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Exco of all residential halls
All contributors of articles
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MESSAGE FROM OUR DEAN

Medical education, whether undergraduate or postgraduate, does not remain stagnant. Changes in perspective, scope, content, as well as teaching methods are hallmarks of the subject. What is relevant 25 years ago may not be as relevant today. With the explosion of scientific and technological advances, medicine today is too big a discipline to be taught, or learnt, in its entirety during the undergraduate years. The emphasis therefore has shifted from details to broad principles. This is likely to be the characteristic of undergraduate medical education in the foreseeable future.

The Medical Faculty of the University of Hong Kong, like many other forward looking medical shcools, has found it important and of benefit to review the curriculum every now and then. A pre-clinical syllabus committee, and a clinical syllabus committee were formed in the Faculty some years ago, and took two years to overhaul the whole curriculum, finally making a package of proposals to the curriculum review committee, which has adotped most of the recommendations and has decided to implement the new curriculum starting September 1987. Changes were adopted to achieve certain goals: (a) Review the teaching time allotted to individual disciplines, to ensure an equitable distribution commensurate with world trends, as well as to accommodate newly introduced subjects. (b) To reduce didactic lecture time, and encourage more teacher-student small group contact, as well as encourage self-learning among students. (c) To reduce the number of examinations where possible, and to rely more on continuous assessment. (d) To review the effectiveness and desirability of present arrangements adopted on a trial basis, such as the integrated teaching term. Due considerations were given to comments of teachers in the Faculty, as well as the views expressed in a report of the working party on curriculum review set up by the University Medical Society.

It is a pure coincidence that the University itself has found it necessary to relook at the degree courses of its various Faculties recently. The impetus has been provided by internally generated needs, as well as changing trends of the secondary school system. There has been an increasing feeling that students who come into this University through the 6th form education (including Form 6 and Form 7) are not firmly prepared for university education. In particular, the two most popular local languages, English and Chinese, have seen falling standards within the last 15-20 years. Furthermore, the year of advanced level studies is generally too examination-oriented, and the whole of the 6th form education is not adequately broadly based. The Medical Faculty is in agreement with these views, and subscribes to the idea that a foundation year for preparation of students within the University has many advantages. Amongst these include the possibility of orientation of the syllabuses of the core subjects (chemistry, physics, biology) towards a heavier medical relevance, and introduction of other non-core subjects either as options or required courses. Subjects related to the humanities and the broader aspects of health issues can be entertained, leaving adequate time for strengthening of English and Chinese if necessary. Not all the subjects in the foundation year need to be examined in the conventional way, making it more attractive for students to learn for the sake of interest rather than to pass examinations. It is generally felt that the 5 years of the M.B., B.S. course should remain as it is,

without "spilling over" into the foundation year.

These imminent and possible changes seem unwittingly to herald the centennary of the Medical Faculty. The Organizing Committee for Centennial Celebrations and its various sub-committees have been working hard to provide a programme of events to mark this auspicious occasion. A monograph on the development of the Hong Kong College of Medicine and the Medical Faculty in the last 100 years is being compiled by Professor Dafydd Evans, Dean of the Faculty of Law. A special set of commemorative stamps will be issued in early September. An exhibition on the growth of the Faculty is being planned by the Medical Society.

Perhaps the highlight of the celebrations will be the multi-disciplinary scientific congress planned to take place from 10th to 13th September of this year. Vigorous attempts have been made to attract as many past and present graduates of the Faculty, both overseas and local, as well as undergraduates to attend and contribute to this function. Distinguished speakers, both graduates, as well as non-graduates, have been invited to deliver papers on the recent advances of medicine in their own respective fields. Symposia on trauma, cardiovascular disorders, hepatitis, biological basis of behaviour, neonatology update, have been planned, as well as sessions for free paper presentation. Three keynote speakers, all distinguished graduates of the Faculty, will grace the occasion, and a special symposium on medical education is scheduled. A donation campaign is underway to set up a Sun Yat San Foundation Fund, and at the time of writing has reached the 4 million dollar mark. Other satellite scientific conferences and events will add to the lustre of the centennary year.

Exciting things are happening in the Medical Faculty, these are but the beginnings for the next 100 years. You as medical students should justifiably be proud to be a member of this fraternity.

John C. Y. Leong
Dean
Faculty of Medicine

PRESIDENTIAL ADDRESS

It is indeed a privilege to have been elected President of the Medical Society. With any privilege there is always a responsibility. Now I am confronted with the necessary to offer you words of wisdom and good cheer before I pass the gavel to my successor.

In the past fewyears, nostalgia has become the "in" thing. With the spirit of these two quotations in mind ("What's past is prologue" — Shakespeare; "Those who cannot remember the past are condemned to repeat it" — Santayana) and the risk of boring you with historical comments and anecdotes, I would like to present to you a brief account of the development of cardiac surgery.

Since the earliest times the importance of the heart has been known. At the time of the first dynasty of the Egyptians (3000 B.C.), the anatomical form of the heart and great vessels were known as shown in their hieroglyphics. Later the signs were translated into amulets, and the heart was usually represented by a heart shaped structure with three blood vessels at the base. It has been said that surgeons, ancient or modern, when confronting a deseased area of the body which is not amenable to medications, instinctively seek a mechanical solution, i.e. a surgical procedure, to the problem. However, in the case of the human heart, it remained a taboo of surgeons for centuries. Probably this was related to the early recognition that wounds inflicted on the heart were invariably fatal. There are many Biblical reference to the vulnerability of the heart. Homeric stories contain many references to wounds of the heart and their fatal terminations, and many other references to the fatal result of heart wounds can be found in ancient literature and among the writings of the great physicians. Because of this, the heart became the last of the organs approached by the surgeons.

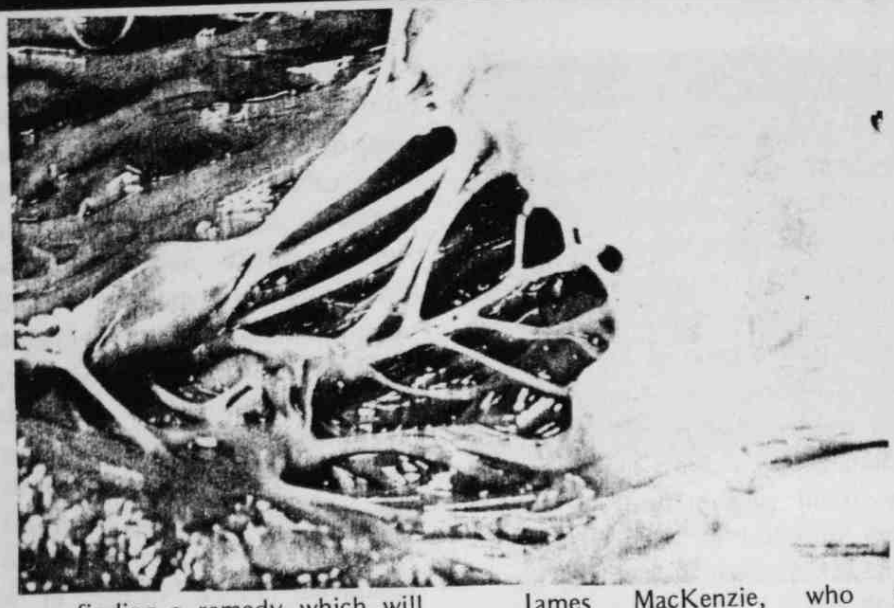
Hollerius in the 16th century questioned the belief that all heart wounds are lethal. It was Idonis Wolf in 1642, who reported that he had observed a healed wound of the heart in a deer, and in the same year Tourby found the scar of a wound of the heart in a man who had been wounded by a sword four years earlier. In 1650, Riolanus suggested that the sternum be trephined for aspiration of fluid from the pericardial cavity. He also demonstrated that heart wounds are not necessarily fatal by experiments in the dogs. Despite of these, John Bell, in his Discourses on the Nature and Care of Wounds published in 1795-1807, noted that heart wounds were fatal. He felt that so little could be done that it was useless to discuss the subject. To illustrate the surgeon's view of the human heart in the 16th and 19th century I quote you the writings of the innovative French surgeon Ambrose Pare and the celebrated English surgeon Stephen Paget. "The heart," wrote Ambrose Pare, "is the chief mansion of the soul, the organ of vital faculty, the beginning of life, the fountain of vital spirits and so consequently the continual nourisher of vital heat, the first living and the last dying . . . ". In the 1896 edition of Paget's book — "Surgery of the Chest", he stated "Surgery of the heart has probably reached the limits set by nature to

all surgery. No new method and no new discovery can overcome the natural difficulties that attend a wound of the heart. It is true that 'heart suture' has been vaguely proposed as a possible procedure and has been done on animals; but I cannot find that it has ever been attempted in practice."

The 'vaguely proposed heart suture' mentioned in Paget's book in fact referred to the first experimental cardiac sugery conducted by M. H. Block, a German surgeon, in 1882. In his report, he described successful suture of rabbit hearts. He strongly urged that the procedure be used in man. However, resistance to this innovation was strong. It has been reported that Theodor Billroth, Professor of Surgery at the University of Vienna, pioneer abdominal surgeon, and the first to perform successful gastric resection in 1881, stated "A surgeon who would attempt such an operation (i.e. suturing a wounded heart) should lose the respect of his colleagues".

Despite Billroth's remark, in the same year as Paget's negativistic statement, Ludwig Rehn of Frankfort first successfully closed a stab wound of the heart in a 22-year-old man who had experienced a three-hour period of unconsciousness prior to operation. He found a wound in the right ventricle with active bleeding. He placed a finger over the wound and controlled the bleeding with three silk sutures. The patient recovered, thus marking the beginning of cardiac sugery, exactly 90 years ago. In 1902 when R. L. Hill reported the first successful closure of a stab wound of the heart in America, a Professor Sherman wrote "The road to the heart is only 2 or 4 centimeters in a direct line, but it has taken surgery nearly 2,400 years to travel it." Apparently, Professor Sherman was dating his 2,400 years back to the time of Hippocrates.

The 10 years surrounding the turn of the 19th century could be regarded as the time of conception of cardiac sugery. In 1898 Samways suggested that the tightly stenotic mitral valve might be opened surgically and then in 1902 another distinguished English physician, Sir Lauder Brunton, wrote in Lancet: "Mitral stenosis is not only one of the most distressing forms of cardiac disease, but in its severe forms it resists all treatment by medicine. On looking at the contracted mitral orifice in a severe case of this disease, one is impressed by the hopelessness of



ever finding a remedy which will enable the auricle to drive the blood in a sufficient stream through the small mitral orifice, and the wish unconsciously arises that one could divide the constriction as easily during life as one can after death." In the postmortem room, Sir Lauder obtained heart specimens and showed that one could successfully incise the margin in order to enlarge the orifice. Since then attempts were made without success to enlarge the stenotic pulmonary, aortic and mitral valves. It was not until 1925, in England, Henry Souttar first successfully split a stenotic mitral valve by introducing a finger into the left atrium through the left atrial appendage and split the stenotic valve with finger pressure alone. However, the procedure did not gain clinical acceptance because it was generally believed that the abnormality of mitral stenosis was in the myocardium and not in the valve. James MacKenzie, who was Britain's leading cardiologist and a respected teacher, hastened to condemn Souttar's accomplishment. Mitral valvotomy was not generally accepted until the late 1940s when Dwight Harken of Boston and Charles Bailey of Philadelphia published their successful series. Despite the remarkable safety and effectiveness of mitral valvotomy as a method of treatment for rheumatic mitral stenosis, early attempts to correct other forms of valvar dysfunction were not significantly rewarding. The solution to these problems awaited the development of open heart surgery.

The idea of using surgery to treat congenital heart disease was first conceived by John Munro after he performed an autopsy on a child who died with a patent ductus as the sole lesion. He proposed that a patent ductus could be ligated surgically. The proposed operation was published in the Annals of Surgery in 1907. But no patients with this condition were referred to him. 30 years later, in 1937, John Strieder of Boston made the bold decision and ligated the patent ductus arteriosus in an 18-year-old girl with bacterial endocarditis. He closed the ductus successfully but the patient died on the 4th postoperative day. In another hospital in Boston, Robert Gross proceeded in the following year to be the first to close successfully a patent ductus arteriosus.

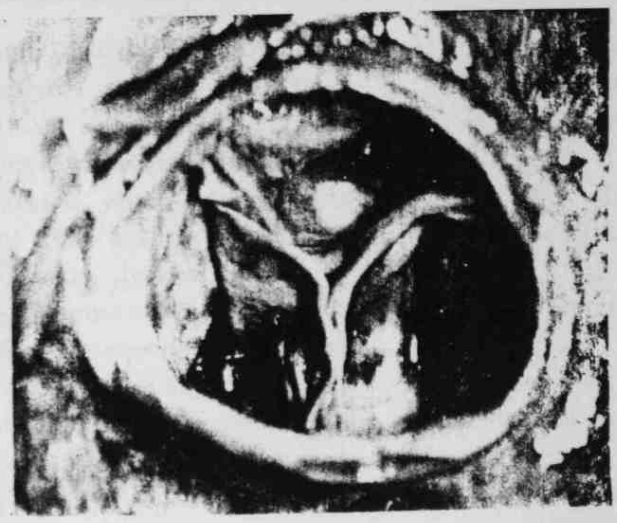
In October, 1944 Professor Clarence Crafoord of the Karolinska Institute in Stockholm performed the first successful resection of a coarctation with re-anastomosis of the aorta. Although the surgical procedure is straight-forward, its development was quite interesting. In closing a patent ductus arteriosus, Professor Crafoord accidentally tore the ductus and severe haemorrhage occurred. It became necessary to cross clamp the aorta in order to control the bleeding. The operation ended successfully and from this Professor Crafoord knew that cross clamping of the aorta would not inevitably result in paraplegia or renal insufficiency. Thus, the unorthodox manoeuvre of cross clamping of the aorta, through serendipity, gave rise to a new procedure.

Another example of how an alert mind, in approaching one problem, finds openings to the solution of another is the devise of the Blalock-Taussig shunt by Alfred Blalock of Baltimore. In 1938, while on the faculty of the Vanderbilt Medical School, Blalock was interested in pulmonary hypertension. He and Sanford Leeds tried to produce an animal model of pulmonary hypertension by anastomosing the left subclavian artery to the left pulmonary artery but this failed to increase the pulmonary artery pressure. In 1942 Blalock moved to Baltimore, when he was asked by Helena Taussig, the paediatric cardiologist to devise a method to increase the pulmonary blood flow to the lungs in patients with pulmonary stenosis, the subclavian artery to pulmonary artery anastomosis immediately came to his mind. An unsuccessful experiment turned into an accomplished method of treatment of cyanotic congenital heart disease with reduced pulmonary blood flow. The subclavian artery to pulmonary artery anastomosis is the first surgical procedure ever devised to treat intracardiac anomalies such as tetralogy of Fallot. It effectively increases the pulmonary blood flow, reduces the central cyanosis and improves the effort tolerance of the patient. This story also demonstrated that the success of cardiac surgery owes to the efforts of a consortium of physicians and surgeons.

Following the Blalock-Taussing shunt, several other extracardiac palliative procedures for intracardiac anomalies were developed, such as the Potts anastomosis (descending thoracic aorta to left pulmonary artery), the Brock pulmonary valvotomy (transventricular pulmonary valvotomy), and the Blalock-Hanlon technique for creating an atrial septal defect to improve the inter-atrial mixing of blood in transposition of great arteries. Various ingenious techniques were devised to repair intracardiac defects without interrupting the circulation. Gordon Murray and T. Sondergaard passed sutures from the outside of the heart to close atrial septal defects. Using a finger in the right atrium to guide the placement of sutures, Bailey closed atrial septal defect by suturing the wall of the right atrium to the rims of the defect. He called this technique atrioseptopexy. Gross on the hand, sewed a rubber well onto an incision in the right atrium and then working by touch through the pool of blood that in the well closed the atrial septal defect. The first successful direct-vision operation within the open human heart was conducted by F. John Lewis at the University of Minnesota Medical School on September 2, 1952. Dr. Lewis, stimulated by the report of Bigelow and co-workers on general hypothermia for experimental intracardiac surgery and after a period of intensive laboratory research, successfully closed an atrial septal defect in a 5-year-old girl under direct vision utilizing inflow stasis and moderate total-body hypothermia.

The foregoing developments bring us to the threshold of perhaps the most significant advance in cardiac surgery, namely, the successful applicantion of the techniques of extracorporeal circulation. For many years previously, physiologists had worked on methods for oxygenating the blood artificially. It was a surgeon, however, who came to realize that the heart-lung machine must be developed as an essential tool in the surgical management of patients with heart disease. The idea came to John Gibbon while watching a patient died with massive pulmonary embolism in 1931. A few years later he began work on the project, both in Philadelphia and in Boston, and ultimately found that it was possible to take over completely the cardio-respiratory functions. The first attempt to use a heart-lung machine for total cardio-pulmonary bypass to permit intracardiac operations in human beings was carried out at the University of Minnesota Hospitals by Clarence Dennis in April, 1951. Two patients were operated on within a month's time, but both died in the operating room of problems of misdiagnosis and massive air embolism. It was Gibbon, working at Jefferson Medical College in Philadelphia,

first successfully employed the heart-lung machine to close an atrial septal defect in an 18-year-old girl on May 6, 1953. Although this first success with the heart-lung machine was well received, it aroused surprisingly little excitement or enthusiasm among cardiologists and cardiac surgeons at the time. According to Dr. Lillehei, there were several reasons for this. First, Dr. Lewis was regularly closing ASDs under direct vision using inflow stasis and moderate total-body hypothermia with excellent results, and other centers had begun to duplicate this results. Second, and probably more important, Gibbon was never able to repeat his one success with an ASD or with the more complex VSD. There were other reported as well as unreported failures with the heart-lung machine. Around that time there was a common scenario, namely, good result with acceptable survival in the experimental animals but nearly universal failure when the same apparatus and techniques were applied to human beings. Thus, many of the most experienced investigators concluded with seemingly impeccable logic that the problems were not with the perfusion techniques or the heart-lung machines. Rather, they came to believe that the "sick human heart", ravaged by failure, could not possible be expected to tolerate the magnitude of the operation required and then recover with good output, as occurred when



the same machines and techniques were applied to healthy dogs. Thus, discouragement and pessimisim about the future of open-heart urgery were widespead.

In the meantime, Lillehei and his colleagues at the University of Minnesota Medical School while using cross-circulation ("placental circulation") to obtain some open-heart experience in animals found that the dogs undergoing a 30-minute interval of low-flow cross-circulation not only survived at a far higher percentage, but recovered more rapidly when compared with the earlier dogs which they had observed undergoing a similar period of high-flow pump-oxygenator perfusion. It became obvious to Dr. Lillehei that this method might have clincial application. Although the thought of taking a normal human to the operating room to serve as a donor and subject him to any risk, however temporary, was considered by many to be unacceptable or even immoral, the continued lack of any success in the many centers worldwide that were working actively on bypass made the Minnesota surgeons to apply the technique of cross-circulation for intra-cardiac surgery clinically. On March 26, 1954, using extracorporeal circulation by controlled cross-circulation, Dr. Lillehei and his colleagues successfully closed a ventricular septal defect in a 12-month-old infant. The patient's father was the donor. From March 26, 1954 to July 19,1955, 45 patients with major cardiac malformations not previsously correctable underwent successful open repair utilizing cross-circulation between patient and donor without donor deaths. This demonstrated that congenitally malformed and decompensated hearts could be repaired successfully and made to function normally.

The breakthrough with intra-cardiac surgery under cross-circulation rapidly dispelled the

pessimism that the sick human heart was an insurmountable barrier to corrective surgery. Attention was directed once again to the previously unrecognized deficiencies of the existing heart-lung machines. When better oxygenator became available, the surgeon's dream of performing intracardiac corrections in the open heart became a reality. Beginning March 22, 1955, the systemic use of a heart-lung machine in an ongoing series of clinical operations was pioneered by Hohn Kirklin at the Mayo Clinic, thereby initiating a new teherapeutic era.

In the quarter of a century that has elapsed since those historic events surrounding the first efforts at open heart operations, each of the various deseases of the heart has come under the scrutiny of cardiac surgeons and the great majority, indeed almost all, of these cardiac lesions have been alleviated to some degree by surgical intervention.

In the last 15 years or so, coronary artery surgery became the commonest surgical procedure performed in an affluent society like United States of America. The historic development of operations for coronary artery disease is fascinating. The first suggestion that a surgical approach might have a role in the treatment of angina pectoris was made by a professor of physiology at the University of Paris, Francois-Franck in 1899, one year following Samways' proposal that mitral stenosis might be treated surgically. Prancois-Franck predicted that excision of the cervical sympathetic chain would interrupt the pain fibers to the heart and therefore provide relief for patients with anginal pain. The procedure was actually performed in 1916 by Jonnesco of Bucharest with a successful result. Despite the relief of anginal pain which occurred in some patients undergoing this procedure, this approach did not provide additional blood supply and was ultimately abandoned.

The next phase of development of surgery of coronary artery disease was aiming at increasing or redistributing the blood supply to the myocardium. Claude Beck of Cleveland, noticed during an operation that cutting a band of adhesions on the heart resulted in brisk bleeding from each end of the transected adhesion. He did thousands of animal experiments to show that artifically created inflammation of the epicardium resulted in the development of anastomotic blood channels that could supply blood from surrounding tissue to the surface of the heart. He abraded the epicardium mechanically, installed bone dust to produce further epicardial irritation and swing a pectoris major muscle to place over the exposed epicardium to promote the development of collateral vessels. Many subsequent modifications of the Beck procedure were developed. Irritant pastes, caulk, magnesium silocate, sand, asbestos, phenol and Ivalon sponge were used to irritate the pericardium; omentum, lung, spleen, skin and segments of small bowel were used as sources of new blood supply for the heart. The operative mortality was high — 38%, but 90% of surviving patients were said to be improved.

In 1937, Gross reported experiments showing that occlusion of the coronary sinus in the dog reduced the incidence of infarction after ligation of a coronary artery. It was postulated that the procedure improved the blood supply to the myocardium. Thereafter Beck incorporated subtotal ligation of the coronary sinus into his original operation, and he believed the results were better. From subtotal ligation of the coronary sinus it was a natural step to arterialization of the coronary sinus, which was first reported in 1943 and adopted by Beck in 1948. It was theorized that the myocardium could be perfused retrogradely. The procedure was risky, critized by many, including Blalock, and never gained widespread acceptance.

Basing on an observation made in 1930 that anastomotic communications existed between the internal mammary arteries and the coronary circulation, in 1954 Battessati and his co-workers in Italy reasoned that ligation of the internal mammery arteries beyond these collateral vessels would increase the collateral supply to the myocardium. This was widely accepted and thousands of patients underwent this procedure in the late 1950s and early 1960s until it was disproved by controlled sham operations.

In an attempt ot increase the myocardial blood supply, Gordon Murray and many others implanted the interanl mammary artery into the myocardium. It was thought that the implanted artery would form anastomoses with the myocardial sinusoid. Murray concluded that the procedure was worthless. However, in 1946, Vinberg, another Canadian surgeon, despite the many previous unfavourable reports on this procedure reported glowing success when it was applied clinically. The procdure remained controversial until 1962 when Sones and Shirey demonstrated by cineangiography that flow through the implanted artery to the collateral coronary artereis did exist occasionally. This procedure was later abandoned because it was shown that the volume of blood supplied by the implanted artery was small.

In 1954, the great innovative Canadian surgeon, Gordon Murrary showed experimentally that direct arterial anastomosis could be made on the coronary artery. He experimentally anastomosed an axillary artery to the anterior descending coronary artery and could then ligate the anterior descending artery without producing a myocardial infraction. He postulated that this might be a method for clinical treatment for the future and predicted the necessity of angiography to determine the site of coronary obstruction. Experimental aorta-coronary bypass using a segment of vein was first reported by Sauvage in 1963. These two experimental procedures initiated the modern era of coronary artery surgery. The first clinical case of aphenous vein bypass grafting was accomplished by Edward Garrett who found it necessary to interpose a graft in order to successfully wean a patient from cardio-pulmonary bypass. Popularization of the procedure awaited the development of selective coronary angiography by Mason Sones in 1959, the work of Rene Favaloro and Donald Effler at the Cleveland Clinic and Dudley Johnson in Milwaukee beginning in 1967.

"The development of cardiac sugery is a story of a continuing growth based on imaginative vision, on technical excellence, on judicious trail and informative error, the sum of the endeavors of the many guided by the inspiration of these few individuals."

To end my talk I would like to leave you with a quotation from the master surgeons from the University of Minnesota Medical School:
"Some see things as they are and ask "Why Change?"
Others dream of things that never were and ask "Why not!"

Prof. C. K. Mok

President Medical Society HKUSU

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Mr. Lung Hin Fai (Distinction in Microbiology)
Mr. Mak Siu Ka
Mr. Ng Chi Yin, Charles
Mr. Ng Hung Yu, Ernest
Mr. Ng Ka Kui, Philip
Mr. Ng Kin Pong
Mr. Ng Man To
Mr. Ng Ping Ki, Gary
Mr. Ng, William
Mr. Ngai Chi Man
Miss Ong Oi Lun, Catherine
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Miss Tse Wan Ting, Philomena (Distinctions in Physiology, Behavioural Sciences, Community Medicine and Surgery)
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Mr. Yam Kwong Yui
Mr. Yau Kwok Ho
Mr. Yeu Yee Man
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Mr. Yeung Ton Cheung, Wilson
Mr. Yik Ping Yin (Distinctions in Pathology and Community Medicine)
Mr. Ying Chi Ho, Anthony
Mr. Yu Kwok Hung
Miss Yuen Oi Shan, Connie
Miss Yuen Suk Fan, Monita
Mr. Yung Lap Kay, Gordon

Teaching & Administrative in the Faculty of Medicine appointed during the period 01/07/85 to 30/06/86

Department	Name		Post	1st appt. in present grade	
Pharmacology	Dr Tam	Wai Ming	Lecturer	860401	B.S. Pharm, Taipei Med Coll; M.S., Ph.D. (Min.)
Medicine	Dr Chan	Chun Kwong Jane	Lecturer	860301	B.A. Yale; M.D. Chic., Dip of the National Board of Medical Examiners USA., Dip in Internal Medicine (American Board of Internal Medicine)
	Dr Cheng	Kum Po Ignatius	Lecturer	860201	M.B., B.S. H.K., F.R.A.C.P., M.A.C.N., M.A.C.T., M.A.C.I.
	Dr Liang	Hin Suen Raymond	Lecturer	851101	M.B., B.S. H.K., M.R.C.P. U.K.
Microbiology	Dr Livermore	David Martin	Lecturer (Temp.)	851104	B.Sc. Heriot-watt; Ph.D. Lond Hospital Med. Coll.
Obstetrics & Gyn	Dr Dong	Zhi Guang	Lecturer (Temp.)	850724	Graduated in Beijing Med. College
	Dr Lo	Chak Cheung Derek	Lecturer (Temp.)	850708	M.B., Ch.B. (Dundee); M.R.C.O.G.
Orthopaedic Surg	Dr So	Yat Cheong Timothy	Lecturer	860101	M.B., B.S. H.K. F.R.C.S. Glas & Edin., F.R.A.C.S.
Paediatrics	Dr Cheung	Pik To	Lecturer	860318	M.B., B.S. H.K. M.R.C.P. UK
Pathology	Dr Wong	Pik Maria	Lecturer (Temp.)	860212	M.B. B.S. H.K.
Hps Haematology	Mr Robertson	Edwin Philip	Scientific Offr	851201	F.I.M.L.S.
Hps Mb Anat Cyt	Dr Chan	Yuk Tat Eric	C1 Pathologist	850701	M.B., B.S. HK
	Dr Liu	Hing Wing	C1 Pathologist	850701	M.B., B.S. HK., M.R.C.P.
	Dr Wong	Pik Maria	C1 Pathologist	860512	M.B., B.S. HK
Surgery	Dr Branicki	Frank James	Senior Lecturer	850718	M.B., B.S. Lond; D.M. Nott., F.R.C.S. Eng.
	Dr Choa	Dennis I	Lecturer (Temp.)	860301	M.A. (Cantab); F.R.C.S. (Eng.)
	Dr Lau	Sai Kit	Lecturer	860326	M.B., B.S. (HK), D.L.O., F.R.C.S. (Edin.)
	Dr Pritchett	Christopher Julian	Lecturer	860503	B.Sc., M.B., Ch. B., M.D. (Brist.)., F.R.C.S. (Eng.)

Teaching & Administrative in the Faculty of Medicine left during the period 01/07/85 to 30/06/86

Department	Name		Post	Termination reason	Termination date
Anatomy	Dr Low	Weng Djin	Reader	Death	851224
Medicine	Dr Wang	Yu Ching Rebecca	Senior Lecturer	Resigns	860331
	Dr Pan	Yue Ming Henry	Lecturer	Resigns	850831
	Dr Chan	Yan Keung Thomas	Lecturer	Expiry	851231
	Dr Chiu	Kin Wah Edmond	Lecturer	Expiry	851031
Microbiology	Dr Livermore	David Martin	Lecturer	Expiry	860430
Obstetrics & Gyn	Dr Chan	Pak Hang	Lecturer	Resigns	860228
	Dr Choo	Yew Cheong	Senior Lecturer	Resigns	850818
	Dr Lo	Chak Cheung Derek	Lecturer	Resigns	860630
Orthopaedic Surg	Dr Tang	Siu Cheung	Lecturer	Resigns	851231
Paediatrics	Dr Chan	Lui Wai Ying	Reader	Resigns	850711
Pathology	Dr Ng	Wing Ling	Senior Lecturer	Resigns	850915
	Dr Kung	Tak Min Ignatius	Lecturer	Resigns	860430
Surgery	Dr Choi	Kam Yee Samuel	Lecturer	Resigns	860526
	Dr Lau	Lim Tat James	Lecturer	Resigns	850928
	Dr Wee	Teow Keong Julian	Lecturer	Resigns	851217
	Dr Ngan	Yum Kay Samuel	Lecturer	Resigns	860303
Postgrad Med Ed	Dr Preston	Peter John	Director	Retirement	860630

BACHELOR OF SCIENCE IN BIOMEDICAL SCIENCES

你知道醫學科學（BIOMEDICAL SCIENCE）是什麼嗎？相信很多醫學院的同學都不很清楚；而知道我們醫學院有這科目理學士（BACHELOR OF SCIENCE IN BIOMEDICAL SCIENCE）課程選讀的人相信更少了。

這課程在英美的醫學院存在已久，但香港大學醫學院則只開設了醫學科學理學士八年，可算仍是雛型階段。爲着更了解這課程的內容，筆者從院方搜集了一些資料，又走訪了幾位講師和曾修讀這課程的同學。希望大家能在看罷這篇文章後，對這課程有更多認識，更或許決定修讀也不定呢！

根據院方表示，設立這一課程的目的是爲一小部份醫學生（及牙醫學生）提供接受更多基本科學教育的機會。這包括基礎醫學科學或應用醫學科學。這些同學將來或會從事教學及研究的工作。

到現時爲止，有七個學系提供這個課程：修畢二年醫學課程的同學，可以選修生理學、生化學式解剖學；而修畢三年醫學課程的，則可選病理學，藥理學，微生物學或社區醫學。修讀期爲一年，成績優異的同學更可獲榮譽學位。

課程的內容因應各學系的要求而異。共同的一點就是修讀的學生要在導師指導下，完成一項研究，並將結果寫成報告供主考的人評核。這部份亦是全個學位課程的特點。學生可以在得到導師的同意下，選擇或設計實驗去研究一特別課題（通常與導師進行之研究有關）；又或協助導師進行研究。在研究的過程中，學生能學會獨立思考，提出問題和用實驗的途徑嘗試找出答案。而在參予學系安排的講座中，又或是在撰寫報告時，個人的表達能力及與別人溝通的技巧將可受到鍛鍊。這些改善表達和溝通能力的機會，未必是每一位醫學生都可得到的。不論你將來會否繼續做研究的工作，又或選擇回行醫那條路，表達和溝通的技巧都是不可或缺的。

除了研究工作那一部份是必須外，每一學系都自行設計這學位課程。由於報讀的人數不多，而這課程仍在新生階段，所以課程設計相當有彈性。如病理學系會在課程內加入一般病理學家的工作訓練，如剖屍，組織病理學等；生化系就會安排修讀這課程的學生與理學院的同學一同上課，增加討論的機會；解剖學系則需要學生在某幾個題目上資料搜集及書寫報告。總之課程隨學系不同，亦隨時間轉變。

無論修讀那一科目，當然少不了對研究題目有較深入的了解和掌握。所以在圖書館中搜集資料，閱讀科學期刊和雜誌亦是學習的一部份。這個充份利用圖書館的機會，相信大部份醫學生都會在繁忙的課程裏錯過了。到學年尾，修讀的學生事實上是需要通過一次筆試，測驗一下他們對該課題的背景知識。

生化系的黃秋霖博士和方毓英博士，都認爲這課程提供一個難得的機會，讓學生接觸到新的學習和思考方法。方毓英博士提及當年她指導的學生曾參予她其中一項研究，及後研究結果更被刊登於科學雜誌上呢。生理系的黃德明博士亦笑說醫學院內或許有不少有潛質當科學家及做研究的同學；或許這課程能助你發現自己的潛質。

要在醫學課程未完成前，暫時中斷一年來修讀這學位課程，可算是一頗大的抉擇。事前當然要考慮一些問題和困難。最重要的當然是認清目的，究竟是爲了興趣，還是要鍛鍊思考，又抑或爲將來走研究的路打好基礎？甚至有些同學可能會趁此機會休息一會，體驗新鮮的事物。（不過筆者要特別指出此一課程未必一定比醫學課程空閒）再實際一點看，拿了這個學位又有何用呢？在英國，如果醫科畢業生有一個理學士學位，是被公認爲有較佳資歷，在升遷和私人執業方面都有幫助。不用多說，如果有意從事教學或考取更高學位的，這年的基礎訓練一定會成爲取錄時的考慮要點的。不過在香港，如果你只打算行醫或再考取會席，這學位就沒有多大作用。

至於花多一年的時間，延遲一年畢業是否值得，就要看你怎樣衡量了。有人認爲將來始終行醫數十年，現在抽一年時間來探索思想一下興趣所在和前途路向，絕不是浪費；相反地，別的人會覺得儘早畢業，爭取時間去建立事業和經濟基礎更爲重要。

此外，課程變轉的銜接問題，與及和新一班同學的相處，就視乎個人的適應能力和性格了。

筆者和另一位編輯，曾走訪在瑪麗醫院病理系工作的陳玉達醫生，讓他談談修讀這課程的經驗和感受。

× × × × × × ×

陳醫生是第一批就讀Biomedical Sci.病理系的同學之一。在短短的半小時交談當中，我們深深的感受到陳醫生是一位對研究工作有着濃厚興趣和很忠於自己理想的人。以下便是我們和他談話的記錄。

當年其實是第一年開始有這樣的課程，我決定讀的原因大概有二：第一，這個課程是個別設計的（Individual design），若果你特別對某一個研究課題有興趣，便可以自由接觸有關的教授，和他一起進行這項研究。我很喜歡這種具挑戰性的工作。第二，我對於純學術性研究的興趣遠遠大於醫學管理，所以我覺得讀這個課程比較迎合自己的興趣。

我修讀的是病理學，其他的科目如生理、生物化學及解剖都可以在完成頭二年去唸。但病理學必須是第三年後才可以唸。這樣學生可以先完成在醫科課程裡的基本訓練。

我本來是想做一些解剖病理（Anatomical Pathology）的東西例如大腸的切片化驗。但後來發覺既然有這樣好的一個機會便應該做一些更具實驗性的工作，比較能學到多一點。

病理學主要分爲解剖病理，免疫學及血液學。解剖病理可容讓實驗的方面不多，主要是做一些統計的工作。例如我曾檢驗很多正常的屍首大腸，看看有多少有 polyp 和 diverticulum。眞正的學習實驗工作最好還是做免疫學。

免疫學部門有一個教授是特別負責做研究工作的。研究的對象通常是一些動物——老鼠。我那時做的報告是研究老鼠在受到流行性感冒感染後所作出的免疫反應。首先我令老鼠受感，幾天後把它殺掉，在顯微鏡下觀察，看看細胞有否任何變化。通常在支氣管及小支氣管週圍都有着高密度的免疫細胞，我便把當中的B細胞及T細胞分開，看誰佔多些。這些程序說來容易，但對於一個第一次從事研究工作，而需要獨自進行的同學，碰到的問題可謂不少。導師是不會幫你做任何技術上的東西的，他只會向你提議一些方法。在那年我可謂接觸到一些醫學生一生也不會接觸的事物

到了年中，我開始考慮我是否會以研究作爲終身職業。其實當初我也是頗衝動下作出讀此課程的決定，並没有仔細的考慮。不過我想若我没有進修這一年，我可能最終都不知其實我眞正的興趣何在。

現在我做的主要是做醫院的工作和準備考會席，花去了不少時間，少了時間做研究。但無論如何，那年受的訓練仍然是很有用的。反之，若我現在是作爲一個醫院醫生，幫助反而不會太大。

至於銜接方面，我覺得是没有問題的，我是在完或了初級臨床期後停學一年，完成課程後再接着做高級臨床課程。至於家庭和與同學相處方面，對於我的問題不大。我覺得一個人對某件事有興趣，這些都不是大問題。在外國這個課程卻很受歡迎，而且對日後找尋工作頗有幫助。

考試方面，大概分三個部份。這個課程一定要在一年內完成，但工作程序卻隨你安排，我可以間中偷閒數天不回實驗室也行。

我個人覺得若果你對醫學科學有興趣又不介意花一年時間的話，這個課程不但可以滿足你的興趣，對將來的工作也很有幫助。因爲這個課程是鼓勵你自己去解決問題，其實是一個很好的機會去訓練個人的思考。

× × × × × × ×

談到報讀的資格，雖然在院方公佈的文件中好像是頗高的；但據一些講師表示，由於報讀人數不多，競爭並不存在，所以學生所表現的興趣反而比優異成績更爲重要。只要成績令系方滿意，而又找到適合的導師，取錄的機會是很大的。

各位同學在空閒時不妨仔細考慮一下這問題，更可與有興趣的科目的講師談談，看看有否得到一些啓發。詳細的資料可向醫學院辦事處查詢。

REGULATIONS FOR THE DEGREE OF BACHELOR OF SCIENCE IN BIOMEDICAL SCIENCES - B. Sc. (Biomedical Sc.)

1. To be eligible for admission to the courses leading to the degree of Bachelor of Science in Biomedical Sciences a candidate

   (a) shall comply with the General Regulations; and
   (b) shall
   either (i) have completed the second year of the curriculum for the degrees of Bachelor of Medicine and Bachelor of Surgery and shall have passed the Second Examination for those degrees;

   or (ii) have completed the first year of the curriculum for the degree of Bachelor of Dental Surgery and shall have passed the First Examination for that degree;

2. (a) For candidates admitted under Regulation 1 (b) (i) the curriculum shall extend over not less than three academic terms and shall include the Final Examination

   (b) For candidates admitted under Regulation 1(b)(ii) the curriculum shall extend over not less than six academic terms and shall include the Final Examination in two parts.

3. To complete the curriculum a candidate admitted under Regulation 1(b)
   (i) shall
   (a) follow instruction and complete all prescribed written and practical work in the equivalent of not less than three course units selected in consultation with the Heads of the appropriate departments from those offered in the following fields:

Anatomy	Pharmacology
Biochemistry	Pathology
Physiology	Microbiology
Epidemilogy	

   (b) satisfy the Examiners at the Final Examination which shall include not less than three written papers, at least one of which shall take the form of a dissertation or a report on a project, and may also include one or more oral examinations.

4. To complete the curriculum a candidate admitted under Regulation 1(b)
   (ii) shall
   (a) follow instruction and complete and prescribed written and practical work in the equivalent of not less than three course units selected in consultation with the Heads of the appropriate departments from those offered in the following fields:

Anatomy	Pharmacology
Biochemistry	Pathology
Physiology	Microbiology
Equidemiology	

   (b) satisfy the Examiners at the Final Examination Part I which shall include not less than three written papers, one of which may take the form of a dissertation, and may also include one or more oral examinations;

   (c) complete the requirements for admission to the degree of Bachelor of Dental Surgery;

   (d) follow instruction and complete all prescribed written work in the equivalent of not less than three course units which shall be related to the field studied in the first year of the curriculum, but of an applied or more advanced nature, and shall be selected in consultation with the Heads of the appropriate departments;

   (e) satisfy the Examiners at the Final Examination Par II which shall include not less than three written papers, at least one of which shall take the form of a dissertation or a report on a project, and may also include one or more oral examinations.

5. The lists of candidates successful in the whole of the Final Examination shall be published in five divisions: First Class Honours; Second Class Honours (Division One); Second Class Honours (Dvision Two); Third Class Honours; Pass.


THE HIGHLANDER
PRESENTATION DAY

SOCIETY PHOTO 85-86

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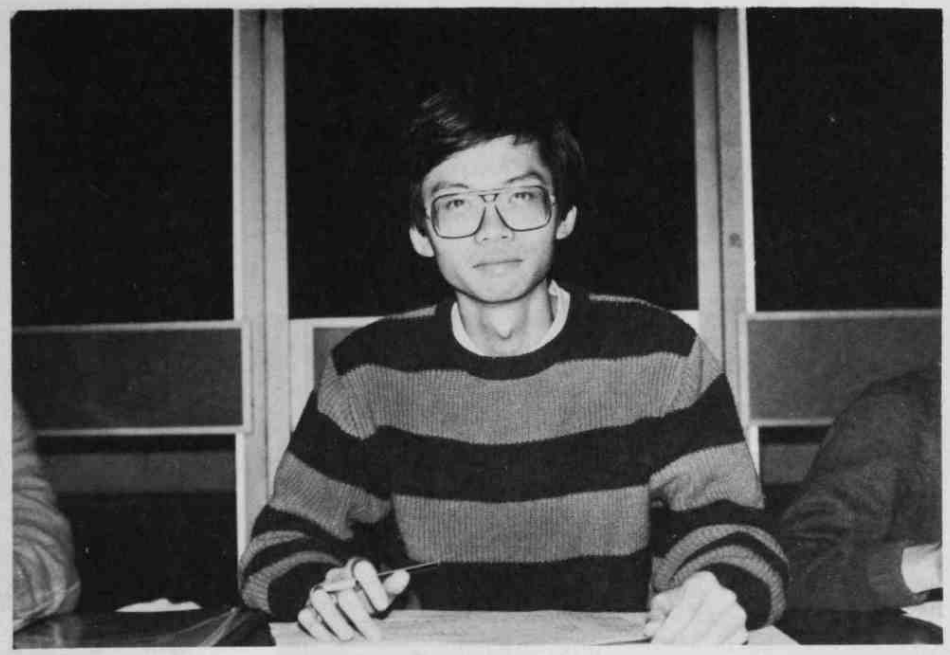


今年Medso所走的路向是保持舊有的活動，沒有加插新的嘗試，目的是希望能夠首先將以往存在的問題搞好些，例如內部的人事關係。

總括今年的活動，除了常設的幾個暑假的活動外，最大型的活動算是AMSC（亞洲醫學生會議），但成績都很普通。這裏反影出同學在籌辦活動方面（尤其是比較大型的活動）的經驗並不足夠。整體來說，大部份的活動都很平庸，沒有特色，而且在安排上亦出現混亂的情況。

至於存在已久的人事問題，在今年的Medso中仍然存在，但情況不是太壞。搞活動的同學除了得到一些經驗外，也可以學習怎樣和其他人相處和處世之道。而現在的情況就是一些同學（例如Excomember）往往搞了一年後便不再搞活動，對Medso並沒有很大的投入感，和從前「一踏江湖，身不由己」的情況很不相同。所以希望同學能夠一方面做得開心，另一方面也能對Medso培養一份歸屬感。

和往年比較，現在評議會的架構（監察、定制和交流）在同學之中的聲望已經不及往年了。而總括今年評議會的運作並不是太理想。其實，它除了依靠評議會主席的工作外，其他評議員的意識也很重要。他們必須尊重在做決定前收集和聽取意見這工作，但今年的評議員對評議會並不是太尊重。不過，評議會仍然發揮了一定的監察作用，處理迎新籌委用錢方面的問題便是一個很好的例子，亦收到了阻嚇的作用。除了正式的會議外，平日亦有一些非正式的接觸，例如暑假和各standing committees保持聯絡，給他們一些意見和支持。這些在開會前的工作往往比正式的會議更重要。

其實每個搞活動的同學都會被訓練成去批評每件事的好壞，但往往只看到了壞處而忽略了這一件事其他方面的優點。要維持人與人之間的關係，最重要的因素就是懂得怎樣去欣賞其他人的工作。所以，展望未來，希望所有搞活動的同學除了去體驗生活外，亦能夠去欣賞自己和欣賞別人。

醫學會主席

衞兆輝

談及自己當初上莊的原因，其實主要有兩方面，一是「學嘢」，另一方面是希望把自己有的經驗拿來服務同學。我一年級時當時事秘書，二年級時主要協助時事組外務方面的工作；到了今年，發覺自己「做嘢」的熱情依然未減，雖然實際工作上不能花上如低年級那麼多的時間，但我覺得作爲主席，其角色應在於監察整個莊的運行並把經驗帶給低年級的同學。我一年級時的心態，只是想着如何把實際工作做得好，而忽略了和其他幹事以及常設委員會間的合作。後來人大了，工作上的和諧，　和其他人 多點溝通、了解也很重要，當然最 好是可以和當中一些人做到朋友。

至於對實際工作方面的期望，我覺得自中英談判後，香港有了很大的轉變；從前大陸發生的事情都像離我們很遠；但現在的大亞灣事件和胡耀邦下台都對香港做成很大的震盪。顯然同學在考慮前途時，再不像以前般對世事不聞不問，而需要對中國和香港的局勢，香港的醫療制度有一定的認識，以考慮自己可以在香港扮演什麼角色以及是否適合在這個環境生活。這樣做，不論最終是去是留，都可以有一個較理性的抉擇。基於這個需要，在外務方面，我期望能喚起同學的反省及注意。

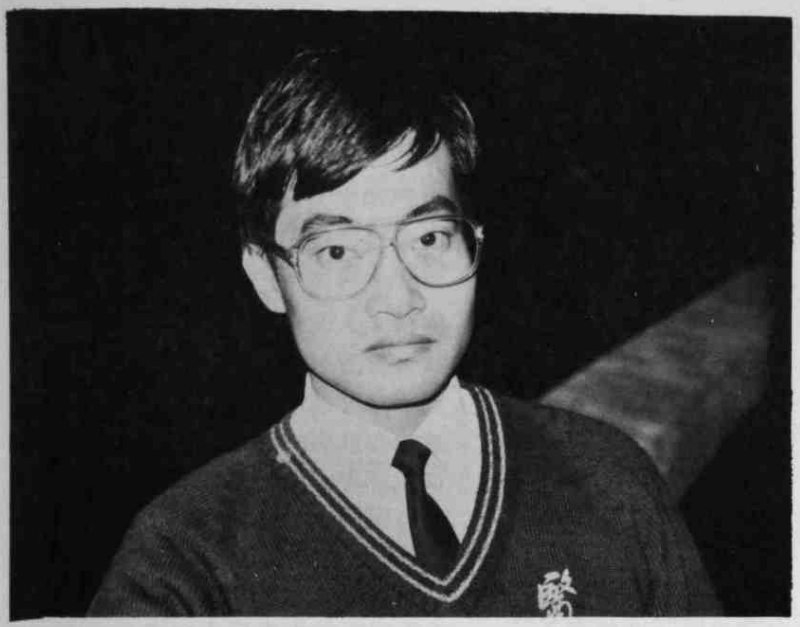
內務方面的重要性常在，例如和院方溝通以至今年對新課程提意見；有時在內務方面了們的角色比較被動，例如當校方提議改課程時我們才可以提意見；當但五年後整個課程實際進行了一次，我們便可主要提意見和要求更改。

回顧過去一年，內務方面我們採取一種比較實際的做法，並不要求基本的轉變，而是在細節問題上，由我們切身處地去經驗以及多些問題時間去考慮，提些適切的意見，而校方也頗接納；於外務方面，成果比較難衡量，但無論如何，講座和展覽的參與率確比以前多了很多。但實際收效可能很久以後才看到。時事組由於有舊人留在組裡，他們彼此間比較有默契、又有經驗，討論及的題目便相應較多；反觀醫療組，組織則比較鬆散，又缺乏舊人作領導的工作，只是在需要討論報告書時才走在一起，我就覺得有點可惜。其實我們份屬醫療界，理應多點走在一起討論其他醫療的問題。但當然醫療組需要的資料掌握比較多，也很需要一些有經驗的人才可以帶得好。

至於人事方面，我也有不滿意的地方，就是一直和常設委員會沒什麼溝通，只可以用沒什麼不愉快事件來形容；和幹事們則比較熟，也有數位到現在仍很熟，在讀書也可以互相幫助。

在整年的工作中，遇着的困難也不少，其一便是功課方面的時間分配不好，以致後來本來打算做的，例如和老師熟一點或是就校政的問題和幹事們多傾談一點，往往因爲做完了必須做的事已時間無多而始終沒有做到。這種情況在近考試的時間就更爲顯著，希望以後當幹事的同學多加留意。

外務副主席　黃一華



外務副主席的工作主要是聯繫醫學會與學生會中央及探討醫療制度。在上莊的時候，對於上述兩樣東西也不大認識，很多不必要的誤解，困擾亦由此而起。

記得最初開學生會中央評議會的時候，因爲不懂會議常規，不敢隨意發言，之後慢慢轉爲有話必說，再轉爲勇於發言，反映了這一年對學生會中央的觀感。對於學生會幹事的工作，最初是漠不關心，在評議會上不聞不問，可是被動的參與使我對他有更深入的瞭解，在我現在要離開的時候，反而有幾分依依不捨。

有很多大學內的朋友曾經在我面前罵過學生會工作同學的不是，其實很多人總是對自己要求少對他人要求高。若果易地而處，我就没有信心一定做得比他們更好。學生會的發展需要我們的支持，最少精神上的支持，有任何意見隨時可以找負責的同學發表，一年的經驗証明很少會被人拒於門外，當然我們一定要體諒他人的處境及尊重他人的意見。

很多人會覺得外務活動没有多大的作用，但歷史告訴我們知道，學運往往帶給社會一定的衝擊，「五四」運動不是一個好例子嗎？學生並不代表社會上任何一個利益團體，我們的出發點往往會以社會的公理，大衆的利益爲依歸，學生活動一定有他的作用。

醫學會對於時事的探索，一向都以時事組的討論爲主，可是限於資源，人力等問題，時事組很難對廣汎的問題作深入的討論。這方面時事組可以考慮多些利用學生會中央的人力。醫學會的外務工作没有什麼突出，可見將來也不見得會有任何轉變，可是這並不重要，每個醫學生也有沉重的讀書壓力，平時很難對各方面的事情也可以顧及，個人相信當我們受到衝擊的時候，總會有人挺身而出。

若果有人問我一年幹事生活裏，實實在在得到什麼，我會說没有。可是他給與我機會體驗不同的生活，無論是苦是樂也是一種感受，在人生旅途上加半點色彩。

時事秘書

楊江帆

掙扎着，脫離睡魔的魔障，踏出肅利的圖書館，矇矓地，不自覺走往Medso 房。原來掛在房門的「營業/休息」木牌給換去了，推門進去，沒有了牆上的掛鐘，沒有了櫃上的鮮花；縱然是人頭湧湧，却找不着一張慣見的臉孔一我不禁茫然——

「正式上庄後，一體的感覺，彼此的支持、默契，亦隨之推向形而上的層次……」曾經這樣寫過，亦確曾感受得到，每當我以「時事秘書」的身份做任何事，都堅信在我身後，有着十張親切的面孔，會爲我所作的承担到底；縱使落庄後，偶然碰上的一個照面、一聲招呼，那份親切、關懷，給我的感覺還是那麼強烈。然而，　自己給與幹事們的承担又有幾多呢？「沒有時間」、「各忙各」只是爲自己找藉口吧！說實在，自己在這方面實在付出得太少，欠他們太多了。

「個人發揮的開始……」，這背後却還有被遺忘的一羣——時事組各組員，因爲他們，各項推廣時事的工作方能完成……

會議室內，落日的餘暉，映得各人暖烘烘的，平添討論的熱烈。你質疑設立中級程度會考的效益，他又提出「三改四」的優劣，最後還決定走訪有關人仕以獲取更多背景資料。

重覆着，時事組就多項issue作過討論，間或有座談會、走訪等，實在談不上深入探討，更遑論是實際行動了。是學生在社會問題上的角色被新興政治團體取代？是考試壓力的限制？又或者是自上庄始的一貫低調子吧！組員們，如果你期望着像學生會時委般的積極反應，不要怪我叫你失望而回吧。此外，回顧整年，實在沒有給與大家什麼，相信大家想來亦發覺浪費了不少時間，而沒有任何得着；相反，自己却在大家當中學回不少；這一點是自己深感遺憾的。

——落庄已有一段日子，景物依舊，人面全非？站在玻璃門旁的我，看着房內的幹事們，你忙着簽大字報，他忙着聽電話寫Board，激起我腦海的一片浪花；彷彿又聽見熊貓接電話的急促對話，Josephine的打字聲，還有……。

（後記：不想像報章雜誌般作全年時事回顧，亦不想將全年工作報告重覆一次，如果要將每項工作作一檢討，又似嫌太長，亦不太適合，故最後決定倒不如寫下一點感想算了，希望各位不要介意。）

內務副主席

陳惠明

敏思的包袱還未卸去，不知道爲什麼還會拖着極疲乏的身軀，走過隔壁的幹事房當起「內務大官」來。當時支持着的「理想」便是希望在一年內多接受一點衝擊，多認識一羣朋友，多學一些東西，多一些「充實的生活」。

但實際上，人非草木，疲倦的腦袋再被上莊的競選活動摧殘，似乎早已註定了這一年是要失敗的。

內務工作去年可算平穩。最值得一提的是課程檢討的工作。

上莊後五日便收到新課程的初稿。跟着的三個月便是內部討論，問卷調查，大字報報導，走訪多位教授，在課程檢討委員會內開會。現在平心而論，新的課程除了假期少了外，其他的都十分滿意。值得告慰的是很多以前參與內務的師兄的努力終於在新課程裏出現。例如增加骨科的時間，精簡臨牀前課程的教授等。當然這些改動不單是靠同學的爭取便得來，但學院方面的確是相當重視學生的意見。接觸過九個部門的教授，討論這些問題時，他們的態度都非常誠懇。即使在課程檢討委員會的正式會議上，學生代表即時提出的意見也有一部份被接納。

經過這些事件使我比上莊時更肯定內務工作的意義。「教學」顧名思義是個雙向的過程，學生的意見是提高教學水準不可或缺的一部份——這和同學們本有着一個極直接的關係，可惜已被很多人忽略了。

落莊後祇可勉勵以後幹內務工作的同學：「繼續努力吧！」

醫學會的一般發展在去年來說

也算是平穩。記得上莊時的口號：

「鼓勵參與，各展所長謀團結

關心社會，鍛練思考探醫療。」

說到「探醫療」，去年份量最重的便是對澳洲醫療顧問報告書的研究。有關報告書的座談會的出席人數已差強人意，後來出問卷收集同學的意見時反應更加是慘淡。我不是負責問卷的工作，但看見這樣的情況，心頭不禁冷了一截。顧問團的建議幾乎是把現在的制度全部改寫，我們是其中最受影響的一羣，但一切冷漠的現象，叫人開始感覺到現代人對發生在身邊的事件總是表現得置若罔聞。

推廣一點說「鼓勵參與」，情況也差不多。

上莊後不久對攪活動有個「供求理論」。活動是一種「貨物」，需要同學參與是「市場」。現在的情況似乎是供應充足，但需求有限。結果很多地方已出現供過於求的現象。曾經有一段時間懷疑過問題是出現在「供」還是「求」。例如：醫學院內有多少人想奪取「　亞米茄玫瑰杯」呢？結果是參加了無數的院制比賽，逼於從「市場」抽取大批人參與。

當然，參加活動不一定等於「好」。但不能否定的是醫學會是代表了全體同學，而醫學會的工作大都是從同學整體的利益着眼。曾經跟一些在早幾年當幹事的同學傾偈，言談之間他們給我最深印象的是他們對醫學會工作的投入，不問收穫祇問耕耘的工作態度。

盲目的參與不是好事。但踏入醫學院後成爲醫學會的一份子也是既定的事實。對醫學會的活動採取消極的抵制或置身事外的態度，也不過是「鴕鳥政策」。但令人失望的是鴕鳥政策的支持者似乎正在增加。

醫學會的存在價值我相信是肯定的。始終醫學生是有獨特相同的地方的一羣人，而團結是力量。再加上將來大家的職業都是差不多，在這個階段加強同學間的認識和信任可能是將來合作的基礎。

因此，現在的問題祇是怎樣改善醫學會的「供過於求」的現象。自然，可以從「供」和「求」兩方面着手。

「供」的方面首要當然是提高貨品的質素，另外不時把不合時宜貨品收回，不時推出新貨品等。但貨品的包裝和宣傳也是很重要。去年的幹事工作似乎忽視了宣傳，於是一些內容不錯的節目便因爲宣傳不足而引不起同學的關心和參與。宣傳工作可能會吃力不討好，但要明白向同學作出足夠的交代是攪活動的基本責任。

至於活動的「量」方面，爲了避免過剩，當然要嚴格控制。在現在這個時候，甚至減少一些活動會更適合。攪活動多不表示這一莊人能幹，問題是誰肯「引刀爲一快」？

在「求」的一方，當然希望更多同學明白到權利和義務的關係。試想一想爲什麼醫學會有文具賣，汽水機有汽水，有電動打字機用，電視房有電視，圖書館有報紙看，聖誕舞會不用收錢，杏雨貸款基金可以借錢，入醫學院的時候有師兄迎新教路，考試肥佬有學生代表求情……。

同樣敏思、杏雨隨手可以拿到。現在你正舒舒服服地看過這本書的時候，想一想以上的人和事，若果你無心無愧的話，恭喜你。

對醫學會的前境我還是樂觀的。最少在新課程下時間並不缺乏，而金錢，設備，經驗等一向都不是問題。決定的因素是有多少同學願意在享受種種福利的時候，付出着應付的一份力量。

總結去年自己的得失，意義似乎不大，而坦白的說失去的實在很多。但路是我自己選擇的，更相信要擁有之前必須要付出。一年不平凡的生活永遠都屬於我的。

文康秘書

李錦霞

一點回顧

如果只是回顧過去一年的幹事工作，不寫也吧！工作嘛，週年工作報告裏已寫得一清二楚，但想寫的實在太多，因爲這一年比中學生生涯，的確充實了許多許多。

自迎新的活動開始，已非常活於班會及醫學會的活動，所以被人「看中」，成爲文康秘書的人選。經過考慮後，毅然答應了，可是現在的確有點兒後悔。後悔的是，自己沒有眞正的計劃好整年的幹事工作，低估工作上的種種困難，以致未能在工作上取得滿足感。可幸的是，在這一年中認識了不少高班的同學，而且在人際關係方面也得到不少經驗。

但當上文康秘書，的確有不少犧牲，未正式「上莊」時已深深體會到其中一些。開會至深夜或甚至凌晨一、兩點，回到家已是夜闌人靜，早上還要清早起床回校上課。家人的反應由責備及疑問變爲關心時，心內眞的難受。難道這就是大學生生活？

吃完午飯後，和同學閒聊，已被我視爲浪費時間之舉，代之的是開會、計劃工作，打字等的煩瑣工作。所以在班內較熟落的同學並不多，這也算是一點犧牲吧。

其他幹事及同學在工作方面的意見及支持，卻是一直以來精神上的支柱，令我知道我的工作是有人知道、關心及需要的。當工作所帶來的失敗、沮喪漸漸憲積，曾經有一個念頭——如果我突然消失，將所有工作拋下，不知道有甚麼後會果。曾經有一股衝勁去嘗試一下，看看眞的會有甚麼後果。但當上文康秘書一職是自己的選擇，不論有多少成功、失敗，自己還是要努力去面對的。

經過一年的文康工作，深深體會道文康工作不是容易「攪」得好。醫學院內七百五十個同學，每個同學的需要也不同。要知道大部份同學的要求已不容易，要滿足他們的要求就更加困難。

現在落莊了，看到新一莊的幹事擁有一股熱誠，幹勁，就好像看到一點點自己的影子。現在應該是努力讀書的時候了，因爲去年的基礎實在打得不好。去年讀書的成績也算令人滿意；在一年的幹事生涯中，未曾因爲工作而「走堂」也是十分幸運。曾經聽過人說：「幹事嘛和其他同學一樣要讀書，要考試，不要用幹事工作　爲藉口，讓自己懶惰。」誠心的，也把這一番說話送給新一莊的幹事們。

國際事務秘書

雷聲亮

國際事務秘書的工作，對很多同學來說可能比較陌生。其實，因際事務秘書的職責，是促進我們與世界各地醫學院的友誼，以及提供和外國醫學生交流的機會給院內同學。爲了達致上述的目標，在過去的一年裏，我們除了處理和外國醫學生組織的通訊外，還接待了三批分別來自暨大、馬大和星大的醫學生，以及舉辦了兩醫交流營和中山醫科大學交流團等活動。

醫學生的活動，和大學其他學系同學的活動比較，其中一個不同之處，就是我們與世界各地同樣習醫同學的交流活動，是較爲蓬勃的，這相信也是當年醫學會設立國際事務秘書一職的原因之一。回顧過去的幾年裏，我們的交流活動大都集中在中國，東南亞等地，至於亞洲以外的地區，基於時間和經濟上的原因，我們暫時仍未有踏足，正因如此，雖然醫學會現時是國際醫學生聯會的成員之一，但我們也鮮有同學能參加他們的活動（他們的活動絕大多數是在歐州舉行的）。

展望未來，醫學生的交流活動，相信仍會集中在亞洲區的，隨着亞洲醫學生聯會的成立，亞洲各國醫學生的合作和交流，將可望得到更進一步的發展。

此外，自從七八年起，我們曾多次組團到國內的醫學院參觀和訪問，但卻很少有國內的醫學生交流團到訪，據我在中山醫交流時，和他們學生會的同學交談所知，其實他們也很希望到香港來參觀一下，只是主要因經濟上的原因，而未有成行。這是十分可惜的。假知未來醫學會能解決這方面的問題，則邀請國內的同學到訪，將會是一項很有意義的活動。

總括來說，對於過去一年的工作，我算是滿意的，不過各項活動如接待外國醫學生、交流營、交流團等之可以順利完成，實有賴各籌委及有關同學給予我的支持和協助，在此，謹衷心地向他們致意。

助理體育秘書

嚴勵良

矇矓中又是最害怕的一刻——起床。鬧鐘呀鬧鐘，下次輕聲點好嗎！

沿着薄扶林道、沙宣道，「早晨」李樹芬樓！

好聽的LECTURE 總很快完結，好聽的還不一樣；唯獨是睡不來而又沉悶的一課。步出李樹芬樓，一陣惘然……惜日很快便消失於人羣，走進辦工室——MEDSO 房。今日，不愛LIB 記的我 ，不愛SL的我，又不什去TEA 的我，往那裏走。唉！原路去原路返，宿舍內睡好，執嘢好，讀書也好，似乎少了很多。

一年EXCO 工作，得失總是有的。建立太多目標是我的弊端。教每做事也不能全身投入，然而，這卻給我帶來適當分配時間的好習慣。做EXCO固然要爲同學服務，同學的反應是最爲我們最關心的，卻常聽到「有時間讀書」這類推敲的說話。

朋友，說實話，MEDIC 一年級的學生並不比其他院系忙，就是忙也忙不了很多。沒有定時的功課，上堂嗎！每星期有幾個清閒的下午！讀書方面，那一科有讀得完的書；自問去年是看少了參考書，但卻不盡爲工作，只是自己愛看電視、貪玩而已，要讀它就總有時間的。懶惰並不是爲掩飾考試失敗的藉口，確實是至根的原因。

一羣高年班同學的熱心參予，是我最難忘的。我敢信他們比我們倍辛苦，讀書的時間也肯定要更多，難得地卻抽空到來，給我們鼓勵。我沒有宣傳「做嘢好」的意思，也不是反「潛艇」份子。我祇相信，貴爲大學醫科生的我們，總有最適合的自己的生活方式，總會爲自己作出最適當的選擇。醫學會林林種種的活動，怕不會沒有一樣適合你吧！搞活動和參予，同樣有不同的獲益……

呀！傻得我，竟然說起「理」來！

「做」的時候總喊辛苦！一班共同進退的朋友啊，我眞懷念忙碌的日子。

福利秘書

黃卓堯

再次接到消息，又要寫文，其實在以前寫那些EXCO 通訊都已經寫清了，不過即管把最 impress 我的再寫一次。

整年來說，我在 medso 的工作做得並不好，原因就是我的時間分配得不好，一方面又要補習，一方面又在 main campus 有活動，在校外亦有其他活動，結果連功課也不好，總括來說，這眞是傳奇的一年，無論如何，到將來我老的時候，我也能有一點回憶！

名譽秘書

楊惠敏

上莊前，心想評議會的原意都幾好，有各工作單位的人及各班代走在一起，一同討論工作計劃及檢討工作很失。可是事實裏的評議會很多時都令我不舒服。一來是因爲會上的氣氛僵冷而嚴肅；更加上有些同學各執一詞，作無結果的爭拗，看了又怎不叫人勞氣？

開會前數天，我的工作就是負責借場地、出議程、會議記錄及影印等。這些都是頗煩瑣的。更令人忙亂的便是開會前數分鐘的工作，我眞是要「一眼關七」、步步爲營，以確保會議每一項程序能順利進行。開會當兒我就留心各評議員發表的意見及記錄一些通常是没有先後次序，甚至是「爆肚」的說話。

總括來言，名譽秘書的工作鍛鍊了我的耐性去應付煩瑣的工作及冗長的會議。它也讓我認識到一羣爲醫學會效力的「搞手」同學，與他們建立了友誼。

啟思

許其發

「發仔，明年還會留在啟思嗎？」熊貓老總在我二年級開學後不久問道。當時，自己很快絕地答道：「不了，玩了一年，今年想試試別的，或者讀多點兒書。」他沒有追問下去，也沒有「威逼利誘」我留下。

離轉莊的日子一天比一天的近了，聽說，啟思來年編委各職位還懸空，但心裏總是想：船到橋頭自然直，不需顧慮沒人上莊的，反正自覺留下也似乎沒有多大用處，倒不如自由自在，無牽無掛玩一年吧。但爲了對其他啟思同志一個交代，年尾的「捉人大會」還是出席了。

「怎麼了？二年級的同志們都說明年忙啊，要攪這樣，弄那樣。總之是非走不可。」最後，還眞的是船到橋頭，炳大哥和肥烏蠅上了副總，剩下的總鷄脚一職，也就毛遂自薦了。

一月初，莊是上了，開工嘛……。就在這時，一位高大威猛的神秘人闖入啟思房。找晦氣？不。「邊個係老總呀？我想做啟思。」這才恍然大悟，原來是新力軍。這人是誰？八九班劉文欽是也。劉公的加入，替啟思帶來了不少生氣。於是，在八九和九〇班同學的合作下，紅噹噹的「恭喜發財」便在農曆新年和大家見面了，應節嘛。

喜歡「遲來的春天」的伙伴、不屈的杏花和長達萬多字的暴風女神—— DAVIDSON 嗎？

在四月初學生會出版的新校長專輯是啟思與學生會之首次合作，雖不算絕後但也算空前了。

還記得在大家ＭＢ試前出版的「學海無涯」和「乘風破浪」嗎？不知這兩份啟思有否在這重要關頭倍伴你左右呢？

紫藍色的「受欺壓的女人」爲何改了如斯名字？各位試在該期啟思首十頁找找答案吧。

一口氣爲大家重溫了五期啟思相信各位也許會有興趣知道道其中的突破吧。除與學生會首次合作出版號外專輯，八八班的老柴更動身北上，與同學在「乘風破浪」中漫遊北上求醫的眞實過程。此外，這年的綜藝也不乏學術性的文章如「醫學中的陰陽」及「 HOMEOPATHY 」等。這些文章，都是由校外友好或醫生執筆的。精采懸疑的科幻小說——「愛的謊話」、「暴風女神」也是這年綜藝的特色之一。

一年過去了，五星期共百多頁雜誌也出版了。表面上，身爲老總的理應放下心頭大石，爲一年的工作沾沾自喜。但卻不然，老總對二件事始終是耿耿於懷的。這年的啟思邀得人見人愛的潘偉豐博士任名譽顧問，這本是啟思的福氣，但基於種種原因（是自己懶惰？）未能與潘博士好好合作，此爲其一憾。另外，對九〇班的同學也未能作出適當的指導及分工，以至內部組織欠缺默契，也令九〇的師弟妹對啟思缺乏應有的歸屬感。

時間已過去了，要補救也來不及了，唯有寄望明年的啟思人人合作愉快，事事進步。

杏雨

蘇志釗 張欣寧

想起已經是二年前的事了。在迎新營裏認識了上屆的總編；在他介紹下初次接觸到這本年刊，對它的製作感到一點興趣。

到了開學之後，發覺在適應大學生活方面有不少困難——支離破碎的講課，令人目眩的大小教科書，還有各類的比賽和活動。這一切都叫一有規律的生活太難培養出來了。那時的心情眞是既開心但又有些擔心。

本來在那混混的個多月裏，早已把搞醫學會活動的念頭忘記了。但當我接到上屆老總的電話時，那股衝勁又湧上心頭。

我在中學時花在課外活動的時間眞是少之又少。對於進了大學但仍維持這般生活好像有些不甘心。所以縱使知道本身連基本的編輯常識也缺乏，就連攝影和美術都掌握不好，我都點頭答應了。

煩瑣的訪問，收稿、校稿的工作，並不是想像中那麼容易。加上在醫學院裏找同學幫忙眞是難事。我的性格就是不愛勉強別人。你可能說我沒有領導才能；但我不想看到同學爲了我而放下考試不理，埋頭做這課外工作。結果就是一拖再拖，百般延誤。這後果最主要是我計劃不夠完善，再加上長久以來對讀書所抱的緊張態度，始終不能放下書本，積極抽身出來趕快完成負上的責任。記得有一個師兄曾經對我說過：「我不是沒有興趣搞課外活動，而是始終不能兩面兼顧。雖然這並不一定代表時間上的分配，但在精神上不免有些分心和記掛。」這或許是我二年來的寫照。

收獲？當然有很多。我絕對不是爲任何活動賣廣告。事實上當你負上一些責任，你必會對你自己了解更多。我亦因爲工作的關係認識了什麼是評議會，也認識了很多朋友，參加了一些難忘的活動。還有機會看見一本年刊的誕生。

最後我要多謝那些義務（我認爲所有幫忙我的人都是義務）助我的同學，指導我的師兄和慷慨給我資料的人士。這本年刊給任何其他同學做，都可以比它更好；但是它有的是我們的心血，　別的永遠都不可代替。　◉ ◉ ◉

執筆寫這篇稿子對於我而言，實在不是件易事，一切都像離我太遠了。記得當初去屆老編找我上莊時，我幾乎連考慮也沒有便答應了他。可能是自己的性格一向是很討厭刻板的生活，加上聽到一些師兄師姐說過讀 Medic　雖然功課繁重，但若過早把自己完全關閉在學業當中便會失去了其他重要的東西，例如經驗、友情和理想等等。現在回想起來，問一下自己究竟當時的決定是否值得呢？誠然，這年多以來，杏雨的工作可謂一波幾折，一開始答應幫忙當編輯的已經不多，而當中亦不乏身兼數職的同學，加上後來又有一些同學不能繼續當編輯，實際上積極參與編輯工作的寥寥可數。我是個喜歡大夥兒一起工作，一起「衝」的人，獨自工作很容易使我感到「有病」，所以後期頗多時間確是爲了責任而工作。

老編說他是個不懂得領導的人，其實我覺得他只不過是太好人而已。我的稿子一拖而拖，他也毫無怒火，反而懂得體諒我的難處，實在令我感激萬分，也希望藉此機會向他致歉。

說了一些負面的東西，其實做杏雨也給我帶來了不少的樂趣，除了認識一羣朋友外，更使我學習到不少編輯的技巧和知識，也得有機會以和一些的老師傾談他們生活的實況。這些都是寶貴難得的經驗，而面對一本自己有份投身的刊物面世，那份欣喜和滿足感也是非筆墨所能形容的。　◉ ◉ ◉

健康委員會

陳國榮

一九八六年可說是健委在鴨脷洲推廣社康活動的一個新開始。隨着「健康之友」義工小組的成立，以後的健委會亦有責任去加以培育，使其更長大穩固。

至於在八六年暑假與鴨脷洲循道衞理教會青年中心合辦的「健康之道齊參與」這活動的詳情，由以下參與過這活動的兩位義工在健委通訊第四期的投稿可以得知——

當你看到健康兩字，你會想起什麼呢？健康，難能可貴；健康，是無價之寶？相信每個人都希望得到健康的，但當你没有生病的時候，又那會想到健康是如何的可貴，又那會想到如何去珍惜健康呢？

偶然間在鴨脷洲循道衞理青年中心內看到「健康之道齊參與」的宣傳單章，內容以講座爲主，加以一些訓練、錄影帶製作來培訓一羣人來推廣社康活動，帶出預防疾病的訊息。這不單有意義而且還能增加知識，故此我便參加了。

個半月的課程終於開始了，從一些簡單的保健常識以致到一些老人病、職業病和精神病也有談論，由於時間有限，故講座的內容不能十分全面，但對一個醫學的門外漢而言，是已經足夠。在課程氣氛中大家都十分融洽投入，相信是由於不太嚴肅的講座，和自由發表意見的成果吧。還記得由Sister Ling所主講的職業病，她除了以幻燈和生活上的實例來講解外，更領導我們作一連串的健美運動，使場內加添不少活潑的氣氛。

在課程的尾聲，我們準備拍一輯錄影帶，用來提醒老人不可輕視糖尿病和血壓高等疾病，希望他們能及早預防和診治。在滿懷信心下，我們遇到困難了，如怎樣去操作一部錄影機，人手缺乏，風球高懸等着實使我們頭痛，幸好大家互相合作，使這輯錄影帶能得以完工。在製作過程中，使我們更了解對方的性格，促使我們有更緊密的合作。

在一切準備工夫完成後，我們便到石澳健康院發揮我們的口才，在播放錄影帶給老人家們時在旁講解，繼而爲他們作身體檢查，這是我感到最有意義的了。他們年紀已老，當然十分渴望知道自己身體健康情況如何，有没有血壓高、有没有糖尿病等等。故此他們都十分樂意來供我們檢查，所以我們都充滿成功的感覺，眞是十分高興的呀！

總括整個活動而言，計劃是很不錯的，但因大家都只能抽出一些課餘或工餘時間來參與，使時間的配合不太理想，很多人都只能出席一半或大半的講座，再加上熱心於此次工作的人實在不多，故常出現人手缺乏的情況，這無疑是一個不足的地方。但無論如何，我並没有後悔參加了此次的活動，因我不單得到很多醫學知識，還結識了很多新朋友。

令我興奮的是，在這次活動的結束後，大家的熱心乃未減，一個類似的義工組將會成立，組合更多的熱心人士，搞更多有意義的課程來充實我們的無知，從而服務和推動保健的風氣。

SPORTS

班際水運總冠軍（紀本生杯）　：'88
班際陸運總冠軍　：'88
班際男子總冠軍（陳棣光獎座）　：'88
班際女子總冠軍（廖獻貞獎座）　：'88
總冠軍（鄭志仁盾）　：'88
最佳體育精神獎　：'90
班際越野賽冠軍　：'89

（1）院際運動比賽（OMEGA ROSE BOWL）

男子

項目	成績	隊長	最佳表現隊員
陸運	冠軍	李威儀('89)	文志強('88)
		張春明('89)	
水運	亞軍	袁柏泉('89)	李軔初('90)
足球	殿軍	葉劍光('89)	鍾健禮('89)
籃球	淘汰	趙振煒('89)	
排球	冠軍	岑旭華('89)	林鑑華('89)
乒乓球	殿軍	鄭建明('88)	鄭建明('88)
網球	冠軍	陳俊賢('87)	林鑑華('87)
壁球	冠軍	鄭楚豪('88)	鄭楚豪('88)
壘球	殿軍	鍾健禮('89)	鍾健禮('89)
曲棍球	冠軍	陳德明('88)	張華('86)
羽毛球	殿軍	余煜基('89)	余煜基('89)

女子

項目	成績	隊長	最佳表現隊員
陸運	冠軍	王韻娜('89)	郭燕芳('90)
水運	冠軍	羅麗婷('89)	羅麗婷('89)
籃球	季軍	倪淑慧('90)	任嘉玲('89)
網球	季軍	王韻娜('89)	王韻娜('89)
乒乓球	淘汰	羅麗婷('89)	
羽毛球	冠軍	張可兒('90)	任嘉玲('89)
壁球	淘汰	張可兒('90)	

全年最佳男運動員：林鑑華('87)
全年最佳女運動員：王韻娜('89)

（2）班際運動比賽

項目	男子組					女子組				
	86	87	88	89	90	86	87	88	89	90
水運	0	6	15	15	8	0	0	18	12	8
陸運	4	6	18	12	8	0	0	18	12	8
網球	0	6	9	4	4					
排球	0	6	4	9	4	0	4	9	4	6
羽毛球	0	0	6	9	4	0	0	4	6	9
越野跑	2	0	9	6	4	0	0	6	9	4
乒乓球	0	0	9	4	6	0	0	4	9	6
籃球	0	4	4	6	9	0	0	4	9	6
曲棍球	0	0	9	6	0					
壘球	0	0	6	9	4					
壁球	0	0	9	4	6	0	0	9	4	6

CALENDAR 1986

一 New Council Session

二
「Exco ，啟思，杏雨，健委四角賽」

24-26 在遊戲室舉行，總冠軍啟思

三 港大學生節八六

3-14 橋牌 殿軍
戲劇 季軍
合唱團由於編曲方面未能與籌委取得一致意見，所以退出比賽，但仍於比賽當晚演出，獲得一致好評

教務及院務委員選舉

6

四 Final M.B.B.S. Exam

教務及院務委員補選

10

醫療顧問團報告書研討會

16, 21, 24 分別由錢劍輝醫生，黃震遐教授及阮博文先生主講

五 頒獎日

5 在學生休息室舉行

六 1st, 2nd and 3rd M.B.B.S. Exam

七 兩醫交流營

2-4

電影籌款八六

20 假大專會堂舉行，選映電影「挑戰者」

八 第七屆亞洲醫學生會議

6-12 在港舉行以「精神健康在亞洲」爲題。共有十個國家參加，合計一百四十名醫學生參予

迎新八六

27-30 主題「輕鬆幽默顯溫情，迎新八六啟我程」迎新營在黃宜洲青年營舉行

九

預科生日

6 在瑪麗醫院地下演講堂舉行

學術迎新

17-20 在學生會大樓舉行

健展八六 —— 腎之旅

21-24 假中環大會堂舉行，參觀人數超過九千人

班際水運會

24 在港大體育中心泳池舉行 總冠軍 89, 90

十

醫學生節八六

7-16 總冠軍 90 班

16 Medic Nite

班際陸運會初賽

29 假何鴻燊運動場舉行

十一

大學改制事件

3 就「五改六」舉行講座 由 Prof. B. Weatherhead 及 Prof. F.C.S. Ho 主講

班際陸運會決賽

5 假何鴻燊運動場舉行 總冠軍 90 班

開放日

8 以實驗、幻燈及展覽形式向校外人仕介紹醫學院及醫學生生活

十二

4th M.B.B.S. Exam

中山醫科大學交流團

9-12 在廣州中山醫科大學舉行

聖誕舞會

27 於陸佑堂舉行約五百人出席

87年一月 會長致辭日

9 莫志強教授就 "Cardiac Surgery" 作出演講

迎新八六

姚玉筠

迎新八六

籌委會成員：廿共六人（八九：十一人，九〇：十五人）

籌委會會議：共六次

工作：四月：對內宣傳
招收組長

七月：編製大信封，資料冊及迎新營刊。

迎新項目：

八月十八—十九日：組長營

八月廿二日：歡迎日及遊戲日

八月廿七—三十日：迎新營

九月二日：舊書買賣

九月十二日：跟進日

九月廿二日至十月三日：迎新雙週

各迎新項目詳情／檢討

一、組長營：

日期：八月十八—十九日

人數：廿一人

地點：梅窩一渡假屋

內容：一、簡介各迎新營及營前活動的內容及要留心的細則

二、介紹一些「彼此認識」的遊戲，以方便組長帶組

意見：1. 爲期兩日一夜，時間適合，值得鼓勵

2. 津貼組長營，能更鼓勵組長的參與，值得繼續考慮

3. 組長營能增加組長之間及其與迎新籌委的默契，有保留之義

4. 宣傳方面應加強

二、宣傳

形式：彩旗、貼紙、橫額、大字報，

成效：組長報名人數

九〇—約四十人

八九—約少於五人

意見：1. 宣傳成效不太大，但仍有存在必要

2. 宣傳（尤以迎新雙週）太集中於九一及九〇，而忽略了高班同學

三、歡迎日及遊戲日

特點：1. 歡迎日與遊戲日於同日舉行

2. 在歡迎日內播映有關新課程之簡介短片

意見：歡迎日與迎新日同日進行

好處：節省新人在迎新其間的「負担」而又並未造成新人體力及精神透支

值得繼續考慮

四、迎新營

日期：八月廿七—三十日

人數：一百七十人

地點：黃宜洲青年營

意見：

1. 節目進行較混亂（尤以早期爲甚）

建議：各組長應盡量參與組長營

每日的(briefing) 十分重要

2. 自由時間較少

建議：延長午飯及晚飯時間，以便各新人能有更多機會彼此認識

3. 太多組際比賽

建議：減少比賽形式的遊戲增加組與組間的合作及認識的項目

4. 營地環境：好處：使用全個營地，使行政及氣氛控制上更容易

壞處：設備差及少，住宿環境過份擠迫、交通不便

建議：此營地環境不太適合

5. 處境遊戲

意見：1. 類似的非純粹娛樂性的集體遊戲值得繼續保留

2. 選擇遊戲應考慮適合大專程度與否

6. 幻燈

意見：1: 幻燈是營內唯一較有感染力及能帶出更深入主題的項目，值得保留

2. 內容方面、應選擇較寫實、有感染力及有討論性的主題

五、舊書及骨售賣服務

特點：本年特設有售舊骨服務

意見：不鼓勵再辦售舊骨服務，因骨的供應不足，成效不大

六、跟進日

目的：照顧較遲接獲收生通知之同學

成效：參與的同學確能對未來的醫學生生活有更大的認識

意見：值得繼續保留，但建議可加上一些以增進友誼及認識的遊戲

七、迎新雙週：

意見：1. 鼓勵新人自己去籌劃雙週中一些項目能使新人之間關係更好，值得保留

2. 「讀書技巧」講座有保留價值，但建議找多些同學負責，以提供更多方面的資料

3. 將「個別委員會」簡介改作中央統籌介紹，能使新人對其有更有系統的認識

4. 建議將雙週縮短爲一週以輕新人之負担

迎接八六啟我程

輕鬆幽默顯溫情

電影籌款八六

周明恩

本年七月二十日假大專會堂舉行，而選映的電影乃「挑戰者」，爲醫學會籌得$88109.30，撥入醫學會中央基金。籌備工作早於三月開始，而總動員的售票同學有九十多人，大部份乃九〇同學，而當晚出席的嘉賓及同學共七百多人，熱鬧非常。


Gala Premiere
電影首映典

兩醫交流營

雷聲亮

醫學會在八六年七月二日至四日期間，和中文大學醫學院學生會聯合舉辦了一個兩大醫學生交流營。這次交流營的目的是藉此增加兩大醫學生的認識和了解，以及促進彼此間的友誼，雙方共有約七十八人參加。

籌備工作

八六年初，我們已開始和中大醫學會方面接觸，討論合辦交流營的事誼，至於籌委會，則在三月中正式成立，並召開了數次會議，確定了交流營活動的大綱。第三個學期開始，我們和中大的同學便各自展開工作，進行宣傳，安排參觀、場地，邀請講者等工作。到了五月中，由於考試逼近，籌備工作被迫停頓下來。直到六月中，M.B.過後，籌委才再次投入工作，爲各項目作最後準備。

實際活動

三日兩夜交流營的活動，算是頗爲多樣化的，簡述如下：

2/7 早 —黃克競樓階集合。
—入住明原堂。
—集體遊戲。
午 —幻燈放映（介紹港大醫學院）
—參觀李樹芬樓，圖書館、陳蕉琴樓等。
—常識問答比賽。
—講座"Future Postgraduate Medical Education in Hong Kong" by Dr. Vivian Wong.
晚 —友誼籃球賽。

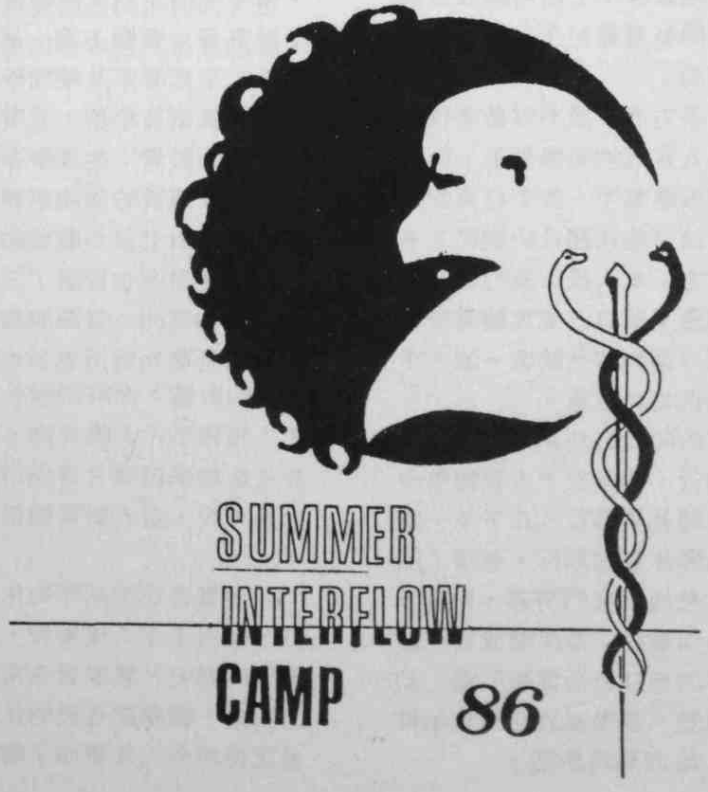
3/7 早 —港大本部校園遊。
—參觀機械及工業工程系。
—前往中大。
午 —幻燈放映（介紹中大醫學院）
—講座by Professor Davison 。
—中大校園遊。
—參觀中草醫研究所。
晚 —綜合晚會。

4/7 早 —參觀威爾斯親王醫院。

感想

兩醫交流營，今年是第二年舉行的，我們吸收了去年的經驗，嘗試在多方面作出改進。例如去年由於住宿安排的問題，因此交流營的活動只能在中大那裏舉，以致參加交流營的中大同學比較少，今年我們有見及此，於年初已在中大和港大的宿舍預留了七十多個宿位，以便我們能在兩大均安排活動，可能由於這個原因，雙方參加的人數比較平均，雙方各有約三十五人參加。

雖然我們和中大的同學，是在不同的地方學習，但他日畢業以後，我們便很大機會會在醫療界一起工作了，因此在我們仍是醫學生時，加深彼此的認識，是有需要的。不過，短短三日兩夜的交流營，是很難令雙方的同學有很深入的了解的，不過這也可作爲一個開端，希望在將來，兩大的醫學生，除了交流營以外，還有其他更多交流和合作的機會，使我們兩大醫同學的友誼，能更進一步！



開放日八六

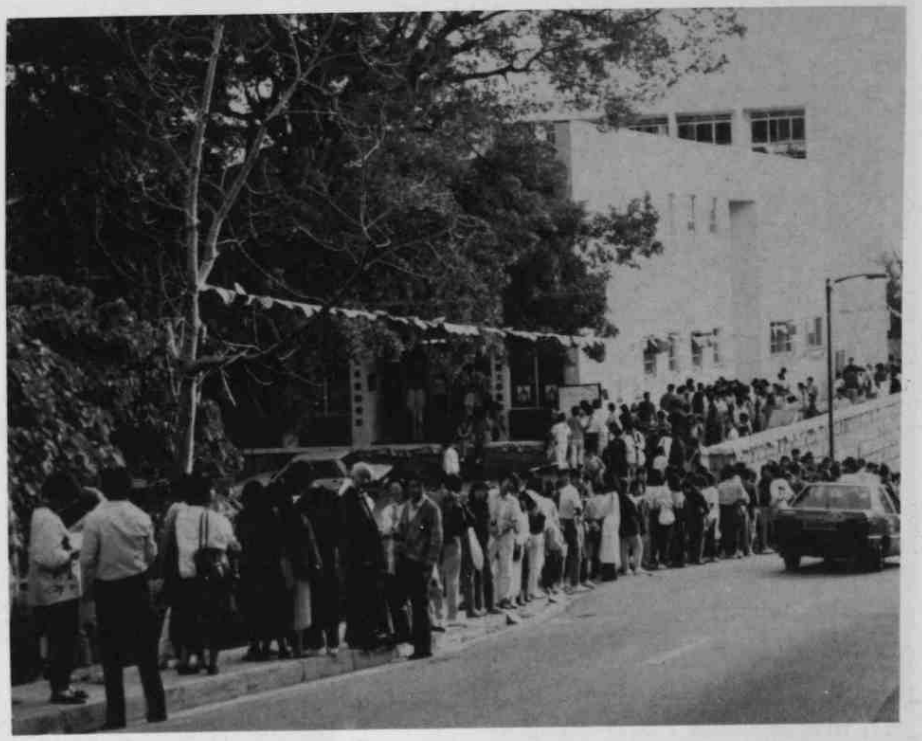
莫志超

「找到你眞合時，三年一度的開放日快到了，現在衆人正忙於籌備迎新及健展，而你又沒有參加任何籌委工作，由你組織開放日節目是最適合不過的！」，內副於七月某天對我說；經考慮後，便答應了他的請求，開始籌備開放日活動。

在籌備過程中，財政及人手的問題是十分嚴重的，學生會中央只撥款八百元，而醫學會卻表示所有非常設委員會應自己去找贊助人，所以對開放日並沒有作出贊助；可是，學生會中央卻統籌了找贊助商的工作，禁止屬會私自找外面公司，我們只好聯絡了三十多間藥房及醫學儀器經營商，但都遭婉拒，結果最後只籌得二百元，總括來說，雖然最後（在開放日前一星期）評議會動用了「Project Fund」資助五百多元，但整個財政預算只有一千餘元，根本談不上任何開放日前節目，連印製書簽紀念品等的念頭也被迫取消。

在人手方面，很不容易才找到五、六名九零班的同學幫手，而且他們只是答應幫手，並不打算安排一切，所以可能在節目的細節上有疏忽的地方；本人最不滿的就是很多同學答應了做導遊或實驗講解員後，竟當日遲到甚至缺席，使人手不足的情況更加嚴重。

今年的開放日是在十一月八日及九日舉行，約有五千人到醫學中心參觀，開幕典禮在八日下午一時半在陳蕉琴休息室舉行，邀請了院長梁智仁教授爲我們剪彩，約有五十餘人參加觀禮；是次開放日，醫學院安排的節目包括實驗示範、幻燈片、展覽、音樂播放及紀念品售賣等等，場面頗爲熱鬧。



幻燈播放是在李樹芬的低層講堂，主要是介紹港大醫學院的課程、醫學生的生活、醫學會的結構及活動等等；實驗方面，很多謝解剖學系、生理學系及藥理學系的合作，借出儀器及模型，並事前協助準備實驗的裝置；生理學系的三個實驗是呼吸系統的功能測驗、血壓量度及藥物對老鼠心藏跳動的影響等等；藥理學系也提議了三個實驗，一是無綫電的心電圖測驗、另外兩個分別是藥物對活老鼠血壓及小腸收縮的影響；而解剖學系則借出了膠人體模型、人體骨骼、X－光照片及組織學玻璃片等供遊人參觀，普遍來說，遊人對實驗都頗感興趣。

展覽是在陳蕉琴的休息室內舉行，動用了十八塊展板，簡介了醫學院的歷史、醫學會各常設委員會的活動、醫學院各班的比賽等等，希望使校外人仕更加了解我們的學習環境及生活。

當日，我們還準備了音樂播放，以點唱形式，替來賓播送流行曲，吸引了不少青少年朋友，可惜在第二天因音响失靈而被迫取消；圖書館今年也準許遊人進入，並安排了一個書展，介紹醫學書藉及雜誌。此外，在圖書館門外，我們設了一個詢問處，並動用了約二十名導遊帶領遊人參觀；在附近處更設了一個售賣站，售賣汽水、醫學會文具、T恤及其他物品，反應相當熱烈，以致秩序有點混亂。

總結來說，今次我們已竭盡全力，但受到財政及人手的限制，未能把節目發揮至最理想，但透過這次的經驗，我們知道了在醫學院找人做內務並不容易，並希望來屆及明年的百週年開放日能夠有所改進。

健展—腎之旅

嚴勵良

自相矛盾

向來健展的老前輩都笑道：「我們做的總遺背道的。」這話何解？每年做健展的一羣，都努力選擇一些熱門題目，盡量帶給市民最基本的醫學常識。然而，自己卻爲「衝」料，展版等連夜通宵；又見講解員不辭「喉痛」地說完再說，就肯定這矛盾的存在。心愧今年還解不開這死結，好減低大家的工作壓力。

GAMES ROOM一羣地頭蟲

「大仙」們怕都認識這羣人吧！健展前多個月便有宣傳秘書做的橫額，繼而學術秘書的搜集資料，美術秘書的畫版，印務秘書的改書行動，甚至常務秘書的雜物放置，都充實着這個供人休憩的地方，妨礙大家的活動，在此深表抱歉。

困難、努力、嘗試、成果

三月籌委的成立，便出現財政上的困難。原因碰着亞洲醫學生會議。財政秘書不懈努力，九月才解決危機。

學術顧問醫生，醫療視聽器材中心（MIU）及高年班同學的熱心幫助，加上籌委的努力，小册子終於八月尾完成。努力是没有白費的；這圖文並茂的小册子，已於九月二十四日（即展覽最後一日）全部沽清。

是次展覽，除展版外，還利用電腦、幻燈、標本及模型等傳遞部份知識，配合錄影帶的播放，選擇題問答箱及講解員，務求將腎病的預防及徵狀，深入淺出的介紹給市民。另一方面，當然少不了一些基本健康常識。末期腎病患者的痛苦，及捐腎救人的眞正概念和意義等訊息，使得整個參觀「旅程」完全又難忘。

給未來籌委的一段話

朋友，不要怕財政指據；
不要怕題目難擇。
不要盲從追隨以往的方法，
不要相信參觀人數這指標，
只要，有熱誠，有衝勁。
合羣，合作。
虛心地問。
小心地做。
關心你的對象。
健展終又會成功地再出現！

是次展覽成功乎？這話不提，改進仍是有待的！

八六籌委主席
嚴勵良

中山醫學院交流團

雷聲亮

醫學會於八六年十二月九日至十二日期間，組織了一個交流團，到廣州中山醫科大學（下簡稱中山醫）參觀訪問。這次交流團的目的，是希望藉此加深同學們對國內醫療制度和醫科教育的認識，以及增進我們和中山醫同學們的友誼。

籌備工作

我們在八六年三月尾，已開始和中山醫學生會聯絡，提出了我們希望在十二月組團前往彼方交流的要求，當時他們原則上答應了。及後，由於考試及暑假來臨的關係，彼此的聯絡停止了一段時間，到了開學以後，我們再恢復聯絡，中山醫方面並於十月底正式來函，答應爲我們安排到訪事宜。有關的宣傳活動，隨即在十一月初展開，同學們對於這次交流團的反應，十分熱烈，報名人數達七十餘人，比名額多出一倍以上，我們只好以抽簽方式，分配有限的名額。

與此同時，我們爲了讓參加交流團的同兒，能在出發前，掌握一些有關港大醫學院，本港醫療制度，中山醫、國內醫科教育以及醫療制度的基本資料，我們時安排了四次學習小組，分別由黃譚智媛教授，張壁濤醫生以及兩位畢業班的同學主講，此外，我們還印製了一本資料册，給同學參考。

交流團之活動

9/12 下午 乘坐直通車到廣州，中山醫方面派出了多位同學到車站接車。

晚上 觀看八六班文藝表演晚會。

10/12 早上 參觀中山醫的電教中心，人體解剖系，組織胚胎學系、葯理教研室和圖書館。

下午 與中山醫各級同學開座談會。

晚上 自由活動。

11/12 上午 參觀中山醫第一附屬醫院，（包括了中心實驗室、高壓氧艙、心臟反博室和專科病房等。

下午 到孫逸仙紀念醫院，參觀院史展覽及在二十樓高的中山樓頂樓欣賞，廣州市容。

晚上 在中山醫教工餐廳設答謝宴，欵待中山醫的同學。

12/12 早上 遊覽廣州名勝（越秀山公園、中山紀念堂）

下午 乘火車經深圳返港。

感想

我們這次到中山醫交流，得到了中山醫校方以及學生會非常熱情的接待，在住宿、膳食以及行程安排方面，都十分妥善。此外，中山醫方面還派了學生處的一位科長和學聯的兩位秘書長，四天來一直陪着我們爲我們安排一切。至於學生會方面，雖然考試逼近，但他們仍派出了三十多位同學，輪流陪伴我們到各處參觀。這實令我們有喜出望外以及受寵若驚之感。

在四天的交流活動裏，雙方同學都很投入，座談會和答謝宴的氣氛也很融洽和熱鬧，不少同學還與中山醫的同學，交換了地址，以便日後聯絡。

這次交流團，由於得到中山醫方面的禮待，因此食住都較一般中山醫同學好（我們一頓飯的價錢，足夠一位中山醫同學吃六、七餐了！）因此我們始終未能眞正體驗到

中國內同學的生活。假如日後再有機會到國內交流的話，或許可以嘗試跟國內同學一起生活，嘗嘗拿着各式容器，排隊買飯的滋味吧！

參加交流團，到外地的大學參觀，實在是一項很有意義的活動，不但可以增廣見聞，也可以擴闊自己的眼光，古語云：「讀萬卷書，不如行萬里路。」也。

醫學生節八六

李錦霞

早在暑假時已開始籌備醫學生節八六的工作，但非常不幸，如去年一樣醫學生節被迫在十月中舉行（由於陸佑堂租用問題）。剛開學不久便成立了籌委，得到一羣九一班同學的支持；但由於部份同學對於醫學會內攪活動的一些細節問題未能掌握，以致部份比賽項目出現一些混亂情況。各班同學也積極參與，爲本班爭取分數，各班的團結精神也表露無遺，經過一輪激烈的比賽後，終於九零班奪得醫學生節八六班際比賽的冠軍。

隨着梁智仁教授於八六年十月七日醫學生節八六的開幕儀式剪綵，醫學生節八六正式開始。一連串的文康活動及班際比賽接踵而來。非比賽的活動包括：土風舞、午間點唱及旅遊攝影展，比賽項目則包括：歌唱比賽、橋牌、常識問答及合唱團比賽等。

其中最受歡迎的項目要算是康樂棋男子組個人賽及小組合唱。康樂棋在醫學院的受歡迎程度是不容置疑的；但以往的比賽是以隊際形式進行，爲了加強比賽的吸引力，今年籌委決定將之改爲個人比賽。自從比賽接受報名後，收到約五十多位同學報名。比賽當日有四十四位同學到場比賽，加上旁觀的同學

，一時間GAMES ROOM 變得水洩不通，人聲鼎沸。比賽在晚上七時正式開始，接近十一時才順利產生四強。經過該四位同學同意後，繼續比賽至十二時許才順利產生冠亞季軍。比賽進行時，不單參賽同學緊張萬分，在旁打氣的同學也十分投入，在指指點點的討論如何「搏孖Q」，「救大回」等。

小組合唱當晚有三十多隊參加，有部份參賽隊伍更以表演台風爲主。在各隊伍各出奇謀下，各同學都非常投入及陶醉，拍掌聲及笑聲不絕於耳。比賽結束後有些同學意猶未盡，竟在沙宣道高歌，幸好沒有被附近的居民投訴。

整個醫學生節八六的高潮在十月十六日晚的醫學生之夜。八七班也有二十多位同學到場可算是十分難得的。更難得的是當晚兩位評判在同學的熱烈鼓掌下，也來高歌一番湊熱鬧。起初兩位評判，黃煥星醫生及蘇國輝博士都推說「見醜不如藏拙」，但終於受衆多熱情的同學的鼓掌，答應爲我們高歌。醫學生節正式結束後，就只剩下空洞的陸佑堂及興奮的同學。籌委們亦舒了一口氣，可以休息一下。

綜觀醫學生節八六，在忽忙的籌備下成績令人滿意。在不足夠的時間下，新的嘗試不多，只有寄望醫學生節八七有一番新景象。

DEPARTMENT OF BIOCHEMISTRY

The Biochemistry Department

Brief History

The history of Biochemistry department cannot be separated from that of the Department of Physiology. Since it grows out of the Physiology department. Hereby we are making a list of the professors of physiology since 1913 when the teaching staff of the Hong Kong College of Medicine became lecturers

The history of Biochemistry department cannot be separated from that of the Department of Physiology. Since it grows out of the Physiology department. Hereby we are making a list of the professors of physiology since 1913 when the teaching staff of the Hong Kong College of Medicine became lecturers in the Faculty of Medicine.

Professor of Physiology & Biology
1913-1915 – G.E. Malcomson, M.D., D.P.H.
1916-1919 – H.G. Earle, M.A., M.B.

Professor of Physiology
1920-1927 – H.G. Earle, M.A., M.B.
1928 – in process of appointment
1929-1938 – L.T. Ride, B.A., M.R.C.S., R.C.P.
1951-1953 – L.T. Ride, CBE, E.D., M.A., D.M., B. CH. OXON, M.R.C.S., L.R.C.R.
1953-1960 – L.G. Kilborn, M.A., PH.D., M.D., Toronto.
1960-1961 – K.K. Cheng, M.B., B.S.H.K. PH.D. Lond

Professor of Biochemistry
1961-1962 – E.O. Farrell Walsh, B.Sc. Ph.D. hon., F.P.S., F.R.I.C.
1927 – vacant (DE. Gray as Head of Department)
1973-now – Boyde TRC, B.Sc., Durby. M.D. London

About the Course

The whole coruse of Biochemistry study consists of blocks of lectures. Each block of lectures is followed by a discussion or Brainstrust session in which students can pursue difficulties or interests with the teacher concerned. Practicals are the only compulsory classes. The experimental work forms the basis of written reports which are carefully reviewed by demonstrators and thus provide at once a means of leaving important aspects of the science, practice in writing scientific prose and a stimulus to proper use of a medical and scientific library. But more valuable than either lectures or practicals are the small discussion groups about four times per term for each set of 4-5 students. In addition to all of these, we have also get a chance to taste the feeling of going on a library research and collect information for a particular topic. The mini-project trains us how to read extract and collect information from journal.

Words from our professor

Almost my first memory is of doing Benedict's test for urinary glucose in the side-room of my father's surgery. It hadn't struck me until Elixir's interviewers called the other day, but with that kind of background you don't really have a choice! The surgery was in a poor, East-End, dockland area of London where idealistic Harry Caine Boyde had gone to serve the men of the docks, who he thought were the salt of the earth and the hope of mankind. He worked single-handed, of course, as was the custom then; The surgery has gone, bombed nine times during the Hitler war and finally obliterated by a V2 rocket. The docks have gone, destroyed by the economic and technical changes which led to ships too big to come upriver as far as London rather than by either the stupidity of successive governments or the

selfish folly of the workers. But my father lives on in the memory of the few remaining old stagers, whilst docks, ships, rivers and the sea have remained with me ever since, not to mention biochemistry.

There was a gap, though. How many interns or even more senior doctors actually understand the reports they get from the Path. Lab. (or Micro, or Clinical Chemistry, or whatever name they go under now)? I didn't. The training in London then, as now, and as in Hong Kong, was gravely deficient in this respect so that the ward staff found themselves baffled and frustrated by their own ignorance. In London then, as now, and as in Hong Kong today, they reacted in a typical self-exculpatory and hostile way to the laboratory staff - criticising without foundation, condemning without hearing the case for the defence. A strange attitude if you think about it, and it made me sensitive to the casual suggestion which came my way to consider a posting in clinical pathology. At least one doctor would learn what it was all about! But then the next step; why Chemistry? Isn't that something for technicians and other low-paid, low-class people to do? Pathologists are actually doctors and accepted as such whilst the chemical work is delegated to underlings who study the recipe and produce results just like we used to so in practical classes.

Well, there you go. If the work of the Clinical Chemistry lab. is done that way, the results will be bad and the poor opinion of the clinical staff will be justified. It struck me very forcibly that the Clinical Pathologists responsible for my training were quite ignorant of chemistry and that it would be necessary to study the subject at a higher level to make any advance in this area. The chance came up because other people, notably the authorities of the Ministry of Health in Britain, were thinking the same way and were willing to help me a little with part-time release for study. It was thought necessary to have at least a few pathologists who actually understood the chemistry of what they were doing, not just the superficial stuff of the biochemistry and physiology textbooks and the technical manuals.

Look at it this way, and you see that there is nothing strange about doing Chemistry in Medicine, or Medicine in Chemistry. What puzzles me is how anyone can think differently. Look a little further and you find that there is room for all kinds of special skills under this medical 'umbrella" of ours; carpenters, tailors, sculptors, service-men, mechanics, structural engineers, production line workers, politicians, policemen, scrap merchants, drug pushers and so on. Why all the fuss about a little chemistry? Not very long ago, four hundred years or so, the whole of Natural Science fell under the Faculty of Medicine. It is a very recent idea that medical doctors should be trained only to deal with prevention and cure of disease and only in the single species, Homo sapiens; a recent idea and a very silly one.

That's enough about what I'm doing in Chemistry and what Chemistry is doing in Medicine. The interviewers from Elixir were interested too in how the Department of Biochemistry here has changed and developed, in its teaching and its research. There have indeed been changes. Fourteen years ago there were just two pieces of equipment in the whole place which had cost more than a thousand dollars - a Beckman ultracentrifuge which is still in use today (and may conceivably be the oldest functioning unit in the world) and a Hilger Spectrophotometer which some ignorant and clumsy idiot had ruined by spilling acid into its intestines. The teaching laboratory had been designed by a high-handed Dean who was not a scientist. This lab. is smaller now but otherwise the most significant structural change is that we have electricity on some of the benches. (Remember that the public electricity supply began even in Hong Kong about a hundred years ago.) To summarise, the department had sufferred in its beginnings from almost incredible parsimony and prejudice: it is still hampered today by the aftermath of that because there is still some catching up to do. The financial provision for basic support of the department has improved to a respectable level. By comparison with the formative years the equipment budget looks generous. But the job is taking far too long: a sick man recovering from severe malnutrition needs more food than the normal Recommended Daily Allowance!

Research is in worse case still. Not long ago it was possible to make a fair and full contribution in almost any field, single-handed, in one's free time and at almost no cost. The chief ingredient was mother wit. It is not possible now, not in popular areas of Biochemistry. One needs a team, modern equipment, communication with other centres, and expensive supplies: it all costs money and a recent comparison with a similar department in Britain showed that we are trying to operate on less than one twentieth of their research grant income, reckoned per capita and in real terms. How on earth can we compete? Parsimony again. Misplaced economy leading to waste of resources. (Perhaps a change is beginning here too, but there is little sense of urgency in official circles.)

Then what of our teaching? The "new new" curriculum is welcomed on all sides as allowing time to breathe and time to learn instead of hurrying students on from test to test. It should be clear from what was said earlier that there is need for more time, not less in the study of basic concepts whereas the "old new" curriculum made the same error

as in dozens of other medical schools - thinking that it would be sufficient to stuff students with a little elementary knowledge of medical sciences and then get on with the "important" part, the clinical work. It isn't either more important or less important than the basic work, but there must be proper foundations as everyone who lives in Hong Kong should be able to understand. There is nothing unusual here in spending two thirds of the cost of constructing any building on the foundations and podium; and the structural engineers are just as much valued as the architects.

Students in Hong Kong more even than in Britain like to make certain of passing their tests, and it is quite simple to do so if you define the task clearly in advance in terms of a list of facts and then examine only on knowledge of those facts. But what if facts are not enough? Suppose there are a whole range of intellectual skills and social attitudes to acquire as well. Can we list them, learn them by rote and examine them by catechism? The truth is that there isn't enough time to waste it learning facts. This may appear more clearly is the case of Biochemistry because the conclusions and unifying concepts are further removed from direct sensory experience than in the case in other basic sciences. Certainly it is one reason why students will not get detailed lecture hand-outs from us and why they will get a varied diet of tutorial, discussion, self-study, preparation, practical and written work. The details vary from year to year - perhaps that will stop when once we are satisfied that the mix is correct - but two things students can be sure of are that the intention is to lead them into an education in the principles of biochemistry and that if they quietly work through the programme offerred, in the manner intended, they will have no trouble at all passing the examinations, without panic and without cramming. We don't like failing people, and we don't even like having to set a repeat paper in September.

And then what of future developments?

The talents of existing members of the department are not fully exploited, for lack of resources. So a growth in research output and a rise in its quality is one area where expansion must occur. Work in so-called molecular biology (protein and nucleic acid structure and function) will receive special emphasis; which does not mean that we will all become gene freaks, there is simply too much else which needs to be done.

Another area where substantial development seems worthwhile is in applications of biochemistry to industry. Hong Kong does virtually nothing in this line whereas elsewhere it is billion-dollar business, and it would be irresponsible for us not to do what we can to rectify matters, for the sake of the economy. For example, almost any biochemically based manufacturing process has need of separation processes of a kind quite different from what chemists and chemical engineers are accustomed to. So while developments in fermentation technology and the like may take place in other laboratories in Hong Kong, it is proposed to press forward here with research to improve ways in which the fabulously complex mixtures which result can be refind to give pure, safe, usable, saleable products. This is all part of the broad view of what Biochemistry is about - not only a division of Physiology, not only the growing edge of Medicine, but a broadly based discipline which touches all areas of biological and medical sciences, physics, chemistry, engineering, and manufacturing industry. That may seem a long way from the narrow interests of the ordinary medical student, but even doctors, you know, have to live in a society which earns its living by producing goods for sale and protects its environment for the sake of generations to come.

As the illustration shows, we are also in the forefront of developing links with the Peoples' Republic of China, especially with universities in Guangzhou, Shanghai, Beijing & Changsha. Joint research is already in progress and we look forward with cautious confidence to a prosperous, biochemical future.

Professor T. R. C. Boyde
B.Sc. Durth,; M.D. Lond.
Head of Department

DR. S. S. C. WONG

B.Sc., Ph.D. H.K.

Dr. Wong received her secondary education in Diocesan Girls' School. After obtaining her degree of B.Sc. in Chemistry and Zoology in 1967 and PH.D. in Biochemistry in 70 from this University, she went abroad to gain overseas experience.

She joined the Biochemistry Department as an assistant lecturer in 1970 and was promoted to lecturer in the following year and finally to the present post of senior lecturer.

Dr. Wong likes talking to students. She chose to be a lecturer in Hong Kong University instead of secondary schools teacher because apart from teaching she enjoys doing research. In her opinion, doing research is very stimulating. Her main interest lies in the field of metabolic control. At present, her research work focuses on control of gene expression.

Dr. Wong thinks that medical students in Hong Kong are very diligent and the main difference between the past medical students and the present ones is that the present students are not only hard-working but active in joining extra-curricular activities. In addition, they are willing to voice their views.

When talking about her way of teaching, Dr. Wong modestly said, "Well, the way I teach is just like others. I don't encourage people to memorize everything. For instance, metabolism, I usually give them some concept of what metabolism is about and then I relate one metabolism to the other so that the students can put everything together in their minds. It is better to know the relationship between metabolism and integrate them together."

After so many years of teaching in Hong Kong University, Dr. Wong notices some changes. In the past, H.K.U. put the stress mainly on the teaching side. Recently, there is more effort put on research work but the fund for research is still inadequate. Since research is very important, she hopes that more money can be obtained in the near future.

As to the new curriculum, Dr. Wong thinks that it is good from teacher's point of view. The new system allows continuity. In the past, examinations were held at the end of first/second year. Questions were limited to the topics taught in that year. This new curriculum, however, allows more flexibility. For instance, when certain staff is away on leave, the topic he/she specialised in can be taught later in the year. Practicals can now start in the second term and in this way the students are given an opportunity to adapt to the transition from secondary school to university life in the first term. In addition, examination questions can be set in scuh a way so that the topics learnt in the first year can be linked with those studied in the second year and thus more in depth. Therefore, personally she likes the new curriculum.

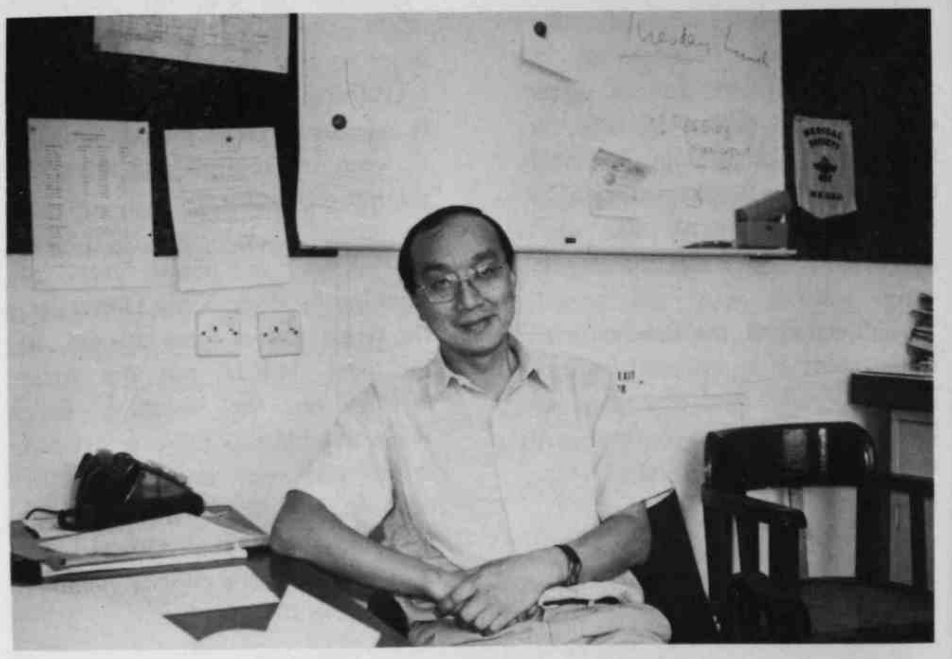
However, she dislikes having the term test at the end of every term.

"Well, the aims of the class test is to see how much the students have understood in that term. The students might like this system because they can then have a real holiday. Looking at the first term class test, some of the answers reflected that the topics learnt were not well digested. I hope the students can get used to the system and can arrange their time more wisely next term."

Dr. Wong is married with two sons. At leisure, she used to play bridge and listen to music, but after her marriage, she spends most of her time with her children. She enjoys her family life very much and during weekends, she usually takes her children to the sports centre.

DR. P. C. L. WONG

B.Sc. N.E.; Ph.D. Flinders



Dr. Wong went to Australia in his secondary school years. He studied in the University of New England where he obtained his B.Sc. degree, first taking forestry but later shifted to Chemistry which he found even more interesting. After that, he spent quite a number of years in Flinders University, from which he obtained a Ph.D.

In 1971, Dr. Wong participated in a post-doctoral research in the University of Alberta in Canada, and after one and half year he joined the Biochemistry Department of H.K.U. The Department had changed a lot since then, especially in the Laboratory facilities and equipment, and the Faculty had been expanded.

Dr. Wong finds the biochemical changes and relations within human body very interesting, and much research can be done in all these fields.

As regard to his opinion to medical students, Dr. Wong feels rather sad that most H.K. students, including medical students, are too well trained to become "examination-oriented" under the present educational system in H.K. He thinks that many medical students are brilliant and have the potential to become great scientists or philosophers if their interest in these fields can be stimulated, which Dr. Wong finds rather difficult to do in the present system of education. Nevertheless, Dr. Wong appreciates the recent new curriculum of the faculty, for it provides more time for students to look at the world around them and can think more about life and their own ideals.

In his lecture, Dr. Wong tries to treat every lecture as a story with its own theme. Examples relating to medical fields are quoted and how these "stories" are derived from laboratory are added.

Dr. Wong is doing research in biochemical reactions in nerve signal transmission, and the biochemistry of a particular parasite which lives in the brain. Dr. Wong is the committee member of the Hong Kong Biochemistry Society, and the Hong Kong Society of Neurosciences.

During leisure hours, Dr. Wong likes reading, especially science fictions and detective stories. He also listens to music, or chats with his friends. Dr. Wong particularly appreciates life in the countryside, and he enjoys visiting other countries.

DR. L. Y. L. CHENG

B.Sc. Lond.; M.Sc. Warwick; Ph.D. H.K.

It was already 3 o'clocks when I got through the door of Biochemistry department. I walked hurriedly along the corridor, Rm. 2-9A, Dr. Y. L. Cheng, Aha! I found it. I knocked the door and entered the room, noticing that Dr. Cheng had just sit properly for my friendly visit.

"Sorry Dr. Cheng" I said, "I'm a little bit late". "Never mind," she said with a smile. I started our conversation by asking about her educational background."I left Hong Kong after I had completed the Form 5 course," said Dr. Cheng, "and I matriculated and got my first university degree (Bachelor of Science) in London, then Master of Biochemistry in Warwick. In 1973, I came back to Hong Kong and found my first job as a demonstrator in HKU. At the same time, I was engaged in research work on protein transamination and clinical diagnosis. In 1976, I went to the University of California to carry out research on free radical attack on protein and lipid. And later I got my Ph.D. in Hong Kong"

"Then, when did you become a lecturer in HKU?" "Eh, its in 1979", she replied. "You had already been working as a lecturer for seven years, why do you choose it as your career?" "The reason is simple," she said, "because science is fascinating and I have particular interest in research. Besides, it is quite difficult to find a job as a research biochemist because drug companies in Hong Kong rarely pay emphasis on research work," she added.

"You said you love biochemistry, can you tell me more about what aspect attract you most?" "It's molecular biology. But the future in this field largely depends on the donation of drug companies and funds to HKU. The lack of money is the main obstruction," she explained.

"How many of your articles have been published so far?" "I had written about twenty articles on different international journal . The topics were varied but mainly on molecular biochemistry of free radicals and thalassaemia."

"Biochemistry covers a wide area and is not an easy subject to teach. That's why the preclinical curriculum will be changed. With one more term, some topics can be taught in more details. To appreciate biochemistry, an analytical mind is required. Some medical students are too reluctant to read. In my lectures, it is more important to understand what I teach rather than copy down all the transparencies accurately." "I absolutly agree," I replied, "but this may be the typical attitude of the students under our education system."

"Dr. Cheng, could you share some unforgetable experience with us?" "Of course," she said, "let me see, ah, when I had changed from a Chinese primary school to a Anglo-Chinese one, I very much admired my classmates because they could communicate with the nuns in the school. At that time, I was weak in English particularly. I was very scared because I did not know what they said. It took

one year for my adaptation." "Ha, English is also my problem too" I replied. "Similarly, it took time to adapt a new style of life in London," she said, "I had suffered from a cultural shock. My classmates in England were more casual. Many of them smoked, drank and took drugs.

During the lectures, my first impression of Dr. Cheng was that she was a cool person. However, after this visit, my mind changed. I can feel that she is quite a sincere person. Besides, she is also energetic. Fishing and hiking are her favourite out-door activities. She practices calligraphy and Ku Zheng occasionally in her spare time. I hope I have the chance to have a look at her calligraphy.

DR. J. W. O. TAM

B.Sc. C.U.H.K.; Ph.D. Calif

Dr. Tam was born in China and studied there during his early ages. After coming to Hong Kong, he continued his studies and was finally offered a place in the Chinese University of H.K. Having obtained his B. Sc degree, Dr. Tam went to the University of California for his PH. D. studies in Physical Chemistry.

During his work of making high molecular mass biopolymers and synthetic enzymes of high catalytic power in the North Western University in Chicago, his interest in Biochemistry was raised. However, the most important incidence that really brought Dr. Tam to the biochemical field happened in 1972 as he successfully modified the conformation of Hbs by aspirin to increase the oxygen affinity of Hbs, so that the Hbs molecules would not clump together so easily as in sickle-cell anemia. Dr. Tam could not continue his work in U.S.A. because he had to come back to H.K. to take care of his father in 1973.

Dr. Tam joined the University of Hong Kong as a lecturer following the year he came back. Seeing that recombinant DNA technology had been developed in foreign countries, and realizing the importance of such technology in clinical research and treatment of hereditary diseases, Dr. Tam was determined to develop in that field. In 1981, Dr. Tam went to a meeting in. Italy and met many experts there. Dr. Tam took the chance and asked some of them to introduce this technology to Hong Kong. Research workers from China & S.E. Asia were also invited to Hong Kong to learn the technology. In 1983, the required equipment & apparatus were installed and the DNA practical course started.

Dr. Tam thinks that the Biochemistry Department of HKU is quite well developed and there are experts in different fields. When asked about the difficulties of working in the biochemical field with his background knowledge in Physical chemistry, Dr. Tam said that it was not a serious problem at all as biochemistry actually incorporates knowledge from physical chemistry in many areas, such as in the separation of protein molecules.

He finds that most medical students regard Biochemistry as an unimportant subject. However, he regards biochemical knowledge as very useful and important for understanding medical knowledge. He hopes that such students will change their attitude towards studying Biochemistry.

When asked about the changes in Biochemistry Department during his work in HKU, Dr Tam pointed out that the department has more lecturers , more active research programs than in the past. Besides, the teaching emphasis has been shifted to emphasize more on metabolism.

Dr. Tam feels that a gap always exists between students & lecturers, probably owing to the reluctance of the students to ask lecturers questions. He hopes the students ask lecturers questions. He hopes that the communication between the two groups can be improved as it is beneficial to both parties.

DR. V. M. S. LAM

B.Sc., Ph.D. Lond.

In many ways, Dr. V Lam is totally foreign to Hong Kong, though her husband is 'native'. She was brought up in Malaysia and then further her studies in England. She likes teaching and is very much interested in genetics. She also teaches science students molecular genetics, besides we medical students.

Dr. V Lam herself having suffered infantile eczema in her younger days and with an apparent family history of allergies, she hopes that some of her present research work could be of use to those who suffers from inherited diseases. Besides being related to her teaching, Dr. Lam finds her present research interest in genetics to have a purpose.

At the beginning of the 1980's, only a few people in Hong Kong are engaged in human genetics research and the funding was poor. The situation has improved during the past few years but more funding for research is still necessary. Working closely with staff of the Government Clinical Genetics Services, she hopes to arouse interest in genetics among the medical students as well as the general public.

She is a founding member and the current Honorary Treasurer of the newly formed Hong Kong Society of Medical Genetics.

Realising the impact of genetic engineering in science as well as medicine, she took the initiative to attend training courses in this then newly developed techniques. She attended the intensive course in recombinant DNA in 1981, under the auspices of COGENE and UNESCO. Subsequently, together with Dr. J. Tam they organised a similar course in Hong Kong in 1983. It was only since then that local research work in this field began to pick up momentum. Currently, Dr. Lam together with Dr. J. Tam and Dr. L. Cheng has a comprehensive research programme to study the molecular aspects of local genetic diseases which include the thalassemias and G6PD deficiency. Part of this research is funded by the strategic Research Grant.

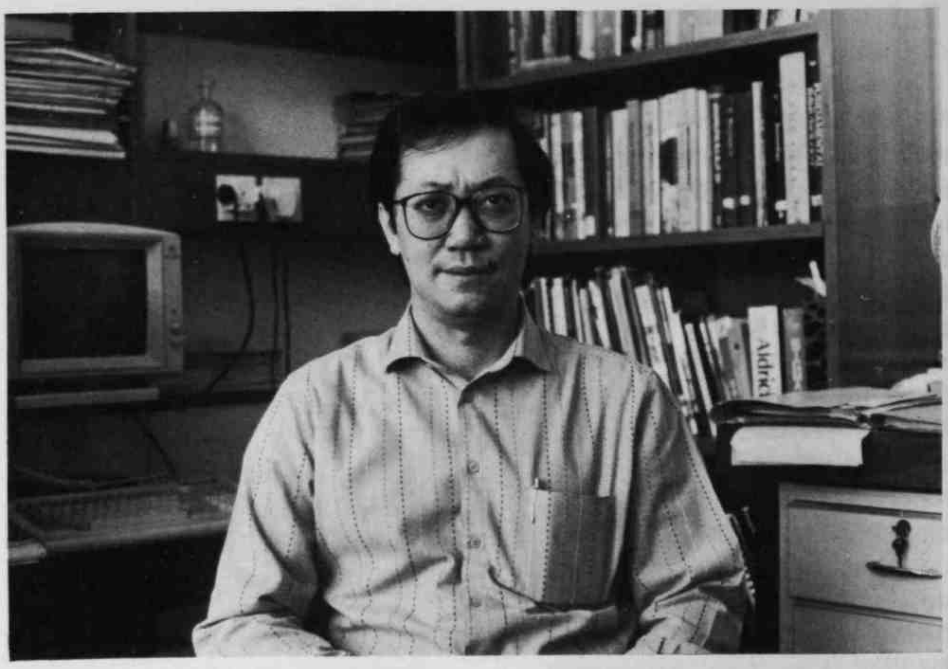
When asked about her impression of medical students, Dr. V Lam said that we are too keen on memorizing facts, but not frequently using logic and basic principles. She hopes that the students can appreciate that the purpose of university education is not just providing technical information, and that students should participate more actively in their studies.

On the new curriculum she comments that it should be beneficial to the students. There is no first year exam and learning is thus uninterrupted. Moreover, the new curriculum is more flexible and the burden of the students should be lessened. The students should thus use this opportunity to broaden the scope of their studies.

Dr. V Lam is interested in swimming.

DR. H. K. F. LAU

B.Sc. Alberta; M.A., Ph.D. N.Y. State



Dr. Lau spent his years of secondary school in New Method College. After that he went to Canada and took up a four-year honours degree course in Biochemistry in the University of Alberta. Later it was the State University of New York in Buffalo where he obtained his masters and doctorate. He did his post-doctoral work as a research associate in Harvard University for five years, in the field of thrombosis and haemostasis.

Dr. Lau joined the Biochemistry Department of this University in 1980. He finds this a good post as he has the opportunity both to teach and do research.

What was the glamour of Biochemistry that attracted Dr. Lau? He said they were the great advancements in biochemical research in the 1960's, such as DNA sturcture, mechanisms of enzyme catalysis, and second messenger system. Biochemistry then was emerging as a new, hot and frontier science, as it is now. Dr. Lau enjoys this very practical research style of approach, which he thinks makes Biochemistry a science based on quantitative observations, reasonings and deductions. Currently, Dr. Lau is engaged in research work on protein chemistry in relation to fibrinolysis and tissue remodelling. He works on the plasminogen activator and the plasminogen activator inhibitor on different cell types. This area of research, as told by Dr. Lau, is very popular in other countries. In his view, Hong Kong is lagging behind in this race, mainly because of the inadequacy of research funding and academic interchange in the form of free discussions and seminars.

When asked about his impression on medical students, Dr. Lau admitted that he has not enough contact with them, as only one-fourth of his worktime is concerned about teaching medical students. Anyway, he thinks that their quality is excellent. However, the transition from secondary school to university still seems to impose certain problems on them. Freshmen too often cling onto the studying method of the old days, when quantity of facts are emphasized. But Dr. Lau reminds us that even 'facts' can be challenged or even changed in science. The best attitude, Dr. Lau suggests, is to be open-minded; and he recommends students to do some extra reading on textbooks and research articles.

In lectures, Dr. Lau tries to cut down the number of slides used, in order for the students to better understand the lecture materials, rather than furiously copying down what is shown through the endless slides.

Dr. Lau is quite dedicated to his research work, but he also enjoys spending leisure hours with his wife and his 4 year-old son.

DR. K. S. E. CHEAH B.Sc. Lond.; Ph.D. Cantab.

Dr. Cheah was born in London UK and brought up in Malaysia, (she speaks Fukien and a little Cantonese) and studied at the University of London to receive a BSc degree in Biology. After completing her PhD in Plant Biochemistry and a post-doctoral fellowship at Cambridge, she continued as a research fellow first in the University of Manchester and then with the Imperial Cancer Research Fund in London.

After 14 years in the UK, Dr. Cheah joined our department of Biochemistry in 1983. Her current research interest is in the control of collagen gene expression and inherited connective tissue diseases. By any standards, she is a prolific worker; she has published 23 scientific papers in all! Although she enjoys teaching, she finds the attitude held by Hong Kong medical students towards Biochemistry rather depressing at times.

Dr. Cheah is married and enjoys reading books, watching plays and movies and eating out in her leisure time.

DR. L. Y. Y. FONG

B.Sc., M.Sc., Ph.D. H.K.

Dr. Fong is a local graduate majoring in Chemistry and Biology during here study in the university. She obtained all her degrees, namely Bachelor of Science, Master of Science & Doctor of Philosophy from the University of Hong Kong. Dr. Fong joined HKU in 1970 as an assistant lecturer and was promoted to lecturer in 1972 and senior lecturer in 1982. The appointment allowed Dr. Fong to pursue her goal in life, that is teaching whilst being at the same time endorsed with the freedom to do basic research. Through her PhD. project, Dr. Fong was first introduced to the exciting field of cancer research. The work involved a study of environmental chemicals such as N-nitroso compounds as possible causative agents for the high incidence of liver & nasopharyngeal cancer in Hong Kong. She has spent 16 years in that field. The association % nasopharyngeal cancer and frequent ingestion of salted-fish is one of the important findings of Dr. Fong's research work. In addition, Dr. Fong had been to Massachusetts Institute of Technology and worked as a research associate in the Nutrition & Food Science department for 1 year. It was during her stay there that Dr. Fong's interest in scientific research was further intensified. After returning to Hong Kong, Dr. Fong spent most of her time investigating the effects of nutritional deficiencies of such as that of zinc, a trace element on human health & the development of cancer.

The funds required for Dr. Fong's research program mainly come from 3 sources: High Degree Research Grant & Medical Research Grant offered by HKU and Overseas Grant offered by the Cancer Research Campaign, United Kingdom.

The equipment & facilities for research in HKU are quite good,' said Dr. Fong. 'Nevertheless, research workers in H.K. can achieve a lot more if more funds are available.'

When asked to comment on the attitude of medical students towards the study of biochemistry, Dr. Fong admitted that most of them regard the subject as un-important and are reluctant to spend much time on it because most of them cannot see the direct application of Biochemistry in clinical medicine.

Besides doing her own research work, Dr. Fong supervises postgraduate students and a B.Sc. biomedical student who had just finished his preclinical course of Medicine.

DR. W. F. FONG

B.Sc. C.U.H.K.; B.Sc. (Special) H.K.; Ph.D. Notre Dame

DR. K. S. AU

B.Sc., M.Sc., Ph.D. H.K.

Dr. Fong was born in Hong Kong but he completed his primary and junior secondary school study in Mainland China. After which he came back and in 1964, he entered the Department of Biology of the CUHK. Later he earned a BSc (special honour) in HKU after a year of research in microbial genetics and physiology. In the States, he got his PhD with a research topic on steroid hormonal action on enzyme induction. After working for 4 years as scientist in a hospital in Canada, he came back to Hong Kong in 1980 and he is now enjoying his research and teaching post here. He likes the atmosphere of the University campus.

Dr. Fong is interested in Biochemistry because it can provide the ultimate answer to the mystery of life. Anyway, he admits that different subjects are of equal importance. Now he spends at least 70% of his time on research, for he realizes that one has to concentrate on research or else no progress is possible.

Dr. Fong said that medical students should remember the importance of general sciences, since the progress in medicine often depends on progress in basic sciences. However, he observed that medical students often regard Biochemistry as insignificant simply on the ground of its abstraction.

In his lectures, Dr. Fong likes to highlight the main points but not repeating the details contained in the textbooks. According to him, a lecture is for helping students organizing materials and at times provide information outside textbooks.

Dr. Fong is married with two daughters. He told us when he was young, he was rather 'political'; and he once was the chief editor of a Chinese newspaper in Ottawa, Canada. He wrote articles in newspaper but now he writes no more.

A rather sportive person one must admit, Dr. Fong was a member of the volleyball U team and he also enjoyed athletics, especially 200m race. At the moment his main interest is tennis.

His interests also spread to Eastern and Western philosophy, religion and even fortune-telling!

Dr. Au joined our department of Biochemistry as an assistant lecturer in 1970 and was promoted to senior lecturer in 1982. Based on interest, he chose to be a biochemist.

When asked for his impression on medical students, he said that their general response during lectures, especially the discussion sessions, was good. "But most of the preclinical students seem to be less interested in basic science subjects like biochemistry than in clinical ones," he commented. He pointed out, however, that there are some medical graduates who end up to be very good scientists, and he hopes to see more of these graduates in the future.

Dr. Au dislikes spoon-feeding his students. He teaches at the right speed so that his students can follow his lectures. He stresses on concepts rather than details.

Dr. Au has been conducting research on calcium pump for sometime. The source of research funding is mainly from the University. He said that the funding is not enough so that it limits the scale of his projects.

Dr. Au is married and has a daughter. In his leisure, he shares the same hobby as our new Governor, Dr. David Wilson ---- Cliff-hiking.

RESEARCH PROJECTS OF TEACHING STAFF

Name	Project Title	Year	Brief Description	References
Dr. HKF Lau	Fibrinolysis and Tissue Remodelling	1986	To study the relationship between the fibrinolytic system and various phenomena involving tissue remodelling, such as in haemorrhage or neoplasia	1-2
Dr. KS Au	Ca^{2+} pump	1976-present	Ca^{2+} pump regulation by protein modulators is studied	3
Dr. K Cheah (in collaboration with Dr. L Hsu Dr. E. Yu & Dr. I Kung)	Molecular Biology of collagen genes and inherited connective tissue disease	1984 present	1. The study of the control of collagen gene expression during development 2. The isolation and characterization of DNA probes for human collagen genes 3. A study of the range of DNA restriction fragment length polymorphisms (RFLP's) in the collagen genes of Chinese people. 4. The use of such RFLP's in 3) to study inherited connective tissue disease in Hong Kong Chinese.	4-17
Dr. SSC Wong & Dr. DCY Yeung	1 Developmental Biochemistry	1983-86	To study various biochemical changes occurring in foetal, neonatal and adult life.	18-21
Dr. SSC Wong	2 Protein Degradation in Reuber H35 Hepatoma	1984-85	To investigate the difference sensitivity towards various hormones on protein degradation between hepatocytes and hepatoma cells.	
Dr. SSC Wong & Dr. SCY Yeung	Expression of pyruvate kinase in hepatocytes and hepatoma	1984-86	To study the expression of pyruvate kinase in rat liver and Reuber H35 hepatoma cells at molecular level using L-PK and M1-PK probes	
Dr. SSC Wong Dr. YG Yeung & Dr. DCY Yeung	Rat Hepatocytes on Biomatrix in defined medium	1985-86	To investigate changes of cell surface proteins of hepatocytes that have been cultured on biomatrix and to study the growth promoting effect of the biomatrix.	
Dr. SCC Wong & Dr. DCY Yeung	Proto-oncogene expression in normal and transformed cells	1986	To conduct a systematic examination of the pattern of proto-oncogene expression by hybridization using proto-oncogene probes. Immunochemical studies will also be carried out to correlate transcription with translation of these genes.	
Dr. WF Fong	Initiation signals for cell activation and proliferation	1970-present	Cells respond to and contain factors which induce or stimulate cell activities and cell proliferation. In this laboratory we study enzyme regulation, the biosynthesis and function of polyamines, amino acid transport, ionic fluxes and intracellular pH with respect to their roles in cell activation and proliferation.	22-23

Dr. LYY Fong	Chemical carcinogenesis	1970-present	1. Nitrosamines in salted fish, Chinese preserved foods and its association with cancers. 2. Nutritional deficiency and chemical carcinogenesis	24-54
Dr. PCL Wong & KM Lai	Structure & function of synaptosomal membranes	1980-present	Elucidation of orgainzation and function of enzyme and transport proteins of neuronal membranes using various agents which affect membrane structure	55-57
Dr. PCL Wong (in collaboration with WS Ng)	B-Lactam Antibiotic Resistance in Neisseria gonorrhoeae from SE Asia	1982-1985	Characterization of B-lactamase from penicillin-resistant gonococcal strains	
Dr. PCL Wong & WF Fong SF Pang	Polyamine function in CNS	1984-present	Metabolism and transport of polyamines in rat brain	
Dr. PCL Wong RC Ko & A Kwong	Lipids of parasitic nematode	1985-present	Composition and metabolism of lipid in Angiostrongylus cantonensis	
Dr. VMS Lam & JWO Tam	Molecular studies of G-6PD gene in Chinese	1983-present	Restriction mapping and search for RFLP around the G-6-PD gene; molecular cloning of the defective gene from a Chinese	58-67
Dr. JWO Tam & VMS Lam	Molecular studies of Hemoglobin switching using the rat as the animal model (Croucher)	1985-present	This involves protein typings, molecular cloning and expression studies of the globin genes in rat	
Dr. JWO Tam VMS Lam & LYL Cheng	Molecular studies genetic diseases of local prevalence (UHK Strategic Research Grand)	1986-present	The thalassemias, G-6-PD etc are the key issues for molecular studies	
Dr. JWO Tam VMS Lam	Molecular studies of a repetitive sequence in rat	1984-present	Molecular cloning, characterization of a new long repeat sequence in rat and its expression	

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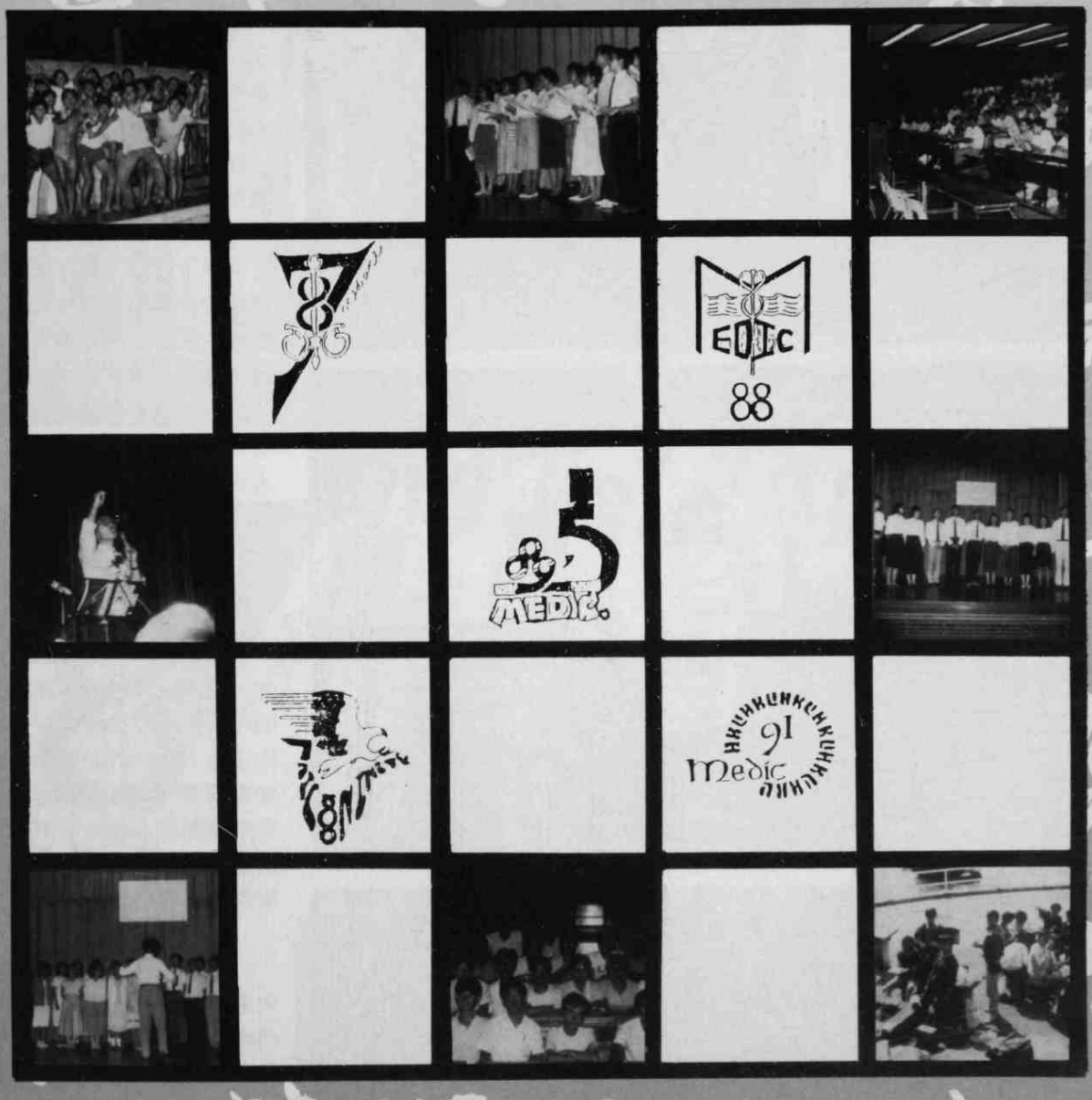
EDIC
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你：

我快要離開了。

五年了，你想知道我是怎樣過這五年嗎？

× × ×

也許我不應告訴你太多事，你是不會感到興趣的，同時各人有各人的理想，生活方式，價值取向……好像學生活動，你可能覺得費時失事，不值一屑，但有些人卻在其中，流連忘返。我也參加了不少學生活動，但仍未能作出定論，畢竟得益是無形的，而付出的代價卻是實在的……又例如讀書，不論讀大書，細書，讀筆記，期刊，結果都可能會一樣？但祇有你自己可以告訴自己究竟適合用那一種方法，別人告訴你這樣讀，那樣讀又怎樣？……不要盲目聽從別人，自己去試一試吧！

× × ×

你曾經試過面對重要決定時，不知如何抉擇；但是結果卻令你失意，而痛恨自己的選擇嗎？你要知到，當你決定去做某一件事，事後你永遠不會知道如果你不去做，或如果你用另一種方法去做那件事，結果會如何！因此，不要太過執着自己的決定所帶來的後果，不要後悔或懷疑自己最初的決定！

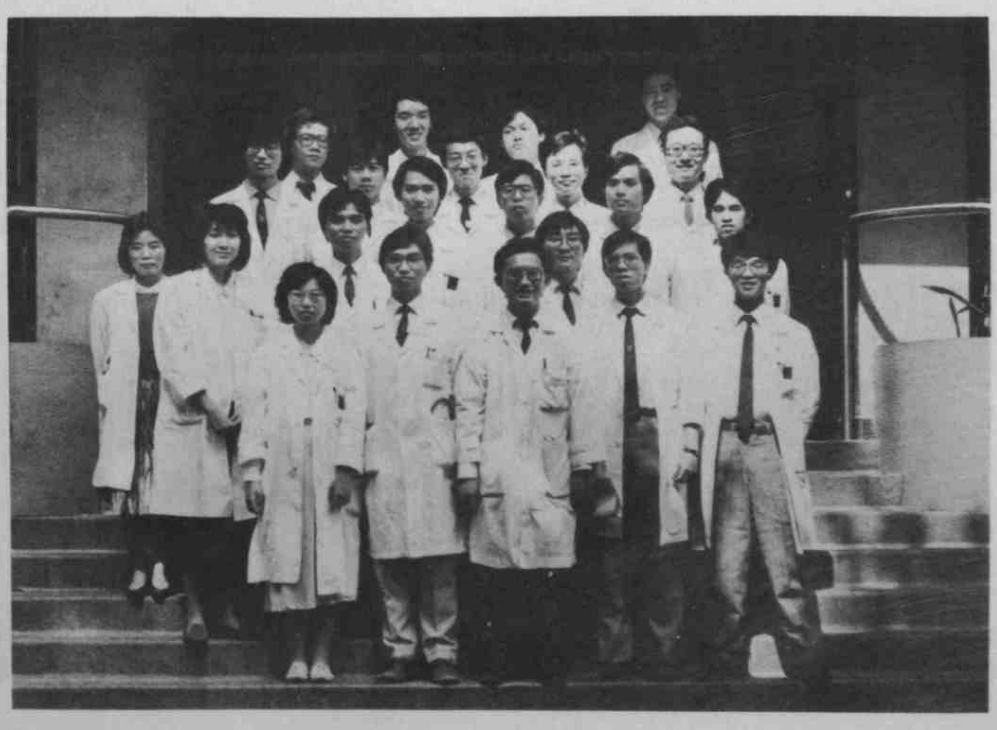
× × ×

不要太過介懷失敗！五年裡，失意、傷心，是在所難免的……它們祇會使你更加陷入低潮。同時，你應該問自己一句：「這事是否仍可以補救？」如果是不能的話，多想又有何用？可能是因爲人的悲觀性作祟，印象最深的都是一些使人黯然的事件，但其實在這裡，仍有很多景物是值得你欣賞的——例如從圖書館望上瑪麗醫院，欣賞她的雄偉，從學生休息室望向大海，欣賞太陽消失前的一刹那光輝……。

× × ×

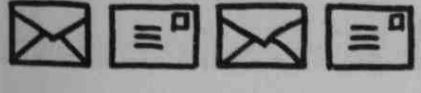
太多太多的感受想和你分享了，但又不知如何說起。同時考試一步步的迫近，使我不得不暫且擱筆

八面玲瓏、
七竅皆通、
八七英勇、
大跌威風、



，考試過後，再和你詳談吧！或者我可以用兩句歌詞來總結我此一刻的感覺　「漫漫長路快要走過，終於走到明媚明天……」

我，
寫於八七年二月九日下午於見習醫學生宿舍



柒々八十八 我們是原 我們大


嘩！
女子多ㄚ呀！

八九八九、精神抖擻八九八九、個個高昂、

還兩星期便要考內科，但却不得不提筆，這篇稿我想是拖了半年了，這裡也應向杏雨老總說句抱歉。

自己也曾當過編輯，知道追稿的辛苦，現在反過被人追稿，都是一臉的無奈。自己不想寫，別人也不想做，可能是「己所不欲，勿施於人」，倒是「求人不如求己」。

一擱經年，「糊喱糊塗」的上庄之後，現又正是望落庄之時了（希望可以吧）

說回來，考完試之後，隔兩星期又考性病，接着就是没暑假的夏日了。再過幾天，連半價証都歇暑了，我們還要在烈日下，套着頸索、披上白袍，在酷熱的、蒸籠一般的病房上課，在廣華、東華、伊利沙伯，瑪麗之間往還。別人問我暑假往哪處玩，眞不知怎樣答自己才會舒服一點。

× × × × ×

明顯的，我班已從火線上退下來了。大家都會專注於書本之上，好些人因爲在別的醫院上課，經月也見不到，想找某人眞難矣。

有同學說醫科是一個不歇止的巨輪，絕不容你停不來歇息，她不容許差錯，追不上一節，没時間給你再衝一次，下一節又在催促你了。如果你自己或家庭發生什麼事，那就麻煩了，因爲她没有給你留下時間去想別的事。

很羨慕我同組的兩位同學，他們曾不顧一切的放下了功課，去了外展學校一星期。顧問醫生對他們的無故失踪一星期很不滿，他們回來時還誠實的說出不上他的課的原因，當然他就更不高興，便以問書來「懲罰」他們，以打擊他們的自信心，好叫他們以後不要亂來。

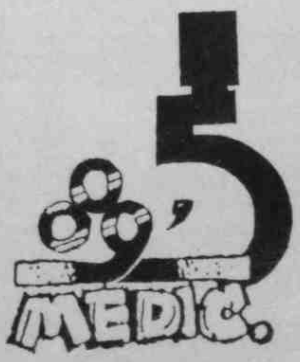
× × × × ×

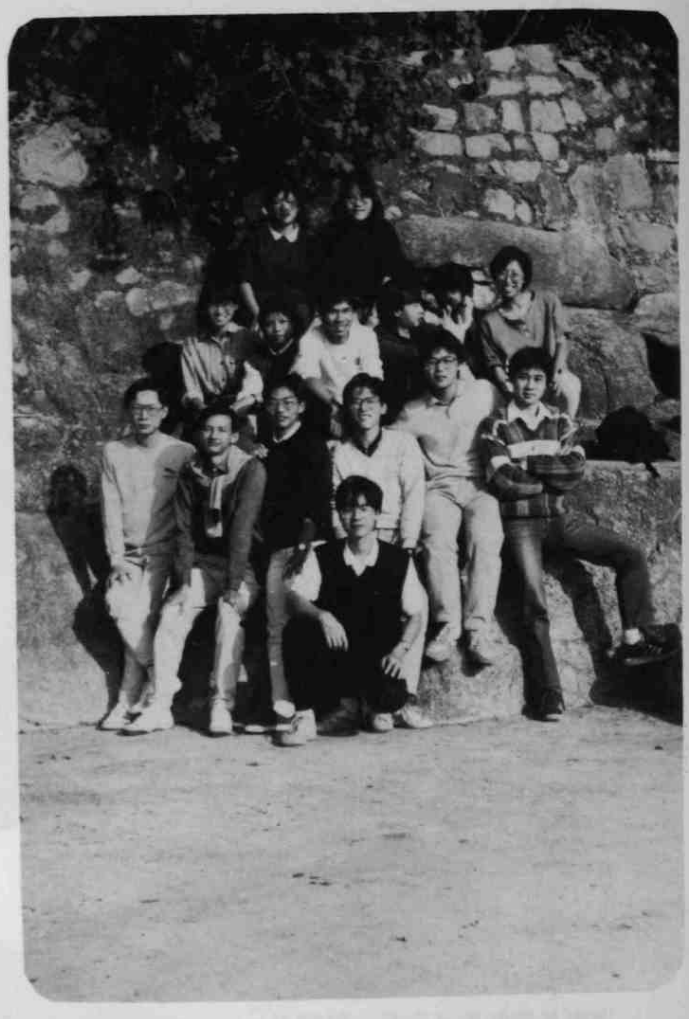
最後，在這裡要對一些人說聲謝謝：

很高興和欣賞班會的學術秘書和財務秘書有很高的工作表現。

更感謝一些同學在體育方面對班的貢獻。雖然自覺爲他們打氣的人不多，但他們仍能繼續代表本班出賽，更說聲多謝。

還有一些默默爲班會工作的人：多謝。





We are the ones
We are the champion,

We are the ones
who've won a better
day

and never give in...

百師滙集在九〇。
奇兵疑時聚精英、
為我醫學振遠聲

自從做了班代後，一切的時間都改變了。首先，要比以前早起身，早些到MEDSO房裏的 PIGEON HOLE有沒有新任務。而且，有時還要在LECTURER未入來之前去宣佈一些事件，以致上堂前一刻必是左插右轉，不能安坐椅上。有時，或會要求講師出一份 HANDOUT，所以上堂前和後都要準備出動！當然，「走堂」的機會簡直微乎其微。

落堂之後，私人的時間更加少之又少。有時，或會去幫MEDSO手；有時，更加要做苦力……。雖然，時時刻刻都要和時間追逐，所得到的一切遠比失去的多。在這一段忽忙的日子裏，可以學到怎樣分配時間，怎樣與人溝通，怎樣應付困難；做班代實為一個訓練自己頭腦靈活，身手敏捷的好機會。所以每位做過班代的同學都會在自己的日記裏寫上一頁自豪感。

信

Is it that the construction of the sewage interceptors at Northeast Kowloon will be finished by then? Or is it that the Legco president will be elected by all the unofficial members from among themselves beginning from 1991? Or rather, is it that the number of lives claimed by AIDS in the United States will reach a total of 179,000 by then? ... .?

Well these answers may be correct. However, what is of most importance to us in this year is of course our graduation - for we belong to the class of Medic '91.

As compared to the more senior classess, ours is a rather special one. Not only is the number of students applying from abroad greatly increased (about 10, but the number of female students is also markly reduced (only 23). In addition, we are the first class to follow a revised pre-clinical curriculum with no M. B. examinations until the second term of our second year.

Having been medical students for just over four months, we are already able to demonstrate our enormous vitality and active participation in many of the functions organized by the Medical Society. To give some examples, our class

91 Medic

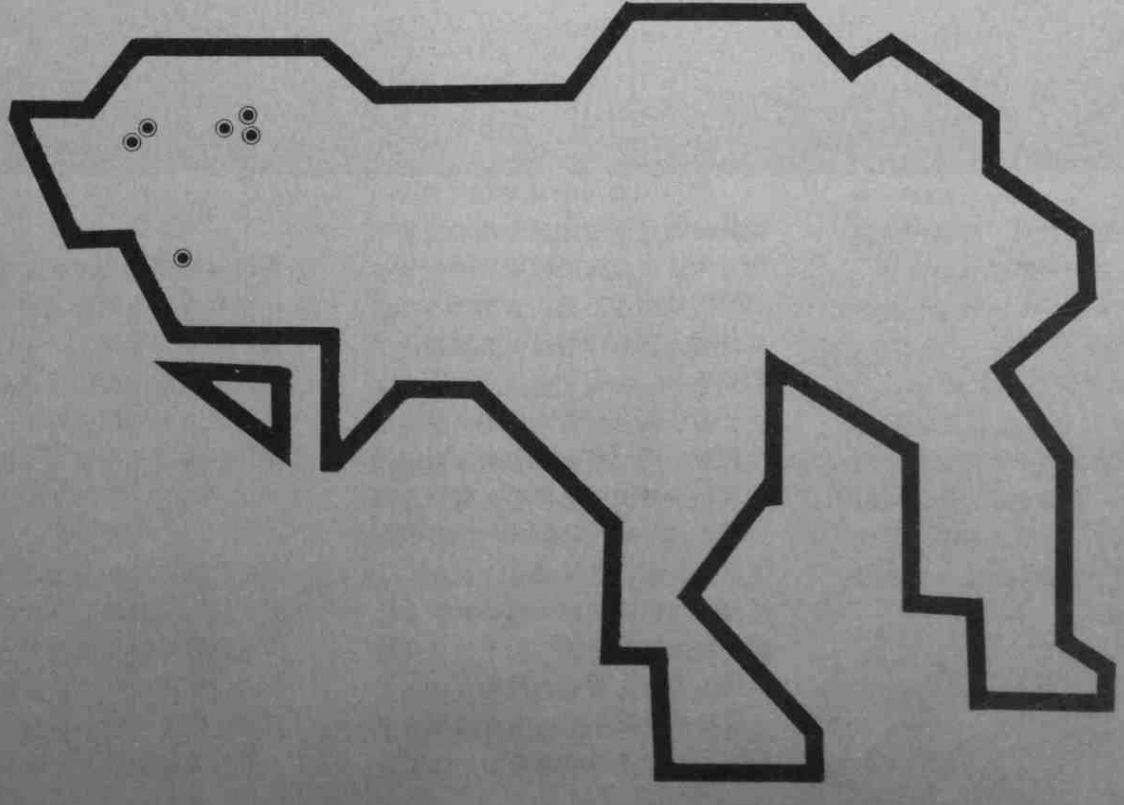
choir came second in the Medic Festival and we were the overall first runners-up in the inter-year atheletics meet. In addition to being active in music and sports, we are also able to do 'deep-sea diving' in the library from time to time when necessary.

As for some personal opinions, I find the seniors very willing to give both advice and help, which do not limit to the academic aspect, to us freshmen Furthermore, the atmosphere of looking after the younger generation is very intense as can be seen from the lending of microscopes to us when ours have not yet arrived, and from the passing down of notes from year to year. These views are actually shared by many of our classmates.

Coming back to describing our class, I would like to quote, as conclusion, a saying I heard from a senior: "We shall be classmates for five years, workmates for thirty years and friends for a lifetime." So, let us hope that everybody will treasure this first year, which symbolizes the beginning of our life-long relationship.

'91 Class representive
January, 1987

舍		堂
	醫	
學		生



由於我們這一羣編輯大都居住家中，對舍堂生活所知有限，只知道作爲堂友，一天除上課的時候外，大部份的光陰都在舍堂渡過，究竟這「另一個家」對同學的學習、想法和成長有何影響，都是我們很有興趣知道的；基於好奇心的驅使，我們便決定循三個途徑對這個問題展開探討。

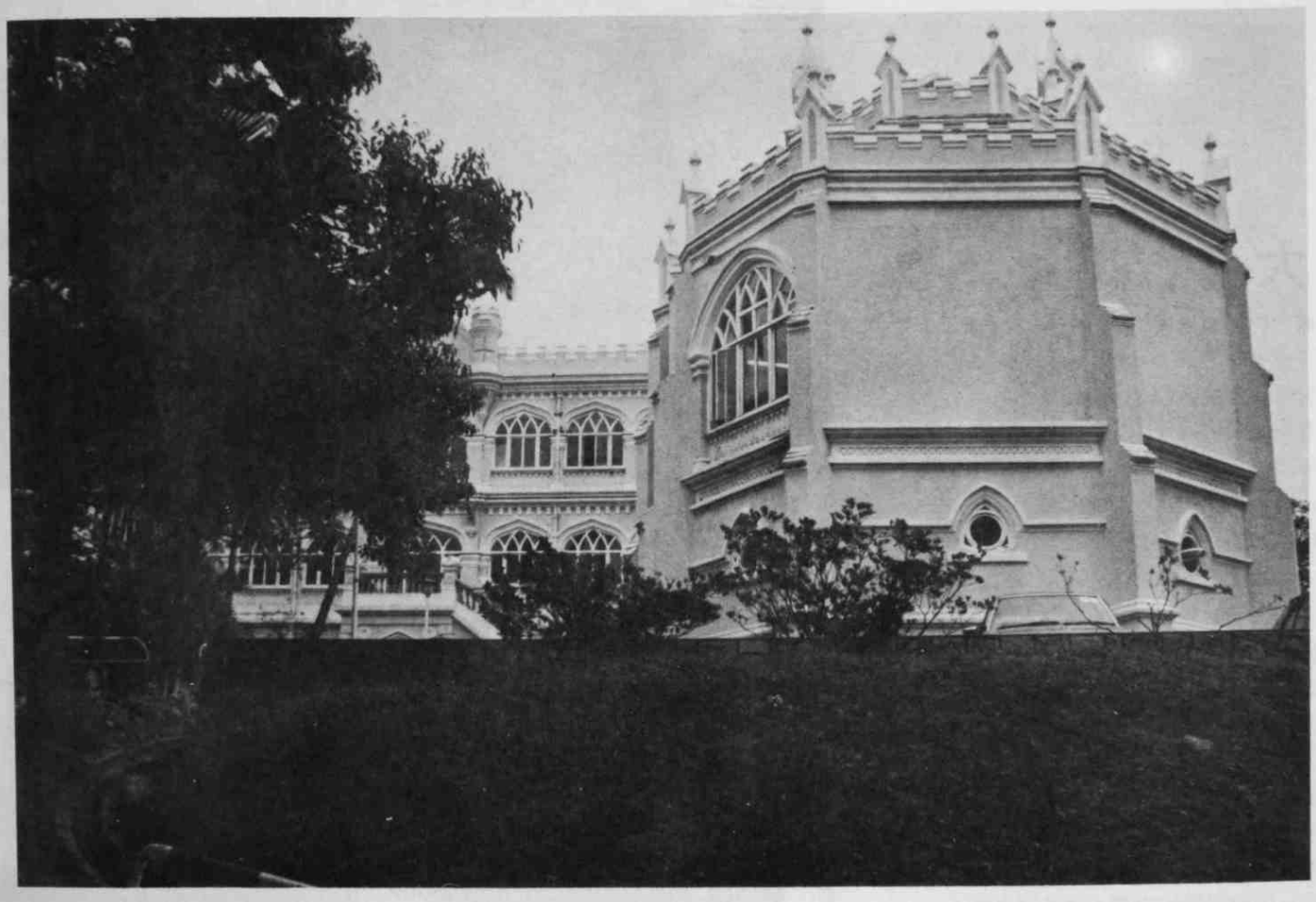
首先我們向舍堂分發問卷，徵詢同學對舍堂生活的一些意見，雖然反應不甚熱烈，但收回的問卷也可作爲舍堂生活的基本指引；我們發的問題大致針對四方面：舍堂生活對學習的幫助，同學參加活動的種類及動機，舍堂裡的人際關係，舍堂裡的環境及膳食。我們發覺大學堂及太古堂的同學對這四方面有頗相同的意見；另外，聖約翰堂、利瑪竇堂、太古堂的同學均認爲他們的好朋友很多都是堂友，相反，其他例如何東及李國寶堂的女生則感到和堂友相處有一定困難存在；置於環境及膳食，除聖約翰堂外，大多同學都不甚滿意。

第二條途徑便是邀請一些堂友執筆抒寫自己對舍堂生活的主觀體驗，大部份被邀的同學亦樂於分享自己的經歷和感受，當中亦不乏動人和發人深省的片段，在此特向他們致謝。

最後亦是較資料性的一條途徑，便是訪問一些舍堂的幹事會職員，查詢一貫的收生標準、醫學生的一般形象及舍堂特色這一類的資料。

這一次的探討，雖然談不上什麼結論，但卻希望能給沒住舍堂的同學對舍堂生活有一般的了解，更希望能幫助低年級同學在選擇舍堂時有一定的資料以供考慮。

大學堂



(i)學習

同學覺得舍堂內的讀書風氣頗爲濃厚，但他們卻極少組成學習小組(study gp)。舍堂對他們的實際幫助主要是有大仙指導及舊試題答案等。一年級的同學多在大學各圖書館溫習，二年級及三年級則多喜歡留在舍堂。

(ii) 活動

同學們對舍堂的參與頗爲積極，原因大都是爲了興趣，認識堂友及培育自己。參與活動的類型主要是屬於體育及文化。當醫學院和舍堂的活動需要取捨時，他們多數參與舍堂的活動。比較學院與舍堂，一、二年級的同學對舍堂的歸屬感比較大，三年級則相反。

(iii) 人際關係

同學現時較好的朋友大部份爲堂友。他們都覺得溝通上沒有問題，和任何人都不會沒話題。舍堂裡的拍拖風氣頗爲盛行。大學本部的消息大都是源自舍堂的同學。

(iv) 環境及一般生活

同學大都對舍堂的衞生環境及膳食不甚滿意，但長假裡卻頗喜歡留在舍堂，尤以三年級爲甚，大概忙於應付考試吧了。很奇怪地，三年級的同學，大都有七八小時的睡眠，但一年級卻平均只有六小時。晚上的時間，大都忙在閒談、鋤書、打桌球及閱讀。走堂風氣在二三年級分盛行，一年級則例外。

(v) 其他

同學大都認同舍堂是大學生活非常重要的一環，在四五年級仍希望住舍堂。同學認爲舍堂主要功能爲擴大社交範圍、節省交通時間及學習與人相處。而現今舍堂大致能乎合以上功能。

大學堂有「三寶」，包括銅梯、四不像和 三嫂。銅梯是旋轉形的，貫通大學堂三層；初以爲是香港唯一的銅梯，後來有同學傷了到聖保羅醫院留醫，才發現原來那裡也有一座類似的銅梯。四不像相傳是大學堂的守護神，取名的原因是由於它什麼也不像；四不像有一對，一雄一雌，雌的一隻還有一個小獅子在身旁。相傳凡觸摸四不像的同學都會遇着不幸，不是考試不合格便是有意外。最近「婦女新姿」爲大學堂拍攝三十週年特輯，工作人員由於不知就裡，無意中碰到「四不像」，後來紛紛拿出錢來請三嫂幫他們買東西拜神。三嫂是一名女工，由舍堂成立一直工作至今，她不但記憶力好，很快把同學們的名字都記好，對堂友也很關心，幫有病的同學煲中藥，爲我們煮粥、魚旦粉，還有其他宵夜。現在很多舊堂友回來都是去探望三嫂，甚或給三叔利是買東西吃。現在她接近六十，快退休了，我們也捨不得她。

李國賢堂

李國賢堂　醫學生　女

學習

她們普遍認爲堂內的讀書風氣屬普通。而入住舍對她們的學習似乎沒有甚麼幫助。組織溫習小組亦是絕無僅有。不過仍有一半被訪者較常在舍堂溫習。

活動

根據問卷的資料，被訪者在參加醫學院或舍堂的活動兩方面，並無很大分別。參加舍堂活動的主要原因，是個人興趣。可是亦有一位同學承認參加乃人在江湖，身不由己而已。

人際關係

與同一舍堂的男醫學生有顯著不同的地方，就是她們大部份感到和堂友在溝通上有問題。大部份被訪者表示她們較要好的朋友是同班同學而非堂友。遇上困難時，她們亦會先向同學及家人找幫忙。不過，日常的交流事實上能對她們提供到一些本部的消息。

環境及一般生活

在膳食和衞生環境兩方面，她們和男醫學生都一致對前者不滿，但認爲後者頗佳。在問及她們平均每天睡多久時，我們得悉是七至九小時（很不典型？）。而夜裏的活動主要是閒談；讀書和「發夢」！

其他

雖然舍堂對她們來說並非十全十美，但是她們仍認爲舍堂生活是大學生活重要的一環。而在臨床期她們亦希望能繼續留住舍堂。

李國賢堂　醫學生　男

學習

堂內的男醫學生普遍認爲舍堂的讀書風氣並非十分濃厚。像其他的醫學生一樣，他們放頗多時間於溫習上。但是，組織學習小組就似乎不大盛行。被訪者中只有一人認爲舍堂的環境、人事十分配合自己的讀書習慣。無論如何，超過一半被訪者仍選擇舍堂爲溫習之所。

活動

至於活動參予方面，他們以舍堂之活動爲多。相對而言，就比較少參予醫學院之活動。參加舍堂活動的目的，主要是個人興趣，認識堂友及培育自己。雖然活動時間的分配並非相等，但是這並沒有影響到他們對醫學院及舍堂的歸屬感

人際關係

在舍堂中人與人的相處無疑是舍堂生活重要的一環。他們和別的堂友溝通並沒有問題。其中兩位同學更指出有超過三十位堂友可和他們閒談多於三十分鐘呢！但如遇困難時，他們則會向家人及非堂友的同學找幫忙。另外，根據被訪者的觀察（經驗？）舍堂內醫學生拍拖的風氣頗爲濃厚呢。

環境及一般生活

對於舍堂的環境能否解除一日的疲勞，回答可算是毀譽參半。但膳食方面則幾乎所有同學都表示十分不滿意。不過舍堂的衞生環境就甚佳。長假裏，大部份的同學都喜歡留在舍堂裏。你猜堂內的男醫學生在夜間有甚麼活動？我們得到的答案是飲酒、閒談、賭博、宵夜、看電視及讀書，可謂林林總總，各適其式。

其他

總括來說，他們認爲舍堂的生活在整個大學生活中是很重要的。大部份同學在臨床期仍希望可入住舍堂，但目的顯然不是爲了增加學習氣氛。

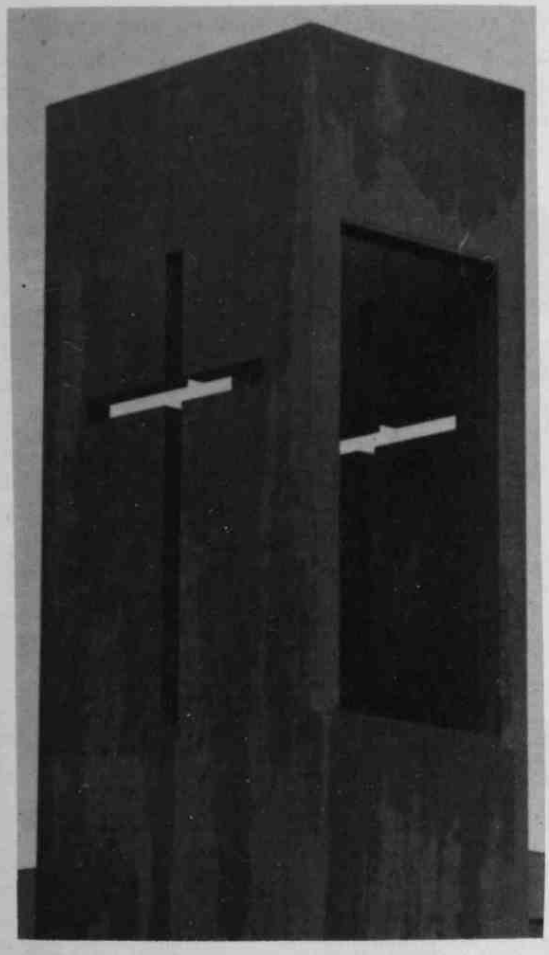
有關李國賢堂的一切，相信大家都略有所聞。它是大學裏最新的舍堂，對於它酒店式的設計，較新的設備，甚至「裝修」工程和收取宿生的準則一時成爲佳話。舍堂的另一特式，是沒有飯堂的設備，加上三百多人居於一所，堂友之間的關係則不及一些舊式舍堂的密切，似乎欠缺了一份溫馨、歸屬之感。由於舍堂較新的緣故，所以沒有什麼傳統，宿生會的運作亦沒有特別的形式規限，但在舍堂的不斷成長中，這一切一切都會有所改變。「新一代精神」更成爲我們去年的標記，雖然這「新精神」未能發揮得淋漓盡緻，堂友對舍堂的歸屬感亦不太強烈，但是樓友之間的感情卻是深厚的。而「兄弟」、「姊妹」的相稱更形親切，相信假以時日，這份關心、互助互愛的感情，必能逐漸擴散，爲舍堂帶來團結的精神與更多的光彩。

不知道其他舍堂的情況如何，我們之間的關心與深厚情誼，亦會見於迎新營的小組當中。雖然迎新營只規限於學期初，但每逢假期，甚至稍爲清閒的日子，組聚都會是必然的節目。組聚的多寡與形式是按個別小組而有所不同——有些會共進晚膳，有的宵夜談心，有時亦會相約共遊郊野，甚至到酒廊舒懷暢飲，總之各式其式。雖然表面上只是吃喝玩樂，但感情亦由此而生。你會發覺在經過一年之後，在功課繁忙當中，甚至當中經已畢業，踏足社會後，仍願意付出時間和金錢，與一羣堂友相交，這並不是一般玩樂能夠維繫的。

宿舍不單提供居住之所，舍堂生活更爲我的大學生涯添上姿采，使它更加完滿。在宿舍裏可以接觸到很多事物，而且與人的接觸更多，關係便更爲複雜。相信這些經歷對於一個普通的醫學生來說，確是不可多得的。就個人而言，舍堂亦爲我帶來了更大的誇進。我逐漸學會了待人處事之道，更明白到與人相處必須坦誠及開放自己，才能好好地把握宿舍所提供的學習機會。所以，無論如何，舍堂生活是值得回味和珍惜的。

最後，想要提及的，是個人對舍堂的感受。能夠入住宿舍，當然是一種幸運。但我最初入住宿舍的目的，只是想覓得一棲身之所，免卻舟車勞頓之苦。幸好經過整整一年的時間，對宿舍已產生了一種截然不同的感覺。

聖約翰書院



較對醫學院爲強，這現象在入住幾年的醫學生中更爲顯著。

㈢人際關係：醫學生覺得他們較好的朋友多來自舍堂，而他們有困難時也會先考慮找堂友幫忙。他們對本部的消息大部份是來自堂友的。

㈣環境及一般生活：醫學生對舍堂的膳食質量和衞生環境都感滿意，而舍堂的環境也能解除他們一日的疲勞。

㈤其他：他們認爲舍堂生活在整個大學生活中很重要，而且都希望在clinical years時仍住舍堂。他們認爲舍堂的主要功能是節省交通，擴大社交範圍，提供課外活動，學習與人相處和發展個人潛能，而聖約翰堂在這幾方面都能達到他們的要求。

聖約翰堂的醫學生認爲……

㈠學習：舍堂內學習普通，他們很少在堂內自組溫習小組，但大仙指導、舊試題答案等也頗能幫助到他們。

㈡活動：他們的參與頗爲積極，活動項目方面主要是體育、文化、社會服務和資訊，而參與原因是爲興趣，想認識堂友和培育自己，但也有人覺得是人在江湖，身不由己。一般來說，他們對舍堂的參與和歸屬感

明原堂

明原堂的醫學生覺得……

㈠學習：宿舍內的讀書風氣普通，舍堂內的環境和人事也頗能配合他們的讀書習慣，但一般來說，舍堂很少能在學習上提供幫助，諸如堂友筆記，大仙指導等並不多。

㈡活動：醫學生的參與頗多，多爲體育和資訊方面的活動，參與的原因是爲興趣和想認識堂友。對醫學院的活動參與和歸屬感則稍比對舍堂爲佳。

㈢人際關係：大致來說，醫學生和堂友的相處和溝通沒有大問題，但較多醫學生覺得他們的好朋友是同班同學而不是堂友。很大程度上，堂友都成爲本部消息的來源。

㈣環境及一般生活：醫學生對舍堂的衞生環境大致滿意，但對膳食質量則微有不滿，而大致上舍堂的環境頗能解除他們一日的疲勞。

㈤其他：醫學生認爲舍堂生活在整個大學生活中頗爲重要，他們都希望clinical years時仍住宿舍，他們認爲舍堂的主要功能是節省交通時間，擴大社交範圍，提供課外活動和學習與人相處，而明原堂在這些方面大致能達到他們的要求。

'The end of Lyttelton Road!' ---- ever since my first year of university life, these few words have deeply infiltrated into my head. Each time they are heard, my mental preparation will immediately give the interpretration----Old Halls, my home.

Old Halls, among other university halls, has its own characteristics. Unique in its 'surface anatomy' with red bricks and a black roof, it is an elegant old British style of architecture. Though many people always say with met eyebrows that this guy is really so old

as its name suggests, and that its 'viscera; are also so inadequate and out-of-date. I, on the contrary, always think it is a pleasure to reside in this special and beautiful building in such an advanced place as Hong Kong.

People tend to think Old Halls is a place of warmth. And every time I feel uneasy when I hear this compliement. "How warm is warm?" --- let me borrow Fielding's style of language. "Do all hallites treat each other as their sibs?" "Do they show concern and consideration to others?" I doubt. In my eyes, warmth is there, but not everywhere. It only exists in individual circles of sworn friends. Nevertheless, this kind of friendship, or better say brotherhood or sisterhood, can run very deep inside one's heart. Fortunate as I am, I manage to have a few friends of this kind. We always chat from the dead of night till dawn comes, sharing joy as well as sadness. That's why I always doze off in lectures, but I still think that's worthwhile because friendship always comes first in my philosophy.

"Then what about the relationship with other hallmates?" Roughly I can classify them into four big categories, with the sworn friends type mentioned above as category 1.

2. Friends of the Ocean Park type ---- they are friends whom one can go out to fever with, but not to share one's internal world because they still lack that intimacy as to expose oneself completely without reservation.
3. Friends of social manner --- they are hallmates whom one can exchange warm greetings with when they come across. Sometimes a few more superficial things can be said, like "Have your meal yet?" "No lecture today?" etc. However few other topics can be found since their familiarity with each other is quite limited.
4. Hallmates-of-no-hello --- this is because they are so stolid that they always pass one's side without looking at him even though he says hello to them. Thank God for the small number of hallites belonging to this group.

So it is obvious that the interpersonal relationship in this small community is not that good as outsiders might have in mind. Maybe someone will ask whether it is just a matter of how much effort one puts in to get to know each other. As far as I am concerned, it is just partly true. As time goes by, I have experienced so many times of heartbreak that others do not treat you as good as you treat them. And by now I start to sense the isolation between people and I have realized that it is a fact of life.

Another peculiar feature of Old Halls is its hall spirit, ah, I better say the peculiar feature of Old Halls is its lack of hall spirit. Whatever social activities, few bother to participate. Whatever team practises, few bother to show up. Examples of this kind are not infrequent. "Freedom" has long been a foolproof shield. "As long as I do not interfere with your functions and activities, please do not impinge my own sovereignty of myself!" --- this type of attitude is not uncommon here. They have the privilege to live here, but they have forgotten the concomitant obligations. In their mind, their sole responsibility is to pay the rent for their 'hotel' and that is all. Even so, no one will, or has the power to, interfere with them as human rights and self-administration are highly respected and encouraged here, and there is no caste system of seniority in Old Halls.

Now let me have a few words on the gain and loss in living in Old Halls.

On the positive side, it is evident that we stand a greater opportunity to meet students of different faculties for intellectual interflow. By dint of this, we can have a picture of the life of the students in the main campus as well as things that are beyond the confines of medicine. Things like economics, marketing, laws, engineering etc are not too unreachable. Besides, owing to the wide variety of hallmates, it is no problem in seeking information and advice when the need comes.

The high-table talk also helps broaden our horizon. Were it not for the high tables, I think the chance to chat with Dr. Hwang (our Vice-chancellor), Mr Justice Yeung and other dignitaries in society is remote.

The hall is a good place to practise one's social skills. One learns to give and take, to share in cooperative venture, to understand how others feel, to consider and to forgive others.

Nonetheless, there are never two points of a needle. We also have to pay for our gain.

The first thing we lose is our time. Some of it is spent worthily to support the hall but the majority is wasted. Your hallmates are always playing and shouting in the floor. All kinds of noise and disturbances are there when you want to, and really have to, dig hard into your books in your room. The consequence is that you usually have to make good for the loss and work hard late in the night.

Another loss is the declining intimacy with your family, classmates and friends because one have little time left to spend with them. It is very undesirable to me and I always try to find some time to get in contact with them.

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Hallites usually stereotyped us medics as bookworms who will not show up at any activities. It is not infrequent to see their surprised when you appear in those occasions. Actually we medics are also human beings who need time to take a breather from their work.

Thanks to the heavy workload, I am always saddened when people around are enjoying playing these and those whilst I myself have to sit still by my desk. This kind of feelings is strongest when they all leave Hong Kong to enioy life at Christmas and Easter while I am worrying about my term tests.

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In a word, hall life definitely adds colors to the boring and tense training of a medic. When still in high school, I was told that one could only get 70% of his university life if he did not reside in a hall. And now, I realize that this statement does carry some truth. Though every one may has his own interpretation of university life, my opinion is that it should have a broader sense comprising not only academic pursuit, but also the refining og one's personality, morality and the widening of one's scope as well as the training to be a 'whole' person.

太古堂

(i) 學習

舍堂內的讀書風氣頗爲濃厚，入住舍堂後，時間也頗多花在溫習上。在舍堂裡功課上的幫助，多來自於大仙的指導和舊試題答案等，和舍堂內的 Medic 同學卻甚少組成溫習小組。

(ii) 活動

受訪同學普遍頗經常參加舍堂舉辦的活動。參加活動的原因大都是爲了興趣和認識堂友，亦有的是爲了認識社會，培育自己，甚至是因爲人在江湖，身不由己。體育和文化普遍是最吸引他們的。一年級的同學普遍對醫學院的歸屬感大於舍堂，但三年級的同學卻剛剛相反。

(iii) 人際關係

同學在舍堂裡的人際關係頗佳，和堂友在交談上毫無問題。對大學本部的消息大部份亦來自堂友。舍堂裡拍拖的風氣頗爲盛行。至於較好的朋友，大都平均分配，屬於堂友和同班同學各佔一半。

(iv) 環境及一般生活

同學大都埋怨舍堂膳食質量極差，而衞生環境則頗爲滿意，使他們能眞正得到　　休息。一星期中，同學大都在舍堂停留六天，每天睡覺大概六小時左右。夜間的活動除讀書外，計有閒談、聽歌、打機和開會。走堂氣氛頗爲濃厚。

(v) 其他

被訪者大都感到舍堂生活的重要性，而舍堂的主要功能則被認爲是擴大社交範圍、學習與人相處和節省交通時間。太古堂的宿舍生活頗能達致以上功能。

A total of 304 residents live in Swire Hall. Of these 21 are medical students, all of which are male.

Our hall is a relativeley new building, clean and neat. We do not have our own canteen. But there is one in the Fong Shu Chuen Centre, which is opened to everyone. So we do not have to purchase the some four hundreds meal tickets, as is required in other halls, and has a relatively free choice as to where to dine.

We are also very free regarding as to when we should return to hall, and do not need to sign in if we return late after midnight. We even do not need to bother to bang the door, waking up the staff in order to be let in, because the entrance is never locked, with a staff on duty twenty-four hours a day.

It would be untruthful, in my opinion , to say that there is a good studying atmosphere in our hall, as I believe is also the case in any other halls. Of course one can always devote all one's time in studying, provided that one can stand the temptation from others. None of our hallmates will press you too hard to participate in any hall activities.

There is also the obvious advantage of not having to travel one hour & so every day from home. Equally important is that one gets to know more friends from other faculties and can thus widen one's social circle later in life. My floormates come from nearly every faculty, and so our topics of conversation are many and varied.

Occasionally, we hold faculty gathering, when all the medics will come together, chatting for two hour or so, discussing anything we care to talk about. A good way of promoting friendship among us!

利瑪竇堂

(i)學習：

被訪的醫學生認爲舍堂內的讀書風氣並不濃厚，住在這舍堂對其學習亦沒有特別的幫助，而他們甚少組成溫習小組。但是同學卻喜歡在舍堂溫習，大概是因爲可以和堂友有較大的接觸。

(ii) 活動

被訪者對舍堂甚有歸屬感，亦經常參加舍堂舉辦的活動。這些活動大都屬於體育和社會服務性質。而參加的原因是爲了興趣和認識社會。

(iii) 人際關係

被訪同學在舍堂人緣甚好，現在較好的朋友大部份是堂友。和一般的堂友交談毫無問題，和幾乎所有的堂友都可攀談超過三十分鐘。可是很奇怪，當遇到困難時，卻不會找堂友幫忙。舍堂的拍拖氣氛頗爲盛行。

(iv) 環境及一般生活

在長假裡同學多留在舍堂，一星期中也有六天留在舍堂。可是舍堂的膳食質量卻強差人意，衞生環境則頗爲令人滿意。

(v)其他

同學認爲舍堂生活在整個大學生活中十分重要而在（Clinical years）亦十分滿望在舍堂繼續生活。這皆因舍堂頗能達致同學理想中舍堂應達致的功能——就是擴大社交範圍和提供課外活動。

何東夫人堂

學習

被訪的女醫學生認爲堂內的讀書風氣屬普通。她們覺得入住舍堂對學習並沒有特別幫助。她們亦甚少以學習小組形式溫習。

活動

她們參加舍堂活動的主要原因仍是以興趣爲主；而體育、文化及社會服務是較爲吸引的。至於歸屬感方面，則在醫學院及舍堂兩方面都沒有多大分別。

人際關係

所有被訪者都表示大部份的朋友均非來自舍堂。但她們並未覺和堂友有溝通上的困難。如遇到有難題，她們亦情願先找同學（非堂友）或教會的姊妹幫忙。

環境及一般生活

被訪者都一致認爲舍堂的環境能解除她們一日的疲勞，而膳食及衞生環境都令人滿意。

「何東」這個名字，對你們來說，可能只是代表港大裏唯一的女生宿舍，但對我們一百零四位堂友來說，她象徵着我們第二個家。她並沒有堂皇華麗的外貌，也沒有先進新穎的設備，但她有着本身的內涵及氣質，三十多年來陪伴着一批又一批宿生的成長。

何東的面積雖小，但各樣設備齊全。在門外，我們有一塊名貴綠色大地毯，也有響噹噹的銅鑼，至於其他的日用電器及用具，更是數不勝數！

不過，生活在何東，是否單靠這些充足的物質供應便可支持呢？答案當然是否定。何東裏住着一羣積極、認眞、有幹勁的年青人，雖然彼此有着不同的性格及生活目標，但爲了建立一個鮮明的舍堂形象，宿生會的成員努力不懈地籌辦各種不同的活動，如球類，社交、社會服務、聯誼等。他們不吝嗇地奉獻自己的精力和時間，鼓勵着堂友積極參與，充份發揮了舍堂團結的精神。值得欣慰的是，她們的心血並沒有白費，儘管箇中的辛辣是不足爲外人道，但當她們捧着一個又一個的獎座凱旋回來，或獲得熱烈的反應及讚美時，小小的苦楚又算得是什麼呢？

何東有着一個恬靜幽美的環境，最適宜於學問的苦修。無論你的房間是向山或是面海，你都可以放眼遠眺，暫時讓緊張的神經鬆弛一會兒。尤其是對我們醫學生來說，在功課忙得不可開交之際，也有一個令人心曠神怡的環境讓你好好去休息或思想。人是感情的動物，往往有情緒低落的時候，而舍堂就爲我們提供一個促膝談心的地方。記不起有多少個晚上是與三兩知己圍在一起，訴盡心底裏的話，共同分享彼此的苦與憂？

何東是一個大家庭，她的成員來自五湖四海，有着不同的特質，身處其中，你可儘量吸取別人的經驗，集合各人的大成，捨短取長，令自家的生命更形豐盛。生活在一個羣體裏，不要以爲甚麼也垂手可得，是應份的。舍堂生活是一個無窮無盡的寶藏，你要收獲越多，你就要付出越多，也要作出相應的犧牲和忍讓。所謂「相見好，同住難」，透過日常生活的學習和體驗，舍堂生活加速了我們的成長。

住在宿舍裏的醫學生，時常有着一個很大的矛盾，就是怎樣同時兼顧繁重的功課又去積極參予舍堂的活動呢？你不能終日埋首書本，對舍堂的事不聞不問，那麼，你只會換來別人的冷眼及非議。不過，身爲舍堂的一份子，大家都有責任和義務去參予活動，再加上舍堂裏並沒有強迫着你去參加一些沒有你興趣的活動，只要能適當地分配好時間，學業和活動是可以平衡地共存。

溫馨、和諧、團結是一個美滿家庭的特質。要達到上述的境界，每一位家庭成員必須儘量發揮自己的潛能，互相互愛，爲何東跳躍的生命而努力！

舍堂?舍堂!

每次見到萬家燈光的情景，便會奇想到要去認識裏面的每一個人，探知他們的內心世界。在旁觀者眼中，這裡或只是一座較爲獨特的建築物而已，但對於身處其中的人來說，這小小的舍堂卻蘊藏着多少歡樂、懷念、親切……

年多前，在接到大學入學通知的當兒，「大信封」內一份份的宣傳單章深深地把我吸引住，其中當然包括各宿舍招收宿生的宣傳了。對於一個「在家千日好」的我，宿舍是一處既新鮮又神秘的地方。於是抱着好奇心，加上爲了節省時間的原因，就決定報名申請了。

迎新活動，踏上了我舍堂生活的第一步。兩星期的時間內，宿舍的人與事一一展現在衆「新鮮人」的眼前，其中不乏有趣和新奇的。但是活動的緊密卻着實使人有點喘不過氣。期間，透過各項活動和探訪，認識了不少新朋友，也對舍堂有了一個初步的認識。還記得在開學的初期，因爲要「探房」的原故，往往要到凌晨時份才能就寢。由於睡眠不足，上課時便頻頻「釣魚」了。此外，學院內的活動，繁重的功課和名式各樣新鮮的事物，在同一時間內紛紛湧現，令人至覺眼花瞭亂，委實有點無所適從的感覺。後來，因爲在宿舍內參與了一項活動的籌備的關係，工作就更是繁忙了。然而，該次卻給予我首次在宿舍內籌辦活動的經驗，使我對它的內部情況有了更深入的了解。再者，數個月的日子，令我不期然對宿舍產生了一種難以言喻的歸屬感，於是便毅然肩負起一項責任，成爲宿生會 Exco 的一員了。

屹立山上的宿舍，對於它獨一無二的建築和周遭的大自然環境，也許早已遠近馳名。而內裡的情況，外間人又可知道多少呢？宿舍是一處自由、開放的地方。日常生活，除了讀書的時間外，堂友們都各適其式地找尋自己的興趣，康樂棋、乒乓球、桌球、結他、煮宵夜、看電視、跑步……，眞是數之不盡，多姿多彩。有些時候，也不知何來這麼多的話題，三兩人可促膝談心至深宵時份，卻也樂此不疲。所以，每每覺得在宿舍的時間過得特別快，而平素在家鮮嘗的夜生活也早已習慣了。至於堂友間的關係。就來得非常密切了。從起居飲食以至生活上的小節，堂友們都清楚知道對方的情格和爲人。日常的接觸，不獨使大家熟落，更可以有思想上的交流。爲此，在宿舍內是容易找到性格上合拍的知己的。來自不同院系的宿生，有不同的背景、人生觀和見解，有令人敬佩的品格、獨特的思維，也有崇高的理想。透過傾談和接觸，大家互相學習，砥勵求進，在個人修養和思想上實有莫大的裨益。況且，要面對百多名的堂友，互相遷就、忍讓和尊重是非常重要的。故此，從舍堂生活中學習與人相處之道也是一個寶貴的得着。有時，一羣人會無聊大聲喧嘩，你追我逐，吵吵鬧鬧。在旁人眼中看來，或許會於他們大學生的身份而感到驚異。但是，在無拘無束的環境下，一羣朝氣勃勃的青年人卻正在抓緊那青春的一刹那，一同生活，那麼放縱一下又何妨呢？

對大多數大學生來說，大學將會是踏足社會工作前最後的學生生活了。競爭劇烈的社會，令人與人之間往往有利害上的衝突，人也就變得冷漠和孤立。正因如此，能夠在大學階段中，享受數載舍堂生活，分享堂友間純那眞的友誼，就倍覺難能可貴了。Exco的工作，除了讓我有更多機會去接觸堂友外，更令我從工作中認識自我。上庄時的理想、抱負，以至後來環境的掣肘、意料以外的失敗均是一些寶貴的經驗，而這些若非經過親身體驗，又那裡能夠輕易得到呢？宿舍的生活，或多或少，付與我人生觀上的轉變。那裡，有歡樂的時光，也有失望灰心的刹那；有知己良朋的關懷，也有話不投機的冷漠。經驗和得着以外，令我至覺珍貴的，卻是堂友間日益增長的友情。多少失落的時刻，那些眞誠的鼓舞說話使我挺起胸膛，繼續堅持下去。置身其中的我，眼見着宿舍內的人與事，當中實有喜有憂。喜的或許已講得太多了，而憂的卻也是一種人生的體驗。它使我明白到世事並非如黑白這般簡單，而且也告訴了我許多非個人努力就能成功的經驗。也許，就是這樣的使個人奔向成熟，而在思想的領域上的拓展也就令人變得更世故了。

過去、現在、未來，舍堂的生活也是逃不過時光的流逝。就現在，我想像得到舊堂友的努力和過去的光輝時刻，當中實有令人敬慕和欽佩的；而未來，新血的注入卻又是多了顆滿懷熱忱的心，爲宿舍作出貢獻，使它延續下去。貢獻無論在精神或時間上都要作出犧牲，然而「一分耕耘，一分收獲」的至理名言，卻告訴我，我的努力並沒有白費過，因爲它已換來一些，一些無形卻極珍貴的東西。

快樂的時光，往往是過得特別

快。轉眼間，三年的舍堂生活已過了一半的時間了。我想，在我離開宿舍後的日子，這數載生活上的點點滴滴，歡笑聲、喧嘩呼叫、考試前夕集體衝書……一切一切均會成爲我人生歷程中一段甜蜜的回憶！

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文仔的肥皂泡

文仔

迎新

是深夜的時份，禮堂內的人也倦透了，只有兩三個大仙還積極地充撐場面，好讓新人能單獨回答選美般的難題。

啊！終於到我了，還未站住脚，司儀便問：「如果你可以選擇，你會過肥皂泡式的生活（七彩繽紛，但瞬息幻滅），還是肥皂盒式的呢！（平凡、長久，但天天如事）？

我想了一會兒，自己中學時所過的正是肥皂盒式的生活——每天只會將老師的筆記熟讀，應附考試，成績中上，年年升班，不談政治，不愛運動，生活離不開學校、家庭與教會的框框內。小說中的大學生活，正是我苦讀的原動力之一，於是我便回答：「我要肥皂泡，因爲生命的可貴，不在乎它的長久，而在乎它的質量，只要找緊剎那間的光彩，就足夠了。」

這樣的答案當然有舊人反對，不過我早就料到無論我怎樣回答，也有人反對，所以也沒有把他們咄咄逼人的續問放在心內。

聲色犬馬

艱苦的迎新活動已過去了，大家也將迎新時所帶的面譜放下，反正一起生活方可感覺到彼此的性格。開始時總覺得有點格格不入，由其是那些猥猥的對話，但相處久了，又不覺是什麼一回事可能是麻木了，我想，一大班人FUZZY，黃色笑話最容易引起笑柄的。

但是在舍堂裏和自己很不同的大學生生活，眞的學會了很多。比方說，同樓兄弟多是泳壇健將，從他們對話中也略懂游泳的技巧、李啟淦的逸事、今年舍制水運會的形勢：…同樣地，和不同人接觸，有不同的體驗、自己的眼光也闊了。漸漸地自己對文化、藝術、政制、天文、盤栽，甚至異性，也有更深入的了解，有茅塞頓開的感覺。

另一方面，舍堂的一流環境和設施，加上聲色犬馬的生活，使在徙置區長大的我，活像在童話仙境中。我愛在牀頭細數星星靜聽浪聲，在梯間自彈自唱，和三五知己傾訴心事，整夜不眠，更愛柴娃娃地去逛街，看電影、跳舞、食宵夜，偷路牌，參加中華英雄常識問答比賽……。

光輝的背後

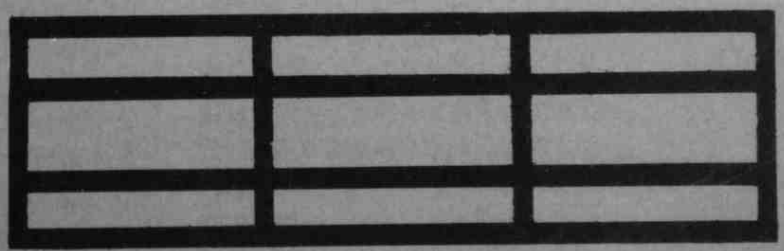
可是浪漫的生活使人失去自我控制，要找緊這生活，就要付出代價。在團體壓迫下，使我幹了不少違背自己原則的事。例如開什麼的AGM，EGM，眞的是不知所謂，不過同樓大仙親自入房邀請你，卻不好意思推辭；眼見朋友有難（畢業論文），又要通宵「做包」、打字，還要走堂去比賽，去叫CHEER，去預備派對。至於讀書方面，每次溫習時也會遭受到騷擾，不是叫你去FLORA HO，就是叫你落火井食宵夜，總之每晚也有節目。

MB一日一日地迫近，心情也越來越緊張，宿舍的師兄常說一次過合格是容易得很的事，並以自己輝煌的戰績作證，就是測驗從未合格過也能一次過升班，他們更加誤導了我，使我相信讀宿舍內相傳的筆記和一些細書，便能應附考試，於是便趁着「騰鷄花」未凋謝前作最後衝刺。但，爲甚麼「意外」總愛在重要關頭發生呢？差不多隔晚不是胃痛就是肚子痛，我想這可能是生活規律不協調所引起，或者是多吃即食麵的後遺症。又爲什麼人總是自私呢？其他學院的同學考試完畢後，便瘋狂慶祝，夜夜笙歌，在狂歡時又有否想到發出的聲浪極之騷擾別人，特別是那些還在挑燈夜讀的醫學生呢！可是醫學生祇是小數民族，而自己在舍堂中又沒有什麼STANDING，就算在民主牆提醒過，也沒有大的作用，祇好避而遠之。

我要肥皂泡，不過……

沒有良好的準備（包括肉體和精神上），又怎能有良好的成績。重讀，可說是我生命中最大的打擊。不是說宿舍是罪魁禍首，但或多或少，它也有其影响力。同學中，無論往年相處是多投契，現在遇見面，好的還能寒喧幾句，壞的就已成陌路人了。何況已沒住宿舍，接觸少了昔日舍堂內的人和事，已漸漸淡忘，現在又回覆中學時代的生活：考試、讀書、再讀書。如果有人再問我迎新時的問題，我會回答說：「我要肥皂泡。」但實際上，我仍會過着肥皂盒式的生活。夢想中的生活和激情一樣，掌握在手上會化爲灰燼，反然藏在心底裡，可以歷久常新。

澳洲醫療顧問團報告書



澳洲醫療顧問團報告書

背景

早在一九七四年的「香港醫療服務的未來發展」白皮書中，已清楚列明政府的兩個醫療政策，就是①保障及提高一般市民的健康水平，及②保證市民能獲得醫療及個人健康的服務，這點特別包括那些倚賴政府所提供的津貼性，醫療服務的中下層市民。

在這份白皮書發表後的十年裏，醫療服務的確有實在改良和在結構上的轉變。例如在嬰兒死亡率及主要的傳染病方面，都有顯著的下降。醫療服務地區化亦已有限度地體現。一些較大的補助醫院也和府政醫院建立起較強的聯系。

可是隨着生活習慣的轉變、本港人口的疾病模式亦轉向於慢性衰退的類別。而此期間人口增長比預期中爲高，致令醫療服務的需求相應增加。與此同時，醫療服務的成本正不斷上升。「澳洲醫療顧問團報告書」就是在這一個對醫療服務質量的供求轉變的背景下，對醫院服務作出檢討。報告書亦趕及在白皮書發表後十年（一九八五年底）完成。

檢討範圍

八四年十月四日，政府正式宣佈檢討政府及補助醫院的行政和人力調配。八五年二月，政府委託一家澳洲顧問公司，執行這項工作，並提出改進的意見。當時工作小組的檢討範圍，已明確地限於在醫院行政、管理和資源運用上。在報告書的附件中，更清楚列明了八項工作要目：

①研究資助醫院和政府醫院合併管理於一獨立機構的可行性。
②醫院內部行政的改善。
③設法改善現存的醫院擠迫情況
④增加醫院的成本效益。
⑤改善醫院的職級制度。
⑥醫療服務收費問題。
⑦改善醫院內的工作環境。
⑧研究是否需要提供較佳住院服務予一些可負担部份住院費用的中產階級人士。

毫無疑問，香港的醫院服務，一直以來都爲人所垢病。但是一般輿論皆認爲十年一次對醫療服務的檢討，不應單單局限於醫院服務，而忽略了公共衞生及基層健康的研究。雖然報告書指出「現時的醫療服務問題大部份似可與公共衞生加以區分」，但這種處理手法能否解決香港人口的疾病模式轉變所引起的問題，很多人都抱極表懷疑的態度。

內容提要

報告書內容主要分四部份：一、背景資料及統計數字；二、統一醫院管理及醫院內部組織的建議；三、醫院運作的改善及四、財政與經費各方面。

報告書所提的大小八十項建議（見註一）其主要精神就是加強醫院的行政管理及改善資源調配，並且讓地區有參與醫療服務的機會。在改善資源運用方面，提出的建議，包括①改善管理架構，成立中央而獨立的醫院管理局，下設九個分區管理委員會。管理局是獨立於政府架構之外，負責管理所有的公立及補助醫院。其經費來自政府，向政府負責，成員有十二至十五人，經政府委任。管理局將集中處理政策事宜、資源分配和財政預算等問題，而醫務衞生署改而專責公共衞生事務。②管理分區化。報告書建議醫務署之權力下放、重新劃定分區界綫，初期有七個新的分區，港島以瑪麗醫院爲中心；九龍二個分區，以伊利沙伯醫院、廣華醫院和聯合醫院爲中心；新界西部二個分區，則以瑪嘉烈醫院和明愛醫院爲中心。將來，設置兩個新的分區，以屯門新醫院和興建中的港島東區醫院爲中心。每個分區各自設立獨立的本區管理委員會，成員均依指定，是有均衡代表性，包括區內醫院及團體人士和醫院管理局的副主席。每一分區設有一系列的醫院，提供種類不同而互相補足的服務。③加強醫院行政管理。報告書建議在每間醫院，設立行政總監，之下分設總經務主任、總護士長及醫院行政主任，全面負起管理醫院之責任。（見註二）

報告書亦提出建議去增加院方之收入和減低濫用情況。①「自負盈虧」政策，可以維持財政資助的角色，和令各醫院和管理局更着意收支平衡的運作。報告書認爲收費可產生增加收入和減低濫用的情況。報告書建議院方要向有關病人，增收急症室費用（十二元）、入院費（相等於一天的病床費用）、病床費（以成本之百分之三計算），和使用腦掃描機及手術的特別費（每次收費五十元）。經濟有困難者，可以申請減費。②增設乙類病床，吸引中產階層人士，收費方面會較現時的甲級和乙級病床爲低，但較丙級病床之收費爲高。施行一段時期後，收費則以市場價格來決定。③避免醫院擠迫，在急症室以外，增設輪候病房和觀察病房。④准許專科醫生可以私人執業，減少人手之流失。（八六年四月五日楊可凡　信報）

此外，報告書亦提出不少技術性的建議去改善醫院的行政管理如改善護理架構、減少顧問醫生直接負責的病牀數目、成立病床中央組控制病床運用、搞好醫療紀錄系統及搞好成本

控制資料等。

這些建議如急症室收費及地區管理等，已在若干醫院中實行。政府已在報告書完成後，成立了一個策劃委員會，研究何種建議可在作出成立醫院管理局決定前先實行。

各界對報告書的評議

港府於八六年三月二十五日公佈了報告書的內容，徵詢公衆意見。兩局衞生事務小組用了五個月的時間，收集各界人士的意見。到了八月三十一日，即諮詢期結束時，小組共收到九十九份書面的意見。它們分別來自公務員協會、補助及私立醫院職工組織、專業團體、學術界及學生組織、社區團體及個人不等。至於在諮詢期內，報章、電視等傳播媒介亦經常刊載及播出各方的意見。討論的題目主要針對幾方面。一、報告書的局限性問題；二、政府對醫療服務的責任問題；三、醫院管理局的員工服務條件問題；四、收費問題。其中公衆最關注的問題，莫如醫院管理局的成立、急症室及其他醫療服務收費、乙級病床等。在大部份的問題上，各界意見並不一致。（見註三）政府亦在諮詢期過後收集到的民意刊成總結報告供市民參攷。

在醫護人員的角度來看，對我們特別有切身關係的相信是醫院管理局成立後的員工薪酬福利及編制升遷等問題。倘若醫護人員脫離了公務員架構，這幾方面的轉變將會很大。此外，建議中的減低醫生與病人比例、行政總監的設立與及容許政府醫生作有限度私人執業，相信會對醫生的工作、士氣及流動有很大影響。

政府醫生協會及兩大醫學會

關注到這份報告書的重要性，政府醫生協會和兩大醫學會都對報告書的把議作出研究和討論。它們更以問卷形式收集會員對報告書中各項主要建議的意見，並將收集到的意見擬成聲明，向公衆發表。（見註四）

香港大學學生會醫學會的醫療組，除了派發問卷予各同學外，更出版了「醫療專訊」向同學表達他們對告書的意見，並提供一些討論的資料。此外，在諮詢期間醫療組舉辦了三個講座，分別由錢劍輝醫生（聯合醫院院長）討論報告書建議的可行性；黃震遐教授對報告書作出評價與及由理工工商管理系講師阮博文先生探討建議中醫院及病房之管理問題。

醫學會的外務副主席（亦爲醫療組的成員）亦替本刊寫文一篇，發表自己的意見：

「

澳洲醫療顧問團報告書：

澳洲醫療顧問團報告書於三月尾正式發表，其建議主要包括統一補助及政府醫院的醫院服務，設立獨立管理局管理現時的政府及補助醫院。另外報告書亦建議增加部份醫療服務的收費。在報告書發表前後，醫學會醫療組曾作多次的討論及走訪，以搜集各方意見。同時亦舉行研討會，印發單張，出版專訊向同學報導報告書的建議。醫學會更於八月中旬發表有關聲明，反映同學意見。

根據某團體一項條查顯示，香港大多數市民比較關心居住、交通、治安等問題，一般市民並不太關心醫療問題。可是若果從政府於醫療開支上看，它佔政府的總開支約百份之八，而且若果要維持現有的醫療服務，政府還要不斷地增加醫療撥款，對政府做成沉重的壓力。政府一方面不能削減對其他公共開支的撥款，另一方面也不能加稅，因爲這樣會損害香港的經濟。所以政府唯有從制度及用者身上想辦法解決問題。

統一醫療服務能令現時空置的補助醫院病牀重新投入服務。醫院內部組織重整可以減少資源浪費。至於設立獨立管理局，對於收回補助醫院的管理權，增加收費，政府醫院內部重整等問題上，政府可以避免很多麻煩。對於報告書的建議，正符合政府的要求。

無論政府的出發點怎樣，我們也不用去猜測。單從醫療服務看，現時的服務是否已在有限的資源下做到最好呢？有沒有証據証明改革後帶能給我們更好的前途？我們不要被政府或者澳洲顧問所引導錯誤；制度雖然重要，可是制度裏面的人更重要，若果制度裏面的人已發揮了他們最大的功能，我們不要希望改變制度可以增強效率。

另一方面，任何一個制度若果永遠不變，整個制度及裏面的人會疆化，減低其效率。所以筆者並不反對改革，只有轉變才有新的希望，新的發展。可是在改革的過程中，我們不能過份犧牲醫護人員的士氣，同時所加的收費要廣大市民所能負擔。

」黃一華

現在雖然已過了諮詢期很久，而報告書亦已通過，但這並不代表事件已告一段落。反之，報告書的部份建議將會陸續實行。但確實的細節仍未訂出。所以，作爲一個醫學生及香港市民，我們是有責任和必要去留意這個醫療制度的轉變。

建議摘要

這個報告已作出多個特別的建議。這些建議已根據章數（及適用範圍項目）列下，而每一項目均附有其在報告書中的章、節、及頁數，以便參考。

第 1 至第 4 章　　這幾章並無提出建議

第 5 章　　醫院管理局結構

5.4.1　管理局——中央組織

現建議當局應根據一項條例設立醫院管理局，該局應為一獨立的法定機構，負責管理各醫院為本港市民提供的醫療服務的有關事宜。

第74頁

現建議管理局應屬於中央董事局。

第74頁

現建議中央董事局應由十二至十五名成員組成。

第75頁

現建議醫院管理局應設一名全職的醫院服務總監。

第75頁

現建議各副總長均須留駐總部。不過，負責分區醫療服務的副總長則須有調查時間留駐所負責之分區。

第75頁

現建議管理局總部須負責中央管理及各項輔助性質的工作。

第75頁

現建議管理局總部須負責醫院服務的各項策劃工作。

第75頁

現建議兩名（視後可增三名）副總長兼任其中數個分區管理委員會的成員。

第76頁

5.4.2　員工編制及僱用措施

現建議管理局的所有員工均不屬公務員編制，亦由管理局直接僱用條件聘用。

第76頁

現建議實施一項過渡期的措施，從政府部門借調人手往管理局總部任職一段時期（比方說兩年），然後重返政府，與其他員工一起受聘於管理局。

第76頁

現建議所有員工最後都是由個別醫院或小規模醫院集團（而不是管理局）自行聘請。

第76頁

現建議另設一項獨立的職工諮詢委員會，直接向管理局負責，但與政府保持密切聯繫。

第76頁

5.4.3　醫務決策小組

現建議在衞生福利科內加強醫務決策小組的功能。

第77頁

5.4.4 分區計劃

現建議設立新的分區如下：——

最初，新的分區爲

港島——
該分區以瑪麗醫院爲中心

九龍——
該分區以下列三間醫院爲中心
(甲) 伊利沙伯醫院
(乙) 廣華醫院
(丙) 基督教聯合醫院（連同擴建部份在內）

新界東部——
該分區以威爾斯親王醫院爲中心

新界西部——
下列兩間醫院爲兩個分區的中心
(甲) 瑪嘉烈醫院
(乙) 屯門醫院（可能包括目前九龍區西北部的某些部份，如荔枝角、長沙灣及深水埗區。）

其後，將設置兩個新的分區並以下列兩間醫院爲中心
(甲) 位於屯門的新醫院
(乙) 建議中的港島東區醫院（在過渡期間，這個分區還可能以東區尤德夫人那打素醫院爲中心）。

第77頁

現建議每個分區應各自設立獨立的本區管理委員會，而醫院管理局副主席須爲其成員之一。委員會的成員均經指定，具有均衡的代表性，本區內的醫院及居民均包括在內。

第78頁

現建議每個分區應設有一系列的醫院，提供種類不同而互相補足的服務。管理局方面應就建議所通過的工作及任務制訂大綱，而有關細節則交由分區管理委員會負責。

第78頁

5.4.5 特別分區服務

現建議不應佈有一間或以上的完善中心提供某些高度專門服務，如心臟病科、腫瘤科及腦部外科。

第78頁

第6章　醫院內部組織

6.7.1 行政總監及高層管理

現建議設立一名行政總監全權負責每間大型醫院的管理。

第97頁

現建議在行政總監下另設一名負責醫療護理服務的總主任醫生，一名負責護理服務的總護士長及一名負責酒店服務及行政的總院務主任。

第97頁

6.7.2 病人護理單位的管理

現建議各醫院應正式考慮清下每個病人護理單位的管理體系和對其所負的責任，並決定每個單位內負責管理資源的人選。

第97頁

6.7.3 醫療服務的管理

現建議總主任醫生在管理，提供及計劃醫療服務方面須向行政總監負責。

第98頁

爲了促進專業責任及提高病人護理的水準，現建議在普通的內科及外科病房中，每名顧問醫生所護理的病人應減爲60至80名。

第98頁

現建議每個顧問醫生單位負責護理60至80名病人，其典型體系如下：
——一名顧問醫生
——一名高級醫生
——三名醫生
如有需要，還可增設駐院實習醫生和非駐院實習醫生。

第99頁

現建議把工作相同的單位合併爲正式的功能科，由該科的主管統領。

第99頁

現建議每組應由數個部門組成。

第99頁

現建議總主任醫生應有一名副手，該名副手最宜爲聯合醫療服務組的主管，因爲該組目前擁有醫療有關的專業人士及醫療紀錄。

第99頁

現建議各醫院採用一個醫療紀錄單位制度，並提供足夠人員爲該制度工作。

第99頁

6.7.4 護理服務的管理

現建議由總護士長全面負責管理多個病人護理單位。

第99頁

現建議設立多個高級護士長職位，負責專科的護理工作。

第100頁

現建議總護士長在醫院資源分配，發展病人護理服務的財政預算，醫院的功能和建築設備等各方面，提供護理方面的意見。同時並建議由總護士長負責從護理立場，就醫院的政策及運作方法提出改善的辦法。

第100頁

現建議由總護士長負責所有與護士訓練和職業發展有關的工作，包括專業上的與管理上的在內。

第100頁

現建議有關當局應積極考慮特別爲病人護理單位的護士提供非具有醫學資格的行政協助。

第100頁

6.7.5 酒店／行政服務的管理

現建議由總院務主任負責提供及籌劃酒店服務，及負責室務辦公室和保養上的工作。總院務主任應向行政總監負責。

第101頁

現建議將醫院行政分爲四大主要範圍，分別由四位適合及富於經驗的人員負責。

第101頁

註一

現建議在大型醫院內工作的符合資格的及富於經驗的財務及會計人員，職務上雖向總部負責，但行政上仍受高級院務主任管理。

第101頁

現建議由總院務主任負責部分的醫院資源分配和財政預算工作，以及就醫院政策、個案性質與醫護服務、資料和管制系統各方面，提出改善的建議。

第102頁

現建議由總院務主任負責組織及管理醫院行政功能的發展，以確保行政人手調配得宜，人盡其才以及職員的管理能力得到發展。

第102頁

6.7.6 職員的委任

現建議除高級行政人員外，所有職員均由院方聘請，但須獲得分區管理委員會的同意。

第102頁

第7章 緩和過度擠迫的情況

7.6.1 急症室服務的增加及改善

現建議各間分區醫院的急症室均應提供二十四小時服務。

第112頁

7.6.2 在醫院接受治療但毋須正式入院的病人

現建議在急症室鄰近加設額外觀察病床以供毋須正式入院的病人使用。

第112頁

現建議急症室應有二十四小時的病理及放射服務作爲有效的支援。

第112頁

現建議所有急症室均應設有適當的石膏室及備有石膏技工。

第112頁

現建議分區醫院應提供日間外科服務。

第113頁

7.6.3 應在急症室提供足夠符合資格的人員

現建議急症室的人員編配方法，應根據目前醫務發展諮詢委員會所訂立一位醫生應在八小時內診治三十名病人的標準。

第113頁

7.6.5 醫院內各單位病人的更佳分配方法

較早之時關於推行一項在接受病人入院的臨床決定作出後，將病人編派至院內各單位的制度的建議，獲得推薦。

第113頁

7.6.6 在醫院制度內更多將病人轉換病房

現建議應作出更多努力，以確保可儘快將病人從急症病房轉往康復病房。

第113頁

現建議有過度擠迫情況的分區醫院除設立觀察病房外，亦應設立容納最多病人的病房。

第113頁

現建議如分區醫院收容能力已無空置病床，則隨後需入院的病人，在收症前應予檢查，並加以診治，然後須與醫生或總主任醫生磋商安排將該病人直接由急症室送往其他適當的醫院。

第113頁

7.6.7 採用一個獨立的監管程序，以確定的標準來量度病人住院期間的長短

現建議管理當局應採用一種住院期指數的方法。

第114頁

第8章 工作環境

8.5.1 改善員工資源的利用

現建議應對新管理當局內各級員工的角色和關係作更清楚的界定和確認。

第133頁

現建議應減少現時部分駐院醫生的臨床診症工作量。

第133頁

現建議在可能情況下，某些和病人直接接觸人員應將某些職責或僅需較低資歷而可勝任的人員負責。

第134頁

現建議管理當局應研究應否採用各種已證實有效的方法去對病人護理質素和員工工作量作客觀的衡量，並將這些制度分期實施。

第134頁

現建議新管理當局的人手編制及僱用政策（如員工諮詢委員會所擬訂者）應盡可能靈活，以確保可以有效地運用會有技術和合資格的人員。

第134頁

8.5.2 減少在高峯時期對醫療及病人護理服務的需求所帶來的影響

對於前述第7章內就減少醫院內擠迫情況而提出的所有建議，我們均予推薦。

第135頁

對於前述有關改善病情記錄系統的建議（6.7.3），我們均表贊同。

第135頁

現建議爲進行所設寫的人手編制（包括長期的訓練需要）而制訂的詳細計劃，必須將突然增加的新職員的要求，減到最低。

第135頁

8.5.3 改善溝通

現建議管理當局應找出適當的辦法使病人與員工可循正式及非正式途徑互相溝通，隨即將這些辦法引進及予以實踐。

第135頁

現建議爲符合進行中的醫院內部組織改革，管理當局應爲改善員工之間的關係而制定程序和提供機會。

第136頁

8.5.4 每間醫院發展個別宗旨及特色

現建議鼓勵每間醫院確立自己的理想發展自己獨特的地方，以別於管理當局轄下整個醫療服務組織內其他與之相輔相成的醫院。管理當局應每年在收支預算內預留一筆款項（數目不大的款項）供作此用途，由各醫院的行政總監決定如何分配使用。

第136頁

8.5.5 改進教學及研究設施

現建議將醫科學生的教學擴展，在建議中的管理局屬下的一些分區醫院辦理。

第136頁

第9章　醫院人員的編配

9.5.2 醫務發展諮詢委員會計劃比率

現建議醫務發展諮詢委員會現時提出的計劃比率（例如(一84/5號文件"醫生供應問題檢討"文附錄II）應作爲目標，即使短期內實際上未必能達成。

第146頁

現建議管理局應選擇一些主要的比率（與醫生、護士和其他醫療專業人員有關的），定期(例如每年一次)公佈當時的情況，並對實現所訂目標的進展作出評論。

第146頁

現建議醫務發展諮詢委員會比率應予以適當的修訂，並須顧及對不同類別的病人護理及醫療專科的需求是否有所改變，並顧及管理制度實際上是否有能力去滿足這些需求。

第146頁

9.5.3 改變服務條件的辦法

現建議應向經挑選的資深醫生提供合約僱用及／或部分時間僱用的安排。

第146頁

現建議在新的管理局內推行一個新制度，使專科醫生能有限度地作私人執業。

第146頁

9.5.4 客席醫生（私家醫生在管理局轄下醫院診病人服務）

現建議應計劃一個制度，容許私家醫生在公立醫院提供有限度的服務，但這計劃只能在容許管理當局轄下醫生作私人執業的計劃運作令人滿意後，才付諸實施。

第146頁

第10章　成本和成本控制

現建議應優先根據新的組織安排訂定有效的資源分配方法。

第156頁

現建議現行的預算制度應包括服務成果的部分，證明所用的金錢是用得有價值，這制度應集中應用於主要成本項目。

第156頁

現建議進一步擴大會計財務資料系統以確定醫院內需特別注意的主要成本項目。

第157頁

現建議在新的組織體制內，分組及部門主管應負責確保其管轄下的資源獲得充分而有效的使用，因此主負責其管轄範圍內的成本控制。

第157頁

現建議應向負責的管理部門提供成本資料，列出實際的成本與標準的比較。

第157頁

現建議應將醫務發展諮詢委員會的標準，在護理及醫療人員的主要程序項目內用作成本控制的標準。

第157頁

現建議在沒有獨立標準的地方，採用內部推算的平均標準，以供監察營運工作表現之用。

第157頁

現建議應將機構內部互相檢討的制度，擴展至成本管理範圍。

第157頁

第11章　成本收回及較高級病房

11.4 收費建議

現建議每床每日標準收費的計算基礎應加以改變，即將目前以膳食成本計算的基礎擴大。

第170頁

現建議應向往急症室就診的病人收費，款額相當於專科診所的診費。

第170頁

現建議應收入院費，以彌補辦理病人正式入院手續的行政費用。

第170頁

現建議應收取一項費用，以彌補使用全身電腦掃描機檢驗和使用手術室等主要治療程序所需費用。

第170頁

11.6 有關較高級病房的建議

現建議應全面改變病床的分類法，並提出「乙」級病床的概念。

第174頁

現建議應進行一項調查，研究有關「乙」級病房的可能市場。

第174頁

現建議應進行兩個試驗性計劃，一個在港島實施，另一個在九龍實施，而其中一個在政府醫院推行，另一個在補助醫院推行。

第174頁

11.7 有關健康保險的事宜

現建議倘若試驗性計劃推行成功，私營機構在遵循政府訂定的守則的情況下，應積極參與提供保險服務。

第176頁

對報告書概括的評論：

（論政團體「香港政策透視」 8.8.86）
—令政府將醫療責任轉嫁市民承担。
—提供不全面。
—不能忽略醫療服務的社會意義。

（各界關注醫療政策委員會：11.6.86 新報）
—報告書把醫療服務不足問題，簡化爲管理不善，是不正確。
—報告書傾向在市民身上直接收取若干成本，令市民百上加斤。
—報告書的提議，要有充足資源下才能成功，但目前未有。

公共醫療私營化→政府可減少長俸公務員數目。
（14.12.85 信報 H.S.）

只就「醫療服務」作檢討，對政府的責任角色、人手訓練不理，太片面
（曾展原 中 H.S.）

（醫務署員工大聯盟：25.6.86 華）
—缺乏全面檢討，只限於醫療行政管理。
—只提及醫生、護士和行政主任。
—醫管局只是變相的醫務署。

（香港工會聯合會社會事務委員會：28.6.86 華、文滙）
反對：理由—只檢討醫院管理，太片面。
—增加病床才是最好的方法
—提高醫療服務質素爲主要

（基督教聯合醫院高級行政主任 鄭儀恒 15.4.86 文滙）
-對於報告書的建議（如改善醫院內部管理、整理govt's & subvented hospitals 之間距離），大體上可接受

（城市論壇 7.4.86）
黃震遐（香港醫療論壇會員，太平山學會會長）
—只集中醫院運作，忽略有關門診服務。
李志輝（香港政策政治代表）
—沒有解釋醫療成本上漲原因和貨源少的原因，所以不知改革可行與否。
周美德（政府護理人員協會主席）
忽略社康護理。

1）報告書沒有觸及整體政策，只能就醫療所提供的服務作出檢討，對其他 e.g. 門診、社康護理 etc 沒有提及。
2）提出的成本收回建議並不能解決基本的問題。
沒有對本港的醫療衞生服務定下長期政策。
（9.4.86 大公）

報告書的整個主體精神，是公家逐步卸責，市民負担逐漸加重，是醫療福利的倒退。
（14.4.86 港時、社論）

報告書提供頗爲適合收費，絕非使窮困人士不能獲得公平醫院服務。
報告書使大型醫院中過度使用設施能發揮更大效用。
報告書沒有建議公立醫院私營化。
（盧保庶 16.4.86 明報）
建議的自負盈虧，無異是變相私營化
（香港政策透視 李志輝 1.4.86 星島 H.S.）

報告書欠全面，只集中於統一醫療制度
（29.6.86，滙點社會政策委員會）
只檢討了醫院服務，忽略了醫療服務的其他方面

現在所擁有的不足以應付未來的挑戰，e.g. 癌症：不能單在醫院進行。
（駱元 香港醫療論壇成員 24.5.86 信報）

「公立」轉爲「公營」——設立醫療管理局

正方

（樂富青年關社聯委會）
—使補助和政府醫院服務水準劃一。
—允許更佳資源調配，如病床。
—使僱傭制度更趨靈活。
—管理局及各分區醫院委員會有更廣泛人仕參與。

管理局可以開源（e.g. 募捐、籌款）節流，靈活性比現在強。
（駱元 21.4.86 信報）

醫務人員和地區人士對醫療服務的參予感可提高。
（楊可凡 26.4.86 信報）

管理局能增強資源及人手調動的靈活性
（准許在醫院工作的醫生有私人診症的機會）
專科門診 X-ray etc 增加夜間服務。
須要有好的監管系統，定期檢討醫院的資源運用和收支情況。
（25.4.86 中 HS）

要向立法局負責
（26.4.86 楊可凡 信報）

贊成 but 1）政府要有效監管
2）政府撥款不少於現在。
3）若部份服務收費，老弱傷殘，貧苦市民應得到適當照顧。
4. 政府應正確指導市民使用急症室方法和提供其他選擇。
5. 檢討沒有包括門診和基本保健服務表示遺憾。
6. 政府應檢討一套全面和適用於香港的醫療政策。
（中西區區議員 11.6.86 新）

贊成，在實行時要考慮管理局成員的代表性及積極性
（吳崇文）

爲使醫管局更能向公衆交代可
1. 遇到重要的政策建議時，應公開諮詢民意。
2. 可出版週年報告。
3. 醫管局可舉辦公開論壇。
（滙點楊森 29.6.86 華僑）

提供靈活架構，以適應未來需要，能增強醫療界和各有關團體對服務發展及管理的參與，容許市民監察，並能統一醫療服務。，不致令目前架構再度過份膨脹臃腫。
1. 責任承擔（權力下放，由了解實情的人承擔）
2. 財政自主（開源節流）
3. 人事組織（脫離公務員死板條例，方便提高效率）
4. 服務發展（開展社區健康服務）

（駱元 24.5.86 信報）

反方

各醫院各自爲政，用本身設備、醫生聲望和條件去爭取發展。
病人拒絕轉往比較「冷門」的醫院，醫生亦選擇有名的大醫院。 ⟶ 名院更擠迫，設備差的則更冷清，資源運用更不平均。

（2.2.86 信報）

醫療服務由市場價格調節→加重市民負担。
政府或會減少撥款，把責任全推到管理局身上。
（駱元 21.4.86 信報）

各區醫院或會壯大自己而努力擴張→惡性競爭
管理局權力過大，過份重視醫院而忽略其他服務（e.g. 門診及健康教育）
（25.3.86 中HS）

打擊原有公務員士氣
統一兩類醫療人員→降低政府公務員的福利。
（26.6.86 中）

—在「自負盈虧」下，若政府資助不夠，決定市民能否獲到服務便不再因病況，而是由市場現律（如金錢）來做主。
（曾廣源 中 H.S.）

（陳華 16.4.86 中報）
—私營化不利於市民需要。
—私營化略整體社會需要。
—私營化打擊員工士氣，影響服務質素。
—私營化使貧困者的情況更劣，因較好的設備已給了富裕者。

（香港政策透視 1.4.86 明報）
—積極爲政府推卸責任。

（關注政府醫療制度委員會（2.4.86，文滙）主席鍾正卉）
—非公務員化可能令醫院主管獨攬大權，令員工不敢公開批評。

醫療服務收費（e.g. 手術室，急症室）

正方

減少浪費，令接受服務之人士，三思應否運用（避免濫用）
（楊可凡 26.4.86 信報）

可行但 1) 考慮對老弱篤殘人士
2) 收費得益，歸還醫療服務應用。
3) 確保質素可改進。
（吳崇文 明報）

（香港工會聯合會社會事務委員會 28.6.86 華）
除急症室外，可行但要清楚界定收費的準則和服務對象。

急症室收費是開源其一種途徑。（林鉅成）

贊成急症室收費，可減少濫用（社聯主席周永新）

反方

不支持急症室服務收費的建議。
政府應加強夜診服務，教育市民使用急症室的常識。
（香港政策透視 黃昌榮 2.4.86 華僑）

支持急症室收費，但必須考慮到沒有付款能力的人能享用此服務及會否因收費而影響求診者的生命安全。
政府應盡量開設24小時診所服務。
（立法局議員招顧洸）

基本上贊成，但政府要照顧貧病市民。
（東華三院護理人員會 29.6.86）

行政費不少（e.g. 找人計算成本，監督收費 etc）
（駱元 21.486 信報）

增加收費不能防止濫用，因市民缺乏醫療知識
（曾廣源 中 H.S.）

急症室收費不能防止濫用，因問題是門診服務不足。
（香港工會聯合會社會事務委員會 28.6.86）

急症室收費，理由不充份：
1) 不能造成阻嚇作用。
2) 急症室未被濫用，反應加強門診服務。
（14.4.86 港時，社論）

收費不能解決急症室濫用；因
1) 83-84 年度，非急性病人使用急症室只佔 8-10%，濫用情況不嚴重。
（香港政策透視 1.4.86 明報）

急症室服務收費違反自然公正原則，亦帶來行政上的問題，不應因防防止一小撮人士濫用，而犧牲其它有需要的人士。
（周美德 政府護理員協會主席）

乙級病床

（樂富青年關社聯委會）
—只向補助醫院和新建醫院發展。
—每所醫院內甲乙丙病床應有固定比例。
—如要改比例，要管理局同意。

（吳崇文（中西區區議員，太平山學會會員）12.6.86 明報）
—政策沒有考慮過究竟政府對中等階層有何意向、有何責任。
若政府資助這病床→私家病床不能與之競爭→市民缺乏選擇。

（香港工會聯合會社會事務委員會：28.6.86 華）
將三級病床改爲乙級，不能解決病床缺乏。
（香港政策透視 1.4.86 明報）
—建議的「乙級病床」收費和私家病床差不多，大眾難以負担，需求不高。
—設立此等病床拖慢三等病床的擴展。

懷疑「乙」級病床的需求，同時懷疑醫療保險是否一般中等人息人士所能負担，過份樂觀和不切實際（～4,000）。

「乙」級病床使醫院增加收入，爲未來醫院獨立經營和自負盈虧鋪路，拖慢三等病床增長率，亦造成公立及私家醫院競爭。
（2.4.86 H.S. 華僑 黃昌華、麥志輝 香港政策透視。

其他問題／提議

（樂富青年關社聯委會）
1. 護士在何種情況下及如何協助醫生處理一些簡單的內外科病；
2. 各席醫生扮演的角色、工作範圍沒有詳細交待。
3. 醫院管理局的人選如何產生及議席比例如何。
4. 興建新醫院費用要來自政府福利開支而不是收費所得的利益。
5. 各區內應增設適量的「特別專科服務」

港府對醫療的撥款應要是資助而不是「借貸」
（楊可凡 26.4.86 信報）

(1) 容許顧問醫生收取自己病人：
須要嚴謹監察制度及限制病人數目。
(2) 防止市民過度集中使用某間醫院→資深醫生同時服務區內多間醫院。
（20.6.86 中灣仔區議員張敏標）

建議設立「工業病床」，並提高收費：增加中等階級市民的負担→不合理。
（14.4.86 港時，社論）

容許顧問醫生有私家病人，增加護士困難和引起誤會
反對削減護士脫離公務員編制後的福利
同意增設24小時急症服務和設立觀察病房。
（東華三院護理人員會 29.6.86 華僑）

政府醫生協會聲明及問卷內容

SUBMISSION ON THE AUSTRALIAN CONSULTANCY'S REPORT ON THE DELIVERY OF MEDICAL SERVICES IN HOSPITALS

Introduction

1. Owing to the report's potentially far reaching impact on patient care, the community and the health professionals, the Government Doctors' Association (GDA) views the Australian Consultancy's Report with great concern and importance.

2. In February 1986, the GDA Council set up a special sub-committee to look into the report. 9 meetings were held with detailed discussions on the report including devising plans to solicit the views of Government doctors and drafting of a questionnarie. 4 open forums were organised in April and May 1986 at the four regional hospitals (QEH, QMH, PMH, PWH). The Council attended a Special Grade Consultative Committee Meeting with the Department and met twice with the Hong Kong Medical Association's Council to discuss the report. Two of our council members were invited as speakers at the Hong Kong Medical Association's open forum. A special issue of the Newsletter was published in early July and a questionnarie was sent to all government doctors to gather their opinion.

3. Our submission is based on opinion collected in the various meetings, debates, forums and the questionnaire survey.

ON INDEPENDENT HOSPITAL AUTHORITY (IHA) AND INTEGRATION

1. We concur with the Australian Consultants' observation about the many problems facing the medical and health services such as, amongst others, inadequate funding in the face of rising public expectation and escalating health expenditure, inflexibility of the civil service, overcrowding in major Government hospitals and under-utilisation of subvented beds. We also agree that there is need for greater autonomy for the services. However, we have much reservation about the establishment of the IHA as recommended in the report.

2. 66% of the respondents to our survey objected to the establishment of IHA (32% agreed). The major concerns are:—

   (1) The report is restricted by its terms of reference. The artificial segregation of the whole service into a Hospital Authority and a Health Authority is one of the drawbacks of the report. General outpatient service and other clinical services like mental health services, chest clinic, etc. should also come under the wing of the Hospital Authority.

   (2) While we agree with the upgrading of subvented hospitals so that their occupancy and efficiency can be improved, it must not be done with a sacrifice of current Government staff. It is stated in the report that future fringe benefits for Authority staff should be 60% of that now enjoyed by civil servants. We strongly oppose this. It is extremely difficult to envisage how the staff could accept anything less than 100%.

   (3) The report made no mention of increase in funding and improvement in facilities of Government hospitals. As all regional Government hospitals are overcongested and their staff overworked, we must remember that they too, need increase in funding, staff and equipmentto improve their services to the public.

   (4) As we understand, the Government is experiencing difficulty in dealing with subvented hospitals (e.g. concerning charges and bed utilisation) despite the fact they are largely funded by public money. Will the subvented organisations be willing to give up the control of their hospitals?

   (5) There is uncertainty whether the proposed reform will bring about any real improvement in the service.

   (6) There is fear that the new structure may create more bureaucracy.

If, however, the Government eventually decides to set up the IHA, we maintain that:—

   (1) The Government must reaffirm its commitment to shoulder full financial responsibility for the medical and health services.

   (2) Serving officers must be given an option whether or not to leave the civil servie. For those who remain in the Government, their promotional prospects and projected benefits must in no way be compromised (91% of the questionnaire's respondents indicated there must be an option and 75% indicated they may choose to remain with the civil service).

   (3) There must be assurance that in future, the terms of service will not be worse than now and there must be no cut in fringe benefits.

   (4) As one of the major causes of overcrowding is shortage of hospital beds (the MDAC target of 5.5 beds per 1000 population is not yet reached), the IHA should not be an excuse for building less or deferment of building new hospitals. They should continue to be built as and when needed.

   (5) There should be professional staff group representatives on the IHA board.

(6) An independent commission should be appointed to oversee the implementation of the Consultants' recommendations and the setting up of the Authority.

ON REGIONAL BOARD

1 The number of proposed regions is excessive. We have reservation about the need for two separate regions given the close proximity of Princess Margaret Hospital and Caritas Medical Centre. As each region will have a separate board and administrative support, this may cause duplication and wastage of the scarce financial and human resources.

2. In the regional boards, the number of members directly involved in hospital management should exceed those who are not directly involved. While we welcome public involvement and scrutiny, at the regional level, we feel that it is in the interest of the public that the professionals should have a leading voice so that the hospitals can be administered efficiently.

3. There should be staff representation on the regional boards.

4. All regional hospitals should play a role in the teaching of medical students and the post-graduate training of doctors. Allowance should be made in manpower and facilities for this purpose. Service, training and teaching are all inter-related and are necessary to maintain the standard of medical care. Segregation of regional hospital into teaching and non-teaching would create the undesirable situation of having two different standards of hospital.

ON INTERNAL HOSPITAL ORGANISATION AND WORKING ENVIRONMENT

1. The future Chief Executive must be medically qualified. Only a medically qualified person can fully understand the special needs of the patients and the health professionals so that a high standard of patient care can be maintained. He should also be one with training and skill in management so that as leader of the team, the hospital can be run smoothly and efficiently (87% of respondents insisted the Chief Executive should be medically qualified).

2. If the future "Chief Executive" has the power of "fire and hire", there must be adequate safeguard against unfair dismissal. It may be more appropriate for this power to be vested in the regional board or above (81% of respondents opposed to vesting this power in the Chief Executive).

3. At the appropriate levels (e.g. SMOs or above), doctors should also receive training as managers to promote management sense and skill.

4. While we fully support the creation of more senior posts and the recognition given to subspecialisation, the proposed rank of "Junior Consultants" is unacceptable. If the current senior medical officers are recognised to be doing a consultant's job, the remuneration and status should follow accordingly - we maintain that all new Consultants must be appointed at the existing D2 level (75% of the respondents opposed the proposed "Junior Consultants").

5. As doctors are ultimately responsible for the well being of their patients, they should control the admission of patients to wards rather than the nurses. It is inappropriate for nurses to challenge admission. This is not in the interest of our patients and may have medical-legal consequences.

6. The Consultants' recommendation that a typical unit of 60 - 80 beds should be staffed by:-
   1 Consultant
   1 Senior Medical Officer (SMO)
   3 Medical Officers (MOs)

is not even up to present MDAC standard (this set-up is opposed by 80% of the respondents). With this level of staffing, it is difficult to envisage how the unit can function properly and maintain a high standard of patient care. In our opinion, a unit of 60 beds must have at least:-
   1 - 2 Consultants
   2 SMOs
   6 MOs

7. The employment of more non-professional staff to relieve doctors from work the nature of wich does not require a doctor's training, so that they can concentrate their valuable time and energy in attending patients, is strongly endorsed. This should be implemented now.

8. The proposed right of limited private practice should extend to SMOs or above. However, to ensure the success of this scheme, there should be careful monitoring and clear guidelines have to be laid down. The percentage of remuneration to be retained by the individual doctor should be agreed upon. The rest of the income should go to a hospital fund with access by all levels of staff for the purposes of continued education, research, purchase of journals and equipment, etc.

9. Computerisation of the medical records should be seriously considered. This will improve the continuity and efficiency of patient care. Moreover, only with a proper system can we generate meaningful statistics for epidemiological data and for formulation of health care strategy.

ON OVERCROWDING

1. The MDAC recommendations in reducing overcrowding are strongly supported and should be implemented as fast and as far as possilbe. They are:-

- to redistribute beds among disciplines ;
- to employ additional supporting staff and facilities to assist the Accident and Emergency (A. & E.) Department;
- to encourage tighter supervision and more guidance for junior A. & E. staff;
- to perform more minor operations in the A. & E. and outpatient departments;
- to redesignate more non-regionalised beds in subvented and district hospitals to the regionalised system.

2. "Central bed availability unit" and "Admission Officers" are not practicable in the present setting. This will create practical difficulty and chaos for the doctor if one's patients are scattered all over the hospital. Moreover, different types of patients may require different nursing care and it would not be appropriate to mix, say, medical and surgical patients in the same ward.
3. Overflow wards will not be able to perform their intended function in light of the severe congestion in major Government Hospitals. In most instances, patients admitted to an overflow ward cannot be transferred back to the regular wards because of the severe overcrowding There are already in existence such wards in some Government hospitals which are actually utilised as regular wards.
4. The transfer of patients from the A. & E. Department of one hospital directly to another hospital if the former is full is impractical and is unlikely to be accepted by the public. There may be medical-legal implication if the patient's condition changed during the transfer. Besides, all regional hospitals are already overflowing with patients.

5. To reduce overcrowding, efforts should also be directed at looking into the adequacy of our outpatient services and after-discharge care. Do we hace enough community nurse services, convalescent beds and infirmaries?

ON CHARGES AND HIGHER CLASS ACCOMMODATION

1. We endorse the philosophy of changing the basis of hospital charge from the cost of food to a percentage of the cost of hospital bed maintenance (agreed by 78% of respondents).

2. A reasonable and affordable charge for services is acceptable. However, instead of itemising the charges, it may be simpler and more acceptable to the public to have a basic charge which will cover all the investigation and procedures.

3. Revenue raised should go back to the medical service and not Government general fund.

4. The poor and needy should be taken care of. Those who cannot afford to pay should be exempted from payment.

5. Charge for Accident and Emergency (A. & E.) attendance (HK$12) is acceptable; this is not to stop people from going to the A. & E. Departments, but rather, a charge for service rendered.

6. We endorse the setting up of B class beds but they should not be created at the expense of C (third) class beds.

7. Charges for B class beds should be set at a level so that the public subsidy for a B class bed must not be more than that for a C class bed.

Conclusion

That the majority of staff is not agreeable to the establishment of the IHA is understandable. The report has failed to convince them that this major change in structure will bring about better service and improved working conditions. Moreover, a lot of the details and actual mechanics of change were not discussed. Nonetheless, this Review has drawn the attention of all sectors of our society and provided an unique opportunity and forum for us to discuss the many problems facing our medical services. We earnestly hope that the Government's final conclusion will bring about better patient care and significant improvement to the medical services in Hong Kong.

DR. BELL TSE
Chairman
The Government Doctors' Association

RESULTS of the GDA QUESTIONNAIRE on the WD SCOTT REPORT

TOTAL RETURN = 400

RESULTS of Part I

The Consultants recommend the setting up of AN INDEPENDENT STATUTORY HOSPITAL AUTHORITY, (IHA) outside the civil service to manage the government and subvented hospitals with the staff of all hospitals eventually having common terms and conditions of employment and a separate Health service body within the government.

Do you AGREE? YES 127 (31.7%)
NO 266 (66.5%)
NO RESPONSE 7 (1.8%)

If you do not agree to the setting up of this IHA, which of the suggested option would you endorse?
(ref WD Scott report section 4.A.1)

Please choose one of the following options and circle the number

1 A strengthened CURRENT STRUCTURE.(30%)

2 The Department controlling the government and subvented hospitals directly with the staff of the SUBVENTED HOSPITALS IN the CIVIL SERIVCE. (38%)

3 The Department controlling the government and subvented hospitals directly, but with the staff of the SUBVENTED HOSPITALS remaining as they are, OUTSIDE the CIVIL SERVICE. (13%)

4 The Department controlling the government hospitals and A SEPARATE AUTHORITY being established TO CONTROL the SUBVENTED HOSPITALS whose staff continue to be employed OUTSIDE the CIVIL SERVICE. (17%)

5 Other suggestions: (2%)

RESULTS OF Part II

At this stage, we do not know how far the WD Scott report will be accepted, nonetheless there are recommendations made by the consultants that can be implemented irrespective of the establishment or not of the independent hospital authority. For this reason we would like to know you views on these issues IRRESPECTIVE of your choice in Part I.

A With the estalishment of the IHA

A.1 Do you agree that serving officers MUST be given the option whether to stay within the civil service? YES 92% / NO 6%

A.2 Would you choose to stay within the civil service?
YES 77% / NO 15%

A.3 Do you agree with the composition of the IHA board?
YES 31% / NO 60%

A.4 Do you prefer more medical profession representation on the IHA YES 95% / NO 3%

A.5 Do you prefer the hospital and general out-patient services to be under the control of the same body? YES 90% / NO 7%

A.6 Do you accept the fringe benefits of the IHA staff to be at 60% of the present level? YES 7% / NO 90%

A.7 Do you agree that '.... the numbers of those involved in the management of the hospitals should be slightly exceeded by those not directly involved 'in the regional board?
YES 28% / NO 56%

A.8 Do you insist to have medical staff representation in the regional board? YES 94% / NO 3%

B At the hosital level:

B.1 Do you prefer employment at the individual hospital level?
YES 29% / NO 66%

B.2 Do you endorse the proposed system with a Chief Executive (CE) supported by Chief Medical Officer (CMO),
Chief Nursing Officer (CNO),
and Chief Hospital Administrator (CHA)?
YES 57% / NO 39%

B.3 Do you INSIST the CE to be medically qualified?
YES 87% / NO 11%

B.4 Do you agree with the Consultants' recommendation that a typical unit of 60-80 beds should be staffed by
1 Consultant, 1 SMO and 3 MOs YES 15% / NO 82%
(ie a total of 5 doctors to take care of 60-80 beds)

B.5 If your answer to B.4 is No,
Which of the following staffing structure do you think will be more suitable for a unit of 60 beds? (choose one)
a 1 consultant, 2 SMOs, 6 MOs (39%)
b 2 consultants, 2 SMOs, 6 MOs (24%)
c OTHER suggestions: (19%)

B.6 Do you endorse the Consultants' recommendation to create a new rank of 'Junior consultants' whose salary shall have no significant difference with the present SMOs (ie Master Pay Scale point 48 to 51) and who shall have 'limited rights of private practive' and portion of the income thus derived shall help to bring their renumeration up to the present D1 level.
YES 21% / NO 75%

B.7 If your answer to B.6 is No,
which do you think is the suitable salary point for the newly created consultants? (choose one)
D1 (35%) / D2 (34%) / D3 (3%)

B.8 Do you agree that the CE should have 'hire and fire' power?
YES 13% / NO 81%
If no, this power should be at regional board level? YES 36%
at IHA board level? YES 50%

B.9 Do you agree that nurses should be ward managers and have authority to challenge admissions?
YES 8% / NO 89%

C On 'limited rights of private practice'

C.1 Do you agree that 'limited rights of private practice' for IHA consultants should be extended to the SMOs?
YES 68% / NO 28%

C.2 Do you think the setting of a limit to the income from this 'limited private practice' at 25% of salary as appropriate?
YES 31% / NO 53%

C.3 If you answer to C.2 is No,
you think the more appropriate % should be: (choose one)

(30% / 40% / 50% / 60% / 70% / 80% / 90% / 100%)
RESULTS: 2% / 5% / 22% / 1% / 1% / 2% / 0% / 17%
50% IF THE RETURNS DO NOT COMMENT ON THIS ITEM.

C.4 Do you accept as an alternative to having the 'limited rights of private practice' to have a 25% increase in salary (which would mean a mere 3% increase of the overall medical staff cost)?
YES 54% / NO 37%

D On the future medical service

D.1 Do you endorse the philosophy of changing the basis of hospital fees charge from the cost of food to a percentage of the cost of hospital bed maintenance? YES 78% / NO 19%

D.2 Do you endorse the policy of charging for 'major procedures' (eg. CT scan, Surgical operations.....)? YES 75% / NO 23%

D.3 Do you endorse the setting up of B class beds?
YES 68% / NO 29%

D.4 Do you think the following suggested benefits of the proposed system are reasonable prediction?

1. better patient care YES 19% / NO 51%
2. better utilisation of existing beds and thus less overcrowding
YES 50% / NO 42%
3. the building of new hospital beds can be deferred
YES 11% / NO 81%
4. staff will be retained in the service YES 32% / NO 61%

D.5 The scope of review of the Australian Consultancy Report is on Delivery of Hospital Medical Services only, do you think that there should be a separate look into the general OPD and rehabilitation services? YES 85% / NO 7%

註四

中大學生會醫學會聲明及問卷內容

（甲）檢討範圍

香港社會不斷地進步，隨著經濟的發展，教育與生活水平的提高，與及疾病模式的轉變，現行的醫療服務已經不能符合香港社會的需要。故此，我們認爲醫療服務改革是必須的。

我們認爲政府沒有一套完整的醫療服務政策，以致基層健康服務、政府和補助醫院服務不足（註一），所以，我們建議政府需要在現階段訂定一套完整及長遠的醫療服務政策。

（乙）獨立醫院管理局問題

我們認爲政府必須直接負起照顧醫療服務責任，同時保証承担醫療服務的開支。基於以上兩個原則，我們認爲在現存的政府架構內推行改革，藉以提高行政效率，比較設立一個獨立的醫院管理局更爲可行，更能符合市民需要。

我們贊成報告書內統一政府及補助醫院的原則，爲了達到這目的，我們認爲將補助醫院納入政府架構內爲較佳的辦法，報告書建議成立獨立的管理局及一個隸屬政府的專責衞生服務組織分別管理醫院服務及公共衞生服務，但我們認爲公共衞生及醫院服務是相輔相成的，兩個不同機構實在難以協調及推行整體性的醫療政策，故此，我們不贊成公共衞生及醫院服務分開由兩個不同機構處理。

（丙）收費問題

由於「乙」級病床可以收回部份成本，以及使到中等階層人仕可以享用較爲合理的醫療環境，故此，在不影響「三」等病床數目及服務質素的條件下，我們原則上贊成設立「乙」級病床，在推行「乙」級病床之前，我們認爲政府應對其需求作更詳細調查。

報告書指出增加收費能夠抑制市民對某些醫療項目的需求，但我們卻認爲增設急症室收費及主要醫療程序收費，實際上不能夠減低市民的需求。

再者，雖然我們原則上同意急症室應收費，但我們不認爲建議中的收費能夠減少急症室的濫用情況，我們認爲需要增設夜間門診，加強現行的門診服務（包括假日及非假日）與及教育市民正確地使用急症室。

—完—

註(一)：政府及補助醫院服務不足，乃包括：醫院人手缺乏，環境擠逼及醫院地區分佈不平均。

（甲）檢討範圍

(1)你認爲現在之醫療服務是否不足？

93% □不足夠　　答(2)

7% □足夠　　答(6)

0% □不知道

(2)你認爲現時之醫療服務在甚麼範圍有不足之處，需要改善？（可選多項）

86% □醫院服務的提供（包括政府及補助醫院）　　答(3)

76% □基層健康服務(PRIMARY HEALTH SERVICE)（包括社區護理，健康教育等）　　答(4)

33% □公共衞生服務(PUBLIC HEALTH)（包括港口衞生，戒毒診療所等）　　答(4)

5% □其他　　答(4)

3)你認爲醫院服務有甚麼不足之處？（可選多項）

70% □醫院人手缺乏

63% □醫院擠逼

59% □醫院地區分佈不平均

22% □醫院員工工作態度惡劣

45% □醫院設備不足

4% □其他

(4)你認爲引致醫療服務不足的原因是甚麼？

22% □政府在醫療服務方面撥款不足

72% □政府沒有一套完整的醫療服務政策（例如沒有作出長遠的計劃討論醫院服務，基層健康及公共衞生服務之間的資源調配問題）

6% □醫務衞生處行政效率低

0% □其他

(5)你認爲要改善本地的醫療服務，政府在現階段應作出改善的地方是甚麼？

20% □首先改善醫院服務

16% □首先推廣基層健康服務

0% □首先改善公共衞生服務

64% □首先提供一套整體的醫療服務政策（包括醫院服務、基層健康服務，公共衞生服務）

0 % □其他

0 % □不知道

(6)你認爲醫療服務，已足夠的原因是甚麼？

40% □政府的撥款足夠

0 % □政府現時的醫療服務政策正確

40% □政府所提供的醫療服務能滿足市民的需要

20% □其他

（乙）以下是就「顧問團報告書」的內容而提出的問題，無論你是否贊成報告書的基本原則，請繼續作答

(一)獨立醫院管理局問題

(7)進一步改善醫院的醫療服務，你

認爲應從甚麼方向改善？

60% □在現存的醫務衞生處的行政架構內改善　答(8)

30% □設立一個獨立於政府以外的醫院管理局　答(9)

10% □不知道

0 % □其他

(8)選擇在現存架構內改善的原因？（可選多項）

40% □員工福利可以繼續得到保障

82.5% □政府可直接承担照顧醫療服務的責任

67.5% □保証有足夠的資源支持醫療服務開支

12.5% □其他

(9)設立醫院管理局的原因？（可選多項）

90% □獨立的管理局擁有高度行政效率能作靈活的資源分配減少浪費

55% □脫離公務員行列使招聘及解僱員工可靈活處理

30% □從以前種種改革証明，在現有的架構下改善是沒有可能的

10% □其他

(10) 你認爲要統一政府及補助醫院服務的最佳辦法是甚麼？

50% □將補助醫院納入政府制度內

29% □成立獨立的醫院管理局統一政府及補助醫院

7 % □其他

14% □不知道

(11) 你是否贊成公共衞生及醫療服務分開由兩個不同機構分別處理？（報告書建議：公共衞生服務由政府負責；醫院服務由醫院管理局負責）

11% □贊成　答(12)

77% □不贊成　答(13)

12% □沒意見

(12)贊成分開的原因？

31% □能夠清楚地指出公共衞生服務是政府的責任

47% □公共衞生服務方便與其他政府機關作適當聯繫

22% □其他

(13)不贊成分開的原因？

31% □兩個不同機構難以協調

22% □難以推行整體性的醫療政策

47% □公共衞生及醫院服務應是相輔相成，不應分開

0 % □其他

(14)假若醫院服務脫離了政府架構而成立了獨立的醫院管理局，你覺得政府還應履行甚麼責任？

26.5% □加強對管理局的監察

70% □在醫療服務上有合理的資助（至少不少於現時8%的資助。

0 % □其他

3.5% □不知道

（二）收費問題

(15)你是否贊成設立「乙」級病床（擁有較好的醫療環境）

55% □贊成　答(16)

42% □不贊成　答(17)

3 % □不知道

(16)贊成設立的原因是甚麼？

48% □可幫助收回部份成本

52% □使中產階層可享用較合理的醫療環境

0 % □其他

(17)不贊成設立的原因是甚麼？

35% □「乙」級病床的需求不大

35% □使三等病床數目相對下降

12% □意味著需要增加額外人手

18% □其他

(18)急症室應否收費？（如建議的12元）

55% □應

35% □否

10% □不知道

(19)你認爲急症室收費（如建議的12元）是否可以減少急症室濫用的情況？

26% □可以　跳答(21)

63% □不可以　答(20)

10% □不知道　答(20)

1 % □根本急症室沒有被濫用　跳答(21)

(20)你認爲怎樣可減少急症室的濫用情況？

21% □加強教育

25% □加強門診服務（包括假日及非假日）

46% □加強夜間門診

4 % □其他

4 % □不知道

(21)你認爲要向使用主要治療程序的病人收費（例如：每次使用全身電腦掃描機和手術室收費爲50元）會帶來甚麼效果：—

43% □減少低下層的醫療照顧

4.5% □能夠抑制需求

36% □收回部份成本

12% □其他

4.5% □不知道

（三）醫生執業問題

(22)你認爲容許醫院內的專科醫生作一定程度的私人執業會有甚麼效果？（這些醫生最高的額外薪酬應不超於25%）

33% □減少醫生離職的人數

10% □加強醫生的積極性

43% □相對地降低對非私家病人的醫療照顧

5 % □其他

9 % □不知道

(23)你認爲容許私家醫生在醫院提供有限度的服務會帶來甚麼效果？

45% □私家醫生可能利用醫院內的設施來爲其病人提供專科治療服務

6 % □能在短期內解決人手短缺問題

34% □能夠容許擁有精湛醫術及資歷甚佳的私家醫生爲大衆服務

6 % □其他

9 % □不知道

港大學生會醫學會聲明及問卷內容

註四

我們認爲醫療服務是一種福利，政府應該繼續承擔此一責任。可是現在政府用於醫療服務的資源不足以及資源未有有效地運用，以致做成服務不完善。爲了增加資源，政府可以增加醫療服務開支在政府總支出之比例，或者推廣醫療保險；另外亦可考慮增加現時醫療服務的收費，但這應以不影響到照顧低下階層的市民福利爲原則。

檢討方向：—

我們認爲政府在檢討醫療服務政策時應包括基層健康照顧及醫院服務。其中基層照顧之檢討範圍需包括：

1. 預防及控制本地常見疾病；
2. 健康教育；
3. 門診及私家醫生之角色；
4. 復康服務；

在檢討醫療服務政策時，政府應該以未來所能達到的醫療服務水準爲主要考慮點，經濟效益爲次。而我們認爲澳洲顧問團報告書所採取的態度則過份偏重經濟角度。

醫療服務的統一：—

我們覺得需要使政府及補助醫院的服務、行政、資源分配及制度等一體化。但若成立獨立管理局，我們恐怕會嚴重打擊員工士氣及在轉變期間出現混亂。因此我們贊成將補助醫院也撥入公務員架構，使醫療服務一體化。雖然這會加大公務員架構及在取回補助醫院管理權過程上會遭遇到實際上的困難，但整體上我們仍偏向這個建議。

醫院內部組織：—

現時院長不能發揮其功能，我們認爲主要原因是院長權力不足，以及此一職位未能吸引有經驗之醫生，報告書建議的行政總監一職，相信可以發揮其功能，故我們同意設這一職位，可是我們認爲這一職位必須由受過管理訓練的醫生擔任，因爲醫生比較了解病人情況，會以病人的健康爲着眼點，以及有學術上的權威去執行其工作。

急症室：—

我們覺得做成急症室被濫用原因是市民醫療知識不夠，夜診、門診服務不足，單靠增加收費並不能解決濫用的問題。可是我們同意急症室收費，使市民較能明白醫療服務的昂貴支出。

乙等病床：—

設立較高級的乙等病床，一方面可以減少三等病床的擠迫；另一方面，也可以減少政府在這方面的資助，使其資源可以運用於其他不足的醫療服務，所以我們贊成此一建議。

建議：

1. 政府在檢討醫療服務政策時不應忽略基層健康照顧。政府在考慮報告書的可行性的同時，應檢討基層健康照顧及其與醫院服務的關係。
2. 醫院的管理需要大量對醫務有認識的管理人才，我們覺得政府應同時研究培養這方面的人才的方法。
3. 我們偏向贊成將補助醫院也括入公務員架構，但如根據報告書成立獨立管理局的話，我們認爲報告書中對於成立獨立管理局財政來源及支出的計算方法資料過於粗略，政府應公佈更詳細的資料。同時，成立管理局的費用應由政府額外撥款，而不應該影響到原定興建新醫院的計劃。
4. 爲了減少急症室被濫用之情況，我們認爲應通過門診尤其夜診服務以及加強市民的健康常識來達到。

問卷的結果

整體概念

1.1 你認爲香港的醫療服務應偏向什麼性質？

(85.4%) □ 福利
(11.0%) □ 用者自付

1.2 你認爲需否增加現時醫療服務的資源（請參照 1.3）

(86.6%) □ 需要
(12.2%) □ 不需要 （轉往1.4）

1.3 以下那一項你認爲可以增加醫療的資源而又合符香港現時情況？（可選多項）

(8 .5%) □ 改變低稅率政策
(52.4%) □ 增加醫療服務開支在政府總支出之比例
(48.8%) □增加醫療服務收費
(47.6%) □ 推廣醫療保險
(25.6%) □ 募捐、籌款
(7.3%) □ 其他：
轉（轉往 2.1 ）

1.4 你認爲不需要增加醫療資源的原因是？（可選多項）

(2.4%) □ 現時之資源已經足夠
(9.8%) □ 可將現時資源作更有效運用
(0.0%) □ 其他：

檢討的方向

2.1 你認爲政府在檢討醫療服務政策時應包括什麼？（可選多項）

(98.8%) □ 基層健康照顧
(87.8%) □ 醫院服務
(1.2%) □ 其他
} （轉往2.3）

2.2 基層健康照顧之檢討範圍應包括

：（可選多項）

(82.9%) □ 預防及控制本地常見疾病

(89.0%) □ 健康教育

(82.9%) □門診及私家醫生

(76.8%) □ 復康服務

2.3 你認爲作以上檢討時主要應採取什麼角度？

(2.4%) □ 政治

(30.5%) □ 經濟效益

(62.2%) □ 其他：

2.4 你覺得澳洲顧問團報告書是採取什麼角度？

(6.1%) □ 政治

(70.7%) □ 經濟效益

(8.5%) □ 服務水準

(14.6%) □ 不知道

(1.2%) □ 其他：

醫療服務的統一

3.1 你是否贊成府政及補助醫院統一醫療服務？

(76.8%) □ 是

(17.1%□ 否)

3.2 你對醫務人員脫離公務員編制有有何意見？（可選多項）

(34.1%) □ 聘請及解僱職員有更妥善控制

(13.4%) □ 接受市民監察

(31.7%) □ 對醫務人員的工作表現施有效壓力

(57.3%) □ 打擊士氣

(40.2%) □可能成立另一官僚架構

(52.4%) □ 轉變時期出現混亂

(3.7%) □ 其他：

3.3 你以爲下列那一項最能使各醫院的服務、行政、資源分配及制度一體化？

(28.0%) □ 成立獨立管理局，脫離政府，管理現時所有政府及補助醫院

(35.4%) □ 醫務衞生署，管理所有政府及補助醫院一全部職員變爲公務員

(18.3%) □ 醫務衞生署管理所有政府及補助醫院一補助醫院職員則乃以不同的聘用條件受聘

(9.8%) □ 醫務衞生署只負責管理政府醫院，補助醫院則另由一個獨立的管理局負責

(3.7%) □ 其他：

獨立醫院管理局

報告書建議成立獨立管理局，脫離政府，管理現時所有政府及補助醫院，以下問題乃根據該模式而設，同學如非選擇此模式，亦請繼續作答：

4.1 你認爲獨立管理局能達到以下那幾種功能：（可選多項）

(63.4%) □ 有效運用資源

(62.2%) □ 行政靈活及更有彈性

(23.2%) □ 政府參與（通過撥款、委任成員等）

(41.5%) □ 鼓勵醫務人員參與

(51.2%) □ 增強市民參與（通過分區管理委員會、管理局、立法局）

(23.2%) □發展地區特式

(2.4%) □ 其他：

4.2 你認爲獨立管理局會引致以下那幾項壞處：（可選多項）

(59.8%) □ 提高收費增加市民負擔

(54.9%) □ 減低員工福利

(17.1%) □ 不鼓勵員工對院方批評

(73.2%) □ 趨向私營化

(2.4%) □ 其他：

4.3 你認爲成立獨立管理局之經費應來自：（可選多項）

(73.2%) □ 政府額外撥款

(61.0%) □ 增加效率收回成本

(1.2%) □ 減少興建新醫院

(3.7%) □ 減少因成立新醫院而額外聘請員工之費用

(1.2%) □ 其他：

4.4 你認爲市民應從那種途徑監察獨立管理局？（可選多項）

(63.4%) □ 管理局向立法局負責

(62.2%) □管理局加入民選成份

(1.2%) □ 其他：

醫院內部組織 註四

5.1 你認爲引致現時院長不能發揮其功能的主要原因？（可選多項）

(57.3%) □ 院長權力不足

(24.4%) □ 院長未受尊重

(46.3%) □ 院長一職未能吸引有經驗之醫生

(11.0%) □ 其他：

5.2 你認爲報告書建議的行政總監一職是否比現時的院長更能發揮其功能：

(54.9%) □ 是

(24.4%) □ 否

5.3 你認爲行政總監由下列那類人士擔當較爲適合？

(1.2%) □ 醫生

(84.4%) □ 受過管理訓練的醫生

(2.4%) □ 受過管理訓練的其他醫醫務人員

(7.3%) □ 醫院管理的專業人仕（（非醫務人員）

(0.0%) □ 其他：

急症室

6.1 你認爲現時急症室有沒有被濫用？

(72.0%) □ 有

(25.6%) □ 沒有 （轉往 6.4）

6.2 你認爲急症室被濫用之原因爲：（可選多項）

(30.5%) □ 免費

(47.6%) □ 市民醫療知識不足

(62.2%) □ 夜診及門診服務不足

(1.2%) □ 其他：

6.3 你認爲急症室收費能否減少濫用之情況？

(19.5%) □ 能

(51.2%) □ 不能

6.4 你是否贊成急症室收費？

(54.9%) □ 是

(51.5%) □ 否 41.5%

乙等病床

註四

7.1 你對於設立乙等（較高級）病床有何意見嗎？（可選多項）

(59.8%) □ 可減少三等病床擠迫的情況

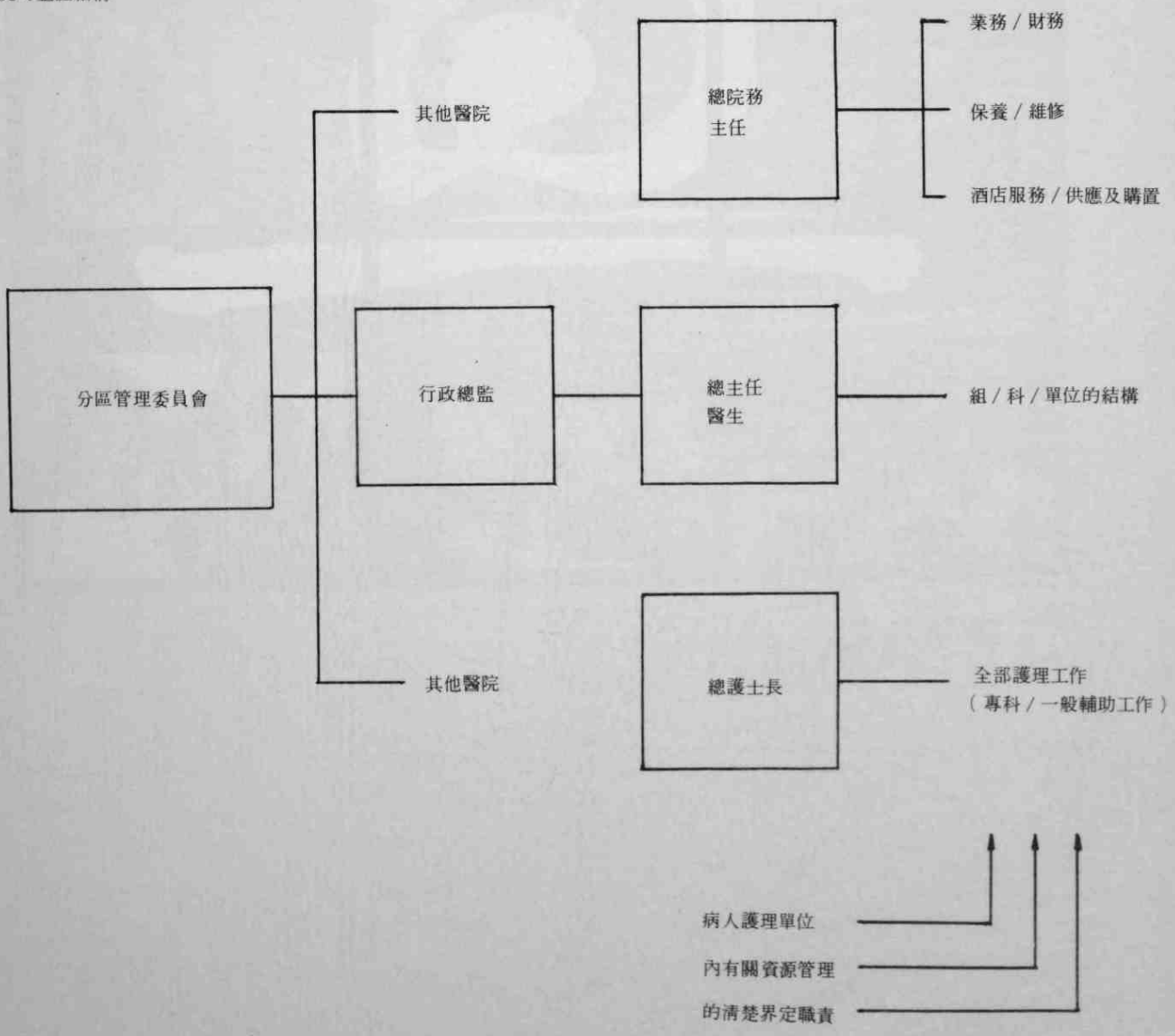
(74.4%) □ 可減少政府的資助

(12.2%) □ 會導致三等病床服務水準下降

(9.8%) □ 其他：

註二

大型醫院的整體結構



7th AMSC

7th AMSC

Have you heard of Asian Medical Students' Conference (AMSC)? Do you know what it is about, its history and background?

It started in 1980, when a group of Japanese medical students were touched by the plight of Vietnamese refugees. They tried to gather information but hardly found anybody to provide them with such. They tried to reach out but found themselves alone.

Months later, they found themselves in the company of Thai medical students who were also willing to reach out. Hence, the AMSC was initiated in 1980 by the Association of Japan Medical Students, with the cooperation of Ramathibodi Medical Students International Affairs Committee, Mahidol University, Bangkok.

Since then the AMSC has been held annually. The number of participating countries increases and co-operation from other medical students in Asia is very

encouraging. Many topics have been discussed, including refugees in Asia, environmental pollution, maternal and child health, drug abuse, child health and child nutrition, and the role of the youth in population control.

This year, the 7th AMSC was held in University of Hong Kong from 6th–12th August, 1986, with a total of 150 participants from 10 different places: Japan, Thailand, Taiwan, the Philippines, Malaysia, Singapore, Indonesia, Kuwait, Australia and the host Hong Kong.

The theme chosen was Mental Health in Asia. At the Conference, each country/locality presented a paper about mental health concerning its own place.

The Conference was not all that academic, however, within the one week's programmes, there were barbecues, tram tour, tours to the Peak and the New Territories, technical tour, cultural night and disco party etc.

WORDS FROM THE O.C.

1) **Preamble**

a) The Seed

"Africa" was a chap who entered the medical school in 1983. In one of the various orientation camps in that summer, he met his senior whom he had missed for 5 years. Interestingly, his senior had just finished the medical course while Africa was just about to start.

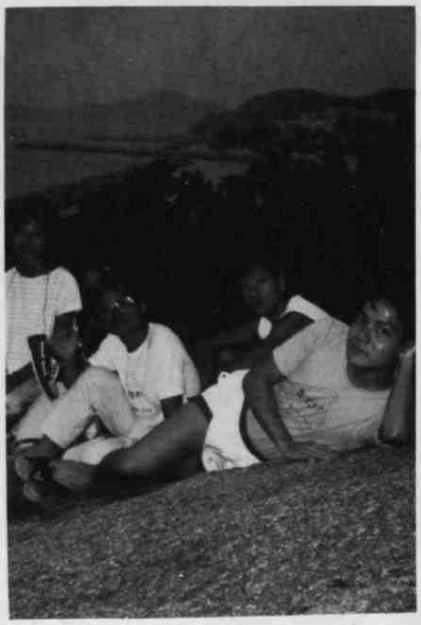
There was a long chat and the senior left with the remark, 'It's impossible to finish all the books in medicine; just read those needed will do.' It planted the seed.

Africa perceived studying Medicine as the prime though he thought he might be able to fulfil some extra. Everyday after school, he might be found joining the swimming team, serving the clubs in the Student Union; dating with his be-loved girl friend or, of course, studying hard in the library. Needless to say, Africa had his first year with flying colour.

b) The Water

The weather became rainy after these fine days. The engagement of 3 years long came to a full stop. It hurt and there was pain. It watered the seed.

Africa found it was easier for him to get through the days if he was kept busy. It was also a good time to see more and to assess himself. After some consideration, he joined the Ex. Co. as the I.R.S. (International Relations Secretary). It was as busy as he had expected but there was still moments of silence.



2) **The 6th AMSC in Manila**

a) In the Conference

Being the chief delegate of H.K., Africa was occupied by all sorts of meetings and was too busy to really enjoy the Conference and yet, he would still sense the warmth and sincerity of the students from elsewhere.

b) Election of the host country of 7th AMSC

As usual, there was a vote for the next host at the end. From seniors, Africa learnt that many countries would like to strive for the hostage. However, it did not seem to be so exciting in the 6th AMSC. Two countries, namely, Hong Kong and Indonesia expressed their interest. Concerning about the H.K. delegations, it was probably due to the inspiration of the atmosphere of the 6th AMSC.

Obviously, Hong Kong won the voting.

c) At the back ot Africa's mind

To be frank, Africa was more reserved over this issue. He took up the duty as the Chairman more out of sense of responsibility rather than interest. His decision was actually the struggle among 3 considerations.

i) It was out of his modified 5-year plan which he had made. To be the Chairman meant that he would have to sacrify some others.

ii) His instinct told him that not all "enthusiastic" delegates were really interested in it and might be not half-hearted. He might get into trouble sooner or later.

iii) Hong Kong had joined AMSC for 3 years already. It should be the time for Hong Kong students to take up the responsibility after gaining so much in the past.

3) **Preparation of the 7th AMSC**

a) The O. C.

The 7th AMSC OC was formed in Sept. 1985. six 2nd year and five 3rd year students volunteered to join the 6 departments, namely Academic, Accomodation & Catering, Financial, General, Publicity and the department of Social and Transport.

Partly out of habit, Africa tried to make the responsibility of each department well defined while he also thought of ways to tie them together. As such, efficiency could be higher and evasion of responsibility less easy to occur.

"Teamwork is desirable but individual's work is essential"

b) The Meetings

As a matter of fact, the main task of the O. C. was to make up the plan of the 7th AMSC and tried to fulfil it later. Hence, the number and the length of the meetings had to be considerable, though none would like them to be so. Here, it was exactly analogus to joining the "Long Distance" event.

The progress was excellent at the beginning while the attitude of each chap started to show up gradually. It was heartening to find that most, if not all, of the O. C. were dedicated and responsible which rendered such a big task much easier to be tackled. The interaction was consolidated bit by bit. However, it had to be admitted that some others were not that whole-hearted. It was amusing to listen to all sorts of excuses while some did not even bother to find one.

'It is true that one can has his own ideal and it differs among individuals. But once he takes up a duty, he has taken it. It becomes a matter of responsibility then, ' Africa believed.

c) The crisis of date

After substantial preparation had been made, the O. C. received a message from overseas. It asked for postponement of the 7th AMSC because some countries would be having their examination then. The first reaction of the O.C. was firm and negative because it was not so according to the information the O. C. had obtained. Most countries should be having their summer.

As time passed by, it seemed to the O. C. that there was really problem for some countries. A consultative meeting was hold with the past delegates of Hong Kong and precious advice was offered. Each country was approached for further information.

Finally, the portponement of one whole month was declared, in order to maximize the number of participants. The price was enormous for the O. C.. All the preparation had to be revised and all the worst was the resignment of some 3rd year O. C. since they would be having their school on the new date.

d) The responses from oversea

The painsteking declaration of postponement was not without its reward. The number of countries expressing their interest shot up to 14 while the number of delegates were estimated to be about 150. Both would be the records of the AMSC.

New comers include China, Sri Lanka, New Guinea, Israel and India. Mysteriously, some of them failed to turn up while some others could not come to Hong Kong. The actual number of countries changed to 10 and around 120 delegates had joined the conference.

4) The Conference

a) The detailed mental rehearsal

As the date was approaching, everybody was getting on his/her nerves. The conference would be open very soon after almost one whole year's hard work. Could one say that the O. C. was feeling like the woman about to labour?

In order to prepare the Hong Kong delegates, there was a detailed count down of each program. The O. C. tried to fore-see any possible bugs. As to be expected, no matter how hard they tried, the rehearsal was definitely non-exhaustive.

b) The Participating countries

In the various programs, each country's culture, belief and practice was shown up vividly. The delegates from Thailand and Malaysia were serious and dedicated people. They were always discussing about the paper. Philippines were active and outgoing. Hence they failed to turn up in the paper presentation. The Japanese did attend the presentation but some were half-conscious. Probably it was due to the long meetings they had on their own. For the Hong Kong delegates, . . .

c) The Hong Kong delegates

Including the workers recruited, there were about 30 Hong Kong students joining the conference. Each was assigned with specific duties such that virtually all Hong Kong students were "workers" rather than participants.

Lots of them had to get up at 7 a. m. but only went to bed after 4 a. m. They had to give morning call, guide the delegates, offer assistance when necessary, arrange the facilities and whole lots. At mid-night, they had to attend a meeting for Hong Kong delegates to evaluate the programs and prepared for the comings.

Only after that would they had their own leisure time. Yet, it was also one of the most lovely and memorable period in the Conference. They might go down-town to have the snack, 3 or 4 in the morning. One could as well find them playing games. No matter what's the functions, they were enjoying.

d) The last night

It was a usual scene to have delegates staying in the podium or the halls till very late at night (or very early in the morning?) They chatted, they discussed, they smiled as if they had known each other for years.

There was something different on the last night. There were even more people than the formers. Some had had the good idea and brought along drinks and snacks while others their games. The talked as before but felt something different. It was their last night in Hong Kong. It was the end of the 7th AMSC. They stayed there as if they would never meet again if they went to bed.

5) **Aftermath**

Africa, still perceiving Medicine as his prime, worked much harder than before. He got to equipped himself before he can ethically be qualified as a doctor. Though he might not be a doctor. Truly he had lost some of the time, some of his friends and some of his life, he had not, or he should not regret since that was all his own choice.

He carried on with the new version of his modified 5-year plan.

As a bystander, it was fair to say, Africa had also been benefited.

Chong Yu Hoi

國際會議、遊埠（其實早知在港舉行）、外國少女、正！於是不及細慮（不需細慮），一聲「好」便答應參加第七屆亞洲醫學生會議的籌委會。第一次非正式開會見到莊董事長的嚴肅外表，知道選擇是對的，能參予籌辦一個大型而嚴緊的國際學術交流會議是很難得的經驗，是訓練籌劃能力的好機會。會上，自願？爲勢所迫？執了宣傳秘書的職位。可能過往經驗，心有不甘、望能完全發揮宣傳的工作。又一次與老拍擋「阿炳」合作。

工作隨即展開，士氣如虹、計劃很多，一同工作的'90同學很用心努力準備。可惜，稍後因考試和假期的阻礙，工作慢下來。更不幸，因自己領導不善，令鬥志受挫。又有隊員退出。失望、沮喪，自我的懷疑將自己包圍、放棄，可能嗎？若地下他們而當迎新籌委主席，良心道義都不容。欣喜的是餘下同學的堅守，自願加重工作負擔、大家對提高士氣作出意見。自此工作又再積極進行。

宣傳對象可分對內與外二方面。最重要的宣傳工作是在會議前半個月，即七月中至八月初。十多張大型的橫額要在大約一星期內完成，大家都得日夜加班。加上一大堆宣傳物品的製造如T恤等，都要很多人力。幸得多位生力軍義助加入，令工作順利。

及至會議前約一星期，同學對會議的將舉行很關心和有興趣，至此宣傳已見成效。因此盡心努力中更見互助、友情。

會議前一二日，百事交加，一大堆宣傳品都得在 MEDIC CENTRE ，大學本部及三間舍堂張起。由於一些誤會，某些地點需臨時申請，幸得批准。於是耀眼奪目的螢光黃底黑字的橫額，設計精美的海報在各處發出訊息，帶着會議的氣氛。不過，工作尚未完結、會議期內，更需身兼模特兒之職，推銷紀念品。更需負責售賣。總之、經歷各種工作感受，有苦有樂。不過這些經歷是非常難得的，令我永留心中。

最後，在此要多謝各位一起工作過的同學、阿炳、ANNA，薇，KIM，朱仔，Raymond ，Ann Fung 等等，如有不盡、請諒！我在此希望來屆會議更能成功，更多同學參予。

Old Man

起初做籌委都是抱着一生難得機會策劃一個國際性的活動，加上跟莊董事長的多年朋友。說也奇怪，在入醫學院之前結識，着實是一份機緣和一份投契，果然在這一次合作內，我也感覺得很愉快。籌備工作在大半年前已經開始了，在這日子裡，我學會了和見識到很多。

在亞洲醫學生會議期間，當然是可以認識到很多外國的朋友，雖工作很忙，但也慶幸在短小的時間內認識到 KAN，SANDEE ，TAKA ，SEI KO ，CHRISTMAS ， 淑慧 ，LAWRENCE …… ，通過閒談，擴闊自己的見聞，尤其在外國的醫療制度，了解到香港的不足及優勝的地方。

在籌備工作方面的得着可能更多，主要是對人的，以前跟莊大哥做過「兩醫交流」，和OLD MAN 攪「聯大理工醫療專題」，現在同羅仔組班會，也想不能跟是次相比。會議之前有長時間的接觸，會講期間大家全身的投入，天光做到天黑（不，是午夜），在短短日子裡相互的認識實在很深。不能不提的是「得米」老板，當時是「新」相識，現在已是「舊」知己了。另外，MEE 姐，JASON ，AMJAD ，LEO 仔，……如要說起來眞可以寫書了。但不能不提的是 MEE 姐，工作能力之高眞超乎想像，所以當大家相約要買束花送給她表示謝意，但我買了並在閉幕晚會中送給她後，竟無人願付錢，不過就我本人而言這五十多塊錢也不能表達我對她的讚賞。

另外學會了跟外面的媒介打交道，在校內做東西所要經過的繁文褥節。最緊要的是看見了人性，「線鷄」，沽名釣譽，是見識不少了，但始終也學不會。

現在，每穿上自己設計的AMSCT恤，結領帶時帶上的呔針，翻書時用的書簽，看到牆上的海報，都爲我帶來一點點的回憶。自己最滿意的是海報，自己對攝影、設計都多了一點信心，多謝AMSC！

酢漿草

The organization work spanned almost a year though the Conference lasted for only a week. It was a hard job definitely, as most of the organizing committee members were inexperienced, not only that we were tyros in organizing international conference but also we had not attended such conferences before. Lack of manpower and financial aids were two constantly debilitating obstacles. We went through crisis when we decided to change schedule after almost everything had been fixed, which nearly led to disembodiment of the organizing committee.

However, the courageous and undefeatable committee never yielded. Instead, we turned the already capsized boat into a sailing ship and raised, from without even a cent, over fifteen thousand dollars, and tried to make everything as good as possible, though may still be far from perfect. In due course, we have become very good friends.

So the 7th AMSC had such a hard gestation period.

With the melodies of the 7th AMSC conference song filling the Rayson Huang Lecture Theatre, the conference was inaugurated. During the following week, everyone was busy with others. We made many new friends, knowing more about other places, and perhaps of Hong Kong, too (Very often, we found ourselves speechless when being asked upon things about our own places!) Certainly, it was a memorable week: BBQ, night chats, peak tour, Thai dances, Japanese sumo wrestling, disco, souvenirs from different countries . . .

The 7th AMSC ended with foundation of the AMSA (Asia Medical Students' Association), which would mean a further move for greater interaction and co-operation among Asian medical students. At present, local branches of the AMSA are being formed in different places, and Hong Kong is going to have one soon.

Thanks to the 7th AMSC, many of our medical students begin to know more about it. Indeed, in the past, except for those seniors who had attended previous conferences, it remained a mystery to most of us, and it was as such to me also when I joined the 7th AMSC OC.

Wong Tak Wai

GUEST SPEECH AT OPENING CEREMONY

Full text of a speech entitled "The Medical Scene in Hong Kong – Now and in the Future" by Dr. Peter C.Y. Lee, President of the Hongkong College of General Practitioners, delivered at the Opening Ceremony of the 7th Asian Medical Students' Conference (about 150 delegates from 15 countries attented) on Wednesday, 6th August 1986 at 9:20 a.m., at the Rayson Huang Lecture Theatre, the University of Hong Kong.

Hong Kong has no national health service. Entry into the medical/delivery system may be either through the public sector by attending one of the government general out-patient clinics or as an emergency case in the Accident and Emergency Departments in public hospitals, or through the private practice sector by going to doctors in private practice or to the numerous herbalists, bone-setters, etc. The more than sixty out-patient clinics scattered all over the territory can be regarded as "the eyes and ears" of the government medical service, and are established mainly for the purpose of keeping in touch with morbidity trends and changes in disease patterns. The clinics do not pretend to practise good general practice or continuing care; but they are there mainly to give symtomatic relief, and to screen patients for referral to specialist clinics if necessary. The Accident and Emergency Departments in public hospitals are run on a 24-hour basis and deal, as the name implies, with accidents and emergencies, even though the lay public usually abuse the system by using it as a regular clinic whenever they wish to see a doctor outside office hours.

The government specialist clinics and hospitals are where secondary and tertiary treatment are available. Because the costs in government institutions are low and affordable, the government specialist clinics and public hospitals are usually very crowded. In particular, public hospitals have long waiting lists for elective treatment of diseases. Those who wish to have good personal service or prompt treament for their ailments will need to go to doctors in private practice and patronise private hospitals. However, irrespective of whatever shortcomings there may be in the government medical service, it must be emphasised that Hongkong enjoys a very high standard of public health and is free from all major epidemics and infectious diseases, in spite of Hong Kong being one of the most densely populated cities in the world. Furthermore, no one who suffers from injury or in need of emergency treatment was ever turned away from public hospitals, which are well-equipped to take good care of any emergency without charge to the patient.

As can be expected under the circumstances, overcrowdiness in public hospitals becomes a fact of life. Because of this, the government recently engaged a team of consultants from Australia to review all aspects of hospital service in the government sector to find ways and means to make government hospitals more efficient and more cost-effective. The resultant report is an inch-thick document of over 300 pages. Not only would it be improper of me to give you details of this report on an occasion such as this, but it would also be impossible to do so because of time constrain. But I do think it is pertinent to make one general comment.

Before doing so, however, I must bring your attention to a consultation document of the Royal College of General Practitioners entitled "Towards Quality in General Practice' which is now being hotly discussed in England. Commenting on this subject, the writer of a leading article in the Journal of the Royal Society of Medicine had this to say, and I quote:–

> "Primary care controls to a large extent to amount of that by introducing quality in general practice, large sums of money may be saved in the hospital setting."

The significance of this statement in the context of Hong Kong, at this moment considering a consultants' report on hospital services, can hardly be exaggerated.

My comment is that having spent a few million dollars to engage a team of experts to look into government hosital services, it is a great pity that the terms of reference given to this team of experts relate only to hospital services and neglect the search for the real cause of overcrowding in public hospitals. It is my contention that better quality of care in government out-patient clinics will go a long way towards decreasing demands of secondary and tertiary care in public hospitals.

The present practice is to staff government out-patient clinics with very junior doctors who are

expected to treat and relieve symptoms without provision of continuing care, and to refer to specialist clinics all patients whom these young doctors feel that they are not competent enough to handle. Such practice, in my opinion, is the least cost-effective, because many referrals to specialist clinics or even to hospitals could be avoided if the skill and efficacy of doctors in out-patient clinics is up-graded and quality of care improved. The first-step in the overall raising of standards in these general out-patient clinics may be the establishment of posts of "Consultants in General Practice" in each of the "regions" in the government medical service administrative structure. This is to say that instead of the present system of doctors in OPDs referring directly to specialist clinics and hospitals, all such referrals will have to go first to the "Consultant in General Practice". I am confident that this is most cost-effective, and will certainly help to decrease public demand for hospital beds. The person appointed to the post of "Consultant in General Practice" will of course need to hold a "membership" or "fellowship" in one of the colleges of general practitioners.

Running parallel to this proposition and to its logical conclusion, the government should now give proper cognisance to the modern trend of medical care by paying more attention to the vocational training of general practitioners, and to support any move towards this goal. Certainly, its present discrimination against general practice in the public sector is not only a retrograde step, but also a great hinderance twoards bringing efficiency and cost-effectiveness into the government medical delivery system. I use the word "discrimination" with emphasis, because whilst both medical schools in Hong Kong do recognise M.R.C.G.P. (Member of the Royal College of General Practitioners) and F.R.A.C.G.P. (Fellow of the Royal Australian College of General Practitioners), the government up till now does not recognise such degrees. I strongly urge the government to review its policy on general practice and family medicine for the sake of the community and in the name of improvement in its medical delivery system.

If these were but a few of our present problem, what of the future? What will the medical profession in Hongkong be like in 1997 and beyond? The simple answer to this perplexing question is that the kind of profession we shall have in future will largely depend on how we doctors conduct ourselves within the next five years!

"One country, two systems" assumes a "Hongkong system". However, for the medical profession at present, we only have in situ a British system operating in Hong Kong, but no "Hongkong system". Therefore, by hook or by crook, we must have in position a real "Hongkong system" well before 1977. For such a "Hongkong system" to be acceptable to China and to the future government of the Special Adminstrative Region of Hongkong, we must satisfy three basic criteria:—

1. The medical profession must be independent and autonomous;
2. Its standards must rank among the best in the world, and be so recognised internationally; and,
3. Must be in very close touch with major medical centres around the world through research and academic exchanges.

Those of you who come from countries which were former British colonies may find it strange that I should mention that the medical profession in Hong Kong must become independent and autonomous. You know that in your own independent country, you still retain certain vestiges of colonial rule within your medical system. For example, some of you may still allow the General Medical Council in U.K. to supervise and oversee the standards of your medical education, and most of you certainly still rely on "the Royal Colleges" for the accreditation of post-graduate or specialist status. But the very fact that Hongkong will not, and will never, be independent in the political sense means that we cannot afford the luxury of gradual change. Come 1997, the present practice of having a British system for the medical profession will no longer be acceptable. That is why we must work towards a "Hongkong system"; or failing that, we may have to accept a "Chinese system" by default. There may be nothing wrong with a "Chinese system", except to say that it is highly doubtful whether a systematic and orderly governance of the medical profession does exist in China at present.

The first thing to do in setting up a "Hongkong system" is therefore to have our own autonomous authority to determine the minimum standards required to practise medicine in Hongkong. This is presently done by having the General Medical Council in England to oversee and supervise the standards governing undergraduate teaching in our medical schools. We must hence set up a local authority to take the place of the GMC in the United Kingdom. The next step is to set up an authority to take the place of the "Royal Colleges" on whom we are at present dependent for post-graduate and specialist accreditation.

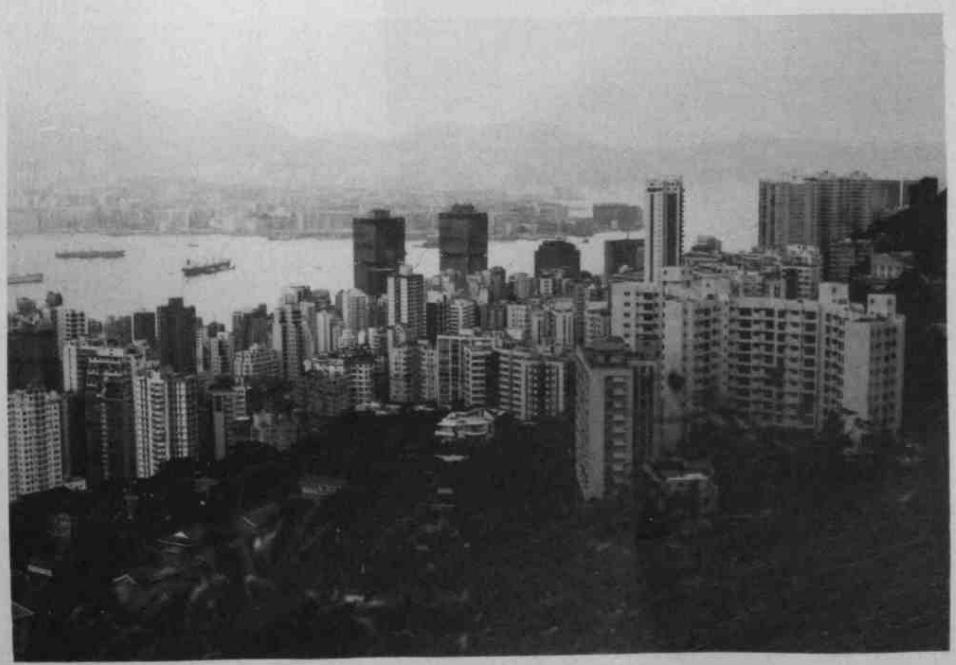
It is my firm belief that these two proposed authorities should not be with the Hongkong Medical Council, but be vested in an independent, purely professional body like the proposed Academy of

Medicine. Under this Academy will be various "Colleges" for post-graduate training and accreditation. As a start, I can envisage four Colleges – the College of Medical Sciences, the College of Surgical Sciences, the College of Diagnostic Sciences, and of course the existing Hongkong College of General Practitioners.

It is further proposed that this Academy will have two tiers. The first tier is to oversee and supervise undergraduate teaching and to conduct examinations for "Membership" of the Academy, which qualification should be enshrined by statute and by law to be the sole and only requirement to practise medicine in Hongkong. The second tier is to oversee and supervise post-graduate teaching, vocational training, leading to the award of "Fellowship" of the Academy of Medicine, which is the equivalent to post-graduate specialist accreditation. Since all "colleges" will be under the umbrella of one Academy, Hongkong will have the unique opportunity of devising a system whereby various postgraduate education and all higher training and vocational programmes can be controlled and co-ordinated under one roof, and thus evolve a postgraduate training system which will be the envy of the world.

The examination for "Membership" may be conducted by the Academy, or may be delegated to the medical schools in such a way that their M.B.,B.S. degree will automatically qualify them for the award of a "Membership". Similarly, the examination for fellowship could also be done by the Academy itself, or be delegated to the various "colleges" under the auspices of the Academy. It is only in this way can a truly autonomous and acceptable "Hongkong System" for the medical profession be evolved. It is only in this way can the medical profession as we know it today survive 1997 and hopefully continue to survive for 50 more years and beyond!

Peter C. Y. Lee
President of the Hong Kong College of General Practitioners



CULTURAL NIGHT

The night of August 10th, 1986 was a special one. It was a night when medical students from 13 countries of Asia, dressed in traditional costumes, presented the best of their nation's culture. It was a night which all participating delegates truly enjoyed and cherished. It was the Cultural Night of the 7th AMSC, held in Loke Yew Hall, University of Hong Kong.

The Philipino delegates share their feelings towards the February Revolution by singing proudly their revolution song – A New and Better Way. Can you recognise 'Mrs. Aquino'?

Chinese dancing performed by medical students from the Chinese University of Hong Kong.

Thai delegates, dressed in traditional costumes, sing Thai folk songs.

A most extraordinary mime performed by the Singaporeans. Do you know what they are doing?

A new Japanese pop star? No! She is a medical student from the University of Osaka.

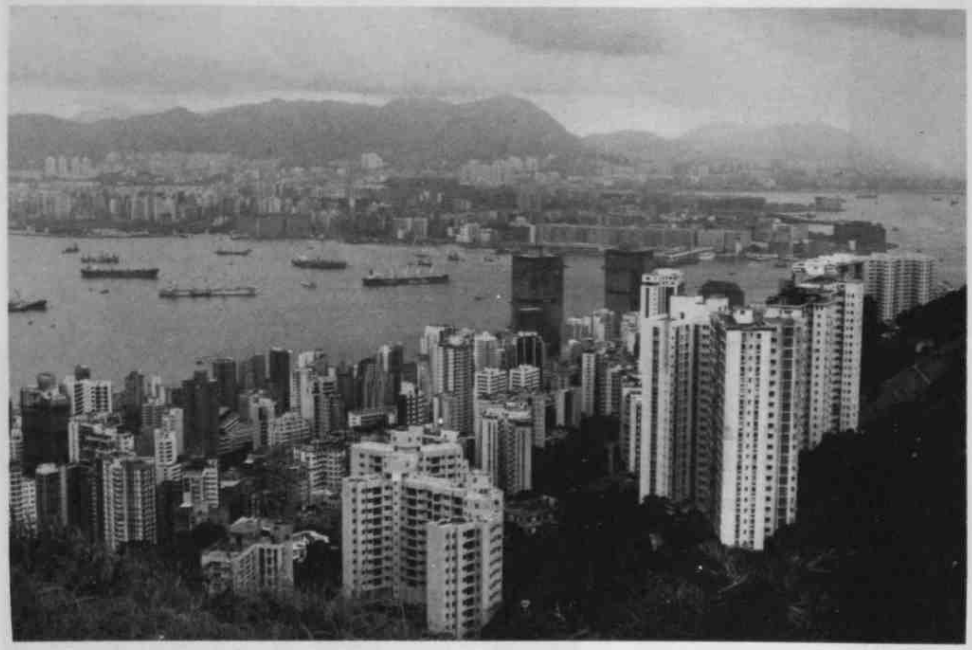
Sumo wrestling – the national sport of Japan. See how everydoby is enjoying the game.

Taiwanese mountain song performed by delegates from Taiwan.

Two samurai performing Kendo in Loke Yew Hall.

PEAK TOUR

Amjad Ali



One of the sightseeing highlights of the 7th AMSC – or A.W.O.L.D., as I call it ("A Week of Living Dangerously!")–was the Peak tour. This enjoyable event took off on a high note when our kindly bus driver resorted to his highly suspect navigational instincts in order to take us to the Peak. We must have made a complete circuit of Hong Kong Island before we finally got on our way towards our elusive destination. Being the charming hosts we were, we took the opportunity to show off some of Hong Kong's beautiful scenery to the foreign delegates, pretending that our meandering, tertuous route was as planned ("Ahem! Actually . . . it was planned this way-Ed.)

Having arrived at the Peak tower, the H. K. tutors turned on the charm and became instant tourist guides, showing the delegates the marvels of H. K. by night from the observation gallery. After half an hour of "Oahs"s and "Aah!"s, we all went on a pleasurable stroll circling around the Peak. During this time lots of memorable photographs were taken and the more adventurous among us socialised with the "birds" (the feathered variety, of course! (Likely story-Ed.))

The end of the walk was the end of the official programme and the buses took most of the AMSC delegates back to HKU. The rest of the gang, under the wise guidance of Jason So, Edward Lee, "Dried shrimp" (Wong Tak Wai) and yours truly, descended the treacherous slope down to Central in H. K. 's favourite funicular railway – the Peak tram.

Following the tram ride, we set off for Wanchai for a night on the town and went to . . . Sun Kwong Restaruant ("Honestly, where did you THINK we'd go!") Here we savoured the delights of Chinese cuisine – yours truly, however, ate little because many of the dishes had pork in them (I still ended up paying though!). Arriving back at H. K. U. we were drenched in the rain – so much for happy endings!

PAPER ABSTRACTS

AMSC – paper summary (Philippines)

Title: Common stressors among medical students in the four leading schools in the Philippines

Introduction:

Stress is the lack of congruency between important aspects of the person and his perceived environment. Fear of one's inability to absorb all the materials taught and fear of receiving bad grades are significant sources of stress for students. It was found that academic pressure and lack of personal freedom are the most pressing for medical students.

Common stressors among medical students:

Academic factors such as information overload, time pressure and performance demands are general stressors among medical students of the four universities studied.

Feelings of loneliness among women medical students in the Philippines were observed and the students' own actual health problem also create stress.

Conclusion:

Academic factors are great stressors among medical students in the Philippines. However, there is not a statistically significant stress factor among all the universities studied. Besides, the severity of stress factors varies slightly in different universities owing to variation in individual factors or school factors. Therefore it would be better for each school authority to find the major causes of stress in its own medical students so as to offer solutions to the problems that beset them.

Title: Mental Health in the Philippine setting

Introduction:

Mental health, as defined by the Philippine Mental Health Association, is the ability to deal effectively & efficiently with one's own self, with others and to take life with its blessing and its problems. However, the boundary between sanity and insanity is determined by society which is fashioned out of its cultural norms and is therefore a subjective entity.

Causes and symptoms of mental illness:

The Filipino culture is still confirmity – conscious and social control is exerted to exact confirmity. Thus a person not in consonance with the existing cultural pattern experiences emotional upheavals and mental illness.

Symptoms of mental illness are conversion symptoms, phobia, depressive phenomena and difficulty in mastery of aggressive impulses. Somatic symptoms can also be exhibited.

Conclusion:

In the Philippines, culture, instead of providing ego support, can be a source of stress and mental illness.

Mental Health In Thailand

History:

The Mental Health Care in Thailand has developed since 1889, which was carried out by psychiatric hospital and mental health institutes. In 1979, there was the beginning of integration of mental health into existing public health delivery system. At present, in the Fifth Five Year National Health Plan (1982-1986), there has been the emphasis on mental health in primary health care.

Introduction:

Mental disorder is a direct indicator showing the mental health status of people. However, it is also related to quality of life and social disorganization.

Psychosocial Factors Affecting the Mental Health of Thai Population:

(a) Population problem

The increase of population has brought problems like migration, unemployment, crime, etc. The age-structure has also changed to a narrow-based pyramid. The consequences are increased economic and social burden of adults and child labour.

(b) Industrialization

This causes mental health problems such as drug dependence, alcoholism, juvenile deliquency etc., and make the psychophysiologic disorders to the higher.

(c) Migration

This may create the sense of uprootedness, the difficulty in adaptation, etc. which may bring to psychophysiological disease or behavioural variations.

(d) Urbanization

This leads to problems like increasing individual stress, family break-down, social turbulence and hence more neuro-psychiatric disorder. Slum-areas are also created which are full of mental stresses and crime.

(e) Deteriorating environment

The problem of pollutions e.g. air, water and food pollution are harmful to the mental and physical health of the population.

(f) Unemployment and poverty

These create stresses and malnutrition status, slums and low I.Q. Also, poverty can bring to poorer family relationship and bad community structure.

(g) Old people problem

The problem becomes more significant because of decreasing extended family and child-adult ratio due to economic problems and change of social values.

(h) Insecurity in life and property

The increase in crime rate affect the mental health of people due to fearness of being done harm.

(i) Drug dependence

Those psychoactive drugs like heroin can be harmful to the CNS if used in a prolonged manner and eventually leads to mental problems.

The 5th Five-Year National Health Plan (1982-1986)

The government has adopted the plan to direct the goal towards "Health for all by the Year 2000". The programme focuses on prevention and promotion of mental health. There will be the standardization of treatment, rehabilitation and integration of people suffering from mental health problems. There will be greater emphasis on manpower development on mental health profession, both quantity and skills. Also, research will be encouraged and facilitated.

Conclusion

Since the mental health activities began quite late in the national scheme of primary health care in Thailand, unless the programme is carried out firmly and systemically, it will be difficult to reach "mental health for all by the year 2000".

I Concepts of Mental Health in Taiwan

In the field of mental health, most people in Taiwan accept the concepts of folk medicine and traditional Chinese medicine, although modern (Western) medicine is gaining support for its multiple factors theory including physical, psychological and social factors for the cause of mental disorders.

Traditional Chinese medicine, on the basis of Yin-Yang hypothesis, defines health and illness according to a unitary world view of cosmology. It has the hypothesis that mental health can be influenced by physical conditions and vice versa.

The concepts of folk medicine originate from Buddhism and Taoism. They regard mental disorders as a state of devil possession, as punishment by gods or as results of previous lives; and patients should seek therapy by religious melieu.

II Patterns and Prevalence of Mental Disorders in Taiwan

The major mental disorders in Taiwan are schizophrenia, manic-depressive psychosis, personality disorder, neurosis etc. Somatization is the most prevalent form of symptom manifestation in Chinese patients with neurosis, depression, hysterical reaction & hypo-chordriasis. It is the articulation of emotional problems & psychosocial stress by way of physical symptomology, such as backache, headache and fatigue. It suppresses dysphoric emotions, which are regarded as shameful to self and family, and only the somatic symptoms are perceived and communicated. Very often, psychological complaints do not have the same social efficacy for gaining support and care than physical complaints. Some specific complaints of Chinese somatizers are Shen Kuei (kidney deficiency), Kon-huo (liver fire), Huo-chi ta (excessive internal hot energy) and Hsim teap tsap (fightness of heart).

Another culture-bound syndrome is frigophobia, which is a sensation of chills. The patient has excessive tendency to catch cold, they wear over-abundant clothings and overheat the surroundings. This results from an imbalance between 'yin' & 'yang'.

III Existing Screening Methods in Taiwan

Every Taiwanese student receives an intelligence evaluation at entrance of junior high school, and an aptitude evaluation upon graduation which serve as an aid for choice of occupation or polarity of learning. Personality, psychological and achievement tests may be included. Before the commission of military service, they are also examined by psychiatric doctors.

IV Treatment & Rehabilitation of Mental Disorders

To many Chinese, the etiology of mental illness is multifacted, including moral (misconduct), religious (offending supernatural power), psychological (e.g. failure in loving affairs) and genetic (e.g. ancestral misconduct). The family of the affected individual usually feel ashamed and guilty. So the first treatment is often exclusively intrafamilial. Folk medicine is often their first choice for help. If he is not healed, Chinese medication is seeked, and finally he is brought to a Western doctor. The label of mental illness on a person almost instantly and drastically alter his status in the family. Eventually he may be rejected by his family.

There are not enough psychiatric hospitals in Taiwan, and they are unevenly distributed. Many of them lack proper environment, facilities and treatment for their patients. Chairs and lock-up rooms are employed not infrequently. Some of the clinics even use Chinese medicine (acupuncture) and fortunetelling as parts of the treatment.

V Conclusion

In order to promote mental health, the Taiwan Government has launched a series of policies, including a 'Five Years' Plan of Prevention and Treatment to Mental Disorder'. As medical students, we should strengthen our knowledge about mental health and arouse community awareness of it. We should share the responsibilities of promoting mental health with the government, doctors and other personels.

Mental Health and Related issues in Malaysia – Country Profile

Introduction

Malaysia comprises of 11 states in Peninsular Malaysia and the states of Sabah and Sarawak on the island of Borneo. It has an area of 127,581 square miles and a population of 14,698,292.

The three major ethnic groups constitute – Malays (52%), Chinese (33%), Indian and Pakistanis (9%), 68% of the population is rural.

The government's policy is to promote a national identity in order to maintain racial harmony and peace.

Cultural Beliefs

Malays – The Malays are the biggest single ethnic group in Malaysia. Their concept of mental illness is quite sophisticated. Physiological explanations exist too, as well as possession by spirits (hantu) or genie (jin). Susceptable people may be those who have lost their spirit (semangat). Healing depends on exorcising the agent that is in the person.

Chinese – The Chinese are the second largest group in Malaysia and are predominantly urban. Classic Chinese medicine as practiced in cosmic forces yin ± yang which must remain in harmony. They regard mental illness as a mixture of organic illness and mystical possession.

Indians – Indians and Ceylonese are mostly Hindu. The Ayurvedic physician follows the ancient Indian theory that illness is generally due to an imbalance of the 3 body humors: mind, bile and phlegm. Mental illness is commonly understood to be caused by an excess of bile that results in an increase of heat in the head. Treatments consist of herbal concoction and oil rubbed on the head by temple mediums.

However, there is much overlap in this multiracial society.

Attitudes to Mental Health and Illness

Symptoms of abnormal behaviour are seen as being possessed by the devil or as a result of having being charmed by a neighbour or foe, or being spurhed in love. This is tolerated and to some degree culturally acceptable by rural malay population. Precious time is lost, when the family seeks traditional treatment for the afflicted individual. But the extended family is an asset to the mentally ill person.

In 1958, there was an attempt to decentralize the mental health service. Now, there are 7 regional centres to provide care on basis of community psychiatry, and psychiatric services are provided at most of the general hospitals and some district hospitals.

Recently, there has been a move to incorporate concepts of mental health in public health education and thus hopefully to extend the diagnostic and curation services to the peripheral rural areas through public health programmes.

Voluntary organisations with some assistance from government agencies have evolved laudable programmes for rehabilitation. The Mental Health Association has played a positive role in promoting health consciousness and provide some facilities for rehabilitation.

It is hoped that by the year 2000 the nation would have developed significant mental health services.

Title: Mental Health In Japan
Abstracts:

Introduction

The state without mental or emotional disorder' is a definition of 'mental health in a limited sense, he does not always have stability of emotions or mind. In other words, those whose 'mental health in a wide sense' is threatened are increasing.

History of Mental Health Care in Japan

Before 1874, the beginning of Meiji Era, mental disorders were thought to be caused by the will of Japanese Gods or some evil spirits. For instance, people believed that the foxes took possession of the spirits of those who made them angry or those whom they loved.

Treatments for mental disorders were very primitive and far from scientific. In 1900 a law on nursing of psychotics was adopted. According to this law, the family of a mentally disordered person, not the government, had all the responsibilities for nursing him or her. In 1919 they started with a new law concerning the establishment of psychiatric hospitals. The responsibility of the government concerning mental health was clarified.

The Problems in Each Stage of Personal Development

a) Adolescence and Youth

The 'self' of a child begins to mature but his emotional state is still unstable in this period, so truancy, school violence and delinquency start to increase.

One day an incident occured in which a group of junior high students beat some tramps to death in a park in Yokohama. School violence, mainly among students, is merely one aspect of the so-called 'ijime' or bullying. The term 'ijime' is frequently used in the media, and the concept includes not only physical violence but also all aggressive behaving with evil intention rather than friendly feelings. Some examples of 'ijime' are teasing with words, ostracizing and even ignoring a student's presence completely.

There is also an increase in young people's suicides. We still vividly remember that more than 20 young people killed themselves after the suicide of a teenage female pop singer. This may have been due to a chain reaction of sympathy specific to adolescence, but it may also be related to their impression-ability, extreme sensitivity to failure and weak ties with friends or teachers. Young people have less experience with the death of relatives because of the nuclearization of the family, and on TV a movie star who 'died' in one program still survives and acts as well as ever in another. In this way they come to feel there is little reality in death.

b) Prime of Life

Because of workoholism, increased job responsibility, and a remarkable increase in the amount and difficulty of work, many people suffer from inappetence, a decline of volition, general fatigue, insomnia and severe depression. And those who retired after working very hard for more than half of their lives sometimes fall victim to 'burn out syndrome,' and they are unable to enjoy healthy lives.

Living in a fast-paced and highly technological society, workers become apathetic and gradually lose the ability for human communication.

c) Old Age

The extension of the average span of life for Japanese and the increase in the proportion of the aged population are more rapid than those of any other country in the world.

If an aged person is able to have a role in his or her family or society, it will help with his or her independent and active life. The role of social welfare in this field is no less important than medical care.

Conclusion

As future doctors, we should not limit ourselves to prevention, early diagnosis and treatment of psychotic diseases, psychotherapy or drug therapy; in addition we should try to treat people as human beings, to help them counter anxiety and maladaptation, to intervene as well as we can in their human crisis.

The role of social support in mental disease

The paper presented by China bore the title 'the role of social support in mental disease', was mainly conducted to investigate into the relationship between onset of schizophrenia and manic-depressive psychosis with social and personal factors. Schizophrenia means a complete psychological breakdown while manic-depressive psychosis is just a fluctuation in mood.

Residential Factor:

The incident rate in urban area remains highest as compared with those in the rural and mountainous areas.

They suggested that in urban area, competitions and conflicts are keener than elsewhere and human relations are also more complicated and inconsistent.

On the other hand, production format of the mountainous area is relatively simple. Better relationship among people both inside family and outside provide good social support.

Social background

Good correlation is observed between the duration of the cultural revolution and highest incidence of diseases. The social change at that period (69 – 78) resulted in a reduction of interpersonal trust and intimacy, and a distinction of social support.

Age

2 prominent peaks are observed at ages 20 – 30 and 45 – 50. These are equivalent to the period of poverty and revolution.

During the 1st period, establishment of intimate and trusting interpersonal relationships is extremely important for pshchological development. If little attention is paid to this continuous progress of socialization of 'newly admitted' adults, some of them may feel it difficult to cope

with the social conditions and interpersonal relationships.

For the second peak, it also reveals that before the time of incidence, most of people have experienced some family disintegration or suffered from serious psychological trauma.

Sex

Females are more susceptible than male to mental disease. The incidence rate of female is significantly higher than male after age of 35. Because of the extent of liberation of the female in China, they are facing many problems in withstanding double loads orienting both from work and faimily. As certain inherent weaknesses of female in social character, congesting situation tends to deteriorate easily results in psychological diseases. In addition, some literatures point out that China has a much lower prevalence than the western countries. In the peper, reasons as suggested for this:

(1) The unique characteristics of Chinese makes them less susceptible to manic depressive psychosis.

(2) Many people with depressive mood do not consult doctors and some might get automatically relieved later.

(3) depressive symptoms are often somatized.

(4) Being an agricultural country, the living tension is less in China.

Many a time, the public will not consider an individual with manic-depressive psychosis abnormal. People still maintain link with him. This kind of social support actually lesser many of the psychogenic stress.

Design for an ideal social support network

The existing social support network consists of the following:

Specialty hospital, general hospital (psychologic consultation and OPD) – Regional Mental health OPD – Regional mental health rehabilitation workshop – Resident committee – family members (mental health home care)

This network serves to

(1) provide systematic therapy;

(2) continuous medication after discharge;

(3) provide job opportunities during rehabilitation.

In the paper, 3 suggestion are made to improve the design:

(1) introduce correct concepts of mental disorder thro' mass media.

(2) sociologists and psychologists join the work.

(3) mental registration will be introduced in addition to personal registration.

THE JAPANESE

The Japanese delegation to the 7th AMSC included students from many medical schools and universities all over Japan and was by far the largest single delegation at the conference with 35 delegates. Accordingly, the Japanese participants comprised a heterogeneous mix of different personalities, including many of the most colourful characters attending the conference. Despite being composed of members from several different universities, the Japanese group were extremely well organized in all their activities as reflected by their well coordinated paper presentations and highly entertaining performances during Cultural Night.

Many of the Japanese participants whom the writer of this article came to know personally were refreshingly different from the traditional stereotype of a medical student. Osamu Kunii, also know as "Sam", is an idealistic young man who expressed the wish that Asian medical students and future doctor would build upon mutual bonds of friendship and understanding established during the week long conference for the sake of friendship and future cooperation. Sam took time off from medical school to spend eight months studying traditional Indian ayurvedic medicine, Sanskrit and Hindu philosophy in South India. Kakue "Seiko" Masuda, potentially the latest and greatest Japanese teen idol, set the audience on fire with her exhilarating solo performance on Cultural Night.

Takako Suzuki, a warm and sensitive young woman who plays the piano and sings in restaurant cabaret acts to help support herself financially, spent her summer conducting field studies on health care in remote parts of developing South East Asian countries.

These and other personalities among the Japanese and other delegations were to a significant extent what made the 7th AMSC tick. But what is life actually like for Japanese medical students? The following profile is based on correspondance with Mr. Masahiro Tanaka, the Japanese chief delegate to the 7th AMSC.

Tanaka-san studies at Akita University which has 620 medical students with a male-female ratio of about four to one (rather unfortunate for the men, like us in HKU-ED.). Tanaka-san is a fourth year student (equivalent to our 3rd year) who says he studies two hours a day on average. His interests including art, pop music, international medical research club membership, sport and karate. The Medical Society at Akita University is not very active, like it's counterparts in other Japanese medical schools, only organising a freshman welcome party and a school festival every three years which entails concerts, exhibitions and so on (take heart Medso Exco!-Ed.)

Needless to say, admission to Japanese medical schools is highly competitive, possibily because doctors in Japan are very well paid and held in high social esteem. This may change in the near future due to an excess of qualified doctors. Most medical graduates receive training to become specialists but increasing numbers are being trained in broader fields before specialising. It is difficult for newly qualified doctors to enter private practice unless they have parents who are private practitioners. This is partly due to an excess of private practitioners in urban areas while rural areas are not sufficiently rich in potential patients to support a private clinic ("inverse care law"?-Ed.). Accordingly, most doctors came to work in hospitals in Japan.

There are two types of medical curriculum in Japanese medical schools. Type I is employed in universities with separate faculties for Medicine, Science, Arts and so on. Type II is used in medical colleges with no general education faculties. The expanding volume of medical knowledge in prompting increasing numbers of medical schools to switch to Type II curriculums.

Japanese medical courses have two or three examination periods each year: this varies from year to year and between different schools Each subject is graded from grade A to grade D, grades A to C re-presenting passes.

Chief delegate Tanaka found H.K. medical students to be similar in nature to those from Japan but "more diligent and more independant...". He felt very much at home in Hong Kong with it's skyscrapers, crowded streets and buses: he found Hong Kong much like big cities in Japan. He enthused that, "I can safely say that every Japanese delegate loves Hong Kong." and was extremely grateful for the hospitality of the HKU students during the 7th AMSC. He and other Japanese participants expressed their wish to reciprocate this hospitality when we visit Japan.

Type I curriculum

Teaching by general education faculties	1st year 2nd year	:-Sciences (maths, physics, biology, chemistry) Foreign languages, Law, Economics, etc. Physical education
	3rd year	Precilinical sciences
Teaching by medical faculty 6	4th year 5th year 6th year	Clinical subjects

Type II curriculum

1st year	:-general education (as described above)
2nd year	Preclinical subjects
3rd year 4th year	
5th year 6th year	Clinical subjects

THE MALAYSIAN

The Malaysian delegation at the 7th AMSC comprised a group of fourth and fifth year students from the National University of Malaysia led by Mr. Harwant Singh. There are about 800 students in the Medical Faculty at this university which is also known as Universiti Kebangsaan Malaysia (UKM). The overall ratio of male to female students is roughly one to one, with a lower ratio in the junior years as compared with the senior years reflecting the recent trend towards more females taking up medicine in Malaysia. All students are provided with accomodation in hostels at UKM. The Medical Faculty is attached to the General Hospital of Kuala Lumpur and is somewhat isolated from the rest of the university. The medical students are therefore less active in activities at the University level but they organize and participate in many medically oriented activities such as talks given by Medical Associations. They also excel at sports, especially hockey and rugby.

Admission to the Medical Faculty is very competitive and priorities is given to certain ethnic group in accordance with the ongoing policy of restructuring of Malaysian society. Following three years of compulsory government services, medical graduates may go into private practice or continue in government service. Despite the greater financial benefits of private practice, a significant proportion of doctors remain in the government sector because of their satisfaction with government practice. The social status of doctors in Malaysia is very high; doctors pursuing more advanced fields such as cardiac surgery have to go abroad for training.

The medical curriculum at UKM, like elsewhere, is rather heavy. The general outline is as follow. The First Year is a premedical course with 400 students, only about 190 of which are selected for entering Second Year.

As in Hong Kong, traditional medicine is a significant health care alternative in Malaysia. Although the relative strength of Western medicine versus traditional medicine is controversial, most of the people believe in both. In fact, traditional medicine is a complex, specialized field in Malaysia.

Year of curriculum	Subjects	Examinations
2nd Year	Anatomy, Physiology, Biochemistry	1st Professional Examination
3rd Year	Microbiology, Pathology, Parasitology, Pharmacology, Community Medicine, Basic Clinics	2nd Professional Examination
4th Year	Medicine, Surgery, Orthopaedics, Paediatres	3rd Professional Examination
5th Year	Psychiatry, ENT, Opthalmology, Anaesthesiology, Radiology, Surgery, Obstetrics and Gynaecology, Nephrology, Dermatology, Community Medicine	
6th Year	Paediatrics, Community Medicine, Psychiatry, Surgery, Orthopaedics, Medicine, Opthalmology Obstetrics & Gynaecology	4th Professional Examination

The view among the Malaysian delegates, at least according to their chief delegate Mr. Singh (whose kind correspondance contributed much to this article), was that Medical students in Hong Kong were "a very talented lot". Mr. Singh found Hong Kong much like Singapore or Kuala Lumpur, also cities with large Chinese populations. He also enthused that the 7th AMSC held in Hong Kong was "the best organized conference so far" but hoped that the 8th AMSC, to be held at UKM would be even better. Let us all hope for the same.

THE SINGAPOREAN

The delegation from Singapore to the 7th AMSC consisted of eight students drawn from the second, third and fourth years of their medical school. They were led by the incomparable fourth-year student Mr. Lawrence Lau, who insisted on always wearing a white party jacket, possibly because he missed his clinical ward rounds! The Singapore delegates represented the National University of Singapore, which has a large medical faculty with around one thousand students.

The medical school curriculum at the National University of Singapore shows a similar overall pattern to our curriculum, with one and half years of pre-clinical teaching followed by clinical courses. There are, of course, the inevitable professional M. B. B. S. exams forming hurdles along the way. Entry to the medical school is highly competitive, with only about one in ten well-qualified applicants being accepted.

Although the medical students from Singapore work hard, at least some of them play hard as well. Their medical society is quite active in organizing extra-curricular activities. The Faculty of Medicine Shield comprises inter-year sports events held annually. Like us in HKU, they have a freshman orientation programme, annual dinner and dance and even an annual medical exhibition. Other activities include the Medic-Law debate, regular dance parties and visits to welfare homes.

After graduation, Singapore medical doctors face fairly good prospects. Although newly qualified house officers do not earn all that much, upwardly mobile medical professionals may gain social status and financial standing as they rise up the professional hierarchy. Singapore doctors are required to work in government hospitals for five years after graduation – this is not so undesirable when compared with compulsory national military service! After the five year bond, private practice is a popular choice for doctors in Singapore. Post-graduate training is generally adequate, with courses being offered in fields such as internal medicine, general surgery, paediatrics and so forth leading to the degree of M. Med. Training for MRCP, FRCS and FRACS is also available.

As Singapore is an Asian country, traditional medicine is widely practised and accepted there although most of the people would turn to Western medicine if their ailment was serious. Thus doctors in Singapore are generally highly regarded as elsewhere around the world.

When asked for his impressions of HKU medical students, one of the Singapore delegates said that they were much the same as those in Singapore: diligent, hard-working and sparing little time for other activities. He qualified his statement, however, by restricting his description to fourth and fifth year students, particularly "those living in Clinical Students Residence". Just where he got his ideas from is not clear. Our friend appeared to like Hong Kong as a City in general, saying, "The city bustles with activity, night and day, seven days a week. Great fun!" As for comments on the 7th AMSC, he was just as enthusiastic, rating the Conference as a great success in all respects! Those who participated all look forward to the 8th AMSC.

SPECIAL PAPER FROM JAPAN

THE EFFECTS OF ATOMIC BOMB EXPLOSION ON HUMAN BODIES

When the atomic bomb explodes, intense heat rays (6,000 degrees C. at the hypocenter)are generated; blast pressure by the atomic bomb explosion covers a wide area; and radio-active rays that are characteristic of the atomic bomb are thrown forth. When the human body is struck by the heat rays, bomb blast and radioactive rays simultaneously, serous symptoms and casualties break out.

As the radio-active rays give effects on human bodies for a long time or hereditarily, it is easier to understand the casualties of the atomic-bombed if you classify them as follows:-

I. An acute atomic bomb disease (within some four months after they are atomicbombed)

This is a disease caused directly by the atomic bomb. Within 1,000 meters from the area of the hypocenter, wooden houses are entirely destroyed, so there are many people who are killed instantly by the blast pressure from the bomb explosion. (Fig. 1) Death within a few days from excessive bleeding by external injury or severe burns caused by heat rays (Fig. 2) also shows a very high rate.

From about a week after they have been atomic-bombed, a peculiar symptom by radioactivity

from the atomic bomb begins to appear. Even those, who have had no wounds or burns but have got strong radioactivity, become less energetic to produce white or red blood corpuscles because of the trouble in internal organs (marrow (Fig. 3) or lymph gland), and finally they become bleeders. It is at this period that they are mistaken for dysentery patients. It was rumoured at this time that Nagasaki had many dysenterv cases, because the victims have bleeding in their intestines and suffer from bloody diarrhea. If the victims have a bacterium in their bodies, they have no white blood corpuscles to defend against it, and suffer also from the complication of septicemia. (Fig.5) These things cause the increase of the death of victims, Alupecia by atomic bomb is also prevalent at this time. (Fig.6)

It is within nearly one month after the A-bombing that the most conspicuous symptoms of radioactive casualities develop.

After a month, a gradual recovery of the attacked marrow is seen, yet various troubles in the internal organs remain apparently.

It is nearly from this time that marks made by the burns of heat rays swell to form keloid whose marks have never disappeared until now Atomic Bomb Keloid.

The atomic bom survivors gradually began to get better. However, they suffered a great deal of psycological shock, and the terrible state they lived in with regard to nutrition, clothing, and shelter was a great obstacle to their recovery. Also, because of a shortage of medication, many patients who should have recovered did not receive adequate treatment and died of complications.

II. The late effects of A-bomb irradiation

There are many people who had suffered for a long time or have been suffering until now from the external wounds or burns caused by the atomic bomb. We call such cases "A-bomb irradiation diseases".

Apart from the above, there are also those, who had not suffered external wounds or burns at that time of A-bombing, yet had symptoms, somtime later, that looked like those caused from the A-bomb. Including hereditary affection, we call them "after-effects of A-bomb irradiation".

5-7 years after the bombing, the victims in Nagasaki and Hiroshima had leukemia (blood cancer) with very high frequency, of whose development we have been in great concern as the aftereffects of A-bomb irradiation.

Besides these, we found later, that the cancer of the thyroid gland develops much among many victims. As the period of the development of the cancer is different from each victims, full investigation and its medical treatment are necessary hereafter.

As for the aftereffects of A-bomb irradiation, it is noticeable that A-bomb cataract, microcephalic symptom which is caused when the embryo is struck by A-bomb heat rays, etc. are conspicuous among A-bomb symptoms.

As for the hereditary effects on 2nd or 3rd generations, long and wide range investigation being necessary, careful reseach has bening carried out by the concerned institutes.

Issei Nishimori (Head of the Atomic Disease Institute of Nagsaki University School of medicine) etc.

THE RECORDS OF THE ATOMIC BOMBING IN NAGASAKI 1982

--This is the summary of the paper, and we want to speak about some points especially late effects

ATOMIC BOMB KELOIDS (Fig.7)

Keloids are also seen in burns and after operations, but among those burned by the atomic bombing the incidence of keloids was high, with many severe, abnormally protruding keloids. These are called Atomic Bomb Keloids.

EYE INJURIES

@Eye injuries can be divided into the following three types:

1. Direct injuries such as burns, especially of the eyelids. External injuries due to flying objects, particulary broken glass. Conjuntivae caused by radiant heat, and damage to the retinae.
2. Local abnormalities due to radiation sickness, for example, abnormalities accompanied by anemia, hemorrhage, and infection.
3. Delayed effects such as cataracts, deformities of the eyelids caused by scars and other accompanying effects.

@ Atomic Bomb Related Cataracta (Fig. 8)

One particularly noteworthy optical injury is a kind of lesion called Atomic Bomb Related Cataracta; it was the first delayed effect to be detected and was very common.

After a latent phase lasting approximately three months after the bombing, Atomic Bomb Related Cataracta appears and progresses during the following ten years. After this, the condition is stationary and subsequent visual disturbance is a result of aging.

MALIGNANT TUMORS

Concerning malignant tumors, it was discovered that over time a great many atomic bomb survivors contracted cancer. At present the types of cancer that are recognized as having, or possibly having, a connection with radiation are cancer of the thyroid gland, the breasts, the stomach, and salivary glands.

LEUKEMIA

@(General considerrations)

Leukemia, or "cancer of the blood", is a disease in which the white blood cells show abnormal proliferation.

In the acute period following the atomic bomb explosion, the bone marrow of victims fell into

Hiroshima.
1yr after the A-bomb.

Nagasaki.
A-bomb cloud
3mins after bombing.
So called "mushroom cloud"
has reached 20,000feet.

Nagasaki.
Remains of a horse
near the hypocenter.
Aug.10.1945.

Hiroshima.
2.2km from the hypocenter.
Aug.6.1945.

TABLE A

rad	0	100-199	200<
male	55.80	66.19	88.09
female	33.24	37.00	62.70

a state of hypoplasia Among some of the people who managed to escape death during this period, autonomous proliferation of abnormal cells began to apperar about one year after the bombings.

@(Frequency)

The incidence of leukemia in atomic bomb survivors reached a peak around 1950 and showed a decreasing tendency thereafter. In Hlroshima, the annual incidence from 1947 to 1958 was 8.1 cases per 100,000 people, while incidence during the same period in Nagasaki was 5.9/100,000.

The annual incidence of leukemia in Japan as a whole is 3 cases per 100,000 people, which shows clearly that there is a high incidence of leukemia among atomic bomb survivors.

@(Chromosomal Changes) (Fig.10)

Chromosomes are located in the nucleus of the cell and play a vital role in hereditary. The number of chromosomes differs according to each species but there are 46 in the human cell.

Exposure to radiation causes various changes to occur in the chromosomes. Chromosomal abnormalities have been confirmed in the lymph node and bone marrow cells of atomic bomb survivors, and in proportion to the dose of radioactive rays.

@(Clinico-pathological aspects)

IN studies concerning leukemia in atomic bomb survivors, it was discovered that the disease appears soon in young people and increas ingly later the older the person was at the time of the explosion. This tendency was particulary evident in chronic myelogenous leukemia

MULTIPLE MYELOMA

The incidence of the diesease is only 0.5 cases per 10,000 people, which makes it much less common than leukemia, but an increases incidence of multiple myeloma was found among older atomic bomb survivors who received a large dose of radioactive rays.

GASTRIC CANCER

Previously, there was no data to prove a causal relationship between exposure to the atomic bombing and gastric cancer. In 1982, however, Dr Sekine, Dr. Matsuura et al (Table A) reported a significantly high incidence of the disease in survivors who received radiation doeses of over 200 rads. They also stated that the histological features of the gastric cancer differed according to the dose of radioactive rays and that a significantly high incidence of the disease was observed in patients who were under 30 years of age at the time of the bombing and who received a high dose of radiation.

INTRAUTERINE EXPOSURE

The fetuses in women at the time of bombing were affected in many ways. Many pregnant women died in the bombing, and among those who survived there were miscarriages and still-births. Also, many of those children who were born and lived died after several years or were mentally deficient.

This tendency was greatest among the women who received high amounts of radiation or who showed symptoms of actue radiation poisoning.

MICROENCEPHALY (Fig. 9)

Microencephaly is the condition in which the head measurement on a standard deviation is more than two times smaller than that of the median measurement for those of same sex and age. Cases in which microcephaly is particularly pronounced are accopmaied by mental retardation.

There was a high percentage of microcephaly among those children who were in the uterus at the time of the bombing. Severe microcephaly accompanied by mental retardation was high among those who were fetuses 3-15 weeks old at the time of the bombing.

GROWTH AND DEVELOPMENTAL RETARDATION

According to a survey of the growth and development of those who were small children at the time of the bombing, in HIROSHIMA in particular, those who received more than 100 rad of radiation showed less than normal growth in height. Since there was malnutrition at the time, however, it is impossible to attribute this solely to the effects of radiation.

GENETIC EFFECTS

If the offspring of animals irridated with radiation are closely observed, it is found that some are born with deformities and many other damages. In other words, radiation affects genetic matter. Therefore, it was feared that there would be a genetic effect produced by radiation on the descendants of atomic bomb survivors; in this regard the investigations have been conducted on the second and third generation -- the children and grandchildren of the survivors. However, in the investigations taken up until now concerning abnormalities, chromosome abnormalities, and abnormalities in the arrangement of amino acids of proteins, it is not clear whether the atomic bombing has caused genetic damage. Despite this, the possibility of radiation-induced genetic damage as seen in the results of experiments with animals is undeniable. It is necessary to conduct careful studies in the future and continue is follow this matter.

LIFE SPAN

It is a fact that animals irradiated with radiation age more quickly, and because the rate of cancer and leukemia due to radiation increases, the death rate increases and the average life span decreases. Because of this, a studies of the life span of atomic bomb survivors is being continued at present.

FIGURES

Fig. 1

Fig. 1
A burned streetcar blown over by the blast wind, and the bodies of passengers. The dark parts of the corpses are burns, and have turned a dark red.

Fig. 2
The burned corpse of a young boy approximately 700 meters from the hypocenter.

Fig. 3
Along with a lowering of blood and immunity functions, hemorrage and necrosis can be seen.

Fig. 4
A section of the thigh bone showing the marrow. Because no blood cells of any kind can be formed, it appears sponge like. (The marrow is that of a dead person who was 2,900 meters from the hypocenter.)

Fig. 5
Burns became infected, making it difficult for them to heal. Because the damage to the marrow, they became even more difficult to heal.

Fig. 5

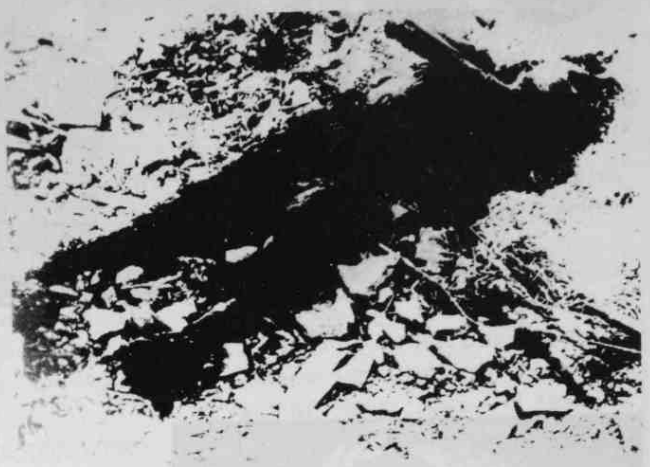


Fig. 2

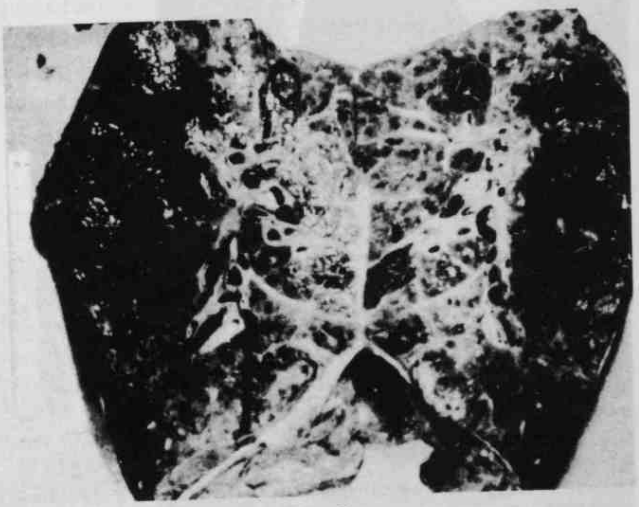


Fig. 3

Fig. 4

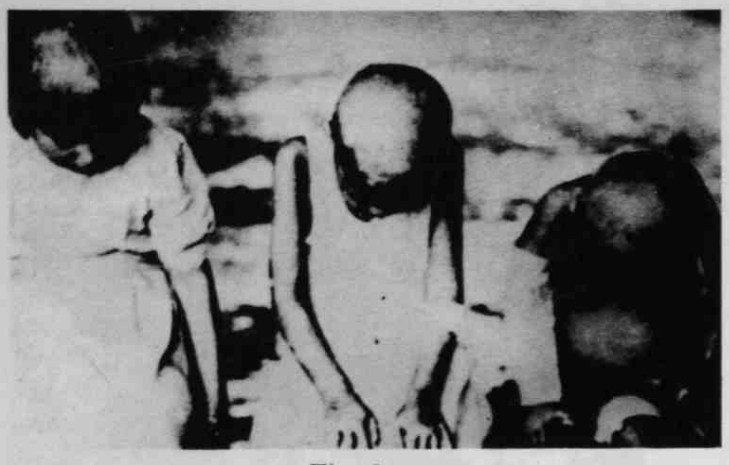


Fig. 6

Fig. 6
The picture showing the falling off hair of three children.
Fig. 7
Moulage a model of keloid caused by heat rays of the A-bomb
Fig. 8
Atomic Bomb Related Cataracta.
Fig. 9
Left: Normal (12 years old)
Right: Microcephaly (15 years old)
He was the fetuses (7 weeks) in woman at the time of bombing. He was died at 17 years old.
Fig. 10
One of the chromosomal changes that was observed among Atomic Bomb survivors.

Fig. 7

Fig. 9

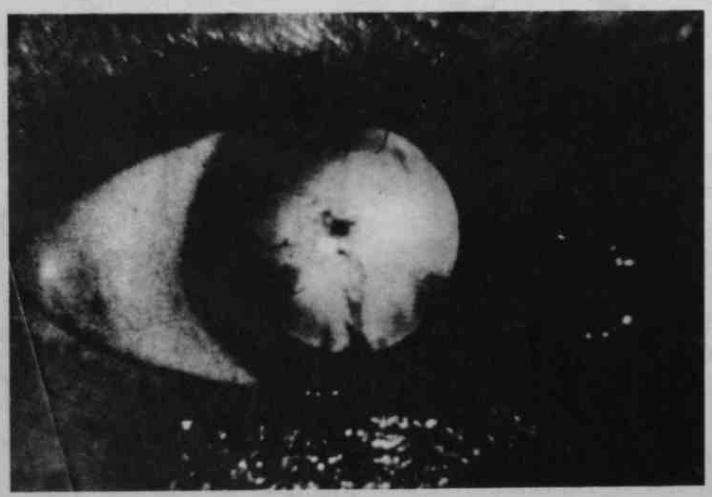


Fig. 8

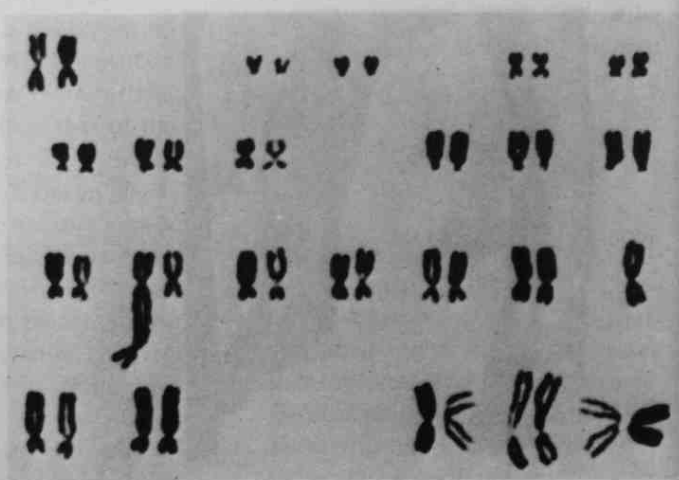


Fig. 10

MESSAGE OF PEACE

The primary task of medical staffs is to save people's lives. And the amazing "advance" of modern technology has led us to this critical situation which does not allow us to accomplish our task through devoting ourselves only to daily duties. If we are unaware of this fact, we may permit, although tacitly, the holocaust of millions or even billions of innocent people to be executed in the near future. What I mean is, of course, the increasing risk of NUCLEAR WAR. It is said that the total storage of nuclear weapons is already enough to kill all living things on this planet not only once but hundreds times.

41 years have passed since the end of World War II. But there has not been even only one day without warfare anywhere else in the world. And the arms race between U.S. and U.S.S.R. is heating up. In our country Japan, it should has abandoned militarism, the reflection for what Japan has done during the WWII is seems to be fading out.

Japanese present political leaders are leaning towards old dangerous militalism. They are trying to strengthen military alliance with the U.S., while stepping up its own military capability, and to carry the burden of nuclear war strategy against the U.S.S.R. Recently, a history textbook for senior high school students that was made by a fascist orgaization has been justified as defensive act. Although there are several other textbooks and regional school authorities are able to decide which one to use, this controversial textbook will be used at some schools from 1987.

This is a one of regretful symptom of the revival of aggressive hegemonism. I think that we are still so far a way from real peaceful world. I want to talk with you about what we can do as medical students to realize peaceful world.

We have to save everyone's lives. We must defend the people's right to live without any oppression. Let's jam for the great future. It will be a long and hard way, but we have to go forward. All over the world, millions of people have already begun to join together under th flag of PEACE.

I think that Japanese youth has especially important responsibility to built one peaceful world. Because Japan itself has committed serious fierce crime of the war not once but repeatedly.

Masaya Haba
a medical student
from Nagasaki university

Nagasaki Medical College was locuted on this hill,1900 feet from the hypocenter.

CONTRIBUTIONS

適逢我們醫學院一百週年紀念的大日子，人人在談追憶往事、前瞻未來的當兒，我也來湊湊熱鬧，翻閱從一九五零至今年的杏雨，看看究竟這三十年多以來，這本醫學院週年刊物的轉變如何，更希望從撰文中探索一下多年來醫學生的思想及意識形態的改變。

遍閱三十多年的杏雨撰文，雖然花去了我整個下午的時間，但卻看到不少感人的文章，亦彷彿把我帶進一個時光隧道，讓我體會不同年代同學的心聲。縱使是身處的時空不同，但這一羣同學卻同樣有着一顆充滿理想的心靈，勇於面對及挑戰生活。誰說醫學生缺乏崇高的理想和抱負，只懂得埋頭書本而缺乏反省生命內涵及週遭事物的能力？雖然，可能這些文章的作者今天已不復再有這些的理想和抱負，當然，他們更可能貫徹始終，達成他們的理想。但無論如何我們不必爲此嘆息，因爲正如唐君毅教授所言「個人不能表現其原有的精神了，只是個人的事。但是那種「精神」，只要曾經存在，其中有一價值，則此價值即存於永恆之世界中，我們亦永當肯定其中之價值。而此價值，亦永遠可爲我們所不忘，而永存於我們之心中，以永遠去啓發後來的青年精神。」以下我摘錄數篇文章，　但求達致刺激大家大腦的活動，再次思索作爲一個醫學生，我們每人應有的使命及責任。

五十年代的杏雨比現在的要薄，文章幾乎全爲英文，內容除報導大事外，多爲一些學術上發展的記載，由教授或醫生撰寫，生活性的文章也有，但眞正對醫學生活和使命有所反省的卻很少。

六十年代學術性文章開始減少，但內容仍以英文爲主，另外還有些短篇的笑話。

七十年代正值學運，杏雨亦刊了不少關於學運的文章，七零年更刊登孫中山先生於大學的講詞及其生平。

八九十年代的杏雨，不用我多說，大家都應該比較熟落，我認爲今天的杏雨比三十多年前進步的地方在於紙質的改良，文章種類的大量增多和較多圖片使閱讀更爲方便，當然還有很多不完善有待以後的接班人發掘及改良，更有賴各位同學寶貴意見的提供。

MEDICAL ETHICS: A CHRISTIAN VIEW

Mok Chiu Yau

It is a pity fact that our Faculty of Medicine, perhaps the best and most advanced medical school in S.E. Asia, cannot even provide its students with sound teachings of the basic concepts of medical ethics which is so unique and characteristic of the medical profession. The practice of good medical ethics is vital for the society to have faith in medical men. There is no need to say why presently in Hong Kong the medical profession is "respected" but not dignified.

No other profession has so long a history of established professional ethics as that exemplified in our Hippocratic Oath, dated from about 200 B.C. Medical ethics is indeed our glorious inheritance. "Ethics" has been defined as the science of moral duty, or, more broadly, the science of the ideal human character and the ideal ends of human action; the chief problems with which ethics deals concern the nature of the highest good, the origin and validity of the sense of duty, and the character and authority of moral obligation1. As medical practice and experimentation concern human beings, totally unlike many other sciences which deal with non-living things (e.g. inorganic chemistry), some kind of ethics is more than appropriate here, all the more so if we consider it as a transaction with the health and lives of men.

Throughout the history of medical ethics idealism is the common attitude. Although a doctor may not be required to take an oath at graduation, he is expected to uphold the highest standard of practice, and this is to be done at all costs. A brief look at the Hippocratic Oath[2], whose influence is felt through many centuries up to the present, would make this obvious. In 1948 a modernised version of the Hippocratic Oath was adopted by the World Health Organisation in Geneva – the Declaration of Geneva3. This was adopted in 1949 by the General Assembly of the World Medical Association as an International Code of Medical Ethics, meant to be observed by all members of the profession in all countries comprising the Association.

From time to time small tracts on medical ethics were published. Perhaps the best-known early book in English on the topic is that by Dr. Thomas Percival4 (1740-1804), a Manchester physician. His "Medical Ethics" had guided the many codes of the English-speaking world, including the American Medical Association Codes. In 1953 the British Medical Association published the booklet "Ethics and Members of the Medical Profession" A special issue of The Practitioner on "Medical Etiquette" (i.e. conventional rules of behaviour) was out in July, 1957. However, in general, works on medical ethics are poorly represented on library shelves as contrast to those on clinical and therapeutic sciences. A good illustration is given in our Medical Library which contains only about 20 to 30 books on medical ethics.

The value of a code of ethics is easily seen. But what are its limitations? In summary, the Hippocratic Oath embodies four main principles: our aim is to advance the Profession and not the individuals; we should not use our knowledge to injure, but to help patients; we should defer to specialist assistance when this is for the best of the patients; we must maintain professional secrecy. There are several limitations for any code like this.

Firstly, there are philosophical questions on the authority of the code: Why must the health of the patient be my first concern? Is this solely for conscience's sake or based on some absolute truth? Why should we maintain a certain kind of doctor-patient relationship? Is this just for society's sake? Why do we think certain relationship as good, or in fact, what is 'good'?

Secondly it is not all-embracing. There are situations in which no relevant principles of the code can be applied. For example, the Hippocratic Oath does not contain principles governing medical research through human experimentation and these have to be provided by the Declaration of Helsinki by the World Medical Association in 1964.

Thirdly a code can only judge actions but not motives while the two are equally important in any inter-personal transaction.

Fourthly in some situations, obedience to laws may precipitate headlong conflict when one principle can only be followed at the expense of another. Professional ethics may have conflict with morality in general.

Lastly, a code is limited by time and place. Society's concepts of 'good' and 'bad' may change with time, and countries of different cultures may need to modify the code.

In the past few decades, advances in chemotherapy, neurosurgery, methods of birth control, transplantation, provision of State Health Systems in many countries and the rivalry among different professional classes pose ever-increasing problems which call for a fresh look on our professional ethics if we are to advance welfare for humanity and dignity of our profession.

Christianity, though it claims to be authoritative in matters concerning the meaning of life and gives guidelines of conduct for the best of human welfare[5], does not set any permanent code to be followed for its sake. Jesus Christ has taught us the golden rule: You shall love the Lord your God with all your heart, and with all your soul, and with all your mind. This is the great and first commandments. And a second is like it, you shall love your neighbour as yourself. On these two commandments depend all the law and the prophets[6] Christ's teaching has much in support for the Hippocratic Oath and Christians should whole-heartedly endorse the main principles of it. However, in some fundamental aspects the Christian ethic differs from natural ethics[7].

1. The authority of natural ethics lies in the opinion of the majority of people while that of the Christian ethic lies in God – the Creator of man and things. A basic Christian belief is that God created man and things, loves them and gives man a perfect goal towards which man should strive in life. There is true 'good' – anything in harmony with the personality and will of the perfect God. Men's utmost happiness is experienced through obedience to God's will – both directly through worshipping God and indirectly through doing their duty among people on earth. Moreover, man is made in the image of God[8] (with personality, intellect, emotion and will) and is loved by Him, so that care for one another, whether medically or otherwise, is a sacred and necessary duty to be done with joy and respect.

2. Natural ethics deal with actions; the Christian ethic is primarily concerned with motives. Love[9] is the supreme law and the keeping of all other laws should be motivated by love. It often involves sacrifice on one's part for the good of others. Christ teaches us to do good, not to bring praise to ourselves, but out of love, to deny ourselves. We should ask ourselves more: why did I take up the medical profession? Why am I studying so hard to get qualification? What prompts me to choose a certain specialty?

3. The demands of natural ethics can be satisfied to the letter; the love of Christian ethic knows no limit. We may fulfill all the routine work of history taking, physical examination, making diagnosis, doing investigations, giving treatment and follow-up with a full sense of responsibility. However, do we often try to know the patient more personally, thinking of him as a 'person to be helped' and not a 'case to be treated', understanding his anxiety and desires? How much time and energy do we spend to help him and his relatives to understand his situation and to solve problems which may not have any clinical significance? Christ has set us a good example: "As he went ashore he saw a great throng and he had compassion on them, and healed their sick."[10]

4. Natural ethics are sometimes practised according to classes, whether of race or socio-economy; the Christian ethic is universal. We may, in a private hospital for the rich, practise the Hippocratic Oath quite successfully, making the patients our first consideration, securing a respect for the Profession, calling specialist assistance when necessary and keeping professional secrecy, besides earning enough for our living. But how often do we think of the poor and under-privileged? Can we notice that nearly all patients staying in government hospitals or attending their out-patient departments are of the low socio-economic class suffering the horrible inefficiency of and neglect by the medical staff? We may not be able to do much to improve the system of medical and health care or the patients' economy; but at least do we wish to give first class medical care to these people? How often do we use these excuses: 'Medicine is a big field in itself', 'We are too busy', 'We'll never finish it if we care so much', for the neglect of people's health and happiness? Christ teaches us to love our neighbours as ourselves and our neighbours are those around us whom we can help.

After all, one may say Christianity is not unique in these as occasionably one may come across some non-Christian doctors who have good motives alongside actions, whose patience and concern for the sick seem so great and who can fulfil his duty to all under his care. But is it not just these things that we fail to do with joy and love, constantly and persistently, because of our corrupted nature in all its self-centredness? Yet Jusus Christ, the Son of God, had come into our world to live out as example for us a perfect pattern of life, and through his death on the cross and resurrection from the grave, enables us, if we so will, to restore a proper relationship with our Creator and Father, and gives us new life and power to carry out our duty to our fellow human beings, either as members of the medical profession or otherwise, to fight for perfect human happiness. This is the Christian answer.

1. Webster's New International Dictionary.

2. See Appendix 1. Hippocrates (460-377 B.C.) was a Greek physician born in the Island of Cos in the south-east of the Agean

Sea and called the father of medicine. He had been given the distinction of being the first to reject the early ignorance and superstition about diseases and to base the practice of medicine on observation and study. The Hippocratic Oath was not written by him.

3. See Appendix 2.

4. Thomas Percival was an English physician and author. While still a student, he was elected a fellow of the Royal Society; it was said that he was the youngest man at that time on whom that honour had been conferred.

5. Christianity is the way of life based on the sole authority of the Old and New Testaments which are the written Word of God.

6. New Testament.

7. Natural ethics here means the ethical systems whose origin is the tradition, experience, and reason of man.

8. Old Testament.

9. Love here means the will to respect people, desiring to help to attain the highest good for them, even at the expanse of one's own benefit.

10. New Testament.

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1. The Distinctive Christian Ethic in Medical Practice (Douglas MacG. Jackson, M.D., F.R.C.S., David S. Short, M.D., F.R.C.P.)

2. Encyclopaedia Americana.

3. Dictionary of National Biography.

FUTURE OF THE MEDICAL PROFESSION

G. Pei

The prime aim of the medical profession is to treat the diseased and to relieve the sick of their suffering. It is, therefore, regarded as one of the most honourable professions.

At present, in our society we have general practitioners who are registered doctors having had one or more years of hospital training after their graduation from their universities or colleges. There are many difficulties in the practice of medicine, we must agree, and the general practitioners encounter them all since they are the doctors in the general public. It is often taken for granted, maybe too readily, that all doctors are omnipotent and infallible to their advantages or disadvantages. A medical man will be accused of ignorance if a case is wrongly diagnosed; for negligence if prompt treatment is not given; and of malpractice if the drugs prescribed to his patients are ineffective. Fortunately, doctors seldom find themselves in these unpleasant situations. If a patient survived after treatment, one could never tell what would have happened if he was not treated, and had he died, he might have died of natural causes.

Doctors are looked upon by their friends and relatives with great admiration and respect, perhaps, not because of their respect towards doctors, but because doctors have good prospects in the sense that fame and wealth will soon be theirs. This wrong attitude is magnified by those who take up medicine as their career so as to become rich when they graduate and will soon reduce respectable medical personnel to nothing more than usurpers and liars.

In the past, the Hippocratic Oath was highly valued, yet I wonder how many of us, both medical students and doctors, really know the contents of the Oath. It is true that there are many patients who demand injections and operations, which should have been decided by doctors, be it for criminal purpose or not. There are others who are displeased when they are told there is nothing wrong and all they need is a holiday. Would it not be better for the doctor to tell his patients the truth than to keep them in the dark in order to please them? Every doctor knows very well that his bank account is not measured by the time he spends on seeing one patient but by the number of patients he sees and that a good beside manner will bring him wealth and good repute whereas strict supervision of his patients activities, dietary habits and complete physical examinations will sooner or later land him in bankruptcy. In order not to lose patients he tries his best to please them which I suppose is not the duty of a medical man. Doctors who have to live by pleasing their patients will soon find themselves prescribing glucose water to hypochondriacs and alcohol to drunkards. There are also doctors who use antibiotics indiscriminately for a trial, when their clinical sense and judgement fail them, on patients which should have been referred to their senior colleagues and specialists. As a result, many

cases are hopelessly delayed and many bacteria are rendered resistant to most useful antibiotics.

To blame the general practitioners for their wrong attitude towards their patients is just like blaming managers of theatres showing bad motion pictures which will not be put on show if the public does not like it. On the other hand, the public will have no chance to see bad pictures if there is none around. To enable general practitioners to withdraw themselves from degrading slavery by their patients, more hospitals should be built with adequate vacancies and reasonable pay for those who decide to go into government service. More stress should be laid on Public Health Work, the teaching of social hygiene and environmental sanitation to promote public health. The other solution is to nationalize medicine. This will eliminate competition for patients and will raise the moral standard of general practitioners. A National Health Service Scheme can do much to remove these evils. However it involves such radical discussions that lack of space prevents its being dealt with here.

There are many solutions to the problem since so many factors are responsible for the present situation, but none would be better than the education of the general public and the proper selection of medical students. The fundamental revolution should be in the man himself. A man with a mature mind is more reluctant to be influenced by his environment, whereas a man with no conscience is not only a slave to his environment but is furthermore creating bad influence on others.

The futures of medical profession are in the hands of recently graduated doctors, students who have already chosen or are going to choose medicine as their career, and especially on teachers of medical schools on whose shoulders are laid the heavy burden of training future doctors. To enable the general public and those who are about to take medicine as their career to have a more sound understanding and attitude towards the medical profession, the profession itself should take the lead in giving them correct and adequate information of health and disease in their proper prospectives, to replace the hotch-potch of novels or cinema which hitherto form the only drink that quenches the thirst of the public. The selection of successful candidates before admission into medical universities should be strictly carried out on the basis that their personality is as important as their academic work if not more important. In regards to the training of medical students, lectures should be given in such a way as to teach the students how to think instead of spoonfeeding materials which can be read up from textbooks. Patients are too often looked upon not as entities or else as feeders of the doctor's purse. Had all these been realised and carried out, we would have no more gloomy situation to face and the medical profession will have a brighter future.

INFATUATION

Howling wind,
Torrential rain,
Endlessly persist.
Pledging my love,
Devoting my soul,
Being lost yet in the middle of mist.

Nostalgic dreams yet never forgotten,
Leaving me lonely lying,
My wounds unhealed,
Only can I regret my infatuation,
My ignorance:
My uncrystallized love being spilt.

Cheung Yiu Fai

閒談生活

鳳元

我是到要創作的時候，才體會到目前生活的貧乏。前陣子音樂老師叫學寫幾句，說要從生活中尋找動機。我於是處處留心，聽清楚每一位病人的呻吟，看清楚每一晚星星的明暗；終於仍是沒有什麼收穫。最後還好憑日記中的一點鱗爪，拾回些以前的趣味，才交成功課。然而，即使近來的日記也不象樣了；斷斷續續，不過是些表面的歡呼慨嘆，每天由上午七時至另一天零晨一時的程序：似乎沒有更無聊的了。

不是說醫學課程令人沉悶。事實上我一直都喜歡着以前和現在的各個學科；更何況自上病房以來，往往又從和病人的交談中得到許多樂趣。我永遠忘不了我的「第一位」老伯。他年青時因家貧失學，後來有個機會學會了做洋服。不幸又因戰亂流落到香港，不名一文。他說：「我從中環走到西環，再由西環走回中環，不知道該到那個地方容身，這樣地來回走了三遍，才給警察抓着。」那時候灣仔是上海洋服師傅的集中地，所以他也聚到他的同鄉同行里去。「我當時年青不懂事，有錢便花掉，待年紀大了才知錯。」但是，他畢竟還能把根基紮好，成家立室。「我們沒用了，你們年青有為，現在可要好好學習，將來做個好醫生啊！」好老伯！可

是，因為課程的緊迫，加上自己又在醫學會中負責些活動，這樣的交談終歸是少。與其說是生活的一部份，許多時候視之為意外倒反適合些。

所以，歸根到底仍是簡單的上課、問病歷、坐圖書館、游泳、跑步、吃飯、睡覺的生活。這樣的日子本來亦很快活；但無論怎樣加起來都不能稱之為豐富。最令我吃不消的是身上沒背着任何責任，什麼也做不成。像有時候問病歷問到病人傷心的地方，他（她）哭了；我傍徨地無言以對，似乎怎麼樣的安慰說話都是虛假。我於是想：「如果我真的是醫生就好了，至少可以為她盡些微力。」另一方面，我在醫學會倒負上點責任。然而這又不是使我太高興的。我總覺得這會內大家說得太多、太理想，却不太切合實際；而許多的理論斟酌，也叫我受不了。我無疑還會視醫學會是個很好的學習和培養自己的地方。總而言之，有些食物本來就沒有味道，醃上醬油不過使入口時大家過癮一點；因此，我其實不太怪自己近來寫的那些日記。

或許，我應該多花點時間創作；又或許，我根本不該住在薄扶林道。

獻給曾協助醫學會發展的同學

佚名

「擴闊胸懷，容納他人他事，培養公德，發揚民主精神，做個好醫生。」

這是八〇年幹事會內閣競選時所提的方向。

在卸任的時候才來再嘗試解釋清楚一年前提出的東西，似乎時間顛倒了。

「擴闊胸懷，容納他人他事」

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

智者求真，仁者求善，勇者求美，我們追求智者、仁者、勇者的擴闊胸懷。

胸懷，是用來容納的。容納就是把一些人和事放在自己心裏。

每一個人都會關心他自己，懂得愛護自己，時刻的為自己打算。

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

人不是獨自為生，人亦不只為自己而活。

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

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

我們已踏出了擴闊的第一步。

問題是，我們還會再走多少步？

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

去關心，去愛護週圍的同學，朋友，大家爲創造快樂的羣體而共同努力。

去關切班會的發展，去參與醫學會的推動，去支持學生會的運作，我們的胸懷愈納愈多。

繼續擴展開去，走入服務人羣的行列，把社會推至一個公平的境地。

將國家人民的苦難，命運和成就與自己連在一起，把民族的責任放在自己肩上。

留意世界各地的事情，把整個地球猶如放在心中，與自己的心房共同跳躍。

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

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

沒有人敢說他的胸懷已大至不能再大；亦沒有人該說他的胸懷凝硬得不可擴展。

只要我們努力，我們胸懷容納的人，可以從自己，多一個人，兩個、三個……以至千個、萬個、億個。

只要我們努力，我們所做的事，可以是一件、兩件、三件……直至千件、萬件。

只要我們努力，我們可以向着至眞、至善、至美逐步進發。

只要我們是向着無限進發，我們已可以問心無愧，不管我們只是剛開始起步，還是已走得老遠。

「培養公德，發揚民主精神」

在人生的每一階段，我們都屬於一個特定的團體。

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

對於每一範疇的團體，我們都有一定的責任，權利和義務。

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

我們每一個都是團體的主人。班會是我們的，醫學會是我們的，香港是我們的，中國是我們的，世界是我們的。

主人便應有主人的風範。試想想你怎樣做你心愛底東西的主人。

主人有管理、改善、發展團體的權利和義務。

這就是「民主」，「民」即我們，「民」「主」，就是「我們」做「主人」。

民做主一定要有兩個條件：

要有民可以去做主的制度。

要有民主動去做主的精神。

兩者缺一不可。

誰敢說醫學會制度不民主，但有多少同學曾發揮民主精神去善用這個制度？

所以只有民可以做主的制度，民主的精神才能夠發揮。

只有民主動做主的時候，民主的制度才得以運行。

做主人是怎樣說的？

第一部是關心，瞭解團體的事情和發展——這是「知」。

第二步是就所知的事去思想，分析，提出批評和建議——這是「思」

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

知、思、行，這就是民主精神三步曲。

我們對班會要知、思、行。

我們對醫學會要知、思、行。

我們對醫學院和大學教育須知、思、行。「爭取權益」是其中的一部份。

我們對社會要知、思、行。「關心社會」是其中一部份。

我們對國家要知、思、行。「認識中國」是其中一部份。

我們對世界要知、思、行，「放眼世界」是其中一部份。

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

這就是培養公德，發揚民主精神。

「做個好醫生」

做好醫生，是絕大部份醫學生的理想。

作爲一個醫學生團體，聯夥做好醫生，是必然的共同目標。

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

我們最少要心懷病者，把他們的需要掛在心中。

我們要對社會和醫療制度鞭策，使服務能眞正切合人羣。

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

爲什麼提這樣方向的口號？

這可以說是兩年大學生活體驗凝聚的成果。

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

但從一年級開始，我一直對這樣的方向感到疑惑，它似乎欠缺很多？

參與校政，改善課程只是爲爭

取禮益？

爲甚麼要關心社會？

認識中國應抱甚麼態度？

關心同學包括在內嗎？

探討人生哲理，追求藝術的美善放在那裏？

找尋人類永恒本質應否是大學生目標之一？

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

我不滿意它作爲大學生的指標。

我要去尋求更眞切的方向。

回頭再看看一些已像投身「放認關爭」的人物。

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

他們埋頭在自己的道路上走，其他方面卻顯得那樣貧乏。人的內心……

也看看那些「放認關爭」以外的同學。

「虔敬」的信徒只着眼別人的靈魂，他們的愛和勇氣比他們所信的是如何的局限。

大部份人都只關心最接近他們的愛侶，課本、小圈子、享樂、心胸是何等狹窄……

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

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

這一切一切都使我覺得非要尋找新的精神方向不可。

環顧全班，相信願意出來做幹事的不會多出於兩三個。

感覺上我不得不盡力使醫學會能發展下去。

但，如果我決定出來的時候，我可以爲同學做些甚麼？我要朝那個方向走？

我不願重拾學界所提的口號，因爲這既不全面，更不能針對同學普遍心態。

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

要訂明一個基本的取向，包括人生一切，並解釋其中意義。

要能聯結所有人，所有人都能投身其中。不管有沒有信仰，不管有沒有參與醫學會。

要針對全部每一個同學。

只關心自己的希望他能關心多一個人。

只關心班會的希望他能支持醫學會。

只關心醫療界的希望他能對香港整個社會關懷。

只談認識中國的希望他能眞正投入民族去。

要提出一個醫學會長期努力的方向，而以我們一屆的幹事會展開第一步。

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

我滿懷信心、希望。

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

但，大家都懷疑怎樣把口號落實。口號太空泛了，包含太廣，摸不着邊際。

口　口號眞是空泛嗎？

不！

如何去使各班同學主動接觸，融洽生活；如何使沙宣道上下歡樂，是醫學生節的目標——這是容納他人。

檢討課程，正因爲我們有權利和義務對我們所接受的教育提出意見。

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

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

搞好班會，讓我們創造一個活潑蓬勃的大家庭。

其實醫學會的一切活動，都可以是落實的好方式。

口號是點出了其中的精神和方向。

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

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

只是個人修養嗎？不。他人他事，公德民主，全是面向外出的。

那麼，這一年來做得怎樣？

慚愧，整年竟是一事無成。

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

也許少在幹事會內部闡釋口號的內容，以至幹事會不知怎樣把行動配合口號。

提出方向的我，更由於本身未能完成責任以致拖累幹事會的強力運作。

整個醫學會也不曾給人一個鮮明的印象。

我們錯失了一年。內中的掙扎，痛苦非外人所能體會。

那麼，放棄了嗎？

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

我們只是第一棒走慢了，但我們可以急起直追。

我們要做的，是去詳細闡釋和