Playfair to his wife. Since Mrs. Kitson was also one of his patients the remark was additionally in breach of confidence. In the course of the proceedings Mr. Justice Hawkins made it quite clear that in his view such a breach was actionable, although this was not the direct concern of the Court on that occasion. The Scottish courts have actually provided in the case of *A.B. v. C.D.* (1851)⁶ an example of legal proceedings based on an alleged breach of confidence. This was an action brought by an elder of the Kirk against his doctor. The latter had reported to the elder his view that the child born to the elder's wife only six months after their marriage was not premature, and had, without consent or authority, sent a copy of his report to the Minister of the Kirk, as a consequence of which the elder was expelled from the session. "The relation between medical practitioner and patient implies an obligation of secrecy" said Lord Fullerton and continued:—

"The obligation may not be absolute. It may and must yield to the demands of justice if disclosure is demanded in a competent court. It may be modified, perhaps, in the case of the disclosure being conducive to the ends of science — though even there concealment of individuals is usual. But that a medical man, consulted in a matter of delicacy of which the disclosure must be most injurious to the feelings and possibly the pecuniary interests of the party consulting, can gratuitously and unnecessarily make it the subject of a public communication without incurring any imputation beyond what is called a breach of honour, and without the liability to a claim of redress in a court of law, is a proposition to which, when thus broadly laid down, I think the court will hardly give their countenance."

Exceptions

(1) Disclosure to patient's relatives

The rule then is proved: what are the exceptions to it? When may, and when must, a doctor make disclosures about a patient without specific consent having been obtained? The most common example of such an occasion is provided every day of a doctor's life when, on the basis of acknowledged custom, he assumes consent to his discussing a

patient's illness or treatment with the next of kin. Ordinary medical practice could not otherwise be carried on; but this familiar experience, this regular and approved behaviour, routine though it may be, must never be taken as indicative of a general removal of the barrier. It is no more than a raising of it for the benefit and convenience of patient, relative and doctor alike. What is important is that the doctor should be able to recognise the occasion when a patient may not be willing for the embargo to be lifted in this way; and then be sufficiently wise and discreet to be able to deal with the enquiring relatives without disclosing anything which his patient evidently wished to be kept in confidence.

(2) When directed by authority

In certain circumstances disclosures have to be made under statutory direction to an authority entitled to receive them. The Public Health Act 1956, for example, requires a doctor to inform the district Medical Officer of Health of the names and addresses of patients suffering from certain notifiable diseases. There are a number of other Acts and Statutes under which he is required to provide information of a similar nature; the notification of births, still births and deaths, for instance; and the completion and provision of certain certificates and records under the National Health Service and National Insurance Acts. Two fresh additions have recently been made in this field: the duty to report a termination of pregnancy under the Abortion Act 1967 (already mentioned) and, under the Dangerous Drugs (Notification of Addicts) Regulations 1968, to inform the Chief Medical Officer at the Home Office of the names and addresses of any persons known to be addicted to certain drugs. The doctor in any of the armed forces has, of course, to accept that he is under a duty to obey orders from his superior officers, which may also require him to disclose information about serving personnel in his care.

A doctor's duty to the public:

The medical profession has long recognised that as well as its duty to its patients it has a duty to the public; and inevitably from time to time there is a conflict between these two. This may arise at what may be described as the domestic level, the schoolmaster, perhaps, with homosexual inclinations, the car driver known to be subject to epilepsy; or in connection with the criminal law, when a doctor comes to have knowledge of a crime which has been, or possibly is about to be, committed. In the former field the contractual duty which is imposed on the doctor remains unchanged, but his conscience may in certain circumstances lead him deliberately to reject it and to pass to the proper person information about a patient which he feels that person should receive in the interests of other members of the community. Dr. E. C. Dawson,⁷ in a Presidential address to the Derby Medical Society in 1954, drew attention to this doctors' dilemma and described an interesting experiment which he had undertaken. He had postulated a general practitioner who diagnosed epilepsy in a patient who was a railway engine driver and who refused either to allow the diagnosis to be made known to his employers or to change his occupation. Dawson wrote to 120 doctors setting out this problem and asked them to tell him whether in their view the practitioner concerned was under a duty to disregard his patient's wishes and to report his disability to the railway authorities. 94 of the doctors to whom he wrote replied, and of this total 84% said

"yes"; 12.5% said "no"; and 3.5% were uncertain. The British Medical Association has considered this situation on many occasions, always with the emphasis on the primary duty of a doctor to his patient. The resolution passed by the Representative Body in 1959⁸ sets out a view with which it is hard to disagree.

"It is a practitioner's obligation to observe the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.

"The complications of modern life sometimes create difficulties for the doctor in the application of the principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be the adoption of a line of conduct that will benefit the patient, or protect his interests."

A doctor who finds that he cannot with a clear conscience remain silent about a patient whose disability in his (the doctor's) view makes him a danger to the society in which he lives should always warn the patient of his intention to inform the appropriate authority of his opinion before he does so.

So far as the criminal law is concerned the situation has considerably altered with the passing of the Criminal Law Act 1967, which abolished the distinction between felonies and misdemeanours and with it the offence of misprision of felony, which had for some time been the subject of doubt and discussion. The police authorities are frequently at variance with members of the medical profession at all levels when they seek from them information needed in the course of their enquiries which cannot be supplied without a breach of confidence. It is difficult to lay down rules which cover every eventuality, but there appears to be little evidence of the existence of any duty generally imposed on a doctor to break faith with his patient in this way, and one comes to the conclusion that here again it is the requirement of conscience and a consideration of the circumstances rather than any legal obligation which should be the decisive factors. *Kitson v. Playfair* (supra) provides an attractive sidelight on this problem. Mr. Justice Hawkins during the evidence said:—

"Suppose a medical man was called in to attend a woman and, in the course of his professional attendance, he discovered that she has attempted to procure abortion. That being a crime under the Law would it be his duty to go and tell the Public Prosecutor?

Sir J. Williams — The answer of the College of Physicians to that very question was, 'Yes'.

Sir H. Hawkins — Then all I can say is that it will make me very chary in the selection of my medical man."

Further light is shed on this matter by the comments of Lord Denning in *Sykes v. The Director of Public Prosecutions* (1961)⁹ when in considering the question of misprision of felony — an offence which as already indicated no longer exists — he went on to make the following comments:—

"I am not dismayed by the suggestion that the offence of misprision is impossibly wide: for I think it is subject to just limitations. Non-disclosure may sometimes be justified or excused on the ground of privilege. For instance, if a lawyer is told by his client that he has committed a felony, it would be no misprision in the lawyer not to report it to the police, for he might in good faith claim that he was under a duty to keep it confidential. Likewise, with doctor and patient, and clergymen and parishioner. There are other relationships which may give rise to a claim in good faith that it is in the public interest not to disclose it."

Dilemma of a Medical Witness

It is when the doctor finds himself required to give evidence as a medical witness that the greatest difficulties arise, for he may well be confronted with the choice between breaking faith with his patient under the Court's direction and being in contempt of court for refusing to do so. Bernfeld¹⁰ has drawn attention to the fact that in some countries a measure of privilege has been granted to doctors in this respect. In New Zealand and in the Australian state of Victoria it is restricted to civil proceedings, but in the Canadian Province of Quebec "No physician may be compelled to declare what has been revealed to him in his professional character". The position in the United States has been described by Cass and Curran.¹¹

"The ethical and legal responsibilities of confidential relationship for professional people have their narrowest application in what is called in America a 'Testimonial Privilege'. This privilege which is statutory in about two-thirds of our States allows a patient to prevent his physician from disclosing in Court any information obtained as a result of the relationship. In its broadest application, however, it is a part of the individual's **right of privacy**. This right is based on the idea that the details of a person's life are private and should be protected from intrusion; but that this right of privacy should be protected by law is a new concept. It is one of the few legal principles which the United States **has not** borrowed directly from English Common Law."

In this country no such privilege exists to protect either the confession made to the priest or the doctor's knowledge of his patient. The limits of legal privilege in the English courts are clearly defined by Lord Parker in *Attorney General v. Clough* (1953)¹² and embrace only four items:

"Professional confidence between solicitor and client, matrimonial communications, questions which tend to incriminate, and questions of adultery in divorce cases."

Medical witness in a case of venereal disease

The extreme illogicality of the doctor's position is, as has often been pointed out, — particularly in Bernfeld's comprehensive review of the subject — exemplified by the requirement under the Venereal Diseases Regulations (subsequently incorporated in the N.H.S. Acts) that all treatment for such diseases shall be offered and provided in complete confidence; and the attitude of the Courts in, for example, *Garner v. Garner* (1920)¹³ and *C. v C.* (1946).¹⁴ In each of these cases the doctor in charge of a venereal disease clinic objected vigorously to the Court's direction that he should provide evidence about a patient whom he had attended there. It is true that in each case the evidence was sought by counsel for the patient concerned, and that consent to any disclosure was thus provided. Mr. Justice McCardie in the first action, and Mr. Justice Lewis in the second, both insisted that the doctors could not resist the court's ruling.

Medical witness in a psychiatric case

Despite these extreme examples it does not necessarily follow that in all cases doctors will be compelled to give evidence against their consciences. It is clear however that they can expect to enjoy legal support for their reluctance only in very special circumstances. In 1965

an anonymous psychoanalyst who had refused to give evidence in divorce proceedings and who had been fortunate in that his refusal had been upheld by the Judge, set out very impressively the grounds on which he had made his decision.

"For me the need to retain secrecy was not just a moral imperative such as might exist, for example, for a general practitioner who was treating a patient for pneumonia. If such a doctor were to talk indiscreetly about his patient he might not be behaving ethically but he might still have treated the pneumonia adequately. But if I were to speak indiscreetly about a patient I should not only be behaving unethically but I should also be destroying the very fabric of my therapy".

The same writer made a further important point:—

"To the Judge's query whether I would still object if the patient gave permission, I answered with an example; suppose a patient had been in treatment for some time and was going through a temporary phase of admiring and depending on me; he might therefore feel it necessary to sacrifice himself and give permission, but it might not be proper for me to act on this."

He added that a psychoanalyst's patient may well present so many differing accounts of the same event, each sincerely given but varying according to the patient's emotional state at the time of giving it, that any evidence provided could not be objectively accurate.

In the majority of cases, however, it must be accepted that the courts are likely to take the view that the interests of justice must come before all other considerations and must be served even if in the process information has to be disclosed which a witness, medical or otherwise, has regarded as confidential.

Position of the industrial medical officer.

Having thus considered the circumstances in which a doctor may disclose his knowledge of a patient, it is reasonable to consider those on which he should resist what may be considerable pressure on him to do so. Doubts were at one time cast upon the position of the industrial medical officer in this respect but it is now defined and generally agreed. It may well be the employer who provides the paper on which the health records of its employees are noted, but the records themselves are now accepted as being confidential to the doctor and may not and should not be disclosed other than with the employee's consent. All certificates of incapacity which state the nature of an employee's illness, or disability, are in theory similarly confidential and it is for this reason that they should always be set out, as they are in the statutory N.H.S. certificates, in the second person and addressed to the employee himself who thus becomes responsible for the disclosure of any information which they contain. Life examination reports and other insurance documents are similarly either addressed to the person concerned or should include a statement signed by him which indicates that he has consented to the disclosure of the contents.

Duty of confidence to the young and the dead

This duty of confidence is limited neither by youth or by death. A young person is as entitled as is anyone else to expect that what he tells his doctor will remain a secret between them in normal circumstances. There will obviously in this respect belong to the practitioner a measure of discretion which he must exercise most carefully in the

case of the very young. The law seems likely soon to recognise formally the age of 16 as one at which a person can be regarded as having a maturity which carries with it certain rights, among them the right to decide in medical matters what shall be done and what shall be revealed. The disclosure of the diagnosis of pregnancy in a girl above that age without her consent would amount to a breach of confidence. As to the secrets of the dead, they also should be respected so far as the law will permit. The so-called duration certificate — often asked for by insurance companies in respect of clients who have been accepted as life risks on the basis of declared statements without medical examination, but who have subsequently died earlier than the insurers had anticipated — should not be completed without the consent of the administrators or executors of the deceased's estate; though if this is withheld the information can be required of the doctor under compulsion.

Where then do we stand at present in this matter, and what does the future seem likely to offer? The omens are far from favourable. There is certainly no reason to think that the law is likely to grant now a privilege to the medical profession which it has thus far withheld. The outside world tends to view with suspicion, if not with cynicism, many of the principles which doctors have for long held dear. When our lives are to such a large extent governed by considerations of expediency, nebulous ideals, such as professional ethics and consciences, are apt to be regarded as inconvenient hindrances and treated accordingly. Even within the profession itself there are indications of a lowering of standards hitherto looked upon as sacrosanct. When one contemplates some of the breaches in traditional professional behaviour which have been overlooked or accepted in recent years, it seems impossible to visualise what licence may be permitted in the future.

Hippocrates, thou should'st be living at this hour!

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Extracts from *Proceedings of the Leeds Symposium on Behavioural Disorders*, March 1965, p.69, 66, 25.

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The Physician's Public Image and His Social Responsibility in 1985

by C. Knight Aldrich, M.D.

Not too many years ago the public pictured the physician watching through the night in a family home at the bedside of a sick child. Without antibiotics and other modern advances, he was often perplexed about both diagnosis and treatment, but he was unquestionably the *physician-humanitarian* — there to give what he could of himself to all members of the family for as long as he was needed. Gradually, as medicine became more scientific and as the locus of care for the seriously ill shifted from home to hospital, the public image of the physician has changed. Currently he is pictured either in the laboratory or behind the surgical mask: more specialized, more efficient, more effective, more remote — the *physician-scientist*.

If we accept the dubious proposition that progress inevitably heads in a single direction, we must assume that the time curve of the physician-image will follow a straight line, and in his future public image he will be even more specialized, efficient, effective, and remote — the *ghost physician*. The ghost physician presumably would spend his day in his laboratory-viewing room, receiving reports by tape or by closed circuit television from technicians who would make the actual contact with the patients. For each case he would supervise the programming of data, check it as it is fed into the computer, interpret the results, dictate the diagnosis, and prescribe the treatment plan. The treatment plan would be relayed to the patient by teletype; therapeutic maneuvers requiring human intervention would be carried out by the technicians, or done by a super-technician, the ghost surgeon.

Understudies for ghosts

But what would a ghost physician prescribe when his Univac reported "no organic disease"? Where would he turn when confronted with a patient whose interpersonal disturbances required for their appropriate treatment an empathic relationship with someone professionally trained to understand them? With no sign that there ever will be enough psychiatrists to relieve him of more than a small fraction of these patients, the consistently ghostly physician either might compromise with the basic problem by using such stopgaps as tranquilizing drugs or electric shock, or he might avoid the problem altogether by delegating his responsibility to a nonmedical substitute. Under these conditions the substitute would replace the presumably archaic physician-humanitarian and would provide the patient with a new parental figure who would give of himself in personal help. The clergyman, the social worker, the psychologist-counselor already are standing in the wings waiting for their cue.

Many physicians, however, are not content to become ghosts, and are dedicated to reversing the tendency to move farther and farther away from their patients. They are convinced that the time curve of the physician-image may be a parabola rather than a straight line. For example although today's pediatricians have learned to prevent or to manage the majority of children's organic diseases with skill and expedition, they have not retreated further into their laboratories. Instead they devote increasing amounts of their time to the emotional problems of children and mothers. Using new, more scientific approaches to personality, they are combining the roles of scientist and humanitarian, less perplexed than the physicians of the past, more willing than the average physician of the present to give of themselves as allies in their patients' struggles against anxiety.

Further evidence of medicine's reluctance to part with its patients is seen in current efforts of medical educators to integrate the scientific and humanitarian images of the physician. In their research and teaching programs, medical schools are fostering this integration through a double emphasis both on the traditional basic laboratory sciences and their clinical application, and on the scientific understanding and practical application of the social, cultural and emotional factors related to illness. Curriculum trends point to the revival rather than to the abandonment of the humanitarian tradition, with no sacrifice of science, but with an increase in the physician's concern for the welfare of his patient. At least in the medical school curriculum, the ghost physician is losing out to the *scientific physician-humanitarian*.

As the scientific study of personality extend beyond the individual to include the family and larger social units, the physician of the future will take on increased social responsibility for groups. Psychiatry exemplifies this trend: not too many years ago its area of social responsibility was virtually limited to the state

hospital setting; now, psychiatrists accept social responsibility in their relationships with adoption, child placement and other social agencies; with schools, colleges and churches; with industry, courts and military services; and with programs for the aged.

Enter the social duties

Medicine in general, stimulated by alarm as its control over its economic fate diminishes, is taking on more responsibility within social institutions. With the increasing role of the third party in medical payments, and as specialization and group practice have increased, the individual physician no longer is the absolute monarch of all of his patient's medical problems. He already has learned to share some of his medical responsibility with his colleagues, and he now is learning to share some economic and social responsibilities as well as to communicate more freely with the administrator, the business manager, the insurance man, the social worker and others. His jealously guarded privilege of dispensing charitable services on his own terms is slipping away from him as the time approaches when society no longer will permit citizens to rely on charity. As the economic distinctions among patients diminish, all physicians are replacing their individual responsibilities for the indigent patients with group responsibilities for the health of the public. The status of the employed physician is rising, and as his status in industry, in government, and in social and educational institutions rises, his influence on them and his social responsibility for them will increase.

In many ways medicine's emergent social responsibilities require major reorientations of the physician's system of values. Value system reorientation is difficult in any case, however, and physicians are notoriously conservative. Their resistance to change already has been expressed in terms that have resulted, temporarily, we hope, in public apprehension that the physician may be more interested in his income than in his patients. By 1985, however, his position in the economic structure of America should be so well stabilized in one way or another that he can be free to strengthen his public image as a scientific physician-humanitarian, and to expand his contributions within his enlarging social responsibilities.

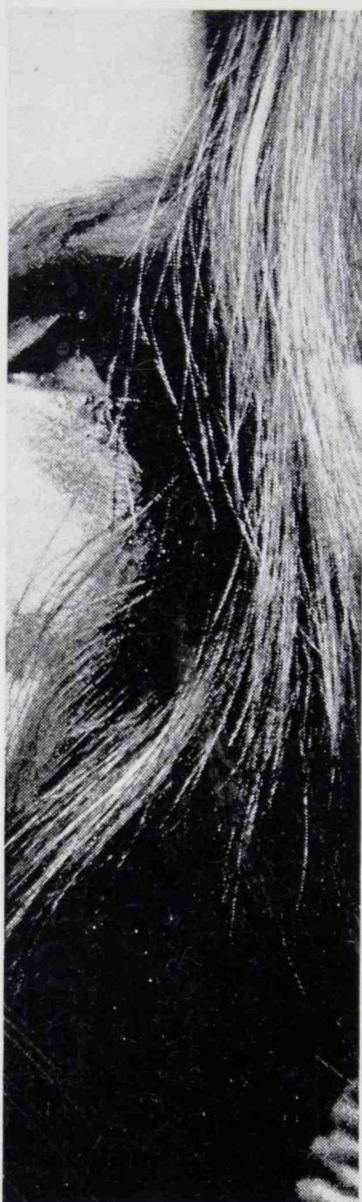
C. KNIGHT ALDRICH, who is professor and chairman of the department of psychiatry at the University of Chicago, was born in Chicago in 1914, received his B.A. degree at Wesleyan and his M.D. at Northwestern. He is a fellow of the American Psychiatric Association and the American Orthopsychiatric Association. His book, "Psychiatry for the Family Physician," was published by McGraw-Hill in 1955.

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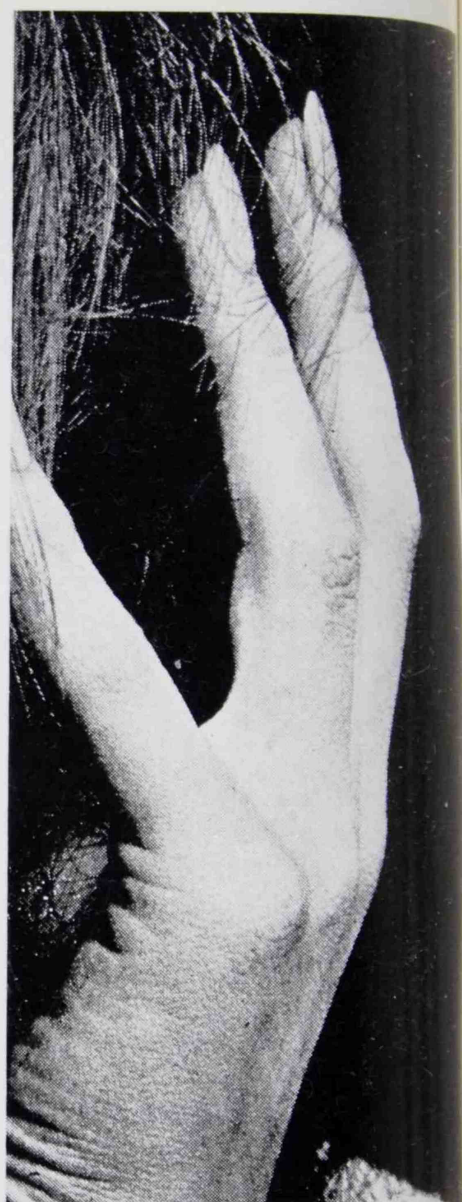
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STUDENTS & SOCIETY

Stephen Ng

Recently students in the three colleges of the Chinese University staged a strike in protest against the small amount of Government subventions available for the Chinese University for the quadrennium 1970-74. This reminds us of a fact which we often tend to forget — that our university education is supported by the local community, that every citizen in Hong Kong is responsible for that from which we benefit.

Rights never go without responsibilities. We have been rewarded without having to work too hard for it (except for some mugging up at times). Let us then ask ourselves how much we have or will, contribute in return. Surely there are things that we can do, things more than Christmas carolling, more than building a few roads, more than showing films to villagers, things that are of substantial good to our community, things which will show that we are worthy of our education.

It is true that politics is a delicate question in a place like Hong Kong. But that is not the reason for not talking about it. Problems exist even if we completely ignore them. Closing our eyes to them does not solve a single thing, unless of course we do not want to solve anything. Thus if we assume that it is our responsibility to do good to the local community that gives us what we are having, if we feel that things are not done as they should be, it is our duty to say so and demand a change. We must not just receive without giving back to the society that rears us. And we can give now, at this present moment when we are university students, for we are in all respects mature individuals capable of independent thinking and critical judgement. It is no use saying how

much we plan to do afterwards when we are not doing what we are capable of doing at present. To keep away from the present and reality is pure escapism.

And yet many of us do not feel that we belong to this place where we are brought up. It is disheartening to see and hear that even some of the so called 'student leaders' openly profess their hatred for this place and say that they will leave at their earliest opportunity. Yes, I admit this is a place of racial inequality, this is a place of injustice, this is a place of corruption and a thousand other vices; but are we not responsible for the eradication of all these? Of course it is easier to run away and keep our hands clean. But is this something we should do? To fulfil one's responsibility is always more difficult than to run away from it. Despite all our education, do we still take this escapist's attitude? We are discontented with the present situation, we call ourselves rebels; but if we are not determined to change the unsatisfactory condition, if we rather prefer to leave things as they are and have nothing to do with their better or worse, we are no better than big bluffs, run-away rebels and sheer cowards. Yes there are gardens elsewhere, there are paradises at the other end of the world; but no matter how broken our backyard is it is still our own. We are born here and raised here. It is true that our home is not comfortable, but we have to stick to it and try our best to change it and not run away to some places which though nice, is not ours.

And then we talk about the uncertainty of the future and the communists' taking over. But who can give us a guarantee of the future anywhere in this world? The future is for us to work out. It is not a

pre-destination but rather an outcome of our work and effort. The disloyalty of her own people will do Hong Kong more harm than any communist can. True we can fly away to some shelter when the communist come; but what about the majority of the 4 million here? Can they all go away as we can? And then are they inferior to us? Are they not Chinese as we all are? Are they less human? Do they deserve a worse fate? And why should they alone be left behind to suffer while we enjoy our lives elsewhere. So that is what they get in return for contributing to educate university students — people that have the talent to go away! Does our education tell us nothing else but to take care of our own selves?

And if we should realise our respon-

sibility and want to make our society a better place for everyone to live in, what must we do? We must prepare ourselves.

We must be respectful first before we can expect others to respect us. We cannot demand anything unless we have good reasons for it; we cannot expect the government to listen to our words unless we mean them and we cannot win a cause without believing in it. Thus first and foremost we have to better ourselves: we have to show that we are capable; we must be responsible; we must have the will to defend truth and justice, and we must have compassion for the suffering of our fellowmen. Only thus can we hope to influence authority, only thus can we bring about reforms; for, we cannot achieve more than what we actually deserve.

* * * * *

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Who lays down the money and does it quite gladly
And casts 'round the office a halo of cheer.*

*He never says: "Stop it, I cannot afford it
I'm getting more magazines now than I read."
But always says "Send it; our people all like it —
The fact is we think it a help and a need."*

*How welcome his check when it reaches our sanction
How it makes our pulse throb, how it makes our heart dance!
We outwardly thank him, we inwardly bless him —
The steady subscriber who pays in advance.*



Chemical Warfare In Animals Other Than Man

Professor E. O'F. Walsh

*As wicked dew as e'er my mother brush'd
With raven's feather from unwholesome fen.
Caliban in The Tempest, W. Shakespeare*

It is only within the present century that man has achieved a degree of sophistication in the use of toxic chemicals as effective weapons and now, having more efficient¹ and less troublesome weapons at his disposal, has agreed to ban their use in war. But long before the use of burning sulphur² to generate SO₂ in the battles of classical Graeco-Roman times or the use of arrows dipped in curare or strophanthin by more primitive men, other animals had acquired remarkable skill in exploiting the chemical weapons with which evolution had provided them.

Venomous serpents perhaps spring most immediately to mind because these are the most feared by man: but snake-venoms are fundamentally digestive juices and for an animal condemned by evolutionary circumstance to swallow its prey alive and whole, it is both reasonable and indeed humane to shorten the discomfort of its victim's being digested alive by first injecting it with digestive and paralytic juices. We are much less considerate of the feelings of oysters.

Scorpions and venomous spiders are also to be feared and avoided like nettles or poison ivy; also jelly-fish, Portuguese men o'war and divers spiny creatures of the sea. There are some snakes and lizards which squirt their venoms at the eyes of potential enemies; so does the skunk which

defends itself by arching its bushy tail forward over its back to squirt butyl mercaptan with some accuracy at the eyes of an attacker. All other animals, with the exception of the dog which is undeterred by the stench of mercaptans, give the skunk a wide berth.

It is, however, in the world of insects, ants and beetles especially, that the elaboration of chemical weapons is really impressive.

The mosquito, like the leach, injects a saliva containing a heparin-like anticoagulant as a preliminary to a meal of blood, but this is not an offensive weapon. The Argentine ant *Iridomyrmex humilis*, on the other hand, has anal glands which secrete a terpenoid lactone that has a toxicity to other insects said to be more potent than DDT. Chemically similar to iridomyrmecin is cantharidin³, the vesicant and highly toxic, irritant principle of the Spanish fly, *Cantharis vesicatoria* and the related *Mylabris* spp. of China, India, and S.E. Asia. Another beetle, *Tribolium castaneum*, has defense-glands which emit an irritant and offensive mixture of unsaturated hydrocarbons, caprylic acid, and benzoquinones. These are generated, on stimulation of the gland, by the triggered action of phenoloxidas peroxidases, and an esterase.

Quinones, as all medical students know, like other compounds with carbonyl

groups attached to unsaturated or halogenated carbons, are highly irritant and their vapours lachrymatory, as are the man-made "tear gases" such as chloroacetophenone (CAP), iodoacetic ester (KSK) which smells of pineapples, and various unsaturated and halogenated or cyanogenated ketones and aldehydes, all of which share with quinones the property of combining with thiol groups and inactivating thiol-dependent enzymes.

There is a millipede, *Apheloria corrugata*, which ejects a mixture of benzaldehyde and HCN from its defensive glands, this toxic mixture resulting from hydrolysis of the cyanohydrin in the outer chamber of its cuticular reservoir. This is of course a much more concentrated and deadly mixture than that generated by hydrolysis of amygdalin on chewing a bitter almond or other cyanogenetic seed, of which there are several among the Rosaceae.

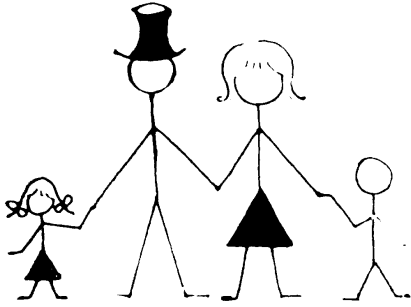
The stings of bees and wasps are elaborate devices for injecting mixtures of toxins, acetylcholine, and painful 5-hydroxy-tryptamine (serotonin) into their enemies. Some hunting wasps have developed a highly specialised skill in the use of their venoms. There is one, for example, which selects the praying mantis as its victim, a David and Goliath affair indeed! The wasp flies backwards and forwards behind its victim just out of reach of the deadly arms and claws of the mantis. The mantis swivels its head astern, moving it from side to side like a spectator of a tennis match, intently watching this curious behaviour of the tiny wasp and ready to strike it down if it should come too close. But the mantis tires first and the wasp, seizing the opportune moment, darts in and stings the mantis through a specific chink in its armour, injecting a measure of venom into the ganglion controlling the mantis' terrible arms, which fall helpless to its sides. The wasp can now take its time: it moves in, carefully injects a measure of

venom into the other nerve centres until the giant lies helplessly paralysed and completely incapable of movement. The wasp then lays her eggs on the soft part of its victim and, having injected just sufficient venom in the right places to ensure that the mantis will remain alive but paralysed for a week or two, it ensures that when the eggs hatch the delicate larvae will have fresh meat to feed on.

But the most spectacular weapon is that of the bombardier beetle, *Brachinus crepitans*, which fires a cannon ejecting a stinging hot mixture of parabenzoquinones. The inner chamber of the offensive gland contains a mixture of diphenols and hydrogen peroxide. To fire the weapon, this mixture is passed to the outer chamber where catalase is added, whereupon oxygen is released and the diphenols oxidised to irritant quinones in an explosive exothermic reaction, ejecting the hot mixture for a considerable distance.

Is it poetic justice that insects are the main targets for man's armoury of chemical weapons, or that he reserves the deadliest weapons for himself?

1. Poison-gases such as cyanogen bromide, vinylchlorarsines etc. were stored in quantity in World War II and the nerve gases such as DFP later in the war, but they were not used because (Hitler had no scruples) high explosives and incendiary bombs were considered to be more effective weight for weight for delivery by air against a population equipped with gas-masks.
2. Sulphur dioxide was found in research by the Medical Research Council's institute in London to be the most toxic principle in the London smog, from which so many deaths from bronchitis and pulmonary diseases resulted.
3. The chemical structures of iridomyrmecin and cantharidin appear on p.354 of the author's *Introduction to Biochemistry*.



Population Control

— H. S.

The present moment is a crucial period in the economic development of most Asian countries. They are now in a position to drag themselves out of centuries of economic stagnation. But this progress is in danger of being overwhelmed by an increase in the population. Population explosion and economic progress are like fire and water; survival of one must always mean death of the other.

The economic progress of a country is measured by its income per head. If population growth falls, income per head will rise. And as there will be fewer children less will have to be spent on welfare projects like schools, and capital released in this way can be spent on industries which will further increase economic progress. Thus a check on population growth will by itself contribute to a greater speed of economic development. This argument holds only for countries that have a labour surplus. In countries where there is not enough labour, a check in population growth would seriously impede progress.

In the development programmes, money is invested in machinery and the profit obtained every year is called the return in investment. It has been estimated that money invested in birth control programmes has a return at least one hundred times greater than any other form of investment.

There are three main ways in which population growth can be reduced — as a natural result of industrialization and urbanization, following the introduction of certain legislation and as a result of birth control programmes.

Young people are drifting into the towns to make an easy living in the factories, and also life in the villages is tough because farming plots have been split into microscopic fragments when large families break up. Marriage tends to occur at a later age in towns. And working people are not so ready to have too many children because pregnancy results in loss of working time and wages for the female, and it is more expensive raising children in towns. According to traditional ideas children pro-

vide a sort of security during old age, but in the towns some factories have old age pensions and other schemes. Industrialization does help in a small way to reduce population growth even though the time lag may be long.

Legislation passed by governing bodies can also help. The most important legislations would be the legalization of abortion and raising the age at which marriage can take place. Abortion is legalized in Japan and the rate of population growth has decreased markedly. Abolition of tax exemption for the third and following children would have some effect in highly developed countries but not in undeveloped countries where the vast majority do not pay taxes.

The most effective means of population control is a large scale birth control programme. The first step in such a programme is to make the public aware why such a programme is needed, why the nation needs to reduce its numbers, or much more straight forward, why the man in the street should have two or three children and not eight or nine. In the towns this can be done through the printed press or magazines and putting up posters and large scale paintings on empty walls and bus stops. In the villages illiteracy is high, the printed word is not understood. Here, the radio becomes of utmost importance. But many villages do not even possess one radio set. To these villages the message is carried by strolling bands of actors and singers who put up drama shows in support of the birth control programme. Such a publicity campaign has to be very intense indeed before a climate of opinion can be built up in the country that is receptive to the birth control programme. The next step would be to educate the masses in the use of contraceptive devices. This requires a large number of medical and para-medical personnel and mobile clinics. Intra-uterine devices and sterilization are the only practical methods that can be used amongst the illiterate masses. Oral contraceptives are a failure because many are incapable of following the simple instructions. Mechanical forms of contraception are also popular but not as effective as the two mentioned above. The intra-uterine devices can be fitted by para-medical personnel, but these must be adequately trained because any mishap which occurs will give rise to bad publicity and all the campaigning for the birth control programme will be in ruins. Sterilization can be done to both the male and female population. The male population is very responsive to this appeal because he is better educated and has to earn for a larger family. Birth control programmes are huge undertakings, the number of people involved is huge and the money spent is tremendous. But the money spent here has a return which is a hundred times greater than any other kind of investment possible.

For much of Asia's youth, life is nothing but an endless series of nights spent sleeping at street corners; of days spent searching the rubbish dumps and gutters for something that can be sold or eaten and evenings spent begging for alms. It is our moral obligation to bring into this world only that number for whom we can guarantee the means by which they can live a good, decent life.

* * * *

Puffing The Magic Dragon

**— A Glance at the Present Day
Drug Addiction Problem in
Hong Kong —**

*by Yim Chi Ming
Ng Man Lun
Co nie Leung
Leung Hin Wah
Harpaul Kaur
Karen Liu*

THE DRAGON AND HIS DISCIPLES

*Between the desire
And the spasm
Between the essence
And the descent
Falls the shadow*

— T. S. Eliot —

The Dragon

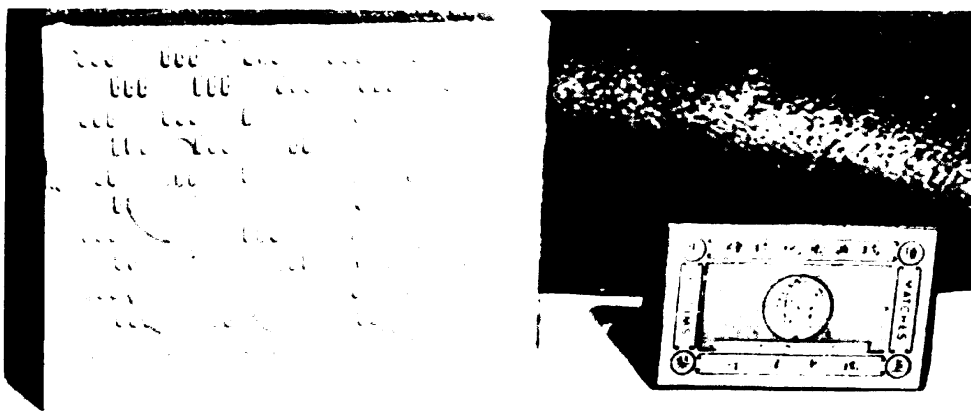
Ancestry:

The great great grandfather of drugs, opium, made its first appearance as a medical drug as far back as the T'ang Dynasty. However, the practice of smoking opium was not established until the 17th Century when it was introduced by the Portugese and other European sailors. The chief supplier of opium then, was the East India Company.

The Chinese Government at that time was not unaware of the dangers of narcotics. They knew that drugs could affect health as well as causing an outflow of huge amount of silver. So, in 1729, an Imperial edict was issued to forbid the sale of opium. Despite this edict, opium still leaked into the Empire, in terrifying amounts, mainly through contraband trades.

In 1938, Lin Tse-Hsu, the Governor of the Kwuntung Province, was adamant to stamp out these 'evil' trades. Tension mounted, and soared to its height with the seizure of 20,000 chests of opium from foreign merchants in Canton. War broke out in 1841, and Hong Kong was ceded to Britain by the Treaty of Nanking in 1842.

Thus, Hong Kong has long been related to opium trade. Despite the Treaty, the contraband trade in opium continued to flourish. In 1891, a really serious attempt was launched by setting up a Royal Commission of Enquiry. The 10 — 70% drug population began to decline. By 1910, most divans were closed. However, the corrupt government at that time still held a monopoly in selling opium. It was not until after the Second World War that the British Government openly abolished any form of opium sale.



*Drug in
its raw
form*

Comings and Goings:

Hong Kong, as one of the world's leading entreports, is favoured by all trades, including drug. Tens of thousands of tourists and goods daily stream into the Colony. The Government is reluctant to exercise strict checking, for fear of breaking the golden egg of tourism. This freedom of movement of goods is well exploited by drug traffickers, whose organisations are mostly international and well-disciplined.

As Hong Kong is not an opium-producing area, the entire narcotic market is dependent on importation. In 1968, there were 14,490 drug seizures of which 11,032 were heroin and 2,391 opium.

The total quantities seized were:—

Raw opium	8811 lb.
Prepared opium	265 lb.
Morphine & morphine hydrochloride	439 lb.
Heroin	114 lb.
Barbitone	829 lb.

*A Land on which
drugs are farmed.*



It is interesting to learn that though China is just the next-door neighbour, practically none of the narcotics comes directly across the border. The majority comes from South East Asia, including Burma, Thailand and Laos. The bulk is then transported to ports like Rangoon, Calcutta, Bombay, Karachi, Singapore, Bangkok etc. Indeed, nearly all S.E. Asian ports are involved in drug traffic.

For smuggling, three methods are currently employed:—

- (1) The narcotics are carried by seamen employed on ocean-going vessels.
- (2) The narcotics are disguised as ordinary goods.
- (3) The narcotics are carried by privately chartered fishing vessels which hand over the drugs to local fishing boats near the Colony waters for landing.

Many ingenious methods have been devised to conceal drugs. Packed opium have been found inside water tanks, under sofas, behind radiators, or under a bunk. The process of manufacturing heroin from morphine is equally clever. No elaborate laboratory setup is necessary. An ordinary residential flat may be transformed into a magnificent plant, or a deserted kitchen room made use of as a drug laboratory.

After processing, the opium is distributed to wholesalers, retailers or drug peddlars. Addicts may obtain their drugs in divans, dens, or even around street corners! (The last statement is by no means false. Several inmates from the Treatment Centres have testified its truth to the editors during our visit.)

The Disciples

Distribution:

As the number of drug addicts cannot be determined precisely from census studies, a large amount of the estimation must necessarily be speculative work. The figure ranges from 30,000 to 300,000. In 1966, the Research Sub-committee of the Action Committee Against Narcotics did an estimation by taking a 5% random sample from 1945-65 drug offenders. This is a bold undertaking, for this method has never been tried in other countries before. As a result, the figures turned out to be 30,000 to 65,000 for the male and 3% of these for the female. However, we think that this figure is a little on the conservative side and the addict population should be around 60,000 to 80,000 i.e. 15.2% of the total population.

Age:

The mean age of addicts seeking treatment is around 40. But it is wrong to assume that narcotic addiction is a problem of the middle-aged. Indeed, the mean age at the onset of their physical dependence is only 26.8 and 24% of the addicts admitted into Shek Kwu Chau in 1968 for treatment began to take drugs when they were below 20. In recent years, the abuse of drug among young people is becoming more and more intensifying.

Education, Occupation and Crime

Among the inmates in Shek Kwu Chau, none whose age is below 25 is illiterate. On the whole, the majority (60%) of addicts receive only primary education. However, this does not mean that the problem of drug abuse among higher schools is non-existent. It only implies that these more highly educated people are less willing to go for voluntary treatment and are better equipped to escape police detection! (A direct outcome of education?!)

The occupation pattern of the addicts is very varied. It includes peddlars, shop salesmen, manual workers, coolies, seamen, unemployed people, in short, a large number of economically inactive men. The female addicts are usually housewives, dancing girls and prostitutes. There is a notable absence of professional people, although sporadic cases of civil servants being addicts are known.

The majority of addicts earn less than \$20 a day. The amount spent on drugs ranges from \$5 to \$30 each day. Therefore, there usually exist discrepancies between expenditure and income, leading the addicts into loans, or even crime, in order to struggle along. Thus, it's not surprising that even among the voluntary patients treated at Shek Kwu Chau, 76.76% have previous criminal records, including such crimes as possession of drugs, triad membership and assault etc.

THE YEARN FOR THE DRAGON

*Until I found
Something
I can never find;
— Something
Lying on the ground,
In the bottom
Of my mind*

— J. Drinkwater —

Appeals and Fascination:

Curiosity and the misconception of drug-enhanced sexual potency are the 2 prime forces that drive people into drug addiction. This is revealed by the 1968 survey of Shek Kwu Chau inmates whence 60.44% fitted this description. On the other hand, negative reasons such as physical and mental exhaustion, painful disease, escape from reality etc. account for only 39.45%. This reflects that most addicts tend to use drugs to seek pleasure rather than to relieve pain.

However, we must always be aware of the fact that addicts' problems are usually multifactoral. There are the psychological, social, as well as physiological factors to be taken into account.

According to some authorities in this field, the many reasons for taking drugs may be classified into the following:—

1. To socialize or to conform with a gang or a group of associates whose norm approves of drug taking.
2. To seek excitement or pleasure through drugs which category includes those who believed in the aphrodisiac property of opiates.
3. To seek relief from physical fatigue, mental pressure or other forms of pain and discomfort.
4. Progression from other vices such as gambling, alcoholism, prostitution and other types of non-opiate drug abuse (i.e. sleeping pills, barbiturates, marijuana etc.) Looking at these reasons, we can easily understand why drug addiction is said to be socially contagious. In fact it can be compared etiologically with an epidemic disease. Firstly we have the "agent" which in case of addiction is the narcotic drug. Secondary, the "carrier" which is the addict and thirdly an "environment" conducive to the spreading of the disease. In other words, it takes a weak willed or immature personality encountering the agent of addiction — availability of drugs, in a situation or sub-culture where drug abuse is condoned or even encouraged to create addiction. It is difficult and illogical to pin point any single cause of addiction to any individual. Drug addiction is a multifactoral disease involving social, psychological and physiological and physiological factors. (From S.A.R.D.A.)

Personality

A drug addict is usually emotionally blunted. His thinking and conversation mainly centre around his own problems. But there is no mental deterioration. His sensation is clear. Retention and recall, manipulation of simple mathematics and conceptual thinking are all intact. Large scale I.Q. tests reveal a figure slightly below average (but in some reports the average figure ranges as high as 113). The Rorschach (ink blot) test at Lexington indicates a marked constriction of the average patient's personality and immature personality. However, with the administration of morphine, the constriction is loosened; movement, response and fantasy appear, making the addict feel that he has attained normalcy.

From the psychiatric point of view, although the number of patients diagnosed as psychotics or neurotics is small, a large number of addicts are believed to have an immature personality. They are usually those placid and withdrawn type with an overwhelming feeling of inadequacy. Some of them are diagnosed as psychopathic because of their anti-social or criminal behaviour. However, there is also another side to be considered i.e. socio-economic causes. As addicts generally come from the lower classes which are often rejected and ostracized, might these not also contribute to their mental stress and "abnormal" personality?!

Theoretical Formulations

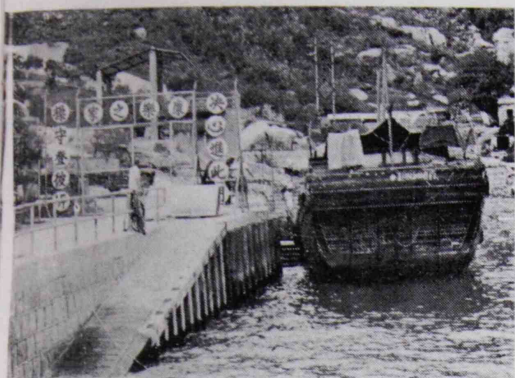
Many theories have been advanced to account for the addicts' personality. Three interesting ones are listed below:—

- (1) **Theory of Avoidance of sex** — It has been observed that drug habits usually develop in adolescence or early twenties, maintained throughout the next two decades and dwindle out in the mid-forties. This observation has been confirmed by statistics from the Castle Peak Addicts Treatment Centre in 1961-65 and Shek Kwu Chau Rehabilitation Centre.

It should be noted that these twenty to thirty years covers the addict's most active and productive periods in life. They also coincide with a man's most active sexual years. It is well known that narcotics can produce an orgasm-like sensation. A patient may begin taking drugs driven by the wish to prolong ejaculation. But this only results in fear and difficulties in his subsequent sexual adventures. Therefore he has to resort to drugs to rebuild his shattered confidence and enhance his potency. Thus he will easily fall a prey to drug addiction.

- (2) **Avoidance of Aggression Theory** — The span from adolescence to middle-age also marks an addict's active assuming of responsibility, his mobilization of sufficient security and aggression to entice him to perform the functions of a mature adult. However, with their immature personality, lack of skill, fear of normal contacts with people, the addicts generally develop a sense of inadequacy. They rather turn to their own addict world to find pleasure, and thus fall deeper into the pit.
- (3) **The Wikler Theory** — Dr. Abraham Wikler, during his studies in Lexington Hospital, has been unduly impressed with the rarity of antisocial behaviour and aggressive type of personality. In contrast to the alcoholic, who is flamboyant, violent and often aggressive, the drug addict is usually quiet and contemplative. While alcohol tends to bring out the aggressive characters in the former, narcotics helps to intensify the indrawn natures of the latter. This theory can also explain the prevalence of narcotic addiction in oriental countries, whose cultural lives endorse passivity, contemplation and inner beauty, and reject aggression.

COMBATING THE DRAGON



Gateway to rehabilitation

*No exorciser harm thee!
Nor no witchcraft charm thee!
Ghost unlaid forbear thee!
Nothing ill come near thee!*

— W. Shakespeare —

The Action Committee Against Narcotics (ACAN) consists of representatives from 9 government departments and 8 voluntary agencies. It was established in 1965 as a co-ordinating body for the various organisations concerned in this field. Its efforts to combat drug addiction are directed towards the following: Preventive measures, Education and Publicity, Treatment and Rehabilitation, and Research.

Preventive Measures

1. Preventive Service: The service is a part of the Department of Commerce and Industry. It has a special Narcotic Section which, in co-operation with the Narcotic Bureau of Police, prevents narcotic smuggling by guarding ships, inspecting aircrafts and searching native vessels.
2. Police: The Narcotic Bureau of the Royal Police is mainly concerned with the illegal manufacture, traffic and consumption of narcotics within the Colony.
3. Law: The Dangerous Drug Ordinance or Dangerous Drugs Regulations forbid illegal selling, carrying, manufacturing and importing of addicting drugs.
4. General measures: The government and voluntary agencies make constant efforts to improve the general living condition, public hygiene, mental health and social service etc. as part of the measures to prevent drug addiction.

Education and Publicity

In view of the increasing drug abuse among young people, this becomes a very important line of work for ACAN. Pamphlets, booklets and posters are used widely. Cartoons like the Lo Fu Tze are published and distributed free, with good responses from both young and old. Slogans and miniature calender cards are also employed.

Besides literature work, the radio and television are also used as weapons in the fight. In 1968, an anti-narcotics play, 'The Abyss' was staged free for almost 8,000 people. A generous grant of \$55,000 from the Lotteries Fund was made use of in making a film entitled "Suicide on Hirepurchase". This film is now available to clubs, associations and schools for showing to their members.

During the 26th Exhibition of the Chinese Manufacturers Association (68-69), the ACAN also set up a stall which attracted approximately 1,050,000 visitors, averaging 30,000 per days.

Through these means, the general public get to know a little about the harmful effects of drugs. To educate the public with these knowledge is a very important job, and further efforts should be devoted on to this field in future.

Treatment and Rehabilitation

(1) Tai Lam Treatment Centre (Government)



Building their own houses

As stated in the Drug Addiction Treatment Centre Bill, passed on 17th Jan. 1969, a court may, in lieu of imposing other sentence, order that a person shall be detained in an Addiction Treatment Centre for a minimum period of 6 months to a maximum of 18 months. The Tai Lam Treatment Centre is designated for this purpose.

After their conviction, the addicts are sent to the Victoria Reception Centre for 1 or 2 weeks where there is a board to decide whether they are suitable for any type of treatment. If treatment is necessary, they are sent to Tai Lam, Shek Kwu Chau or other appropriate centres. The withdrawal symptoms are treated at Victoria Centre, while their stay at Tai Lam is mainly for physical and psychological rehabilitation, with regular labour and supervised activities.

Every month, there is a special Board to discuss individual progresses. After 5 months, if an inmate is considered suitable, he is allowed to go on home-leave. This is the first test to see whether he can be trusted not to relapse into his old habit. When he comes back, if the urine test is negative, he's passed the first test.

From 6 months onwards, the inmate is liable to release at any time. After release, he is subjected to 1 year's supervision. Under the new Treatment Centre Bill, if during this the person is found to have broken the

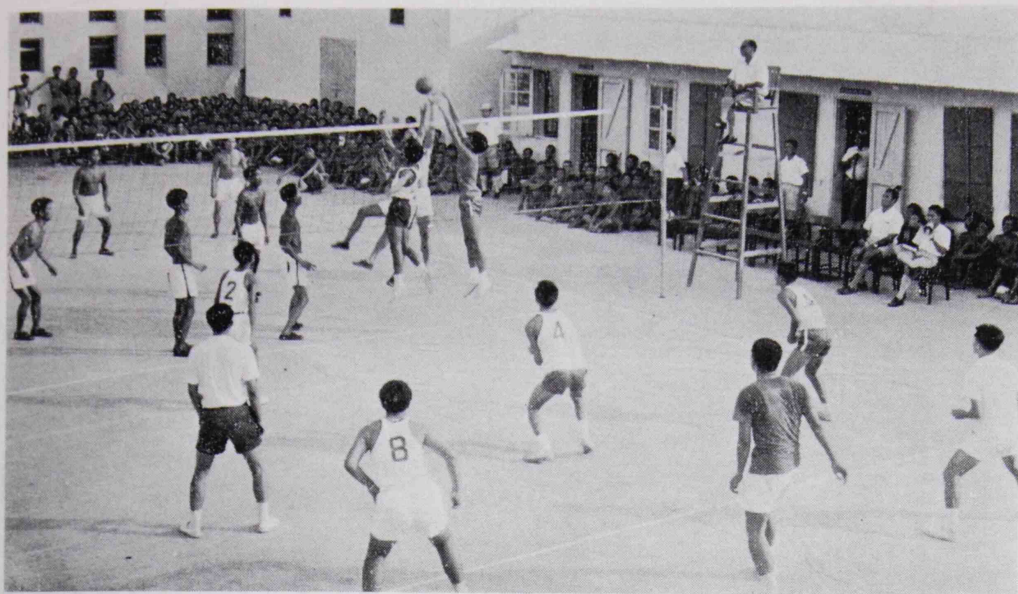
terms of his supervision notice, he could be detained again. Also conceived as part of the follow-up programme, the first half-way house, New Life House, was erected in 1968 to provide better after-care and rehabilitation.

Four years ago, the majority of the inmates are middle-aged or old-aged. However, in recent years, the picture has changed. The number of young addicts is sharply increasing. A most recent figure gives that over 50% of the inmates are under 25 years of age!

According to the statistics of 1969 on the 1 year follow-up cases, the results are not very encouraging:

Subsequent readmission rate	.. .. .	60.3%
Subsequent readmission on drug change	. . .	8.4%
Success rate	.. .. .	31.3%

However, this is still a new programme on trial, improvements will inevitably establish soon!



Enjoying life at leisure time

(2) Voluntary Agencies

Shek Kwu Chau Rehabilitation Centre



A lovely valley with playground and reservoir

This centre, established in 1963 by the Society for the Aid and Rehabilitation of Drug Addicts (SARDA), can now accommodate 500 inmates instead of the former 70. This expansion (including a local reservoir) is made possible by grants of \$2,000,000 from the Lotteries Fund and \$200,000 from the Sir Robert Ho Tung Charitable Fund. Due to the difficulty of recruiting staff, the present number of inmates is still only 250.

The method of treatment is essentially the same 3 stages, treatment for withdrawal, rehabilitation and after-care.

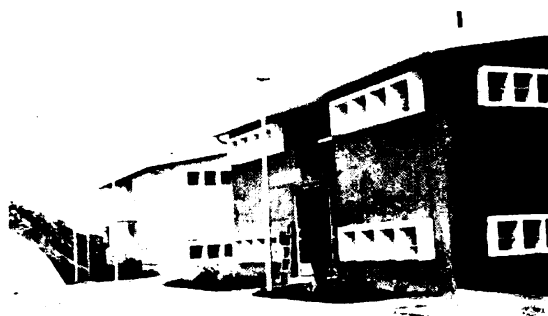
Period I — Withdrawal and convalescence, first 2-3 weeks.

Period II — Rehabilitation —



*Hospital to treat
withdrawal symptoms*

*Houses for the 'Hong Fuk Yuen'
(Addicts who have treated for
their withdrawal symptoms)*



- Stage 1 (1 star) — to unfreeze behaviour.
and deviant the patient from previous anti-social attitude
- Stage 2 (2 star) — initiate positive change more towards the desired level
of social functioning and acquire a new self image.
- Stage 3 (3 star) — to stabilize the patient in the newly achieved level and
self image with maturing personality.

Period III— Follow-up and after-care — this period of social rehabilitation is continued for 3 years, and the patient is encouraged to live a law-abiding and productive new life.

The rehabilitation tools are group therapy, individual counselling and programmed activities. The inmates are grouped into Houses so that they can learn to live with others. Incentive pays are given to their work to help them to appreciate socio-economic values and cultivate in them a sense of responsibility and self-respect.

The abstinence rate during the subsequent 3 years follow-up period are approximately as follows:

1st year	..	..	..	..	..	..	..	..	..	75%
2nd year	..	..	..	..	..	..	..	..	..	50%
3rd year	..	..	..	..	..	..	..	..	..	25%

Other smaller centres include the Rotary Hostel of DPAS, a centre in Rennie's Mill and a new one in Tai Po.

For the women addicts, SARDA operates a Treatment Centre in Wanchai. It can at present hold 30 patients. Following withdrawal, the patients do various types of occupational therapy in the mornings and group discussions, role plays etc. in the afternoons. A small centre at Kwan Tong is run by the DPAS. It has an accommodation capacity of 10.

(3) Aftercare work

In the whole scheme of anti-narcotics work, aftercare work plays a very important part. Without support and guidance, the ex-addicts will almost inevitably relapse, and the several months' stay in the Treatment Centres are but opportunities of abstinence so that they can get a higher 'kick' when they come out.

Many organisations are interested in aftercare work. The Alumini Association of SARDA, the DPAS's Wui Lai Club, the Pui San Fraternal Association of the former Castle Peak Hospital ex-addicts, receive discharges from the respective parent treatment centres. The Caritas Lok Heep Club accepts Tai Lam discharges as well as those from other agencies. By far, the largest aftercare club is the Pui San Centre, run by the Lutheran World Service.

The aim of the aftercare centres is to create a spiritual bondage among the members and provide the necessary environmental support for the ex-addicts. These may take the form of recreation programmes, group work and counselling. Take for example, in the Pui San Centre which we've visited, various recreational groups have been organized. These include the Chinese instrumental section, drama, outings, athletics, games and parties. Discussions are held both in the Centre and in monthly district meetings. These serve the purpose of promoting the creative use of the members' leisure time and prevent them from going into other less desirable forms of entertainment.

As we observed, one of the most useful programmes is the organization of the members' relatives into Women's Club (for member's wives or females over 18) and Youth Club (for members' children). These 2 suborganizations have their own activities including free tuition for the children. These clubs serve a very important purpose of building up a family bond as well as helping them to realize the actual situation of drug addiction in the society.

Besides recreational programmes, counselling is also given by case workers. Sometimes, if necessities arise, financial and medical aids are also granted. If a member is found to go back on drugs, the problem is discussed with himself and his wife. If he is willing to undergo retreatment, he may be sent back to Shek Kwu Chau, to other treatment centres or to private practitioners.

The relapse rate in the Pui San Centre is less than 20%. This is a very encouraging figure, and no doubt an outcome of their brilliant work. But we must remember that application for membership is selective i.e. not all who apply are accepted. They are first asked to be associate members for a period of time during which if no signs of abstinence are shown, membership is granted. This naturally excludes some of the young ex-addicts, who are usually less determined to abstain and who usually expect immediate gratification. This problem no doubt awaits further improvement.

Research

Due to scarcity of resources and facilities in Hong Kong, researches in this field are very limited. There have been some sporadic efforts in assimilating data on the psychological side and methods of treatment. A recent report on Community Attitude Towards Drug Addiction points out some of the deficiencies in education and publicity done to the public. A special analysis on the 1961-65 Castle Peak Treatment Centre Addicts has been assimilated into a book 'The Epidemiological Study of Narcotic Addiction in Hong Kong'. Otherwise, large scale and well-controlled studies are still on the wait for their chance of budding into fruitful growth.

Remarks

We hope by now the readers will have caught a general picture of one of the most serious problems in Hong Kong. As have been stated, the reasons for people taking drugs are often multifactoral. We have to consider the personality defects of the addict, physiological effect of the drugs and the oppressive social forces before we can get to the crux of the problem.

Before we go into the intriguing problem of drug addiction, we must first ask ourselves why we should attempt to do so. Why is it that another drug, alcohol, is so well accepted in our society? Yet the damages it does to the chronic drinker, his family and society is no less than those of narcotic addiction. Nor are its 'physical dependence' and 'tolerance' effects less serious than, says, opium. Indeed, the narcotic addicts are often placid, indrawn and harmless to others while the alcoholic is rowdy, boisterous and often violent. (It is curious that often medical people forget the damages alcohol can do to the body, especially in Western societies). The idea that drug addiction is a crime because of its anti-social and demoralizing implications should now be reconsidered. In truth, some authorities in this field are now beginning to regard drug addiction more akin to a natural disease process and the addict as a victim of the disease rather than sighting it as a vicious crime.

Considering narcotic addiction as a disease, and noting the successful results of the work of Preventive Medicine in our age, we may wonder why yearly the number of addicts is not on decline! To explain this fact, we must understand that drug addiction is not an ordinary disease which gives people pain and therefore rejected by all. On the contrary, drug addiction seems to bring pleasure to the addicts. It's a disease that people enjoy! Once it has taken root, it is difficult to displace it. Therefore medical therapy alone cannot be an efficient cure to this disease.

The best method of preventing drug addiction is of course to strike out all drug traffic, like stopping the chance of contact with an infectious disease and it will not spread. Although we know that the long coastline of Hong Kong is somewhat difficult to guard against smuggling, we still cannot understand why packs of heroin are daily being sold semi-openly in street corners or under staircases! Go to any treatment centre and the inmates will tell you where they obtain their daily rations, even the number on the door of the divan! Yet day in and day out the divans still flourish and the drug traffickers loaded with more and more money. What could have led to this but corruption? It is obvious that corruption is still enjoying a good time in Hong Kong. If the authorities could do no more than setting up a few anti-corruption committees, if the present social and political structures could not be reformed, corruption will still thrive; and no matter how hard the various treatment centres try to devise new measures, the present problem can never be alleviated. This will lead to a forever losing battle, and if things don't improve, money as well as energy will be lost against the gain of nothing!

As for the various treatment centres, voluntary or government institutions, their work deserves appreciation although their present results are not very encouraging e.g. the 1 year success rate in Tai Lam is 30% while the 3 years abstinence rate is only 25%. This discrepancy is due to the fact that Shek Kwu Chau admits only voluntary patients while in Tai Lam the inmates are all convicts. At this juncture we would like to bring out one point is that for future comparison means, the same criteria should be used by the different agencies in assessing their results and we hope that the ACAN can do more in promoting this aim.

Aftercare work is one of the most critical phase in determining the success or failure of the whole treatment scheme. It is encouraging to see that more and more agencies

have directed their efforts to this important field. However, the most alarming problem at present is that of young ex-addicts under 25. Generally it is this group which tends to stay away from after-care work and subsequently relapse into drug habit. More work should be done to help them, such as the establishment of halfway houses. It is a growing concern that increasing numbers of youngsters are misusing heroin, pep-pills, marijuana etc. Besides wider publicity, a more important tool is to incorporate the discussion of drug addiction into secondary syllabus. Students, as well as parents, should be educated with these knowledge.

If all the afore-mentioned measures are taken seriously and with improvement, there will surely be one day when the problem of drug addiction will vanish like smoke into the air! However, we must not only be audiences in watching a play, we must also act to help. So, medic students, put forth your efforts and bring new light to the drug addicts!

* * * *

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THE NUFFIELD FOUNDATION TRAVELLING SCHOLARSHIP ON TROPICAL MEDICINE

Kevin Loh

The Nuffield Foundation Travelling Scholarship provides a medical student exchange programme. Altogether 26 medical schools in the United Kingdom and 13 in tropical countries, mostly in the Commonwealth, participate in this exchange. The Hong Kong University Medical Faculty sends two final year students to England each year, alternating between Guy's Hospital in London and Sheffield University Medical School. David Chan and myself were selected to spend 3 months in Sheffield this year. I hope the following account of our experience will serve as a reference for those who intend to apply for the same Scholarship in the future.

We heard the news of our successful application in early December and we had about six weeks to prepare for travel documents and make other arrangements. The only time for us to make this trip was the semi-vacation period between the Paediatrics examination in January and the final examinations in late April. This was not the ideal time to do an elective posting, because even far away in England, the final examination was a constant pressure. However, hoping for the best, I left Hong Kong a few days after the Paediatrics examination and after a rendezvous with David in Frankfurt, we arrived in London together. The British Council arranged for our accommodation in one of their residences. The next day we went on to see the Nuffield Fellowship Advisor, Mr. D.D. Yonge, who had previously corresponded with us and advised us on the

trip. In this first meeting, we were told by Mr. Yonge that whilst in England, we should try to divide up our time wisely. We should not concentrate wholly on studying, but should also take every opportunity to meet other students and staff, to participate in their functions, experience fully life in a foreign country, and travel around the United Kingdom as much as possible in our spare time. Those were sound advice and for the next three months we tried to do just that. We found the people there, in the University environment or the ordinary man in the street, eager to find out about us, Hong Kong and China. At the same time, we tried to absorb just as much. This free flow of ideas in both directions was in every way very educational and valuable.

It was a 4 hours' train ride to Sheffield which was about 200 miles north of London. Sheffield is an industrial city in the Midlands and is famous for its steelworks and coalmines. Its population numbers about half a million. Sheffield used to be referred to as a 'Dirty picture with a golden frame' because the polluted city is surrounded by beautiful countryside in Derbyshire and Yorkshire. However, even the city was not as dirty and polluted as described to me and a lot of new buildings were replacing old ones everywhere. We were met on arrival by Mr. Andrew Brooks, the Nuffield scholar who visited Hong Kong last year. We found it is the usual practice for a Nuffield Fellow to look after the exchangees who visit his medical school the following year. This

ensures that the new comer will always have a special friend on the inside who will help him to settle down quickly.

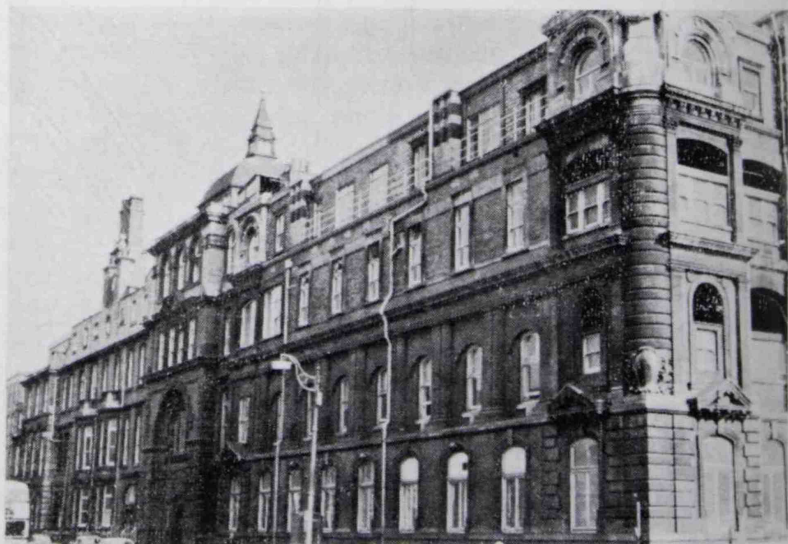
Our first impression of the Royal Infirmary where we stayed for ten weeks was that the buildings were very old. In fact they were over 170 years old. In time, we were to find out that despite the out-

every 4 weeks, which was about one-tenth of our allowance for the month. In the residence we met medical students from the United States, Germany, Holland, and doctors from Nigeria and Sudan. They were our day to day acquaintances and we soon settled down without much difficulty.

We discussed our work schedule with



*The Royal Infirmary
at Sheffield.*



*The Royal Hospital
at Sheffield.*

ward appearances, the facilities inside were most up-to-date. We were put up at the Centenary House which specially caters for foreign students and doctors working in the hospital. The facilities in the residence were very satisfactory, with central heating, free laundry and three meals a day. Furthermore, it was cheap, about £6

Miss Jordan, the Faculty Secretary, and decided to do 4 weeks of internal medicine, 4 weeks surgery and 3 weeks orthopaedics. David and myself were attached to 2 different firms when posted to Medicine and Surgery. The system in Sheffield was that 6 to 7 students were attached to one firm headed by a consultant with 2 or 3 regis-

nurs and one house officer. Under each firm there were 30 to 40 patients. Ward teachings were given by the staff of the firm in rotation. Each consultant also had his own out-patient-clinic which students could attend. In short, students attached to one firm would have ward teaching entirely from staff of that firm for the whole period of the appointment, usually about 6 weeks. The disadvantage of this system, as I could see, was that the scope of teaching tended to be rather restricted



Hallamshire Out-Patient Clinics and the new Sheffield Teaching Hospital

because if the consultant was a specialist in one field, students would be seeing a lot of patients of that field, with the neglect of other fields. This drawback was compensated to some extent by tutorials and clinical demonstrations. In Sheffield, students were distributed to 3 to 4 teaching hospitals so that there was no lack in teaching material. I believe it would be beneficial to the students in Hong Kong if one day, QEH and other major hospitals in Hong Kong can be utilized for teaching purposes. Students in the United Kingdom are also allowed to stand in for the houseman when the latter takes a holiday (2 weeks in a year). This is called doing a 'locum'. So far under this system, there is no serious mishap to the patients, and students in general emerge from a 'locum' more familiar with ward routines and confident in the management of patients.

There are also 2 selective periods in the Sheffield curriculum, in the 4th and 5th years respectively (equivalent to our 3rd and 4th year). Most students use the time to do an elective posting outside of the country. Popular choices are European countries, North America, India, and African countries. Over 80% of the students have travelled abroad for these clerkships which serve the dual purposes of furthering medical knowledge and a welcome change of environment.

And what about the medical students in England? They are not very different from students here. They have the same usual past-time, such as dating, going to movies, pubs, or a football game. One may say they are more mature and a great number of them are married when they come up to final year. They tend to concentrate less on books but rather spend more time in the wards, going through the interesting cases themselves. Everybody takes tutorials, clinics quite seriously. Lectures are not so well attended as is the same everywhere. The pressure and stress of examination are not so evident, perhaps because the failure rate is much lower. Most of the students we come across are friendly, helpful, and frank. Students are much more argumentative with the staff when approaching a clinical problem. Each student is also assigned to a social tutorial group when first entering the University and the social tutor will advise him on any problem throughout the five year course.

In retrospect, we think our trip to England was a most worthwhile experience. Academically we were taught on clinical materials which we would not see in Hong Kong and new methods of approach to a clinical problem. Socially, we met a lot of new friends from many countries and enjoyed the free exchange of ideas, and as a tourist, the United Kingdom had a lot of interesting places to offer. In conclusion, I would strongly encourage students to apply for this travelling scholarship in coming years.

Vibramycin^{*}

(doxycycline)

hits hard where it counts. In the tissue.

Vibramycin hits hard:

Vibramycin passes readily from the G. I. tract to the blood stream and then concentrates in the tissue, the site of most infections.

Vibramycin hits fast:

Oral Vibramycin is rapidly and almost completely absorbed so therapeutic blood level is achieved within the first critical ½ hour.

Vibramycin has a wide spectrum of antibacterial activity:

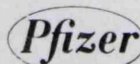
Its range of coverage is currently unattainable—by any natural or synthetic penicillin. The antibacterial spectrum includes many penicillinase-producing strains of staphylococcus, E-coli, Pseudomonas, and Klebsiella—Aerobacter as well as M. pneumoniae responsible for 24% of adult pneumonias requiring hospitalization.

Convenient dosage: once a day dose minimises risk of missed dosage.

Dosage: Adults: 200 mg. on the first day followed by 100 mg. daily.

Children: 2 mg/lb. of body weight on the first day followed by 1 mg/lb. of body weight daily.

Supply: 100 mg. capsules in bottles of 5, 25 and 100
syrup of 30 c. c. (25 mg. /5 c. c.)

 **Science for the world's well-being**

*Trademark of Chas. Pfizer & Co., Inc.

Class Reports

FIRST YEAR



The first difficulty we encountered when we joined the University was getting to know our own classmates. Thanks to the Fraternity Committee, many of us became acquainted with each other early in the summer vacation in a picnic to Cheung Chau Island.

The Medic Nite was the first challenge to our co-operation. Though we failed to capture any prize, we were overjoyed to find so many helping hands in the class.

This did pave the way to success in the Union Carnival. Thirty odd of us sweated and worked overnight to set up the Medical Society Stall. Anyway, our effort did not vanish without any reward — we got the first runners-up in Stall Design and Decoration, and to tell you secretly, the Society Committee treated us to a delicious dinner celebrating our success.

The “Interfaculty Debates” was another occasion for us to show our colour as Medical students. Beating down the teams from the Faculties of Science and Social Science, we managed to reach the Final and ended up with being runners-up — courtesy to the Arts ladies.

This year, we were divided into six groups, meeting almost daily in tutorials and dissections. This allowed further opportunities for personal understanding and

it was on these groups that our activities centred.

An inter-group basketball competition, as well as an individual table-tennis competition was organised and carried out with success. Many participated and shared the fun.



Edmund rowed the boat
ashore

— Picnic to Shatin —

Group activities were by no means rare, as none of the term holidays went without our get-togethers. Our feet have trodden places like Shatin, Un Long, Tai Po, Tsuen Wan, Plover Cove and Middle Bay.



We too have traffic jam at sea.

All people are equal . . . but one is more equal than others.



Mind you, this does not mean that class functions were such only. So far we had three Social Gatherings and our boys were charmed by the ladies from St. Paul's Convent, Royden House . . . and especially our own lady classmates.

Fortunately or unfortunately, we had also to take the Organic Chemistry Examination this year: Luckily all of us passed. Nevertheless, occasional Anatomy vivas still posed a considerable psychological burden on us throughout the three terms.

Shortly after the announcement of the 1st MB results, our class committee invited the 5 distinction holders to give a talk. The occasion was well attended and with their dynamic voices, the distinction holders covered their experiences and advice to us.

Sportwise, basketball, table-tennis, soccer, badminton, squash and netball attracted many of us. Just before this report was written a friendly soccer match was held against second year, with a "V" for us. This looks like a good prelude to the approaching sports competition. We know our teams are still not good enough for the Braga Cup, but we are sure that, among us, some great sportsmen and sports-women are on the way.



Our Basketball team
in action!

— A match versus
second year.



SECOND YEAR



It is indeed impossible to write a Class Report of the Second Year Medics without mentioning our 1st M.B. — the exam that had been haunting our dreams for long.

At the very start of the preceding summer vacation, many of us had already considered it necessary to begin burying ourselves in our Anatomy, Biochemistry, and Physiology. Thus, in the whole summer, we could only manage to hold a Social Gathering with St. Margaret's Girls' College and a swimming outing at Kiu Tsui in Sai Kung.

Once the holidays were over, even the laziest among us had to return to our textbooks. And in the ensuing two terms, we held informal meetings daily, not in So-Gats, BBQ's or picnics, but in the library.

One event worthy of note took place on October the 22nd. On that day, we had a tea party with the Anatomy Department to welcome our new Professor. Practically every member of the class turned up for the occasion.

And then D-day came, when the fruits of our toil and moil ripened. Altogether we harvested a yield of five distinctions — three in Biochemistry, of the remaining two, one each in Anatomy and Physiology.

By the time these results were known

our third term had already begun. This proved to be a term of activity.

Thus, on the very week end when we resumed school, we had a Social Gathering at the Snack Bar. This was followed by a barbecue at Nam Sang Wai, Yuen Long, just a week later.



有隻茶話就落來……

Our activity reached its zenith on the 24th of April when we had our traditional Class Dinner at the Mayflower Restaurant. We were honoured by the presence of the Professors of the three Preclinical Departments together with their staff. The delicious Chinese food, the friendly atmosphere, the cheerful and maybe slightly reddish faces — all integrated together to make the evening a success.



Class Dinner

Drinking toasts to our Professors



Our charming ladies.

That, however, was not the end of our activity. And on May the 9th, we had another So-Gat with ladies from Maryknoll Sisters' School. Though there were more gentlemen than ladies, we had so much fun together that we could hardly forget that evening.

THIRD YEAR

Thanks to the efforts of our sportsmen and sportswomen and the past sports captains, the Braga Cup is again ours this year.

The year 1969-70 saw an important change in the structure of our class committee. Instead of the usual 2 social convenors, a social convenor committee was set up. The office-bearers of 1969-79 class committee are:

Class Representative:

Chen Chia Lu, Sylvia

Hon Secretary:

Siu Yum Keung, Matthew

Hon. Treasurer:

Au Wing Fai

Social Convenor Committee:

Chan Pik Wah, Lily

Ma Yat Tai, Edward

Ng Tat Ming, Ambrose

Won Chun Chung

Sports Captain:

Wong Chun Chung

Lady Sports Captain:

Kwan Shuk Wa, Margaret

In December, Mr. C.C. Wong resign-

ed from the post of sports captain for the more influential post of sports captain of Medical Society. Mr. Wong Yin Wai was elected his successor.

The social convenor committee did not disappoint the class. Up to now, 3 social gatherings have been held: with Maryknoll Sisters School, Sacred Heart Canossian College, and St. Paul's Secondary School. We were drowned in the light music, soft light and amiable friends as we danced under the moonlight.

Under the sun, our courageous mountaineers conquered Lion Rock and spent an enjoyable afternoon in Shatin.

Social gatherings promoted our sociability, picnics our health and 'Talent Time' our mentality. Folk singing, acting etc. that draw forth a great variety of talents, can only impress us with the giftedness of medical students.

To celebrate the Braga Cup, a class dinner was held just before Christmas. The enthusiastic attendance and support well illustrated the old Chinese saying: "民以食為天".

FOURTH YEAR

This year we had very few activities.

During Christmas time we had a social gathering with the girls of Royden House in the Snack Bar of the Union Canteen. All the participants enjoyed themselves very much that evening.

At the beginning of the year we had a soccer match against the combined staff of the Orthopaedic Department and Surgery Department. We won the match by 2:0. We intended to organise more matches with the staff but unfortunately this was not successful.

FINAL YEAR

The Paediatrics Examination at the beginning of 1970 marked the end of our formal teaching period and served as a red-light warning of our impending final examinations. After a series of revision lectures and clinics which our class attended with unprecedented enthusiasm, came the dramatic days of the written examinations, practicals and vivas.

The middle of May found our group of Final Year Medical students waiting apprehensively for the examination results. And now that the results have been released, the most senior medical students have become the most junior housemen!

In retrospect, the past year has been one of continual struggles — to pass our Degree Examinations. Yet it has not been devoid of the lighter side of life and not without considerable achievements (not only in our examinations!) but also in the class competitions.

Our class scored its first success at the 'Medie Nite', the annual inter-class light drama competition. We performed a short play with our experiences at Tsan Yuk Hospital as the theme, and carried off the

'Winthrop Shield'. Our thanks to all who took part in the play and also to those who gave us much moral and oral support in the audience.

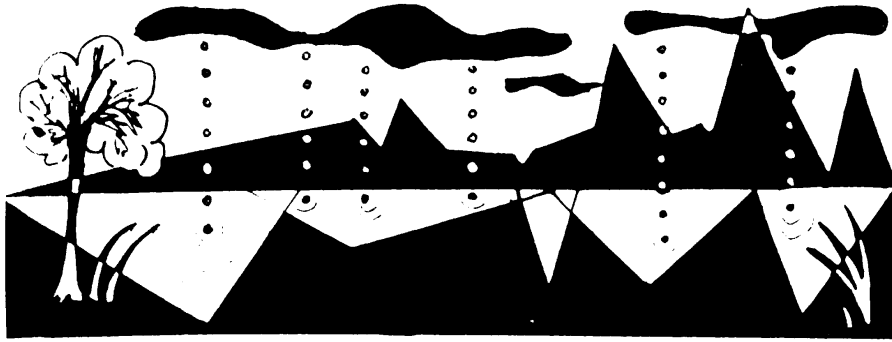
During the Medical Society Barbecue, our class's seven-member choir sang a medley of improvised songs to the tunes of 'Michael', 'Jamaica Farewell', 'Settle Down', 'Lemon Tree' and 'Que Sera, Sera'. Although competition was keen, our enthusiastic team emerged as the champion!

The houseman allocating system has undergone a great change this year. Instead of individually applying for posts at the different hospitals, as was formerly done, allocations this year were made by the drawing of lots. This new system ensures that everybody can obtain one major post or a post of his own choice.

The grand finale of our Final Year was the Graduation Dinner held at Café de Chine, attended by many of our professors and lecturers and by all of us graduates. The evening was a very enjoyable one, many of us drinking much more than our normal fill of wine!



The adjudicators and the final year after capturing the Winthrop Shield.



Dripping Drops

—Sillel

Another of those gloomy afternoons which start one seriously considering suicide.

I was pushing through the inner door into the library.

Suddenly all the lights went out.

Surprised, everyone turned to see what had happened. And, automatically, they all focused their eyes on to the entrance door.

And there I was, standing right in front of the door, transfixed by their scrutinizing glances, not unlike the convicted in a court-room.

A wave of embarrassment surged up inside me, as the implication of their glances dawned upon me.

Why, I have only done a harmless little thing like pushing open a door, and if the lights went off, at least it could not have been my fault. But, God, the suspicion in their eyes was killing me!

It was just as I had decided to declare to the world that *I did not turn off the lights*, when those darned lights came on again.

Then, suddenly, with everyone returned to his own work, I was left alone in the world, looking like an idiot with my mouth half-open.

Once again, I was thrown into confusion.

"It must have been the fuse", a voice piercing through the door from behind restored me to my senses.

I took a deep breath, braced myself, and walked down to the basement, faltering a little.

* * * *

I was lazing there, nothing to do.

You came along and said "let's go out."

"Let's" I said.

We went out.

We walked along the street which was desolated except for a few passers-by. The afternoon was sunny, but hazy and filled one with lethargy.

We strolled along in silence, passing the coffee house where we used to stop to have a drink, and then the theatre showing a movie we decided to see but never did.

"Where are we going?" I asked you.

You said nothing.

We walked on in silence.

Then, abruptly but quietly, you said, "I don't know."

I said nothing.

We walked on, in silence.

"Yes, where are we going?" You said, after a few minutes, half to yourself.
"I don't know." I said.

We walked on.

Suddenly, you gripped my shoulder. "Let's get back."

"Where?"

"Just BACK."

"How?"

"Bus."

We jumped on to the first bus that came along.

* * * *

They were having a barbecue.

Jokes, laughter, shouts.

Suddenly, I got so lonesome in the crowd that I wanted badly to go away for a while.

So I walked off.

It was so dark out there. There was no moon. A light wind was blowing; and the leaves softly sighing.

I took a look behind, the crowd and the fire appeared so far away and intangible.

I walked on.

Then, suddenly, I know that I was afraid not of the loneliness, but of the darkness and emptiness that embraced me.

I could feel the darkness getting into the very core of my bones, and threatened to dissolve the whole of me. And there I was, alone, helpless, forlorn.

I was about to turn back.

A light flickered, somebody was coming up.

I heaved a sigh of relief.

"Who-ever you are, pray, come along." I said to the approaching figure.

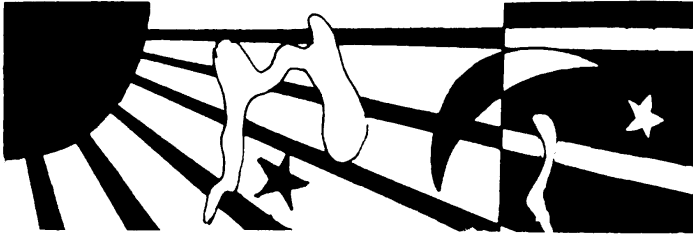
* * * *

The doctor serves best who most cares for his patients, losing sight neither of what his patient wants and needs, nor of what medical research offers for his use in the art of practice.

What's happening in the practice of medicine is determined not alone by the quality of the products of our medical schools, but increasingly by the wants, knowledge, and attitudes of the larger social group whom we serve.

— R. H. Alway, M.D.

Mixed Up



clement ho

*Sleep-talking as I drift down this sleepwalk lane,
Finding my way to Dreamsville, looking for some
Peace of mind.*

*The sun is shining, yet its warmth is cold.
Things aren't the same any more since I left
My love behind.*

*Our story is fated to have a sad ending, we both realize,
And if you know you should leave me long before this
Why didn't you go?
There is nothing to save, now that it's all over,
But how come I still dream of you at times and often
I miss you so?*

*Remembering . . . the grey days and the heydays we had.
Remembering . . . the laughter and the tears we used to share.
Now it's only pain!
From the faded pages of your once colourful memory,
Let me relive of the moments that are gone
Still it's all in vain!*

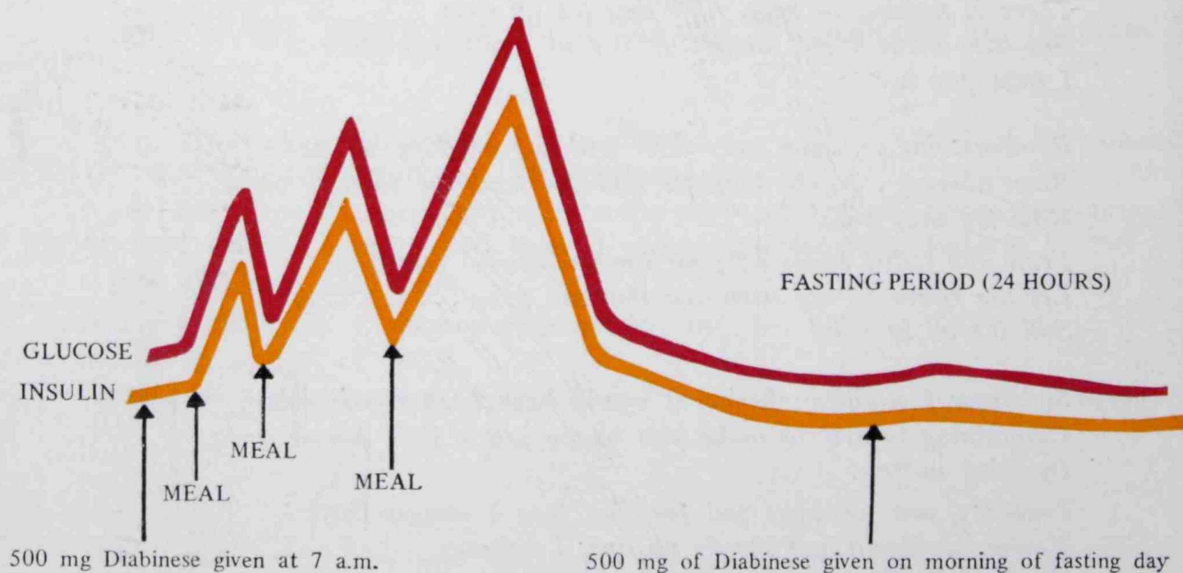
*Somehow I wonder whether it would have been worthwhile
Committing myself to make you happy just a little longer
By lying to you.
Probably you wouldn't fall for that 'cos I always think
You're intelligent and there's no one, I believe,
That's quite like you.*

*Whoever you're with, whatever you're doing or wherever you are,
Feelings will be a lot easier if there's someone
To take you to the sea.
Now I've found my escape and it's as good as yours,
For last night in my dream I was told that somewhere my princess
Would wait for me.*

*Guess I'll never know how much you've been hurt
Letting the stardust in your eyes turn to earthdust, as
You cried on my door.
'Sorry, girl', but I won't say 'forgive me' for having left you.
Just allow me a chance to ask pardon for one thing:
I LOVED YOU BEFORE.*

Diabinese® (chlorpropamide)

*** a close-to-normal insulin response
pattern makes hypoglycemia unlikely**



1. (Adapted from Chu, P.C. et al.)

Chu et al.¹ have shown that the meal—not Diabinese—is the direct stimulator of insulin release. In their study, the administration of Diabinese to fasting diabetics was *not* followed by increased insulin secretion. This may account for the relatively low incidence of hypoglycemia with Diabinese.

- * Lowest incidence of primary and secondary failure proven in long term studies.
- * Maximum convenience, true once-a-day dosage
- * Potency and demonstrated safety

Pfizer

1. Chu, P.C., Conway, M.J., Krouse, H.A. and Goodner, C.J.: Ann. Intern. Med. 68:757, Apr., 1968.

LOOKING BACK

dedicated to our

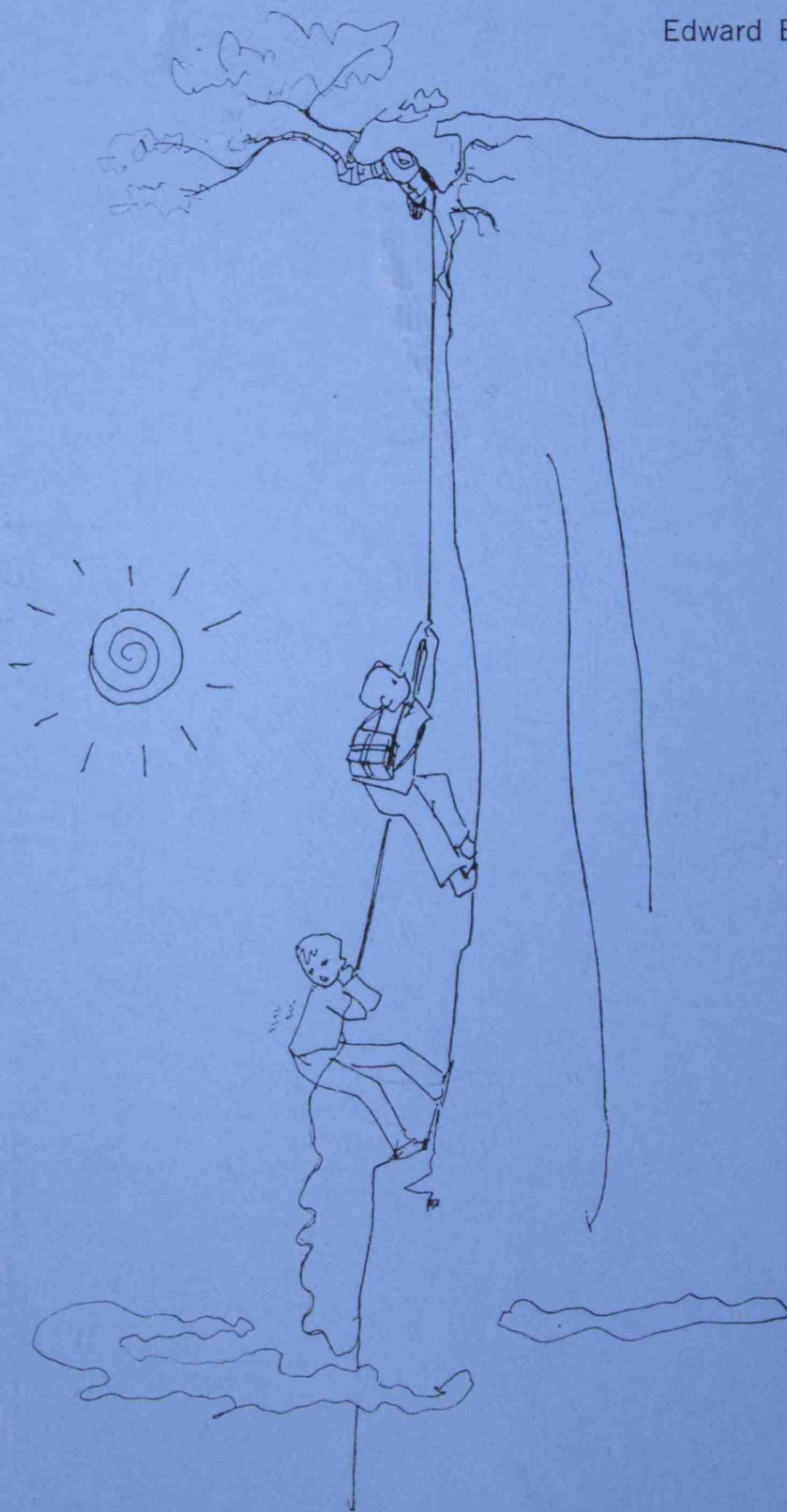
Junior colleagues

By a finalist

ENTERING UNIVERSITY IS LIKE SUNRISE — FULL OF HOPE

To look up and not down,
To look forward and not back,
To look out and not in, and
To lend a hand.

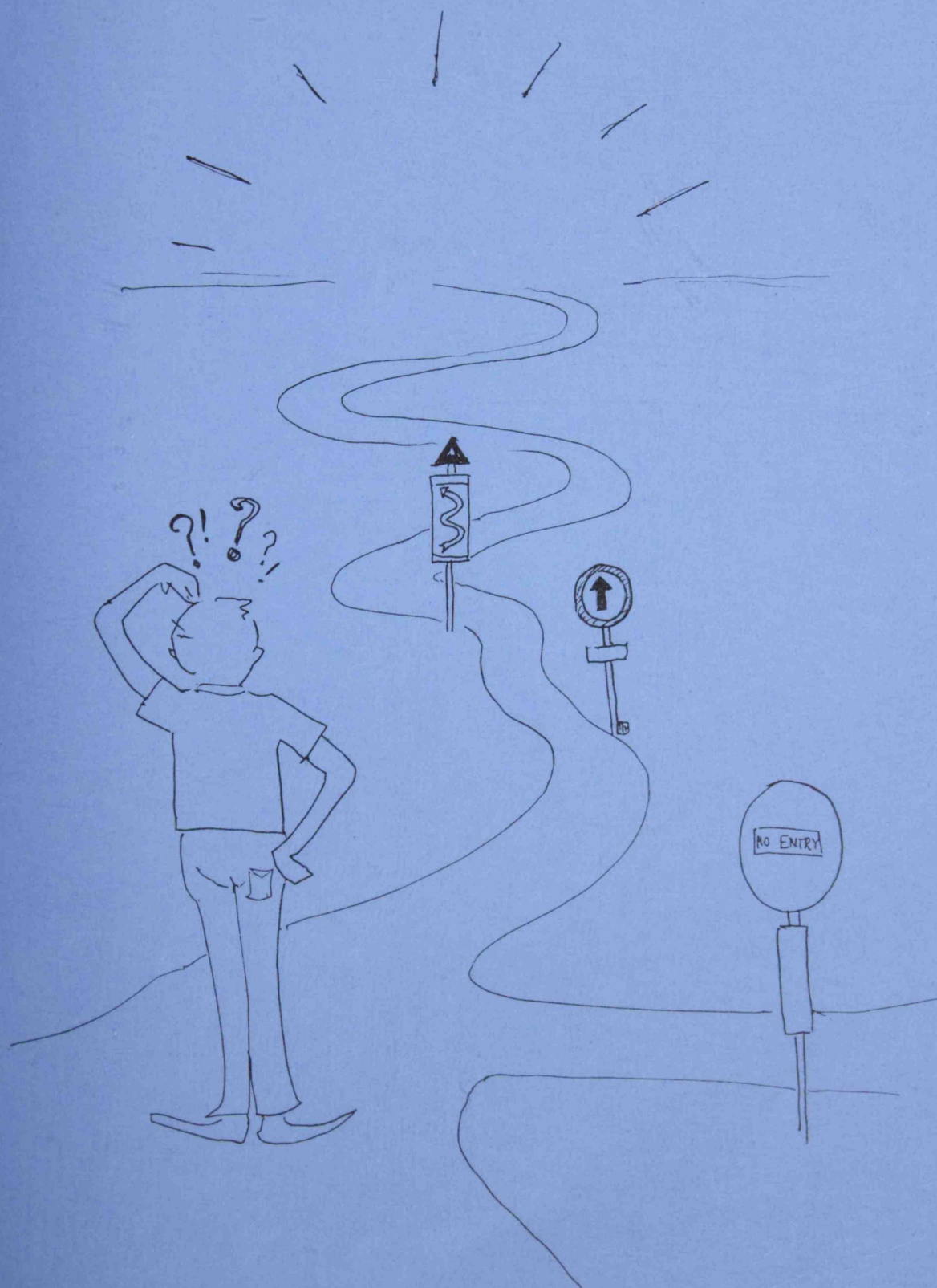
Edward Everett Hale



SOME DO NOT KNOW WHY THEY HAVE COME IN

The best educated human being is the one who understands most about the life in which he is placed.

Helen Keller



EVERYONE SEEMS TO HAVE HIS OWN GOAL

It is for us to pray not for tasks equal to our powers, but for powers equal to our tasks, to go forward with a great desire forever beating at the door of our hearts as we travel towards our distant goal.

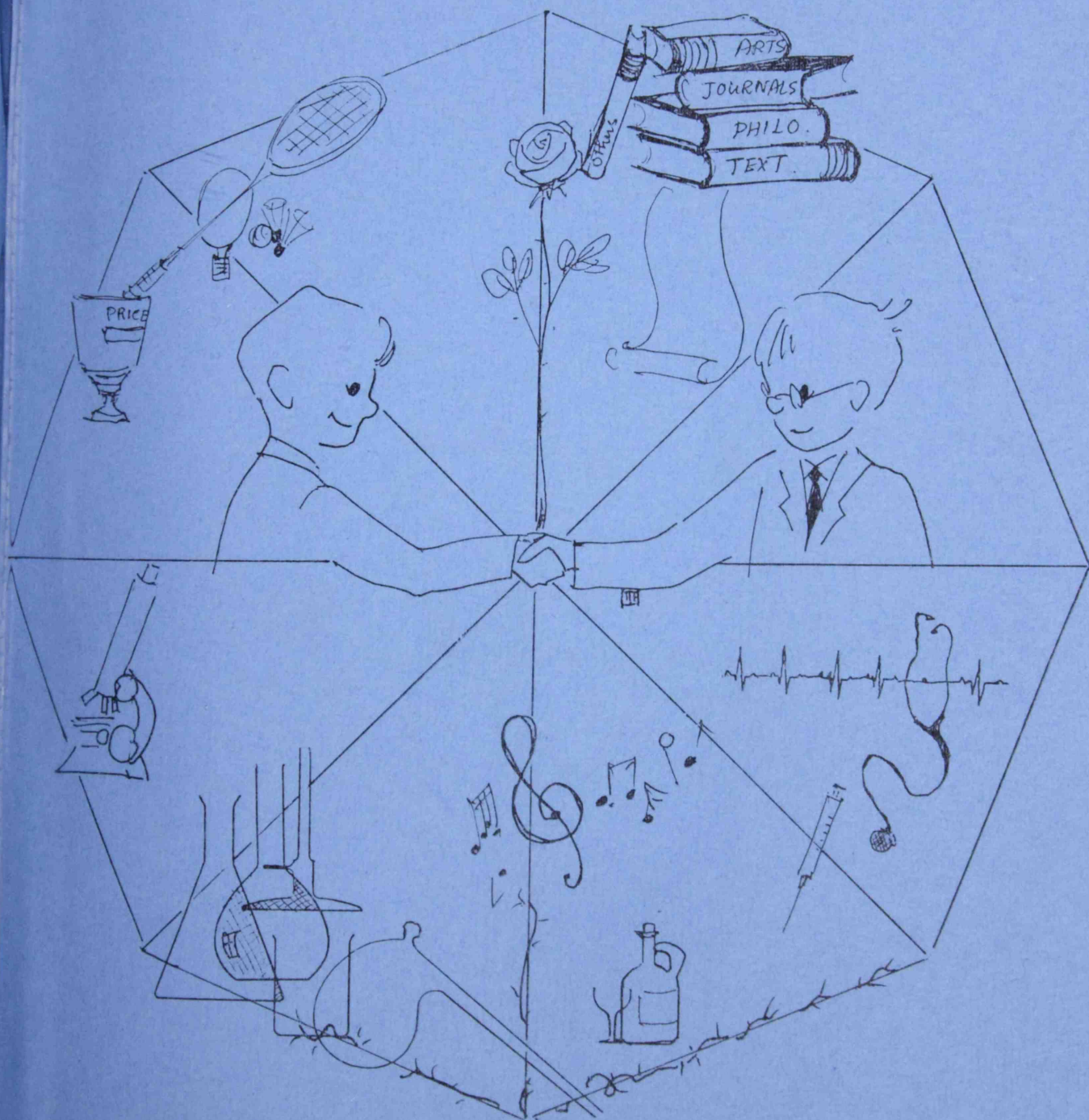
Helen Keller



UNIVERSITY LIFE IS LIKE LOOKING THROUGH A KALEIDOSCOPE — SOME SEE,
OTHERS PERCEIVE.

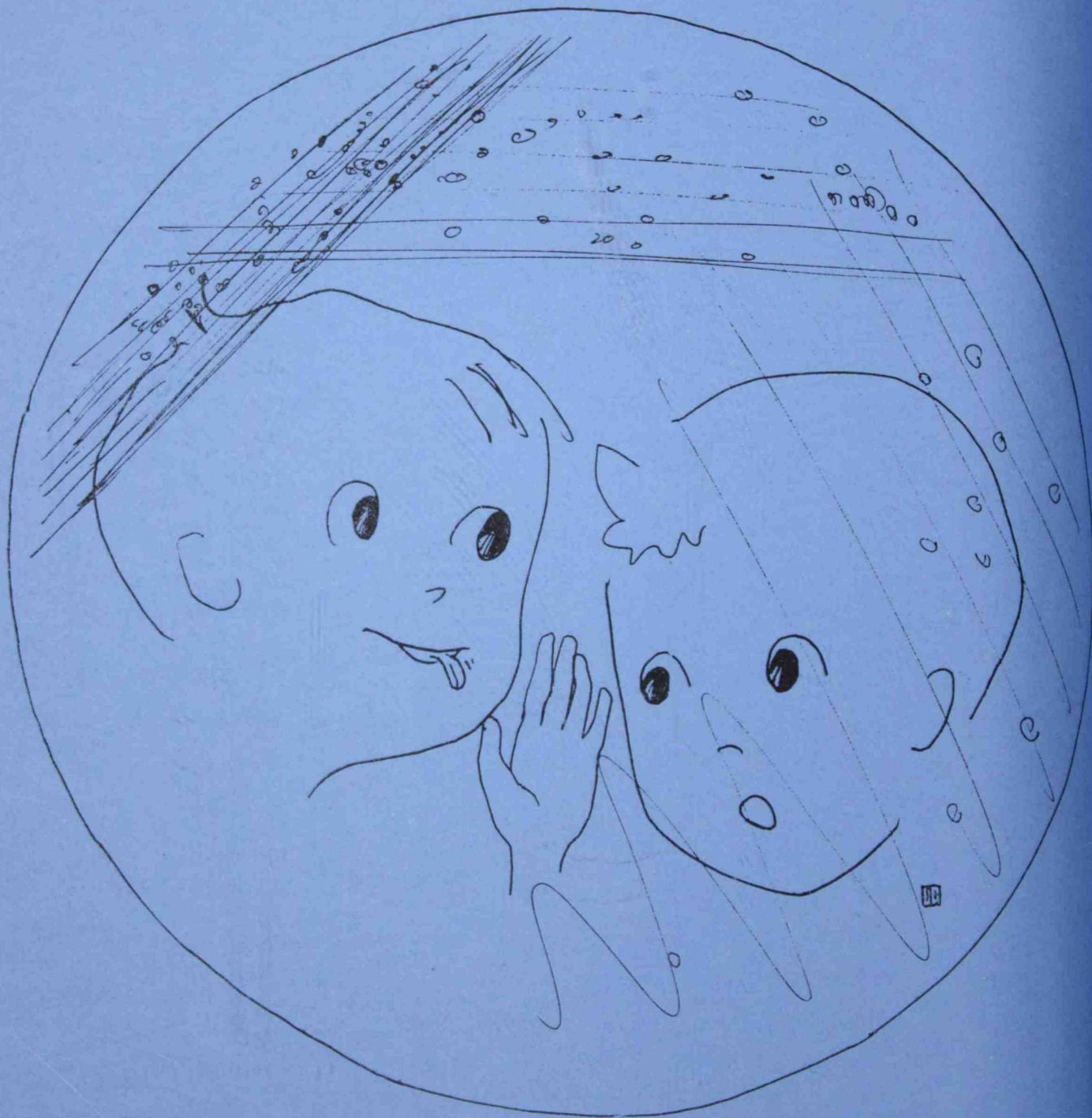
To see, Like Blake,
"The World in a Grain of Sand
And Heaven in a Wild Flower".

Katherine Edelman



NEWS CERTAINLY SPREADS FAST, EVEN AMONG MEN.

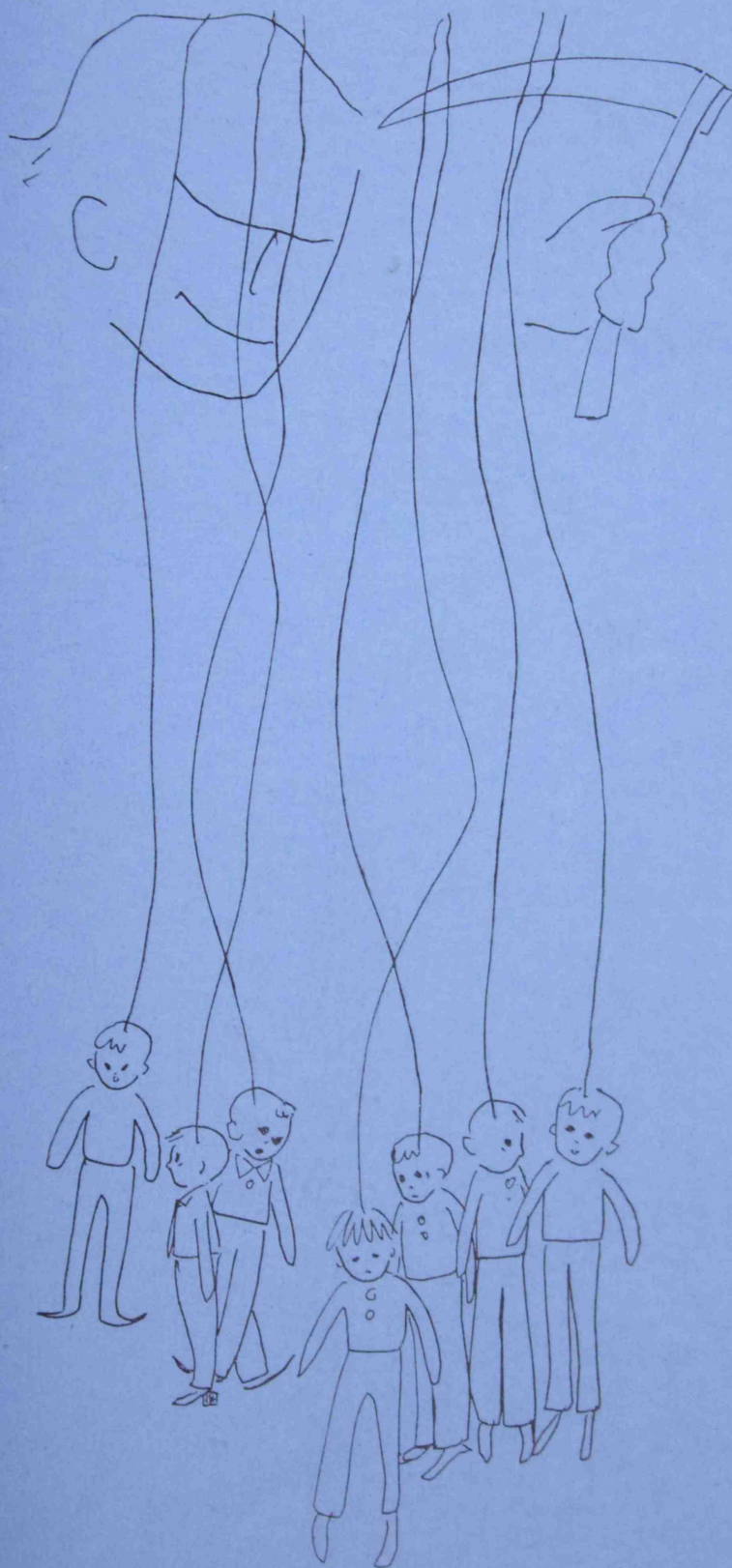
Virulent bacteria kill the host by invasion and multiplication. It is time to build up one's own resistance and to stand this unavoidable trial.



EXAMINATIONS

The glories of our blood and state
Are shadow, not substantial things,
There is no armour against fate,
Death lays his icy hand on Kings, . . .

James Shirley



GRADUATION IS LIKE SUNSET — FILLED WITH MEMORIES

I am not afraid of tomorrow, for I have seen yesterday and I love today.

William Allen White

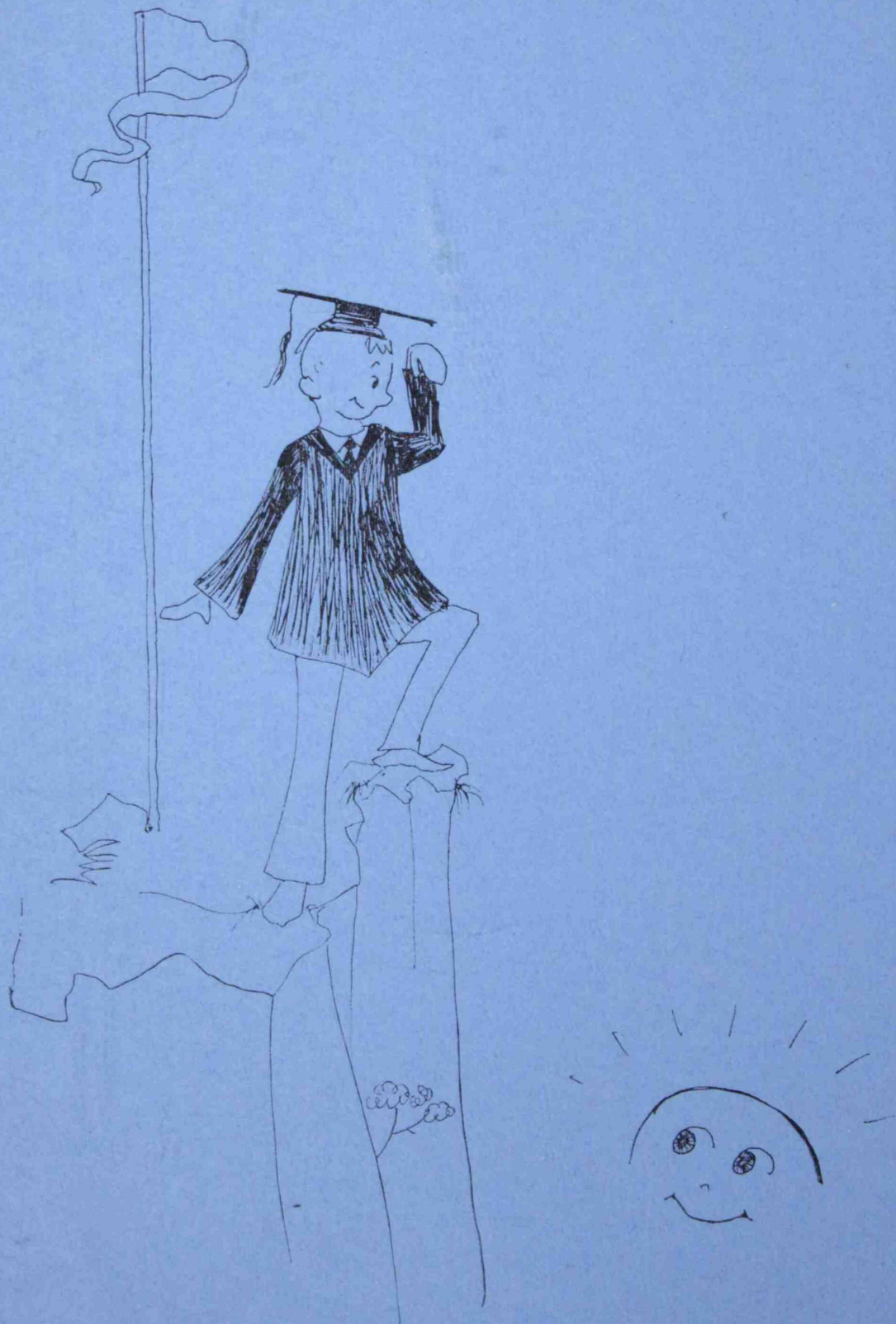


FOTO ALBUM

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Basle, Switzerland

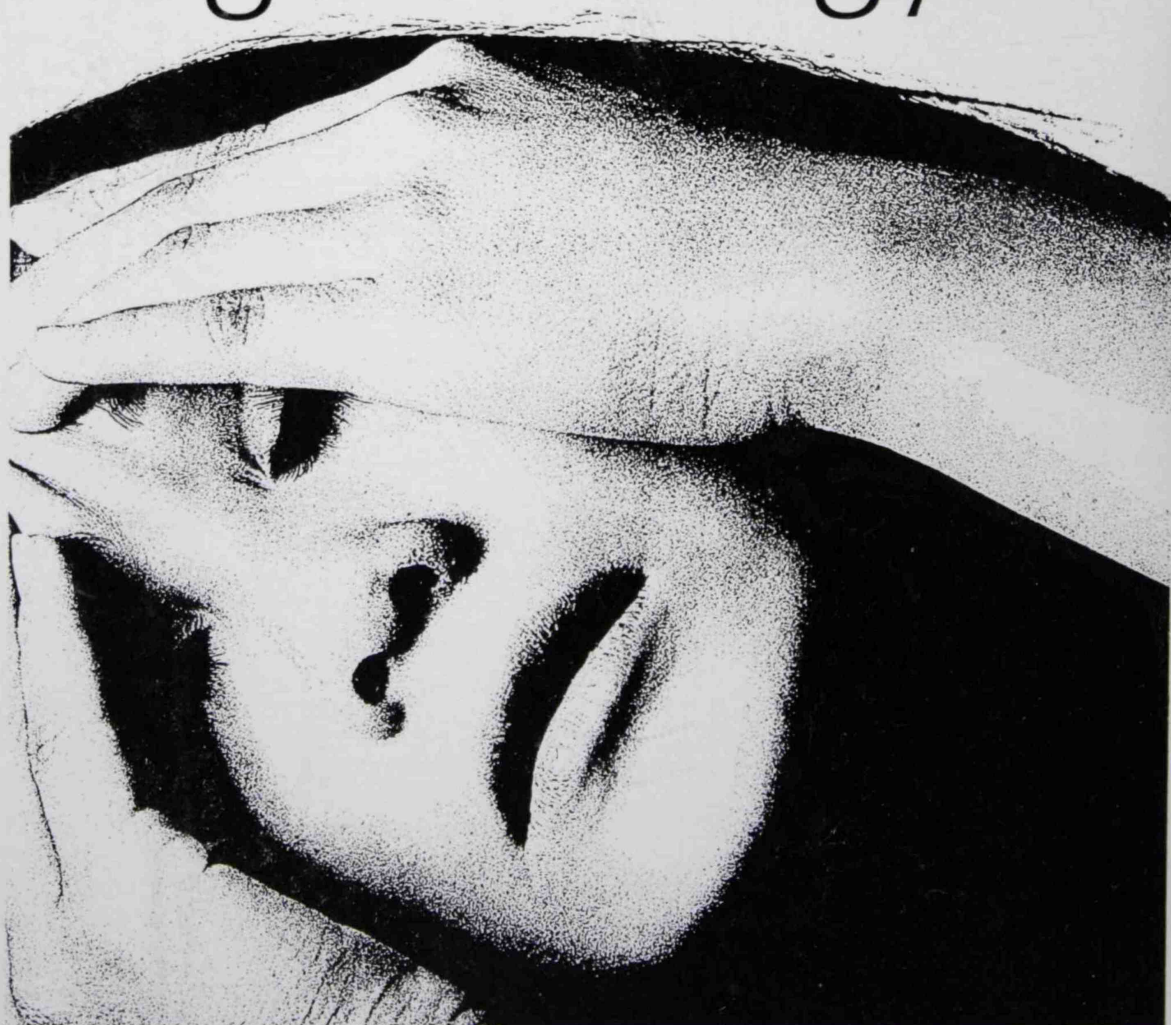
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Control of epilepsy

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epileptic personality and behavioural disturbances

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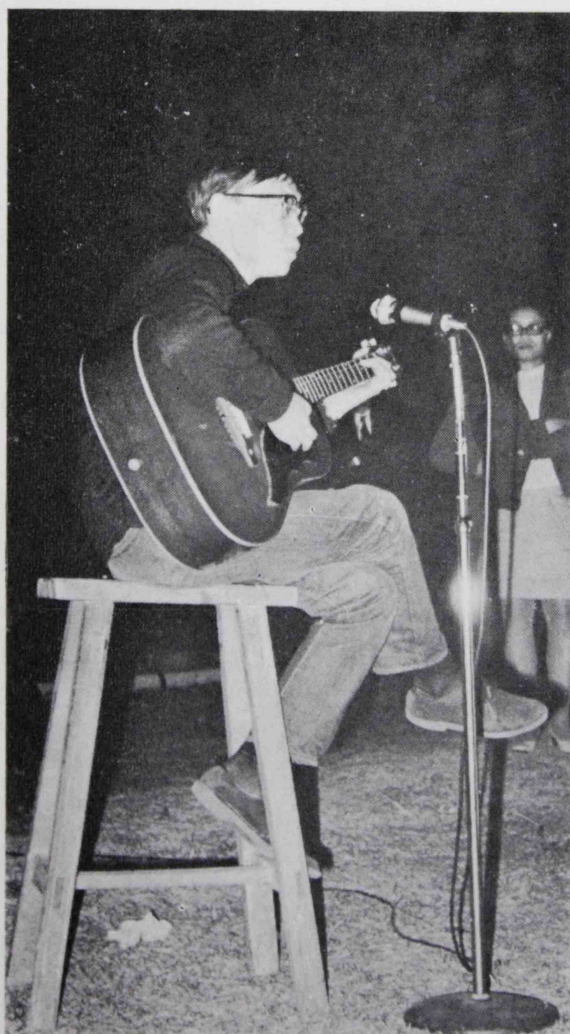
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B.B.Q.



The happiest moment in the life of medic students

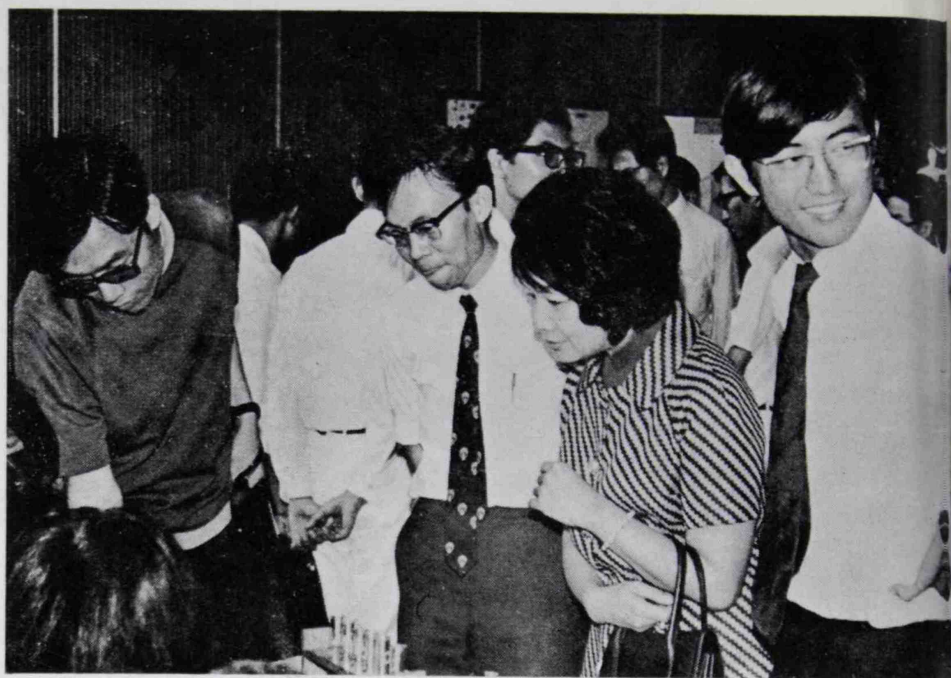


The chairman jokes, "I have to listen to what she said."

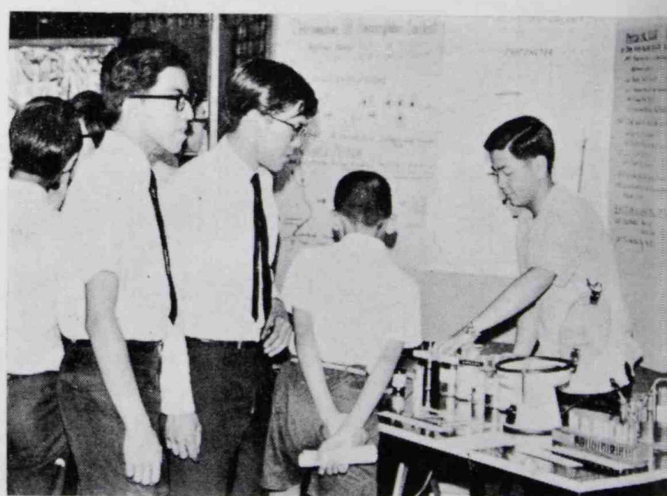


指揮若定
(惜 Sports Centre 非莫邊府)

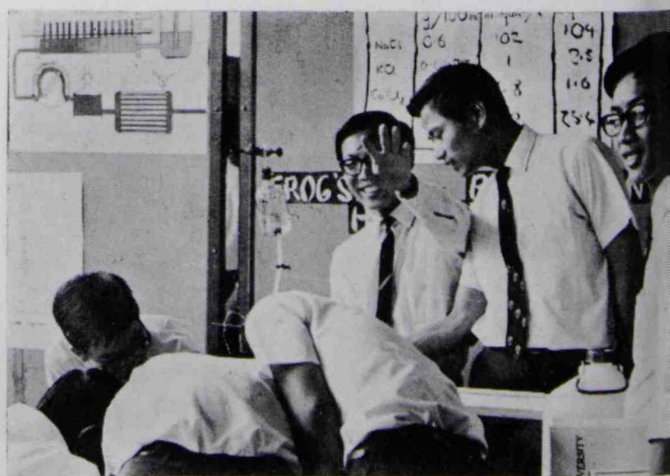
仔俾你聽



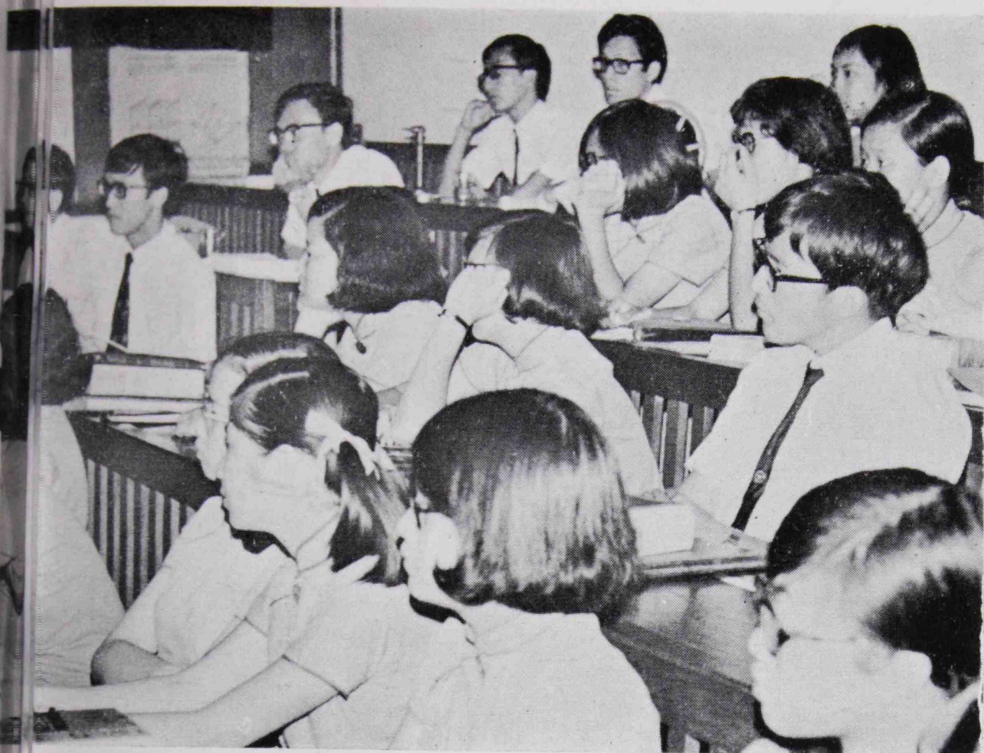
Never mind, girls, everyone must have such experience.



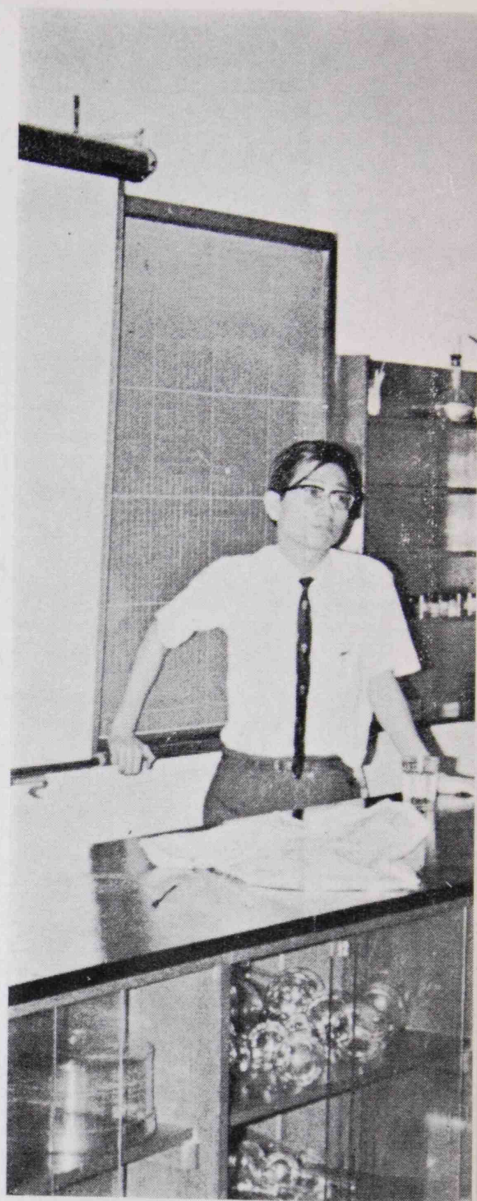
“呢個哥哥咁多八寶嘅！”



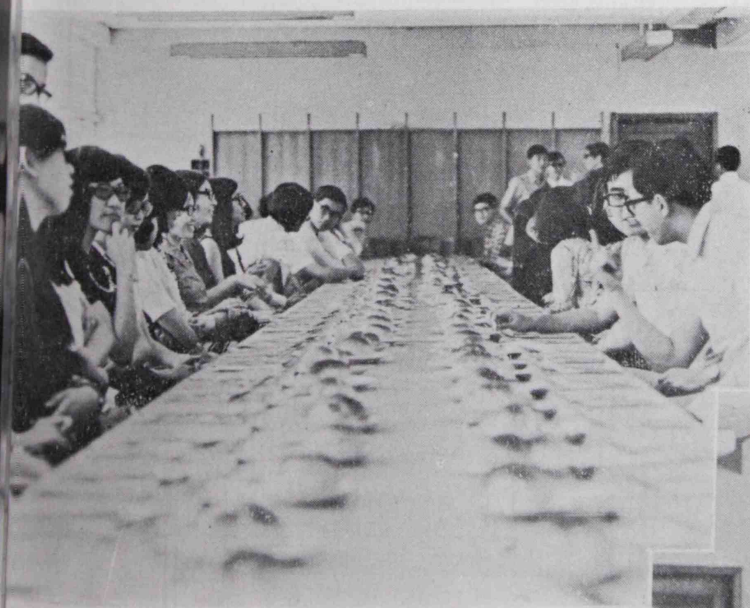
“Not yet! Till I've got my new Suit on!”



The bewildered audience



Any questions?



We eat



Listen to us

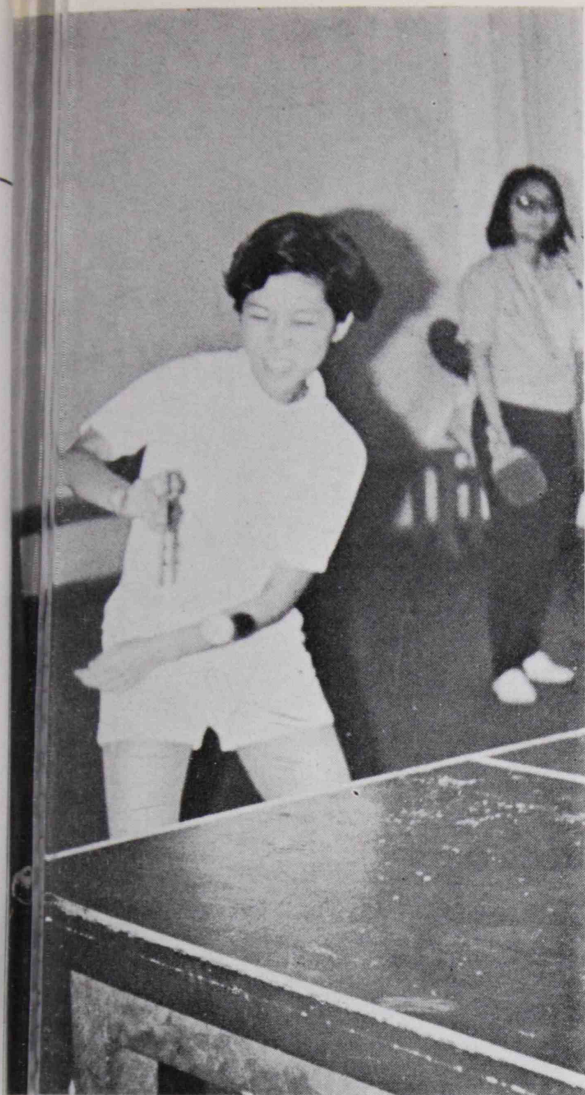
Arlef 100

a new non-steroidal
anti-inflammatory analgesic



helps the arthritis to
get a grip on things

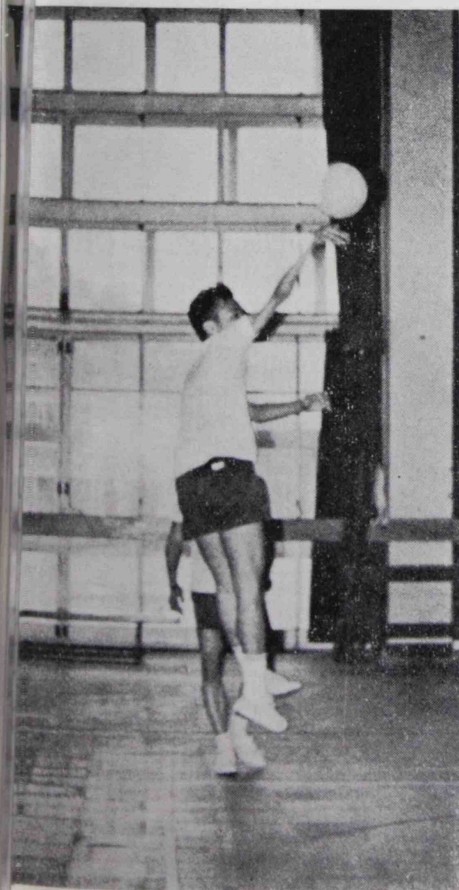
PARKE-DAVIS



I am serious



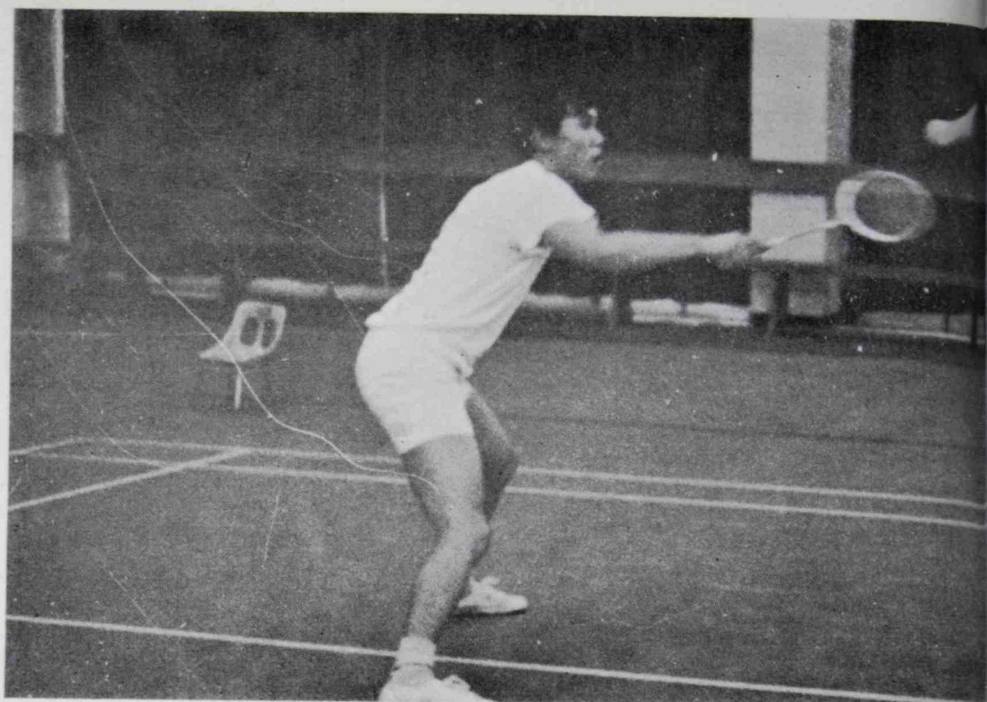
I take it easy



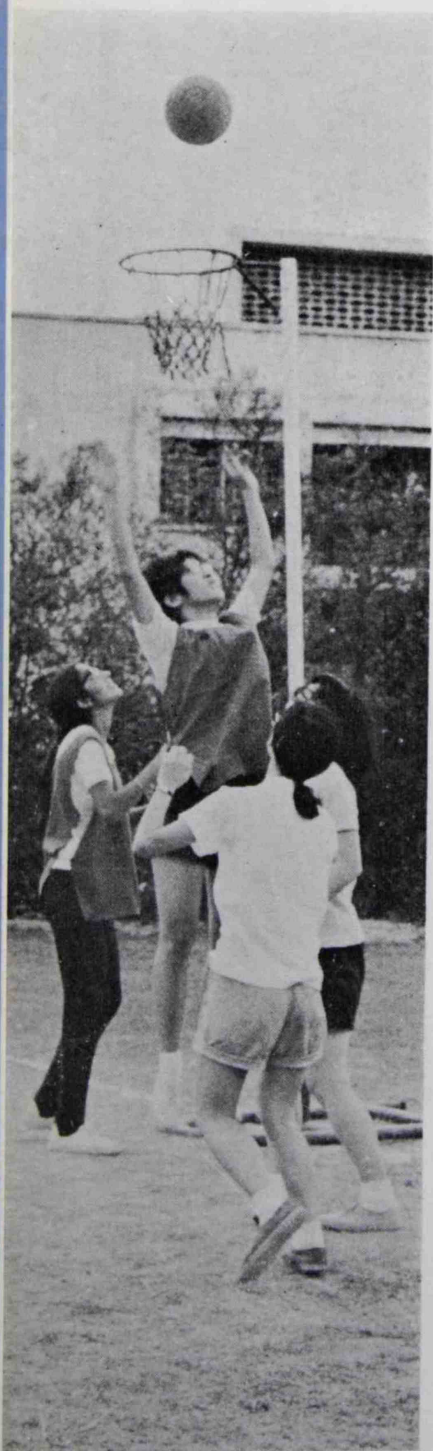
Up, up and away



Twist and shout



Come on, you little ball



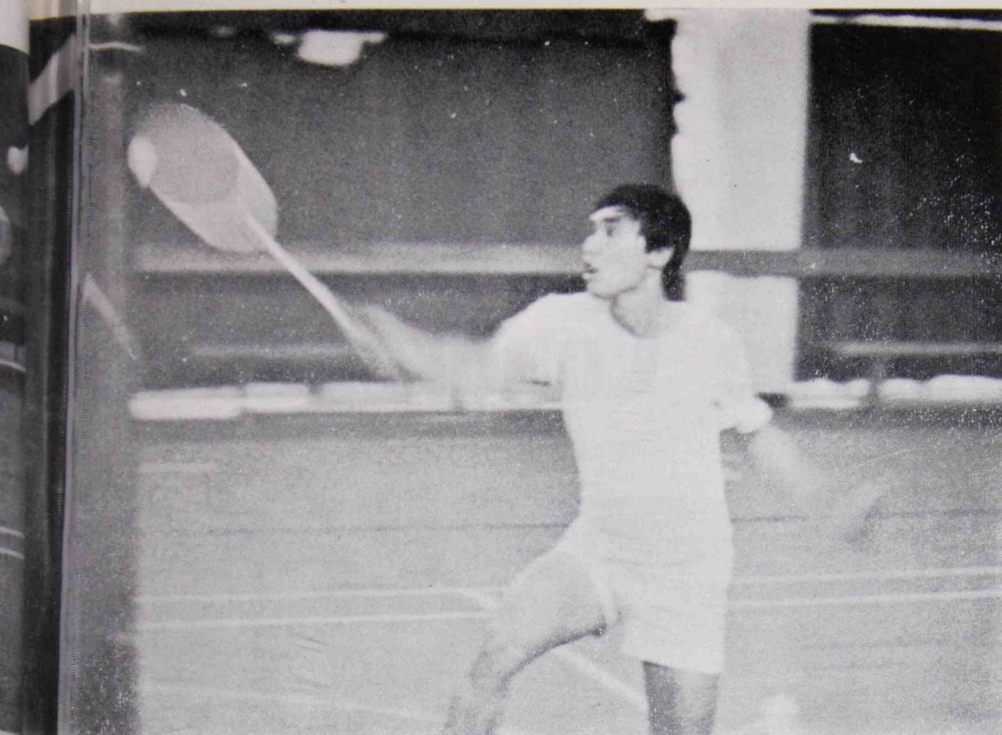
4 people on a circle
 $(x^2 + y^2 + 2gx$
 $+ 2fy + C = 0)$



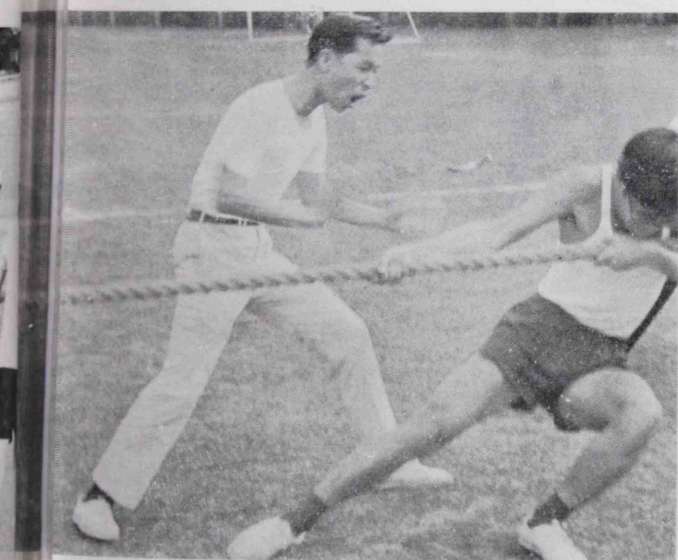
4 people on a line ($Y = C$)



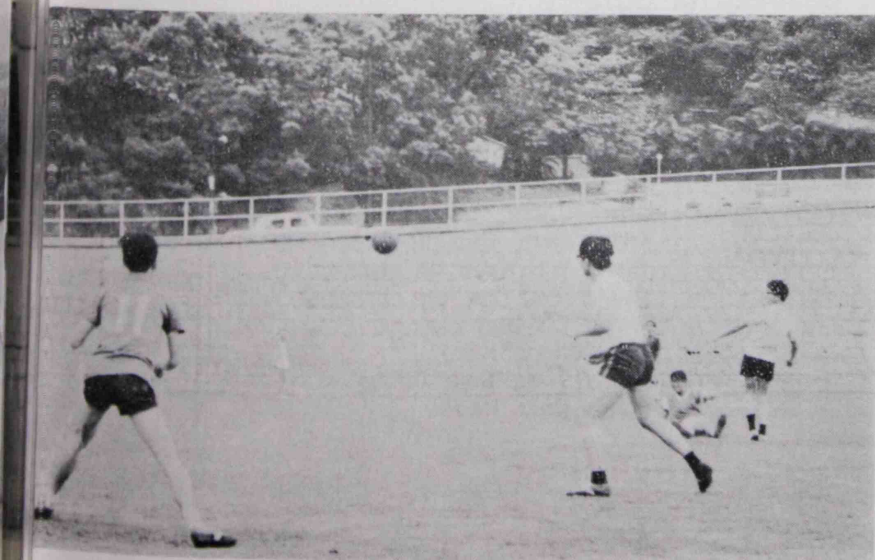
七又入咗



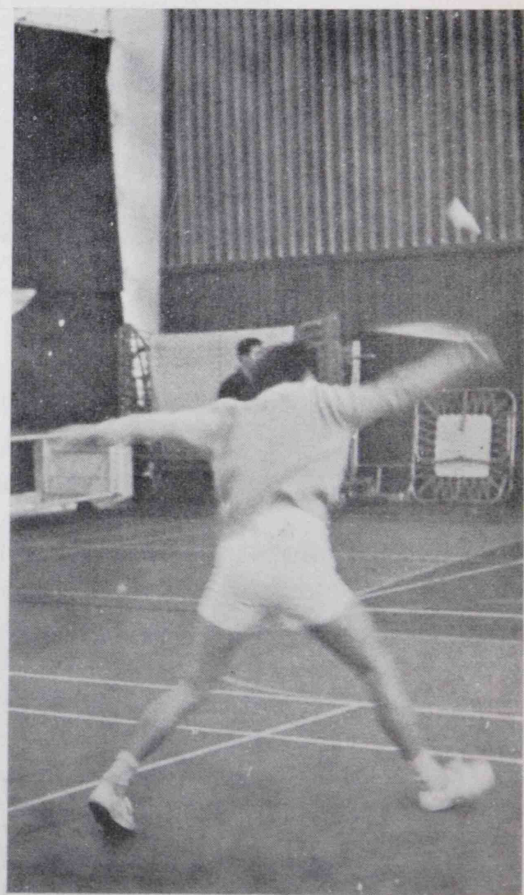
喂，咪落咁快



"One two pull, one two pull . . ."
邊個重話我潺



重唔 out 西



*A queer backhand,
A queer backstroke*

73th Degree Congregation



Degree of Doctor of Laws

Professor the Hon. Teng Pin Hui, C.M.G., O.B.E., M.B., B.S., D.P.H., J.P.

Degree of Doctor of Science

Professor Alexander James Smith McFadzean, O.B.E., M.D., F.R.C.P., F.A.C.P., J.P.

Degrees of Bachelor of Medicine and Bachelor of Surgery

1969

Honours List

So Sing Cho (with Distinctions in Anatomy,
Pharmacology, Pathology and Paediatrics)

1968

Pass List

Ho Fook To
Lee Shiu On
Kwong Sze Khin (in absentia)
Tsang Wai Kuen (in absentia)
Yeung Sau Yin (in absentia)
Leung Lit Bun
Teng Chong Kwok
(Miss) Tong Shiu Ching
Tsang Chiu Kwok

1968

Pass List

Mahommed Bin Ali (*in absentia*)
Ronald Chan Chin Pang
Patrick Chan Ki Wing (*with Distinction in Anatomy*)
Chan Lai Man
Chan Man Cheung
Chan Shu Kai
Chan Siu Hung
Chow Chung Wo
Chow Hing Ping
Chung Chak Man (*with Distinctions in Preventive and Social Medicine and Paediatrics*)
(Miss) Helen Chung Siu King (*with Distinction in Preventive and Social Medicine*)
Diu Kai Cheung (*with Distinctions in Preventive and Social Medicine and Obstetrics and Gynaecology*)
(Miss) Betty Fung Mei Ling
Anthony Hsu Chung
(Miss) Hsu Hing On
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Tsang Wing Keung
Tse Kin Chuen
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Tsoi Kwei Sang
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Wong Ho
Wong Tak Cheung (*with Distinction in Preventive and Social Medicine*)
Wong Yeung Chi
Cleophas Woo Chi Pang
Woo Wing Hung
Yeung Chak Ming (*with Distinction in Paediatrics*)
Patrick Yeung Kai Tai
Yeung Kung Ming
Lawrence Young (*in absentia*)
Henry Yu Ho Yam
William Yuen Wing Hung (*with Distinction in Preventive and Social Medicine*)
Yung Ming Tung
Yung Yue Hung

NEWS *from*

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UNIVERSITY OF HONG KONG G A Z E T T E

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Election of Dean

Professor A. J. S. McFadzean has been re-elected Dean of the Faculty of Medicine for a further three years from February 1, 1970.

Emeritus Professor

The Council has conferred the title of Emeritus Professor upon Professor K. S. F. Chang, who retired from the Chair of Anatomy on September 16, 1969.

Visiting Reader

Dr. J. P. Royle, F.R.C.S., F.R.A.C.S., appointed Visiting Reader in Surgery for March and April 1970.

Appointments

Agnes Mary Glen-Bott, M.B., B.S. (London), appointed Lecturer in Anatomy from September 1, 1970.

Louise Fong Yuk-Ying, M.Sc. (Hong Kong), appointed Temporary Assistant Lecturer in Biochemistry from January 1 to June 30, 1970.

Michael Bristow Roberts, M.A., D.Phil. (Oxon.), M.B., B.S. (London), L.M.S.S.A., appointed Professor of Pharmacology from September 1, 1970.

Personalia

Professor G. B. Ong was appointed Visiting Professor at the University of Toronto from February 22 to 25, 1970.

Dr. T. Sun, Lecturer in Microbiology, has been appointed a member of the Advisory Board of the *Southeast Asian Journal of Tropical Medicine and Public Health* of the Central Co-ordinating Board of the Council of Southeast Asian Ministers of Education.

Dr. K. H. Wu, Lecturer in Surgery, has passed the primary F.R.A.C.S. examination

and has been awarded the Gold Medal of the Royal Australasian College of Surgeons.

Retirement

Professor R. C. Y. Lin from the Chair of Pharmacology on August 31, 1970.

Resignation

Dr. C. C. Gruhzt, Lecturer in Pharmacology, from September 8, 1970.

Dr. J. Chisholm, Lecturer in Biochemistry, from August 27, 1970.

Dr. J. P. O'Brien, Lecturer in Orthopaedic Surgery, from December 1, 1970.

C. K. Shiu, Lecturer in Surgery, from December 31, 1969.

Dr. H. E. Von Ertfelda, Temporary Lecturer in Orthopaedic Surgery, from July 1970.

K. W. Ho, Assistant Lecturer in Pathology, from November 28, 1969.

External Examiner

Professor S. G. Clayton, Professor of Obstetrics and Gynaecology at King's College Hospital Medical School, University of London, in obstetrics and gynaecology, for the Final Examination in May 1972.

Professor J. A. Davis, Professor of Paediatrics at the University of Manchester, in paediatrics, for the Final Examination in January 1971.

Professor D. V. I. Fairweather, Professor of Obstetrics and Gynaecology at University College Hospital Medical School, University of London, in obstetrics and gynaecology, for the Final Examination in May 1971.

Professor B. Hudson, Professor of Medicine at Monash University, in medicine, for the Final Examination in May 1970.

Professor Sheila Sherlock, Professor of Medicine at the Royal Free Hospital School of Medicine, University of London, in medicine, for the Final Examination in May 1971.

Publications:

Department of Anatomy

- H. C. Liu and R. B. Maneely: 'The development of muscle spindles in the embryonic and regenerative tail of *Hemidactylus bowringi* (Gray)', *Acta Anatomica* Vol. 72, pp. 63-74 (Basel, 1969).
- H. C. Liu and R. B. Maneely: 'Observations on the development and regeneration of tail epidermis in *Hemidactylus bowringi* (Gray)', *Acta Anatomica* Vol. 72, pp. 549-583 (Basel, 1969).
- S. T. Chan: 'Electronmicroscopic study of the granules in guinea-pig bone marrow basophils', *Acta Haematologica*, 42, pp. 258-268 (1969).

Department of Pathology

- J. Belamaric: 'Malignant tumours in Chinese: a report based on biopsy and autopsy material from Chinese in Hong Kong', *International Journal of Cancer* Vol. 4, pp. 560-573.
- J. Grant: 'Haematological indices in healthy Chinese (a survey of 3,983 students in Hong Kong)', *Singapore Medical Journal* Vol. 10, No. 3, pp. 211-213 (September 1969).

Department of Microbiology

- C. T. Huang, Ming M. Wing, S. L. Ma, and T. Sun: 'Post-mortem and laboratory examinations for human intestinal helminths in Hong Kong', *Tropical Medicine, Nagasaki*, Vol. 11, No. 3, pp. 136-144 (December 1969).

Department of Medicine

- A. J. S. McFadzean and Rosie T. T. Young: 'Further observations on hypoglycaemia in hepatocellular carcinoma', *The American Journal of Medicine* Vol. 47, No. 2, pp. 220-235 (August 1969).

Department of Orthopaedic Surgery

- A. R. Hodgson and A. Yau: 'Anterior surgical approaches to the spine', chapter in *Recent Advances in Orthopaedics* (J. and A. Churchill Limited 1969).
- A. R. Hodgson, W. Wong, and A. Yau: *X-Ray Appearances of Tuberculosis of the Spine* (Charles C. Thomas 1969).
- A. R. Hodgson (with F. E. Stock): 'Anterior spinal approaches', in *Operative Surgery* (Butterworths, London 1969).
- J. O'Brien: 'The manifestations of arrested

bone growth. The appearance of a vertebra within a vertebra', *Journal of Bone and Joint Surgery* No. 51A, No. 7, pp. 1376-1378 (October, 1969).

Department of Paediatrics

- C. Elaine Field: 'Bronchiectasis. Third report on a followup study of medical and surgical cases from childhood', *Archives of Disease in Childhood* Vol. 44, No. 237, p. 551 (October, 1969).
- Juliet Hopkins: 'Some observations on the reaction of Chinese children to hospitalization', *Far East Medical Journal* Vol. 5, pp. 279-284 (September, 1969).
- K. C. Nip: 'Estimation of serum bilirubin on neonates by direct spectrophotometry', *Journal of Hong Kong Medical Technology Association* Vol. 1, No. 3, pp. 17-21 (August, 1969).

Departments of Paediatrics and Pathology

- Y. C. Tsao, W. C. Chan, and J. B. Gibson: 'Persistent proteinuria in children', *Archives Disease in Childhood* Vol. 44, No. 236, pp. 443-453 (August, 1969).

Department of Surgery

- F. C. Y. Cheng (with G. P. Burns, A. G. Cox, R. A. Payne, J. Specer, and R. B. Welbourn): 'Significance of early and late positive responses to insulin hypoglycaemia in patients with intact vagi', *The Journal of the British Society of Gastroenterology — GUT* Vol. 10, pp. 820-824 (1969).
- F. C. Y. Cheng and G. B. Ong: 'Perforated peptic ulcer', *The Bulletin of the Hong Kong Chinese Medical Association* Vol. 21, No. 1, pp. 45-56 (July, 1969).
- G. C. G. Koo and C. K. Shiu: 'Surgical management in diseases of the thyroid gland', *The Bulletin of the Hong Kong Chinese Medical Association* Vol. 21, No. 1, pp. 73-82 (July, 1969).

Department of Obstetrics and Gynaecology

- H. K. Chung (with W. F. McLimans, J. Horoszewicz, and M. Hreshchyshyn): 'In vitro studies of human trophoblast', *American Journal of Obstetrics and Gynaecology* Vol. 104, p. 945 (1969).
- H. K. Chung (with M. Hreshchyshyn): 'Evaluation of chemical pregnancy tests based upon the presence of magnesium', *American Journal of Obstetrics and Gynaecology* Vol. 105, p. 990 (1969).

平心而論，這真是一件可惜的事。不能否認該系的教學並非太差，但深信那位同學亦非惡意攻擊全系的教員。和一位講師閒談時，他曾慨嘆：「你們今年合格了，定會忘記我們了。」若是這樣，只顯出人格的渺小了。

放了榜，合了格，你道一個醫科二年學生極渴望的一件是什麼？MEDIC 吠是也！

記得第一年學生運動如火如荼之際，系會曾派出兩位「大仙」來班內問取「民意」；不知怎地，竟談到 MEDIC 吠的事，質詢為何一定要高班才可以打 MEDIC 吠；立時各人交頭接耳，並留意「來使」如何處理這個微妙的問題；他的答案，却是值得拍案叫絕：「當然，你現在用 MEDIC 吠也不會有人打你，不過若果打起 MEDIC 吠來，特別『過癮』而已。」

勞力耕耘者，當得着糧食，這事也如此。這條吠之受人渴望，主要不是來顯威風，更有意義的，於它代表一種獎賞，用五個月的努力換來的。它也帶來一種接納，是我也參加了這醫療的行列，雖然現在還是學生，但只要我盡忠盡責，能真正地幫助人的那日，必要來臨。

在 Locker Room 買吠的情景，難以遺忘：你看各人氣揚揚，熱哄哄，歡欣地，細心的選，驕傲地拿在手裡……。心底有呼聲說：「這是可喜可念的時刻，但不要自滿，不要自高，更不可忘記起初的決定，走上這條又大又難的道路時所立的理想……。」

你看，急不及待地，不少人已打上 MEDIC 吠了！

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試前，試後

木

(一)前言

第三學期開始，讀新的科目，不只有趣些，更足以為喜者，是新氣象的出現，如對功課重視些，實驗室也盡責些；究其原因，非因什麼，却是覺得所學之事，終有一天要用來醫人，固當小心盡責。或許諸位「大仙」以為小兒科，幼稚，但如一首詩歌所說：

「小小許多水滴，積聚成江河，
小小許多砂粒，積聚成大地，
一分一秒，好像不希奇，
倒會積成年歲，積成無盡期。」

我們小小過失，會使我的靈，
離開德行路程，轉向惡中行，
小小慈愛事情，小手播了種，
能够開出香花，施福千萬眾。」

小心火花，可以燎原，小小愛心和盡責，亦可成為匡世救民的基礎。

(二)試前

在 1st MB 試前，圖書館的空氣緊張得要凝結了；但亦盡非如此枯燥。某日一羣基督徒收到一些慰問帖，歡喜不迭，擺在書旁；其他人看到其美麗的圖案，及關心的慰問，嘖嘖稱羨。在普遍以為人是萬能之時，仍有些時刻，會察覺人生到底有未完滿，有空虛；美國太空人遇險，各地人一致發出為他們祈禱的呼籲：到底向誰祈求呢？或許這就如聖經所記：「自從這天地以來，神的水能和神性，是明明可知的，雖是眼不能見，但藉着所造之物，就可以曉得，叫人無可推

試期愈近，愈感到那壓力；持久力是一個重要的因素，每天都讀，讀完又讀。

記得一天各位「拉記同志」吃過晚飯，拉隊往沙宣道逛，適逢日落，海天共同一色，一位同學不禁脫口而出，讚賞景色的迷人。有人隨口說，日起日落，讀完一天書，倒可安心回家酣睡一覺；這話說得好，在如此時期，每天拖着疲乏的身體回家，恨不得立刻投到床上大睡。那知跟着另加的一句，更為貼切，謂「第二早起來，又要讀書了！」

朋友，這是真的啊！

於試前的一個午間，曾和一位同學散步，看到解剖學新來的教授。這並不足以令人緊張，是嗎？怎道他却催促我，還不快點上前 GREET 他，考試肥佬仰合格都靠他了。

這豈不悲哀麼？我要和他打招呼，原來不是因他是個人，不是因我對他學者的質素的尊敬，不是因他人格值得敬重，却只因他可以影響我的成績！如果我有自信不需要 Pull up，豈不是可以不和他打招呼？

人的價值觀念，若是淪到這地步，難怪他會撇棄諸般的美德，而變成唯利唯物的軀殼了！

(三)試後

考過試，循習例有個謝師宴（只是這謝，值不值得，真不真心，配不配得，是個別同學的意見，亦同個別老師們有不同。），要交三十大元，真是心痛，回想這五個學期，許多都是要自己從書本贖出來的。將要舉行時，却鬧出風波。於某科的口試中，有位同學認為其中的一位考試官犯了錯誤，而投訴於啓思的讀者欄，引起一場誤會。

勝枚舉，由各種健康調查，研討會，以至各類宣傳運動，均可推行。

(二) 一般行政方面：值得研究的地方，有以下數點：

甲、各班會與醫學生議會之聯系，目前似未够緊密，在這方面，筆者認為各班會應保持目前之充份自主，議會無須干預各班之活動。但在形式上，班會則應承認議會為最高領導組織，故筆者認為每年各班之選舉，應由議會指派一監選團執行，該監選團由三人担任，其中二人為該班同學，另一人則最好為執委會秘書。如是則各班會與議會之間，會有系屬的感覺，但不影响行政工作。此一提議，初時實行或有困難，但如能在新學年於一年級開始實行，則新學生當會習以為常，於數年後當可在各班中順利推行。

乙、目前醫學會之普通會員，只限於學生，筆者則認為普通會員之資格，實可擴大至包括見習醫生。此一改革，當令醫學會會員人數擴大，在財力，人力方面，都有裨益。且身為見習醫生而仍願參加醫學學生會者，必為熱心的同學，且經驗，見識亦比在學同學較高，能羅致他們入會，對醫學會必有一定貢獻。

丙、在聯絡舊日師生一項工作上，醫學會以前似未注意到。筆者認為當事者實應在此多下工夫。譬如在會刊中，我們可以闢一專欄，刊載舊生消息或通訊，已經離校的同學，當會至感興趣。

(三) 組織方面：現時的會長及副會長職，實應改為名譽會長及名譽副會長，更為恰當，此二職為顧問性質，毋須有表決權。現時之執委會主席，應改為會長而另選議會主席，方能監察、行政二權分立，杜絕舞弊之可能性。另外，鑒於前面申述之理由，目前之體育及康樂秘書二職，應目執委會中撤消，其工作由兩個常務工作小組担任，而執委會中應另加上教育及健康二員，負責推行該兩行面之工作。

以上所述數點，均為個人愚見，筆者謹希望藉此拋磚引玉，誘發更多寶貴意見，當為學會之幸。

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改進港大醫學會我見

· 觀天 ·

港大醫學會自成立以來，經有多年歷史，年來它負起了團結醫科同學，促進師生感情等工作，給予各同學一個參加團體活動的機會，對本系同學的「大學教育」，實有其一定的貢獻。隨着時日的邁進，今日的大學生，包括醫學生在內，在思想及行動上，亦有相應的變更，以適應今天社會上各方面的需求。故近年來各高等學府中頻聞改革之聲。本人身為醫學會會員之一，亦希望在此討論一下醫學會之各項政策，制度等，並希望其他同學能不吝賜教。

首先談及醫學會在學生組織中所佔的地位。在學生會發展中，最近有三件事是和各學院系會有着密切關係的：

(一) 學生代表得以參加校務委員會，醫學院將選派一名代表，參與大學行政。在醫學院中，由於全部學生均為醫學會會員，故此一代表將於一會員大會中選出，該代表將於校務委員會中，負責幹旋一切與醫學生有關之事宜。此一制度無疑提高了系會的權力，增強了該會的代表性。

(二) 醫學院當局，亦日漸趨向更加尊重學生之意見。目前之學生諮詢委員會 (Dean's Undergrad Committee) 即為一例。該委員會會中之學生成員，皆為醫學生議會之議員，可見校方當局，對醫學會之重視，認為乃醫科學生之合法代表。此外，在學院當局之投訴委員會 (Appeal's Committee) 及圖書委員會 (Library Committee) 中，以至星系報業醫科學生貸款委員會中，皆有醫學生議會所指派的學生代表。

(三) 此文執筆時，剛傳來消息，校方將廢除學生須加入宿舍學生會為會員之硬性規定，港大學生會並將召開會員大會，徵求一般學生意見。照筆者觀察，該規定之被廢除，只是遲早問題。港大學生宿舍的不及四份之一。硬性規定其餘四份三之學生隸屬於某一宿舍，在精神中來說，是強人之所不欲，是違反民主；在實際上來說，是增加

了外宿生一些非必要或不一定樂意接受的經濟和體力上的負擔，此條例修改後，外宿生能各依自己的環境愛惡，自由參加或退出宿舍活動，實在至為合理，故此大學當局此一改革，當符合大多數同學之利益，必獲學生會之支持。故此我們可以預測到，各宿舍學生會在學生行政中之地位將逐漸轉弱，而相對地，各學院學生會之地位將增高，更有可能將來各學生在學生議會中將純由學院代表。

既然學院學生會之代表性將日漸增強，權力日見提高，我們自然要求它們有相應的改進，方能擔當重任，對醫學會的工作，筆者希望提出下列數點，俾供在任者參考：

(一) 工作重點：在醫學會活動中，康樂及體育兩項，素有一個相當重要的地位，此等活動，固然有其一定之貢獻，不宜忽畧，但數十年以來，經已變成十分規律化，每年所舉辦的，不外如野火會，遊船河等等。目前社會及學生對醫學會之要求，已漸超出了原來的範圍，故醫學會除保持以往所舉辦之康樂及體育活動外，對下列兩項工作，有增強及擴充之必要：

甲、課程及教學方法之研究及改進：知識的傳授，須由師長經過各項媒介傳達到學生。故師、生及媒介三者，均須各自能達到盡善的地步，並互相配合，教學方能發揮其效能。學生處於感受的地位，故應最能衡量各種教學方法，作出客觀的分析，精確的調查，並將結果呈上校方參考。此等工作，用予日常授課，以至考試方法，皆無不可。運用得當，當可令學院教學日漸進步，學生水準日漸提高。如我們只知自己得益而不願將自己的經驗傳授後人，以改善當前環境，則是太自私了。

乙、推行社會健康計劃：醫學生所學，為濟世之術，我們應在學生時代，即培養這服務精神。在這方面，醫學會可藉各種健康計劃的推行，喚起同學的注意，鼓勵各同學參加。健康計劃的種類，實在不

看過前一期醫學會會刊的「傲」一文後不覺對它的作者肅然起敬。誠然，「人生的意義在爲一個目標，一個理想，作不斷的奮鬥，絕不退縮，絕不爲魔鬼所引誘。」甚麼殺身成仁，甚麼捨生取義，不過是這樣的一種表現而已。

但是，我並不認爲要達到這個目標，這個理想，便要鋒芒畢露，四出批評他人，以致結怨於四方，爲衆人所不滿。因爲這樣的做法，並不能將我們帶近目標，更難以將理想變爲現實。原因是正當我們想把理想傳播開去的時候，我們已受到各方面的排斥，遇着重重的阻力；這樣，我們雖然「作不斷的奮鬥，絕不退縮，絕不爲魔鬼所引誘」，只是事倍工半罷了。

請不要誤解；以爲我們反對批評，我相信對於邪惡，除了對它作出澈底的攻擊，把它的勢力粉碎蕩然，是別無他法的。但這不等於鋒芒畢露地結怨四方！罪人本身是個弱者，對於本身的過失，具有高度的敏感性，最怕他人論及自己，倘若我們不顧一切向他抨擊指責，這樣徒然幫助他築起一個心中的圍牆，增加彼此的隔閡。因此，要令浪子回頭，較佳的辦法不是刑罰，不是苛責，而是深切的了解，同情，感化。我們同意這個方法也是有它的困難的，但起碼我們已盡了我們一點力量，去打破彼此的圍牆，使我們的理想，我們的目標，能夠闖進他們的心靈。換句話說：邪惡的本身，與及犯下邪惡的人，我們要分開來處理，一者要滅此朝食，另一者則須諄諄善誘；倘若混爲一談，只會徒勞無功而已。

另一方面，我們還要反躬自問：當我們正在批評他人之際，自己是否無可置評？我們攻擊別人賭博，指責他人酗酒，責備社會上的飛型青年，抨擊政府的短視；可是環顧我們的同學，又有多少人賭博？多少人酗酒？多少人的生活比飛型青年更爲糜爛？我們學生組織，又比政府遠視多少？其實我們很容易發覺；我們實在自顧不暇！我們雖然有目標，有理想，但如果自己都不做好，怎能令他人做好？有一個故事：當一羣人聚集起來，正要向一個淫婦擲石，耶穌經過那裡，向人羣說：「你們中誰人沒有罪過，就來向她擲石吧！」人羣聽了，一個也不敢擲。當我們要攻擊別人時，最好先想一想這個故事。

是故一個理想，一個目標的達到，不在鋒芒畢露，四出批評，而在當先不斷批評自己，改善自己，樹立良好的風範，才進一步去影響，感化他人。首要的條件：是能對自己「作不斷的奮鬥，絕不退縮，絕不爲魔鬼所引誘」！讓我們把第一步做好，把自己的污點洗滌乾淨，再做第二步吧！