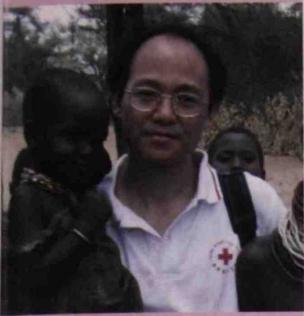


On the Cover



Interviews

Interview with Dr Au Yiu Kai

Dr Yiu-Kai Au is a general surgeon who has worked extensively in humanitarian missions with Red Cross (ICRC) and Doctors Without Borders (MSF). He was recently named Humanitarian of the Year by the Hong Kong Red Cross. Our editor-in-chief, Yan-Lin Li, interviews him at Medical Sunday, where he shared his experience with a group of Catholic doctors.

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Future

Nano - The Next BIG Thing!

Imagine a future in which tiny nanorobots introduced into your body will deliver a specific dose of drug to a specific target cell, ensuring your treatment is 100% effective while abolishing all side effects on neighbouring cells. Such wonders are almost upon us. Let us usher in the new age of nanomedicine!

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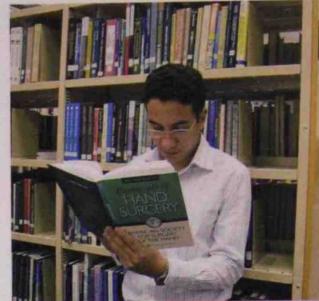
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* Photos of Medical Campus on Page 11, 18, 25, 34 and 37



Books & Films

Diving for fun in the Medical Library!

Ever imagine fun in the medical library? There is actually some - if you dig deep enough. Know more about the library's collection and brighten up your study!

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Current affairs

醫療事故頻生，誰之過？

醫療失誤屢見不鮮，從遺失病人資料到打錯針、食錯藥等無奇不有。市民反應亦由震驚、憤怒、責罵到開始麻木，反映出公營醫療體系已經令市民失去信心。問題的根源是人為疏忽？管理不足？又或是政策失誤？究竟責任應該落在誰身上？

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Submissions

探訪痲瘋康復村

痲瘋村？聽起來很恐怖！團契成員在暑假期間到了廣東的痲瘋康復村探訪，到底這些村子是怎樣的？康復者的生活又如何？

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Interview with Dr Au Yiu Kai – Winner of the Hong Kong Humanity Award 2009

Yan-Lin Li (M13)
Lisa Cheng (M13)

Introduction

Dr Au Yiu Kai (MB BS 1983), chief of surgery at Our Lady of Maryknoll Hospital (OLMH), has been awarded the Hong Kong Humanity Award 2009 by the Hong Kong Red Cross and Radio Hong Kong. He shared his experience as a war surgeon at Ricci Hall, where Caduceus editor Yan-Lin Li reports...

Personal Background

Dr Au was born in 1959 and attended Bishop Ford Memorial School and Queen Elizabeth School before studying medicine at HKU. As a student, he was a sports enthusiast and headed St John's College's sports teams. Even now, he still runs marathons and Oxfam Trailwalkers. After graduation, he joined the Department of Surgery of United Christian Hospital (UCH) as a medical officer.

Early Career

When Dr Au joined UCH, Dr Yuen Kwok Yung – now Professor of Microbiology – was also a first-year surgical officer there. He had just finished his

first specialist training in internal med-



icine and switched to surgery for more exposure. Dr Au thought very highly of Dr Yuen, describing him as a 'prescient' figure 'of great intelligence and wisdom'. As early as 20 years ago, Dr Yuen had already predicted that traditional surgery might have major changes, as many surgical conditions could be explained and managed by knowledge in microbiology and molecular science. Dr Yuen later became a dear friend of Dr Au and gave him much advice.

First call to humanitarian work

By the early 1990s, Dr Au had obtained his Surgical Fellowship from the Royal College and became a fully qualified specialist at UCH. This was when his friend, an Emergency Medicine specialist, first invited him to take part in voluntary medical work overseas after attending an ICRC War Surgery Seminar in Geneva. Dr Au, when recalling the occasion, described it as 'an opportunity as a lifetime' as

he had always wanted to help the underprivileged since he was a teenager. Moreover, as he was trained in general surgery, he had the ability to operate on most parts of the body, while the ER physician had little surgical skills. That said, humble as he was, Dr Au still felt that he had not acquired enough clinical experience to head a surgical unit alone. Furthermore, he was freshly married and did not want to leave his wife and children for an unknown place. In the end, after thoughtful consideration and praying, he decided not to take up the post. Nonetheless, he also promised himself that he would work on the field some day. Throughout his sharing, Dr Au stressed that there was a lack in experienced doctors in the war-stricken areas in Africa. This is because doctors are usually the more privileged bunch in society and if war breaks out they are financially capable of leaving the region immediately. This exacerbates the situation and starts a vicious cycle, culminating in a full-blown humanitarian crisis.

... and he answers after ten years!

In 2001, Dr Au, in his forties, had already become Chief of Service of the Department of Surgery, OLMH. At that time, the Asian Financial Crisis was in its full force and Dr Au found many of his friends depressed. He also felt that his trainees were less interested in learning basic surgical skills and patient care than new surgical technologies. He sat down and re-examined his medical career and the meaning of life and success. With God's blessing, he picked up his dream years ago and called his friend from Hong Kong Red Cross. After visiting a field hospital in Kenya, he agreed to undertake a 3-month mission in the same hospital. But for a mission to be successful, preparation is essential. In the following months, Dr Au tried to prepare himself for his new challenge in a new environment.

Learning from scratch

The surgeon in the field has to be versatile and independent. He must be able to operate on all surgical conditions, from head to feet, with little support from other surgeons or related personnel like anaesthetists, radiologists, pathologists and nurses. He had to make his clinical diagnosis and management based on his medical knowledge and some fundamental tests. Like many general surgeons, Dr Au did not have much



understanding or appreciation on obstetric and gynaecological disorders that required surgical correction. But unlike other general surgeons, Dr Au decided to ask for help from his gynaecological colleagues at Kwong Wah Hospital (KWH), and was met with overwhelming support.

'When I went to the OG wards in KWH for the first time, Dr Lawrence Tang, Chief of Service of the Department told all the doctors and nurses that I would be practising O and G in Africa very soon. He asked everyone to help in my preparation' Dr Au recalled, 'Everyday, the secretary would send me the elective OT list. I would arrange my schedule to attend different operations. I sat in many surgeries. I am really grateful to the colleagues at KWH who taught me everything as concisely as possible. I truly owe them a lot.'

Dr Au was also grateful to the support he received from his other friends when they knew that he would be leaving for Africa.

Reciprocating to the world

Dr Au was particularly touched when the Mother Superior of Maryknoll Convent, the religious group that runs OLMH, gave him a blessing before his departure. It was in 2001, at the 35th anniversary of OLMH. Mother Superior expressed how glad she was to see that after all these years, OLMH has been able to nurture fine doctors capable of contributing their skills to other less fortunate areas in the world like what the Maryknoll sisters did to the refugees in HK in the early 60's. Dr Au said that the support given to him by the patron organization of his workplace was no small encouragement, and he has taken Mother Superior's words to his heart all these years working in the field.

With greater power comes greater responsibility

As the first doctor from the Hospital



Authority to be granted a 3-month no-pay leave for his volunteering work and with all the encouragement he received from friends and the public alike, Dr Au confided that he set out to the Red Cross headquarters (ICRC) in Geneva with a halo on his head. He received information about the Red Cross Movement and learnt that medical relief in the fields was a serious business. He felt proud to be part of a great team.

For example, ICRC's policies specified that if one of its volunteers were to be captured by terrorists, no ransom would be paid in exchange for the hostage. Although this policy was formulated to discourage abductions, when Dr Au was asked to sign this form he felt uncomfortable with it and it was only then he began to appreciate the potential costs of the mission. Nevertheless, he fended off these obstacles and set out to Kenya, armed with an ICRC badge and passport.

In the fields

Throughout the three months in Kenya, Dr Au operated on more than 400 patients. 'The instruments we had were very rudimentary and the hygiene level was barely acceptable,' he said, 'so don't even think of laparoscopies!' Since Dr Au was the only surgeon at the clinic, he also had to perform new operations that would have been done by another specialist in Hong Kong. For example, he removed a grossly enlarged eyeball from a young boy after reading the Holy Bible of field surgeons- Primary Surgery. 'There were no pathologists to confirm the diagnosis, but it was probably a retinoblastoma. We did the best we could for the kid and hope that he survives,' said Dr Au. 'The O and G skills I learnt at KWH helped me a lot, but I also realized that we could not apply the standards we have in Hong Kong in the fields. For example, there was a pregnant woman whose spine was severely deformed by tuberculosis

and she could only sit when I did the C-section. When I showed the photo to the obstetricians in KWH, they were completely dumbfounded! Of course, both the mother and the baby survived the operation...'

There are two main reflections that Dr Au has gathered from his mission that he would like to share with the audience:

The first one is about work ethic. In Hong Kong, doctors are inclined to ask themselves 'What's the specialty responsible for this?' or 'I'm not able to do it with the resources I currently have.' But in the fields, doctors have to think 'How to do it?', because no support is available most of the time. Dr Au thinks that young doctors nowadays should try to solve problems themselves before relaying the more difficult patients to seniors/ other departments. In this way, the quality of care can be enhanced while the young doctors can also get more out of their training. Dr Au believes that 'holistic care' is better delivered if the same doctor takes up different roles on himself: surgeon, physician, rehabilitation therapist, so on and so forth.

The second reflection is about the essence of doctor-patient relationships. After the mission, Dr Au realized that the human touch is the most powerful tool for communication. In the absence of a common language or cultural background, the human touch is most capable of conveying positive emotions, like empathy, confidence and joy to others. He recommended doctors to use this as an alternative tool for reassuring and communicating with patients.

Besides work, Dr Au also spent time understanding Kenyan culture. For example, instead of going to English Sunday services he tried to join the Holy Mass held in tribal languages so



as to share the unique joy of the local people. He noted that the Kenyan people were very rich in their spiritual life despite material deprivation. From what we see, Dr Au clearly shares this joyous vision – he dresses simply, eats simple food and exhibits great joy and calmness when talking about his vocation. Clearly, one does not need to amass earthly riches to become happy!

The influence of religion

Since 2002, Dr Au has completed 7 missions through Red Cross and Médecins Sans Frontières (Doctors without Borders). One may wonder what makes him so persistent in sacrificing his own time and effort to help others. Throughout the talk, Dr Au emphasized the importance of his Catholic faith for motivating him to start and sustain his volunteering efforts. He believes that God has

made everyone a tool of Him. From his childhood all through his medical training, God has guided him to become a surgeon, and in prayer he finds that it is God's Will that he should leave Hong Kong to serve the needy. And thus he obeyed His Will and found joy within it. In difficult times, he prays to God and he has been given consolations to his soul and solutions to practice in the material world.

Reaching to a wider audience

Dr Au understands that there is very little that he can do as one doctor to help the oppressed people in Africa. He believes that using his own example to inspire younger generations is a better way to achieve changes in the world. Therefore, he has shared his own experience at schools, offices and hospitals alike to call for more attention to the humanitarian crises in

the Third World. In particular, in late 2006, he expanded his preaching to mainland China, returning to Sun Yat Sen University in Guangzhou to share his volunteering experience with MSF. To his surprise, the sharing was very well received by the staff and students – they even had to hold an extra talk at the Faculty of Medicine separately in addition to lecturing the university in general! He disagreed with the 'selfish, money-oriented' Chinese stereotype, and saw that many mainland doctors were genuinely interested in committing themselves to service of humanity, but face many difficulties. This feeling was also shared by Dr Joyce Ching (MB BS 2002), a family physician who had also been to missions in Africa through MSF and had another sharing with the students in China in early October.

Advice to medical students and young doctors

At the end of the sharing, Dr Au entertained questions from some of the audience...

	<p>Dr James Fung (MB BS 2003, MRes 2000) UCH Surgery</p> 	<p>Dr Kenneth Li (MB BS 2006) QEH Clinical Oncology</p> 	<p>Dr Michael Poon (MB BS 1994) NDH Surgery</p> 
Question	In your opinion, doctors in which specialty are most needed in the field and when is the best time for a doctor to work in the field?	How do you manage to find time to go on so many missions (once a year)?	Apparently the patients in Kenya treated you with great respect. But in Hong Kong, patients are rude and may even have unreasonable demands. How do you cope with this transition?
Answer	Both physicians and surgeons are in great demand in the third world. However, physicians (like Joyce) are usually required to complete a 3-month course in tropical medicine before they can work in Africa. This is because the disease pattern there is very different from that in developed countries. Also, in most missions physicians usually have to work for a whole year so they have to take a year off. For surgeons/anaesthetists /obstetricians, the length of missions may be as short as 4 weeks so it is more flexible for the schedule.	(Laughs) Every year our team will plan the leave in advance. I am the head of my department so that I can try to schedule my leave with my missions. My colleagues look after the department while I'm abroad. Fortunately I also have very good support from my colleagues in KWH.	This doesn't seem to be a problem for me. Patients are generally very polite to me even in Hong Kong... It depends on your attitude and relation with your patients. Empathy and care are important.



何栢良醫生專訪

李恩年 (M13)

何卓邦 (M13)

黃基基 (M14)

何栢良醫生(內外全科醫學士1989)這名字，相信對於港大的醫學生來說，一點兒也不陌生——沒錯，他就是在一、二年級時經常出現，教授我們內心膜發炎、性病、細菌抗藥性等等的微生物學教師。但是，原來何醫生除了熱心教學外，還是香港公共醫療醫生協會(HKPDA)的會長，積極參與工會的活動，希望為醫生爭取權益。今天，我們三位啟思的編輯來到瑪麗醫院K座地庫的臨床微生物實驗室來訪問他。

問：何醫生，你可以介紹一下HKPDA嗎？

答：當然可以。HKPDA(香港公共醫療醫生協會)於1990年成立，至今已有20年了。我們的會員一定要是下列三類人之一：

1：於港大/中大任職的醫生

2：於醫管局任職的醫生(佔絕大多數)

3：於衛生署及其他政府機構任職的公務員醫生

此外，我們的會章規定會長只能夠連任一次，所以我便是HKPDA的第十任會長了。

HKPDA成立的宗旨是為公營體系中的醫生爭取福利，是一個註冊的工會，現時大概有1500個會員，而全體公營醫院醫生大概有5500位；因此，大概有三至四分一左右的公營醫院醫生都是我們的會員。

問：通常一般工會都有大部分的工人作為會員，為何HKPDA只有不及一半的會員比例呢？

答：其實根據我們的認知，絕大部分的公營醫院醫生都認同我們的行動宗旨，只不過是因為懶、抗爭太久而感到厭倦或其他種種原因而沒有填我們的入會表格罷了！

問：我知道HKPDA的一些成員(梁家驥、蔡自怡、蘇勇柏)曾就醫生工時問

題入稟法院。你可以為我們解釋一下嗎？

答：就讓我先解釋一下現時醫生的工作時間吧。從圖片中我們可以看到醫生每星期工作達9天之久，在候召(On call)的日子中更加有連續30小時工作的現象。而根據我們的調查，醫生每週工作時數平均達78小時之久，這是實在十分驚人。

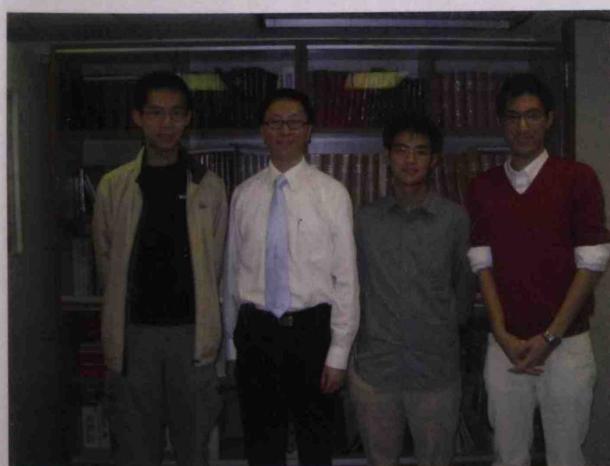
第二個問題就是，醫管局屢次觸犯勞工法例，例如，沒有每星期給醫生放



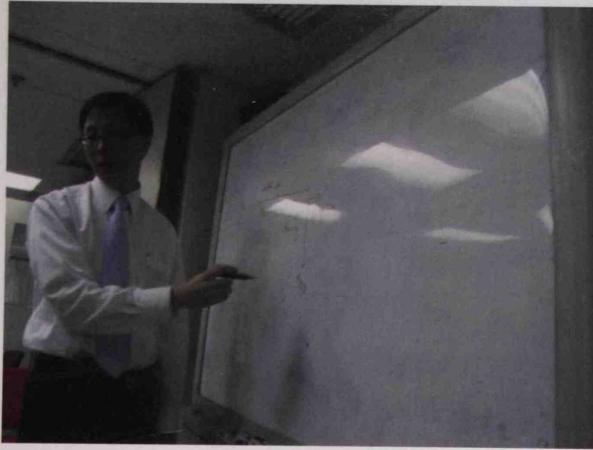
與何醫生進行具資料性的交流

假一天，而且又從每年17日的公眾假期(PH)和受薪假期(SH)中，不斷剋扣醫生的假期。醫管局在打官司的初期，因為自知理虧，於是在2003年聘請新一年入職的醫生時，在合約加上「醫生須在醫管局制定的時間表之內，無限時加班」和「沒有額外金錢回報」的字樣，強迫新入職的醫生同意、默認這不合理的制度。

最後，在2009年的終審判決中，醫生雖然在剋扣有薪假期這方面獲得勝訴，得到醫管局補發假期和提供合共約4億元的賠款，但由於超時工作已被納入為醫生合約的一部份，故判醫生們敗訴。



何醫生與我們的合照



何醫生正在解釋公立醫院醫生的工作情況

醫管局期後雖然承諾把醫生的工時削減至65小時，但實則上只是取巧，譬如在On Call時，如果醫生被召喚8次，每次為時15分鐘，那麼醫生便只是工作了2小時而不是整晚。但試問被吵醒8次的晚上又怎能算是休息呢？

總括而言，醫管局並沒有正視醫生工時過長的問題，只顧以旁門左道作權宜之計，是很不負責任的行為。

問：看來醫生的工作時間確實是長得可怕，何醫生，你有沒有一些減輕醫生工時的理據呢？

答：理據大致可分為三面：

首先，醫生長時間工作對病人是構成危險的。有外國的研究顯示，一個人在連續二十多、三十多小時沒睡的情況下，精神狀況(Cognitive function)其實跟一個喝得酩酊大醉的人沒有任何分別。要這樣的醫生為病人開刀、開藥，作出生死攸關的決定，又怎能對公眾作出一個交代呢？

其次，在公平、公義方面，要求醫生連續工作這麼長的時間，對醫生生理、心理方面都有害處。而且，綜觀醫療界(Allied Health)中的其他成員，如清潔工人、藥劑師等，他們也有自己的當更表，不需要工作這麼長時間。事實上，照我所知，醫生是全香港唯一需要工作這麼長時間的一個職業。

最後，法例亦規定每個工人在一週內最少要有連續24小時是脫離工作的，而在一年內必須有17天的假期——這是基本的人權，但醫管局卻連這樣都做不到。



可能由於經常與傳媒交流，何醫生與我們對話顯得滿有自信

問：超時工作在行內是不是非常普遍呢？有沒有哪些專科在這方面的問題特別嚴重？

答：“On Call”這東西在每一個專科都有。基本上，每一個未成為專科醫生的年輕MO(Medical Officer)，每星期均需要On Call一至兩次。在需要動手術的專科內，年資長的醫生由於經驗充足，因此亦需經常被召回醫院主持大局，所以工時亦相對地較長。而兒科因為人

手不足，而且私人市場有限，醫生不能離開公營醫院，因此問題亦十分嚴重。

問：我們在大眾傳媒中經常看到有一些因醫生疏忽而引致的醫療事故，若果有的話，那不是引證了你說的醫生工時過長的後果嗎？

答：首先，香港發生重大醫療事故的比例在世界上已經是非常之低的了，只有十萬分之一次。

其實，醫生工作時間過長狀態不佳引起事故的例子當然有，但是在法律上很難證明純粹是因過勞引致的。比方說，若實習醫生在On Call的第30多小時中犯錯，「經驗不足」或「沒有高級醫生在旁指導」亦可能是原因之一，所以很難以此作定論。

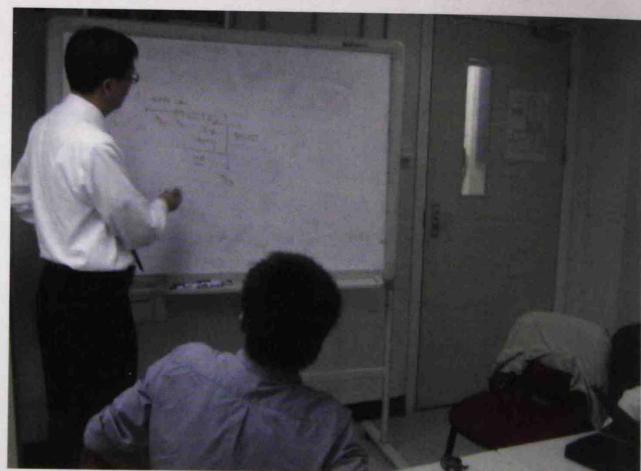
但是，我們的工會並不會以醫療事故作為一個爭取權益的噱頭，因為這存在一些道德上的問題。

問：你認為醫管局如何才能妥善解決醫生工時過長的問題呢？有些人提議增加醫學生的名額/增加/減少醫生薪酬以解決這問題。你認為可行嗎？

答：首先，我們認為醫管局要承認問題，才有討論的基礎。

其次，我們認為醫管局應該成立一個專責小組，檢討醫生的工時問題，找出一個兩全其美的解決辦法。

我們認為增加醫科生學額或投放更多資源並不能解決這問題。在過往，我們曾經有過180人一年的班，也沒有明顯的改善。此外，加/減薪並沒有動搖到最核心的輪班制度，所以亦不能



公立醫院醫生的苦況令我們感到震驚

解決問題。

問：最近HKPDA與政府又就減薪方面意見不合，又是甚麼的一回事呢？

答：其實，我們最不滿的是我們只能跟隨公務員減薪，但公務員加薪/其他福利都不享有，更重要的是醫管局總裁蘇利文和總監張偉倫以「不簽減薪『同意』書便解僱」的威脅態度跟我們交涉。

醫管局每每都以醫生不會採取工業行動而欺壓公立醫院醫生。雖然醫生確實不會作出影響病人利益的行為(如罷工)，但醫管局的行為的確是太離譖了，完全忽視自己前線員工的感受。

又好像早前逼新入職醫生簽下的「賣身契」(需要無限的、無補償的加班)也是採取這種強制壓迫的態度，對於加強雙方合作是無補於事的。



解剖實驗室背後

專訪：解剖實驗室主管丁偉明先生

何卓邦 (M13)

問：聽說丁先生你的父親是香港首名解剖實驗室技術員，而你亦是子承父業的。其實你當初入行的經過是怎樣的？

答：沒錯。我父親在年青時已經加入了香港大學，不過他當時是在校長室那邊擔任文職，而非在解剖學系工作。第二次世界大戰結束之後，他重回港大任職，不過那時因為職位空缺的問題，他轉到了解剖學系，就此成為了香港第一名解剖實驗室技術員。此後他一直工作，直到六十三歲退休為止。如果你認識老一輩的醫生的話，他們都會稱呼我父親做「丁伯」，叫我做「丁仔」。至於說到我入行的經過，我認為是受到父親的薰陶。我小時候就住在黃克競樓對面（那時解剖和生理學系都在同一座樓房，即黃克競樓的現址），家中的環境比較嘈雜，因此時時都會到父親的辦公室溫習。那時的人體標本只是用一些黑色的箱子裝著，所以我有時亦會好奇打開箱子，一窺內裏的情況的！之後到我中五畢業，父親介紹我到解剖實驗室工作，於是我就入了這行，由低做起。那時應該是一九七一年。

問：那麼你小時候在父親的辦公室裏見到這麼多的屍體，有沒有曾經害怕過？

答：都有少許的。我小時候曾在收音機聽過幾個「鬼故」，都頗為恐怖的，所以間中也會想父親那兒可能也會有僵屍呢！受到了這些「鬼故」的影響，我有時走過一些黑暗的走廊，也會害怕會有鬼走出來的！不過久而久之，我也習慣了，所以也就沒有問題。

問：那麼你克服了這些恐懼之後，何時開始對處理屍體產生興趣？

答：沒有那麼快就有興趣的。那時我父親在大學工作之餘，亦有在殯儀館裏做兼職，負責替屍體防腐。有一次，父親問我有沒有興趣幫手，說事成後會給我幾角零錢作為獎勵，於是我就跟著他去了。最初我只是替他拿些工具，一起乘巴士而已，到達了便在工作室外等候，也不知道父親在做甚麼。但當我長大了以後，他便叫我進去看看，繼而叫我幫手。那時我循序漸進的學習著，一步步的便學會了防腐，亦慢慢對處理屍體這方面產生興趣。所以在我進入港大之前，已

經懂得防腐，不過用的是我父親的方法。

問：那麼你父親最初又是如何學會防腐的呢？

答：是當時的教授教他的。但當時的教授可能只知道防腐之法，卻沒有真正做過防腐的工作。所以我父親聽了那些方法之後，會再自行鑽研和改良。因此，如果你問一問以前的醫科畢業生，個個都會說那些屍體有很重的防腐劑氣味，十分難聞和刺眼，往往是流著淚上課的。

問：但我知道最後你也曾留學英國，學習正統的防腐知識。那時又是怎樣的？

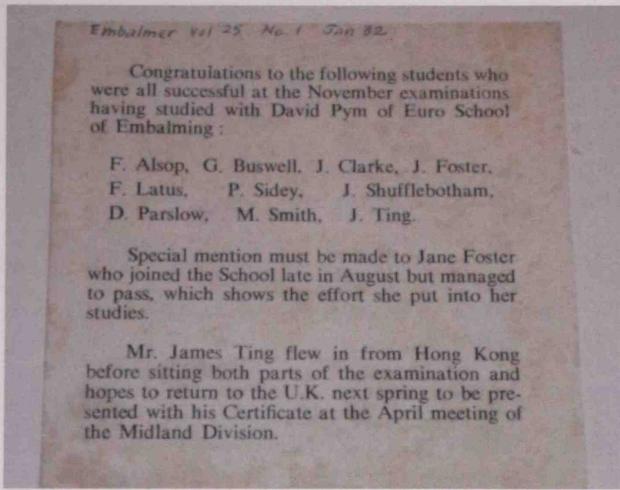
答：對。其實我進入了大學之後，也有接受過大學安排的一些培訓，在那時的工業學院（即香港理工大學的前身）讀了三年的實驗課程。之後我也報讀了一個有關醫學實驗的課程，但一年之後卻覺得實用性不夠，於是我便找了一個由British Institute of Embalmers舉辦的課程，一邊工作一邊進修。到了一九八一年，在教授的支持之下，我拿了四十四天的有薪假期，去到了英國做實習和考試，最後也成功及格。但那時考實習試的時候，其實是有一點波折的。那時我一打開屍袋，發覺那屍體是經過檢驗，曾被法醫解剖過，而最不幸的是連條股骨(femur)也拿了出來，因此情況十分複雜。最後我花了兩至三個小時，幸好也能順利過關。之後到了一九八二年，我回到香港，發現原來大學替我拿了全額資助，讓我到倫敦的Royal College of Surgeons再深造三個月的防腐和標本制作技術，從而改善醫學院這邊的情況。

問：你工作了這麼久，有沒有一些趣聞可以和讀者們分享一下？

答：對著屍體又怎會有甚麼趣聞呢？



解剖實驗室門外的碑誌



丁偉明先生成功考取防腐師的資格

我們工作的時候是十分認真的，對屍體十分尊敬。而且我也學不到我父親那樣擅於交際，能和同學打成一片，所以也沒有遇到特別有趣的事情。至於那些「鬼故」呢，我也略有所聞，而有一個亦是我同事親身經歷的。故事是發生在以前李樹芬樓五樓的解剖實驗室。一晚，我同事要開夜班，需要工作到很晚。忽然，他在辦公室裏聽到實驗室傳來一陣開餐的聲音，於是便前去察看，卻是甚麼也見不到。但當他再回去辦公室時，又聽到這些怪聲。最後，他當然立即離去了！

問：通常解剖用的屍體是從哪裏來的？為甚麼大都是男屍？而屍體解剖完之後，又會如何處置？

答：如果你有看過實驗室門口那個碑誌，便會知道是人們死後把屍體捐獻出來，但這只是近幾年的事而已。以前用的屍體，大部分都是無人認領的，因此政府便根據法例賦予的權力將之處置，而其中一個處置的方法就是送來醫學院這邊了。而因為多數無人認領的屍體都是男性，因此就比較多男屍了。我想男女的比例大約是十比一吧。至於解剖完的屍體，我們會把它們交回政府那兒，然後將之火化或土葬。

問：當屍體來到醫學院這邊，你們要做甚麼步驟？而屍體又會不會發臭呢？

答：以前醫院的殮房冷凍設施不太好，屍體來到時的確會有機會發臭。至於防腐的工序，

通常是用一個壓力泵，把防腐劑從血管裏泵進去。由於防腐劑一般都可以滲透至皮膚表面，所以我們的屍體是不用浸在藥水裏面的。而理論上，屍體其實不用放在雪櫃裏，不過雪櫃可以保持適當的濕度，亦能夠防止一些蒼蠅在屍體上面產卵。另外，我打算將來學習一個被喻為當今最好的防腐方法，如果成功的話，屍體便不會像現在那樣僵硬，而是十分柔軟，關節可以如活人般正常屈曲。希望不久的將來可

以跟照配方調配然後試試。不過這個方法可能只會應用在那些臨床工作坊(c clinical workshop)上，給一些外科醫生學習做手術之用。

問：我見到屍體上面的大腿上都開了個洞，是不是就是為了把防腐劑泵進去呢？另外，既然屍體是不用浸在藥水裏的，為何打開屍袋時會有防腐劑留在袋裏面呢？

答：沒錯，我們一般都是會用大腿上的股動脈(femoral artery)來把防腐劑泵進去的，因為它就在表面，較容易找到。但如果死者在生前有一些血塊阻塞著血管的話，便要用別的地方了。有時可能用頸動脈(carotid artery)、肱動脈(brachial artery)、橈動脈(radial artery)，甚至是足背動脈(dorsalis pedis artery)我也試過用呢。由於在防腐的過程之中，我們要確保是百分百完成，因此會出現防腐劑滲漏出來的情況。

問：為甚麼有些屍體的腳被鋸了下來呢？

答：因為有些長者生前患有嚴重的骨關節炎(osteoarthritis)，肢體不能伸直。防腐後，屈曲的下肢阻礙了屍體存放在雪櫃裏，因此只好把它鋸掉。而因為課程改革的關係，現在醫學生不用解剖下肢，因此亦就沒有甚麼大的影響。不過，雖然我們把腳鋸了下來，但它仍然會與屍體一起存放，解剖完後一併交回政府那邊。

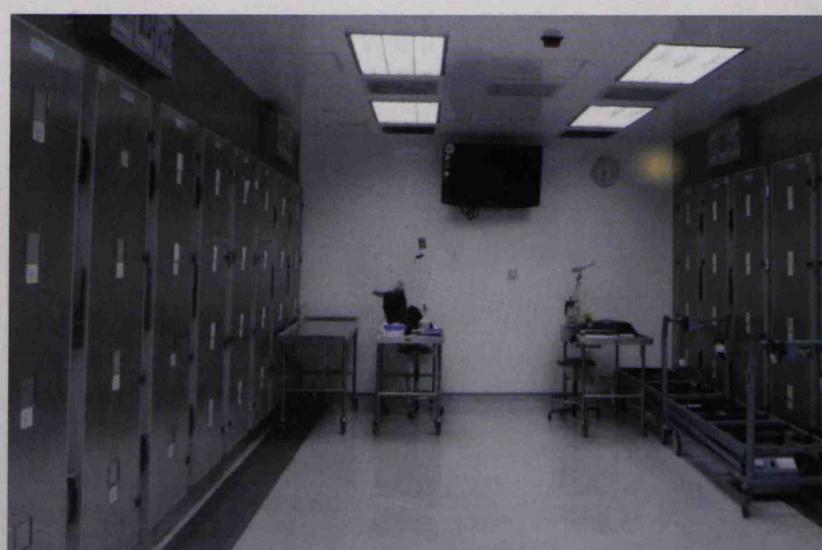


儲存標本的雪櫃

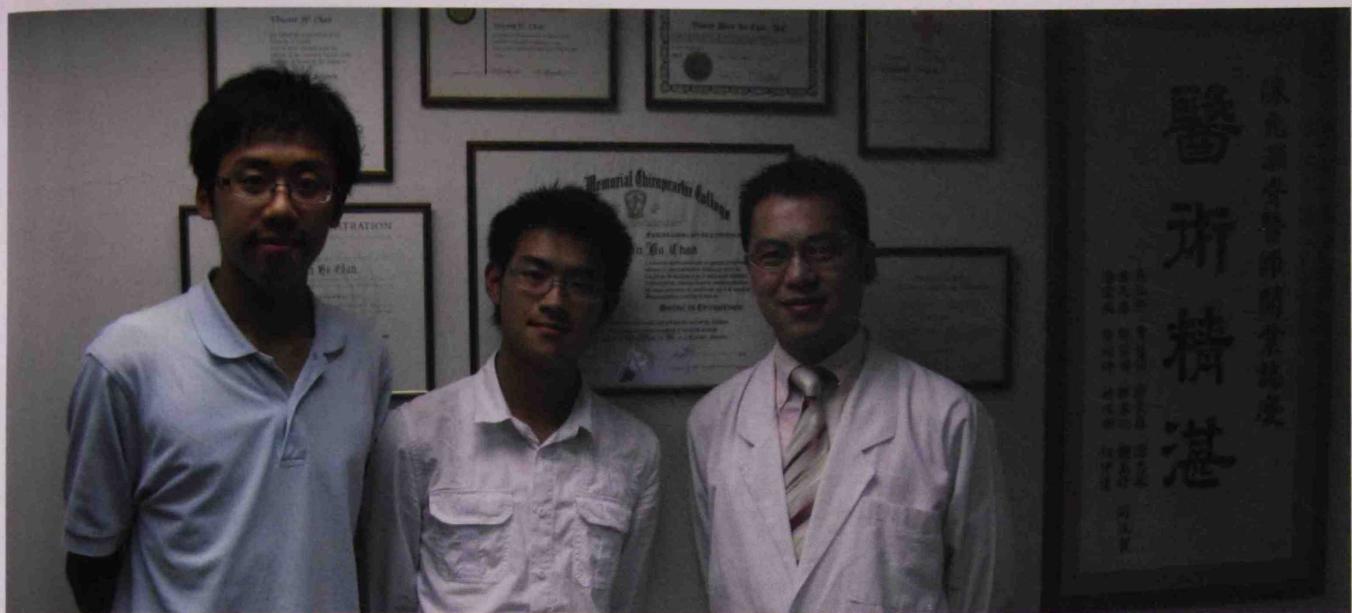
問：你工作了這麼久，打算何時退休呢？而你覺得作為一個解剖實驗室技術員，要具備甚麼條件？

答：其實正式來說，我明年就會退休的了，不過我正申請延長退休期。如果成功的話，將會是在2013年退下來，剛好是和你們畢業的年份一樣（恰巧亦是解剖學系成立一百周年）。

至於實驗室技術員的入行門檻其實是很高的，因為我們既要懂得解剖、生理等知識，同時亦需要懂得標本製作。能在外面請到這樣的人是很困難的，因此通常是聘請了之後再作內部培訓。不過這個人一定要有愛心、懂得尊重屍體和有耐性，因為有時製作教學標本(prosection)，快則要兩日，慢則要一個星期甚至以上，所以是很考耐性的。



製作教學標本的地方



甚麼是脊醫？

專訪：香港執業脊醫協會主席陳允灝醫生

何卓邦 (M13)

陳允灝醫生於1996年在加拿大脊醫學院畢業後，便回香港執業，至今已行醫十三年。當年，他有感香港市民對脊醫的認識十分不足，而脊醫業界亦像一盤散沙般，自顧自的行醫，因此對剛回香港執業的脊醫來說有一定的困難。於是在1999年，他與另一位脊醫梁濟康醫生創立了香港執業脊醫協會，旨在推廣脊骨健康的重要性，亦讓市民大眾知道脊醫所負責的工作。時至今日，該會已由原先只得兩名會員，擴展成香港最大規模的脊醫學會，成員多達四十多人。

問：脊醫其實是不是只是醫治脊骨呢？

答：其實脊醫是醫治關於神經肌骨骼系統(neuromusculoskeletal system)疾病的，涉及的範圍包括關節、肌肉和神經線的問題，如肩周炎、扁平足、腳踝扭傷和網球手等，並不只是醫治脊骨。因此，我覺得脊醫的中文翻譯其實並不傳神。脊醫的英文是Chiropractor，在希臘文來說是「用手治病的醫生」。

問：脊醫在見病人之時，會做些甚麼呢？

答：我想這其實和西醫所做的十分相似。當病人進來的時候，我們會先問病歷(history taking)。如果這方面做得好的，其實已經可以知道問題的七八成了。之後做的就是身體檢查

(physical examination)，包括一些骨科及神經科的項目，如直腿提升檢查(Straight leg raising test)、反射(reflex)和知覺(sensory)的檢查。而有需要的話，我們亦會做一些小腦(cerebellum)功能的測試。做完了這些步驟，便可能會照X光，找出正確的病因，然後就是治療了。另外，我們亦會找出病人受傷的原因，教導他們正確的姿勢、飲食習慣以及運動。

問：那麼脊醫的治療方法是甚麼呢？

答：脊醫不會用藥*或做手術，做的都是保守性(conservative)治療，主要是脊骨關節矯正(spinal manipulation)。簡單來說，一個關節組合(joint complex)是由周邊的肌肉和骨骼等組成。但關節可能因為日常生活的錯誤姿勢、運動創傷和交通意外等各種原因引致移位。移位小當然不會有大問題，但若是嚴重的話，便會有機會壓著周邊的神經線，影響了神經訊息的傳遞。這理論和你們西醫學的其實是同出一轍。例如第六條頸椎神經(C6 spinal nerve)出現問題，便會影響了相應的皮膚神經節段(dermatome)。脊醫做的，就是找出哪個位置有脊骨錯位(subluxation)，然後用手或矯正槍將之矯正。之

後，脊醫亦會用一些輔助儀器，如超聲波、干擾電流、衝擊波、紅外線或是激光等，以保持周邊的肌肉及軟組織在一個健康的狀態，防止關節再次移位**。

問：但假如保守性治療對病人無效呢？

答：是有這個可能的。例如一些嚴重的椎間盤(intervertebral disc)問題，保守性治療對病人無效，那麼我們是會在適當的時候將病人轉介至西醫的。又或者病人剛剛受傷，照了X光之後發現原來是有骨折，這些我們也會轉介出去，並不是每一個個案都會由脊醫接手。因此脊醫的訓練其實是很重要的，必須能夠分辨出眼前的個案是否在脊醫的範疇之內。

問：說起脊醫的訓練，其實脊醫需要接受多少年的培訓？課程內容又包括甚麼？

答：一般在美國、加拿大、澳洲和英國才能修讀脊醫。在美加而言，脊醫屬於一個博士學位，因此我們先要得到一個四年制的學士學位，然後再申請入讀脊醫學院，修讀四年的脊醫課程。在頭的兩年半內，我們所學的其實和西醫是十分相似，一樣有解剖(anatomy)、生理(physiology)、生化(biochemistry)、病理(pathology)、微生物學(microbiology)和實驗診斷(laboratory diagnosis)，而教師亦都是醫學院的教授，不過就不用修讀藥理(pharmacology)。到最後的一年半就多了些臨床的脊醫課程。事實上，在最後的一年裏，我們整個下午



脊醫所用的矯正槍，通常用於小童或老人，以代替人手做的脊骨矯正。

都會在學校開設的診所裏實習。病人進來診所的時候，我們負責將個案報告給導師聽。如果他同意我們的診斷和治療計劃，我們便會在他的監督之下替病人治療。

問：但之前說過，脊醫只是醫治神經肌膚系統的問題，沒有接受過關於其他系統疾病的訓練。舉例說，如果病人是因腰背痛(low back pain)而求診，若脊醫沒有受過全科的訓練，會否錯過一些因其他系統引致此病徵的問題，如前列腺(prostate)癌擴散至盤骨引起的背痛？

答：如果你說癌症擴散，我們也能夠找出來的，因為脊醫的X光訓練是做得很好的。在四年的脊醫課程裏，其中三年都有關於X光的訓練。而我自己也曾診斷過幾個癌症擴散的案例。其實一個有足夠訓練和經驗的脊醫，見到一些不尋常的病徵時，便會格外小心，而且通常我們也會替病人照照X光，而X光一般都可以見到這些腫瘤的。其實很多原因也可以引致腰背痛，如腎臟發炎或動脈瘤(aortic aneurysm)等。當脊醫碰到一些例行(routine)的病例時，當然會知道是例行公事，但如果見到一些不對路的病徵，便自然會提高警覺，必要時當然會轉介出去。

問：你覺得脊醫比起傳統的西醫，有甚麼優勝或不足之處？

答：我覺得脊醫和西醫在處理問題的方式上是不同的。脊醫是一個治標亦治本的方法，不過在醫治慢性病者的時候，可能需時較長，要三至四次的治療才有顯著成效。這是因為脊醫不用藥亦不開刀，不能一下子就能止痛或消炎，但就可以治療到問題的根源，而風險亦較手術低得多。通常脊醫醫治的都是一些機械性(mechanical)的問題，如關節或肌肉的疾病，而我們的療法對這方面的功效(efficacy)

是很高的。外國很多研究都指出，脊醫的療法在臨床上是有效(clinically effective)及能節省成本(cost-saving)的。

問：你覺得脊醫和跌打醫師或物理治療師的角色有沒有重疊？

答：一定有的。以扭傷腳為例，物理治療師和脊醫都一樣會用超聲波或冰敷，但不同的是，脊醫會找出病人腳部有沒有一些機械性的問題，引致病人經常扭傷。之後亦可能會做一些增強腿部肌肉的療程，以協助韌帶鞏固關節。

問：通常病人為甚麼會選擇看脊醫呢？

答：我現在大部份的新症，都是由別的病人介紹過來的。例如一個病人在脊醫的醫治之下痊癒了，便會介紹他的同事、朋友及親友前來。而亦有一些家庭醫生會轉介他們的病人前來我這裏的。

問：近年脊醫的知名度大大提高，你覺得背後的原因是甚麼？

答：不錯。在1996年我剛回香港的時候，香港只有三十多個註冊脊醫，但到現在已有一百三十個了。我想背後是有幾個原因的。第一個是因為香港現在有一個註冊的制度（香港是亞洲第一個有脊醫註冊制度的地方），市民受到法律的保障，因此對脊醫的信心增強了不少。而第二個原因是因為本會近年大力推廣脊骨健康，使脊醫的知名度有所提升。而在外國執業的脊醫見到香港脊醫業前景好轉，便會回流香港了。

問：但脊醫在香港的發展有沒有受到甚麼阻力呢？而貴會在未來打算如何繼續推廣脊骨健康？

答：香港的脊醫發展，最大的問題是在於供應這方面。從香港兩間醫學院的人數中，可以知道每年會有多少新的西醫註冊，但脊醫卻不是。好的一年，可能會有五六個脊醫在外國回來香港，但若是差的，可能連一個也沒有，所以脊醫的發展就受到了局限。因此，除非香港有一間脊醫學院，否則這個問題永遠會是一個障礙。另外，由於本會的會員都是執業的脊醫，所以他們都是比較忙碌的，但我們也會在有限的時間內盡量推廣。其中一個推廣的方法是夥拍一些商業機構，讓脊醫的名稱可以在廣告之中出現，同時亦在商品之中放入一些推廣脊骨健康的單張。



多功能電療機，能調較出多種電流或聲波。



脊醫在治療之前，可能會用儀器替人放鬆肌肉

問：之前你說過脊醫和西醫都是各有長短的，而你和幾個西醫亦曾經互相轉介病人。那麼你覺得普遍來說，脊醫和西醫的合作是否足夠？

答：我覺得現時的合作是不足夠的。現在的西醫，在培訓的時候，只是聽過物理治療，而從來未聽過脊醫這個行業。因此，很自然地，你是不會將病人轉介至一個你從沒認識的東西上。故此，我認為雙方若要加強合作，必須要互相認識和了解，在培訓的初期便要互相接觸。在脊醫來說，之前說過，我們在頭兩年已接觸到很多西醫的科目了，知道西醫到底做些甚麼。但相反，由於香港沒有脊醫學院，所以西醫卻似乎很少接觸脊醫。其實不管是甚麼醫生，認識多一點別的療法，才能為病人提供最合適的治療。

問：那麼你認為雙方可以如何加強認識？

答：首先接受你們的訪問是一個很好的方式，因此我十分重視這次的見面。另外，我剛剛亦接受了中文大學的邀請，會在一個痛症研討會(pain symposium)上主講脊醫如何治療痛症。此外，我覺得讓醫學生真正見見脊醫的日常工作，對加深西醫對脊醫的認識是很有幫助的。

*脊醫亦會處方一些營養補充劑如葡萄糖胺(glucosamine)。

**超聲波能增加血液循環及減少發炎反應；電療可因應病者的需要而調較電流，能強化肌肉、止痛及加快傷口癒合；而衝擊波及激光亦能幫助傷口復原。



Taken by Keith Wong (M13)

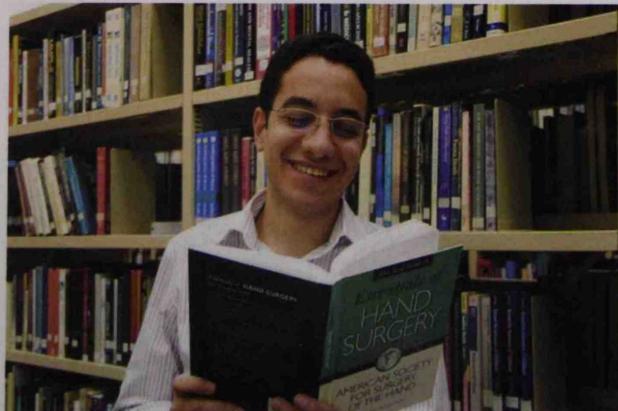
Diving for fun in the Medical Library!

Lo Hui Yin (M13)

Last year when I was still an innocent freshman I did not like to go to the medical library. It was so quiet, people there so focused – it almost made breathing a heinous crime. The cold glares I got when I was walking past the book shelves and desks together with the blank faces staring into the books terrified me. It was not until the study leave for my first summative exam before I dared step into the library once again. Now being a year two student it seems that I should appear in the library more often; so in order to overcome my fear and develop my love for the library, I tried to search for the fun side of it – for the few entertaining books buried in piles of difficult texts.

First there is “Medical knowledge for fun” by Richard Worcester (M610 W922V). He must be a real innovative guy to come out with such a title - at least I cannot imagine the “brevity in medicine” (Ch. 4). However “do-it-yourself diagnosis” (Ch. 43) may help us with our so-called “medical students’ syndrome” when we suspect meningitis with a slight elevation of our own body temperature.

If you had three martinis and feel studious suddenly (or if you read 3 chapters of pathology, which does just the same), you can try Mark Leyner and Billy Goldberg’s “Why do men have nipples - hundreds of questions you’d only ask a doctor after your third martini” (M 610 L68). The advantage of reading this book is you can be entertained and gain some useful (or trivial?) knowledge at the same time.



Does bathing in tomato juice remove the smell of a skunk? Does marijuana help glaucoma? Is there such a thing as male menopause? Borrow the book and study yourself!

For those who want to relax a bit but will feel guilty reading something “funny”, “The making of Mr Gray’s Anatomy” by Ruth Richardson (M 611.0092 G77 R52) may just be the book. Mind you, it is “Mr Gray’s Anatomy”, not “Grey’s Anatomy”. The book talks about Mr Gray’s life, and how the evil book of “Gray’s Anatomy” was written. Sounds interesting?

I guess all of us have thought about the greatest mystery of the universe – why are we here? Well it is because of urea! At least biochemists think so – it is how they sing along with the “Biochemists’ songbook” by Harold Baum (M 783.0942 B615 b)! For medical students (at least for me) biochemistry and biochemists are quite hard to understand, but with this songbook we may be able to get a glimpse of that secret world. So let’s sing together in the tune of “My Bonnie lies over the ocean”:

The primary sequence of proteins/ is coded within DNA; on sense strand of the double helix/ coiled anti-parallel way...

Singing in the library may be considered naughty by the librarians. In fact, medical students, in many people’s eyes, are very mischievous. During the summer I took a ghost tour in York, a walking tour from the Trinity College in Dublin and a ghost bus tour in Edinburgh. During the three tours I heard the same story over and over again: medical students in the past (or even now) would bribe the guys who worked in the cemetery, dig up the newly-buried bodies in the middle of the night, and drag the bodies all the way back to the

university and cut the bodies open to “study Anatomy”. (Most of the students also laughed wickedly along the way.) But maybe we should not be blamed, because, according to David Wootton, the practice of medicine itself is flawed. His book “Bad medicine: doctors doing harm since Hippocrates” (M 610.9 W9) has clearly stated how bad Hippocrates (whose theory includes bloodletting and cauterisation) and the subsequent generations of doctors were!

This review is just to give you a brief glimpse of the treasures hidden in our beloved Medical Library. Now it’s your turn to dive in there and explore, and see what wonderful diversions you can find in there!

More for Nursing, Chinese Medicine and Pharmacy students:

The Best of nursing humor : a collection of articles, essays, and poetry published in the nursing literature / compiled and edited by Colleen Kenefick, Amy Y. Young.
M 610.730207 B5

Tales from the bedside / by Wise, nurse cartoonist.
M 610.730207 W81

The poetry of nursing : poems and commentaries of leading nurse-poets / edited by Judy Schaefer.
M 815.09892161 P7

中医趣谈 / 杨辅仓著.
[醫] **R601.Y362 2004**

杏林夜話 : 中醫文化趣談 / 王禮賢編著.
[醫] **R601.W355 2004**

中醫藥真有趣 / 余寶珠編著.
[醫] **RM216.Y83 2007**

中醫藥趣聞 / 邱仕君, 肖瑩, 李姝淳著.
[醫] **R601.Q58 2007**

Pharmacy history : a pictorial record : photographs from the Museum of the Royal Pharmaceutical Society of Great Britain / [compiled by] Nigel Tallis and Kate Arnold-Forster.
M 615.10941 P536Z

Pharmacy : an illustrated history / by David L. Cowen and William H. Helfand.
MLB 615.109 C8

Is Medicine Heading the Right Way? Inspired by "The Rise and Fall of Modern Medicine"

by James Le Fanu

Koel Ko (M13)

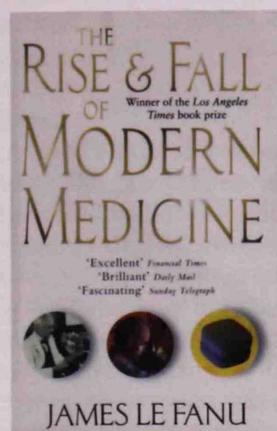


Figure 1:
The Rise and Fall of Modern Medicine
by James Le Fanu

WWII – the Prelude

Imagine you were a medical student back in 1960. The circumstances were auspicious: the aftermath of World War II has given way to restoration of international order and widespread economic rebirth. Modern medicine has benefited immensely from this apocalyptic era spanning the first half of the 20th century, and the benefit was, in reality, twofold: soldiers and civilians suffering from injuries and infections spurred medical personnel to innovate, fuelling the intellectual search for cures to infectious diseases and the maturation of modern critical care and trauma management. Even more importantly, the fruits of industrial revolution have crystallised in the form of rapid growth in physics and engineering – also gathering a lot of momentum as warfare spread like wildfire throughout Europe – providing the essential technological support for the development of life-sustenance, diagnostic and surgical equipments. You were in the middle of an awe-inspiring epoch – this was an age of paradigm shifts and key discoveries that would transform medicine beyond recognition.

Along Came "Clinical Science"

What was the software that propelled the field of medicine forward? As one of the first proponents of meticulous research to foster progressive medicine,

E.H. Starling stated the meaning to his intellectual practice: "not simply diagnosing a patient and deciding what to do for him in order to earn our fee, but what we can get out of his case in order to do better next time". Modern doctors could scarcely imagine that this was a difficult view to maintain, as the profession widely regarded full-time clinical research as a "refuge for those unable to withstand the constraints of a consultant's life" – and by clinical research we mean giving treatment regimens of as yet unproven efficacy to patients that usually have agreed to try out the new treatment. Good diagnosticians like Gregory House (bar the misanthropy and misdemeanours), or more realistically, Lord Thomas Horder – top diagnostician working as the physician of Royal Household during the early regime of Queen Elizabeth II, upheld their expertise by making accurate diagnoses, based on eliciting physical signs in clinical examination and inferring what was missing from the patient's history to treat their patients. In the old days when good doctors equalled good diagnosticians and no one else, the recognition of clinical research scientists did not come by easy. Luckily, this sentiment against bedside research was completely reversed in the years during and after the war. Clinical science ascended to the mainstream, based on the ideology that experimental "treatments" that may have no immediate benefit to the patient whatsoever would bring the miracle cure to generations of subsequent patients. And miracle cures came in the form of drugs.

The Rise of the Drugs

The discoveries of penicillin and cortisone in 1941 and 1949 did not just bring two new drugs to the face of the earth. Both discoveries were responsible for sparking off the age of pharmacology, but we cannot help noting how accidental and irreproducible they were. Alexander Fleming did notice how the *Penicillium*



Figure 2: The discovery of Penicillin has changed the treatment of infection and the course of pharmaceutical development for decades to come.

mould killed off *Streptococcus* in vitro, but believed that the toxin involved would also kill human beings – thankfully Chain and Florey did not agree. Were it not for Philip Hench, who noticed a remission of rheumatoid arthritis in many of his jaundiced patients, not even the endocrinologists of the time would have noticed the miraculous anti-inflammatory effects of cortisone. Apart from the serendipitous nature of drug discoveries, it was also interesting that one drug discovery often led to another – in fact a series of others. Today no medical personnel would recognise the name "prontosil", a red dye that was shown to be active against bacterial infection in mice in 1935. What we do recognise nowadays is the anti-bacterial ingredient of this dye, subsequently identified to be sulphonamide. The full weight of this discovery can only be noted when one takes into account the fruits of pharmaceutical exploration based on this interesting organic molecule. When chronic sulphonamide users reported the unusual side effects of passing massive volumes of urine, the doctors realised that these adverse effects could be turned into therapeutic benefit for other patients. That led synthetic chemists to the discovery of bendrofluazide (the first thiazide diuretic) and frusemide (the first loop diuretic). Similarly, ingenious synthetic chemists were to boast of the introduction of acetazolamide (the first anti-glaucoma drug), sulphonylureas (the first anti-diabetic drugs), and many more drugs based on the parent molecule. With this irrepressible surge in pharmaceutical advancements, it is not difficult to see how in 1930 a doctor may have only 20 drugs in their inventory, but almost 30 years later those "therapeutic nihilists" would be able to

prescribe over 2000 drugs. And not only the doctors, but their euphoric patients all leapt with joy at the rise of drugs. In those days the technically challenging part of medical advancement was not in devising a better drug as most of the drugs poured into the market really carried substantial therapeutic effect. The real challenge was taken up by the persevering individuals that revolutionised surgical treatments, as we shall see.

The Age of Optimism

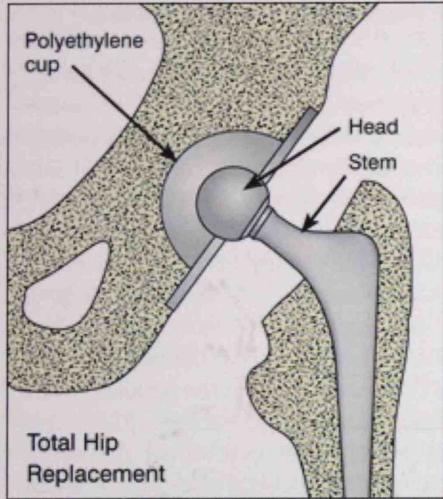


Figure 3: Charnley hip represents the synergy of medicine and engineering to produce a unique solution to a debilitating degenerative condition, signifying the role of medicine in improving the standard of living in patients with chronic diseases that have been becoming more prevalent with the ongoing epidemiological transition.

Just as the pharmaceuticals churned out miracle pills, we must not forget the monumental progress made in surgical fields that contributed to establishing the progress of modern medicine both in saving more lives and improving the standard of living of the previously handicapped. The great discoveries on this front did not differ much from how Thomas Edison tried his 9990 experiments to come up with tungsten wires for our light bulbs: they simply required perseverance, diligence, and a sense of direction to be accomplished. This was the manner with which the heart-lung machine was perfected in 1960 with almost 20 years of dedication by Dr and Mrs John Gibbon, rendering congenital and degenerative heart defects amenable to routine surgery, saving the lives of many "blue babies".

Similarly, Charnley's artificial hip joint required the collaboration between an orthopaedic surgeon and a material scientist to come up with the perfect material – polyethylene – needed to minimise allergic reaction while providing an essentially frictionless interface between the metallic femoral head and the hip acetabulum, improving the prognostic outlook of osteoarthritis patients from 1961 onwards. Renal failure did not become manageable until the dialysis machine came to light in 1941 on account of Wilhelm Kolff, but it was Joseph Murray and others who through dogged determination came to recognise the role of anti-rejection drugs in enabling kidney transplants to be carried out, which also led to the exploration of corneal, liver and heart transplants. "The Age of Optimism" had begun, in which people were flooded by exciting news offered by clinical scientists.



Figure 4: Heart-lung machine allows surgeons to cheat death and sustain the patient's life with yet another engineering feat. This highlights the key role technology has played in giving rise to the spurt of medical advancement in the later half of 20th century.

The Age of Pessimism

Yet as quickly as the optimism set in, the momentum for research began to falter in the 1970s. Biologically important chemicals were not turning out at a rate concomitant to earlier discoveries, and pharmaceutical companies were feeling the pressure of diminishing marginal returns. The thalidomide scandal seriously undermined the authority of the pharmaceuticals, triggering a grave confidence crisis as the public grew critical towards the safety assessment of novel drugs whenever they recall the

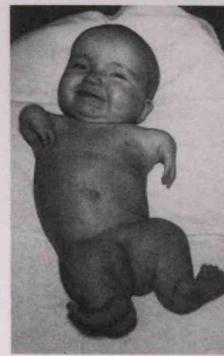


Figure 5: Thalidomide babies still serve as a poignant reminder of how little humans know about nature – and in particular the medicines that we have advised for various treatments.

For many common drugs in use we still do not understand the full spectrum of side effects – fortunately with the advent of animal clinical trials and rigorous clinical research procedures, pharmaceutical companies have learnt to pay due attention to safety in introducing new drug treatments.

image of "thalidomide babies" afflicted with phocomelia. With new exciting surgical methods and increased demand for these services, manpower was increasingly drawn away from research and innovation that would bring more effective treatment. It was not that new technologies were always in favour of the medical profession, either. Paradoxically, the more diagnostic tests that doctors can run, the more reliant doctors become to the tests to such a point that less weight than proper is attached to clinical examination skills. Cardiologists are no longer listening to valve sounds with their stethoscopes, but instead are specialised in passing catheters into the patient's arteries and veins to look for abnormalities. Le Fanu interprets this as "downgrading the importance of wisdom and experience in favour of spurious objectivity" – there might not be absolute truth in this statement, but as we reflect upon the vices of technological abuse, we could see how doctors can be misled into treating the "disease" rather than the "patient". Not only are the medical professionals disillusioned under the deceleration of innovative treatments and a re-evaluation of the meaning of their career, but the public have also become disillusioned and not merely health-conscious, but health-worried. Why is that?

Bradford Hill Revisited

To answer these questions we must examine the great paradigm shift introduced by Sir Bradford Hill circa

1950. We may be familiar with Hill's criteria and the extent of its application in modern medical statistics, but it would be hard to appreciate the background against which Hill's criteria rose into significance. When everybody smoked and somehow the causal linkage between smoking and lung cancer was circumstantial at best, Hill devised an epidemiological proof that smoking is associated with increased risk of lung cancer. The application of Hill's statistical methods to show that people with severe hypertension could have their risk of developing stroke reduced to almost zero whereas people with "mild" hypertension could scarcely show any difference when prescribed anti-hypertensive drug treatment is an important event in medical history – this represents the turning point beyond which the public are educated of lifestyle factors. As Le Fanu put it, in the name of preventing stroke, the scope of medicine has been expanded "from treating the sick to finding, in the majority who are well, 'illnesses' they do not necessarily have, and treating them at enormous cost". We are blessed with the technology for detecting some diseases at an early stage with sensitive imaging and biochemical tests; the by-product is that apparently healthy people cannot tell whether they are truly "healthy", due to exposure to one or other "lifestyle factors" that might predispose them to disease, statistically speaking (only). It is fair if the lifestyle of people have been changing in such a systematic way as to be correlated with disease, for example in the case of smoking. However as we come to concepts like the "Western diet", to which authorities may choose to loosely attribute metabolic syndrome and many cardiovascular disorders, it may be beneficial for us to revisit Hill's ideas every time – and it would not surprise me to find that very few of these claims give any consequential health advice.



Figure 6:
Bradford
Hill trans-
formed
medicine
by estab-
lishing the
role of sta-
tistics in
biomedical
research.

Sir Austin Bradford Hill

The Search Goes On

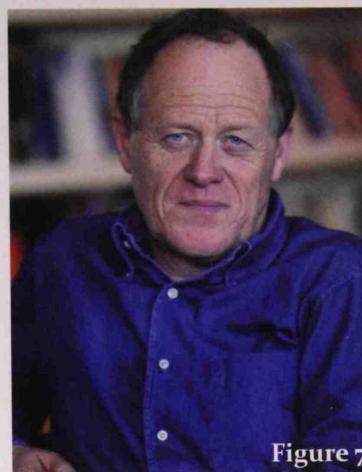


Figure 7

Now we are back to 2009. We are all familiar with the great "epidemiological transition" that began decades ago with the spurt of development in clinical research, sending many of the great infections of the past to death sentence, while putting the rest under a tight reign, leaving the majority of the human population much less susceptible to the terrorising microbes (despite the augmented fear from anticipation of "superbugs", avian influenza, SARS and the like). The focus of the majority of medical research has been shifted to either genetics or epidemiology, but critics like Le Fanu would tell you that there is not much promise in either of these twin towers in fostering medical progress. If there is anything that we learn from studying past patterns of medical discoveries, they are usually the results of persevering with subtle clues obtained from chance observations in a clinical setting. Maybe what Le Fanu is trying to suggest is that as we pertain to rigorous scientific and statistical methods in the laboratory, we are taking painstaking steps to study molecular details, but gradually getting out of touch with clinical observation – which was the crucial skill behind so many seemingly fortuitous discoveries. In our obsession with appealing either to the "genes" or the "environment" to explain the cause of diseases, maybe we should take a step back and consider the diseases for which mechanisms are better known, and for which there are indeed genetic "predisposition factors" and environmental "risk factors". Yet as we look more closely, we may wonder why heart attack can strike individuals that have healthy diet and do regular sports, why an autoimmune disease like multiple sclerosis (MS) should increase tenfold in incidence and

becomes attenuated in severity in the last 50 years in the UK like an infectious disease, and why rheumatoid arthritis (RA) and schizophrenia just chose to strike someone with familial tendency but no clear inheritance pattern. These apparent medical mysteries and idiopathic diseases actually reminds us of the ignorance of physicians to the cause of infections – we simply do not know the biological agent or mechanism involved, but we are very good at observing patterns – and that is when "risk factors" comes to the rescue. With evidence suggesting Coxsackie B infection occurs in almost all patients with infant-onset type I diabetes (2), discovery of cross-reactivity between anti-Proteus antibodies and collagen II and elevated anti-Proteus antibodies in RA patients (3), and evidence linking Epstein-Barr virus infections of the brain with MS (4), the hypothesis of biological cause behind most diseases at least deserves another critical review. In any case, Le Fanu has written a thought-provoking masterpiece that may well leave the reader thinking: is medicine heading the right way?

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Pictures taken from:

- Figure 1: <http://www.jameslefanu.com/books>
- Figure 2: http://www.mieliestronk.com/flem_flor_chain.jpg
- Figure 3: <http://ortopedika.com/Hip-anatomy-taperfit.gif>
- Figure 4: <http://heatherwritesablog.files.wordpress.com/2009/06/heart-and-lung-machine.jpg>
- Figure 5: <http://www.femfatalities.com/buttons/thalidomide2.gif>
- Figure 6: <http://www.sciencemuseum.org.uk/hommedia.ashx?id=10303&size=Small>
- Figure 7: http://www.jameslefanu.com/wp-content/uploads/2008/11/jlf_portrait.jpg

Invisibles

Lo Hui Yin (M13)

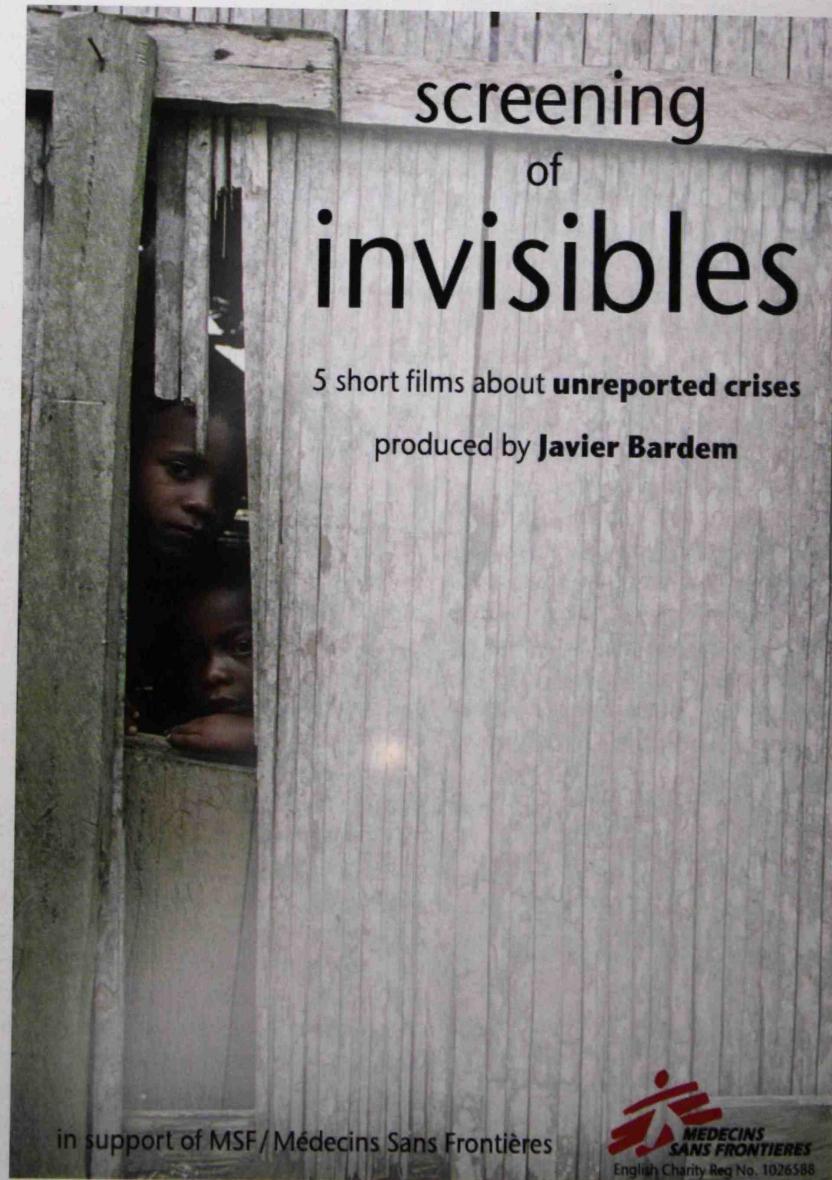
"We are totally forgotten, by everybody. Is not that they can't see us, it's that they don't want to see us."

"Invisibles" is a short film directed by 5 directors, with the assistance of Médecins san Frontières (Doctors without borders). The first case of the film tells the story of a Bolivian girl named Nora, who left her country to work in Spain, making a living by taking care of Spanish children in order to support her sister's household and her daughter back in her home country. From the letters her sister wrote to her, Nora learnt of the epidemic of Chagas' disease (American trypanosomiasis) that broke out in her hometown, which affected many of her family members and friends: even Nora's own daughter got infected. Still, Nora could do nothing but crying into the phone. Chagas' disease is a tropical parasitic disease that occurs only in the New World, particularly in the poor rural areas of Central and Southern America. When symptoms start to appear, such as signs of heart failure, it is always fatal without treatment. Even if the patients are treated, the outcome is not always desirable. Currently there is no cure for Chagas', and the disease kills 50000 people each year. At least 16 million people are infected – many of them are extremely poor and pharmaceutical companies cannot earn much from them; therefore they are not trying hard to improve the treatment. That's why Nora's family members and friends were taken away one by one. There has not been any significant research in the past few decades. It is hard to believe that nowadays, when new drugs for treating flu or even slimming pills are launched into the market everyday, there is still a parasitic disease that has no cure. Nora is still mourning. It has been a century since Chagas' Disease was discovered, WHO was to talk about it, but at the end, H1N1 took over, Chagas' was once again ignored. Nora is still mourning; we hear her, but we shut our ears.

I do not know if Bianca, the protagonist

of the second story, is luckier or not. She suffers from Trypanosomiasis, more commonly known as "sleeping sickness". Her central nervous system has been invaded by parasites and she may die from it; alternatively she could have died in accidents, because sometimes she just drops onto the ground and sleeps without knowing at all. Bianca is perhaps luckier than Nora, because there are drugs available for treating sleeping sickness. There is an older one called melarsoprol, which is highly toxic, quite often fails and occasionally kills. The newer one, eflornithine, is a much better drug for the disease, but Bianca is still dreaming. Eflornithine is a powerful chemical

which effectively inhibits hair growth. It is popular among cosmeticians and women around the globe. So there is the chemical, and we know it works, but some people, knowing the cure for such a parasitic disease will not bring much profit, put money in hair growth inhibitor cream instead. If better drugs were available, Bianca would have awoken, but no, Bianca is still dreaming. Over the years MSF and WHO have been trying to improve the situation; negotiating with the manufacturers, adjusting the funding plans. To some extent they succeeded, with more people benefited by the drugs over a five-year period; however the plan expired and more research should be done to find out new and cheaper ways to produce the drugs, but who is going to fund the research? Perhaps Bianca no longer dreams, but someone somewhere is still dreaming, of a world where lives are more important than money. I remember studying about globalisation in secondary school.



**screening
of
invisibles**

5 short films about **unreported crises**

produced by **Javier Bardem**

in support of MSF / Médecins Sans Frontières

MEDECINS SANS FRONTIERES
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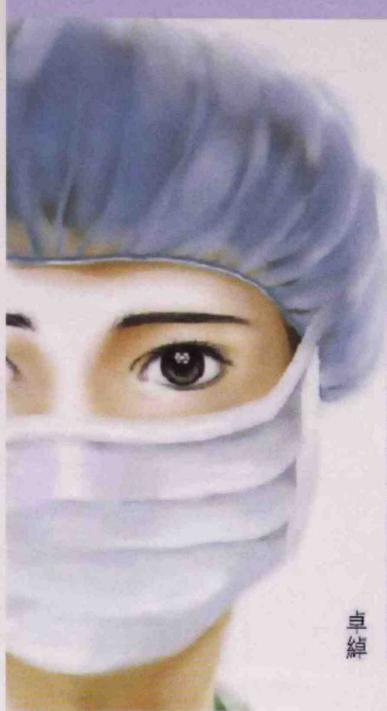
Countries will work closer together and acts as villagers in one same village, and we will know more about the neglected as we watch news about them. But seeing does not mean everything. It is easier for us to see Nora and Bianca now, we see them, but most of us chose to ignore them; some did not active ignore but over time they forgot about their plight.

The film was not long, showing only five cases. Apart from the two cases described above, there are also one on women being raped in Democratic Republic of Congo, one on children who walk miles every afternoon to sleep in fear of being kidnapped in Uganda, and the last one about Columbians that there were forced to leave their home. You could probably understand how children in rural China walk miles a day to go to school; but could you imagine there are children who walk even farther just to sleep? Protests in the US, UK or Australia tell us how their soldiers should not be sent to Iraq, but at the same time children in Uganda are kidnapped at the age as young as seven to fight on the frontline, holding guns and being killed! I am not trying to compare the problems but to show you the difference how things can be if we'd cared. We can still say it is hard for us to tackle the problems in other countries despite globalisation as countries like Congo or Uganda are still ravaged by civil wars.. But those problems are not only the problems of those countries. They are the problems of all mankind. According to statistics provided by the RAINN (Rape, abuse and incest national network), every one in six women in the US has been victims of complete or attempted rape, with only 6% of rapists ever spend a day in jail. There is no civil war in the US. There is a developed, advanced education and government system. There should be no excuses.. It is easy to forget, but it is not hard to remember. We may not be able to do something huge or change the world tomorrow, but there must be something that we can do. Something, as simple as seeing, remembering and caring could make a change.

For more information, check up the MSF HK blog, or this page <http://www.msf.org.uk/invisibles.aspx>

好書推介： 口罩背後——手術室護士的真情記事

梁家威 (N12)



口罩背後

手術室護士的真情記事

卓綽

書名:口罩背後——手術室護士的真情記事

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作者卓綽是一名手術室護士。本書由五個單元共五十二個故事組成，每個單元都有各自的主題，帶出不同的感受和訊息。

病房中有不同性格的病人，每一種性格，每一個患病經歷，都編織了一個獨一無二的故事。在這眾多的故事當中，有開心的，有悲哀的，有驚險的，有無奈的，亦有感動的。這些故事除了觸動護士的心靈外，還可以影響其他病人。正如書中一位患有多發性硬化症(Multiple sclerosis)的女病人，她樂觀的生活態度令鄰床不斷生事的吸菸者安靜下來，變得合作。用生命感動生命。在這故事交織的病房是為「病房眾生相」。

手術室對於很多人來說，一定是一個神秘的地方。那一扇冰冷的大門，那「手術進行中」的大字，那從紅燈發出的鬼魅紅光，還有在門外焦急等候的病人家屬，令人不禁猜想門後那可以主宰生命的手術室，到底是不是一個冷冰冰的世界？醫生的冷笑話、捐贈器官的腦幹死亡病人、死於腹中的嬰兒。作者卓綽就以手術室護士的身

份帶我們進入一個可喜可悲的「手術室世界」。

死後人會到哪裡去？死亡可說是世上最神秘的一件事。醫院每天要處理無數的生與死，這個背景正好是鬼故事的開始。書中包括了不同的詭異鬼故事，究竟鬼魂真的存在嗎？還是過於疲累所產生的幻覺？種種的巧合，到底是真是假？除了恐怖的鬼故外，還有各種令人捧腹大笑的誤會。這就是「醫院不可思議」。

作為一個準醫務人員，你對醫院又有多熟悉？一些醫院的禁忌你又知道嗎？為何夜宵不能吃西瓜、紅豆沙和炒米粉？雖然這個單元裡的故事對於我們這班「準護士」來說，可能早已知曉，但當中亦有很多作者的經驗之談，一些特別的經歷都可以在「醫院放大鏡」中看得到。

生、老、病、死，是人一生必經的階段。在醫院工作，作為一個旁觀者，我們注定比其他人經歷更多。但這樣並不代表我們會對此麻木。醫護人員只是我們其中一個身份，當我們的親友生病，甚至去世的時候，我們亦會像普通人一樣悲傷。除此之外，我們亦會生病，當我們由醫護人員變為病人時，我們的感觸可能更深。作者卓綽也有親人離世的經驗，這些經歷都使她對生命有新的啟發。她亦做過病人，看著乳白色的天花，有著自己的「醫院回憶錄」。

我看過不少醫生所寫的散文。他們所寫的故事可能和卓綽所述的大同小異，但在醫療程序的實踐中，護士擔當著繁忙而重要的角色。她們站在第一線上，負責滿足病人們的各種需要及渴求，面對病人的時間更長，對病人的感情也更深。正如作者自己所說：「每一天，我像是在閱讀一本厚疊疊的小說，意料之內，意料之外的，應有盡有。」醫生和護士在看待病人上有不同角度，若你想看一些不同類型的醫學散文，不妨看一看卓綽這本《口罩背後——手術室護士的真情記事》，加上女性的細膩文字，應該能帶給你一種新鮮的感覺。



Taken by Keith Wong (M13)

Nano – The Next BIG Thing!

Tiffany Lau (M13)

Nanotechnology is all the rage nowadays. Even the name "nano" seems to reverberate in your head, holding a certain power – the promise of a future in which we can tailor our gadgets down to the very last molecule! Nano, a concept which used to be the stuff of sci-fi, is now the way forward in almost every field, from medicine to electronics, harnessing energy to manufacturing.

What is nanotechnology?

As its name suggests, it is the study of materials at the nanometer scale (10^{-9} m). In other words, specialized nanoparticles (the size of a few atoms) are being synthesized, manipulated and pieced together to create a perfect, precise structure.

What's so good about nanotechnology?

Because nanomaterials are built and perfected one atom at a time, scientists will be able to produce materials with all sorts of special properties: materials which are lighter yet stronger, computer chips which are smaller yet much more efficient, and so on.



This graphic, called Nanoinjector with Red Cells, shows a nanorobot injecting a substance, perhaps a therapeutic drug, into a red blood cell. (Courtesy of Coeneyl Jay)

When we apply nanotechnology to medicine, there are additional benefits. Since the structures are so small, they can interact with our cells better than ever, for example by activating specific cell surface receptors. It also means that they can cross the blood-brain barrier, opening up all sorts of possibilities for treating neurological diseases.

There is talk of creating nanorobots, tiny machines which can be programmed to carry out a specific function. In fact, scientists hope that these can be used to deliver drugs to specific cells in the body.

PERSONAL Nanofactories

Scientists are dreaming up personal nanofactories, small desktop appliances which can manufacture all sorts of products, atom by atom! Imagine being able to construct, from your desk, a notebook computer with a billion times the processing power of today's computers, with warm air and water being the only waste products! The possibilities will be limitless! Incomprehensible, isn't it? Believe it or not, this may become reality in only ten years' time.

Implications for medicine and healthcare

Water purification

Portable nanomembranes have been designed which can purify water, a neat solution to prevent the spread of many water-borne diseases in the developing world.

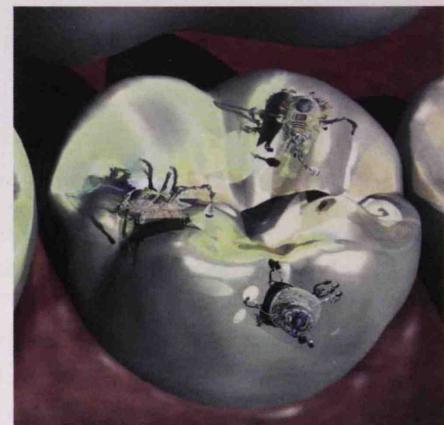
Drug delivery

Nanoparticles can be used to deliver drugs to specific cells. Because of their small size, they will be taken up more easily by cells, thus increasing their bioavailability. This in turn reduces the dosage required to produce a given effect, and so side effects are minimized. In particular, nanoparticles may be small enough to squeeze past the

astrocytes and endothelial cells making up the blood-brain barrier, allowing a greater dosage of anti-epileptic drugs, for example, to enter the brain.

Cancer

Nanotechnology also holds much promise for cancer patients. Early detection of tumours can be achieved by highly sensitive nanowires which can trap and detect proteins and other tumour markers which are only present in tiny quantities in blood.

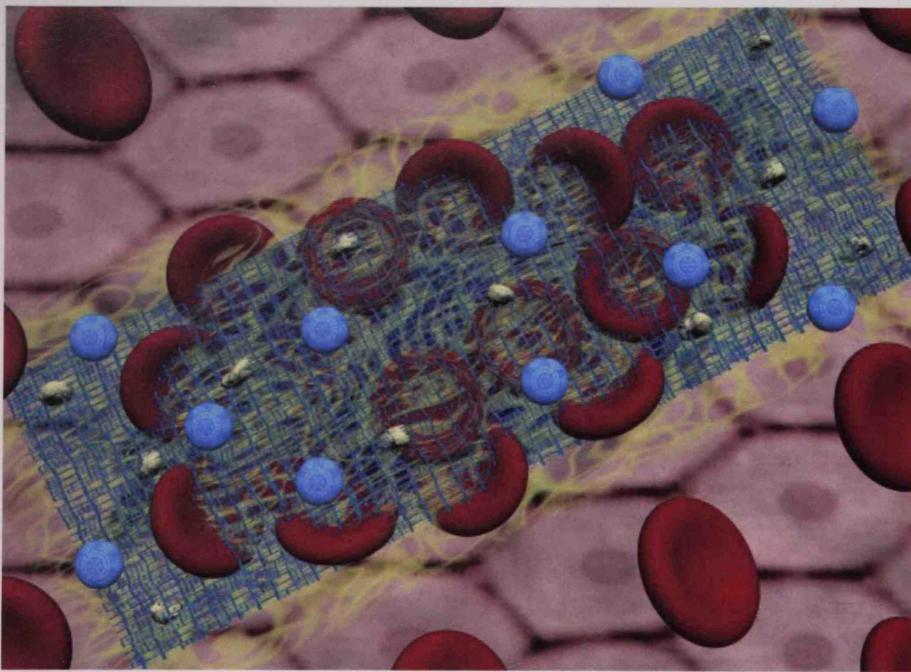


Dental Nanorobots II shows remote-controlled nanorobots cleaning and examining a tooth. (Courtesy of Peter S. Solarz)

Contrast imaging can also be greatly enhanced with the use of quantum dots (nanoparticles with special properties) as a contrast agent in MRI, a scanning technique used to visualize tumours. This is due to two special properties possessed by quantum dots. Firstly, they can emit light which is much brighter than conventional dyes. Secondly, their small size gives them a very high surface area to volume ratio, which means that more functional groups can be attached to them, allowing them to seek out and bind to cancer cells more easily. Once bound, the light-emitting nanoparticles can be used either to guide surgical resection of the tumour, or to kill the cancer cells directly and conveniently! For instance, a team of scientists at Rice University created gold-coated nanoshells which were designed to bind to tumour cells in mice. When infra-red rays were aimed at the tumour, the waves were absorbed only by the gold, which then heated the surrounding tissue and killed the cancer cells.

Surgery

Suturing of arteries and other tissues



Fibots 5 shows nanorobots clotting red blood cells by producing a mesh.
(Courtesy of Tim Fonseca)

during surgery can also be achieved much more easily with nanoshells. A liquid containing gold-plated nanoshells can be applied to the two sides which need to be sealed. When an infra-red beam is shone, the two sides are simply welded together by the gold.

Tissue engineering and regenerative medicine

Regenerative medicine is another exciting application. In tissues such as cartilage, which have limited regenerative capacity, research is well underway for developing scaffolds and extracellular matrices (the "cement" which holds cells together) using

nanofibres. Why do the scaffolds need to be made of nanomaterials? This is because scientists have found that adult mesenchymal stem cells can be coaxed into proliferating much more quickly on nanofibres than on microfibres! So with the involvement of stem cells, nanotechnology can be used for the repair of tissues, for instance skin burns, and treatment of degenerative diseases such as osteoarthritis.

The possibilities really are endless!

Dangers

However, that is precisely the problem. As you know, there is a flip side to



Artery Cleaner III shows nanorobots treating atherosclerosis by cleaning up fatty deposits in arteries. (Courtesy of Tim Fonseca)

everything. This wonderful technology with its amazing applications can also be applied in frightening, malicious ways. And if used recklessly, the manufacturing process can pose a threat to the environment, our health and our security.

Some people fear that nanomaterials will be used to create untraceable weapons of mass destruction, tiny hidden cameras or vast networks of spy computers.

Looking at the biological end of the spectrum, silver nanoparticles, which can be found in industrial waste, can inhibit the bacteria which break down organic waste matter in treatment plants. The immediate consequences are predictable: water contamination and food poisoning.

Here is another example: a study done in 2008 suggests that inhalation of sufficient quantities of carbon nanotubes may have a similar effect to asbestos, causing mesothelioma, cancer of the membrane enclosing our lungs.

Another worrisome thought is the fact that nanofactories are exponential. Not only can they replicate themselves, but they can also do that at low cost and high speed! So the development of a single nanofactory can soon lead to millions more being produced. That is a prospect that is both unnerving and thrilling at the same time.

Therefore, as with all things new and brilliant, the development of nanostructures must be carefully regulated.

Finally, a word of caution: you'd better keep an eye out for the latest advances in nanotechnology. After all... it's so tiny you might just miss it!

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中醫戒毒

張宇昊 (CM 13)

【明報專訊】一名14歲姓林少女，昨凌晨3時許外出盡興後返回屯門友愛邨愛明樓寓所，被51歲姓夏母親發現神情呆滯，未幾更陷入半昏迷。林母見狀懷疑女兒「索K」闖禍，為女兒生命安全着想，決定報警。救護員到場前女童回復清醒，送院檢驗後並無大礙，事後承認曾經吸食K仔，涉嫌吸食毒品被捕，警方正追查毒品來源。

上述新聞如今真的屢見不鮮，

濫用毒品已經成為一個世界性的社會問題，困擾著各國政府。解決這個問題最難的一環是如何幫助吸食者減除對毒品的依賴，但這並不是一時之間就能做到的事。毒品的依賴性是長期的，而現時的西藥能有效控制前三天嚴重的戒斷症狀（就是毒品上癮者停止吸食毒品後，身體作出的急性病理反應，如劇痛、頭痛頭暈、嘔吐乏力、暴躁不安等），但對之後一年出現的慢性戒斷症狀（如煩躁失眠、食慾不振、肢體疲倦、便祕腹瀉等）和吸食後遺症，尚無有效的療法。可是，慢性戒斷症狀的折磨，是戒毒者重投毒海的主要原因。現時一般都會使用遞減的方法，使吸食者能一步一步的減除毒癮。這方法就是以某種藥物去滿足吸食者對毒品的渴求（現在常用的是美沙酮），然後再慢慢的減少藥物份量，最後就能完全脫離毒癮。但這種方法最致命的缺點，是直到現在還沒有找到一種沒有依賴性的藥物來作為吸食者的「代替品」，導致很多人毒還沒戒好，反而對這種藥物上癮，結果功虧一簣。

當大家將視線都定焦於西醫，希望它可以快點研究出更有效的方法時，其實不妨轉移方向，想一想——原來中醫也有自己一套的戒毒方法。

相信對很多香港人來說，中藥戒毒是十分陌生的，甚至可以說是聞所未

聞。其實在古時的中國，遠至晉朝已經有吸食丹藥的風氣。古時的人們誤以為這些丹藥可以使他們長生不老，化仙升天。儘管服藥後會上癮及帶來諸多的副作用，但當時的文人雅士卻視為一種潮流，爭相仿效。而現代人津津樂道的竹林七賢，更是當中的佼佼者。據記載：竹林七賢當中就有人因為服用丹藥太甚，引起強烈的副作用，要於冰天雪地中在冰上打滾，來冷卻發燙的身體。

在這歷史環境的驅使下，古時的中醫就開始研究戒毒及治療吸食副作用的方法。但由於這種吸食的風氣只維持了一段很短的時間，所以之後中醫在這方面也沒有繼續作深入的研究。直到西元1773年，外國向中國大量輸出鴉片，導致本來只用於臨床治療上的藥物，變成了一種不論達官貴人，抑或平民布衣都吸食的毒品。當禁食鴉片的呼聲越來越響亮時，用藥物來戒毒的臨床研究便順勢而生。

最早研究戒毒方藥的是林則徐。他首創了戒毒藥「忌酸丸」和「補正丸」。這兩種藥的成分大致一樣，惟獨忌酸丸比補正丸多用鴉片一物。治療毒癮之時，病人逐漸減少忌酸丸量，而加大補正丸量。事實上，這就是現代遞減戒毒的雛形。林氏開創了遞減戒毒法的先河，而他對中藥戒毒的研究，亦影響了之後一代又一代的醫家。

其後於1892年，程履豐在其著作《戒煙全法》中，以林氏理論為基礎，發展了「五臟六腑受癮」的煙毒成癮病理學說。他於書中指出：「近世生人，秉賦多薄，五內均有虧損。煙毒之中，損者先受而且重，餘臟次之。但虧損各殊，形証亦異，且癮亦有大小之不同，証亦有一臟、二臟及三、四臟之不等。」程氏指出，各人之體質秉賦有異，因此五臟強弱亦有不同。在煙毒下，五臟中最弱的一臟

會先受損，而且病情最重，其他內臟則次之。此外，臟腑受損的方式亦有不同，癮性的深淺也有分別。再者，受損臟腑的數目也不一樣。因此，他在治療時主張根據臨床實際情況，選用不同的治療方法。他重視病人個體差異，把中醫的辨証論治原則，具體的應用到戒毒治療之中，豐富了中醫戒毒理論，也指導了往後的發展。

中醫看毒品性質及危害

鑑於不同毒品作用於人的效果都不同，所以沒有固定的病理解釋。因此，這裡只簡述兩種比較多人服用的兩種毒品：可卡因 (Cocaine) 和大麻 (Cannabis) 在中醫理論下的致病和成癮原因。

這兩種藥物在中藥學上來說是性燥味辛。由於其燥辛的作用過強，作用於人體，會耗氣血傷水液，因為辛味可以開泄皮孔，所以氣便從之外洩；性燥會耗損水液，導致血液變稠、體內水液量減少。氣為推動人體各器官運作，調控機體運動的原動力，還有禦外的作用。而水液減少，會使血液與其他體液的濃度增加，因而出現瘀阻、瘀滯，中醫稱之為「毒瘀」。氣虛加上「毒瘀」，會使人體各組織器官發生病變，導致各組織器官不能正常運作，功能衰退，處於半癱瘓狀態，導致營養輸布出現問題，身體各部位不能得到正常的營養供應而出現萎縮。所以長期吸食的人就會面黃肌瘦，骨瘦如柴。由於機體防病抗病能力減退，各種致病源很容易侵入體內，各種疾病便伴隨而生，久之甚至機能喪失、營養枯竭而死。

毒癮的形成

這些毒品大多有強烈的麻醉效果。當毒品作用於人體，各器官的新陳代謝以及營養的輸送都會減慢，直至毒品作用時間過去，人體各組織器官會在麻醉中逐漸甦醒，慢慢恢復各種功能，而功能恢復最快的是神經系統。處於飢餓狀態下的各組織器官，一旦功能恢復，最迫切需要的就是營養物質的補充。這些功能已經恢復，但營養物質尚未得到補充的組織器官，在恢復過程中會給人帶來錐心刺骨般



左起：可卡因、大麻葉、大麻、美沙酮、林則徐像



的劇痛，同時還會出現流眼淚、流鼻涕、出虛汗、失眠、噁心、嘔吐、皮膚癢行感等各種症狀。當忍無可忍，得不到有效藥物控制或減輕這種痛苦時，人們就會想到繼續使用毒品來制止這種痛苦。這就是人們對毒品產生的生理依賴。此外，初食毒品者以其辛香開泄氣道，使倦者不倦，乏者不乏，精神感到陡然爽快，精力倍增（即舒適欣快感），如此反復渴望再吸，追尋快感而成癮。以上就是我們稱為的「毒癮」，也叫「戒斷症狀」。我們常說的「戒毒」，就是消除戒斷症狀。

中醫的治療原則

稽延症狀難以消除，心癮難斷，複吸率高，是當前困擾醫藥界及吸毒品者的一大難題。中醫在分別疾病標本的方法中指出：「病因是本，症狀是標；內臟是本，體表是標。」實踐證明，單一使用高強度的鎮痛藥物以毒攻毒及遞減法只能治標，而毒瘀得不到消除，受損害的組織器官得不到修復，病因便得不到治療，待發展到一定程度時毒癮還會發作。這就是「稽延症狀」。這種治標不治本的戒毒方法，是不可能徹底戒斷毒癮的。

中醫認為，人體的生長發育、各臟腑經絡的生理活動、血液的循行和津液的輸布，均靠氣的激發和推動。根據中醫「痛則不通，通則不痛」的原理，戒毒使用「補氣活血」的方法

最為適宜。「補氣」可以增強人體「氣」的推動能力，促進各臟腑經絡的生理活動，促進血液循環，增強活血藥物的功能。「活血」可祛瘀滯，排除毒瘀，使全身經絡暢通，各臟腑組織器官功能恢復。行氣和活血都可以止痛，所以補氣活血可加快其止痛效果，再以各種補益藥物，借補氣活血功能之助，使身體急需的各種營養物質，快速地輸送到各組織器官，使身體很快得到康復。隨著機體抗病機能的恢復，其它戒斷症狀也會隨之消失。

中藥治療

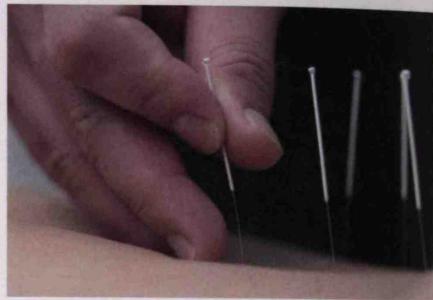
用於治療上述毒品依賴的中藥多屬補氣安神、解痙鎮痛等方面的藥物。實驗證明，川芍、鈎藤、羌活、延胡索和附子能明顯降低毒癮發作時身體晃動、頭部和四肢顫抖的徵狀；洋金花能明顯減少肢體伸展、面部顫抖、腹瀉、多尿及異樣姿勢，亦能阻止連續應用毒品所出現的鎮痛耐受性，恢復人對痛感的敏感性。

針灸治療

神經生理學機制指出，針刺可使交感神經與副交感神經的功能狀態恢復相對平衡，消除植物神經的功能紊亂，使戒斷症狀得到抑制。與針刺麻醉相反，針刺可減輕戒斷症狀引致的疼痛或不適，從而起到戒斷毒癮的作用。

針刺戒毒具有簡便、易行、痛苦小、損傷小及經濟等優點，但針刺戒毒與其他療法一樣，療效都會隨時間而下降，即時效應亦變得不穩定。然而，針刺戒毒可與其他戒斷療法互為補充，以提高療效。

總括而言，中西醫於戒毒方面各有優點，只有合兩者之長，才能讓吸毒品者得到最好的治療。



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News: Regenerative Medicine - The Way Forward!

Koel Ko (M13)

Why Regenerative Medicine?

Regenerative medicine is the therapeutic discipline relying on replacing damaged tissues with living, viable tissues, which will eventually lead to restoration of organ function. If the claim that regenerative medicine is the ultimate cure of a long list of intractable diseases (including cancer, type I diabetes mellitus, Parkinson's disease, Huntington's disease, cardiac failure, renal failure, hepatic failure, and a whole battery of myopathies and neuropathies⁽¹⁾) were not convincing enough for researchers to pursue cell therapy, we still have patients on the organ transplant waiting list and hospital administrators that agree with their patients to support the development of this miracle cure.

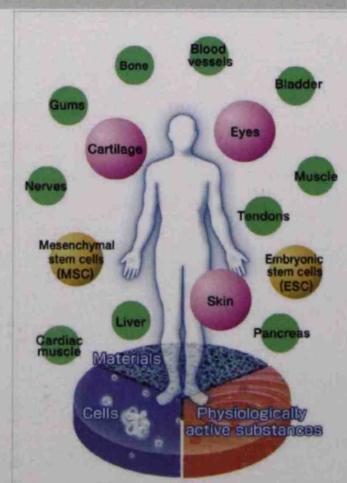


Figure 1: Regenerative medicine presents immense potential for future medical treatment.

Some definitions

The fertilised human egg initially consists of stem cells that have the potential to divide indefinitely into each and every cell type in the adult body (totipotent) (2). As the egg divides, an isolated mass of embryonic stem cells become the only ones to give rise to all cell types in the baby (pluripotent), while the rest develop into the placenta to support embryonic growth. In the adult, the ability of cell division is limited only to adult stem cells present in restricted areas of the body, which are able to serve as the progenitor for a few (oligopotent) or only one (unipotent) cell type, and can only divide under appropriate chemical stimulation(3). Many organs, like liver, kidney and brain, simply do not have adequate number of stem cells that are potent enough for replacing unexpected loss of tissues from injury.

Where do we get Stem Cells?

Theoretically, there are two ways to get cells to grow into what we want. Embryonic stem

cells (ES cells) come from the inner cell mass of blastocysts (4), and they could be "coerced" to develop into any type of cell in the adult body provided we find out the chemical signal the body uses to do that. Failing that, we can tap into existing sources of adult stem cells: neural stem cells develop only into nerve cells, while mesenchymal stem cells (MSC) are able to differentiate into various connective tissues and blood progenitor cells, and these MSCs have recently been discovered to give rise to pancreatic islet cells under certain chemical conditions. Most recently, immature stem cells have been discovered in human umbilical cord blood, which in particular contain haematopoietic stem cells ideal for autologous bone marrow transplant (discussed below) (5). The most ingenious method, however, is to find the genetic specifications for ES cells so that we can turn normal terminally differentiated cells back into pluripotent stem cells.

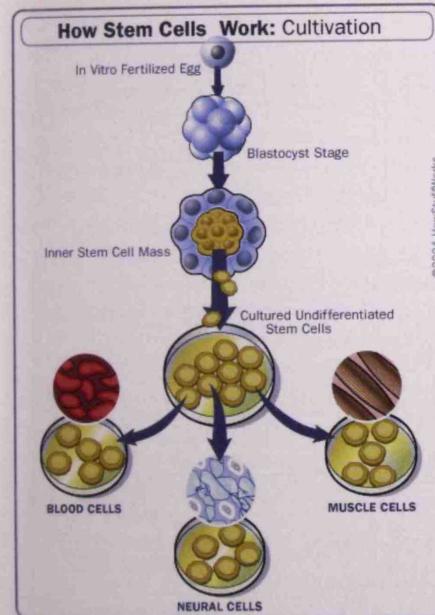


Figure 2: Cells from the inner cell mass can be induced to form all cell types in the embryo, presenting therapeutic possibilities for regenerating muscles and nerves – but practicalities are barely able to catch up with theory.

Stem Cells – the Dangers!

To recreate ES cells from skin cells in a mouse model, researchers have found a way to reverse the developmental programme using a cocktail of four transcription factors (*Oct4*, *Klf2*, *Sox2* and *c-Myc*), the genes for which were engineered into the genome of these



Figure 3: Embryonic stem cells may develop into hideous teratomas like this one. The lesson here is that although stem cell therapy sounds very attractive, we have to learn much more about the full scope of adverse effects that these cells may bring about in vivo in order to ensure stem cell treatments are safe for patients.

adult stem cells (6). However, we know that genes that drive cell division may become constitutively activated to give cancerous cells (*c-Myc* in particular is an oncogene) – which sounds exactly like what the researchers are doing here. Embryonic stem cells have also been shown to have the propensity to form teratomas, and even though research may attribute the tumorigenic tendency to one or another proto-oncogene such as *survivin* (7), involvement of other pro-growth genes may mean that ES cell therapy still incurs an increased risk of cancer.

Immune rejection of the transplanted cells also poses obstacles to cell therapies. However some of these dangers are being overcome. Some researchers have devised a way of using recombinant proteins of the four genes in the cocktail to avoid constitutive expression of potentially oncogenic transgenes (8), which will significantly reduce the risk of overdriving the division of the stem cells and reduce the cost of treatment, as transgene introduction would be much more time-consuming.

The Most Primitive Cell Therapy

Since some five decades ago, adult haematopoietic stem cells have been used to treat non-malignant haematopoietic disorders such as sickle-cell anaemia, and for blood cancers bone marrow transplant can supplement normal blood cell production such that much higher dosages of myelosuppressive chemotherapy can be achieved to clear the patient of malignant haematopoi-

etic progenitor cells (9). The key to the successful use of these particular adult stem cells lie in two important factors. Firstly, the regenerative capacity of bone marrow stem cells is so high that with an initial healthy marrow volume 5% of normal, the marrow function can still be fully restored (10). Haematopoietic stem cells also possess the unique ability to find their way to the marrow cavity following intravenous injection, and ongoing research shows that this ability is mediated by the interaction of specific cell-surface molecules called selectins on bone marrow endothelial cells, with particular types of integrins on the cells lining the marrow cavity. There may indeed be potential in exploiting these cell surface recognition molecules to allow stem cells to reach more diffuse targets with biochemical similarities on the cell surface. Bone marrow transplant aside, many other forms of regenerative medical treatments are under current investigation, of which a most poignant form is tissue engineering.

Grow me a Bladder

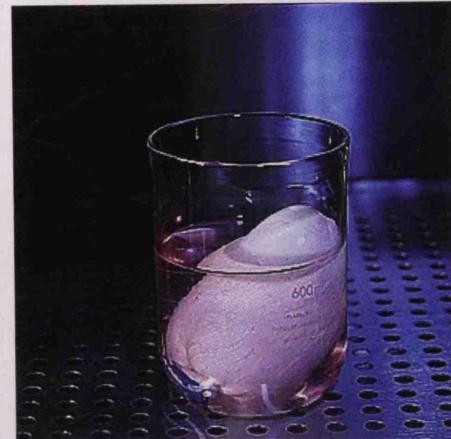


Figure 4

Tissue engineering bypasses both the risk of transplant rejection and the difficulty to control the manner of tissue repair in vivo. The solution is to grow an artificial organ, and scientists have started small – sphincter muscles, arteries, and now they are advancing onto whole organs. In 2006, scientists announced the first lab-grown organ in the world, an artificial urinary bladder (11) used to help patients with an anatomical defect of the bladder associated with spina bifida. The bladders were grown from a sample of bladder smooth muscle from the patient such that there would be no risk of transplant rejection, and to induce the cells

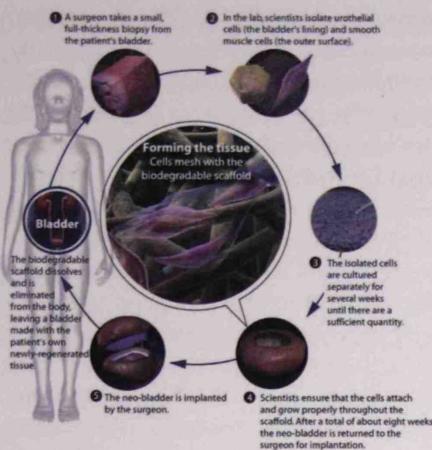


Figure 5

to grow into the shape of a normal bladder, a biodegradable scaffold (12) is made and several weeks later, the bladder would be ready for transplantation. However, researchers admitted that they were only able to grow half of the functional bladder not including the trigone area (13), which would involve constructing the ureterovesical valve to link the bladder to the kidney – another technical challenge by the anatomy that they have yet to overcome. Yet in time tissue engineering technologies such as these may give the ultimate solutions for patients with premature single organ failure.

Light at the End of the Tunnel

Apart from growing artificial organs, more subtle forms of tissue regeneration therapy are working their way up into the limelight. One interesting example comes from the eye. In many eye conditions, including retinitis pigmentosa and age-related macular degeneration, a layer of cells called retinal pigment epithelium (RPE) is often first affected. Since the RPE is the key layer for protecting and nourishing the photoreceptor neurons, irreversible damage to these cells will compromise vision (14). Researchers injected RPE cells grown from ES cells into the eyes of rat models with a genetic defect that leads to premature RPE degeneration. Encouragingly the rats displayed significant improvement in vision within three months, but the long-term survival of regenerated photoreceptors were rather low. Despite this, long term studies have also shown the stem cells did not increase the risk of tumour formation (15). While the safety in trials is reassuring, many more studies are needed to project these results into human clinical trials.

Rebuilding the Heart from Within

Cell therapy is also showing promise with both ischaemic and non-ischaemic cardiomyopathies, according to multiple animal, preclinical and early clinical trials. In a myocardial infarction episode, the heart may lose up to 25% of its myocytes, amounting to over 1 billion myocytes; for the therapy to work the regenerated heart muscle would need to be innervated and be able to obtain vascularisation. Despite these technical hurdles, induced pluripotent stem cells have been put under trial and showed that with little transplant rejection, some patients may potentially enjoy totally restored cardiac function as measured by left ventricular ejection fraction (16). These results again prove the point that the field of regenerative medicine is more vibrant than ever, and though proven treatments are still on the way, they should not be far from reaching patients in real need.

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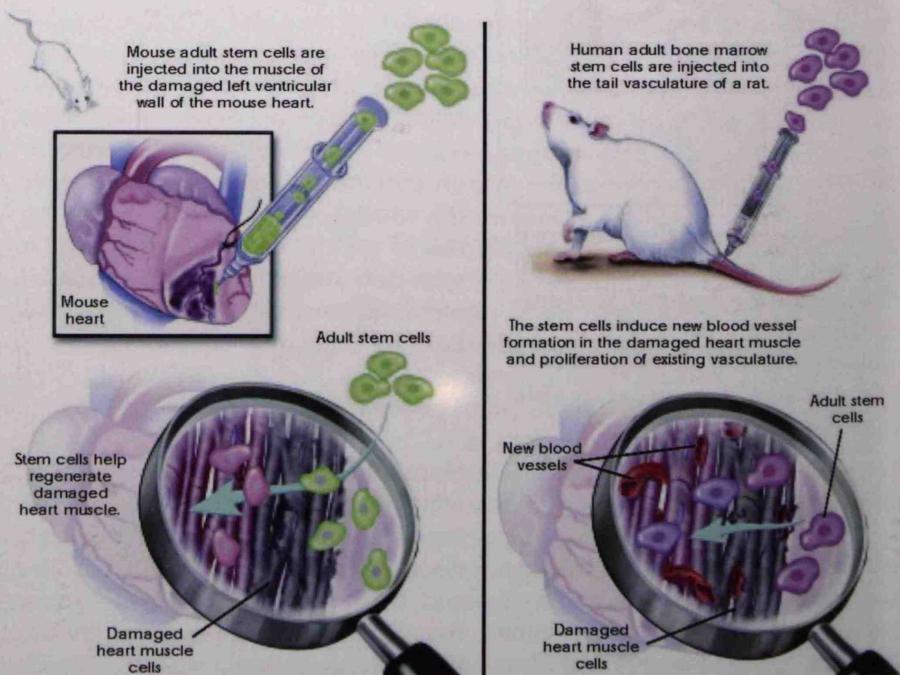


Figure 6

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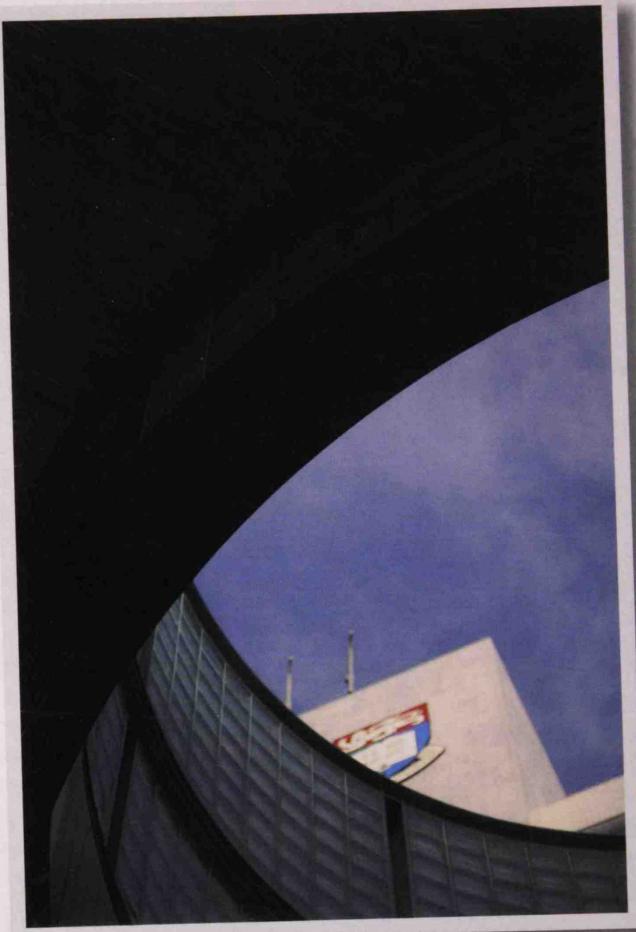
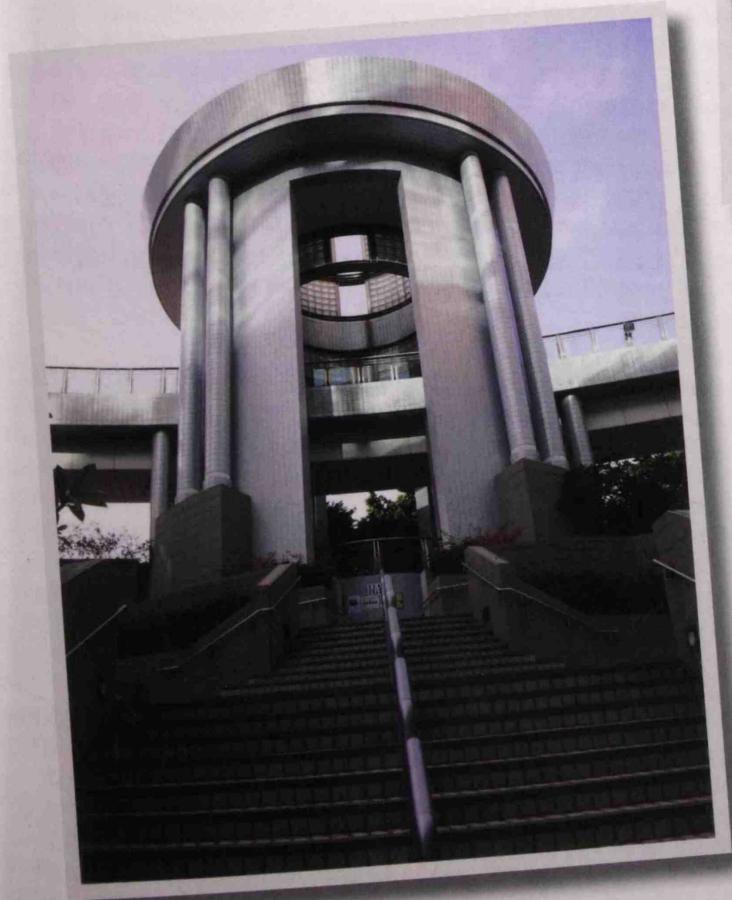
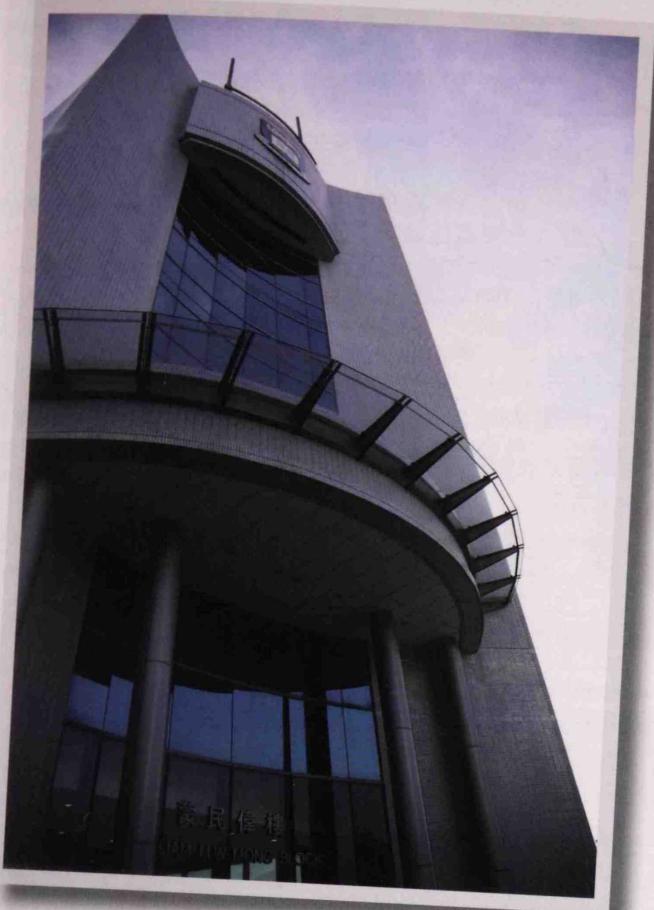
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Taken by Keith Wong (M13)

醫療事故頻生，誰之過？

梁家威 (N12)

近期揭發的醫療事故：(資料來源：明報通識網)

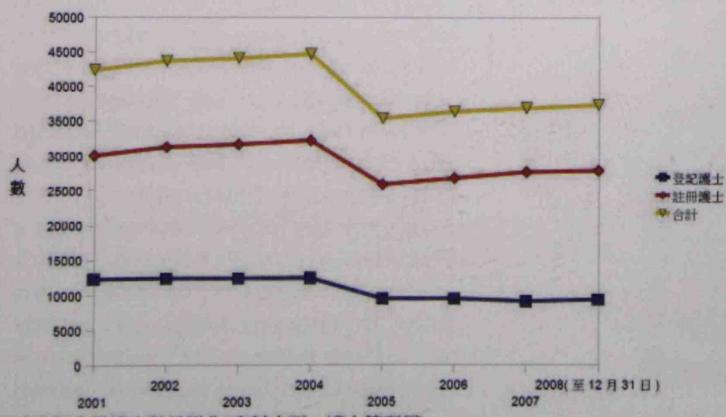
09年10月	浸會醫院醫生遙控護士落催生劑，病人疑羊水栓塞死亡
09年10月	內地孕婦在浸會醫院剖腹產子後死亡
09年10月	瑪嘉烈醫院延誤治療，男子留院五日仍未找出病因
09年9月	威院護士沒有核對手帶資料，為嬰兒注射了過量抗生素
09年8月	癌症病人錯注嗎啡，七日後死亡
09年8月	五嬰兒被接種過期卡介苗
09年8月	伊院護士無即時為兩名新生女嬰戴上腳帶，兩名嬰兒被對調
09年5月至7月間	醫護人員忘記將擴張血管器抽出，洗腎病人無辜捱刀
09年4月	東華醫院藥量出錯，一人死亡
08年8月	護士未覆核病人身分，調亂標籤病人輸錯血
08年7月	伊院嬰兒被錯誤注射十倍嗎啡

醫療事故頻生，誰之過？

09年8月，威爾斯親王醫院一名產婦誤將嬰兒放在另一名嬰兒的床上，而當護士為嬰兒注射時，卻沒有核對手帶資料，為嬰兒注射了劑量不符的抗生素；北區醫院一名護士長錯誤將口服嗎啡糖漿當作生理鹽水注入癌症女病人靜脈，女病人七日後死亡；伊利沙伯醫院一名護士使用稀釋後只有四小時效用的卡介苗針劑時，沒有檢查有效期便替五名嬰孩注射，覆檢時才發現針劑早在兩日前稀釋.....近年香港醫療失誤的新聞比比皆是，每月我們不難從報紙的頭版上看見各種各類的醫療事故，當中的嚴重程度可大可小——小的令病人蒙受不必要的傷害，大的甚至導致病人死亡。頻頻發生的醫療事故不但引起市民及社會各界的譴責，更令大眾對醫護人員的信心大大降低，嚴重打擊了整個醫療團隊的士氣。為防止悲劇再次發生，我們要探討問題的根源，才能對症下藥，找出解決問題的辦法。

資源不足及去護士化

香港社會人口老化，各類長期病患者亦隨之增加。社會各界對公營醫療服務的期望不斷上升，所以提供有效及高質素的服務才能切合社會需要。因此，醫護人員的工作量一直有增無減。可是醫管局的資源分配卻不平均，人手亦見短缺，配套嚴重不足。以護士為例，根據早前香港護士協會的護理人力資源問卷調查顯示，每名在前線任職的護士每日平均要照顧多達十二名病人，相對歐美國家1：6或1



：8的比例，實在有很大的差距；他們的平均工作壓力更高達八分(十分為滿分)，接近「爆煲」的情況。在公眾不斷對公營醫療服務需求上升的同時，護士的工作量亦隨之增加，令發生失誤的機會大大提高。

近年，醫院管理局為了降低財政負擔及解決護士人手不足的問題，推行了「去護士化」的方針，新增了成本較低的健康服務助理 (Healthcare assistant) 及技術助理 (Technical Services Assistant) 兩個職位，以協助護士處理部分的日常工作，從而減輕護士的工作量。他們的工作範圍包括很多簡單的護理工作如量度血壓及整理床舖等，但有時亦會被安排負責「洗血」這類較複雜及高風險的工作。長久地依靠助理員代替護士執行職務，會使護士對助理員的人手比例失衡，令「去護士化」的情況進一步加劇。這個「去護士化」方針，表面上看似能解決護士人手不足的問題，

但實際只是一個「望梅止渴」、治標不治本的方法。護士的價值在於其豐富的專業知識、批判性的思考、管理及領導能力。當非專業人士進行專業工作，除了影響護理質素外，醫療事故的風險亦隨之增加。

醫療制度問題

本港的護士教育一向以醫院為中心，即是以護士學校的模式於同一間醫院內上理論課及實習。縱使這種教育制度被人批評為「學徒式」訓練，但我們亦不可否認它存在的價值。由於護士學校會因當時的人手情況來制定學額，因此便能為公營醫療體系提供穩定和充足的人力資源。到了二零零零年，護士專業進行改革，護士學校停辦，使護士教育學位化，改由大學訓練，使學生能多元化發展。有很多研究顯示，大學內各項的訓練有助培訓護士的獨立思考能力及加強準確的臨床決定，令護士變得更加優秀。護士質素的提升當然值得高興，但代價是人手的增幅由每年約一千人減至三、四百人，加上人手的流失，令護士數目逐漸減少。這個缺乏長遠性、錯誤評估的人手規劃，縱使重開護士學校，不斷增加大學學額，仍未能解決人手供應的問題。

正如上文提及，醫院管理局為了節省開支，提出了一連串的新措施，而定薪合約的聘用模式亦隨之誕生。當時有部份合約期只有十二個月，令不少視護士為終身職業的人卻步。最神奇的是於零四零五年期間，因公務員減薪方案，加上缺乏彈性的合約，令一些遲入職護士的薪酬竟然比早入職的護士還要高。雖然事件最終能順利解決，但這樣的合約制度早已令公立醫院轄下的員工失去信心。相反，私家醫院的合約則較有彈性，工作量又比公營醫院少，所以有不少護士投向了私家醫院的「懷抱」，令公立醫院的情況雪上加霜。

除此之外，醫院管理局為方便管理，定下了不少指引讓員工跟隨。當然，指引本意是為了防止出錯，出發點是很好的。但當這些指引愈來愈多，程序一個比一個繁瑣複雜，問題就應運而生了。指引給人的感覺就是一個標準，當你遵守了、順從了，你就是一個合格、一個「好」的員工，因為你已經做足了自己的本份。在這種管理文化下工作，久而久之就失去了警覺性。但護士難能可貴的地方，就是

他們擁有比常人高的使命感，能以專業判斷作出適當的臨場反應，不怕做多，只怕做少。若抱著「多做多錯，少做少錯，不做就不錯」的心態，靈活性就大大降低，甚至發生明愛醫院病人於急症室外失救這種嚴重醫療事故。

人為疏忽

有很多醫療事故都是由藥物所引起的。為減少藥物事故，公立醫院醫護人員為病人注射或在病房派藥給病人時，都有一套簡稱「三核五對」(3 checks 5 rights)的程序，以確認病人身份和所派的藥物無誤。每一格病房約有6至8名病人，而以內科病房為例，每一個病人又要服用大約8種藥物。屈指一算，護士每次都要派至少48種藥，經過「三核五對」後，就是「核」了144次和「對」了240次。當人手不足，又面對著沉重的工作量時，很多護士就選擇性地省略了以為不重要的步驟，當中未必考慮到安全性，令出錯的風險增加。

正如上文所提及的「護協」問卷調查中，護士除了承受很大的工作壓力外，他們的工作滿足感指數亦很低，平均只有三分(十分為滿分)。這反映出前線護士在龐大的工作壓力下，瀰漫著一片士氣低落的氣氛。在缺乏發展前景及晉升機會底下，不少人都感到意興闌珊，甚至變得消極起

來，不能認真投入工作，導致醫療事故的風險大增。

總結

醫療失誤針對的是嚴重的人為疏忽，包括管理階層的問題及政策失誤，以及前線醫護人員的錯誤。龐大的工作量及工作壓力令護理人員喘不過氣來。正如再堅韌的橡筋終有一日也會被拉斷，再仔細的醫護人員也會有犯錯的一天。當然，我不認為一句「人手不足」就可以以偏概全，把所有醫療事故都推在「人手」身上。正所謂「食得咸魚抵得渴」，選擇了這個行業，就要接受它的一切，沒有甚麼藉口可言。就算「人無完人」，醫護人員在任何情況下都不應犯錯。我認為絕大部份的護理人員仍有著一顆「南丁格爾」的心，不是一部冷漠的機器。他們會盡最大努力照顧病人，將犯錯的風險減至最低。但如果政府及醫管局能作出長遠的護理人手規劃，減低護士與病人的比例，令前線的護士可以安心在低風險的工作環境下，全面發揮他們的專業護理水平，提供高質素的護理服務，以滿足病人的需要，那麼我相信發生醫療事故的機會一定能減至最低。

若醫療事故頻頻發生，醫療服務又怎能發展成特首所說的六大產業呢？

Global Warming Calls for a Global Health Warning!

Tiffany Lau (M13)

In December 2009, a monumental event will be hosted in Copenhagen, Denmark. Eyes all over the world are set on COP15: the most important conference on climate change to be held since the famous Kyoto Protocol was adopted in 1997.

What is COP15? COP15 stands for the "15th Conference of the Parties" to the United Nations Framework Convention on Climate Change (UNFCCC). The COP is held every year between the 192 countries who agreed to the UNFCCC, that is those who agreed to work together to combat climate change.

This year's conference is particularly crucial because the aim is to reach a global agreement on tackling climate change by the end of COP15, which is on the 18th of December, 2009. By common consensus, this year is the very last chance for such an agreement to be made if it is to come into force in time for 2012, when the Kyoto Protocol expires.

Sounds ambitious? Well, either way, what is frighteningly clear is that this long-awaited agreement is urgently needed. The evidence for global warming is no longer disputable. The Earth's temperature is rising exponentially: over the past 25 years, it has increased by 0.18 °C per decade, a rate more than double the average for the past 100 years.

Global warming is a very hot topic (pardon the pun). We all know about the catastrophic consequences of climate change to Planet Earth – the well-known chain of events leading to rising sea levels and freak weather events. But

have you ever thought about the threats it poses to our health?

You may not realize it, but climate change is having a huge impact on health, contributing to disease and premature deaths around the world. All countries will be affected, although the developing world will suffer the most, due to their poor sanitation and healthcare system, heavy burden of infectious disease and limited ability to adapt to climate change. Following the recent release of several reports on the effects of climate change on our health ^{4, 5, 6}, this topic has been pushed to the forefront and I wish to bring it to your attention. It is vital that we, as future healthcare professionals, become aware of the health challenges we face in the coming years so that we can strive to mitigate and prevent them.

The effects of changing weather patterns on health are both direct and indirect (see diagrams). Direct effects include injury, disease and death due to extreme weather conditions such as heatwaves, cold-waves, floods, droughts, fires and storms. Extreme cold, for example, can lead to frostbite and hypothermia. On the other hand, heatwaves and high outdoor temperatures have serious implications for workers'



Help! The Earth is reaching a critical temperature. It needs to be treated, quickly. (Courtesy of Climate Change Emergency Medical Response)

occupational health, particularly those in construction and agriculture, who are at increased risk of dying from heat stroke. Increased exposure to UV radiation, which will occur in some parts of the world due in part to changes in cloud distribution, can lead to health problems such as skin cancer (cutaneous melanoma), sunburn and cataracts.

Indirect effects of extreme weather events include the destruction of crops, disruption to food logistics and loss of food and freshwater supply, leading to starvation in the short term, and malnutrition and associated developmental disorders in the long run. Natural disasters may also cause population displacement, which can easily lead to outbreaks of infectious diseases such as diarrhoea as a result of overcrowding and lack of clean water and food. Floods in particular are often followed by outbreaks of cholera and typhoid fever due to faecal or chemical contamination of water supplies, especially in countries with poor sanitation. Meanwhile, droughts can lead to malnutrition due to decreases in crop yield, and this in turn increases the risk of contracting and dying from an infectious disease due to poor immune function. In addition, droughts are usually accompanied by dust storms, which cause respiratory problems.

While on the topic of respiratory diseases, it is worth mentioning that ozone gas concentration at ground level is increasing, probably due to rising temperatures. This is because ozone is produced from vehicle exhaust gases reacting in the presence of heat and sunlight. The consequences of exposure to elevated ozone levels include respiratory problems, such as pneumonia, asthma and chronic obstructive pulmonary disease, due to irritation of the respiratory tract, and resulting cardiovascular problems like congestive heart failure.

Moreover, the warming of the planet is changing both the seasonal distribution of allergenic pollen and the geographical regions affected by vector-borne diseases

such as malaria and dengue. In the Northern hemisphere, the spring pollen season is earlier than before, which has implications for people suffering from allergic rhinitis. In addition to this, ragweed, a new species of invasive plant which produces highly allergenic pollen, is now spreading rapidly in many places. There is evidence that a rise in temperature and CO₂ concentration increase ragweed pollen production and prolong the pollen season.



The worsening air quality is taking its toll on our respiratory health.

At the same time, the geographical distribution of mosquitoes and other disease-transmitting vectors is being altered. Although the precise effect of rainfall and temperature on the transmission of malaria and dengue fever are still unclear, some areas will certainly experience an increase in incidence in vector-borne disease. The same can also be said for diseases transmitted by rodents, such as the hantavirus pulmonary syndrome, since contact between humans and rodents increases during times of flood.

A rise in air temperature also has an adverse impact on food and water safety, since the warmer it is, the more flies and pests are active, increasing the risk of food contamination. Warmer sea temperatures also increase the bacterial load and algal toxin concentration in shellfish, further increasing the incidence of food poisoning outbreaks. Additionally, since the microbial load in water reservoirs also changes in response to temperature and amount of rainfall, the pattern of infectious water-borne disease will be altered as well.

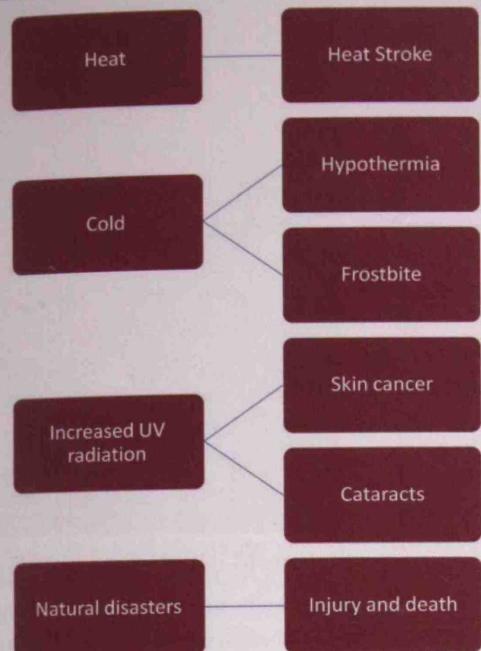
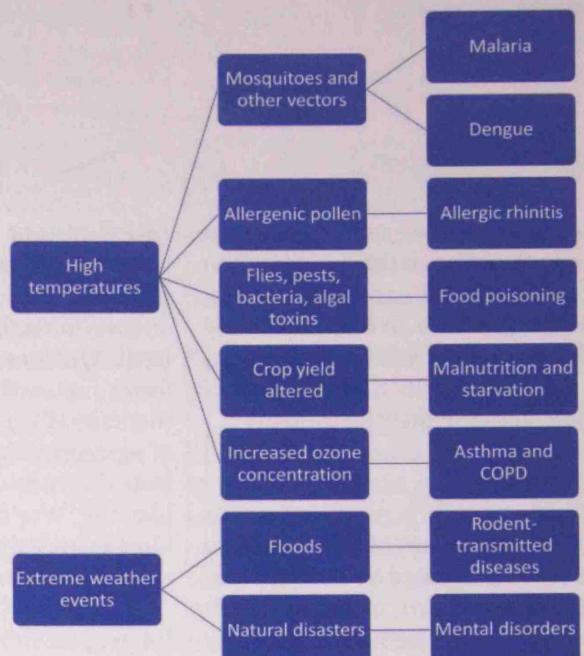
So far, we have only covered the physical aspects of health. In addition, extreme weather events can lead to displacement of populations, social instability and economic decline. Such socio-economic disruption may have a negative impact on both an individual's psycho-social wellbeing (and consequently his health) and the provision of healthcare services by the community. Mental disorders such as depression, anxiety, post-traumatic stress disorder and behavioural disorders in children may stem from floods and other natural disasters. Psychological health is an area which has previously been neglected by researchers but is now receiving much more attention.

Of course, having listed all the harmful effects of climate change on our health, it would only be fair to mention the benefits: higher temperatures will reduce cold-related injuries and deaths, increase crop yields in temperate regions and reduce mosquito activity in some parts of the world. Furthermore, increased exposure to UV radiation can reduce vitamin D deficiency diseases such as rickets. However, it should be clear that the hazards climate change poses to our health far outweigh the potential benefits.

Protecting ourselves from these health hazards requires intervention at every level: the individual, the institution, the government and international organizations. At the national and international level, monitoring and warning



Hotter and wetter climates will breed mosquitoes, the vector for malaria.

Direct effects on our health**Indirect effects on our health**

systems for extreme weather events, heatwaves, malaria outbreaks and other epidemics are being put into place, along with the appropriate management strategies to tackle these events. Infectious diseases like diarrhoea can be reduced by relaying the right messages about hygiene, water safety and disease vectors to the public. And what can individuals do to protect themselves? By being more aware of prevailing weather conditions, disease outbreaks and potential threats posed to our health by climate change such as those described above, we can make adjustments to our clothing, activity level, personal hygiene and living environment, so that we can avoid injury and disease.

Nevertheless, as healthcare professionals always say, prevention is better than cure! Therefore, it is high time

that the root of the problem, global warming, is addressed. A reduction in greenhouse gas emissions is essential to averting a crisis, and this can be done in a variety of ways, such as improving energy efficiency, using renewable energy and restricting the number of cars on the road. Reducing emissions will benefit our health both in the short run – by improving air quality – and more importantly, in the long run – by slowing down and even reversing global warming.

So let this article on global warming be a global health warning to you all. Be prepared to defend your health and that of your patients against the onslaught of climate change. And let us hope that the COP15 in Copenhagen will achieve its goal and mark a turning point in the history of this troubled yet delicate world of ours.



Freak weather events will not only injure and kill, but will also destroy homes and displace millions of people. (Courtesy of UNESCAP)

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Intellectual Property and its Discontents

The Embattled Leftist

"If you have an apple and I have an apple and we exchange these apples then you and I will still each have one apple. But if you have an idea and I have an idea and we exchange these ideas, then each of us will have two ideas."

- George Bernard Shaw (1856-1950)

Introduction

While 'traditional' or 'tangible' property has been recognized for thousands of years, perhaps as early as human civilization appeared, 'intellectual' property (IP) is a very recent concept. Coined in the early 20th century, the concept quickly spread all over the world.. As of now, although piracy is still common, few doubt its legitimacy and moral authority. Essentially, IP has been assimilated to the ideology of the modern world, and became a set of assumptions that underlie our daily lives.

IP comes in four forms, each of which confers the holder some sort of monopoly. To begin with, copyrights grant the authors of a text the ability to publish, distribute and utilize it exclusively within the public domain. In most jurisdictions, it is valid through the lifetime of the author to 50 or 100 years after his death. Trademarks, on the other hand, are distinctive signs utilized by organizations or individuals to permit recognition by the public. Once approved, the registrants' party will hold monopoly over that sign forever. Finally, patents and industrial designs are detailed technical specifications of a novel invention, which holders claim exclusivity in their usage for a limited

period of time. They can be technical drawings of machines, chemical structure of a drug, computer codes, so on and so forth. IP rights are backed by legal sanctions, that is, those who infringe upon them will face punishments by the government. International agreements such as the TRIPS have been drawn by dedicated organizations like the World Intellectual Property Organization (WIPO), a constituent of the United Nations.

Its proponents' arguments

The concept of intellectual property arose from specific historical circumstances (the modern industrial era) and was strongly espoused by interest groups who subsequently substantiated it by elaborate philosophical theories. By the end of the 19th century, new inventions have reached a saturation point to which competition is extremely intense between entrepreneurs producing a similar product, e.g. a textile machine. As a result, copycat behaviour was rampant and many a time inventors were incapable of reaping the full benefits of their invention. The intellectual property movement thus began.

In the Berne Convention – the first international meeting enshrining copyrights – the organizers presented a classical (Lockean) justification of the concept. They argued that in the process of literary creation, the author mixes his mental efforts into the text just as a farmer mixed his manual labour into the crops he grew. Therefore, the resultant creation became his own property. This idea was applauded by most publishers in Europe and America, as they see it as a new way to profit over authors' works. The concept was subsequently expanded horizontally to include pictures, videos, industrial models, recipes – and virtually everything that is created from human agency.

Towards the later part of the 20th century, utilitarian arguments have been forwarded to justify the existence of IP,



Sick child in sub-Saharan Africa

particularly in relation to pharmaceutical patents – which frankly have become quite a phenomenon on its own. The argument was that in a technologically advanced society, drug discovery is achieved through a capital-intensive trial-and-error process. For drug companies to be willing to commit into the process, clear benefits must be present. Granting pharmaceutical companies monopoly over their drug for a certain period of time (say 10-15 years) provides a proportionate and just remuneration for their efforts. It was therefore argued that if the patent system were absent, we would plunge into an era of technological stagnation where no new drugs would be invented anymore. Again, this argument was expanded laterally to include copyrights.

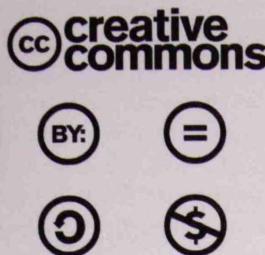
Is IP really property?

But, is IP really property? Can we really consider the ability to control the distribution of a piece of music as fundamental a right as that of physically holding a CD disk? If we return to the philosophical grounds of property it is not hard to find that these are actually distinctly different concepts.

First of all, the concept property in itself implies scarcity. If a good is so abundant in amount that everyone on the planet is able of getting enough of it, the good ceases to be property. The reason why a laptop computer or a motor vehicle can be regarded as property is because their amount are limited and thus incapable of satisfying human wants for them. Moreover, their usage by one individual necessarily prohibits



Drugs are a rarity in Africa because of their inflated cost



Creative commons: Defying human selfishness

the usage by another person: if one is driving a car the other cannot, at the same time, drive the same car. However, in the case of intellectual property, ideas can be shared and multiplied among different individuals without a cost (see quote), and therefore use by one individual does not impinge upon the use by another. Essentially, ideas are not consumable. They are never 'used up'.

As a result, there can be no equivalence of 'theft' in intellectual property. Theft, essentially, is the deprivation of property rights from its owner. But even in the case of 'piracy' the author's right to use his own intellectual creations is not diminished – it's just that an extra copy of the intellectual work has been created in the minds of other people.

Inconsistencies in law

It is perhaps because of this intrinsic difference between tangible/traditional and intellectual property as outlined above that the law has been very careful in assigning full property status to the intellectual creations of men. For example, while the punishment of theft is incarceration in most countries, that for intellectual piracy is only fines or injunctions. While traditional property rights do not expire – that is, when I purchase tangible property I own it forever – some IP rights only last for limited periods. For example, patents 'expire' after 10 to 15 years. Many debates have from thence stemmed from these inconsistencies. For proponents of IP, they seek to perpetuate ownership of patents and copyrights. For its opponents – like the author of this article – they seek to abolish it once and for all.

But the ambiguities do not stop here. What things are patentable and what things not? Can gene segments be patented? What about a language? Ayn

Rand, author and philosopher, noted that if the English language were patented by its inventors we would all be slaves to him since we owe him so much in royalties. And what about mathematical laws? Why can complex statistical models be patented but not the multiplication table? Why does 'being easily understandable' prevent

something from being patented? The truth is: the nature of IP laws requires arbitrary separation of 'superfluous' inventions from 'registerable' inventions, which isn't fair at all!

Not a necessary condition for invention

But the most celebrated and 'powerful' argument for IP proponents is actually an observation from hindsight. Many theorists have observed that since the introduction of the concept of IP in the 1900s, the amount of technological inventions, industrial designs and literature available in the public has increased exponentially. As a result, many products became available for public consumption on the market. They conveniently conclude that there is a causal relationship between IP rights and invention and use it to justify its existence. But I argue that there is no such relationship.

It is absurd to suggest that authors wrote their novels, professors published their papers, or engineers invented their designs purely for obtaining the IP rights involved. From our personal experience and countless historical examples, we see that the tendency to share discoveries with other human beings is something intrinsic in all men and women alike. That is why even before the advent of IP, great authors like Shakespeare and Confucius, brilliant musicians like Beethoven and Mozart have already emerged.

A more plausible explanation for this expansion in public knowledge would be the popularization of education in the 1900s. Many universities were established and knowledge to art and science ceased to become a privilege of the royal classes. This translates into an increased understanding in science which in turn leads to more research and discovery by brilliant scientists.

The popularization of publishing houses in Europe allowed authors to make known their ideas to the public through publishing their works, and thus the increase in books within the public domain. In conclusion, that there was an increase in invention following the introduction of IP seemed only to be a coincidence – the trend had been there all the way and correlation does not imply causation.

Not an avenue for just remuneration

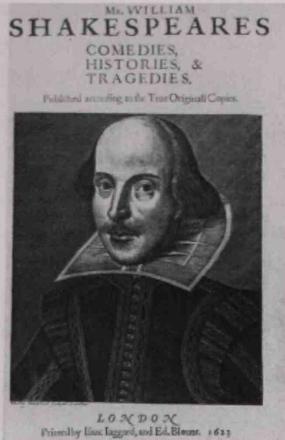
IP was established with the intention to justly reward the creators of ingenious works. The cost of rewarding the creators is a higher price bore in consumer goods by the general public. After a century, have these creators truly been rewarded, and if yes, how efficiently? Moreover, have alternative avenues for remuneration that do not require distortions to the definition of property emerged? These are all burning questions that we must answer as the amount of public money spent on IP increases year by year.

In reality, we see that IP is a very inefficient system of transferring money from the consumer to the creator. In the example of authorship, publishing companies engulf the vast majority of profit gained in selling books – the original authors of literary works receive as little as 3% of the income derived. In the pharmaceutical industry, as few as 10% of the income from selling drugs go into research and development (R&D), even less into the medicinal chemists and pharmacologists who synthesized the compound. On the contrary, a huge market failure exists where companies who have registered the IP rights, by virtue of their capital and scale, exploit the fruits of the inventor, and achieve market monopoly sanctioned by IP laws. This is one of the major ills of IP 'rights'. Empirically, we see the prices of products can fall up to 90% when pirated (refer to the fake electronic hardware on sale) and even 99% if it is informational (books, music, videos)! For the case of therapeutics, their price can fall up to 85% once they have 'generalized' (had their patents expired). The amount of extra resources spent on creating these market monopolies is staggeringly unacceptable to the public.

So, are there better ways of rewarding inventors – assuming at a moment that such is socially and morally required? Such alternatives will be provided later in the section dedicated to discussion on pharmaceutical patents.

Technological gap: the road to perpetual slavery

Not only does IP pose unacceptable costs to society, on an international level, they discourage both competition and collaboration and lead to both the wastage of resources and the artificial creation of lasting inequalities between nations. How is that so? Nowadays, the economy in the developed world is essentially knowledge-based. However, technological inventions build on knowledge discovered in the past. The vast majority of these knowledge are patented and held by 'First world' countries such as the US and European countries. The amount of patents held by developing countries occupy a meager 5 percent, with most held by China and India. This staggering inequality not only reflects the technological inequalities between different nations, but also perpetuates it and creates wastage of resources. One salient example is in space technology. Despite the fact that the United States has been able to launch astronauts onto the moon as early as the 1950s, since most of the technology required were patented and kept secret, China was required to spend double the resources to obtain the same information to send Yang Liwei to space.. Moreover, in the field of computer hardware and software production, since most of the information are patented/copyrighted by large first-world corporations like Intel and Microsoft, developing countries have to spend unbearably large parts of their GDP into purchasing these 'IP rights' to develop their own secondary and tertiary industries. For this reason, poorer countries fall out of this process and have to rely on primary industries such as agriculture to maintain their international balance of accounts. This leads to perpetual submission of third world countries to developed countries.



Shakespeare: Does brilliance require copyright protection?

Saharan Africa, malaria kills 3 million per year. Another infamous trio of 'neglected diseases' – including leishmaniasis (Kala-azar), trypanosomiasis and schistosomiasis cost 1 million lives per year. For all these diseases, effective drugs exist. However, since most of them are patented, they are too expensive for African governments and NGOs to afford.

Developed countries are also not immune to the far-reaching harms of patents. In Hong Kong, as in Europe, the government pays for most of the cost of healthcare for the public. The majority of healthcare expenses is used to purchase drugs to treat patients. For example, in Europe, according to the

The ills of pharmaceutical patents

So, how does IP harm medical practice? If, at the moment, your mind is on downloading medical ebooks, you cannot be more mistaken. It is no exaggeration to state that the most direct and identifiable cause of death in sub-Saharan Africa is the existence of pharmaceutical patents. While HIV/AIDS is responsible for 1.5 million deaths in sub-

European Federation of Pharmaceutical Industries and Associations (EFPIA), direct payments from the government amount to the excess of 90% of the pharmaceutical company's income. We can truly say that our government nowadays fund the research of pharmaceutical companies.

As mentioned in paragraph one, many justify that pharmaceutical patents are necessary because they give drug companies sufficient capital for drug research, and if we don't do so, new drugs would not be developed. However, if we look into the budgets of major drug companies like Novartis, Pfizer and AstraZeneca, the amount of income spent in R&D are all around 15% only. This means that if our government would take 20% of what it currently spend on drugs, and directly allocate it to pharmaceutical research, there would be more money than today for research!

Worse still is that the pharmaceutical companies nowadays direct their research on profitable drugs instead of drugs that are truly needed. This means that much of the research money, mostly paid by the government, would be spent on, for example, weight-reduction drugs where there is a large market demand. Moreover, in an essentially monopolistic market (because of patents each large pharmaceutical company has their own patented/monopolized drug), since the

SYSTEMS AND NATIONAL HEALTH SERVICES (AMBULATORY CARE ONLY)	PAYMENT FOR PHARMACEU- TICALS BY COMPULSORY HEALTH INSURANCE
EFPIA 2004	million
Austria	€ 1,693
Belgium	€ 2,584
Denmark	€ 906
Estonia	n.a. (private healthcare)
Finland	€ 1,014
France	€ 19,879
Germany	€ 21,834
Italy	€ 11,988
Netherlands	€ 4,003
Spain	€ 9,160
Sweden	€ 1,891
Switzerland	€ 1,781
United Kingdom	€ 12,284
Total	€ 97,709

Diagram 1, Source : EFPIA member associations (official figures)(Excerpt)

drug offered is already unique, drug companies direct the majority of their budget in unproductive aspects such as advertisements, persuasions to doctors to use their drug, packaging, so on and so forth in order to further distinguish their product on the market. Considering that most money they get to spend comes from the government, this is a terrible waste of public resources.

Alternative: government prizes as a viable solution

Intellectual property rights, as applied to pharmaceutics, sets out to reward the scientist who discovered the drug, the clinician who proves its efficacy and to provide an incentive for future discoveries. The reality, sadly, is that the pharmaceutical company establishes a monopoly, fetches exorbitant prices for patented drugs so that sick people who need them can't afford it and die, while the pharmaceutical executives take the meat of the government funding and spend a meagre amount (15%) on research. This system clearly needs major revamp.

One alternative to restore the intents of IP is to abolish patents and establish government prizes. As explained above, if we use even 20% of what we spend on healthcare and establish drug discovery centres at public universities to fund medicinal chemists to pursue their work, we spend more money than present in research. To encourage production and discovery, government prizes can be set up for scientists who successfully solve medical problems - e.g. find a drug that can kill HIV or cancer cells. The fruit of their research would be freely available to the international public to benefit poorer countries. In this way, the spirit of IP can be preserved while its evils removed.

Encouraging trends: the praxis of the intellectual

The multiple evils of IP 'rights' have been noted by a few prescient philosophers whose theoretical criticism culminated in the mobilization of ac-

tivists calling for the abolition of IP, employing a three-pronged strategy. The first is to directly call for the abolition of intellectual property legislation through political activism. However, due to the international nature of the problem and a staggering lack of awareness there is little progress. The second is to establish a pool of non-copyrighted/patented resources readily available without a cost so as to out-compete copyrighted/patented resources. Throughout the past few years immense success has been achieved, particularly in internet-related enterprises. Open-source Linux operation systems have gained significant market share from the copyrighted Windows system. Wikipedia - an open-source, uncopied encyclopedia founded by philosopher Larry Sanger and engineer Jimmy Wales - has emerged as the most common general reference source in the world. Organizations such as the Free Culture Movement and Creative Commons, both founded by Harvard professor Lawrence Lessig, who explicitly reject the absurd premises of intellectual property and call for the liberation of information on the internet, has gained immense support from people all over the world. The third

way is to defy copyright regulations through direct civil obedience. As St Augustine exhorts us, 'An unjust law is no law at all'. People all over the world have vented their discontent over the oppression of IP through using peer-to-peer resource-sharing software and many other means. It has been estimated that for every IP-restricted information transfer, there are ten 'pirate' equivalents. This has been immense suc-

cess and law-enforcing authorities have found it hard to enforce IP laws simply because of the enormous amount of 'transgressor' online or otherwise.

As medical students and future doctors, our opinion on healthcare policy is one that the public can count on. Awareness on the absurdity of pharmaceutical patents is the first step to their abolishment. I, for a start, have written this article to increase awareness in HKU. What about you?



John Locke
(1632-1704)
English physician, paediatrician and philosopher:
Founder of the classical theory of property

Conclusion

In the first part of this short article, I started with an introduction on the history and concept of intellectual property (IP) and subsequently discussed its eligibility as genuine 'property' on a philosophical level, concluding that there are significant differences between 'tangible' and 'intellectual' property. Afterwards, I argued that the original intentions of setting up IP - providing just remuneration for inventors and encouraging invention - are not served through our existing IP legislation. Further to that, I pointed out inconsistencies in law such as the peculiar notion of 'limited temporal validity of property rights' and differences in punishment between theft and piracy, revealing deeper conceptual ambiguities and poverty in theory of IP.

In the second part, I noted that IP not only hinders international cooperation in research and causes resource duplication, but also perpetuates and widens the technological gap between the developed and developing world. I then directed my attention to the specific case of pharmaceutical patents, and described three major evils: the millions of deaths per year in Africa due to inflated costs of patented drugs, the wastage of billions of public dollars in profit and meaningless competition between drug companies, and the distortion of research emphasis. An alternative of nationalizing research and providing prizes for inventors was described.

Further reading:

- 1.'Against Intellectual Property' by Stephan N. Kinsella, Esq., BS, MS, JD (LSU), LLM (KCL) (www.mises.org/books/against.pdf)
- 2.'Against Intellectual Monopoly' by Prof David K. Levine, BA, MA (UCLA), PhD (MIT) (www.dklevine.com/papers)



Taken by Keith Wong (M13)

【中醫保健】秋冬養生

張宇昊 (CM 13)

【秋冬季節和致病特點】

中國養生學認為一年四季具有春暖、夏熱、秋涼、冬寒的特點，天地萬物都順應著大自然的變化而呈現出春生、夏長、秋收、冬藏的現象。

此時自然界乾燥之氣瀰漫，常令人感覺皮膚燥癢、口鼻、咽喉等呼吸道乾燥、乾咳無痰，甚至出現大便乾結、小便短赤等現象。這些皆因燥性容易耗傷人體中之水液，以致產生各種「秋燥」症候群。

此外，氣溫逐漸降低，寒邪容易侵襲人體，輕則傷風感冒，重則誘發中風或心肌梗塞。風濕病人、慢性支氣管炎、哮喘或胃、十二指腸潰瘍等患者容易於秋冬氣溫驟降時舊病復發。

【秋冬養生方法】

飲食起居

為了順應這些變化規律，從而達至養生的效果，中醫便有「春夏養陽、秋冬養陰」的說法。

秋天宜「早睡早起」：早睡以避其寒，早起以受秋爽。氣候轉變，人的心情也容易受影響，所以適當的戶外活動，對心情和體力都有幫助。

秋冬季氣壓高，早晚溫度低，空氣漸轉乾燥，所以秋季的保養以「潤燥」為主，尤其是呼吸系統的「防涼」、「防燥」。秋燥時節，不宜大補，應以「和」為貴，重的是「養肺潤燥」，以「清補」為主。辛熱之品不宜過食，口味宜清淡，更不宜吃羊肉、狗肉等，以免加重秋冬乾燥的不適。多吃豆類等高蛋白植物性食物，少吃油膩厚味。不宜多吃燒烤，以免傷陰助火，而致虛火上擾。

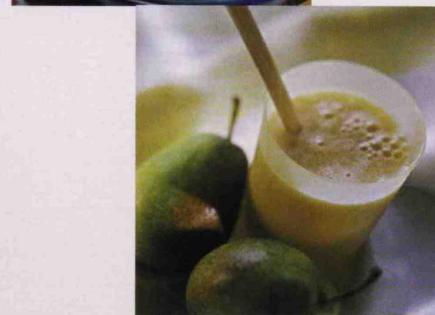
宜多食溫食，少食寒涼之物，以保護胃氣。如過食寒涼之品或生冷、不潔瓜果等，會導致寒濕傷脾，引起腹瀉、痢疾等，老人、兒童及體弱者尤要注意。

藥膳食療

燥是秋季的主氣，而肺易被燥所傷，因此進補時應注意潤補，即養

陰、生津、潤肺，採取平補、潤補相結合的方法，以達養陰潤肺的目的。寒是冬季的主氣，腎、心、脾胃等均易被寒所傷，寒會傷陽氣及致氣血凝滯，所以進補時應注意補腎健脾，養心通絡，即溫補通滯相結合。

雪梨



一、生吃梨能解除因上呼吸道感染所產生的咽喉乾燥癢痛、音啞、乾咳及便秘溺短、生瘡作瘡、癰疽發背、煩渴、潮熱等陰虛，虛熱之症狀。

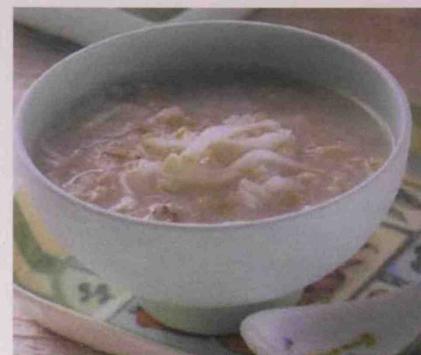
二、將梨搾成梨汁，或加澎大海、冬瓜子、蟬蛻、冰糖少許，煮服飲之。天氣亢燥、體質火旺液虧、易生喉炎咽嚙乾澀、聲音不揚者，具有滋潤喉頭、補充津液的功效。

三、把生梨加冰糖或蜂蜜，熬成膏即成「秋梨膏」，可治療肺熱咳嗽。

四、用梨一個，削去頂尖，成一蓋形，挖去核仁，納入川貝母少量，加入少許冰糖或蜂蜜，將梨蓋蓋回，隔水加熱燉熟，可治療痰火胸痛、咳嗽。

五、同上法，將黑豆納梨肚中，加冰糖（蜂蜜更佳）適量，用吹籠蒸熟，或隔水加熱燉熟，即成「黑豆瓢梨」，患有慢性支氣管炎及長期閱讀書報引起視力減退者，常食用之，對於保護氣管與視力，都有不錯的療效。

1.玉屏風茶：



材料：黃耆、白朮、防風、紅棗、水。

作法：材料入鍋中，加水煎煮，水滾後轉小火煮30分鐘，當茶飲，早、午、晚溫服（紅棗可食）。

滋補功效：補氣斂汗。適用於多汗、容易感冒、鼻敏感及多汗畏風者。

2.桂圓紅棗茶：



材料：桂圓肉、大棗、水、薑片。

作法：材料入鍋中，加水煎煮，水滾後轉小火煮20分鐘，當茶飲，早、午、晚溫服（桂圓肉、紅棗可食）。

滋補功效：補血安神、溫補脾胃、虛寒者冬日飲用，有暖胃助眠作用。

Reference:

春夏秋冬養生 - 二十四節氣養生經
秋冬養生系列藥膳

Medical Evangelism Training & Strategies 2009

Lo Hui Yin (M13)



The conference

METS Conference HK 2009 was held from the 10th to 14th of June, attended by medical and nursing students from both the University of Hong Kong (it was counted as a half ssm) and the Chinese University of Hong Kong. It was a conference aimed at equipping health care professionals to heal physically and spiritually, extending the whole person care to the spiritual aspect. There were speakers from the US coming to share their experience. Joining them were Leo the Chaplain of HKCMDF (Hong Kong Christian Medical and Dental Fellowship), Dr. Tipoe that we probably all know, and also Sonia and Lincoln who are from the Global Hope Network. In these five days, students were separated into level one and level two (for those who attended the 2008 conference). My fellow level one students were then separated into 3 groups, led by one or two US guests. Judy, a US general practitioner, and her daughter Jordan joined my group. Everyday we started with worship and prayers, followed by lectures, workshops, discussions, sharing and games. The lectures and workshops were designed to prepare and equip us with knowledge. Their content ranged from skills training to theories understanding, including spiritual history taking, ethics for spiritual care and whole person care. In the following discussion and sharing, we talked about how to apply those skills and knowledge in real life practice.

The Sharing

One thing Judy always mentioned was a bridge. On the paper she drew two valleys: we stood on one side while God stood on the other. The valleys were steep and we could not find our way to God. Then Jesus with his cross came-

and lay himself between the valleys, allowing us to reach our God. From her experience she told us, we might think that most people do not believe that there is God on the other side, but in fact, most people knew God is over there, but they just stood on the other side, thinking that they will never be able to reach that far. Similarly, some people too could see God, they too wanted to change their lives, and they could even see the bridge of Christ, but they do not believe they can actually cross it. Sometimes, she told us, people were ready to accept God into their lives; they just need someone to encourage them, or to give them a little push. Therefore, she said, do not be afraid to start talking about God with patients, and do not fear the risk of being rejected or complained about. Because eventually it is God who is doing the business and it is God's business – so he will take care of it. She, together with other guest speakers, delivered a touching message: We are Christians that happened to be doctors, not doctors that happened to be Christians. Therefore, we should not put God at the end of our consultation, but put God into every aspect of it.

Practicum

After a few days of lectures and workshops, we had our practicum in a church in Sham Shui Po. It is a small church without much worldly property, but there go the most passionate sons and daughters of Jesus. We were welcomed and invited to join their worship, then separated into small groups to share our experiences with them. Joanna and I sat down with 4 middle-aged men, and while we were still wonder-

ing and worrying about what we should say, they already started to share their lives with us. Most people going to that church were once homeless, poor or drug abusers. They felt hopeless and gave up on themselves, until Jesus sent the pastor to "pick them up", leading them back home with love and hope again. When they were left by the whole world, without family and friends, God took them and sacrificed his son for them. God gave them new lives and so now, they are dedicating their lives back to God. They touched us but at the same time made us feel shameful. We were so much more fortunate than them, as God gave us so much and he is still providing for us, but we were offering so little in return. I prayed in my heart that God might give me faith as strong as theirs. They encouraged Joanna and I to be strong, and told us not to be afraid of God leaving us, for it was not us who knocked on Jesus' door, but He came and knocked on our doors. After sharing and praying we borrowed songbooks from the church and sang hymns together. At the end of such an inspiring conference, none of us wanted to leave. .

What's next?

METS Conference 2010 is now under planning and preparations. It is likely to last for longer and include more activities. Details will be released soon and I cannot wait! To make your wait shorter, you can go to the following website to know more about the conference:

About METS: <http://www.mets.org.hk/>
About METS HK:

<http://www.mets.org.hk/>

About Global Hope Network:

<http://www.globalhopenetwork.org/>

About Global Hope Network HK:

<http://www.ghni.org.hk/>





Taken by Keith Wong (M13)

探訪痲瘋康復村

Cally Wong (M13)

八月二十五日，我和另一位同學一起隨香港醫療動員會(HKMMC)到廣東南沙的痲瘋康復村探訪，同行的還有香港基督徒醫生及牙醫團契的團牧潘醫生，及中大的護理系團契成員，包括學生及在職護士。

以前從來都不認識這些痲瘋康復村是甚麼。原來，中國大陸政府在五十年代，在全國各縣鎮撥出土地，將患痲瘋病的人集中，以公社形式來管理，給與他們治療和讓他們過自給自足的生活。在廣東省約有六十條這樣的「痲瘋村」，而仍然留在這些村子裏生活的治癒者約有四千人左右。這些早在五、六十年代，痲瘋病已治好的人，因家人的拒絕和社會人士對他們的誤解和歧視，而無法返回家庭和回歸社會。只有一直留在村裏生活至今。

如今這些痲瘋病治癒者都已是一些上了年紀的老人，年齡平均六十至七十歲。隨著公社模式的解體，加上年老和疾病導致的傷殘，使他們不能靠勞動來養活自己。現在他們只靠政府每月給他們，由幾十元到不超過二百元的津貼來過活。而香港醫療動員會的痲瘋康復事工所服侍的對象，便是這一群生活在偏遠、交通不便、與社會隔絕的痲瘋病治癒者。

那天早上，我們一行二十人由上水出發，經落馬洲過境，再乘坐兩個半小時的旅遊小巴到達位於南沙工業區內的這條痲瘋康復村。帶領我們的，是動員會的何寶玉姑娘。他們當中有些人曾經去過探訪其他的痲瘋康復村，但我們都只是第一次去。

寶玉姑娘告訴我們，今次探訪的痲瘋康復村，是全國環境最好的康復村之一，因為他們本來居住的地方，被工業集團看中了要開發，便協助他們搬到工業區裏。他們的生活費由政府供給，也是全國收入最高的康復村，因為生活費與地區的富裕程度成正比。但縱使生活環境比較好，他們的心靈卻仍然貧乏。長年累月的身體殘疾、孤單及歧視，使他們很需要我們的關懷。

寶玉姑娘還提醒我們，不要稱這些村為「痲瘋村」，因為他們都是已經康復者，應該稱作「康復村」，不

要給他們負面的感覺。另外，痲瘋康復者已無傳染性，但他們肢體或有殘缺，請我們不要表露懼怕神情，因他們十分自卑及敏感。還有，原來這些康復村都是附屬於一些醫院。我們今次探訪的，便是屬於紅衛醫院。有時候探訪隊也會幫忙清洗傷口，但今次我們則不用。

信仰方面，他們當中有大概一半人都信奉天主教，甚至已經接受洗禮，因為天主教的神父及隊伍數年前已經開始服侍他們，附近更有一所天主教堂呢！有些人也已經決志相信主耶穌基督，感謝主！其餘的大都聽過福音，寶玉姑娘也希望我們可以關心他們的靈性需要。

我們到達時已經是中午時分了，寶玉姑娘為我們安排飯盒。我們四周走走，環境果然不錯！那裏的都是一幢幢兩層高的平房，分了四座。每座每層又有數間房子，而每間房子裏有一個客廳和三間睡房，每間睡房住兩個人。還有一座醫療樓作醫院用，一座作文娛用。而我們遇到的公公婆婆都很友善地歡迎我們來訪。我們吃過午飯，便準備一個類似「聯歡會」的節目。

準備期間，我和另一位姐妹跟他們聊了一會。我接觸的一位伯伯，一條小腿被切，需要坐輪椅。他不是信徒，但當我們問到他有關聖經和耶穌的故事，他都知道不少。他也很感激來服侍的同工們，認為基督徒都很好。真的希望他能夠不單在頭腦認知上知道，更能親自認識耶穌。

到了「聯歡會」，我們首先跟他們一起做手部運動「十巧手」。雖然當中很多人都活動不靈活，但他們都很享受一起做。然後，我們就分享了四首詩歌，都是關於愛和喜樂的，希望能透過詩歌與他們分享喜樂和愛。我們也加入了一些動作，有些公公婆婆都很投入，縱使行動不便，也跟著

一起做！之後，他們當中有些人出來表演粵曲，歌詞十分有趣，逗得全場大笑起來！最後，我們跟他們一起玩遊戲「世界之最」，並送上一些小禮物。

之後，我們便分為四組，到他們家裏探訪。我和四位弟兄姐妹準備出發時，我突然被叫住，伴隨一位婆婆回家。

她是潘婆婆。她的腳掌因痲瘋關係已經不完整了，要慢慢地拿著拐杖一小步一小步地走。於是，我們便先到她家裏去聊聊。原來他們會自己煮



些瓜菜吃，是從入村兜售的菜販買的，而飯大都是飯堂供應的。她信奉天主，有時候也會到附近的天主教堂去，她說去念念經，唱唱詩，也不太明白念和唱的是甚麼。她唱了一首歌給我們聽，就是「願你平安」。我們鼓勵她去更認識神，認識聖經（就是神的話語）。最後，我們和她一起祈禱祝福她。

然後我們到第二間房間，那裡有三位婆婆。我們在客廳裡跟她們聊著。其中兩位婆婆不停地你一句我一句，談了不少她們的生活，都很有趣。突然下起大雨來，轟隆轟隆的，婆婆們都很關心我們，叫我們不要在天熱的時候來探訪，又擔心我們下大雨怎麼辦……後來我們見時間不多，便往另一房間去。

最後一間房間客廳裏坐著一位婆婆，我們便跟她聊聊。房間裏面也有另外兩位婆婆。這位婆婆也稱信奉天主，但好像不太清楚信的是甚麼。她的左腳掌上有一個傷口，要小心護理。她雖然行動不便，聽力視力都不好，但她卻會經常幫助其他的公公婆婆，例如煲飯。談話途中，上一間房間的那位婆婆就突然進來問其他人要不要煲飯……看得出他們之間的關係都很好，在村裏就像是一家人，無分彼此地關心和幫助他人，這是身體上的殘障都不能阻止的。

我們只能逗留短短的數小時，下午四時就要集合離去了。正打算離開的時候遇見一位婆婆，不停地邀請我們進她的房間聊聊天。但沒法子，我們不得不離去……上車離開的時候，有些公公婆婆包括村長都來大門送我們……甚至包括行動不便的潘婆婆！寶玉姑娘說她每次都一定要來送行，還要給我們唱著歌……我們拍了大合照，上車時她還一直唱著：「願你平安，願你平安，平安！平安！願主祝福你，願主保佑你，平安！平安……」

我們的車一路駛離，經過的他們一直揮著手目送我們離去……

這是我第一次到訪這些康復村，更有機會去到環境比較好，生活指數較高的一群。物質上，她們都得到了比較好的照顧，基本的起居飲食都被照顧到。

我從來沒有接觸過痲瘋病人，不知道他們是怎樣的樣子……去之前總有丁點兒擔心我會害怕。我擔心我看到他們的傷口殘缺時，會露出害怕的神情，使他們自卑。明明是希望去關心他們，反倒傷害了他們。感恩的是我沒有絲毫的害怕，還很想親近他們……我又擔心他們會沉默寡言、不苟言笑，幸好原來他們當中很多都很開朗

的，雖然有些比較含蓄，不大說話，但大部份都很幽默樂觀。

公公婆婆們都很欣賞長期服侍他們的同工們，連對我們這些只到訪數小時的不速之客都十分歡迎和感激……我也十分佩服忠心服侍的同工們，也深深感到我的不配。只是獻出丁點兒的關懷，又做不了甚麼，又怎配得這些感激呢？我更希望他們會感謝天上的父，因為「我們愛，因為神先愛我們」（約翰一書四章十九節）。

看到了當中有些人都認識了天主教，但都只是認識了一個「宗教」。很希望他們能夠更多的認識這位神，能被神親自地觸摸，醫治他們的心，就像這節聖經所說：「有一個長大痲瘋的，來求耶穌，向祂跪下說：『你若肯，必能叫我潔淨了。』耶穌動了慈心，就伸手摸他，說：『我肯，你潔淨了罷。』大麻瘋即時離開他，他就潔淨了。」

當中最深刻的，莫過於潘婆婆，她行動何等不便，卻仍堅持出來送行，祝福我

們平安，我也很希望她能享受從神而來的平安和喜樂！

只是短短的數小時，真的很短。但看到這些公公婆婆如此喜歡有人來訪，縱使我們能夠做到的不多……未來不知道是否再會到痲瘋康復村去，也不知道會不會到同一個地方去……但真的很值得一去，縱使我要花上差不多八小時舟車勞動，和接近二百塊的車費等，這些都不重要了。感謝主，有這樣的一個機會！

有關痲瘋康復村及香港醫療動員會：
香港醫療動員會：

<http://www.hkmmc.org/index.htm>

漢達康復協會：

<http://www.handa-idea.org>



別無其他。我說話雖然並不響亮，卻已驚動了不少長者，但爺爺卻似乎仍然別無異樣。只見他坐在床上，雙目無神，正自發愣，似乎沒有在意我的到來。昔日翩翩君子的模樣，早已不復存在。在我眼前的爺爺，蒼老了不少，憔悴了不少。

「爺爺，我來探你了！」我再叫一聲，爺爺終於轉過頭來，卻面露疑惑之色，似乎認不出我。我心中微微一驚，道：「爺爺，你認不認得我？我是阿子！」

爺爺「哦」的一聲應了，目無表情，全無欣喜之色，也不知是不是真的知道我是誰。我開始有點兒後悔，心想為甚麼進了大學的這一年裏，我竟然一次也沒有來探望過他？「因為忙嘛。」我嘗試安慰著自己，使自己好過一點，但我知道，這只是一個藉口。

「坐吧。」只見爺爺把床頭的抽屜拉出來，然後對我說道。我心中微微一奇，心想抽屜怎能當椅子般坐下呢？我搖了搖頭，道：「我不累。」但爺爺堅持要我坐下，我只得勉強就範，輕輕坐在抽屜上面。

「吃一點吧。」爺爺伸出他的右手，只見掌上有一團白色糊狀物體，甚是噁心。我望著這團東西，已無暇

猜謎語

何子

「阿子，你知道嗎，有甚麼東西是取不去，奪不走；用不完，長擁有的？」

「嗯……我猜不到啊，爺爺！」

「是知識。你讀書多了，知道的事多了，那些知識永遠就是你的，人家怎樣也搶不去。有些人覺得金錢是最好的，但其實金錢很容易就會被人偷走了，亦有用完的一天。但是，屬於你的知識，就永遠都是你的。」

「但為甚麼它會是用不完呢？」

「哈，阿子，一個人所知的當然有限，但當你運用你學過的東西時，用多少次都可以的，那當然就是用不完了！現在的學生讀書只為將來謀生，從沒好好的認真學習過，考試完了就甚麼都忘記得一乾二淨，追求的是金錢而非知識……」

記得我還小的時候，由於父母都要上班，因此就由爺爺嫐嫐照料著我，直到我升中一為止。那時爺爺差不多

天天都會叫我猜一個謎語，然後借著謎底，教我道理。爺爺以前是個教書先生，學識甚豐，時時引經據典，借古諷今，極具君子之風。看著爺爺手執木扇，踱著脚步，侃侃而談，正氣凜然的樣子，正是古時候文人雅士的模樣，不禁使我為之著迷，視為偶像。我聽父親說過，原來爺爺以前很窮，不能上學，但他天資聰敏，勤奮過人，最終得到一個老師的賞識，教他讀書。後來他日夜苦讀，甚麼四書五經、唐詩宋辭等都能倒背如流，因此在香港覓得一個教席，直至十多年前退休。可是在一年半前，嫐嫐不幸過身。不知是否因為失去了這個老伴，爺爺的柏金遜病開始惡化，記憶亦大不如前，已逐漸變得痴呆，失去了自顧能力，被逼遷進護老院裏去了。

「爺爺，我來探你了！」老人院中死氣沉沉，除了電視的聲音之外，

思索那是甚麼來頭，因為爺爺的手一直前伸，已向我口中餵去！

就在這千鈞一髮之間，我迅捷地站了起來，問道：「不如我和你出去吃點東西？」

可是爺爺卻道：「雙腳不見了，走不到路。」

我大吃一驚，心想：「發生了甚麼事？」我顫抖著把掩在爺爺跟前的被子拿走，卻見爺爺的一雙腿不就好端端的在這兒麼？我實在大惑不解，道：「有甚麼事？」

爺爺搖了搖頭，道：「不見了。」

我腦子轉了轉，問道：「是不是拐杖不見了？輪椅？」

爺爺都搖了搖頭，堅持道：「雙腳不見了。」

我環顧四周，只見地上空無一物，十分光滑。我忽然靈光一閃，道：「是不是鞋子？」

爺爺「哈哈」一笑，道：「對！是鞋子，不是腳！」

我也笑了一笑，心想謎底終究被我猜了出來。折騰了一陣子，終於找回爺爺的一雙鞋子，再清理了他的雙手，然後便帶他來到了附近的一家茶餐廳。我問道：「爺爺，你有甚麼想

吃的？」

爺爺道：「那個呢……圓形的呢……有些東西在裏面的……」

「是甜的還是鹹的？」我問道。

「我說不出來……」爺爺帶點焦躁，亦帶點失望的道。

「不要緊的，慢慢來，不急的。」我安慰著道，但心中卻暗自黯然。以前的爺爺出口成文，怎會想到他現在竟然得出這麼一個病，而且在短短的一年間惡化得這麼快。

「那個啊……阿子最喜歡吃的那個啊！」過了半晌，爺爺終於想出了些甚麼。

我怔了下，然後道：「是不是蛋撻？」

爺爺笑逐顏開，道：「對！就是蛋撻了！多買幾個，待會兒阿子放學見到有蛋撻吃，一定開心死了！哈，還是你知我心意，知道我想的是甚麼。」

聽到此處，一陣酸楚之意自我心頭湧起，而我亦再也按捺不住，兩行熱淚亦就自眼眶徐徐流下。我用衣袖輕輕把淚水拭乾，苦笑道：「以前你要我猜謎語，我當然能夠猜到。」

爺爺彷彿記起了以前的往事，道：「以前我問阿子，有甚麼東西是取不

去，奪不走；用不完，長擁有的。我說答案是知識。現在想起，原來錯了。」

我沉默了一陣，道：「但有另一樣東西，同樣是取不去，奪不走；用不完，長擁有的。即使爺爺你記性差了，但它一樣在你的心中。只不過它實在太易得到了，使我忘卻了它的存在，忽視了它的價值，上了大學以後就更加把它拋諸腦後，渾然不懂得珍惜。這一年間，我的確嘗試了很多新的事物。我上過莊、住過宿舍，亦參加過不同的活動，結交到不少新朋友，但我卻忽略了以前所擁有的，沒有好好保全，直到現在想去補救，卻已太遲……」說到這裏，我的聲音已經哽咽得說不出話了。

爺爺呆呆的望著我，全然不知我說些甚麼。

他已經不知道我是誰了。

後記：事後和母親說起，方知道她留下了一條香蕉給爺爺，著他肚餓時拿來充飢。那團白色糊狀物體，應該就是香蕉，但事實如何，已無從考證。

這又是投訴的原因。由此可見，醫患爭執常常是由一連串可以改善的態度和行為引起，令到雙方產生誤會而造成的。只要醫護人員反思一下自己的行為和態度，病人和家屬停一停，站在醫護人員的角度想一想，他們會發覺投訴只是浪費力氣、金錢和時間。

透過溝通、信任和彼此諒解，醫患爭執是可以化解的。放下己見及耿耿於懷的心情，爭執是可以避免的。停下來，為對方想一想，做多一點點，例如主動幫助老病人聯絡社工。這種小事，更會令對方永記於心。

《拆走醫院的炸彈》是一本簡單、輕鬆，但又含有深層意義的書本，適合醫生、護士、病人、家屬或任何人士閱讀，讓他們了解現時的醫患關係。雖然書中有各種跟內文無關的奇怪照片，但隨書附送了精彩DVD。作為未來的醫護人員，我們有責任從現在開始認識現時的醫患關係和改善方法，《拆走醫院的炸彈》就給了我們一個初步的了解。我們要重覆反思怎樣才能夠將醫患關係做得更好。最後，我們要謹記，要做到「仁心仁術」，我們要先「仁心」，後「仁術」。所以一位對醫患關係毫無認知的醫護人員，是絕對沒有可能做到「仁心仁術」的。

新書推介： 拆走醫院的炸彈

胡冠一 (M14)



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醫院有炸彈？《拆走醫院的炸彈》透過40位醫生、護士、病人及家屬的真實故事，描寫出現代醫護人員和患

病者的關係——「醫患關係」。隨著社會的轉變，醫患關係變得更加複雜。因為網上的資訊愈來愈普及，大眾的醫療知識愈來愈豐富，所以他們對醫療服務的要求也愈來愈高，甚至到了一個吹毛求疵的地步。這本書利用不同角度和輕鬆的手法來表達出醫患關係不融洽的情況——「炸彈」，也提及一些令人感觸的故事，希望從這些故事裡，能令醫、患雙方學到如何建立一個和諧的醫患關係，把「炸彈」拆走。

在現時的社會，我們差不多每星期都聽到投訴醫護人員的新聞。投訴！投訴！投訴！醫護人員對病人和家屬的不良態度往往對醫患關係造成極大的負面影響。例如「醫生只望電腦，不望病人！」，這是一個常見的投訴原因；忙碌的護士不理睬病人，



English Journals – Inspired by a Trip to the British Isles and Ireland

Huiyin

Light

My favourite colour is when I sit beside the window, on a train that is moving, or on the car my father is driving - when the vehicle moves through the trees on a bright summer day, when I close my eyes and see a shiny pale shade of yellow, through the branches, giving some whiteness in between, with a sense of warmth, slowly, gently coming in. Or when I am sitting under the sun, on a bench or the sand with the waves hitting the shores, when I close my eyes I see a purple or deep pink, with little particles bouncing and jumping, sometimes there are bands of light orange, coming out and fading away. When I close my eyes - when I close my eyes I see the best colours. When colour no longer serves only to differentiates the shape or the texture of what we see, when it starts to show something that seems to come from another universe, something that is deep within, something that varies, comes and goes yet synchronises, I see my favourites colours. When our car was slowly driving away from the magnificent glens and lochs to the city of Edinburgh, the sinking sun chasing us from behind, colouring the glasses and my sleeping mother's hair, our GPS's grey turned to brown and white and back, and through the gentle soothing orange that passed through my eyelids, I think I saw something different, I felt

something that I cannot describe. And finally when the sun had gone there was a shade of blue, it seemed to be ocean blue, but sometimes I thought it is the colour of sapphire, or the back of a blue whale, or the colour of our planet from far, far away.

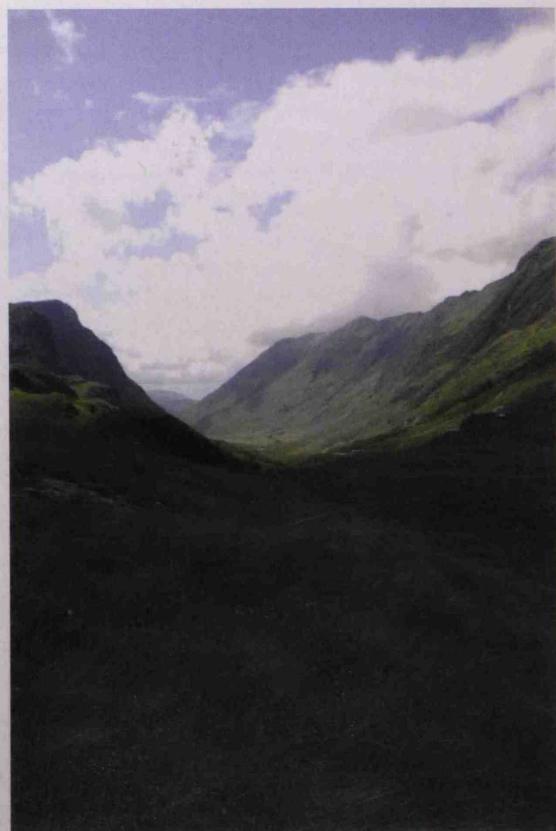
Love

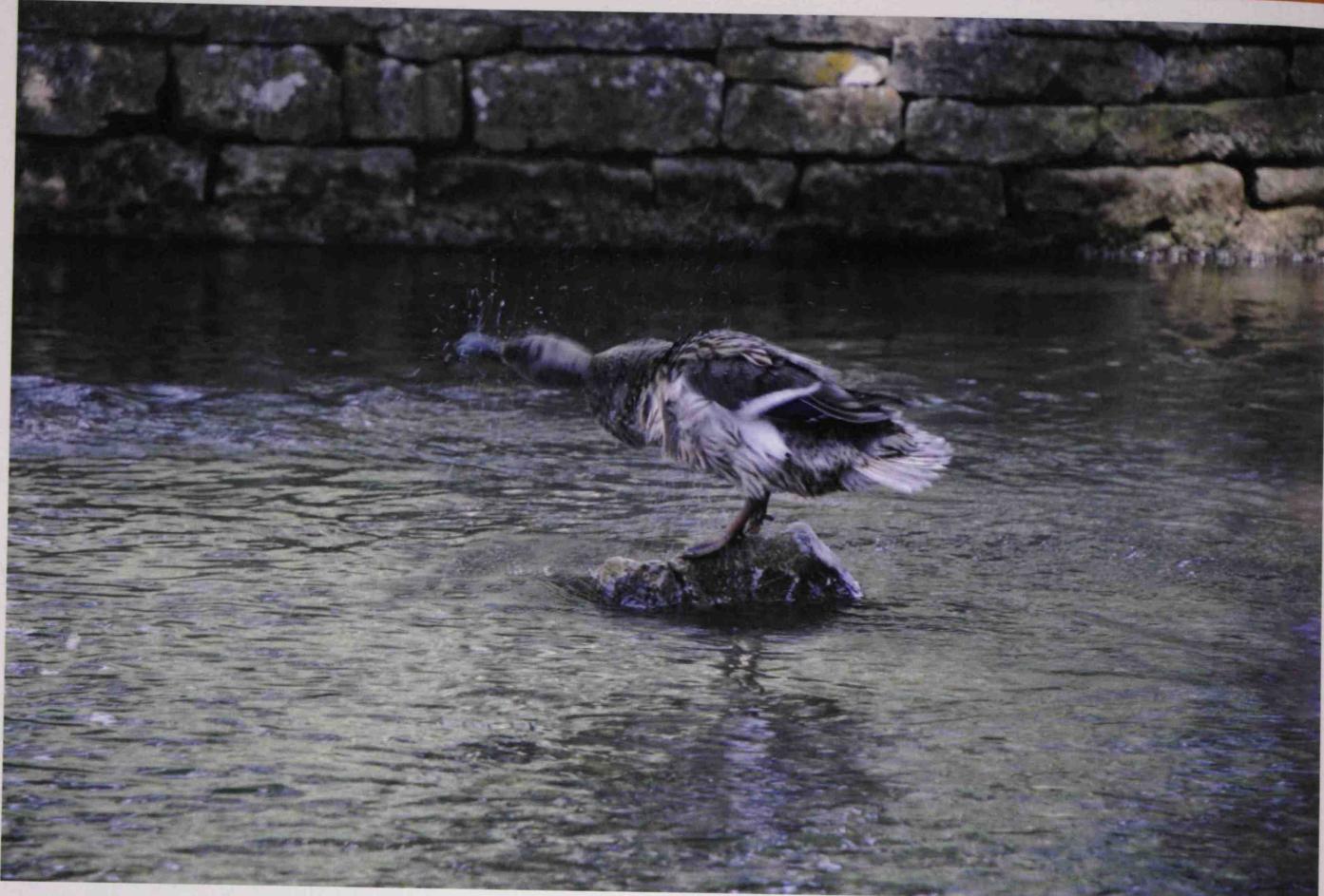
I remember once in a public speaking competition one fellow contestant said the tennis court is where we hear the word "love" most often. After spending a day on a seat in the last row of No. 1 Court in Wimbledon, I guess he is probably right. Most of my favourite players were not playing that day in that court; I did not know which side I should cheer for so I just screamed for everyone. I saw people crying, screaming and laughing. As the match carried on all of us seemed to be infected by an emotion, we jumped up and we shouted, we cursed the umpire or the rain, we stared at the screen when one ball was challenged. Our eyeballs followed the balls from this side to that side, our heart bouncing as the ball bounced once, and

twice. When the players were serving it was almost ceremonial, when they were about to toss our mouths were shut and we could almost hear them breathing; and as the racket struck the ball, as the player on the opposite side jumped and reacted, our brains were in a craze, our fists tightly held and we started to scream. I remember playing the crowds with thousands of strangers; I remember cursing and cheering on the same player. But I did not understand how such a small yellow fluffy ball, just like other seemingly trivial things in this world, could dictate the emotions of so many people.

One fine day

There is a town called Bourton-on-the-water, somewhere in the Cotswolds in England. My friend and I spent a few days there, staying in Cheltenham and leaving every morning by bus to a small town. On one fine day we set out to Bourton-on-the-water. In any tourist guide there is only little space for this town, because to some it only has a narrow shallow river, no castles or museums, no rich or famous men were ever born there. But, my friend said, she read so many blogs online and almost everyone said Bourton is the most beautiful one. So there we went. The river was indeed shallow and narrow, even ducks could walk along the





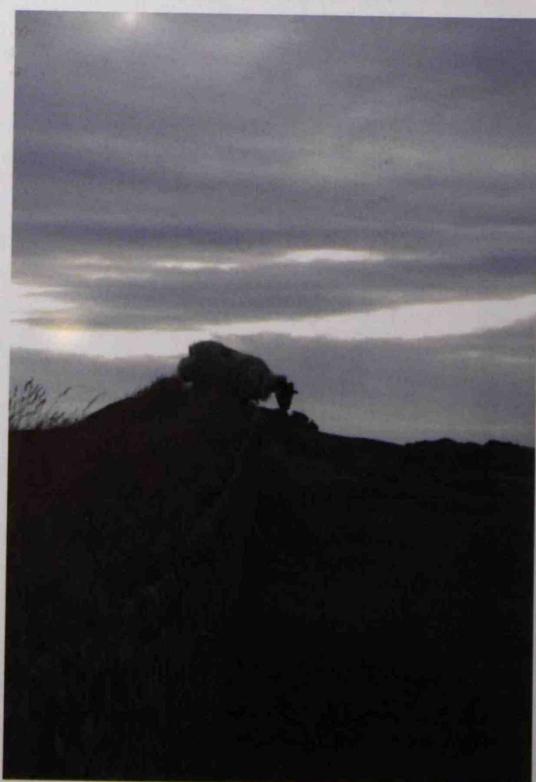
riverbed without getting their feathers wet; but still, people built stony arch bridges over it, trees and flowers were carefully tended to. We tried to visit all the "spots" the town has to offer, but we were not satisfied. After a late brunch we were considering staying there overnight, because our stay was so short and there was simply so much to see. Looking at the river, however, and the ducks floating on it, or the people having picnics under the trees, we thought perhaps we could sit besides the river for a while, and then we might leave. So on the wet, soft grasses we sat, and there one part of my heart still stays. It was meant to be a short stay, but minutes later I took out my camera, then we both took off our shoes, and socks, soaking our foot into the water, like everyone else did. Our eyes followed the ducks and their ducklings drifting by, or red leaves that fell and thereby floated; we sometimes talked about the people we saw. There was a young gang, boys acting intimately with the girls, splashing the water and making the riverbed their runway. We saw an elder sister taking her baby brother out for a walk, she was wearing sunglasses and he was so innocent, making the scene resemble what we used to see in the newspaper – one superstar has a new

found pet. A busy father was talking on the phone and his little children were throwing away and picking up some seaweed, having great fun although their father seemed troubled. We saw an old man sleeping under a tree whose leaves turned all red. We certainly do not want to grow as fat as him, but how he ends up seems better than cramping in a couch with the TV on. We did not know how to pull ourselves away, and in the end it was the last bus back to Cheltenham that dragged us up. But as I said, one part of me never left.

Magic

I love to imagine another world since I was small. On one cloudy day near the border of Scotland I woke up at six and went for a walk. I was alone in the high grasses, the sorrows from the past and the fantasies of the Romans. I walked up and down the hills, there was nobody else; sometimes a sheep or two went by, and the sun was only half-way up. The sky was grey, sometimes disturbed by a slight ray of orange. I like cloudy days. I

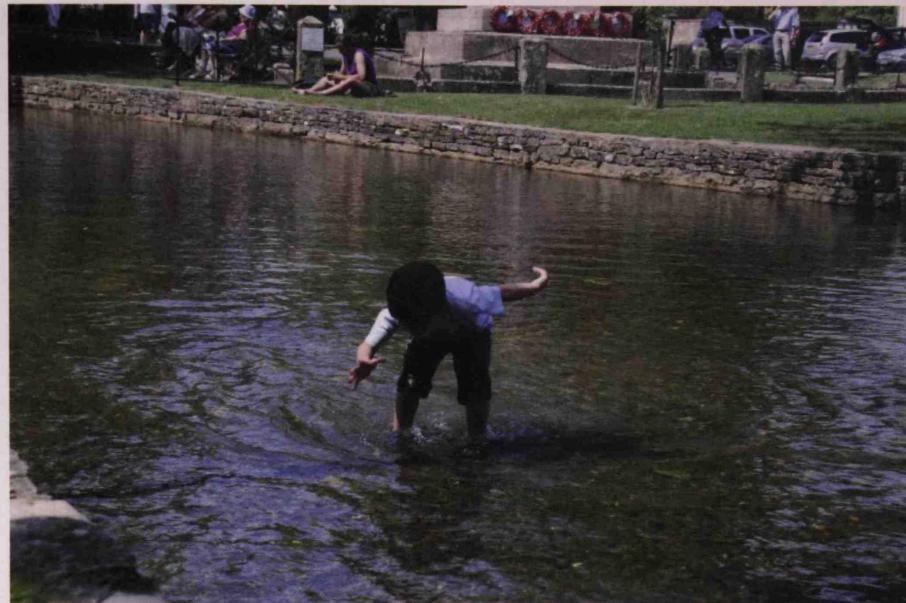
like English weather. When the clouds cover the sun, when it seems like it is going to rain, there is a mysterious sense of sorrow and loneliness, which brings back the old days when castles are built and fairies fly; the age of Camelot and Mercia. When it is grey and the sun is out but not bright, the



ruins seem to come alive again, old but alive, telling its stories with the wind blowing. The wind never grows old; it is forever the witness, forever the bard. When I close my eyes on the top of one hill, with a Roman milecastle beneath me, with miles of nothing but glass, with the weak moony sun, with the wind stroking my hair, I can see something – I almost see the universe. Then I went back to five years ago, in the seaside walled town of Saint Malo, it was raining and there were two large windows in my hotel room. I opened them and I saw the stone wall with cannons, the seagulls screaming. At night when I slept I heard the accordion, singing, fading into the old days. There were times when I think magic does exist.

Walking past you

During my stay in Dublin everyday I walked from St. Stephen Green to the other side of the river. I wonder if I like the route or not. In the early morning there was clean fresh air, but when I got off the tram LUAS besides St. Stephen Green I could usually see vomit and cigarettes on the ground. Then I would cross the street, entering the Grafton Street. At the entrance there was always a violinist, playing broken tunes



and next to him the best hot chocolate was sold. With the treat I walked further and I saw florists carrying flowers from a trunk, an old man starting to carve something out of sand. Then the sun went up and started to sink, and I, after a day of the seaside, valleys or ancient ruins, was back in the city. The sand of the old man, like it did everyday, turned into an ugly flattened dog; the florists were throwing away dead flowers, preparing to leave; the violinist must have been disappointed by

his own skills and the tips he got, and therefore he was replaced by someone younger, playing with fire or performing acrobatics. Back at the station the clubs were opening again, and people started to vomit. I do not know if things were the same in the days of Oscar Wilde or Yeats but during my stay day by day the same happens; perhaps there was a small twist or two, perhaps sorrows still flow in Dubliners' blood, perhaps some of them were falling in and out of love - I shall never know.



中醫是甚麼？

香港大學學生會醫學會中醫藥學會
學術秘書 黃耀連

中醫學是根植於中國傳統文化之中，運用動態系統方法認識人與天地相關過程中與人體健康（包括生理、病理、疾病的診斷與預防等）相關的知識體系。中醫是一門成熟的科學。德國漢學家M·波克特如是說：“中醫是成熟的科學，而且在兩千多年前就達到了成熟科學的水準”。

成熟的科學必備的三個條件

- (1) 特定的研究對象；
- (2) 特定、有效的研究方法；
- (3) 獨有的概念範疇體系。

中醫學定義的三個要素

- (1) 中醫以整體層次上的證候研究為對象；
- (2) 建立在哲學和系統科學基礎上的陰陽五行為方法論；
- (3) 成功地建構起以藏象經絡和病因病機為核心的基礎理論體系。

中醫不能脫離哲學。“形而上者謂之道，形而下者謂之器。”《易經·係辭上》自然狀態下之形或象，稱為形、象。中醫學乃屬“形而上學之道”，運用動態的、整體的、系統的研究方法，以天地之人為研究對象，治療病之人。而西醫則屬“形而下學之器”，運用靜止的、局部的、遲原的方法，以生物之人為研究對象，治療人的病。康得：“自然科學以形而上學為先決條件”。黑格爾：“一個有文化的民族沒有形而上學——就像一座廟，其他方面都裝飾得富麗堂皇，卻沒有至聖的神那樣”。本性上屬於形上性科學的中醫，如果疏遠了哲學，如果偏離了形上之思，是沒有其他道路可走的！

從上可知，中醫與西醫採取的研究方向大有迥異，因而兩者起互補互助之效。在人類生命科學和醫學中，中醫非存在不可。

參考資料：

李致重，科學、哲學、人、中醫、名實—關於中醫科學定位的探討，8/6/2008



疾病「皆」由風、火、熱、毒引起？！

香港大學學生會醫學會中醫藥學會
出版及宣傳秘書 林雅鳳

若干月前，當大家乘坐港鐵時，不知有否發現一張有關某中藥食品公司的廣告橫額內標明「中醫認為，疾病皆由風、火、熱、毒引起...」？當我看到有關橫額時，心想：假如有一位學過或正在學習中醫藥的人看到這，那人必定會和我一樣，皺起眉頭，完全摸不清頭腦。

回想我正學習中醫基礎理論時，老師曾提及過，凡是可以引發疾病的因素，稱之為「病因」，就如徐大椿《醫學源流論》中所說：「凡人之所苦，謂之病。所以致此病者，謂之因。」至於造成疾病的「因」，其實亦分為「外因」及「內因」兩種。

外因，指的是六淫（即風、寒、暑、濕、燥、火）、癟氣、外傷與蟲獸咬傷等所引致疾病的外在因素。《金匱要略》記載，「夫人稟五常，因風氣而生長，風氣雖能生萬物，亦能害萬物，如水能浮舟，亦能覆舟」。意思是，人稟承於天地間之五行（即木、火、土、金、水），又因著四時之六氣，即風、寒、暑、濕、燥、火而生長.....看到此，也許大家會發現，這裡對六氣的解釋與剛才所指的六淫解釋都不一樣嗎？為什麼一個是使人生長的因素，另一反是致病因素呢？原來，當風、寒、暑、濕、燥、火六種自然的氣候因素，按著四季時節正常出現時，中醫稱之為「六氣」；當六氣在不適當的季節出現時（如：春天來到，冬寒還未離去），或某季節的氣候因素太過或不及而為邪氣，這種不符合自然規律的氣候因素，便被稱之為「六淫」，如《金匱要略》中提及的「有未至而至，有至而不至，有至而不去，有至而太過」，就是這個意

思了。

癟氣，指的是具有強烈傳染性的外邪，是導致疫病的主要病因。癟氣亦為天地之氣。當天地陰陽之氣失衡、寒暑錯時之時，癟氣便因而產生，所以它常伴有明顯的地域性和季節性。簡單而言，它就像今天我們所說的流行病，如SARS和豬流感等，不但發病急驟，而且具有強烈的流行性及傳染性。

內因，即是指七情、勞逸及飲食等引致疾病的內在因素。《素問·天元紀大論》提到：「人有五臟化五志，以生喜怒悲憂恐。」而七情，則由五志再化生而成，是為喜、怒、憂、思、悲、驚、恐也。適度的七情變化可調節相應臟腑的功能，但如果七情變化太過，則會影響其相應臟腑之運行，使臟腑功能失常，氣機失調而引發疾病。例如：《素問·舉痛論》道：「怒則氣上，喜則氣緩，悲則氣消，恐則氣下.....驚則氣亂.....思則氣結」指的便是七情太過對人體氣機運行的影響。氣上者則容易臉紅、頭暈；氣緩者則心神不定、心神無主等。另外，飲食失常（如：暴飲暴食或過飽過飢）、飲食偏嗜（如：冷食涼飲、五味偏好）、飲食不潔（如：受污染、腐敗或有毒之飲食）以及過逸過勞都是能引發疾病的一些原因。

《靈樞·順氣一日分為四時》中指出，「夫百病之所始生者，必起於燥、濕、寒、暑、風、雨、陰陽喜怒、飲食居處...」所以說，「疾病」又怎會「皆」由風、火、熱、毒引起呢？

中醫花茶推廣

香港大學學生會醫學會中醫藥學會
學術秘書 黃耀連

香港大學學生會醫學會中醫藥學會今年繼往開來於十月十九日至廿一日於大學本部及廿二至廿三日於醫學院進行花茶售賣推廣。

《本草綱目》記載：“花茶性微涼、味甘、入肺、腎經，有平肝、潤肺養顏之效。”各種花茶根據它們的性味而有不同的功效。

玫瑰花

性味：味甘、微苦，性溫

功效：行氣解鬱、和血散瘀、活血止痛

茉莉花

性味：味辛、甘，性溫

功效：理氣和中、升鬱辟穀、清熱利濕

杭菊花

性味：味甘、苦，性微寒

功效：疏風散熱、解毒、清肝明目

川銀花

性味：味甘，性寒

功效：清熱解毒、涼血、疏風散熱

蠟梅花

性味：味辛，性溫

功效：解暑生津，順氣止咳

桂花

性味：味辛，性溫

功效：散瘀行滯、化痰健脾

甘草

性味：味甘，性平。

功效：補脾益氣、清熱解毒，祛痰止咳，調和諸藥

田七花

性味：味甘、微苦，性涼。

功效：清熱、平肝

飲用花茶時需要留意：花茶性質溫和，適合每天飲用。但沖飲花茶時，需留意個人體質，有些茶有通經或活血化瘀的作用，因此不適合孕婦及特殊疾病者使用；體質虛寒的人亦不宜長期飲用如綠茶、金銀花等偏涼的花茶，故飲用前需了解各種花茶材料的特性及飲用禁忌後才可使用。亦可透過適當的配伍，如菊花加枸杞、玫瑰花配紅茶、桂花則加上甘草，能使花

茶為個人發揮最大的功效。另外，需注意材料的用量，以免用量過大對人體造成刺激，如茴香、肉桂一般不可超過 10 克。原則上乾燥茶材為 3-5 克，新鮮茶材則為乾燥的 2-3 倍。了解最合適的燜泡時間，一般根據花草的特性及取用部位而定。如花、葉應以 3-8 分鐘不等；若是果實或根部就要浸泡 10 分鐘以上。

為自己選擇最適宜的花茶，須向中醫師查詢，以達到最佳的調理、保健作用。

今年本會於推廣花茶外，還增加有關睡眠及穴位的養生保健知識。

你會睡覺嗎？

正確的睡眠習慣不只早睡早起這麼簡單，人要懂得順應四季的自然規律，起居作息，養生保健，強健體魄。

《素問·四氣調神大論》：“春三月，此謂發陳，天地俱生，萬物以榮，夜臥早起……”

意思是說，春天萬物萌發，要入夜即睡，適當早起。

《素問·四氣調神大論》：“夏三月，此謂蕃秀，天地氣交，萬物華實，夜臥早起……”

意思是說，夏天陽氣旺盛要稍晚入睡，適當早起。

《素問·四氣調神大論》：“秋三月，此謂容平，天氣以急，地氣以明，早臥早起，與雞俱興……”

意思是說，秋天陽氣收斂，要早睡早起，在雞鳴時起床。

《素問·四氣調神大論》：“冬三月，此謂閉藏，水冰地坼，無擾乎陽，早臥晚起，必待日光……”

意思是說，冬天陽氣內藏，要早睡，早上不要起得太早，要等到太陽出來以後才出門。

中醫認為睡眠的質素對人體的身體健康有舉足輕重的影響。睡眠質素欠佳甚至失眠能引起各種各類的疾病。因此，要有健康的身體就要懂得睡眠之道。

你懂得這些保健穴位嗎？

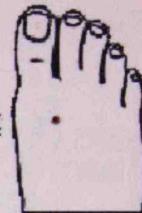
1.人體自身的“菊花茶” - 太沖

動作要領：用手大拇指按揉兩太沖穴 3~5 分鐘，力量以該穴位達到酸脹感覺為宜

功效：平肝清熱、清利頭目，與中藥菊花的功效相似；治療女性月經不調、痛經

太沖

拇趾和第二趾骨結合處



2.心臟的隨身保健醫生 - 內關

取穴方法：位於前掌從手腕之橫皺紋往上約三指尖寬的中央，在兩筋之間

動作要領：垂直的直上直下按壓，每次按壓 0.5-1 秒，放鬆才再按。左手 30 次、右手 30 次輪流按，力量以該穴位達到酸脹感覺為宜，約 10 至 15 分鐘或覺有療效可停。其他功效：暈車、暈船、噁心想吐



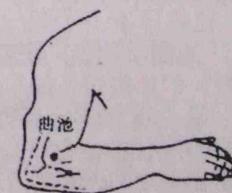
3.治口腔潰瘍、過敏性鼻炎、皮膚粗糙的名穴 - 滾泉 (人身第二長壽穴)

動作要領：用雙手按摩或屈指點壓雙側湧泉穴，力量以該穴位達到酸脹感覺為宜，每次 50 至 100 下。



4.讓心情安逸的曲池

動作要領：以大拇指指腹按壓在曲池穴上，食指頂住肘橫紋下方，大拇指行順時針揉按，由輕到重，反覆幾次，力量以該穴位達到酸脹感覺為宜。



何謂陰陽？

蘇子謙

序

常聽到別人說：「中醫是調節身體的陰陽平衡。」即使西醫界也認為，中醫所說的陰陽理論，只是一般的平衡理論。即陰多陽便少，陽多陰便少。「陰」和「陽」，就像各在天坪的一邊，一邊升另一邊則降，就這樣簡單。「陰陽」在他們眼中，只是「yin」和「yang」，只是正和反，只是兩個符號。「陰陽」其實和西醫所說的反饋作用(negative feedback)沒有分別。

這是錯誤的理解。中醫說的「陰陽」不只是這麼膚淺和簡單，而是有更深奧的意義。得出以上的結論，是不了解中國傳統文化，卻強行把中醫的理論和中國文化分開的必然結果。

中醫和西醫有很大的分別：中醫學不只是一門醫學，它與中國文化根本分不開。又或者說中醫學本身就是中國文化。要學好中醫非要有深厚的中國文化根底不可。上述的就是一個例子。中醫學由理論的平衡觀到實際的療法如中藥、針灸等，也是基於「陰陽」。也可以說，明白了「陰陽」後，中醫所有的東西便能「通」了。所以本文以下將簡單地談談中醫真至的陰陽理論到底是甚麼。

所述的或未能完備，如有錯誤，請予指正。

陰陽理論來源

很多人都知道中醫學的基礎理論就是陰陽理論和「金木水火土」五行理論。很多人常覺得陰陽五行是很玄的東西，於是就認定中醫是不科學的，是迷信的東西。這是錯誤的理解。中國文化有一個特點，就是「通」。「通」是指中國古代不同的東西也借用同一套哲學理論(陰陽五行)來解釋。陰陽五行在古代能用於軍事、天文、政治、占卜等，醫學只是其中之一。陰陽五行只是一個方法論(methodology)，借用來解釋人體的醫學，而不存在迷信的問題。故此，陰陽五行可說是中醫學的核心，古代很多大醫家亦說只要掌握了陰陽五行，這就完全掌握了醫學的道理。正如古代大醫家孫思邈所說：「不知易(易學，陰陽五行)不足以言太醫矣。」

陰陽理論基本內容

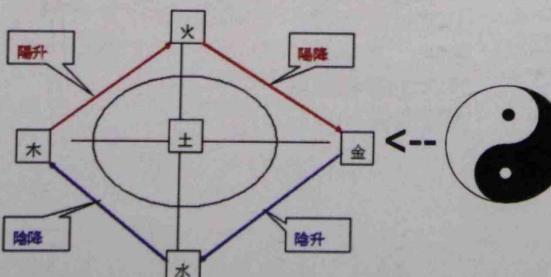
「陰陽」理論，是中國古代的哲學思想。但什麼是「陰」和「陽」？「陰陽」是「宇宙間相互有關又相互對立雙方的屬性的概括。」天下間所有事

物都有正反兩面。一為陰一為陽。既矛盾又統一。這是很淺白的道理。中醫在漢初就套用了陰陽學說來解釋人體的生理和病理情況，和人與自然界的關係。漸漸中醫理論就結合了哲學的陰陽學說，形成中醫自身的陰陽學說。

那麼中醫是如何認識陰和陽？<<黃帝內經·素問>>中的<陰陽應象大論>如此說：

「陰陽者，天地之道也，萬物之綱紀，變化之父母，生殺之本始，神明之府也。」

陰陽是抽象的，即「抽離」於「象」。「象」是一切可見的東西。陰陽是抽象的，故陰陽是不實指任何的事物。「陰陽」是萬物天地變化的根本，是相對來說，沒有絕對的。但陰陽亦可對應於象，對應於事物上。故<<黃帝內經>>中有一篇名為<陰陽應象大論>，談的就是如何把這形而上的「陰陽」應於各種事物當中。陰陽是「既可標示相互對立的事物或現象，又可標示同一事物內部相互對立的兩個方面。」中醫認為凡上的、表面的、急性的、運動的、熱的都屬陽；凡下的、深層的、慢性的、靜止的、寒的都屬陰。說到這兒，陰和陽都好像很空泛，很難明白。我以下試用人體生理來說明陰陽概念。



上圖其實就是陰陽太極圖的簡化。

陰主內，陽主外

中醫認為人體的所有功能全在一道「氣」。這道「氣」，用現代術語來說，可稱作能量。氣運行全身，無處不到，維持著人的生命。氣的其中一個功能，就是溫煦作用，即保持人體的正常溫度。氣亦可分陰陽，這提供熱能的是陽氣。因在外的和熱的皆屬陽，如<陰陽應象大論>中說：「清陽發腠理，濁陰走五臟」。陽氣是清的，向外發散；陰氣是濁的，主要向內歸於五臟。那麼當我們感受到寒冷時是陰氣的作用？非也。是陽氣入內了。陽氣不在表面了，入了身體的內部，所以體表失去了陽氣的溫煦，故覺冷矣。這種陽氣入內的收藏狀態，就是「陰」。同一道氣，在人體表工作時就是陽氣，在內收藏時就是陰氣。陰陽兩者本是同一樣東西(氣)，故統曰一；兩者一表一裡，一寒一溫，故曰矛盾。這就是真正的陰陽概念。所以人睡覺時會覺得特別冷，為什麼？正如日間人們要出外工作，陽氣在人甦醒時也在表(日為陽)；又好像晚上人要回家休息，陽氣在入睡時亦一樣進入體內，這個狀態就是「陰」。體表(皮膚)失去了陽氣的溫煦作用，人睡覺時便覺得特別冷，要蓋被了。

陰陽與睡眠

另一個相似的例子就是睡眠。中醫認為人之所以會睡眠，是因為陽氣向內藏了。當人活動時，陽氣向外發散，於是人就感到精神有力(陽主動)；相反當人需要睡覺休息時，陽氣向內收斂，即是陰的狀態(可說是陰氣盛)。陰主靜，故人便感睡意，需要休息了。簡單的說，中醫對睡眠的理解是「從陽入陰」。這正和一日的時間相應。中醫經典<<黃帝內經>>如此寫到「夜半為陰隴，夜半後而為陰衰，平旦(日出)陰盡，而陽受氣矣。日中為陽隴，日西而陽衰，日入(黃昏)陽盡，而陰受氣矣。」(<靈樞·營衛生會>)。從此可見，日間有太陽時，天地陽氣盛之時，人的陽氣與之相應而盛，故人感精神出外活動及工作。日落西山，天地陽氣開始衰減，人的陽氣亦隨之衰減，故人在黃昏始感疲倦，而要回家休息。夜間天地陽氣收藏，即陰氣盛，人之陰氣亦盛，故人便睡覺了。這正是中醫學的另一特點——「天人相應」。

陽氣與休息

這亦可解釋為什麼人晚上要睡覺，日間才有精神工作。因為陽氣在日間發散，在夜間收藏。若把陽氣比作一

個拳頭，這就更容易理解。打出了第一拳，必須把拳頭收回來，否則怎能打出第二拳呢？人在夜間不睡眠，陽氣在夜間不收斂，那陽氣在第二朝早怎能發散呢？人怎能有精神工作？這亦可談到為什麼漢字要用「休息」這詞語。「休」本身已有睡覺之意，為什麼要用「息」呢？「息」即「利息」的「息」，有增加的意思。人體是為了「息」。「息」甚麼？增加陽氣是也。故人睡覺是為了使收藏的陽氣得以增加，以供日間的工作使用。故陰氣得以保存，陽氣才會增長。這正是常說的陰陽互根，陰陽都是同一樣東西，互為根本，陰陽有所增，陽氣才有所長。「獨陰不生，孤陽不長」，此之謂也。那麼日間睡覺，夜間工作行不行？很多人亦有經驗，晚上不睡覺，即使日間再睡多久，也會覺得很疲勞。因為這是不順從天地陰陽變化，是逆天而行。長久下去，身體也會變差。

從此可見，中醫不同西醫的是西方醫學主要著重人體本身，而中醫考慮問題是從宏觀出發，不單考慮人的自身，更著重人與天地四時的互動。這也是中國文化著重「通」的原因。中國古代追求通才，因古代各種知識（如中醫學和天文學）也能互相交通，不是絕對的獨立，故學醫者必須匯通其他知識。正所謂「上知天文，下知地理，中知人事」，才能成為大醫家，即古代說的「上工」也。

陰陽與失眠

談到中醫的治病，亦是運用陰陽學說。既然談到了睡眠的生理，現在就再用睡眠來作例子。中醫認為正常的睡眠是「從陽入陰」，那麼失眠呢？就是「陽不入陰」。再看 <<黃帝內經>>如何談失眠：「今厥氣（致病因素）客於五臟六腑，則衛（陽）氣獨衛其外，行於陽（外），不得入於陰（內）。行於陽則陽氣盛，陽氣盛則陽躉陷，不得入於陰，陰虛故目不瞑（失眠）」。<<靈樞·邪客>>即是說各種致病因素（淫氣）入侵人體，使陽氣行走在外（皮膚），陽氣不能收藏入於五臟六腑，所以說「陽氣盛，陰氣衰」。陽不入內，故不能眠。明白了病理後，治法就容易理解，就是消除淫氣，並要把在外的陽氣引回內部，即「引陽入陰」。當陽氣能入回內，陽能與陰交接，失眠就能癒了。

陰陽治失眠

要「引陽入陰」，可用中藥治療。其中半夏和夏枯草，是十分有效的藥物。<<醫學秘旨>>內有治失眠的藥方云：「余嘗治一人患不睡……診其

脈，知為陰陽違和，二氣不交（陽不入陰）。以半夏三錢，夏枯草三錢，濃湯服之，即得安睡……蓋半夏得陰而生，夏枯草得陽而長，是陰陽配合之妙也。」半夏得其名，是因為為它過了夏季才生長，夏季之後陰氣開始盛，故半夏是得陰而長；夏枯草正相反，夏天時便枯萎，夏天後陰氣始盛，陽氣始衰。它陽衰則枯，冬天後陽氣始盛則生，故是得陽而長。一得陽長一得陰長，故能使陰陽之氣交接，從而「引陽入陰」。可見中醫治病無處不滲有陰陽學說。

中醫傳統思維

中醫的辯證方法正是中國傳統思維方法之「取象比類法」和「聯想法」。「取象比類法」即觀察事物的外部特點（象），而把它歸納於某一屬類中（通常是五行歸類）。如因木有生長升發、舒暢條達之性，肝喜條達而惡抑鬱，又有疏通氣血的功能，因此木代表肝。「聯想法」是透過聯想推測事物的屬性。如見半夏在夏季後才生長，有別於一般植物，就聯想到它是「得陰而生」；因夏枯草在夏天枯萎，認為它「得陽而生」。半夏加上夏枯草就能「引陽入陰」。另外一個思維方法是「推演絡繹法」，即把事物某些特質與已知五行的某些屬性相配，從而把該事物歸類。這思維方法在辨別中藥性能中最常用。如麥芽，它色黃，黃屬土，而五臟六腑的脾胃亦屬土，故麥芽屬土，能治脾胃食滯；麥芽是芽，有生長之意，生長屬木，肝亦屬木，故麥芽亦屬木，入肝經，可疏通肝氣。這種思維亦可稱為「同氣相求」，即相同歸類的事物，必有相似的屬性或功能。

陰陽可分不可離

上面已談到陰陽實是同一東西，只是狀態的不同，陽為發散，陰為收藏。陰陽二者在人體的工作，亦有不同。<<內經>>謂：「陰者，藏精而起極時；陽者，衛外而為固也。」即是說陰氣是在內收藏著人身的精氣，當有需要時才交給陽氣使用；陽氣就在體表守衛著身體，保護著體內之陰精。又云：「陰在內，陽之守；陽在外，陰之使。」道理也是一樣。故可說陰是陽的基礎，供給陽所需物質；陽氣則是在外工作並守護著陰。陽氣和陰氣是互

相倚賴，互
相依存，不
能分離。故
曰：「陰平
陽秘，精神
乃治；陰陽
離決，精神

五行可根據中醫辯證思維法配於各種事物，見下表：

類別	內容				
五行	木	火	土	金	水
五臟	肝	心	脾	肺	腎
五腑	膽	小腸	胃	大腸	膀胱
五官	目	舌	口	鼻	耳
五形	筋	脈	肉	皮毛	骨
情志	怒	喜	思	悲	恐
五季	春	夏	長夏	秋	冬
五方	東	南	中	西	北
五氣	風	暑	濕	燥	寒
五化	生	長	化	收	藏
五色	青	赤	黃	白	黑
五味	酸	苦	甘	辛	鹹

乃絕。」這其實正正和古代的社會情況一樣。女為陰，男為陽。男的要出外工作，守護著家庭；女的要留在家中，打點家中一切。夫婦互相倚賴，互相依存，不可分離。俗語云：「成功男人背後必有一個成功的女人。」信矣！可見，中國文化與中醫是一脈相成的，根本不能分離。

「陽生陰長，陽殺陰藏。」是說夏季天上陽氣生，地上萬物（陰）也欣欣向榮地生長；冬季天上陽氣衰減，萬物也停止生長，樹木枯萎，動物冬眠。故可說陽是陰的主導，陰是被動。故中醫治病也常以治陽氣為主，因陽氣是主導。古代家中，男人為一家之主，男尊女卑，和中醫一脈相通。現代社會越來越多女強人，女人漸成主導，在中醫學中可說是逆陰陽而行，故有人提出這可能是現今癌症越來越多的原因之一。

五行學說

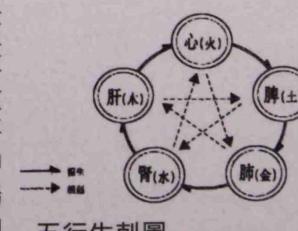
明白了陰陽理論後，談談五行學說。因五行學說內容實在太多，以下將只會淺談陰陽變化如何產生出「五行」。「金木水火土」就是五行？這是錯誤的。「金木水火土」只是五種物質代表，是「五材」。五行說的不是五種物質的變化，而是說天體運動的抽象變化。五行最先見於<<尚書·洪範>>：「水曰潤下，木曰曲直，火曰炎上，金曰從革，土爰稼穡」。

現以四時配陰陽的方法來談五行。

春天陽氣生長，大地回暖，萬物生長，在圖中陽氣向上升。木曰曲直，有上升、生長的意思，故春屬木。

夏天陽氣旺盛，萬物華麗，天氣炎熱。火曰炎上，有熱之意，故夏屬火。

秋天陽氣收斂，萬物始枯，陽氣在圖中向下降。金曰從革，金屬性重向



下沉，有收斂之意，故秋屬金。

冬天陽氣完全收藏，萬物盡枯。水日潤下，水永遠向下流，在最低位，水亦有寒意，故冬屬水。

四時萬物也要在「土」上生長。土爰稼穡，滋養萬物，故土主四季，在中央。

可見陽氣的變化，一散一收，一消一長，就產生了五行。故可以說「陰陽變化」就是「五行」。陰陽是五行之根本。如果把上圖放在一日中看亦可。再引回上文：「夜半為陰隴，夜半後而為陰衰，平旦(日出)陰盡，而陽受氣矣。日中為陽隴，日西而陽衰，

日入(黃昏)陽盡，而陰受氣矣。」(<靈樞·營衛生會>)

總結

陰陽學說的內容十分廣泛，而且十分深奧，云云幾千字是沒有可能完全把陰陽學說完全說清。本文只是筆者對中醫陰陽學說的一些體會，從本文可見「陰陽」是中醫學理論的基礎。陰陽並不只是一個簡單的平衡觀。陰和陽，是別有一層深層的意義。中醫從認識人體，了解疾病到治療疾病中，都離不開「陰陽」。所以抓緊「陰陽」是學習中醫的唯一辦法。

在中醫學中，有很多地方與中國傳統文化有不可分離的聯繫。又可以

說，中醫本身就是中國傳統文化的一部分。沒有中國文化的根底，根本很難去理解中醫的理論。

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的：任何一種「如果」都可被討論，何況，我們永遠沒法清楚知道八九民運和六四對中央人民政府的真正影響。因果律 (causality) 這觀察，只告訴我們結果大概發生在原因之後——會長的潛台詞不需要，亦並不是邏輯推論，因為任何假說 (hypothesis) 背後只需想像力：

「哈！如果沒有鎮壓六四，我可能以為人臂可以擋車，晨早比車死啊！」

科學方法，基於設立假說並加以驗證。我們沒可能知道事實的全部，而在事實不斷曝光的過程中我們亦很可能要調整我們的假說：

「哈！原來六四條片裡面呢，著學生衫果啲解放軍，坦克入面果啲先係學生呀！」

規範性 (normative) 的答案，無法用理性的科學方法求得。主觀判斷，很多時候，只需一種感覺：

「哈！我覺得呢，六四死左果啲學生其實幾好彩呀，佢地唔駛驚沙士禽流感播……」

陳會長的確很傻很天真：因為他不太明白他壓根兒沒可能三言兩語代表「所有學生」。更趣緻的是，陳會長似乎並不明白位居學生首長的他其實並不能奢求「言論自由」：正如，假設曾大權心裡是反獨裁陶鑄公司的，作為子公司香城公司的首席執行官，他也不能洩露半句。

公投是無助平反六四的。學生會不需要為社會議題擬定立場——這一點，在教導學生獨立思考、探求真理的大學中更為重要。學生對不清含混的公投議案投下的棄權或反對票，將可能被詮釋為對六四事件的冷漠無知，或是被用作某些人支持自己「代表了某

淪亡作政治鬥爭的棋子

回應 M12 積子牛有關六四定性和反思的評論

共三三 (M11)

罷免會長、公投確立學生會對六四事件立場……在爭辯聲中，我們被呼籲明示立場、「為公義與真相發聲」。然而，在這「盲超邏輯」當道的時空，我們先要了解我們行動可能帶來的後果，以及這場表態運動將被賦予的意義，才能免被用作一場政治鬥爭中的棋子。

學生會的公告是這樣寫的：

六四屠城立場全民投票

適逢今年為六四屠城二十週年，我們認為這是一個契機、也是一個時候向前多走一步。香港大學學生會將於二零零九年四月十四至十六日就六四屠城立場進行一次全民公投，議案內容為「中華人民共和國中央人民政府必須平反八九民運，並就六四屠城負上責任。」，而公投結果將成為香港大學學生會固定立場。希望各位同學踴躍參與公投，為公義與真相發聲！

(<http://www.hkusu.net//content/view/293/70/lang/>)

作為大學生，為公義、為真相作一點付出，我並沒異議；只是全民投票動議內容背後的邏輯紊亂，卻令我認為應該和這場公投劃清界線。

首先，中華人民共和國中央人民政府並不等同其執政黨。八九六四可以是一場愛國運動，但相信很難認同六四是一場愛共產黨的運動——連法輪大法的矛頭都指得比我們的學生會清楚！與其要求中央人民政府平反六

四，倒不如要求共產黨、要求李鵬平反六四。當國家不過是政黨的機器，而政黨又不過是少數既得利益者所操控的傀儡，把矛頭指向中央人民政府徒然是一種怯懦而不著邊際的申訴。集體負責，從史例看來，往往等同無人負責。

六四的「定性」一直是個公說公有理、婆說婆有理的題目。歷史事件，從來不該有「定性」的執著：民運人士眼中的愛國，在專政者看來難道不是動亂嗎？執政者對危害自己統治的行為加以鎮壓是可以理解的——能否諒解，則屬個人意見。我們總不能要共產黨接受一場執政危機吧？

在六四論壇中，有看來像內地生的同學不同意「六四是屠殺」的說法，提出了軍民死傷人數論。是的，關於屠殺，我們沒有一個共通的定義，以至於，當疑似天安門母親運動發言人回應的時候也給誤導了：

「多少人死才叫作屠殺呢？……假如那些手無寸鐵的人不應該死，那麼死一個也嫌多！」

要知道，對獨裁者而言，異見人士從來是相當該死的。難怪共產黨領導的中央人民政府一直不願平反六四。至於負上責任的問題，就更有趣了：當執政機器的責任是維護它的治權安定，殲滅不願降服、阻礙公眾地方、危害國家安全的學生難道不合理嗎？

孺子牛同學並沒能指出陳一誦會長的邏輯謬誤。歷史事件從來不是獨立

些同學」的鐵證。誠然，不可能所有人對六四持相同的訴求或見解，但我們應可令同學明白港大是一個鼓勵求真探究，但絕對尊重不同意見的地方。正如（常誤為出於）伏爾泰的名言：

「雖然我並不同意你的觀點，但我會至死捍衛你說出那觀點的權利。」

"I disapprove of what you say, but I will defend to the death your right to say it."

我們不需要獨裁。我們不需要被

人擺佈。我們也不需要一個「固定立場」。假若學生會急於為澄清誤解而舉行公投、定下立場，則其無可避免地灌輸予同學「六四已成過去，一切已成定局」的信息；這對維繫同學對民運的持續探尋和理解、對民運和六四事件的發掘和追尋是不利的。事實上，倖存的學運領袖至今仍不斷為我國的民主開放努力，這些都是應該讓同學主動了解而非不求甚解地被填塞的。

最後我要衷心感謝陳會長：是您牽動了我們的赤子心，是您點燃了這二

十年後的點點星火，是您讓我們明白統戰機器溫水煮蛙的計劃、讓專政黨的支持者從我們當中顯現。您是忍辱負重的無間臥底，是民運人士的親密戰友，是燦爛閃爍的民主之光。

謝謝您！



09年4月15日孺子牛於啟思號外發表有關六四定性和反思的評論

來到我們稱為Final MB的大考，我們都像在寫一個故事的結尾。我知道，這會是一場轟轟烈烈的敬拜。我和我的學習小組一起哭過、笑過；我們會互相扮演精神科病人向對方問症，又會捧著對方的腳伸伸縮縮的學習檢查。

很快，「小麵團」滿一歲了，我們的考試也來到尾聲。「小麵團」每天都在學習新的事物，我們的求知慾卻在考試中減退。也罷，在日本餐廳裡舉起茶杯慶祝完結的一刻——我知道，在這場敬拜裡我們已盡心、盡性、盡意、盡力的作好我們的角色，神已在拍拍我們的頭說：「孩子，乖。」我也知道，我們都長大了。

人們都喜歡為著一段日子感謝一些人，而我最感謝的是耶和華我的神，也就是自有永有的獨一真神。我刻意在文字裡減去五年來對祂的認識，要讓你們看得舒服點；再者，五年裡每時每刻都有祂的恩典和憐憫，要寫也不知從何寫起。是祂，讓我不是活了一場虛空；也是祂，讓我成長。

第二個要感謝的是二十四個小時不睡覺，小心翼翼保存這份熱情的男人。他懂我，也有很多大道理和小道理，有時很牢騷，但更多時候為我吻去眼淚，給我一個肯定的擁抱。

接下來的我不會點名多謝，也不會排名了，因為我是個很著意自己在別人心目中位置的人，卻又清楚，其實愛你的人多得很難刻意去排名。謝謝你，我的家人、朋友，你們當中有的沒說過甚麼，只是在背後默默支持；有的是一起奮鬥的戰友；有的可能只擦身說過一些令我鼓舞的話。你看著這些，就知道，我在跟你說話。

是時候開始新一個五年了。我不知道前路是怎樣，但我知道這條路要怎樣走，和誰一起走。五年後我又會說些甚麼？誰知道呢？Let's start the beginning of a story ☺

五年時間—誰說只是一場夢

此木

很多人喜歡把過去的時間形容作一場夢，彷彿活過，轟烈過，斑爛過；醒來時，照照鏡子，卻仍是昨晚的睡衣、宿醉和倦容，也說不出臉上有沒有增添過去拼搏的痕跡。

過去的五年時間，說是夢，未免貶低了時間的真實流逝；何況我在流逝中真正活過，鏡子裡的我已有點不一樣。

五年前，朋友說她母親的朋友的女兒讀醫科很辛苦，經常哭；我們就喜歡把這「麥嘜式」故事不問情由的從「聽說」變成「事實」。因此，當年已選讀醫科的我，恐懼亦就油然而生。（後來才知道這種選擇恐懼的思考模式在醫學院裡很普遍，也刻意花了點力氣才慢慢改了過來。）

第一年，帶著中學生十八、九歲稚氣和傲氣進出這座新簇簇的藍灰色建築物，不適應新的學習模式，加上很多新的事物等著我去嘗試，有時候讀書會讀至凌晨三點。那一年，中大一位醫科五年級生因不堪讀書壓力，跳樓身亡。我們正好安排去看他的驗屍過程：看著他年輕的身軀，我有點茫然。

第二年，開學不久，正為兒子籌備婚禮的舅父突然心臟病發逝世。拿著電話筒，我哭了好久，連來找我跑步的同學也被嚇壞了。第二天早上，上課時間到了，我仍躺在床上，在想：除了世上又少了一個人，除了每年回鄉時又少了一張臉，死亡本身是甚麼？那陣子很辛苦，在想很多不屬於填鴨式教育範圍內的問題。不能一步到位得到一個絕對肯定的答案，我更茫然。他們說這叫成長。但我不明白，小學三年級時，婆婆逝世也不見得自

己生命起了甚麼變化。

第三年，從書本知識轉戰臨床學習，排山倒海的知識讓我喘不過氣來。有臨床學習必定有臨床考試，而我的考官是公認嚴謹的一個（行內稱為malignant，如果你是醫學生，你一定懂），也流傳著很多關於他的「聽說」。上完課，離開講室準備考試時，同學們紛紛投以關切的眼神，加上一聲：「加油呀！」我覺得自己像要上刑場的死囚；當然我不是死囚，因為要是上刑場的話，怎樣加油也沒有用。那年考試，病房外穿上白袍的一刻，我忽然意識到穿上白袍的我就是醫生，試場內的考官就是同袍，病人就是病人，不存在考試。即使是有話，亦只是準備我作個更好的醫生。我第一次體會到，這叫成長。

第四年，蜜月的一年。有了三年級的根基，又沒有五年級的趕忙。有時候，我行山，看著藍天的我最高興；有時候，我靜靜的看海，聽著海浪訴說時間。這年，在一次長洲旅行中得知同學懷孕了；又過一陣子，知道比我大幾年的師兄因肝癌主懷安息。從此，我的日子又添了生命和死亡。

來到最後一年，充滿驚喜和愛，少了些「聽說」，因為每一刻我們都在真正走過。同學的小生命誕生了，我抱著「小麵團」在想未來；每兩個月一次的大考讓日子過得很快，讓未來很快變成現在，現在又成為過去。