（丙）主試團體應包括香港大學成員若干名、英國負責同等考試之團體之成員若干名、及來自東南亞英聯邦國家之成員一名或數名。

（丁）考試報名費應與舉行此項考試之實際開支相抵。

（戊）若考試之一部分未能合格，在通常情況下，該部分應准予補考。

（己）應考者如考試合格，應准予臨時註冊，俾得從事定期之日班見習。

會受全日制醫學訓練不少於五年，並能提出證名者，始具備應考資格。

（甲）凡符合此規定者，均應准予參加此項考試。

（乙）應考者須持有能在香港居留及工作之證明。

（丙）應考者須行為良好。

（丁）香港醫務委員會應負責解決與應考資格有關之一切問題，該會或需設立一「證件審核小組」以負專責。

（戊）凡提供偽造資料或證件者，均屬犯法行為。

凡考試合格者，在正式註冊前應先完成臨床訓練，稱「日班見習」。

（甲）在本計劃試行初期，日班見習醫生通常須實習十八個月，即內科、外科及婦產科各六個月。

（乙）上述之見習期限應適用於一般情況，但暫勿訂為法律規定，應俟有相當實施經驗後再定。香港醫務委員會應有權延長或縮短個人或全體之見習期限。

（丙）倘日班見習醫生於日常見習考核中發覺其完全不適宜為註冊醫生時，香港醫務委員會應有權隨時終止其日班見習。

凡考試及格及日班見習期滿，成績滿意者，應發給香港醫務委員會執照（LM-CHK），並准予正式註冊。

於實際需要之情況下，考試及接受日班見習醫生之措施，應繼續舉行。

與英國有關當局之磋商

應與英國醫學當局繼續保持已有之正式接觸，如有可能，並應就香港所動議之此種新措施，取得其贊同。

對特殊類別之建議

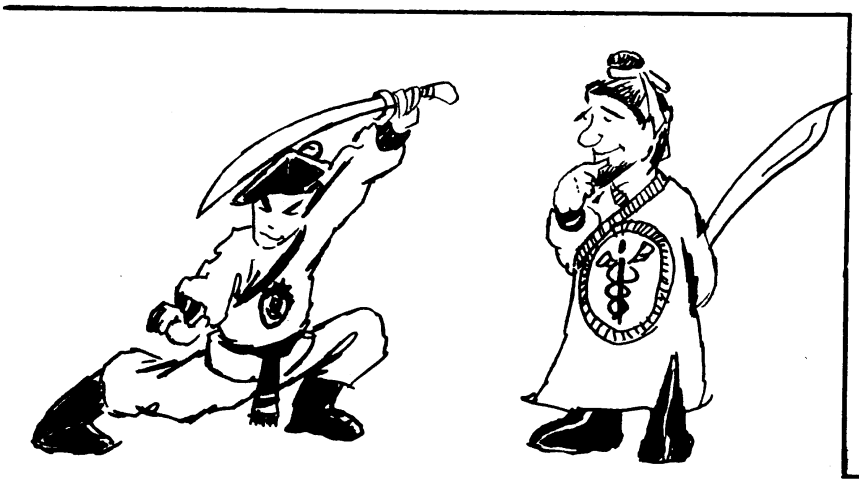
（甲）曾有建議凡在政府或香港大學醫學院服務達十年以上而未能註冊之醫生，應免除其考試或其他手續，立即准予正式註冊。此項建議礙難接納。但香港醫務委員會對此兩組醫生，得根據各人之適當經驗及工作表現，個別豁免其部分或全部日班見習。

（乙）在政府服務而未能註冊之醫生，倘於考試合格後未能獲得香港醫務委員會豁免其全部日班見習，而需作特殊安排時，應予以同情之考慮，俾得經適當之程序，獲得正式註冊。

（丙）在註冊診療所服務而未能註冊之醫生，若考試不合格，亦不應剝奪其在註冊診療所繼續行醫之權利。

參考資料：

（一）七三年醫務發展諮詢委員會報告書
（二）七四年醫務白皮書
（三）七五年未能註冊醫生問題工作小組報告書
（四）七五年「啓思」四、五期合刊



教職員意見

「啓思」編委會就今次「非英聯邦醫生問題」專輯，分別走訪過幾位在本校任職的非英聯邦醫生，請他們發表一些個人觀感，其中不乏本報獨有的寶貴意見，謹此致謝。

我們亦曾分別訪問每班的幾位同學，雖然只有二、三十位，相信亦能代表多方面的不同意見，由於有很多意見重複，所以沒有將個別同學意見刊登，而是經整理後再統一刊出，對於未能搜集到的其他意見，希望同學能來稿在下一期討論。

黃醫生

黃醫生曾在生理系任助教。他贊成這一個考試制度的設立，因為比較公平。但他似乎不滿意政府經過多年才有這樣的決定。

黃醫生覺得英文試是必需的，因為很多醫務上的文件都是英文的。整個考試制度沒有多大的問題，但唯一欠佳的是十八個月的實習。他認為很多未能註冊的醫生現在有自己的工作，要放棄這份工作來參加實習會有困難，況且他們很多都已經是上了年紀的人了。但他亦提出會有一部份未能註冊醫生對考試沒有多大興趣。這些近期從國內出來的醫生，因為學了針灸，靠着針灸診療所的工作，生活都很安定。他們未必會放棄這份優差而參加考試。

黎鴻釜醫生（病理系）

黎醫生認為政府立法甄選是無可厚非的，一方面保障本港醫生的利益同時亦可劃一醫療服務水準。談到是否公平，黎醫生表示就考試內容而言，香港是根據英國法例，而從各地的制度比較之下亦很難作一個評語。不過，就人情而言，香港政府一方面利用非聯邦醫生替香港社會取務，而另一方面沒有建設性幫助他們（如設立輔助課程）。黎醫生等會就此問題，呈函有關方面，希望考慮免除一部份對香港醫學界有一定貢獻的非聯邦醫生（在港大執教十年以上者）之甄選試。

袁大任醫生（生理系）

香港政府應該准許非聯邦醫生正式註冊和執業，但要嚴格審查資格，考試就是其中一種方法，由於有很多有資格的醫生（尤其是大陸來的）是沒有證書的，所以不應斤斤計較醫面證明，而應以考試作為評定的最終標準。

現時委員會所提出的考試辦法原則上很適合，但十八個月實習期似乎太長一點，應該有伸縮性。英文方面，只要普普通通——如看得懂藥品說明便夠，同時在考試前應予考生實習的機會，使他們能把握重點。

這個甄別試的程度既然與英國看齊，就應該得到全英聯邦承認，同時應該一年舉行一次，長期實施。

如有講師要預備考試，相信大學當局會方便他們的時間，而避免影響教學，同時亦不愁他們考試後會放棄教學，因為講師的待遇亦不差呢！

湯其博醫生（生理系）

目前即將實行的非聯邦醫生考試制度雖然是進了一大步，但是仍有很多問題仍沒有解決，因為如果只進行全面的嚴格考試並以英聯邦國家為水準。那麼，恐怕將有一大部份非聯邦醫生被考試淘汰，即使有重考機會，荒廢時間一定不少，浪費了經驗也造成他們很多人生活困難，例如香港早已實施之牙醫考牌制度，由于考試標準是根據外國的，筆試，出題及改卷全由外國考試官負責，所以歷年來考上牙科註冊醫生比例也不很多。多數未能註冊牙醫仍失業，而香港卻面臨嚴重地缺乏牙醫，這是有目共睹的。即使香港大學目前能開辦牙科學院，要等第一批畢業生出來也非三五年之事了。

我想最好的辦法仍是像一九六四年一樣先給予非聯邦醫生以面試甄別（Interview）。資格審查合格者，則可以在醫院，診所或註冊醫生監督下工作。這個辦法的好處是可以即刻解決香港醫生荒的情形，這些有資格但未能註冊醫生也可以即刻貢獻自己力量服務並解決本身生活問題，他們醫病之經驗也不致荒廢或遺忘。經過一段醫院，診所及註冊醫生監督下工作後，這些醫生已漸漸熟習本港病人情況及各種藥物的應用註並可以有充份時間來複習醫學課程。那麼以後，凡願意註冊的可以申請考試。這個辦法亦可應用在未能註冊牙醫身上。凡通過本港牙醫考試第一階段口試即面試，（由本港牙醫考試官負責）後，應准許在醫院診所或註冊醫生監督下工作。以後可再考筆試而獲註冊。

曾在一九六四年經過面試甄別（Interview）而獲准在社團診所工作的非聯邦醫生，他們均有良好服務成績，沒有出過醫療事故，這也證明了面試甄別是有效的和正確的，政府醫院也是用面試錄取合標準但未能註冊醫生參加醫院和診所工作。我們香港大學醫學院也錄取了有資格的未註冊醫生任教。從臨床課（抱括外科、病理、微生物）至基礎課均有不少此種教師。香港大學一向認為資格和經驗是主要的，事實也證明這些有資格未能註冊的醫生教師的工作教學均夠水準，成績良好。

有些在政府醫院服務廿多年退修後的未註冊醫生常可獲得註冊牌，這也許是對他們貢獻的獎勵吧，目前政府醫院內，香港大學內，以及豁免診所內的未能註冊醫生希望要求能於服務十年後獲得註冊。雖然他們多數表示仍願服務于原崗位，爭取註冊主要是為了爭取名譽平等，發揚實際精神，當然對他們年老退修亦有些保障。我想這也是對他們一種服務獎勵，希望有關方面能慎重考慮。

非英聯邦醫生

「目前在醫療界頗受注目的問題就是非英聯邦醫生在港執業後將產生的影响，是好是壞，現在尚難下定論，在今期的專輯裏，我們將首先簡單介紹一下該等醫生在港服務的一點歷史，目前和未來十年來的醫生供求情況和政府委任的「研究未能註冊醫生問題」工作小組所作的建議，另一部份將包括校內同學、非英聯邦醫生教職員和邱明才教授的訪問，希望大家看後多一點討論和發表意見，記着，香港醫療的發展是和你我息息相關的。」

編委會

非英聯邦醫生在港服務的歷史

太平洋戰爭結束後，本港恢復民政管理，政府即已開始聘請未能註冊之醫生。當時本港註冊醫生極為缺乏，政府難以招請足夠之醫生。當時招聘之註冊醫生，來自海外者人數仍然有限，本港註冊醫生亦少有加入政府內服務之興趣，而當時卻是招募之主要來源。同時香港大學經過日本佔領後，欲完全復課，亦困難重重。因此，為着維持醫療服務起見，乃聘請畢業於中國及世界其他地區，但未能在香港註冊之醫生。此乃權宜之計，醫務衞生處處長於一九四八至四九年度年報中表示：「本處之政策乃於時機成熟時，由可註冊之醫生取代之」。

可是招聘之困難並未因時稍減，至一九四九年中國政局變遷後，為數衆多之醫生從中國進入香港，而其資歷大多不能在本港獲得註冊，因此，聘請未能註冊醫生之人數更為增加，以填補政府空額。有關此等醫生問題，當時亦曾與英國醫學會（香港及中國分會）及香港中華醫學會（現稱香港醫學會）磋商，議定此等醫生雖不能准予註冊，但應儘可能由政府聘用，直至有足夠註冊醫生替代為止。至一九五〇年三月三十一日，醫務衞生處醫生人數共計一二七名，其中三十六名為未能註冊之醫生。

由於招聘註冊醫生於政府服務仍有困難，故須繼續聘用未能註冊之醫生以担任多項工作。至一九五一年三月三十一日，一二五名醫生、助理醫生與實習醫生中，有六十二名為未能註冊者。該處一九五〇至五一年度之年報中指出如無該類醫生，「本港當不可能維持目前之醫療服務水平」。

此後，曾於一九六三、一九六八及一九七四年三次招聘較多之未能註冊醫生。一九六三年因東華三院醫生辭職之人數突增，故需較往年聘用更多醫生以便借調東華三院；一九六七年騷動時，有等註冊醫生辭職，因此需於一九六八年招聘醫生填補空缺，而一九七三至七四年之招聘，乃因空額殊多，且醫務衞生處迅速擴展服務範圍需多量之醫務人才，並兼三年來並無聘請未能註冊之醫生，故有大量之招聘。

至一九七四年十月，醫務衞生處專業人員之編制總數為八四五名，但實際人數只得七五七名，其中一三二名（17%）為未能註冊之醫生。編制中有三十五個職位乃指定用作借調專業人員往補助機構者。至一九七五年二月，所借調人數為二十二名，其中十七名為未能註冊醫生。

以往聘請未能註冊醫生原則

於醫生短缺期間，聘用未能註冊醫生以填補醫務衞生處之空缺一向乃在醫務衞生處處長權限之內，而處長則審市民之需要，以及保持適當之工作水平而作出決定，其原則乃根據服務上之需要而定，在可能範圍內，盡力以求獲得足額之註冊醫生，但與未能註冊醫生之數目相比，則從未按照任何比例或限額以作出決定。

審核聘用時，處長必定考慮有關職位之需要，並衡量是否適宜由未能註冊醫生充任。該等職位包括服務於醫務衞生處之門診醫療所、家庭健康服務診療所、胸肺病診療所、水上診療所、監獄醫療服務，以及補助醫院等機構之借用醫務人員。

聘用條件

如上所述，聘用未能註冊醫生，一向均先充任助理醫生級之職位，並按月續聘。至一九五〇年，聘用規定有所改善，若服務期滿四年，成績良好，一切情形皆適合晉升者，可擢升為醫生級。該等規定最近再予改善。目前聘用之未能註冊醫生，一經晉升為醫生級後，與服務於政府之註冊醫生享受同等待遇。

遴選方法

政府聘用未能註冊醫生為助理醫生時並無公開聘請，但有意充任者可自行向醫務衞生處申請，若某申請人被認為適合，則予以面試。面試由醫務衞生處兩名至三名高級專業人員（助理處長及首席醫生級）主持。

面試通常需時三十分鐘，目的在於探求申請人之有關學識與經驗。此外，實用英語知識（書寫與會話）亦屬重要。

未能註冊醫生於醫療服務功用之評價

以上所指，本港於戰後初期，如非聘用未能註冊醫生，則醫療服務當不能獲得過去之水平。至於此等未能註冊之醫生所接受訓練之性質與經驗，則各有不同。因此，醫務衞生處處長必須儘量確保所聘用者皆能向市民提供滿意之服務。在基本政策上而言，醫務衞生處聘用之未能註冊醫生皆任職於普通門診醫療所、胸肺診療所、產婦及兒童健康診療所、麻醉科、水上診療所、監獄醫療服務、東華三院、其他政府補助醫院，與新界、大嶼山、長洲等診療所。

香港大學之年青畢業生大多不願任職於政府補助機構、鄉村診療所以及上述之其他機構工作；而醫務衞生處能有足夠之人員任職於該等機構，全賴未能註冊醫生加入服務。

政府醫生之需求

在一九七三年醫務發展諮詢委員會發表了一份報告，其中涉及醫生供求情況部份曾作以下建議：「在未來十年內，僅以政府醫生而言，供求差額每年平均為四十名，除非在本港能獲得一個新的供應來源，否則這種情況到一九八三至九二年內仍將繼續，而且可能會更為嚴重。因此，本委員會建議考慮到一九八二至八三年時，應如何供應政府及私人兩方面每年所約需增加的醫生人數一百名」

政府醫生之需求

對於未來十年（一九八四）政府醫生供求情況之預測，在一九七四年所發表的醫服白皮書曾作出如下估計：

醫院	七四零名
門診	四四零名
行政工作及專科服務	一一六名
非留醫病床	四名
合計	一三零零名

而根據該項估計，則在今後十年內平均每年不足人數約三十名。

要達到每年多訓練一百名醫生，只有擴充港大醫學院或另設一新醫學院，然而港大醫學院現每年已招收學生一百五十名，要增至二百五十名實在太多了，所以白皮書建議在中大設立新醫學院，然而新醫學院畢業醫生距今還有一大段時間才可加入服務，要滿足目前需要實有賴新來源補充，而在港的非英聯醫生實為最快捷的補充辦法。

在港非英聯邦醫生資料

僑港中國醫科畢業同學會與社團診所主診人聯合會共計會員五百五十名，其中一四三人畢業於中國大陸四九年之前，三七五人畢業於中國大陸四九年之後，另外三十二人分別畢業於日本、德國、台灣等地。

香港非英聯邦醫科畢業同學會會員五百七十六名，除十六名外，全部會員均在中國大陸畢業，全部均在四九年之後畢業。

香港大學教職員中未能註冊醫生共二十一名。

服務於政府之未能註冊醫生為一三二名。

工作小組的建議

（甲）考試應包括以下三部分：

一、多項選擇性試題（筆試）以測驗應考者之專業知識（試題應有中文翻譯，應考者可選用中文或英文作答）。應考者於此項考試合格後，方可參加第二部考試。

二、簡單之英語筆試，以測驗應考者之英語寫作能力是否足以應付其專業需要。此項考試合格後，應考者方可參加口試。

三、口試：測驗應考者在實際臨床時應用其專業知識之能力。此項口試，可由應考者選擇用中文或英文舉行。

（乙）考試應由香港醫務委員會主辦。

POTENTIAL STAFF SHORTFALL—DOCTORS

Year	12 per cent Wastage	Forecast recruits	Net Staff	Forecast Need	Potential Shortfall	Increment
1972 ...	—	—	808	861	53	43
1973 ...	97	105	816	912	96	21
1974 ...	98	125	843	960	117	18
1975 ...	101	125	867	1,002	135	23
1976 ...	104	125	888	1,046	158	24
1977 ...	107	125	906	1,088	182	32
1978 ...	109	125	922	1,136	214	40
1979 ...	111	125	936	1,190	254	30
1980 ...	112	125	949	1,233	284	44
1981 ...	114	125	960	1,288	328	46
1982 ...	115	125	970	1,344	374	

書告報會員委詢諮展發療醫年三七自錄摘

An Interview with Professor Yau.

Editor's note: Professor Yau, Head of the Orthopaedic Surgery Department, is a member of the Working Party on Unregistrable Doctors. He has recently been appointed Head of the Board of Examiners.

The LMCHK Board has recently been set up and the Board of Examiners is one of the committee under it. A meeting of the Board of Examiners is expected to be held next January when further details concerning the examination for the unregistrable doctors in H.K. can be decided.

The first examination may possibly be in next summer. The examination will be specially designed for the situation in Hong Kong. Consideration will certainly be taken to the fact that a proportion of candidates may have had their medical training two or more decades ago and have not been practising medicine for quite a long time. The subject matters of the examination will be all round professional knowledge with emphasis on common conditions met with in practice in the colony. Subjects of paraclinical and preclinical interests may not be required to the same extent as clinical subjects. A syllabus will be helpful to candidates.

As recommended by the Working Party the examination will be in three parts: a written paper, an oral examination, and a paper on English.

(1) Written paper on prefessional knowledge:
This will be in the form of multiple choice questions. Questions on the same sort of examinations in other countries are being collected for reference so that questions suitable to Hong Kong can be set.

(2) An examination on English:
Professional English is required to ensure that candidates can later sign statutory forms, prescribe drugs, order laboratory investigations etc. The various organisations of unregistrable doctors have not objected to such an examination.

(3) Oral examination:
This is to test the ability to apply professional knowledge in discussions. Yet this is not a clinical examination with long cases or short cases as in the clinical examination of the final M.B.B.S.

Since it is an open examination, external examiners will be invited, possibly from Britain or nearby countries. This would ensure fairness of the examination and allow other countries to get a knowledge of the standard of the examination.

As to the eligibility, any residents of Hong Kong with good personality and can show satisfactorily that he/she has received five years full time course of medical training will be accepted. The credential committee is specially set up to check such eligibility and consists of both registrable and unregistrable doctors. It is understood that some graduates of medical college of mainland China might have lost the necessary certificates concerned but due regard would be given. At the same time penalty is liable on any forgery. For medical students of our University there does not seem to be any reasons against them taking this examination if they want to so long as they can be shown to satisfy the criteria for eligibility.

There have been thoughts on a refresher course for candidates before the examination. However, neither the number nor the standard of the candidates can be defined clearly. Besides, such a course will need the necessary facilities, teachers and inevitably finance. The money would be of an amount that both the government and the candidates might not be ready to pay. Perhaps after this first examination consideration may be different.

If a candidate passes the examination as a whole he is allowed to register as an extern and goes on to externship. If he fails in any or all parts, re-examination is allowed but the number of such re-examination may be restricted. The examination is expected to be held regularly until it is no longer required.

Externship under the guidance of a separate committee is a form of clinical attainment in the day time of successful candidates whereby supervision and assessment of clinical practice on medicine, surgery, obsteetrics and gynaecology may be done. Lectures during this period will help to bring up-to-date some of the professional knowledge. As to the duration, eighteen months are the proposed basic period and increase or reduction as recommended is possible, at the discretion of the Externship Committee.

If a successful candidate finishes the externship satisfactorily he is eligible for a licence and full registration with the H.K. Medical Council. The doctor would then have every right to practise without any restrictions.

one has to consider the duration and interests of work of the future licenced doctors. The majority of unregistrable doctors are now of the age 40 to 50. Their expected duration of work will apparently be much shorter than the newly graduated doctors from our medical school. Besides it would more likely be interests of our graduates to work, at least initially, in the public services and government training posts. With a view that graduates from the second medical school will not be ready to join the service until a number of years later, the licenced doctors in addition to our graduates will no doubt play significant role in safe-guarding health of the public.

僑港中國醫科同學會主席唐歐州博士訪問記

訪問・熊良儉

「編者：十二月八日午間，啓思訪問了唐博士，請他對最近提出的未能註冊醫生的考試辦法提出意見。雖然是匆匆的在電話上的訪問，但包括了不少有價值的資料和意見。」

事情的發展

唐博士表示香港近二十年來都存在着醫生不足的問題。雖然香港大學醫學院從每年訓練七十多名醫生增至一百五十多人，但由於人口的不斷增加，加上醫療服務的日趨複雜化，醫生不足的情況不但沒有改善，而且是較前為嚴重。

政府的設施

一九五八至六零年間港府邀請倫敦藥物委員會在港主持一次考試，原意是透過是次考試甄選合資格的醫生在港服務。但鑑於專業團體的反對（中華醫學會——即現今的香港醫學會，和英國醫學會香港分會），只得限制應考者的資格為十三間中國醫學院在一九五六年前畢業的學生。是次考試有百多人合格。但自此沒有舉行過類似的考試。

一九六四年前醫務總監麥建時（譯音）在卸任前極力提出並實行診療所登記條例，規定所有未能註冊醫生一律要經過考試。考試合格的醫生可以在港執業，但不是註冊，因此只可以在社團診所服務（是所謂社團醫生）。這一次應考者有八百多人，合格的佔百份之六十。自此以後，十年來再沒有其他公開考試。

目前的情形

唐博士表示目前每天約有二萬名病人到社團診所求醫，可以見得社團醫生實在負起香港醫療服務很大的責任。

唐博士表示在香港服務的未能註冊醫生有三類人：

一、在香港大學醫學院任教職的（約二十人）

二、在政府醫療機構服務的，

三、社團醫生（約有二百九十人）

這些人都是服務了十年以上的，他們都有足夠的資歷。加上他們本身已有固定工作，所以問題焦點不在他們身上。問題的中心是近兩年來從國內到港的醫務工作者。這批人當中受過傳統的五年醫學院訓練的有差不多八百人。他們很多都做着和所學的絕不相同的工作。最近提出的考試甄選制度是對這些人影响最大。

未能註冊醫生研究委員會報告書內的建議

唐博士認為這個研究委員會的設立反映着政府開放非英聯邦醫生在香港服務的誠意。但報告書中所建議的考試有值得商確的地方。

他認為對那些在醫學院任教職的實在不公平。原因是他們可以教授醫學生，本身的學歷肯定已有一定成就。況且受僱時也曾經過甄選。那些在政府機構或慈善機構所辦的醫院內服務的醫去已經服務了多年，加上受僱時同樣經過考試，他們實在沒有必要再接受考試。至於那些社團醫生，他們都是經過一九六四年的考試合格後才獲准執業的，而且服務了十年、從沒有犯任何錯誤，每天照顧着二萬病人，他們是有理由不用考試的。推論現在下來需要考試的便是那些最近才到港的國內醫科畢業生。他們很多的資歷很好，考試可以確定他們的資歷，使他們得以在香港服務。

問題的結徵

從上面的一些討論，可以發覺香港很多現正在服務中的未能註冊醫生有足夠的資歷，他們的被承認是無可懷疑的（事實上他們一直以來都在服務中）。為什麼遲遲未能獲得合理看待？唐博士認為這是這是香的專業團體為維護自己利益所制造的阻力。長久以來這些團體以由英國系統訓練出來的醫生壟斷着醫療界，所以整整的二十多年來除了上述的兩次「破例」的公開考試外，再沒有其他公開考試。（微妙得很，政府機構和慈善團體卻僱用着不少非英聯邦國家訓練的醫生。）

目前各界的反應

唐博士透露僑港中國醫科同學會會向港督提出他們的理由，而要求免除那些在香港服務多年的未能註冊醫生（上述之三類人）的考試。不少的團體（約一百五十個）亦表示支持他們，而且那些正在政府機構任職的亦向醫務衛生署提出理由，要求免考。

解剖系一講師

贊成給予非英聯邦醫生執業機會。

在美國有 ECFMG 的試給外來醫生，如合格及經訓練後可成註冊醫生，在英國亦有同樣制度。香港又缺乏醫生，而最近廿年來，有很多外地，尤是大陸的醫生移居本地，所以應該讓他們有機會註冊。

至於考試包括英文科，在香港亦不太過，因為香港現在仍應用英文以處理藥物，不過要看考至甚麼程度，如太深奧，便不適當。名詞翻譯大多一樣，因為標準譯法，所以名詞方面，應不會引起含糊。

如考試合格後，應該可以在所有英聯邦國家執業，如只可在香港掛牌，便不應以英國的考試為標準。

十八個月的實習應該要短點，因很多醫生都曾在醫院，診所做過，訓練時間應依他們的經驗和學歷而定。至於在大學任教的講師，如果認為臨床訓練不足，可供一段時期的臨床實習，而免除考試。

大學的教員未必每個人考試合格後便會掛牌；有些人仍有興趣教書的。不過也有些不滿自己現有的地位，而香港的醫生又容易賺錢，這樣當然會影響到講師人數，不過最嚴重的還是當他們預備考試時，為了花時間去讀書而影響備課時間。

本人將不會參加考試，教了這麼多年書，亦無謂轉行啦！

蘇寬宏醫生（病理系）

在政府診所、社區及醫學院內的非英聯邦醫生，只要他們是醫科畢業，經當地政府承認，在香港應可註冊而不須考試。

本人將考慮參加今次的考試，一方面可以有保障，另一方面退休後亦可以行醫，目前並不打算離開現有工作崗位，相信今次的考試將不會影響到醫學院做成人才損失。

潘家琳醫生

為着要給非英聯邦醫生一個在港合法執業的機會，考試甄別是無可避免的一種做法，因為到現時為止考試制度仍然是甄別學識的一個有效方法，至於這個考試應該怎樣執行，就要詳加考慮。

首先，在一九六四年考試合格的非英聯邦醫生，應該無須再參加這次考試而直接准予註冊，同時又由於今次考試是有英聯邦著名教授參與，水準將會甚高，所以考試合格後應給予在其他英聯邦地區行醫的機會。

十八個月的日間實習有減短的必要，因為有很多未註冊醫生都會任職於診所，又怎能說他們經驗不足呢？同時亦應考慮到這些醫生的家庭及經濟能力。

在醫學院任職的非英聯邦醫生相信大部份都不會再參加考試，所以多數不會影響到醫學院的教學質素，但應給予他們名譽註冊，不須筆試，而以要實習一段時期便准予註冊。

本人將會參加該項考試。

王紀慶醫生（生理系）

任何政府都會保護自己訓練出來的專業人員，所以純站在商業的立場上來看，餘港政府是不應准許非英聯邦醫生註冊的。然而醫生並不是一個純商業性的職業，它是有服務性的，故此政府應給這些有志服務的人士正式執業的機會，不過一定要有嚴格的標準，而考試就是唯一鑑定標準的方法。

一九六四年政府曾面試過一些醫生，但這個並不是嚴格和詳盡的考試，所以那些正在慈善診所工作的醫生都應參加正式考試，同時為公平起見，就算是那些在大學裏任教的講師都應參加考試。

十八個月的實習期是太長了。一個受過正式醫學訓練的人，臨床經驗應該是足夠的，況且很多非英聯邦醫生現在都是在診所裏工作的，難道還不能應付工作嗎？

這個甄別非英聯邦醫生的制度，應該是一個長期性設施，而且不應限制投考人數和次數。

本人可能參加這個考試，但不會因預備考試而影響教學質素，而就算考試合格，可以正式執業，亦可能繼續教學。

同學意見

（一）是否贊成給予非英聯邦醫生執業註冊的機會：

原則上贊成給與非英聯邦醫生註冊機會的主要理由是：

△香港一向都缺乏醫生。

△可以增加香港私家醫生的數量，在供過於求的情況下，可改善私家醫生對病人「搶錢」的態度。

反對的同學提出的理由是：

△目前並非適當時候，因香港現時經濟不景，每年用五百多萬來支持他們實習的薪水實是個問題。更急需的是去改善香港醫療服務，如建築醫院等。

△由於政府醫院不能提供足夠的職位，他們給予註冊後大多會掛牌開診所。對香港私家醫生不平均分佈情形，未會改善。

（二）用考試作甄別是否公平及它的內容是否適當？

△考試制度一定需要，此是甄別他們資歷的最好方法，可確實應考者曾接受正規醫學訓練。

△形式亦應與港大醫學院畢業試相仿。

△至於在社團診所及在醫學院任職的非英聯邦醫生亦應同等看待，因為在醫學院任職的講師可能過於注重科學性研究工作，而將醫學知識掉下過久，所以實需一個考試作測驗其行醫能力。

△考試制度也公平，而且「肥佬」後可補考，頗算週詳。

（三）對十八個月的「日班見習」之意見。

△贊成，因為由大陸來的非英聯邦醫生可能有很久沒有行醫，為了保障病人，實習是必需的。

△贊成，因為可以提高非英聯邦醫生的水準。

△贊習是必需的。而且現時在社團診所服務的醫生亦應接受，因為診所與醫院的病例分別很大。

△十八個月的 Extern，計起來和十二個月的 Intern 差不多，因此時間亦頗合理。

△十八個月不算太長，因為醫生一定要有臨床經驗。

△贊成，不過要視乎現時醫院的設備能否供應。

△贊成，因為有些新發明是他們在求學時沒有學到的，在實習時可以補學。

△贊成，如果他們希望以後行醫，應不會對此不滿。

（四）對醫學院教育質素的影響。

△講師預備考試時，些微影響當然會有，但並不嚴重。因為相信大部份都不會考。

△影響不大，如果他們考取了，或可以證明這些教授是有眞材實料的。

△影響不會大，就以 PRE-CLINICAL 來講，他們若考取了，請回來的教授可能會更好。

△辭職亦不成問題，其他來源的講師亦可以很好，這要看負責取錄的人的決定。

（五）香港醫生人數會否過剩。

△現時給予他們註冊，時間上不適當，因為政府正在鬧窮，很多港大畢業生也不能在政府醫院服務，如果每年多了二百多位見習醫生，更會減少了空缺。

△歐美畢業的香港學生，可能會回港執業。

△其實不用害怕以後會有太多外來醫生。因為歐美各地的醫學院，近年來已很少接納香港的學生。而目前的非聯邦醫生，主要是一九四九年後由中國大陸來的。

△第二間醫學院快要成立了，可能使醫生人數過多。

△醫生人數會大增，而政府醫院不夠容納，所以很多會掛牌。

△醫生人數多，政府要安排職位給他們。

△會防止人才外流，過去很多不能在港註冊的醫生，去了歐美各地，事實證明他們的醫術是很高明的。

（六）對同學求學態度之影響。

△同學們競爭性必會增加，學生會更博命，甚至會演變成為勾心鬥角。

△影響不會大，低年班同學不會這樣快想到競爭方面，或者高年班同學會較為關切。

△應該不會，同學們應保持認眞態度，不應受競爭或其他因素影響而加强學習。

△同學們會更努力充實本身知識。

（七）對醫療服務的影響。

△醫生分佈情形可能更不平均，目前很多在新區診所和新界地區服務的非英聯邦醫生，可能回到市區服務。

△醫生多了，對貧苦大衆沒有多大好處。如果政府一日不改善醫療服務和增加政府醫生人數，就算多幾百個私家醫生，貧苦大衆也沒有足夠能力請他們醫治。

△一旦私家醫生多了，他們為了爭取病人，違反醫德的情形可能增加，因而影響到現有的醫療服務水平。

△現時很多在港的非英聯邦醫生都是上了年紀的，他們所學的都是很舊的了，所以知識不能交流，對提高服務水平沒多大幫助。

△有了競爭，一些掛牌醫生便不能收那麼貴，服務水準也會提高。

△合格後便應該要規定他們在政府診所服務一段時間後才准出外行醫，此所謂「取之於民，還之於民。」

△受訓醫生應該對當地病人負責。最好是在那裏畢業，就在那裏行醫。這樣，對於醫療發展，訓練醫生的數量才能有更好的估量和計劃。

Meaning of Life

Editor's note:

This article was contributed by a psychiatrist. At first sight, you may think of it too long and boring. Heretoreassure you that it is the most entertaining and refreshing article that you have ever read. Go ahead and read it, the meaning of life is just before you!

A common complaint of patients today is that their lives are meaningless. "They lack the awareness of a meaning worth living for. They are haunted by the experience of their inner emptiness, a void within themselves; they are caught in that situation which I have called the **'existential vacuum'"** (Viktor E. Frankl: Man's search for meaning, 1963). Frankl explains it as follows: with no instincts to guide his behavior, and with the disappearance of traditions to guide his choices, but with the necessity of making choices, man doesn't know what to do or what he wants to do. "This existential vacuum manifests itself mainly in a state of boredom." The model of existential neurosis is also supported by S.R. Maddi (Journal of Abnormal Psychology, 1967, 72: 311-315) and E.K. Ledermann (Existential Neurosis, 1972). One manifestation is the "Sunday neurosis," which is "that kind of depression which afflicts people who become aware of the lack of content of their lives when the rush of the busy week is over and the void within themselves become manifest." (C.H. Patterson: Theories of Counselling and Psychotherapy, 1966) There are also certain periods during the course of life where the quest for meaning comes to the foreground. One, for instance, is the climacterium in women, when one's task, the bearing and rearing of children, is usually accomplished, and the search for another purpose may leave lift temporarily meaningless. (C. Buhler and F. Mssarik: The Course of Human Life, 1968).

Among the youth here, after a 'joyous' weekend, they will suddenly feel that an overwhelming impulse is pushing them and they need to plan for another 'joyous' weekend in the coming days. On Monday, they have already started to look forward to the coming of Saturday. On Saturday, they find that their mind has been rejecting the reappearance of Monday. All their lives are but a chain of weekends and holidays of pleasure, only to be punctuated by weekdays. All they ask for is the escape from dryness and monotony, release of anxiety, freedom to choose, and evidence of own existence.

Many people could say out of their own inner experience the prophetic words T.S. Eliot wrote in 1925:

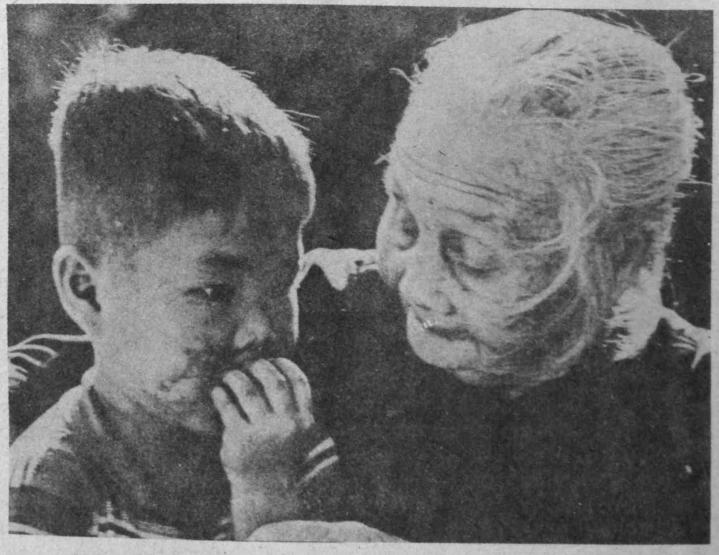
"We are the hollow men
We are the stuffed men
Leaning together
Headpiece filled with straw. Alas!

Shape without form, shape without colour,
Paralyzed force, gesture without motion;. . . . . "

More so, we can see how the character in Alexei Tolstoy's "Memoirs of a Medman" thought and sobbed:

"What is life for? To die? To kill myself at once? No, I am afraid. To wait for death till it comes? I fear that even more. Then I must live. But what for? In order to die? And I could not escape from that circle. I took up the book, read, and forgot myself for a moment, but then again, the same question and the same horror. I lay down and closed my eyes. It was worst still."

The meaning of life differs from man to man, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but the specific meaning of a person's life at a given moment (Viktor E. Frankl: Man's search for meaning 1963). One should search for his meaning of life at various moments, to revise it or to strengthen it. He should remember that everybody is born onto earth for a role to play or a mission to fulfil. This vocation could have been ordinary, but it must be unique for each particular individual concerned. Even a stillborn baby can be as "meaningful" and important as a president of a country, depending upon the group of people he may affect. This baby, though born dead, has nevertheless been spared from this evilish world. Anyhow, he has given his pregnant mother and his expectant father months of joy; in that way, he has imparted a new meaning of life to them by a presumed new life, however short it may be.



Life ceases to have a meaning when the person denies his particular assignment in the world. By the same token, life can have a meaning only if he accepts his living conditions, his existence, and last but not the least, his suffering. Every evidenced or his existence or every piece of his suffering must carry a meaning. "The meaning of suffering lay precisely in the fact that they were triumphant, as men, over their illness long before that illness was victorious over their bodies! An aunt with an inoperable cancer, but also with an incurable sense of humor, wrote me that people came from all over Indiana to comfort her in her last days. "But several times," she wrote, "the room was filled with mournful and weeping people whom I had to cheer up!"" (A.J. Ungersma: The Search for Meaning 1961).

有朋自遠方來

誼

「媽的！怎麼開來像蟻一樣？」我心中不禁暗咒罵，看看時間，九時三十分，唉，起碼過了一半。

「唏！落車呀」我半粗暴地推開塞在車門的幾個人。

再看一看錶，嘩！乖乖不得了，九時三十五分，不顧一切，由車站直衝落沙宣道，來到圖書館門前已上氣不接下氣，「眞水皮，以後必要做多點運動」心內一面滴咕嚕，然而腳步並不慢下來。

一、二、三，衝上電視房，未到門前，耳畔已飄來陣陣悅耳的鋼琴聲，立即幾個箭步衝前，拉開房門，迎眼的就是七、八個背影，正在聚精會神注視著前方的螢光幕，幕前播送的就是今次我急不及待趕回來聆聽的上海管弦樂團演奏會。

隨便找來一張椅子坐下，耳畔便响起熟悉的保衛黃河前奏曲，這首曲實在太熟悉了，每晚臨睡前總會聽一次，而每次都有一種新的感受。

螢光幕正集中在鋼琴師的手指上，靈活、輕快、有勁，指頭飛快地在琴鍵上跳躍，啊！實在太快了。看看他的臉孔，他的表情已說明他。已將生命注入了曲調中。

風在吼，
馬在叫，
黃河在咆哮，
……

陶醉在樂聲中，我不禁在心內隨著曲子而唱起來，雖然未經歷過戰火的洗禮，然而日軍當年侵畧我國的慘烈激況彷彿就在眼前出現一樣……

保衛家鄉！
保衛黃河！
保衛華北！
保衛全中國！

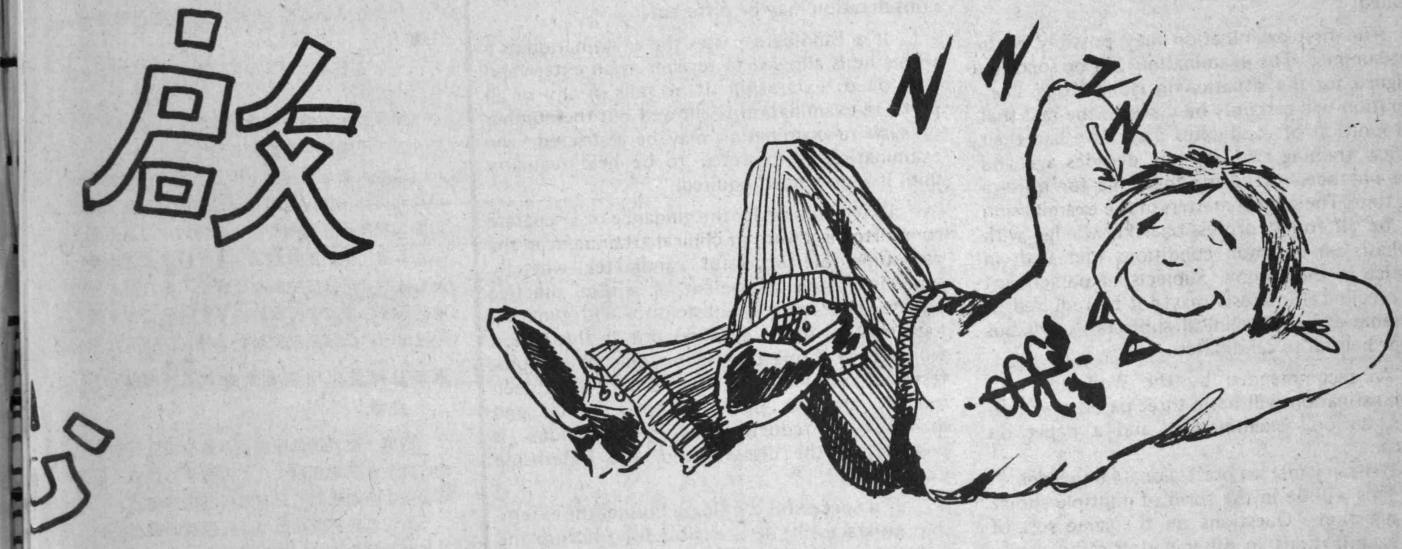
一曲既終，台下掌聲轟然雷動，琴手謝幕多次始告雛場，可見知音客實不少，很可惜，我們的電視機實在年事已高，不單畫面變形，音响亦受嚴重影响，所以整首曲聽來總覺不上不下，音帶來得悅耳，氣氛的營造亦未足夠，同時畧嫌稍為恁弱一點，另外模仿的風聲又沙啞，簡直慘不忍聽，於此奉勸醫學會考慮添置新電視機。

隨著演奏的是白毛女揷曲，水準相當高，我最喜歡結尾的一段，很美，但絕對不是濃裝艷抹。

該團演奏的一個最大特色就是中國樂器和西洋樂器一起運用，所以很能表現到中國音樂的特色，未知聽慣純西洋音樂的朋友又怎樣看法呢？

今次是國內大型樂團的首次來港演出，相信知音者對國內的音樂水平已經有一定認識了，然而最重要

的還是聆聽的一分精神。



集思

聽蔡元雪醫生後有感

友

十一月廿日晚上，聯誼會舉辦了一會座談會，邀請講者為有名的怪論專家三蘇先生和突破編輯蔡元雪醫生兩位，是晚座無虛席，其熱鬧可想而知，筆者無幸，未能趕及準時入席，錯過三蘇先生的演講，猶幸仍有機會恭聽蔡醫生一夕肺腑之言，於此亦有意和蔡醫生討論一下為醫之道，惟都只是井蛙之言，望有識之士，不吝賜教。

為方便當晚未能出席的有關人仕（此典型官方口語），於此簡述蔡醫生演說內容要點：

蔡醫生認為照顧一個病人應該可分為三個層面：

一、肉體上（Physical）——此為最基本的層面，內容包括病理，病源，病歷等技術性的照顧。

二、心理上（Psychological）——心理對病人的影响至為重要，一個醫生要清楚瞭解病人的心理狀態（譬如恐懼死亡，孤寂等）而加以開導，才能使治療達到效果。

三、靈性上（Spiritual）——未知是蔡醫生沒充份發揮，抑是筆者耳拙，到現在仍未掌握到此點之精髓，據理解，大意為病人在病床上往往會思考到一些人生的問題，而醫生應該去試圖和病者一同去溝通這些靈性的問題。

以上所簡述的三點均為筆者憑記憶寫出來，如有誤引蔡醫生演說者，謹此致歉。查蔡醫生所說者，筆者亦前有所聞，然從未有過如醫生能深入淺出，以輕鬆幽默字句將其帶出者，是故當晚掌聲之熱烈，實曠古絕今，而筆者雖未言之於口，內心實亦狂叫「安哥」不已。

未知是否當日演講室空氣混濁，令人頭腦不清，散會後，在沙宣道上漫步，經清風拂面後，回味醫生所言與自己臨床體驗一比較，不禁長歎三聲，頹然而廢。

小兄弟們或者未有臨床經驗，然而總看過醫生吧，筆者並非大富大貴，未有機會看過一百幾十元診費的大國手，所知道的診所醫生，無時無日其候診室不高懸滿座牌的，少說平均每日診症八十人，如以每日工作八小時計算，每一個病人平均有幾分鐘時間，筆者就從未見過醫生試圖去瞭解病人的家庭、事業或婚姻狀況，然而並非這些醫生故意忽視，實在因為在幾分鐘內根本沒可能兼顧如此多問題，在病人方面亦已經因為輪候太久，只求一針見效，從此無病無痛便已經心滿意足矣。

說到公立醫院方面（私家醫院筆者並不清楚），醫生和病人的比例實在小得可憐，就以依利沙伯醫院為例，內科病房輪次 On call，每次 Call day 完了之後，整間病房就好像戰時的軍醫院，帆布床遍地皆是，簡直連通道都沒有，病人則乖乖地在床上呻吟，可憐的實習醫生則滿頭大汗地診視絡繹不絕地送入來的病人，我無意在這裏誇大其詞，事實上只能自嘆筆拙，因為恐怕還未能描繪出其擁擁和混亂情況的十分一呢！

筆者一直以來都極喜歡看醫生電視片集，甚麼嘉能醫生，韋比醫生，占美遜醫生等都有收看，而亦很欣賞他們行醫的態度，尤其嘉能醫生，以其英俊瀟洒，醫術高明

零碎的回憶 完整的異象

四年級一同學

【註：在本年十一月五日至九日，在星架坡舉行了第五屆國際「基督徒醫生會議」，主題是「Christian Partnership in health Care」同時間內，亦舉行第一屆的「亞非基督徒醫學生會議」，主題是「Christian Medical students in the changing world」。本文不是一個記錄，只是一連串漫散的回憶。】

等候了很久的兩個星架坡醫學生，示意給機場的檢查員，「他們是參加亞非基督徒醫學生會議的。」於是我們拿着行李順利步出機場，和風迎上我們充滿期望的一班人。

× × ×

忙着為我們登記，分配參考資料的，張張都是笑臉。

「怎麼，你們正在放假？剛考完 First Prof. Exam.?」操着生硬的英語，香港口音他們一聽便知。

「噢，原來你懂廣東話。是客家人還是福建人？」

面對一班主內的星架坡弟兄姊妹，又是醫學生，眞是巴不得坐下來談個暢快。還有來自澳洲、紐西蘭、肯雅、泰國、馬來西亞、印尼、菲律賓、日本、韓國的。唔，這七日眞夠瞧。

× × ×

捉着我們心神的，不是星架坡清新寬濶的馬路，有條理的城市設計，不是聖淘沙島的南洋風光，更不是大會堂豪華莊嚴的會議開幕儀式，而是那些款款深談，晚上的祈禱會，研經會，就是這樣，三天的 Pre-Conference 便溶化在縱橫交錯的友誼裏。

× × ×

「Impact of Medical Proceress on Medical Ethics」——是第一個圓桌會議的主題，其中「墮胎」這個問題討論得最激烈。我們這一羣毫無經驗的，只有聽的份兒。有人提出在醫學道德上有很多沒有肯定答案的問題，墮胎便是其中之一，它是一個「Necessary Evil」，我們一方面積極反對毀滅生命，但另一方面，墮胎可能是一件好事。墮胎的後面可能隱藏着破裂的人際關係，而身為醫生的基督徒更應該針對這人際關係。

× × ×

「Christianity is Not Transmissible by Argument, But by Demonstration」——這是閒談時，有名的 Dr. Denis Burkitt 說的一句話。雖然已是六、七十歲的年紀，還是那麼有活力和風趣。謙虛，愛主之情洋溢在他的主語，談笑之間。

× × ×

溫文，安詳，蓋不住底下一股傳道醫生的幹勁，Drs. John & Ann Townsend, 談及早在大學時已定的意向，和在泰國的工作經驗，也談到一般醫生常遇到的問題，就是時間和對家庭的責任。

「Behind a great man is a great woman,」

「Behind a great woman is an Understanding husband.」

這樣好的配搭，難怪他們在這忙碌的生活中，仍能時常喜樂！

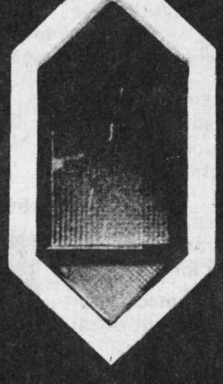
× × ×

是令外一個的圓桌會議，主題是「Health and Educational Problems of Medical Students」，剛輪到發問最後一條問題的時間——站起身的原來是肯雅的那位同學。「在我的國家裏，找不到一個熱心的基督徒醫生，事業成功後他們便逐一消聲匿跡。為什麼你們「指四個講員」到這把年紀，還能保持信仰，並且在這裏將經驗傳給我們呢？」

答這個問題的醫生說他心碎，在座的每一個人也被提出的事實打動得沉默起來。

× × ×

「我們都說在這次會議裏學了很多東西，但不要只是感情上一時的激動，因為每一個人都要把他得到的異像和使命帶回自己的地方，繼續會議的精神」——亞洲基督教學生會議主席。



啓思

括筆者在內），很不幸地，某日筆者心血來潮，屈指一算，這位醫生不可，天呀！香港全部醫得能夠照顧三幾個病人，引伸起來，香港豈非有百萬個醫生人喫「醫生」加埋亦不超過五千人，莫說百萬，就是一萬亦只是夢話而已。

話題似乎扯遠了，不過我相信大部份的醫生都是希望能夠全面地去照顧自己的病人，然而為甚麼醫生們（尤其是政府醫生）往往得到這麼多不滿的投訴呢；答案很簡單，大家只要花一個上午，到各個政府門診部看一看，和排隊輪候的病者談一談，便會很清楚。

大部份的同學在畢業後都會有一股為社會服務的熱誠，不過在經過幾年工作重担的煎熬後，當初的那一份熱誠自然會冷卻下來，這種情況亦出現在其他醫務人員身上，香港的醫務就是在這個惡性循環下掙扎，而病人就往往成為犧牲者。

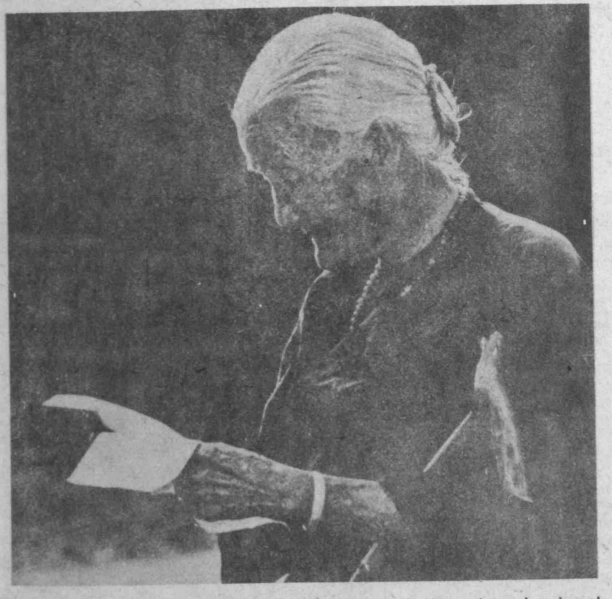
我無意貶低蔡醫生的論調，不過在香港的目前情況，似乎有點像在閒處於饑餓邊緣的比亞法拉人民為甚麼不用上湯來煲魚翅，可能殘酷點，不過這就是現實。

然而大家並不要洩氣，謹此寄語所有未來「嘉能醫生」，你們的理想是完全正確，認清現實的環境，正正就是幫助認識問題的本質，從而將腐敗的雜草連根拔除，好使新的幼苗能夠茁壯成長，只有這樣我們的理想才有根，才會堅固，否則只有埋沒在污泥裏，最後亦卒腐爛而湮滅。

It has been said with much wisdom that we cannot understand life nor its meaning unless we really face the fact of death (Britton: Philosophy and Meaning of Life, 1969). In the same breath, we will not appreciate the importance or beauty of an object or person until we are sure to lose it. As a consequence, at times when we think that our lives are barren or monotonous, then imagine that you have to die tomorrow, and see what you wish accomplish before your farewell. More than occasionally, you will find a thing to do that worths your living on.

Patients often assert that the meaning of life is pleasure, "that all human activity is governed by the striving for happiness, that all psychic processes are determined exclusively by the pleasure principle .... Now, to our mind the pleasure principle is an artificial creation of psychology. Pleasure is not the goal of, our aspiration, but the consequence of attaining them." Pleasure cannot give meaning to life. If pleasure were the source of meaning, life would have little to offer, since unpleasant sensations outnumber pleasant sensations in life. "In reality, life is little concerned with pleasure or unpleasure..... Life teaches people that **'we are not here to enjoy oursleves. And those who are bent on the search for pleasure and happiness fail to find them, because of their concentration upon them.** (C.H. Patterson: Theories of Counselling and Psychotherapy, 1966)

The people who can grasp or will make most effort to search for the meaning of their life are most probably, in my opinion, those who have lost or failed most of the time or those who have been all but stripped to more or naked existence. It is only these people that can understand deeply what life actually means and what their original naked self is. For those who have nothing more to lose except their ridiculously bare life, whatever they gain must be precious. Whatever be seized will not be possessed without a hard struggle, nor will this is grabbed to their selves without much resolution. Their environment has served to discriminate those meaningful things from those not. What is of no import cannot stay long to act as a driving force to toil their life on and on till the last flicker of LIFE goes out. What springs or adds to them must be LIFE, life in its own sense. It thus follows that, until you are ready to lose, you will not gain, a new life or a new meaning of life. The best and most vital meaning of life, as long as your heart still beats, albeit slowly, is that which remains the last after every other possession is lost, every other value destroyed, and extermination expected every minute. Yes, indeed, you have to die to live again, perhaps for a better life.



For those whose lives are thought to be shattered to slender threads life could have been meaningless. A question put to them, "Why do you not commit suicide?" (Viktor E. Frankl: Man's search for meaning, 1963) can often start the broken-down engine again and light up the thread in a pat of wax for a long, much much longer, time. Indeed, the only reason a person desires to linger on is in most instances the best reason he should beautify his life. If it were a girl, go and fetch her. Should the need to accomplish some objects be incriminated, ask him to finish them before he is justified to leave. Once and again time will prove that he will be much happier if he goes on like this, or, less fortunately, his responsibilities will drive the person on without permitting him a moment of standstill for him to fall into the valley of depression.

Another way of tackling with a person who claims to lose his meaning of life is to convince him that he is precisely the meaning of another man's or woman's life and the latter's life would in turn follow the sole existence of the former. Alternatively, you might be able to to creep into the core of another's heart and give meaning to his or her life.

One of the best meanings of life is trial to give and take love. My point of view is that love can, as far it goes, remove the existential frustration – despair over a meaningless life, and a lack of knowledge of what makes life worth living. If a lonely person, feeling unloved and unwanted, is led to recall that he has experienced love – even if only once – no additional unhappy experience can obviate the fact or annihilate it. (A.J. Ungersma: The Search for Meaning, 1961) True, as long as one has really or has been loved truly once, one's life has been complete, as commented by a Chinese writer (Y. Chu: The Black Sum, 1967). The inerasable memory of true love will be enough to induse a person to pursue after another experience in life or to make him regret if he is not able to meet it.

As much as love, hope can lighten the road of life. In 'Le mythe de Sisyphe' (The Mythe of Sisyphe) by A. Camus, Sisyphe was punished by God to roll a huge rock up a mountain. Whenever he had succeeded with great efforts to roll it up to the top of the mountain and prepared to take a rest with joy, the rock started to roll downhills back to the starting-point. He had to push it up once and again, only to be followed instantly by the fall of the rock each time. With this continuous failure and endless torture, Sisyphe was neither annoyed nor frustrated. He might have been disappointed, but the appearance of hope on moving the rock uphills had backed him up every time. And he would not give himself to the hard fate. So, we must imagine that Sisyphe was happy. The efforts of struggling his way up the hill were enough to strengthen and fill his heart.

"Love is only one of the possible ways to fill life with meaning, and is not even the best way. Our existence would have come to a sad pass and our lives would be poor indeed if their meaning depended upon whether or not we experienced happiness in love..... The individual who neither loves nor is loved can still shape his life in a hightly meaningful manner." 'Frankl, V.E., The doctor and the soul. 1955)

Yes, a man should so live that at the close of every day he can repeat; "I have not wasted my day." (The Zohar, circal 190) For everyday well spent, he has added a meaningful day into his life. Every yesterday is the past of today and every tomorrow is a continuity of the well spent today. He has proved himself to be a useful person and he knows jolly well that he is needed by society as he has been constructing all the time.

Not infrequently I has been asked back whether I do have a meaning in my life, my answer is often in the negative, for this is not a question-answer matter or yes-or-no business, nor can this be said in a few words. When I say I cannot answer it, it does not follow that I do not have a meaning in my life. Rather I do not know it NOW. In point of fact, the doubt of the meaningfulness of one's life many a times leads to the need of exploration, and the growth in own belief is further strengthened by its antithesis. And this is where I AM NOW. My need for a meaning in my life will eventually, I believe, help to create one in my life!

Postscrift

The manuscript was written some years ago when I was (and I am) being perplexed with the meaning and truth of life.

I am looking back upon my past few years and I am taken by surprise (and no less joy) that I HAD "more" meaning of life than I have now! I do not think this is all of this. I do believe one day I will be rewarded with what I have been searching for; then I will write to you again.

WHO NEWS RELEASE

Issued by the Information Unit
World Health Organization
Regional Office for the Western Pacific
P. O. Box 2932 Manila (Tel. 59-20-41)
Cable Address: UNISANTE, MANILA

PREVENTION IS MOST IMPORTANT IN CANCER CONTROL

About 75 per cent of cancer cases are related to environmental factors and a group of cancer experts called urgently for intensifying research to find the cancer-producing agents or substances in the environment and thereafter avoid them.

The experts emphasized the need for intensive epidemiological enquiry on the causes of cancer and for setting up nation-wide cancer registry in the Western Pacific Region. The experts also agreed that anti-smoking campaigns are priority measures in cancer prevention.

In addition to cigarette smoking, other habits considered cancer risks were chewing of betel nut, lime and tobacco and excessive exposure to sunlight.

Aflatoxin was considered particularly important. The fungus which produces the poison is prone to grow in peanuts and cereals stored in humid conditions and improvement of storage conditions was recommended.

Other substances suspected to cause cancer included high fat diets, low fibre diets, high salt diets, air pollutants, etc.

75% of Cancer Preventable

It was estimated that about 75 per cent of cancer in man may prove to be preventable and prevention of this disease could be essentially carried out by (1) avoiding exposure to the causative agents, (2) protection against the action of these cancer-producing agents.

Early detection is Feasible and Effective

Early detection programmes consist of identifying pre-clinical cancer cases by means of various tests or procedures and its adequate treatment. Over 50 per cent of cancer patients can be cured of the diseases, if found in its early stage and if prompt and proper treatment is given.

However, it would be futile to advocate early detection of cancer cases unless proper facilities for treatment are available to everyone diagnosed anywhere in the country.

Size and Nature of the Problem

The cancer experts were convened by WHO as a working group on the organization of comprehensive cancer control programmes which met in Manila from 22 to 29 October. They came from Australia, China, Fiji, Japan, Malaysia, New Zealand, Papua New Guinea, Philippines, Republic of Korea and Singapore. As reported by experts, the pattern of cancer in these countries appear to be as follows:

Australia: Incidence of lung cancer has increased in recent years, in both males and females; the increase was more marked in migrants from the United Kingdom. Incidence of skin cancer is exceptionally high.

China: Epidemiological studies have shown geographical variation in cancer pattern. Incidence of oesophagus cancer is remarkably high in areas of North China, particularly in Linhsien county of Hunan province; incidence rates are highest in counties and cities in the southern part of Taihang mountain range. High incidence of nasopharyngeal cancer is also reported in Kwangtung province in southern China.

Fiji: Common sites of cancer in Fijians are the stomach and lung in males and cervix and breast in females. Oral cancer occurs more frequently in Indians.

Japan: Outstanding feature of cancer pattern is the exceptionally high incidence of cancer in the stomach. In females there is a high incidence of cancer of the cervix and relatively low incidence of breast cancer.

Malaysia: Efforts are going on to introduce a cancer registration scheme.

Philippines: In males, the most common cancers are those arising in the lung, liver, nasopharynx, stomach and lymphoid tissue. In females, the common cancer sites are breast, cervix, thyroid, ovary and uterus.

New Zealand: Cancer is the second ranking cause of death. The common sites of cancer are lung, colon, prostate, stomach and rectum in males and breast, colon, uterus, ovary and cervix in females. The cancer pattern among Maoris (Polynesian population in New Zealand) resemble that in Caucasians but Maori women have an exceptionally high incidence of lung cancer.

Papua New Guinea: Common cancers in males are those arising in the mouth (associated with the betel-nut/lime chewing habit), liver and skin, mainly associated with chronic tropical ulcers. The most common in females are those arising in the cervix, breast and skin. The incidence, as a whole, appears to be low but there is a possibility of under-reporting.

Republic of Korea: The most common sites are in the stomach, lymphoma, liver, large intestine, lung and larynx in male and cervix, stomach, breast, large intestine in females. High incidence of stomach cancer is suspected to be due to carcinogen in the environment. One of the features of cancer pattern in childhood is the relatively high frequency of acute leukemia. The most common cancer among children are acute leukemia, lymphoma, retinoblastoma, neuroblastoma, Wilms tumour and osteogenic sarcoma. By hospital statistics, cancer is second ranking cause of death.

Singapore: The most common cancer sites are lung, stomach, liver, nasopharynx and oesophagus in males and in the breast, cervix, stomach, lung and colon in females. There were significant differences among the major ethnic groups. Chinese communities or specific dialect groups also showed interesting differences in the cancer pattern. The Chinese have a higher incidence of cancer of the lungs, nasopharynx, liver, stomach and oesophagus. The Indians have a higher incidence of cancer of the tongue, mouth and hypopharynx. The incidence of cancer of the nasopharynx and liver among Malays is intermediate between those among the Chinese and Indians.

Importance of Cancer Registries

Registries of cancer are important instrument in cancer control. The data from such registries may be used to assess demands on medical resources and to determine priorities for research as well as the efficacy of the various forms of treatment.

Among others, the working group recommended continuing WHO assistance in the methods of collecting cancer data and the provision of WHO technical expertise and training programmes on cancer registration.

Congratulation to the Executive Committee session 75-76,

and wishing them every success in the future.

Chairman: Miss Lilian Pusavat
Vice Chairman: Mr. Tsang Wai Chi
General Secretary: Miss Kwan Yuk Lin, Susan
Financial Secretary: Mr. Chan Man Chung
Internal Affairs Secretary: Mr. Wong Chun Por
External Affairs Secretary: Mr. Fung Yiu Fai, Anthony
Sports Secretary: Mr. Chan Shu Yu
Social Secretary: Mr. Foo Wai Lum, William

EFFECT OF SMOKING ON HEALTH

Most countries have not as yet taken any legislative measures, while ıers have taken measures relating mainly to cigarette advertising. For ɜ 100 countries for which WHO has information, around 70 have no ;islation whatsoever aimed at controlling the promotion or use of ;arettes.

Research evidence published over the past few years strengthens ɜ view, previously advanced with reservation, that cigarette smoking is ıajor risk factor for both fatal and non-fatal myocardial infarction.

Carbon monoxide plays an important part in the mechanisms ıereby smoking increases ischaemic heart disease. The amount of car- n monoxide produced increases towards the end of the cigarette.

In young people, ischaemic disease of the legs (thrombo-angiitis literans), causing intermittent limping or lameness, appears to be nfined almost exclusively to those who smoke.

Several recent studies carried out in various countries have nfirmed that the incidence of gastroduodenal ulcer is about twice as gh in smokers as in non-smokers.

The main effects of maternal smoking are to retard fetal growth and crease the risk of perinatal death, but there is some evidence that the ildren of mothers who smoked during pregnancy may still be slightly ıaller and show slightly lower levels of achievement by the time that ey are 7 years old.

Several studies have shown that the children of parents who smoke ɜ more liable to chest illnesses than the children of parents who do not ıoke.

* The worldwide increase in cancer mortality in those countries where cigarette smoking has been widespread continues without interruption.

* In women, whose cigarette consumption has been rising rapidly in the past 30 years, lung cancer mortality continues to rise at an increasing rate.

* The reduction in the risk of lung cancer in smokers of filter-tipped cigarettes with relatively low tar delivery compared with those who continue to smoke plain cigarettes has been confirmed.

* The mortality of Japanese cigarette smokers, both male and female, is some 22% higher than that of non-smokers. The risk increases with increasing cigarette consumption and with inhalation of smoke.

* The striking reduction of lung cancer mortality in British doctors, the majority of whom are non-smokers or have stopped smoking, has been documented.

* The non-smoker exposed to the side-stream and main-stream smoke of smokers in enclosed ill-ventilated spaces, such as cars and small offices, may be exposed to harmful concentrations of smoke.

* In some communities, the traditional way of smoking tobacco by bubbling the smoke through a pot of water may be less damaging than cigarette smoking. On the other hand, some other ways of using tobacco, e.g., chewing, may produce other manifestations, such as cancer of the oral cavity.

* Pipe and cigar smokers, who do not usually inhale, are exposed to lower health risks than cigarette smokers who usually inhale.

* In certain developed countries, the publication of scientific findings on the effects of smoking seems to have reduced cigarette use to some extent. On the other hand, the consumption in developing countries is rapidly increasing.

The Editorial Board wishes to thank the special support of Glaxo Hong Kong Ltd.

投票、競選

編委會

醫學會幹事改選今年首次採用 General Polling，原意是希望方便同學投票，事實上，今年投票人數竟達五百人，可說是一個空前紀錄，反映出同學愈來愈關心醫學會的發展，此亦一可喜現象。

為了使選舉能在公平的情形下進行，所以每個選舉都定有嚴例，以防競選者因過於熱心而犯錯誤，然而可能由於注意力過於集中在競選者的身上，往往忽略了投票者事實上亦需要有適當的投票知識。雖然在憲法上每一個會員都享有投票權，然而每一個投票者實都有義務去認清自己所投一票的意義才有資格去投票。

由於每一個被選出來的幹事都會對醫學會以後的發展有重大影响，所以投票者都應該認識清楚投票的對象是否就是自己要求的人選。當然，如果候選人是你的朋友，在日常接觸之中，你已經能對他相當瞭解。但對其他同學來說，這樣的認識根本是不可能的，就正因為這樣，每一個候選同學都會設法在投票前將自己介紹出來，而投票者都有義務利用這些機會去認識每一個候選人而後作出決定。在今年的選舉過程中，兩個閣的同學都已儘量將自己的政綱宣傳開來，然而每次競選演說的聽衆都不多（除一年級外）。如果以為只有聽過競選演說的同學才可以投票的話，今年的投票人數就似乎出人意表，莫非這兩個閣的同學交遊廣濶，所以很多同學不用說已經可以作出選擇了嗎？

不過無論如何，今次破紀錄的投票數字將使醫學會更具代表性，而工作的同學亦能更具體地感到自己是得到很多同學的支持，這樣在爭取同學福利的時候將更有力量，不用說，醫學會的發展又將得到一個空前的進步。

Community Health:

Absence of disease plus Well-being

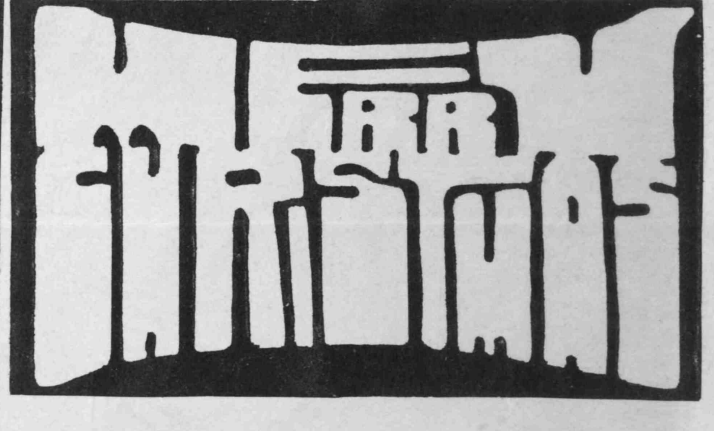
The definition of health by the WHO (as you know, it considers health to be something different from the absence of disease and infirmity, and speaks instead of a state of physical, mental, and social well-being, and a right for everybody without discrimination) was brought up once again in the seminar held by Caduceus on "Community Health Service in Hong Kong". This was one of the activities organized in the Caduceus Week. The seminar took place at 5:15 p.m. on Wednesday, 29th. October in the Anatomy Lecture Theatre. Guest speakers invited were Professor Coulborne (from the Department of Community Medicine) Mrs. M.J. Carter (from the Department of Social Work), Sister Aquinas (from the Society of Community Medicine) and Mr. Lee Yung Wong (from the Kwun Tong Community Health Project). We had also the pleasure of having Professor Hodge and Doctor Wong (from the Department of Social Work), and (Doctor Thomas Ng from the Department of Community Medicine) attending the discussion. Some fifty students were present in the meeting.

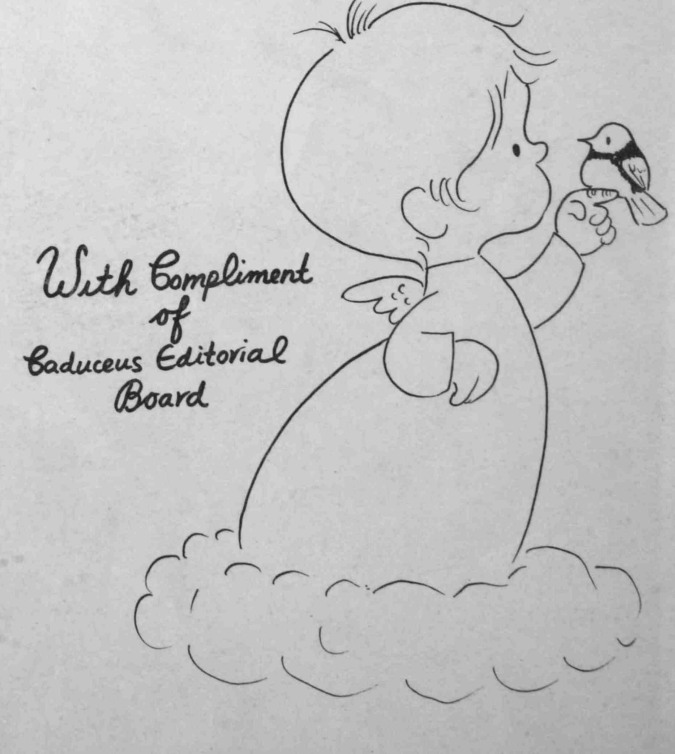
The discussion was preceded by a slide show introducing the Kwun Tong Community Health Project (K.T.C.H.P.). Then we had speeches made by our guest speakers. Professor Coulborne pointed out that the demarcation between disease and health is just a thin vague line. A good illustrative example of the above statement is the existence of societies like National Tuberculosis Organization and National Anti-Tuberculosis Organization in England working with the same aim of fighting against T.B.. Doctors should be concerned in both these aspects, namely, the "who, when, where" of diseases and the physical, mental and social well-being of people. Community medicine hence functions over a wide range, including health information and education, control of diseases (especially communicable ones), environmental health, liason with education and social work, organization and and delivery of medical care and lastly, but not the least, long term planning and management.

Next, Mrs. Carter gave the audience an enlightening speech on the parallels between social work and community medicine, and the cyclicity of social work development. Both social workers and doctors, she said, should show concern for people. Without this concern, they are no longer doctors or social workers, but just technicians. Both social workers and doctors try to minimize problems faced by people, and are concerned with their well-being. All people are equally important and should be given equal chances. Social work, she said, started in the 19th. century. As it develops, it has changed from a curative to a developmental approach, directing people to turn to self-help and lay-help rather than rely on professional help. It is also looking into matters with both individualistic and community approaches. Hence social work can be divided into case work, group work and community work. Mrs. carter also pointed out the phenomenon that those who are most at risk are usually the latest ones to approach for professional help. This happens in both the social work and medical field. So, we should always remember that "Prevention is better than cure"

Next, Sister Aquinas took Tuberculosis and drug abuse as two examples of diseases commonly met with in community health care. She also stressed the importance of health education in the field of community medicine.

Finally, Mr. Lee talked on the problems and outlook of the K.T.C.H.P. The main problem, he said, is the financial one. But it is also difficult to get the right person for the post — a doctor who has both initiative and genuine interest in thinking for the community and not just individual cases. There is also the problem of communication with the general public. Besides, the K.T.C.H.P. often finds itself in a dilemma, competing with the general practitioners, for example in the Students' Medical Service. Despite these difficulties, the outlook of the K.T.C.H.P. is quite good at present. A community health centre will soon be set up in Nam Tin and two industrial health centres in Kwun Tong. A considerable fund will be soon available and response from voluntary workers is good. This will help in the development of the Good Neighbour Programme and the expansion of the Community Nurse Service. Mr. Lee's speech was followed by a brief discussion and the seminar ended at 7:15 p.m.





IFSMA, SUMMER 1975.

The 24th General Assembly of the International Federation of Medical Students Association (IFMSA) was held from 29th-7th August, 1975, in Philadelphia, USA. I was very and honoured to be selected as the official representative of the Hong Kong University Medical Society.

Twenty one countries were represented at the GA. They consisted of Austria (2), Bangladesh (2), Denmark (4), Egypt (6), Finland (5), France (1), Ghana (2), Greece (2), Hong Kong (1), Isreal (3), Italy (1), Japan (3), Nigeria (1), Poland (1), Sudan (1), Sweden (2), Switzerland (2), West Germany (1), Zambia (1), U.S.A. (17) and Mexico (2). The meeting start off with the opening ceremony official welcome and an address on "Serve The People: Lessons From Health Care In The People's Republic Of China." by Victor W. Sidel, M.D. Since the President of IFMSA, Dr. Alex Ooi (Singapore) was unable to attend, Peter Schatzer, the Director of the Standing Committee on Professional Exchange (SCOPE) was elected to preside over the sessions.

The assembly members were nominated to different working committees such as credentials, financial, constitutional, Standing Committee on Medical Education (SCOME), Standing Committee on Population Activity (SCOPA), and 'future projects'.** No committee was selected for SCOPE as a whole session would be devoted to it.

Credentials from all countries were found to be satisfactory. Canada was added as a member.

The financial report, audit report and the budget for the year 1975/1976 were distributed.** The members voted for the continuation of the IFMSA magazine — the Intermedica** for another year provided that it became self-balancing.

Changes in the constitution as proposed in Haifa, 1974 and the Graz Exchange Officers Meeting minutes were adopted.

The committee on the workings of SCOPA reported that nothing much had been achieved after the Population Seminar in Lagos, 1974 except for the work done by Singapore. The Papua, New Guinea Project was at a stand still and unless something was done the funds allocated to it would be revoked.

Hong Kong was among the 6 countries on the committee reviewing SCOME. The others were Sweden, Denmark, Finland, Austria and Greece. After a long discussion, the committee recommended the following motions:

1) The GA abolished SCOME.
2) Each region was to select an education officer (this could be incorporated into the duty of the Regional Vice-President).
3) Each National association should select an education officer (this office could be assumed by the National Exchange Officer). The various EO's should try to co-ordinate with the Regional education officer. Names and addresses of the EO's — national and regional — should be given to the General Secretary and other member countries.
4) Each future GA was to fix 1 point on the agenda for: Problems, Projects in Medical Education in different countries.
5) The GA would consider the founding of another SCOME should such a committee be found necessary in the future.**

Two future projects were proposed. One was to expand the 'Drug Appeal' which was until then handled by Denmark to a world-wide basis.** The other was the 'Book Appeal'** The committee comprised of Hong Kong, Isreal, Bangladesh, and Finland. The aims of the project were to increase co-operation between the medical students and to obtain books from other countries at a rate lower than the home country. The recipient country was responsible for the cost of the books and mailing.

Two days were devoted to discussion on the 'Problems of Physician Migration' during which talks were also given on the topic by different U.S. medical personnels. Papers were presented by Egypt, U.S.A., France, Denmark, Japan, Nigeria, Ghana and Austria.** Group discussions were also held, the result of which would be published in the December, 75 issue of the Intermedica.

Political differences between Egypt and Isreal flared into a minor conflict when Egypt showed some movies and distributed pamphelts, the contents of which were found to have political bearings and therefore objectionable as IFMSA was supposed to be a non-political organization. A motion was later proposed and passed that no movies or literatures of any country with political overtone would be permitted at future GA's. Differences of opinion between the members on how the GA should be run also helped to split the delegates into separate camps.

Japan gave a progress report on the International Student Workship on Environmental Pollution to be held in Japan from July 25th-August 7th,' 76.**

Isreal Shapiro, the IFMSA Relief Officer for Bangladesh reported on the contributions by 9 countries in response to the appeal sent out on behalf of the flood victims, in which Hong Kong sent a draft of HK$78.**

The meeting of the National Exchange Officers in Graz, 74 decided that part of the programme would be computerized. The Director of SCOPE gave his report.** There was a heated discussion on the value of the Winter meeting for the National Exchange Officers. Finally, it was decided that the meeting was essential to ensure a maximum efficiency of the Exchange Programmes and that it would be held as scheduled in Yugoslavia in late December, '75.

Among the final items on the agenda was the election of the Executive Board 1975/1976. I am very proud to report that Austria has enough confidence in my ability to nominate me for the post of President. There were two other candidates for the position — Isreal Shapiro of Isreal and Samuel Fifi Ellis of Ghana. In the run off between Fifi and I, I am sorry to say that I lost by a marginal vote. The General Secretary and the Treasurer positions were linked together and elected by the country. Finland who occupied the posts for 1974/1975 retained the positions as did Peter Schatzer as the Director of SCOPE for another year. Egypt captured the directorship for SCOPA with the promise to set the ball rolling on the Papua New Guinea Project so as not to lose the fund.

Jersy Plechanow of Poland, the designated site for the GA 1976, reported that country may not be able to host the '76 meeting due to the lack of facilities as another International Youth Conference was also scheduled to be held there at the same time. Hong Kong and Egypt were considered as alternate sites. It was decided that the next GA could be in Cairo, Egypt, provided that Egypt's Foreign Ministry could produce a letter of guarantee for the admission of all the member countries including Isreal by December, 1975. If not the honour would go to Hong Kong automatically. If Egypt can produce such a letter then the choice would be up to the Executive Board.

I sincerely hope that Hong Kong would be given the chance as then more of our students would be able to participate in the workings of IFMSA. It had been on whole an enriching experience for me and I would like to thank everybody for choosing me as your official representative.

**More information can be obtained from the Medical Society Office.

Lilian Pusavat.

回顧

本綠邦

時間過得眞快，一年幹事會的工作又告結束。回想初出來競選幹事時，對醫學會發展確是有一定理想，我希望從工作中獲得一些經驗。在過去大半年來，這些目的在某個程度上，可算是達到了。雖然醫學會內務工作比較繁重，自己付出的時間亦不算少，然而工作上有苦有樂，始終我不失為鍛鍊自己的一個好機會。在醫科課程檢討方面，更獲得不少難得的工作經驗。

回顧過去一年幹事會的工作，始終覺得幹事們合作性不高。其實一個幹事出來，首先就要考慮時間分配問題。在醫學院功課壓力是相當重的，若果一些幹事在任期間的功課出了問題，便要「隱居苦讀」，將任的事務擱開，對整個幹事的工作是有一定的阻礙。

在過去一年，香港社會發生了兩件大事，新醫學生是有相當影響的。它們是第二間醫學院的設立及非英聯邦醫生問題。這兩件事，尤其後者對現在就讀中的同學有極深切影響。幹事會未能帶領同學就這兩件事作出通常討論和反應，未免遲鈍了一點。

對於直接關係同學利益的社會的事件，幹事會是須要敏感一點。

同學在過去一年，對醫學會活動的參與顯著增加了。「性與健康」展覽，觀塘區健康計劃，迎新等等都有非常多同學參加，使醫學會發展，跨進了一大步。大部分同學對幹事會都能給予相當建設性的支持和督導，這是值得大家高興的。我們歡迎批評，只有批評才有進步，但是我們要的是有建設性的批評，對於一些以「鋤」人為快樂之本的「放砲」，我是不能容忍的。這種「放砲」風氣不但破壞同學間的團結，更加大大的打擊醫學會發展。

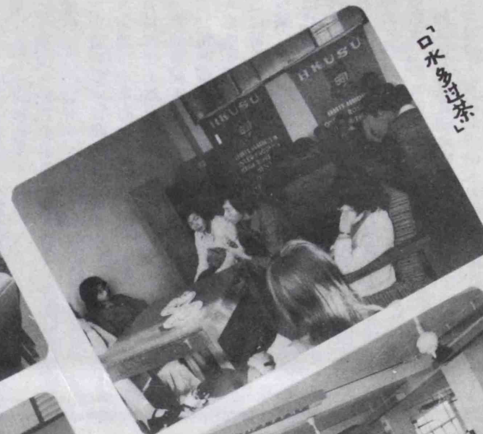
隨着學運的發展，醫學會的活動就日益增多，和變得多元化，更不限於醫學會，同學對於社會事務的參與亦大有增加。一個院會最初成立的目的，只是為同學的基本福利而設。為同學籌辦課餘活動和參加院際比賽等。我始終覺得醫學會在任何時候都應該把同學福利放在第一位，團結同學，辦好福利，爭取合理補益。對於社會性的活動，站在醫學生的立場作出一定程度的參與是值得鼓勵的。但絕不應投以大部份人力物力。所以我覺得如果在中國科技展覽發動的百多位同學及在「性與健康」展覽所用的一萬六千餘元的部分人力物力在發動同學對本身更切身的問題如課程檢討，第二間醫學院，香港醫療制度，及非聯邦醫生問題多加參與，多加討論可不是更有意義嗎？

最後，我希望來年的幹事們能從我們不足的地方吸取教訓，盡力以赴，將醫學會辦得更好。

十一月大事回顧

中學生探訪日


「讀MEDIC係唔係好辛苦㗎？」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「呢道的沙發真好瞓。」

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