Caduceus

MEDICAL STUDENTS' CENTRE,
SASSOON ROAD,
HONG KONG.

VOLUME 2 NO. 2 OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY, H.K.U.S.U. 15TH FEBRUARY, 1970

EDITORIAL

The Fraternity Committee recently organised a talk on the subject "Doctor-Patient Relationship", and Dr. Todd from the Department of Medicine, Professor Field from the Department of Pediatrics, and Dr. Paul Yu from the Department of Surgery were invited to express themselves. A glimpse of their views can be found on page three. Different aspects were stressed on, and the audience was much entertained by the wonderful approaches and presentations of the three honoured speakers. The programme was highly praised a successful one for the first trial. We hope the Fraternity Committee will keep up their spirit and organise more programmes in the months or years to come, so that we can enjoy their work and be fraternal, and far more important, come to be familiar with this newly elected committee who seem to be starting smoothly.

With regard to "Doctor-Patient Relationship", we can benefit by remembering the Hippocratic Oath:

"I swear by Apolls the Physician and Aesculapius and by Dygeia and Panacea and by all the gods and goddesses, making them my judges, that this mine oath will I fulfill as far as power and discernment shall be mine. Him who taught me this at will I esteem equally with my parents; he shall partake of my lifelihood, and, if in want, shall share my substance. I will regard his offspring as my brothers teaching them this art without fee or stipulation if they shall wish to learn it.

*** I will instruct by precept, by discourse and in all other ways my sons, the sons of him who taught me and those disciples bought by oath and stipulation according to medical law, but to no other person.**

*** I will carry out that regiment which, according to my power and discernment, shall be for the benefit of the sick and will keep them from harm and wrong. To non willl I give a deadly drug even if solicited, nor offer counsel to such an end. Likewise, to no women will I give a destructive suppository, but, guiltless and hallowed, will I keep my life and mine art.**

*** I will cut no one whatever for the stone, giving way to those who work at this practice. Into whatsoever houses I shall enter I will go for the benefit of the sick, abstaining from all voluntary wrong and corruption and from lasciviousness with women or men — free or slaves.**

*** I will keep silence regarding that which within or without my practice, I shall see or hear in the lines of men which should not be made public; holding such things until to be spoken.**

*** And now if I shall fulfill this oath and break it not, may the fruits of life and of art be mine; may I be honoured of all men for all time; the opposite if I shall transgress and be foresworn."**

Hoping that all medical students, doctors, including medical officers, physcians and surgeons, and general practitioners would be willing to entertain carefully "Doctor-Patient Relationship".

NOTICE

Notice is hereby given that nominations are now open for one delegate and several observers of the Medical Society delegation to the 5th General Assembly of ARMSA held in Australia in May, 1970.

Please note: (Resolutions of the 2nd Council Meeting)

(1) 'that the Medical Students' Council resolves on financing as far as possible one delegate to the 5th GA of ARMSA and when funds are available, subsidies be given to observers.'

(2) 'that the selection of delegate and observers be made at a Council Meeting.'

Closing date: Feb. 27, 1970.

January 27, 1970 — Ambrose Ng, General Secretary

NOTICE

Notice is hereby given that nominations are now open for the post of (1) one Health Officer,
(2) One Assistant Health Officer,
of the Standing Committee on Health, H.K.U.M.S.
Closing date: Feb. 27, 1970.

January 27, 1970 — Ambrose Ng, General Secretary

The Hong Kong Chinese Medical Association Scholarship Award

The Hong Kong Chinese Medical Association has generously established a Scholarship Award open to medical students at the University of Hong Kong, including graduates who are doing their internship. The sum of $1,000 will be awarded annually to the student or students who have submitted the most original essay on any subject within the curriculum of the Faculty of Medicine, up to and including clinical observations and/or research during the year of internship. All essays submitted will be judged by the Board of the Faculty of Medicine, which may decide not to award the prize if none of the entries is of a sufficiently high standard. In this case, the award for the following year will be $2,000.

It is hoped to make the first award at the beginning of the next academic year.

Hong Kong University Medical Society

CONSTITUTION FOR THE STANDING COMMITTEE ON HEALTH HKUMS:

Article I. Name

The name of the Committee shall be called the Standing Committee on Health HKUMS hereafter referred to as "the committee".

Article II. Aims

a) To promote social consciousness among medical students through involvement (committment) in community health projects.

b) To be responsible for carrying out health activities in the name of HKUMS.

c) To safeguard and to promote the health standards among university students.

Article III. Composition

a) The Committee shall consist of one Health Officer, one Assistant Health Officer and 2 committee members.

b) The 2 Health Officers shall be elected after open nominations annually by the Medical Students' Council during the last Council meeting and shall have a term of office coinciding with that of the next Council session.

c) The 2 committee members shall be appointed by the Health Officer and the Assistant Health Officer.

Article IV. Duties of Members

a) Health Officer
1) The Health Officer shall be the Chairman of the Chairman of the Committee and will represent the Committee in the Medical Students' Council.
2) The H.O. shall be the representative from the Medical Society to the Students Health Committee of HKUSU.
3) The H.O. shall be responsible for external liaison.
4) The H.O. shall be responsible for planning.

b) The Assistant Health Officer
1) The A. H. O. shall be responsible for administrative and secretariat work.
2) The A. H. O. shall be the local health officer for ARMSA.

c) The committee members shall assist the Health Officers in carrying out their respective work.

Article V. Finance

The Committee shall request a budget from the Medical Society at the beginning of each financial year.

This Constitution is drafted by the ad hoc committee — Mr. Wong Kwok Kee, Miss Della Chu and Mr. Paul Lam. It was adopted by the Medical Students' Council at the 2nd Council Meeting on Jan. 24, 1970.

Dean's Undergrad Committee Meeting

(9th January, 1970)

1. The Dean agreed that a speaker be set up in Orthopaedic Surgery.
2. Records release from wards was not possible.
3. The Surgery Lecture Theatre would be provided with a new speaker.
4. A notice board has been set up in Tsan Yuk hospital.
5. The library agreed to house non-medical journals purchased by Medical Society.
6. The Dean said that reduction of supplementary fee was impossible.

From Class-representatives:

Final Year: 1. Elective clerkship — voluntary, 9 a.m.-5 p.m.
2. House-officers allocation: by a double system of allocation and drawing lots.

4th Year : 1. Lecture time (Tuesday morning) overlaps Surgery Specialty clerk ward — The Dean remarked that this could not be avoided.
2. Water-closet in 5/F in Professorial Block was always closed.
3. The state of ventilation in the library was brought to the Dean's notice.

3rd Year : Date of 2nd M.B. Exams.:

March 31	April 2	April 4	April 7
Pharm	Pharm	Path	Microbiology
Paper I	Paper II		

2nd Year : 1. Date of 1st M.B. Exams.: last week of February.

1st Year : 1. P.E. lesson were to be compulsory.

H.K.U. MEDICAL SOCIETY 2ND COUNCIL MEETING

(24th January 1970)

1. The minutes of the 1st Council Meeting were adopted.
2. The minutes of the 1st Emergency Council Meeting were adopted.
3. Mr. Wong Shou Pang, the EAS, reported on matters concerning the 5th GA of ARMSA. Three resolutions were made:
   (1) 'that this Council resolves on financing as far as possible one delegate to the 5th GA of ARMSA in May in Australia, and when funds are available, subsidies are given to observers.'
   (2) 'that the general secretary shall open nominations for the delegate and observers to the 5th GA of ARMSA.'
   (3) 'that the selection of delegate and observers be made at a Council Meeting.'
4. The reports on Medic Barbecue and X'mas Hospital Visits by Miss Grace Tang were adopted.
5. Mr. Wong Kwok Kee presented the constitution by the ad hoc committee for the setting up of a Standing Committee on Health. It was reviewed and adopted. Then it was decided that open nominations be made for the positions of Health Officer and Assistant Health Officer.
6. Miss Angela Ng reported on the Society Stall in the Union Carnival. We came 2nd in decoration and 4th in ticket sales. The Council then passed a vote of thanks to the 1st year Organizing Committee.
7. Mr. Vincent Leung was elected to be the Representative to the Grants Committee of the Standard/Sing-Tao Fat Choy Loan Fund for medical students.
8. Elixir Standing Committee:
   Dr. Doris Gray was elected to be the Hon. Advisor.
   Mr. Sin Chu Fun was elected to be the General Manager and Mr. Herbert Ho was elected to be the Financing Manager of Elixir.
9. It was decided that notices were to be posted in Tsan Yuk Hospital.
10. Dr. Ding informed the Council that there would be a seminar on Community Health Care sponsored by the H.K. Christian Service in Metropole Building in Kowloon on Saturday, February 21st, 1970 from 2:30 — 6:30 p.m.
11. Dr. Ding informed the Council that there are many Lange medical books given to him for donation to medical students by Dr. Lange of California and that any medical students can go to his office to get one.

GENERAL PRACTICE IN HONG KONG

MAN

Editors' note: The following account is a brief summary of an interview with two General Practitioners. Hence the information is by no means comprehensive or representative.

Q. What is the basic requirement for a General Practitioner in H.K.?

A. In H.K., as in all other places, the sole requirement to become a G.P. is to have a basic recognisable degree. Apart from the M.B., B.S. degree which our university offers, any other medical degree that is recognized in the British Commonwealth will serve the purpose. (in H.K.)

Q. Is there any measure by which a doctor can prepare himself for general practice?

A. Ideally the preparation should start from the period of internship. It would be nice if a 'potential G.P.' can help himself to 'a bit of everything', i.e. if he can do all the specialties during his internship and years of residency in the hospital. Such experience will prove to be valuable to any G.P.

Apart from the academic side, one has to go deep into the delicate study of doctor-patient relationship (with the least intention to say that this is unimportant in the hospital), or else one'll never find patients coming for second consultation.

Q. Can you tell us some of the major problems that confront a G.P.?

A. "A good beginning is half done", the proverb goes. In order to have a good practice, the 'setting up' is of paramount importance. This includes the choosing of a good locality and the actual details of 'setting up' the office. By 'good locality' one has to take into account the population density of the area and at the same time, the factor of competition with established G.P.s in that area should never be neglected.

A G.P.'s office is an entirely different place from the hospital, and one has to adapt quite a bit to fit oneself in. For general practice, one has to be contented with the limited facilities available. The time factor too, is a serious handicap — normally a G.P. can spend at most ten minutes for one consultation which includes the history taking, physical examination, diagnosis, and treatment. Moreover, most patients ask for immediate relief and this may sometimes force the G.P. to resolve to symptomatic treatment. Experience in general practice can however overcome, or at least minimize most of these difficulties.

Q. What do you think of the prospect of a G.P. in Hong Kong?

A. Well, that depends on what you mean by 'prospect'. So far as 'money making' is concerned, the prospect is quite promising provided that you've got enough patience and perseverence to get through the early period of 'disappointment'. Nowadays, a young G.P. usually has to start working for the lower or lower-middle class of patients. On the other hand, the prospect of improving one's medical knowledge is comparatively poor for a G.P. — some will tend to care more for their income than medical advances, while others may be eager to learn and yet find their practice so engrossing as to leave them little time for reading.

CORRESPONDENCE

Dear Sir,

With reference to the correspondence of last issue concerning the supply of toilet paper in the preclinical building, I wish to inform you that negotiations are being made with the University Maintenance Office concerned. (It is not under control by the Faculty Authorities).

As this involves a change of the established policy of the University, it is quite understandable that the matter cannot be settled in a short time. Anyhow, toilet pater will be supplied to the toilets in the preclinical building by the Medic Society in the meantime to relieve the "embarassing and frustrative" situation.

Yours sincerely,
Andrew Ho
Internal Affairs Secretary

The 75th Congregation for the conferment of Honorary Degrees February 18, 1970

The University of Hong Kong announced today that its 75th Congregation for the conferment of honorary degrees will be held on Wednesday, February 18, 1970, at 5.30 p.m., in the Loke Yew Hall of the University. Honorary degrees will be conferred by the Chancellor, His Excellency Sir David Trench, G.C.M.G., M.C., LL.D., upon two eminent visitors as well as four distinguished members of the community.

The degree of Doctor of Laws will be conferred upon Mr. Lee Kuan Yew, Prime Minister of Singapore, Mr. M.S. Cumming, O.B.E., Dr. the Hon. P.H. Teng, C.M.G., O.B.E., J.P., and Mr. A.W. Wilson.

The degree of Doctor of Science will be conferred upon Professor A.J.S. McFadzean, O.B.E., J.P., and Professor Kenzo Tange of Tokyo University.

Mr. Lee Kuan Yew and Professor Tange will visit Hong Kong to receive their degrees.

Doctor of Laws

Professor the Hon. P.H. Teng, C.M.G., O.B.E., Director of Medical and Health Services since 1963, was born in Fukien, China. He graduated from the University of Hong Kong in 1937 and spent two years in epidemic control in China, before taking up his first appointment with the Medical and Health Department in Hong Kong. In October 1942 he escaped to free China and again joined the National Health Administration in the field of preventive medicine. He returned to Hong Kong at the end of the war and in 1963 his high reputation in the field of preventive medicine and as an administrator earned for him the appointment of Director of Medical and Health Services. Professor Teng's contributions to the control of cholera has brought him worldwide acclaim. He has been a member of the Legislative Council since September 1963 and in addition a member of the Executive Council since November 1966. On several occasions he has served as Consultant to the World Health Organization on public health subjects. Professor Teng has been a part-time teacher in the University's Faculty of Medicine since 1952 and since 1957 he has been Professor of Preventive and Social Medicine.

Doctor of Science

Professor A.J.S. McFadzean, O.B.E., Professor of Medicine, was born in Troon, Scotland. In 1936 he graduated from the University of Glasgow, with the degrees of M.B., Ch.B. with honours, and was awarded the Brunton Memorial Prize as the outstanding graduate of his year. After war service with the R.A.M.C., he became Lecturer and subsequently Senior Lecturer in Medicine in Glasgow University, and in November 1948 came to Hong Kong to be Professor of Medicine. He was Vice-Chancellor of the University for three months in 1965 in succession to the late Dr. W.C.G. Knowles, and has been Dean of the Faculty of Medicine since February 1967. Professor McFadzean is a scholar of high international repute. Among his many contributions to medical and scientific knowledge are outstanding studies of certain diseases of the liver and of the spleen. Professor McFadzean is a Fellow of the Royal Colleges of Physicians of both London and Edinburgh, and Fellow of the American College of Physicians. He was awarded the degree of Doctor of Medicine with honours by the University of Glasgow in 1959, his thesis earning the Bellahouston Gold Medal. He has been honorary consultant physician to the Government of Hong Kong and to H.M. Forces since 1948 and has served on the Medical Council of Hong Kong since 1[illegible].

Doctor-Patient Relationship

A.E.

Editors' Note: The following is a report on the talk organised by the Fraternity Committee on 30th January 1970 on the subject "Doctor-Patient Relationship". We are printing in this issue the words of Dr. Todd (Department of Medicine) and of Professor Field (Department of Pediatrics); and in the next issue those of Dr. Paul Yu (Department of Surgery).

PROF. C. ELAINE FIELD

"The other day a rather chatty four-year-old came into my office with her mother and greeted me with "I don't like doctors". Now, how should that be answered? After a moment's pause I replied "No, neither do I!" I had hastily cast my mind back a long way to when I was a little girl walking into the doctor's office — Oh, how I hated it! So you see, to understand your little patient you must try to put yourself in his shoes.

"Now let us consider the doctor-patient relationship as it commonly presents in every day practice, first in the office when the child usually meets the doctor with his mother, and secondly when he is in bed at home or in hospital.

"As the child enters the doctor's office with his mother, it is better to ignore him initially whilst chatting to the mother. His confidence will return a little if he feels he is not immediately to be examined. From about seven years of age the patient perhaps appreciates a greeting such as "Hello son" or preferably "Hello, Jim" calling him by his name, then ignore him and concentrate on developing a relationship with the mother. Nevertheless all this time you are observing your little patient without directly looking at him as an indirect assessment is valuable.

"There are two extremes of behaviour which can be observed and of course all shades between. The introvert or very shy child who hangs on to his mother's skirts, and the extrovert or permissive child who immediately decides your office is his playground so that very soon it looks as if a typhoon has been through the room! With the shy child, casually push a toy toward him whilst talking to the mother. The choice of the toy is important as it should be entertaining yet suitable to assess the child's intelligence.

"Doctor-patient relationship is also doctor-parent relationship in paediatrics. However trivial the mother's story, consider it important yet calm her anxiety. For example, when mother says "My child is not talking yet and he is 1½ years old now, yet my neighbour's daughter is talking at one year of age." Reply with the quip, "Some very intelligent children may not talk much until they are two years". Nevertheless pay attention to the mother's story as mothers are often very observant although their memory of past events may get a little blurred, and remember they cannot experience the symptoms suffered by the child.

"When is it possible to obtain a history from the child himself? A child under five years of age gets funny ideas about himself and his surroundings so his story may be rather odd. From about five years it is worthwhile to ask simple questions about their symptoms but reliability must be doubted until the child is coming up to 10 years of age.

"When examining a child, the order of systems learnt in your adult experience just cannot apply. For the child under 5 years it is best to examine on his mother's lap at first to give him a feeling of security. Most children will allow you to put your hand on their 'tummy' particularly if you hold their interest in a chatty conversation, likewise let them play with your stethoscope so that you can encourage them to put it on their own chests, and so discreetly the abdomen is felt and the heart sounds heard before the child cries. Some children hate being put on a couch so delay this procedure until crying will not interfere too much with the rest of the examination. The throat should be examined last as your relationship with your patient will reach breaking point after this procedure, so have the child held firmly and do it quickly, then say, "All over, dress him up", and the tears soon dry up.

"The approach to the child already in bed is a little different as there is usually less time to make a liaison. The history has already been given by the mother or another doctor, nevertheless it is best to prolong the conversation with the mother, nurse or doctor whilst you make contact with the child. A squeeze of the hand or some friendly gesture will give the necessary re-assurance, then the cot sides may be lowered gently. Undress the patient little by little, still talking to the mother or nurse or to the child himself if old enough. There are children in hospital who just want to be carried, these I will pick up and carry around the ward, at the same time visiting and chatting to other patients — yet all the time feeling the child's abdomen!

"The taking of blood for investigation is one of the procedures most children dread. It is best to prepare everything out of sight and then walk over with the nurse and say you have to give him a prick but he's going to be a brave boy, then finish the task as quickly as possible. Always be truthful to a child and do not promise something which will not happen e.g. it won't hurt (when it will!). Sedation should be given to difficult children or for difficult or lengthy procedures.

"Telling the child about his illness is not usually difficult as he is easily satisfied. The younger ones in hospital just want to know when they are going home, the older and more intelligent ones accept a simple explanation of the trouble and like to know what you will be doing and also when they can go home. Fortunately children do not fully understand the nature of death, so even in incurable diseases such as leukaemia the treatment can be briefly explained to an older child always with the hope that it will make him better so that he can go home. Parents should be told the truth but until the diagnosis has been confirmed it is wise to be evasive particularly with incurable diseases, and then break the news gently always tempered if possible with the hopeful effects of treatment.

"And so back to our chatty little four-year-old, "Do you still dislike doctors?" I asked as she left my office. "Yes" she said.— May-be someone else should have given this talk on doctor-patient relationship!"

From left to right: Dr. Todd, Prof. Field, Dr. Paul Yu.

DR. TODD

"The subject of doctor-patient relationship is poorly taught in medical schools and this is not helped by the impersonal attitudes in large hospitals. However, the relationship between a doctor and his patient is a personal interaction and so cannot really be taught by a third person.

"The relationship has a legal as well as ethical aspect. The basis for the ethical considerations are based on the Hippocratic Oath which you have been told about. It must be remembered that medicine is a profession and not a business, and like all professions should have service as its chief aim. For example, a shopkeeper will not sell his merchandise to anybody without money, but doctors often treat patients without monetary reward. The doctor-patient relationship is not static. Three models are described: Activity-Passivity, Guidance - Cooperation and, lastly, Mutual Participation. An example would be a patient admitted in diabetic coma: initially the doctor administers to a completely passive patient, when the patient wakens, he (she) will have to cooperate as regards rest, diet, drugs etc. under the doctor's guidance and lastly, after discharge, the doctor will have to plan a maintenance regime which best suits the patient's economic and social circumstances, and this regime may have to be adjusted from time to time. If the doctor is too rigid in his approach, he may be considered unsympathetic.

"It must be remembered that in any doctor-patient relationship the former is usually at an advantage and this may lead to temptation and abuse. Patients attend doctors with almost child-like faith, believing at least initially that they will be helped, little realising perhaps how ignorant the profession is about many diseases. Intermingled with this may be a 'parental' image. The deportment and dress of doctors should accordingly be sober. Also, in the course of seeing patients a doctor should withhold undue expressions indicating anxiety, surprise or uncertainty but this does not mean putting on a long face constantly!

"Professional secrecy must be adhered to as once patients realise that the results of a visit to a doctor are not confidential, important information may be withheld or the patient may leave that doctor's practice.

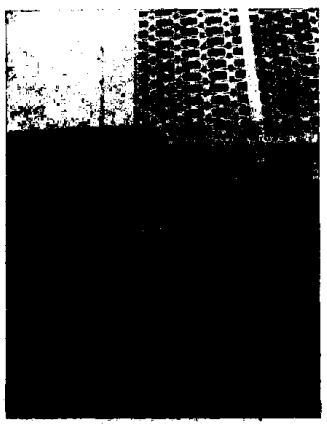
"The difficulties of communication between doctors and patients are often not fully appreciated, even by those who have been in practice for years. Patients should never be left in the dark; they should be clearly informed about their drug and other regimes and some indication of the disease and prognosis should always be given. Information imparted to patients must be simple and concise. In a recent study by Joyce et al from the London Hospital, London, England (Quart. J. Med., N.S., 38, 183, 1969) it was found that (i) information recalled by a patient decreased as the amount told by the doctor increased, (ii) recall was related to the degree of anxiety, being poorest in the most and least anxious and was best in those with moderate anxiety, (iii) recall was not related to age nor intelligence, (iv) about 50% of information could be recalled and the last mentioned was remembered the most clearly, (v) the doctor's emphasis mattered less then factors in the patient in determining what was recalled. Patients are free to choose doctors and vice versa. However, in any emergency a doctor is morally though not legally obliged to attend to the patient until other medical attention is ensured. In consultation practice the consultant should only see referred patients and these patients should be returned to the care of their general practitioner. Doctors should not 'take over' patients seen in the course of consultation unless it is for specific therapeutic purposes e.g. a surgeon might 'take over' a patient suffering from carcinoma of the stomach from a physician. Also doctors should not 'take over' patients seen while acting as a locum tenens. It is considered unwise for doctors to visit patients under the care of other doctors for this may lead to misunderstanding. If you wish to do this, the doctor in charge must be informed first.

"A recent occurrence at the Sai Ying Pun Polyclinic leads me to my final remark, which is to remind you of the physical privileges of doctors. It is perhaps common sense that a male doctor should not examine a female patient except in the presence of a nurse or female doctor. You would do well to remember the saying 'A patient must not become a mistress, but a mistress may become a patient'."

How Well Do You Know The Medid Centre

Here is a test for your knowledge of the Medic Centre. Can you recognise the sites shown in the following photographs? Would you like to go and find out?

(Editors' note: We welcome photographs taken around the Medic Centre.)



A VISITOR'S VIEW

G. J. Coltheart

Editors' note: The following article is contributed by an Australian medical student from Tasmania. He has done one month's surgical clerkship at the Surgery Department and the following is his opinion of his stay here.

On coming to Hong Kong I had little idea of what to expect; I knew that the Medical School was a substantial one with the English tradition of bedside teaching and ward clerking, but of the city itself I had little conception. My first impressions were the tremendous population (Tasmania has less than 400,000 people in an area about that of Ceylon), the busy narrow streets with both drivers and pedestrians seemingly bent on self destruction, and the junks on the harbour, which, I was disappointed to find, mostly had engines and not sails as I had imagined. Generally my experience in the six weeks I have spent here have been very favourable. Winter in Tasmania is accompanied by much rain, hail, and snow, and it was a relief to find a winter like our spring, much more pleasant than the hot Australian summer I had just left.

The Queen Mary is an excellent hospital and the Medical School is very fortunate to have it available for teaching, especially in that such a wide variety of disease is to be found in such a small area. In Australia the students tend to be scattered around several different hospitals in order to make use of all the available clinical material, and this leads to loss of contact with the rest of the year apart from those in the group you happen to be assigned to. There are a few differences here that I noticed early on, small things, but a contrast to my previous experience. These include the lack of individual screens around the beds, and the necessity for manoeuvring clumsy portable screens whenever it was necessary to examine someone. The patients here are very much more strical than the usual Australian, and don't seem to mind how many people examine them. The amounts of analgesics and other drugs used are also much less, although weight differences may be partly the reason for this. The usual premedication in Australia is 100mg. pethidine one hour before, and few patients will become unconscious with less than 350 mg. of intravenous thiopentone. With ward teaching it is a great convenience to have the patients' notes available on the end of the bed, and to be able to discuss the patients' prognosis in front of him without causing him any alarm. Neither of these things are possible in Australia, where you have to retreat out of the ward to discuss the patients' progress.

Among the students the main differences are that in Australia about half are married by the end of the final year, or very shortly after graduation. The proportion of girls in the courses is about the same as Hong Kong. Most Australian students are moderate beer drinkers and prefer to spend part of Friday evening in the hotels near the hospitals celebrating the end of the working week. I have not been able to discover an equivalent vice here. Hong Kong students tend to be more conscientious about attending lectures, ward rounds, etc., than Australians. It was a great surprise to me to find that it was necessary to arrive ten minutes early to get a good seat at a lecture. In Australia the seats are all filled in the thirty seconds before the lecturer is due to arrive. Australians are also more prone to cease attending if they feel that the lecture is dull, the hour too early or too late. Working on Saturday morning, as is the routine here, would make most Australian students horrified.

I thought the standard of teaching here was of a high standard, although it seemed to me that it was more from the textbook standpoint than through a consideration of the signs and symptoms actually displayed by a patient in the wards. I was astonished to find at bedside tutorials that while waiting for the tutor to arrive everyone except the person presenting the case studied, not the patient, but the sections in their textbooks dealing with his disease, the reason being that the tutors tended to be more interested in the textbook picture than in the features of the individual case. Formal lectures are very good, as are the ancillary teaching aids such as the library and the surgical pathology museum, to name only two.

The contrasts in diseases are quite interesting. Nasopharyngeal carcinoma is virtually unknown in Australia, and carcinoma of the liver is rare, although it does occur. Cholangitis is seen occasionally following the appearance of stones in the common bile duct, but they nearly always have their origin in the gall bladder. If the latter is palpable in someone with jaundice of insidious onset then it nearly always indicates a carcinoma in the head of the pancreas or some other sites where it can occlude the extrahepatic biliary tree. Tuberculosis is seen only infrequently and then in the lungs only for the most part, since it is usually detected before it has a chance to cause damage anywhere else. Typhoid is uncommon and most of the cases are in travellers who arrive during the incubation period. Pagets disease of bone is quite common, and so is hydatid disease. One striking difference is the absence here of deep venous thrombosis and subsequent pulmonary embolism. This is a benefit best appreciated by those who have had the worry of looking after patients likely to develop this complication, and the almost equal headache of managing the anticoagulant therapy of patients who have developed it. Few things are as depressing as having a patient survive a hazardous opertion only to die post-operatively from a pulmonary embolus. Alcoholism in patients in Australia is of fairly frequent occurrence, corresponding roughly to drug addiction here, except that the long term effects of alcoholism (delirium tremens, etc.) are possibly more dramatic than those of a drug overdose. Disseminated sclerosis is relatively common, especially in the Southern states of Australia, while for malignant melanoma a reverse trend occurs, it is most common in the northern tropical areas.

The medical course in Australia is on the whole easier than it is here. It lasts six years, the first year being about equivalent to the last year in a secondary schol in Hong Kong. There is a long holiday at Christmas time, i.e. in the summer, amounting to six weeks in the case of my own faculty. It did seem to me that having three clinical years without any substantial holiday, as is the case here is rather a heavy burden. In no university in Australia does the medical faculty occupy the pre-eminent position such as is held by the faculty here, nor do medical students (or any other university students for that matter) have the privileged position in the eyes of the community held by the students here. The popular misconception of a university student in Australia is someone who loafs for several years, grows a dirty beard, fornicates frequently, demonstrates against Vietnam, conscription, etc. and at the end of it all gets a highly paid job on false pretences. Educated people are in general respected in Australia but only after they have completed their education. College life in Australia is restricted for the most part to those who have to live away from their homes, and usually the distances are too great for casual visits home at the weekend. The Australian equivalents of the medical students centre are usually built into the clinical building or the teaching hospital. Finally a word on your nurses, who struck me as being as capable and efficient a group of young women as any I have met. My greatest disappointment in Hong Kong was that I didn't get to meet any of them on a non-professional basis. Perhaps a case of better luck next time?

LYMPHOCYTES AND ANTILYMPHOCYTIC SERUM

(CONTINUED FROM LAST ISSUE)

In the absence of complement, ALS agglutinates lymphocytes and in appropriate conditions of culture stimulates blast transformation and uptake of uridine and thymidine. In the presence of complement, it causes lysis. Both the in vitro immunosuppressive activity and the in vitro agglutinating, cytotoxic and stimulating activity have been found to reside mainly in the immunoglobulin G (IgG) fraction.

It would be expected that only a portion of the immunoglobulin molecules obtained by chemical fractionation of ALS would be antilymphocytic, since the animal in which the serum was raised will inevitably have encountered a variety of antigens during its life. If the immunoglobulin is arbitrarily divided into two parts, it is found that the antilymphocytic portion only occurs in 1%. Recently however it is shown that antilymphocytic molecules are much more heterogenous than was thought and differ in their avidity for, and their effect on, the lymphocytes on which they are absorbed.

It seems likely that the main way in which ALG acts is by causing selective depletion of the long-lived recirculating lymphocytes. As a general rule, skin homograft recipient slowly regains the capacity to reject once treatment is stopped. However such treatment combined with thymectomy may produce an enduring state of specific immunological tolerance.

As a research tool ALG has many possibilities.

1. **the possibility of using sera raised in thymocytes and spleen cells in further studies on the inter-relationship and population dynamics of different categories of lymphocytes.**
2. **lymphocytes coated with ALG remain immunologically** unresponsive for one or more cellular generations.

Antilymphocytic globulin has been used in conjunction with azathioprine and prednizone in human patients with the object of preventing rejection of homotransplants of kidney, liver or heart, and for the treatment of auto-immune disease. The results in animals raise the exciting possibilities that it may be possible with the help of ALG to induce in transplant recipient a permanent state of specific immunological tolerance to the tissue of the donor. If this was achieved, all immuno-suppressive treatment could then be discontinued without risk of rejection. At present clinical use is limited by:

1. painful local reaction which it causes, and
2. possibility of acute anaphylactic reaction and damage to the kidney.

Thus there are difficulties to overcome before the potential of ALG as an immunosuppressive agent can be fully realized in human medicine, but there seems no reason to suppose that these will prove to be insuperable.

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* **Any suggestions or criticism concerning any aspect of the Medical Faculty, the Medical Centre, the Medical Council, or the Medical Students are alike welcome.**
* **We heartily thank the Glaxo Company for their enthusiastic financial support.**

—from the Editors, Caduceus.