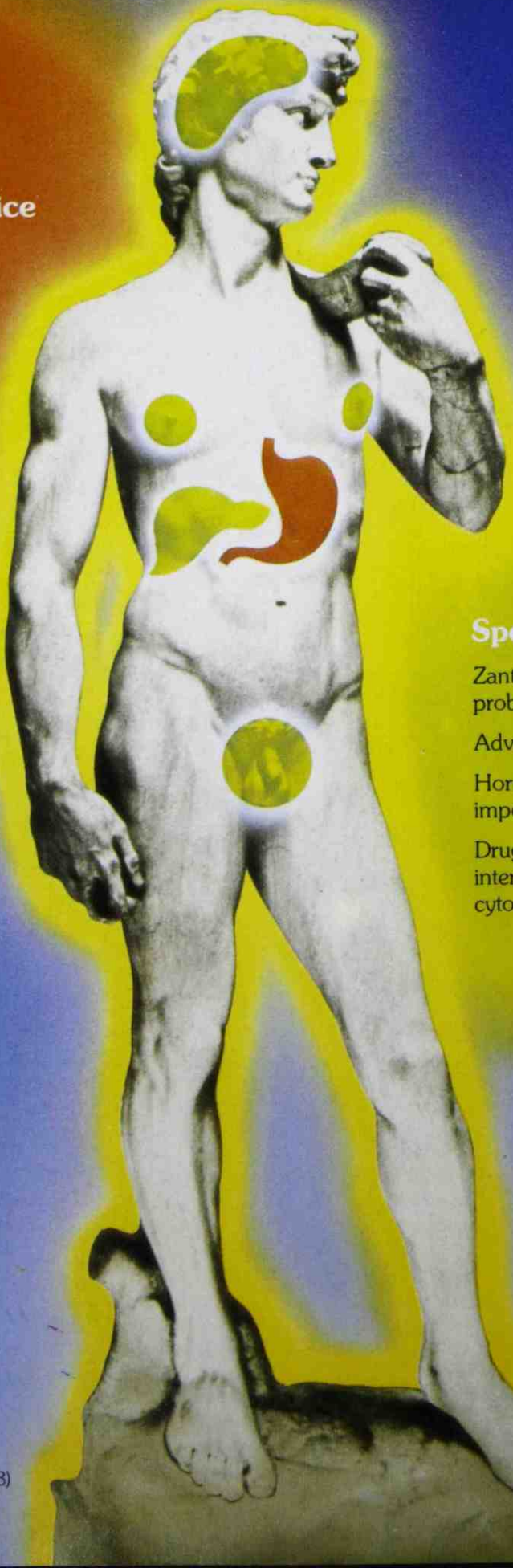
Effective in practice

80% ulcers
healed in one month[1]

Rapid pain relief[2]



Specific in action

Zantac is without clinical problems resulting from:

Adverse CNS effects[3]

Hormonal disturbance causing impotence and gynaecomastia[4]

Drug interactions due to interference with the hepatic cytochrome P450 system[3]

Zantac
RANITIDINE

the superior H2 antagonist

References:

1. Digestive Diseases and Science, Vol.27, P.712-715 (1982)
2. Scand J. Gastroenterology 1981 16 (69) 101-105
3. Lancet, 1982 (i), 601-602
4. Gastroenterology 84 (5) 1127 (1983)

Glaxo

CONTENTS

Editorial Board

Editor-In-Chief:	Fan Wing Cheong
General Manager:	Tso Lui Ming
Financial Manager:	Choi Sum Hung
Ex-Editor-In-Chief:	Lau Tin Kay, Peter
Editors:	Cheng Pui Wai
	Lee Siu Yin, Ruby
	Yuen Yin Fun, Canissa
	Wong Kar Yin
	Tsui Kwing Wan
	Tong Wah Lung, Doris
	Poon Man Kay
	Ming Kee Ying, Thomas
	Leung Ngan Ho, Teresa
	Lee Chi Kin
	Kong Chi Ho
	Choy Tat Lam
	Cheung Chi Chung
	Wong Yuen Man, Carol

ELIXIR '83 EDITORIAL

Continuing the Good Work

The publication of ELIXIR now is a far more complicated business and demands more devotion than it was in the fifties. With so many attractive Society functions, it is difficult to find editors fully dedicated to their job. Besides, a great deal of patience and perseverence is required to finish the lengthy editorial work, which spans across at least one and a half year. It is in this perspective that we believe the editorship of ELIXIR should go to first year students. Though this has been done before, there is still a 'standard' practice to have second year students taking charge of Standing Committees. Not for ELIXIR! Unfamiliarity with the Medical Society proves to be no obstacle. On the contrary, the ample time one can spare during one's first and second years is crucial to ELIXIR's successful publication.

All students activities, it is said, are to instil into their participants social and administrative skills. The work of ELIXIR, however, remains uniquely challenging and rewarding in the sense that it can serve as a lasting memento of one's efforts. The editorial process, from data collecting to layout design to final printing, not only allows one to be familiarised with publishing work but enables one to gain insight into the multi-faceted life in Medic as well. All in all, the editing of ELIXIR is a valuable and worthwhile experience that one should treasure.

In the past, ELIXIR used to be the sole publication of the Medical Society published by an independent Editorial Board. As the Society expands, ELIXIR becomes incorporated as one of her Standing Committees. Nevertheless, our editorial independence has not, and probably will never, be compromised. For an annual journal like ELIXIR to be credible, its views must be unbiased. Being a brother within the Medic fraternity, co-operation and co-ordination with other Society committees is, of course, essential. But let it be noted that many aspects of our work are distinctly different from our colleagues. We, therefore, would wish not only to preserve our editorial independence but also have more autonomy in carrying out our everyday business. Freedom of the press is the key to democratic governing. Looking ahead to those inevitable political reforms in twelve years' time, we have determined that the independence of our editorial work is imperative to, albeit on a minor scale, the maintainence of our Faculty and Society as liberal bodies in pursuit of knowledge and humanity!

Last but not the least, we take to task the future editors of ELIXIR to uphold her role as a journal dedicated to medical students. If we can make it a practice to enroll the energetic freshmen as editors, and if they can fill our journal with vitality and dynamism, ELIXIR will surely remain a valued possession of students as well as teachers for many years to come!

Editor.—

SOCIETY PHOTO 83

Message from the Dean

The annual message to the Elixir is by tradition a unique opportunity for the Dean to address the student body on topics which are uppermost in his mind. On this occasion the pronoun used should be feminine and the message is not all that rosy.

Two years ago, the Faculty of Medicine was busily engaged in plans for expansion to a total intake of 225 students per year in the mid 1980's. For reasons that my predecessor Professor A.C.L. Hsieh gave you in his message last year, planning had slowed down considerably or virtually come to a halt in 1983-84. However, resources permitting, it will resume later this year for the new preclinical building which will occupy a site in Sassoon Road opposite the Li Shu Fan Building. If all goes well the first intake of an additional 75 students will be in 1990-1991 and the East Kowloon Hospital will be our second teaching Hospital. The obvious question you wish to ask is whether we still need so many doctors in Hong Kong after 1997. What will be the population in Hong Kong then? Does our M.B.,B.S. curriculum today produce the kind of doctors that Hong Kong wants after 1997? These are just some of the questions, and I am sure you will have more in mind.

Pondering these important issues myself, I strolled down to the Faculty Office one Sunday afternoon and found buried among the archieves some records of Faculty meetings conducted in 1942. In those dark days of the Japanese occupation of Hong Kong several expatriate members of the Faculty held regular meetings in Stanley where they were kept as prisoners of war. The minutes of these meetings were handwritten in pencil or ink depending on what they could lay their hands on. They formed moving records of examples of hope, courage, perseverance, wisdom and farsightedness of human beings under the most difficult circumstances. They planned for the reconstruction of the University and Faculty of Medicine if and when peace should return to Hong Kong. They talked about the syllabuses of different subjects, the staff structure and new developments such as medical and surgical specialities e.g. cardiology, neurology, dermatology, ENT, ophthalmology, anaesthesia, radiology etc. This gave me a feeling of déja vu since later this year we will be establishing a number of new posts for the teaching of many of these same specialities. The internees even proposed to the Senate that the time had come for the University to have a dental faculty! The uncertainties they faced then were much greater and more numerous

than those we face today. Yet they had as their first concern not their own safety or fortune but the future of the University and the well-being of Hong Kong.

The question we should ask ourselves is not so much whether Hong Kong after 1997 will need more or less doctors than the two universities can produce, but how we can equip our doctors with the necessary professional skill, knowledge and grounding in medical ethnics to enable them to function effectively in a society which may not have the same socio-economical or political structure as they are used to. In due course we may need to make some changes in the emphasis of our curriculum as we are already doing by introducing general practice, behavioural sciences and other new subjects. But the principles of medical education always remain. Our medical students must understand the scientific basis of medicine and how to apply it to clinical practice. They must cultivate the habit and ability to continue self-education and keep abreast of medical progress and above all they must be ready to serve unstintingly the community to which they belong.

On a brighter note, the Faculty has at last started its Curriculum Review. The 2 syllabus committess (Preclinical and Clinical) will have a series of meetings in April – June and their recommendations will be discussed by the main Curriculum Review Committee later this year. In this respect I must thank the Medical Education Review Committee of Medical Society 1981-82 for having produced a very comprehensive and constructive document on this subject. It is not expected that the curriculum will be overhauled once again, but certain improvements and changes are required e.g. a redistribution of time to accommodate the teaching of specialty subjects. I can assure you that the "Consumers" view and interest will be given due consideration in our deliberations and no doubt the Faculty will welcome were "pearls of wisdom" from the students later.

I must stop now and leave something to say next year.

April 17, 1984

R.T.T. Young,
Dean, Faculty of Medicine.

Office-Bearers, session 1982-83

Council Chairman:
Mr. KAO Hing Kee, Frederick (M'84)
President:
Dr. Felice LIEH-MAK
(Dept. of Psychiatry)
Vice-President:
Dr. S. K. WOO
(Dept. of Obstetrics & Gynaecology)
Honorary Treasurer:
Dr. Patrick Y. D. WONG
(Dept. of Physiology)
Associate Members' Representative:
Dr. K.M. MOK
Council Hon. Secretary:
Ms. LAM Woon Yee, Polly (M'86)
Ex-Chairman:
Mr. FUNG Kin Wah (M'84)

EXECUTIVE COMMITTEE

Chairman:
Mr. CHUNG Kam Man, Thomas (M'85)
Internal Vice-Chairman:
Mr. LIT Chau Hung, Albert (M'86)
External Vice-Chairman:
Mr. AU Tak Kwong (M'86)
General Secretary:
Mr. WONG Chi Keung (M'86)
Financial Secretary:
Mr. HO Pak Cheong (M'87)
International Relations Secretary:
Mr. CHAU Pak Fai, Francis (M'86)
Welfare Secretary:
Mr. NG Tat Yuen (M'87)
Sports Secretary:
Mr. CHIU Kwong Yuen, Peter (M'87)
Assistant Sports Secretary:
Mr. PENG Wenn Hsin, Philip (M'87)
Social Secretary:
Ms. CHEUNG Sau Yi, Clara (M'87)
Current Affairs Secretary:
Mr. LEUNG Chau Mau (M'86)

CADUCEUS

Chief Editor:
Ms. SHAM Fung Ting, Connie (M'86)
General Editors:
Mr. NG Hung Yu, Ernest (M'86)
Ms. WONG May Ling, Dora (M'86)

ELIXIR

Chief Editor:
Mr. FAN Wing Cheong, Fernand (M'86)
General Manager:
Mr. TSO Lui Ming (M'86)
Financial Manager:
Mr. CHOI Sum Hung (M'86)

HEALTH COMMITTEE

Health Officer:
Mr. CHAU Kai Yin (M'86)
Assistant Health Officer:
Mr. CHUNG Hon Ping, Joseph (M'86)

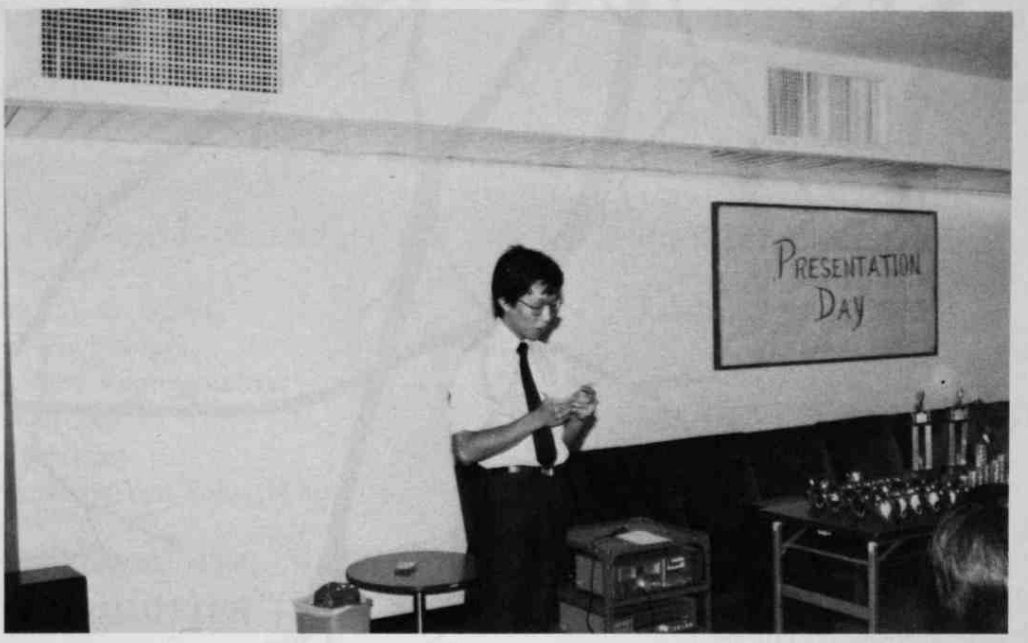
STUDENT REPRESENTATIVES in

Senate:
Mr. LAU Tin Kay, Peter (M'86)
Faculty Board:
Mr. TUNG Man Chung, Michael (M'85)
Mr. CHAN Kwok Keung (M'86)
Mr. TAM Kam Wa (M'87)
Selection Committee of Various Loan Funds:
Mr. HO Pak Cheong (M'87)
Library Committee:
Mr. LEE Shun Wah (M'86)
Mr. HUI Tak Wing, Samuel (M'86)
Ms. TSANG Man Ching, Anita (M'86)
Faculty Review Board:
Mr. FUNG Kin Wah (M'84)
Mr. CHUNG Kam Man, Thomas (M'85)
Senate Library Committee:
Mr. TAM Kam Wa (M'87)

CLASS REPRESENTATIVES

Medicine Final Year (M'83):
Mr. NG Man Ho
Mr. LEUNG Yun Sum
Medicine Fourth Year (M'84):
Mr. YIU Kar Chung
Mr. NG Kwok Keung
Medicine Third Year (M'85):
Mr. TSOI Tak Hong
Mr. TAM Kin Ming
Medicine Second Year (M'86):
Mr. CHAN Nim Tak, Douglas
Mr. YEUNG How Cheung, Gustus
(Oct - Nov, 1982)
Ms. FANG, Jane
(from Nov., 1982)
Medicine First Year (M'87):
Ms. CHEUNG Kak Yan, Grace
Mr. CHUI Cup Yan

醫學會整年活動回顧



✣✣每一年醫學會改選，新的競選內閣必定有自己的口號，這口號代表著十數位幹事的來年工作指引和抱負。因此，要回顧整年醫學會的活動，亦應該由幹事會的口號說起。

「羣策羣力，積極參與社會事務，
推己及人，齊心發揚互愛精神。」

從這個口號，大家可知道我們是希望在過去的一年能做到對內加强醫學院同學的互愛精神，對外在各社會事務上積極參與和關注。

「羣策羣力，積極參與社會事務」

在過去一年內，全港市民最關注的莫如香港前途問題了。我們和其他市民一樣，都希望我們現時享有的自由和繁榮安定不會因爲主權的轉移而有所改變。在轉庄之前，我們肯定了「港人民主治港」乃是香港政制的最佳出路。但是，在民主化的過程中，最首要的就是要提高市民的民主意識和對周圍事物的關注。因此，幹事會亦提出了「羣策羣力，積極參與社會事務」作爲外務工作的方向。在一月的九龍灣事件，二月中的市政局選舉，幹事會都儘量搜集資料，以大字報形式向同學介紹，並發起討論、探討和講座，使同學能更加了解事件的眞相。四月的香港政制初探，亦提供一些有關本港政府的一些基本資料，以大字報形式向同學介紹，並舉辦第一屆「麥列菲菲盾」時事常識問答比賽，來激起大家對時事的興趣。

幹事會覺得現今校園內對社會事物討論氣氛的不足，主要原因是因爲在中學時期學校沒有灌輸足夠的公民意識所致，我們希望進一步推動中學生對社會事物的關注，因此，幹事會決定承辦第二屆聯校及港大專題計劃，而今年的主題是「破繭的新一代」，在這個活動中，二十餘個醫學生和二百餘個中學生，以社訪、討論、資料搜集等形式，合力去探討一些社會問題，如新移民，房屋和勞工等問題，雖然由於經驗不足，和行政上發生問題等原因，這個活動仍有很多值得改善的地方，但是，對參與的同學來說，這無疑是一個寶貴的經驗。

在年中，我們曾經檢討上半年度外務工作，覺得醫學生除了要關心整個社會的事物外，還有其獨特的使命，就是要去關注醫療界，因爲，環顧其他各學界的團體裏，實在是沒有其他組織比醫學會更適合去關注醫療界的問題了。八四年亦是香港十年醫療服務發展計劃的最後一年，因此，這年亦是時候去總結政府在過去十年內

醫療發展的得失了。三年一度的開放日，更加是一個適當時機讓我們透過探訪，研討和學習去向市民介紹本港的醫療制度。籌備了個多月的開放日，終於在十一月初開幕了，而醫學會所籌備的兩個展覽，包括醫療制度的探討和醫學生生活剪影，吸引了不少市民參觀。一連串的開放日前的活動，如講座，醫療常識問答比賽等，亦有不少的同學參加。

我們並沒有忘記了國內的醫療制度，在九月中旬，一個小型的探討團，曾經遠赴廣州，透過中山醫學院的事前安排，探訪過廣州的中山醫附屬醫院和訪問過一位在廣州執業的私家醫生，對國內的醫療制度作出初步探討。

在暑假期間，我們曾經和理學院學生會合辦「草與葯」計劃，以圖增加同學對傳統草葯的認識。

「推己及人，齊心發揚互愛精神」

在內務方面，幹事會是希望在醫學院發揮互助互義的精神，增進各班同學的感情和聯繫。各項的班際活動，如班際體育比賽，問答比賽，辯論比賽和醫學生節等等，實在提供了不少機會給各班同學接觸。幹事會亦明白一年級同學在解剖實驗考試時，是極需要高班同學幫助的。因此，我們亦與全班會合辦一些模擬考試，使同學熟習考試的形式。個人覺得此項活動甚有意義，亦希望來年的三年級同學亦能夠如此幫助一年級的同學。在此亦謹向曾參與籌備的全班同學致以最深的謝意。

幹事會亦希望在各項活動上有新的突破，給同學帶來新鮮感。而醫學會第一次高桌晚餐亦在此原則下成功地在二月中舉辦，並邀請內科學系主任達安輝教授，楊紫芳教授和醫學會會長麥列菲菲教授就醫德問題發表演說。福利工作亦不斷推陳出新，如在飯堂增設蔬菜供應和小菜服務等，都是福利秘書不斷努力爭取的成果。

迎新八三的主題是「未來的醫生，醫生的未來」，籌委嘗試以三套幻燈片，刻劃兩個不同性格的醫學生的遭遇，由入學，畢業後成爲醫生，在醫院服務以致兩人以不同的態度面對香港未來的轉變，配合不同類型的活動如角色扮演等，來刺激新同學去思索入醫學院的目的和自己的將來。今年首次舉辦的迎新雙週，是希望在開學的首兩個星期內，協助一年級同學熟習醫學院的生活，項目包括有講座，水運會和各項比賽等。雖然由於經驗的不足和各種客觀因素，迎新雙週還有不少值得改善的地方，但是，迎新雙週仍不失爲一個很好的嘗試！

健展八三的主題是「癌症知多少」，主要是向市民介紹本港的第一號殺手——癌症，使他們對其早期症狀有更深刻的認識，以便在不幸染病時得以及早延醫治理。而醫學會的全年經費主要來源——電影籌款人員，亦在籌委們的努力下順利籌得六萬餘元。

今年的活動的繁多在歷年來說，可算是少見的。單靠我們十一位幹事是不可能辦到的。最重要的還是有不少曾經爲各項活動出力的各位同學，才可以有如此豐碩的一年，在此謹向這些同學致謝！除此之外，我們的老師麥列菲菲教授，鄔世傑醫生，黃宜定教授，附屬會員代表莫嘉明醫生，他們對各項活動的意見和支持實在是十分重要的，在此亦謹向他們致謝！

在此請容許筆者向評議會主席高興基同學和在每次評議會都默默地盡忠職守，抄錄下每一句會議記錄的林煥兒同學致以最高謝意，沒有他們的幫助，醫學會各項會務肯定不會進行得如此順利。

過去的一年在自己的腦海裏留下了不可磨滅的回憶，其中令筆者最珍惜的，就是有機會和各幹事捱過了這一年，箇中當然有不少的歡樂，也有不少的誤會，有通宵達旦的趕工，也有徹夜不眠的談個通宵，自己確實犧牲了不少時間和精力，但是卻一點沒有白費，因爲，正是在這同甘共苦的日子裏，才能夠孕育出我們之間深厚的友誼！

八二至八三年度
醫學會幹事會主席

鍾錦文

✣✣一年的時間說長不長，說短亦不短。這一年裏自己所幹的東西不多，亦沒有甚麼建樹，但感受卻不少呢！聽到杏雨八三的總編輯要我們十一個過氣幹事每人交文一篇時眞有點驚訝。想來想去亦不知寫些甚麼才是，因爲我恐怕會出現十一篇類似的文章！終於還是決定寫些較爲個人的感受吧。

還很清楚記得當初決定當內務副主席的一切一切。相信有一點是我與歷代祖宗很不相同的———對於副主席一職沒有太大的理想和期望。在我一年班的時候，我跟大部份的同學一樣，對甚麼是醫學會（Medso）根本一竅不通，亦遑論那些社會醒覺，認中關社等等的東西。所不同的，可能就是我過份活躍好動吧。我出來的原因無他，只是爲了朋友。我知道他們需要我，亦很希望與我一起工作，因此便勉爲其難地出來了。說實話，我眞是很勉爲其難的。既然已決定了，本想趁此機會接觸些新事物，多認識新朋友，可是做來卻因種種因素而令我對自己不大滿意。其實這責任應由自己來負，不能歸咎甚麼。

一年總也過去了。轉眼間便已回復「平民」之身。＊「註」

不知道是時間跑得太快，還是我走得太慢。落庄日眞有一份空虛失落之感。雖然那時候這一切感受都被那如釋重負的喜悅所掩蓋！除了書桌上的那面紀念盾外，我沒有甚麼實實在在的得着。是否我白白地浪費了一年呢？落庄固然開心，但奇怪得很，我又極之懷舊，那時我們在Medso房內的囂鬧聲還不時在耳邊出現。Medso房的一切還是這樣的熟悉，每天自己都不自覺地要跑來看一兩趟。

漸漸才發現自己在這一年內得到了很多。（雖然學到的比我可以得到的爲少。原因很簡單：我這一年來付出的不夠。）半個月前與一位同學談起來才發覺甚麼才是空虛。原來我這年是過得如此充實的！雖然沒有實在的得着，可是原來一切均在無影無形之中。我開始成長了！我的思想較前成熟，我的接觸面廣了很多，而最重要的還是我交了很多朋友。朋友是何等的可貴呢！同學們，千萬不要道聽途說，千萬不要相信大學裏是找不到眞正朋友的。其實問題只是我們是否願意付出吧。世上沒有不勞而獲的東西，你要找到友誼，就得主動把內心的種子撒出去，就得每天去耕耘和灌溉，願大家從今天起都充作「農

夫」吧！

千萬不要誤會，我並不是要爲Medso費廣告。其實這一年內我亦損失了很多東西，放棄了一些別的事情和計劃，得與失永遠都是一併而來的，因爲任何東西都要代價。

寫完「日記」之後，腦海中突然浮現出一件令我感慨良多的事。那就是第三十七屆的週年全民大會（ＡＧＭ）。那次的流會確令很多同學不滿。這是可以理解的，因爲經過了一年的辛勞工作，對我們來說那個ＡＧＭ代表了很多的東西。但同學就連一晚的時間也不願付出，這確使人傷心失望。我並不例外，當時亦頗爲不快！現在已事過情遷，冷靜下來後又有了新的看法。自己一年班的時候根本就全不知道甚麼是ＡＧＭ，當然亦沒有出席。假若我不曾出任幹事，相信我亦不會看重那個所謂ＡＧＭ。現今普遍香港學生對於施與受的概念認識得太過膚淺了。（我亦是一樣！）但是話又得反過來說。Medso是否給了同學很多東西呢？我們所幹的又是否同學們所關心，是他們希望我們代勞的呢？我不知道。我全不知道。但無論如何，希望大家（包括Medso幫）都能嘗試易地而處，用另一個角度去先看一看問題。這是我由衷之言。

冬去，春至，夏又快來了。沙宣道地上的樹葉不知從何日何時開始不見了，路旁的殘樹亦重新長出嫩葉來。是新的開始？沒錯，是新的開始。雖然沙宣道的一切始終依舊，但人面卻全非。一批大家熟稔的面孔從此「消失」，代之的是另一批新的同學。一批相信是充滿朝氣的同學。各位師弟師妹，珍惜光陰吧。趁你們還未被功課的重擔壓得動彈不得前，善用餘暇，幹些別的東西，多交點好朋友，千萬不要虛渡寶貴的兩年。你們隻身空手地進來，但願五年之後，你們不會隻身跑出去，你們不會只學到一些醫學的「方程式」！

註：我從不喜歡同學將「Medso幫」作「官」來看待，因爲我們大家都是同學，根本就沒有甚麼分別。但不知道爲甚麼一些同學總是要這樣稱呼我們。眞令人沮喪之極。

列就雄

送他們一首詩，寫在雲彩上，他們看了，便知我的歸航。

*　　*　　*

祂是知道的……從日出彩霞、藍天共白雲、青山和綠水、浪濤的細語、海鷗的長嘯、到黃昏的寧靜，是我捨不得的。

朋友，看，我又回來了。

當外副時，信我們友誼在心，如今久別重逢，在親在深。與你們一起，使我心凝形釋。他們，可不同；海鷗兒，明白嗎？指的是當外副時結識的，理性理想永屬他們。知嗎？我欣賞理性，但不懂享受它；我欣賞他們，正如他們讚賞我在他們面前的理性。

還是他們的好，他們給我支持，給我鼓勵。外副生涯中最深刻的，九龍灣事件、戴信風波皆不是；而是他們。可是我帶他們遊了半年多花園子，看完，他們原路回去了。

他們比我幸運：雖是原路，始終也是路，浪濤，你可知道嗎？在路途中我迷失了方向，迷失中更愛依戀著你。

夕陽，老者的平淡、完成任務時滿足、及後的孤零，信你我最能感受。

現在我們在快樂，但總有玩的時候；若有期，我要出去重尋路向時，請你們不要傷心，回來也好，不回也好，我們還是在心在深！

區德光

已經卸下了幹事的職務好久了，但有時和好久沒見面的朋友談起，他們總會問一句：「幹了一年，有什麼感想呀？」

是的，感想是太多了，而且好像隨着歲月的溜走，是愈來愈多了。當年在任及剛卸任時，我總會很氣憤的在心裏回答：「感想？爲什麼你不去親身參與，那你便知道是什麼感覺了！」

那時候被孤立的感覺很重。各幹事都有本身的份內事和他自己可供發揮的範圍，而且總不能老是找「自己人」做事，唯有到其他的同學中找幫忙的人手，可是往往得回來的只是沮喪。更令人失望的是甚至連參與活動的同學都是少得可憐。當活動牽涉到非醫學院的嘉賓時，情形便顯得非常尷尬。所以幹事都學乖了：邀請嘉賓前須愼重考慮；各活動都盡可能以班際比賽形式舉行，將保持參與率的責任推到各班會身上。

看起來手法似乎不很光明磊落，但事實上在醫學會這個不大不小的團體內，手段是存在的。爲了辦事順利、有成績給同學看和避免他日被批評，幹事會內部的事前討論及其與攪活動或一般同學的人事關係等都非常重要。爲此幹事會便曾被某些評議員批評爲權力過大，左右着整個評議會的決策。其實，這亦證明了兩個不變的道理：團結便是力量；知己知彼，百戰百勝。

幹事會內部的意見其實並非時常都會一致的，但經過詳盡的內部討論和分析後，大家通常都能在一個折衷的意見上達成協議。雖然不一定是最好的，但在評議會上發表起來，不免會比較少準備的評議員有說服力。

在醫學會內，幹事會對於會章通常都比其他常委會有較全面和頻密的接觸及運用，更不用說與一般不熟悉甚至不關心會章的同學比較。在處理一些富爭論性的問題（如幾次的大字報事件）上，最簡單、最少費唇舌（不一定最好）的方法莫如按最權威的會章辦事。對於不明會章就裏的同學，最能靈活運用會章的幹事會便是最「官」的了。

其實，靈活運用並不等同於正確運用。會章都是寫得很簡潔、亦很含糊。會章的精神，便聽憑運用的人抽取（各取所需）。那個「熟書」，那個便有理。這個漏洞，唯有靠一班明瞭會章的同學去監察。很可惜，通常這都只包括了去屆攪活動的同學。於是，周而復始，醫學會便爲一小撮人所「壟斷」了。

幹了一年，眼見種種的荒謬事：幹了再找理由（自我合理化），攪活動但求體面（活動要大型），做事要順利（人事關係最基本）。最令我印象深刻的，莫如爲週年全體會員大會補開的非常全體會員大會中，爲了湊足法定人數，大家竟容許二十多個由見習醫學生宿舍拉下來的同學在一個他們未參與討論旁聽的動議中投票！然後在動議通過後的兩分鐘內全數離開會場！

我相信，要堵塞這種種漏洞，實有賴一般同學的積極參與和監察。可是，我曾經聽過一位同學質問幹事會，爲什麼在一連串的事件之後沉寂得無聲無息，爲什麼不「帶領」同學爭取「民主」。在開放的架構下，要求自己作主，但又同時要人帶領。我相信，誰也幫不了他。也許，這不再是火紅的年代了。

大學生曾有過積極輝煌的過去，但這些光輝的歷史會否成爲今日的枷鎖呢？我們應否順應潮流，減少全體會員大會的法定人數，還是繼續自欺欺人，敷衍過自己那一年，保存那10%的法定人數，其他的光采和前人的使命在會章上，但願明年會比今年強？活動的數量又是否只可加不能減呢？——減掉一個受歡迎的、有意義的活動，開起來這個罪可是誰也担當不起。

今天，我又回復我的「草民」身份。對於今年醫學會的事務，我沒有什麼實際的貢獻，我也說不出原因。也許，累了。朋友會問：「怎麼，覺得這一年不值得嗎？」絕對不！那一年的經歷，令我的眼界開闊了，認識到團體之運作程序、與及該年曾參與討論的各種社會問題。人們說：『不在其位，不謀其政。』我說：不在其位，不明其理。雖然創痛的經驗比美好的更多、更深刻，要是從頭再走，縱使沒有那屆的幹事會催促，我還是要走這條路！

總務秘書　黃志强

從八三年十月開始，便一直在隨著日子不斷回憶著過去一年的事情，怎樣沒有詳細考慮、自告奮勇地答應了參加競選文康秘書，怎樣大伙兒一起討論路向、方針、政綱、口號，一起通宵工作，怎樣漸漸掌握那些開會程序，怎樣學習和人交往、相處、工作和分配時間，怎樣對醫學會由毫無認識以至產生親切的歸屬感……。

當上了醫學會文康秘書的職位，最初的心情眞是戰戰兢兢和終日惶恐不安的，有時甚至乎要後悔，但實際上卻只能勇往直前，起初的一腔熱誠總不能就這樣冷卻了的。在這一年內，雖然做了的事情一件一件好像很多，但實在是靠其他很多的同學和一些人的幫忙、關懷、鼓勵和支持才得以完成，這些都令我時常內心洋溢著一片的暖洋洋，而雖然工作上會有令人洩氣，沮喪和不稱意的時候，都很快便過去了，抖擻一下精神，又再迎上了新的挑戰，這實在催化了我的成長。

進了大學，擺在眼前是多姿多采、各式各樣的東西，令人眼花撩亂，但我們都可以自由攫取，怎樣的生活方式，怎樣去花費自己的時間，全在自己決定。敢信沒有人可以嘗盡全部，我所經歷的可能你會缺少，但同樣地我亦缺少你所經歷過的，但我實在慶幸和珍惜有這一年的經歷和體驗。

八四年一月卅一日完稿

張秀儀

八四年一月的某一個晚上，我拖著疲倦的步伐踏上通往太古堂的樓梯，經過「東翼學生會」的時候，慣性地往內看看，學生會的時事秘書看見了我，便硬把我拉入時委有關地車司機怠工、靜坐和絕食一連串時件的討論。

回想起去年的同一時候，醫學會的幹事會剛剛結束，便風塵樸樸地趕往「東翼」（當時是凌晨一時許），九龍灣的居民正在房屋署門口靜坐，明天如果不能與房署達成協議，他們便會絕食！

外面正刮著刺骨的北風，「東翼」裏聚集了廿多人（大多數是單位的時事秘書、外務副主席和時委等），熱騰騰的「人氣」，熱烈的討論令人把外面的寒風忘記了。經過八小時漫長的討論，我們決定了學生會在今次事件的立場、如何將事件介紹給同學和怎樣動員各單位同學參與和關注事件等。凌晨四時，會議結束了。回到舍堂看見同房的同學正呼呼入睡，養好精神準備上明早的生化堂：我靜靜地走到桌邊，亮了枱燈，埋頭地寫大字報和工作計劃……

一年來奔走在醫學會與「東翼」之間，在醫學會和「東翼」渡過了不少個類似的晚上。這一年來醫學會的外務工作也可算「多姿多采」。在周年工作報告中有書展、講座，有市政局選舉研討計劃、有香港前途的研習和外國醫生註册事件等，毫不費力便填滿了半份周年工作報告。

但是，有多少同學知道我們面對的問題，有多少同學知道醫學會的外務組織鬆散，高低班同學沒有默契（同一性質的講座可以搞兩次），沒有計劃，沒有延續性呢？而更重要的是面對同學的冷漠，甚至以奇異的眼光看待我們！同樣的問題也可以毫不費力地填滿半份週年報告，但是從來沒有人寫，也鮮有人提出討論。

隨著醫學會第一屆時時事秘書的落任，醫學會第一屆的時事組也解散了。我衷心感謝這一年來在時事組工作過的八七同學和所有曾經關心過時事組的人。一個組織的解散並不意味著什麼，自己也不覺得可惜；我只希望曾經與我一起工作的同學能夠繼續拿出他們的熱誠來關心社會，在實踐中建立自己的理想，價值觀和獨立思考能力。這些都是一個「好醫生」（甚至是一個「普通人」）不可或缺的，也是在正式的大學教育裏唯一缺少了的。聽說一個名叫「外務及時事小組」的組織已經成立，我衷心地希望他們搞得比我們更好！

同樣是靜坐和絕食，地車司機爭取的已不是九龍灣居民的牛油與麵包問題了，他們要求組織工會，參與影響他們的事務。這幾年來香港的社會運動似乎有了很大的進步，但靜靜的醫學會、靜靜的沙宣道、靜靜的「東翼」似乎期待著有一天的來臨，我也同樣地期待著……。

梁就茂

✣✣杏雨范老總一聲令下，「寫什麼也好罷！」可眞叫人頭痛！重新拾起已掉下數載，重若千斤的筆桿，心頭想訴說一番的多的是，唯是面對枱頭的原稿紙，Professor Huang 的一句「Mental constipation 」這回眞的來得貼切！

亦曾考慮到杏雨這份「官方」刊物的特性，但最後仍是自私地決定寫一些自己期待已久，希望寫下來的所謂「感受」。

不知道，也不理會別人對自己以下所持的態度是否贊同，但是一向以來，自己都不是以國際事務秘書（簡稱IRS）的名義，而是以一個普通幹事的身份在幹事會及醫學會內做事。加上感覺上會對歷屆及來屆的 IRS'S 不公平，在此也不準備對這個職位的工作範圍及其在醫學會的存在價值作出甚麼評價。況且寫了下來有多少Medic同學會有興趣知道，自己也心裏有數！因此，若然本文違背了杏雨的一貫路綫或方針，或是未能向各位同學有所交待的話，本人特此致歉！

（附：有關國事務秘書在過去一年之工作報告，有興趣者請參閱「醫學會第三十七屆周年報告」）。

× × × ×

一向頗佩服鍾錦文此君說話的說服力及其「死纏爛打」的心理戰術，而且各人肚子裏也很明白兄長的傾談是否眞的有建設性，但是這屆幹事會內閣由初步接觸以至組成的整個過程，仍是花上了個多月的時間，經常長達至凌晨的會議及討論非但不好受，其必要性也值得商榷。但是這段頗長時間的接觸，卻肯定加深了各人之間的認識和了解，正所謂甚麼「團結」、「坦誠」……等，理論上也應爲日後做事除去不少跛脚石罷！感覺上大家似乎有了一個默契：「即使未來一年內這班幹事一事無成，祇要大家做得開開心心及於心無愧，也達到了我們對自己的最低要求！」

偶爾的一、兩盤冷水，在這時候根本是不足夠把這班候任幹事心中的那份所謂「熱誠」冷卻下來。一位畢業不久的「大仙」曾對自己說過以下的一篇話，到現在還是記憶猶新：「在Medso出來攪活動的同學最容易領悟到的，就是『失望』這兩個字的意思；而學會了怎樣去應付『失望』，已是一個很大的收穫了。」當時聽起來刺耳得很，到了今時今日才曉得這個忠告是多麼的誠懇；到了今時今日才懂得說一聲，「多謝！」

當年十二月一日上庄的十一個幹事，相信與別屆的幹事無異，大家心中似乎都有著或多或少的「雄心壯志」——爲了自己也好，一廂情願的爲了Medso也好——希望在未來一年裏做一番事，追尋一下自己的理想。

無可厚非罷！對不？

× × × ×

縱然有了像以上前人留下的忠告，縱然大家對同學參與活動的反應都有了心理準備，普遍同學的冷感依然是令人沮喪的，而且每每都令人有被孤立的感覺。相信沒有什麼比周年大會流會更能支持這個觀感了；人數不足豈不是說關心醫學會過去一年來工作的同學，還不到醫學會員會人數的十份之一？這可是對這羣在Medso工作了十二個月的人的一個諷刺？

曾不祇一次心頭湧現一個可悲的想法——Medso「塌了檔」又會有什麼關係？會有多於十份之一的同學感到惋惜嗎？上庄初期大家碰上面還有興趣研究一下自己的工作大計，到了後期除了「算了吧！你也不是不習慣了罷!?」外都不能說什麼了。三月間大字報事件正處於風頭火勢的關頭，緊急幹事會會議中的一個話題竟是「很久沒有見過那麼多同學在Footbridge看大字報了！」滿是一副「老懷安慰」的樣子。可笑，抑或是可悲？

就算撇開令人汎喪的不說，過去一年的工作進度距離最初的理想似乎還是很遠。幹事會及其他評議員的大部份精力和時間，都似乎花了在處理善後工作上：外務因工作上未能取得協調而「桌上會談」了整整一個月，一如去年的大字報風波、暑期活動「爆棚」和人手大缺短、醫學生節因意見不合而鬧得頗不愉快、周年大會流會後通宵達旦的研究對策方法……！「補鑊」在Medso的運作上似乎已是家常便飯，亦是大學裏攪活動的通病，因此，不祇是自己學會內的「鑊」，連人家的「鑊」也要花上心思去！（例如「致戴卓爾夫人信件」的餘波等。）這些「鑊」是否能夠用一句「估不到同學的反應是如此……」來加以推搪？又能夠以一句「醫學會的討論氣氛很濃啊！」來掩飾呢？這些事情發生後作檢討時，往往會發覺原來是可以避免的。那麼，是否負責同學的事前準備功夫做得不夠徹底（包括研究前人所得的經驗！），辦事經驗不足？是否他們未能揣摸各班同學的心態及需要？未能夠息事寧人？抑或是參與的同學未能顧存大局？未能體量攪活動的處境，或是誤會了他們的出發點？

攪好醫學會內的人事關係，是幹事會最初組成時所定下其中的一個重要目標。但概觀整年醫學會內的氣氛，幹事會在這方面是失敗的。各常設委員會及幹事會各自爲政，互不「侵犯」，也互不「干預」，醫學會評議會中的討論氣氛已不復返，代之而起的是越濃的火藥味、針鋒相對、意氣之爭！評議會分成兩派已漸明顯了！歸根究底，原因並非難尋——十一名由全民投票選出的幹事，差不多佔了評議員人數的一半，「exco玩晒啦！」這種想法的出現，是不難明白的。再加上甚麼「推己及人」、「容納他人他事」、「互愛精神」……等都似乎早被置諸腦後，去年評議會的運作及功用是叫人失望的！「責任誰屬？」肯定地說是不能單怪任何一個評議員；比較圓滑的說一句：「是大家的責任！」

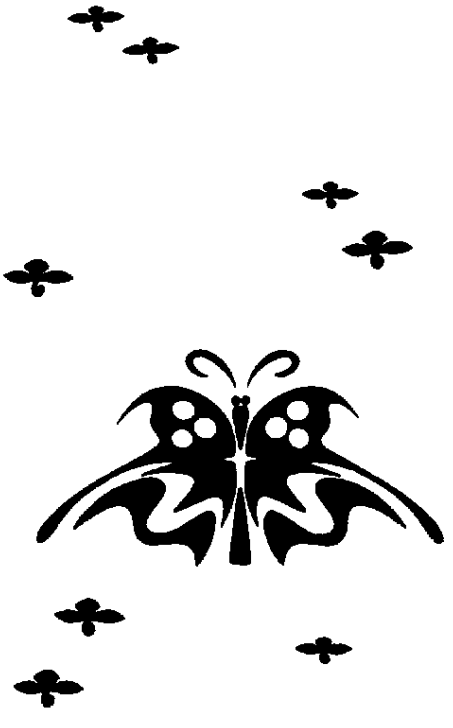
× × × ×

沒錯！連自己也覺得本文是給人有些極端和「有彈冇讚」的感覺！無論讀者們覺得此文「倒也有點道理」也好，或是覺得「此君一派胡言」也好，這篇文章落了在杏雨中也代表了一個幹事經過在醫學裏十二個月後的一點感觸？

不管這十二個月來的經歷是甘是苦；也不管它是否醫學會史上光輝的一頁；更加不管別人對此屆幹事會的評價是好是壞，過去了的這年是值得我懷念的一年！

後記：本文內容乃屬個人意見，而並非代表其他幹事的觀點及感受。

周百暉



體育在醫學院

「M-E-D, D-I-C, MEDIC MEDIC 喺醒啲！」，「Hip-Hip！ Hurrah！」。在衆人的歡呼聲中，接過了亞米茄玫瑰盃（Omega Rose Bowl）。這座頒發給每年院際運動比賽總冠軍的獎杯，代表着醫學院的運動員在過去的一年（83—84）內幾經艱辛，流血，流汗，在比賽中奮力爭取回來的成果這已是醫學院連續第四年奪得這項殊榮了。

醫學院在港大院際運動比賽所得到的優異成績，是有目共覩的。可是這個優勢卻有消退的趨勢。從82—83兩屆的總成績來看，醫學院都只是以極微的比數，稍稍壓倒勁敵工程學院，而且其它院系的運動都有增長，對於前兩者長期對持的局面，構成了威脅。更重要的是，低年級的同學對體育運動參與偏低，從一年級體育堂學比較率奇低和到場參覽比賽和打氣的同學寥寥無幾便可知一二。這現象是令人担心的。

究竟有些什麼原因導致這危機呢？繁重的功課，緊密的課程，無疑都打擊了同學參與體育活動的興趣。另外，醫學會的運動日趨多元化，除了文康、體外，更有思認性和認識性的活動，佔去不少時間，同學便不能積極參加體育活動。當然，課外活動的參與，是要以同學自己的興趣和價值觀作出取捨，而且更加要使同學有整體的發展。另外，同學對院會的歸屬感偏低和愈來愈少低班同學去住宿舍，都導致了醫學會運動員減少的現象。

要重振醫學院在運動的威望並不是一件易事，同學們必須加强參與和關心，但悲觀地說，這仍是不夠的，因爲院際比賽需要的是技術高超的運動員，而院會因爲資源的分配，並不可能有深入的訓練。但祇要同學能同心一致，爲院會出力，相信仍是有一番可爲的。

當然，除了院際比賽外，醫學會還舉辦了班際比賽，希望能提高機會給各同學活動筋骨，强健身體，以應付繁忙的功課，並能夠參與一些自己有興趣的運動；更重要的是可以聯絡高低班的感情，使醫學院內各級能更趨整體化。

去年，醫學院的運動員更曾和羅富國師範學院的同學砌磋彼此的體育，進行第二屆的「沙宣道挑戰盾」，加强兩院校的聯繫。

最後，希望同學能考慮運動的價值。體育運動的推廣對每一位同學其實是非常重要的，沒有强健的體魄，又如何可以完成有如「苦行僧」一般的醫學生涯呢？

體育活動成績（83—84）

A.院際比賽

水運	男子組成績：冠軍	
	女子組	冠軍
	全場	冠軍
陸運	男子組成績：冠軍	
	女子組	季軍
	全場	亞軍

壘球	冠軍	乒乓球	亞軍
網球	冠軍	籃球	季軍
棍網球	亞軍	排球	季軍
壁球	亞軍	羽毛球	殿軍

連續第四度保持院際總冠軍。

B.班際成績

男子組		女子組	
陸運運	85	陸　運	85
水　運	84	水　運	84
足　球	85	籃　球	84
排　球	86	排　球	85
籃　球	85	羽毛球	84
乒乓球	85	乒乓球	85
羽毛球	84	拔　河	87
壁　球	84		
網　球	86	男子總冠軍	
壘　球	84, 85	女子總冠軍	
棍網球	85		
曲棍球	87	總冠軍	85
拔　河	84	總亞軍	84
越野跑	85		

Dear Medso,

怎去開始，解釋這段情？頓感千頭萬，恨愛交纏。

因爲緣，使我投向你的懷抱，也是緣你我間竟會發生一段情。

未識你前，我的生命祇是死黑和死白是你爲我添上了繽紛的色彩，替我幾近枯朽的靈魂灌輸了絲絲生氣，是你帶魔咒的手，牽引我進入了一個新的世界，你飄逸的背影，陪伴我經歷了多少大事，擴闊了我的眼界。

抗日改史血書上的熱血，九一八集會的激情，九龍灣事件的夜訪，木屋區的衝擊，致戴信事件的參與，學苑兩閣對壘…這許多許多，如今都祇能在你我漸褪色的記憶中尋到一鱗半爪，但重要的是，我曾參與，我曾投入，我曾付出。

你給我的改變眞大，你把我不定性的孩子氣趕走了許多，把我鍛鍊得縝密、穩重，我知你對我很是繾綣愛護，但你又怎能忍起心腸來如斯對待我呢？那接踵而來的挫折，期望的失落，同學的冷漠，理想的消沉，家庭的壓力，如山的工作，功課的重擔，又豈是我所能獨力承擔的呢！也許人總是喜歡傷害愛他的人呢。

有時我將在要鬱悶中溺斃，我曾呼叫，但你又爲何寒傲似冰，加不理睬呢？冷漠的人際關係，像一堵堵冰牆，保護了自己，卻也困死了自己，我要跟羅青問：「天上的星星，爲何像人羣一樣的擠擁，地上的人羣，爲何又像星星一般的疏遠？答案啊！答案！」

前塵往事，愛恨交纏，如烟如夢，虛幻是夢裏的眞實，我本無形，我本無根，他日我人海飄蕩，你可否認得夢中人？

Sometimes we watch the days go by,
Wishing they could last,
And we can't help but wonder
why time must fly as fast,
But we can keep in memory
every happy or bitter moment left behind,
And we can keep our special dreams of
joy and hope to find.

Your love,
NG TAT YUEN

18-4-84, 4:30 a.m.

別矣！幹事會！

歲月如流，滔滔逝水，
在衝擦，
許多往事，
一段理情——

還記，
當時年少不知路途險更寂，
飛身撲出，
胸懷壯志，
莫信理想可望不可即。

曾幾何時，
挫折憂患來相迫，
卻是，
悽悽又戚戚。

面對疊浪重重，
百折不回完壯志，
在橫牲中成長，
經火浴而再生，
仍堅信，
我對往事無悔！

學院事務委員會

背景：

在醫學院裏有參與校政事務的，包括了學生教務及院務委員，幹事會和班代表，而且當有特殊需要時還會成立專責小組處理（如八二年度的加位小組和課程檢討小組）。但在與校方交涉的事宜上，卻每感缺乏一個有代表性與連貫性的組織，而校政參與的整體性亦未能顧及。

學院事務委員會（Faculty Affairs Committee），作爲一個成立於評議會之下的專責委員會（Ad Hoc Committee），便是要協調各同學在校政參與的努力，而且亦能將校政參與納入醫學會的常務工作裏。由是在「杏雨八三」裏，大家看到的不是以往的「學生教務及院務委員報告」，而是由學院事務委員會負責的篇幅。

成員：

當然成員包括了下列同學：

劉天驥（學生教務委員，Student Senator）
陳國强（學生院務委員，Sudent Members of the Faculty Board）
董文忠
譚錦華
列就雄（幹事會內務副主席）

其他成員計有幹事會主席，各班代表及數位熱心的同學。

工作概要：

一、醫學院加位——曾於四月間印發小册，詳述政府擬將東九龍醫院撥作加位後的教學醫院一事。年中加位事件沉寂下來，關注工作亦暫告一段落。

二、收生制度——「延長評核法」（Extended Assessment Scheme）施行僅一年，大學方面又再修改八四年的收生細則，我們於是將搜集到的有關資料提供給負責迎新的同學。此外，我們將醫學會的建議，提供給學生會中央轉交校方。可惜我們在見習醫學生宿舍和來往醫院的交通安排兩方面的要求，並未能列入學生會之報告書中。

三、港大三年發展計劃（Triennium 1985-88）——我們

四、UPGC 訪問——在八四年一月初，大學及理工教育資助委員會（UPGC）醫務小組到訪醫學院，並聽取學生的意見。我們提出的要求，主要是擴建見習醫學生宿舍和改進圖書館的設施。

五、其他工作——每月一次的教務及院務會議上，盡量反映同學的意見（如爭取較理想的考試及上課時間安排），並將一些有用的資料轉達給同學（如校方對課程的檢討）。此外，不時在評議會上報告工作的進展，使校政參與更受關注。

展望：

校政參與是一項長遠的承擔，經驗的累積和傳遞非常重要，以往提出的要求，須不斷重申，才可望得到成果。八三年工作的接續，似乎很理想，新一屆的幹事會，曾將校政參與列入政綱，而八四年度的學院事務委員會亦已成立，期望醫學會在這方面的努力能持續不懈。

校政參與也不僅是學生教務、院務委員，幹事會主席、內務副主席，和班代表的工作，還有很多同學，如負責外務和福利的，以及圖書館委員會和課程檢討委員會的學生代表等，都扮演着重要的角色。希望各有關同學都能抱著一份參與校政的熱誠，經常接觸，衷誠合作。

一九八三年的學院事務委員會是個新的嘗試，工作上不少地方有欠妥善，更談不上爭取院方對這個委員會的承認。但來年負責校政的同學倘能繼續努力，必能使這方面的工作發揚光大，爲大家爭權益，謀福利。

八三年度學院事務委員會
主　席　劉天驥
副主席　列就雄

八四年三月

GALA PREMIERE 電影籌款

醫學會每年的活動都是十分繁忙而且多樣化的，對內舉辦活動以團結院內同學，對教育政策及課程提供意見；對外關注醫療時事，走出校園，服務社會。所以醫學會雖是學生會的屬會，然而論活動的質與量，和學生會中央比較，也是毫不遜色的。

要籌辦上述的活動，便需要龐大的經費，由於醫學會是財政獨立的，故此每年都要舉辦籌款活動，以彌補該年的支出，並作爲下一年度的經費。

以電影首映禮作爲籌款形式已有很多年的歷史，除了比較斯文之外，它還提供了一個給醫療及社會各界人士共聚一堂，交流經驗及舒懷欣賞電影的好機會。事實上電影籌款所籌得的款項續年遞增，去年更創下了一個新高峯，這足以證明各界人士對醫學會的支持，是有增無減的。

對曾經參與的同學來說，這也不失爲一個很寶貴的經驗，因爲在籌備過程中，同學們透過討論和合作，充份體驗到團體活動的樂趣；新同學們更能藉此對醫學會的運作有更深入的了解，並誘發他們籌辦活動的興趣和熱誠，爲日後成爲醫學會棟樑而作好準備。

今年的電影籌款晚會於八月三日假座利舞台舉行，放映「GTI大機密」，導演爲曾執導「黑太陽」的HENRI VERNEUIL，此片據說在法國大受歡迎，可惜在港並不叫座，足見香港與外國的口味確是有所不同。其實，近年來港產片也有很多佳作，是值得考慮的。

這次活動共籌得款項超過八萬元，在此我謹代表醫學會向曾經支持及參與電影籌款八三的朋友們致謝！

啟思

啟思啟我思
我思啟啟思

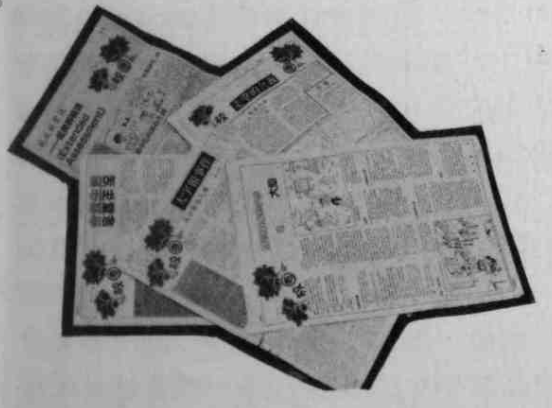
我們懷着理想，熱誠出發。
爲了貫徹這精神，我們付出了精力和時間，當中有苦有樂！現在都應是檢討的時候了……

✣✣要檢討一年的啟思，眞是談何容易！其實怎樣才是一份好的醫學生報紙，同學們對啟思的要求和寄望又是怎樣等問題，我們到現在還未能充份掌握呢！不過總結工作，始終都是要做的，可從兩方面着眼——報紙的水平及編委會內部運作。

回頭望過去

共五期的報紙先後順利出版了，論水準，當然與我們所冀望的有所差距，但是在環境及時間的限制下，報紙的水準及份量也算中規中矩了。

在專題版方面，年初時我們決定嘗試跳出校園，接觸一些社會問題。但結果五期的專題都是環繞醫療界的問題取材，範圍似乎是狹窄了一點。但想深一層，難道醫療問題不正是我們這羣醫學生應該多些關心，有「本錢」多去接觸的嗎!? 其實或許我們應相信「分工」這道理，啟思既是醫學生的報紙是應多着重研究醫療問題的。



在校園版方面，我們厭倦了公式化的校聞報導。所以我們除了增加校聞評論外，還努力發掘了一些新的及有趣味性的題材，用輕鬆的筆法寫出來，如可令大家重溫醫學院以往面貌及風俗的「Medic知多少」。在某些問題上，更深入研究以做成小專輯。效果可能未必達致我們的理想，但這些嘗試肯定是令人欣喜的。

綜藝版方面，質與量比以往提高了不少，而且種類也頗爲多樣化，無疑是令人鼓舞的。但可惜投稿的始終都是局限於一小撮同學，反影着大部份的同學仍未懂得充份利用啟思，仍是有着一些陳舊的錯誤觀念——以爲他們只是啟思的讀者，而非啟思的主人翁。這現象何時才能改變，於圖書舘內的投稿箱何時才能名符其實的「常滿」？

同甘共苦

今年編委會的規模也不算小，但老問題始終存在；編委們除了投入專題或校園版的工作外，便再沒有時間及心情去做一些別的。年初時所希望能做到的研習班，例行午間討論及剪報紙等計劃都一一胎死腹中。報紙一期接着一期的出版，工作一期接一期的延續下去，因循的感覺不免出現。可幸部份編委的向心力很强，憑着互相的支持，終於渡過難關。對抱着要學習的目標而加入啟思的編委來說，這一年可能是一個失望，但有一點是可肯定的——我們都認識了一羣共同工作的好朋友。

希望在明天

同學對今年啟思的評價如何？同學可喜歡啟思的專題題目？等的問題都無從分曉，因爲同學時常都那麼沈默。試想如果編委會只是一廂情願的辦一份啟思强逼同學閱讀，是多麼沒意思啊！

我們願意相信，同學對啟思是關心的，只是不懂得把這份關心形諸於行動罷了！我們願意繼續耐心等候同學們更加積極的參與，願意繼續爲同學努力，貫徹「我思啟啟思，啟思啟我思」的精神！

願啟思繼續成長！願醫學更加茁壯！

最後，謹向各編委於這一年中付出熱誠及毅力致謝！

健委會・目標

鄒啟賢

健委會跟醫學會的其他常設委員會（啓思和杏雨）有很大的分別；在醫學會憲章，健委會一節中開宗明義指出有兩項「目標」，就是：

一、提高醫學生的社會意識

二、舉辦醫學會有關醫療衞生的服務活動

至於啟思和杏雨，它們的工作就是分別辦報章及年刊，在憲章上清楚明瞭，至於各項目標及政策，盡可由編委會決定，但健委會的路向，卻「受制」於憲章的兩項目標中。歷年來這對負責的同學都構成一定的壓力，尤其是第一項，形上而廣泛，每人的理解都有不同，用什麼方法才可達到更是費利思量，令負責同學感到茫無頭緒。

其實要達到憲章上的目標，有很多實制的可行方法，決定全在各屆的健委會委員之上，而歷屆健委會的工作手法，亦鮮有相同者，有時更是南轅北轍。以今屆爲例，工作主要在社會服務方面，希望從中可以將眼界從醫生擴展到社會上的更廣層面；而健委會在醫學會架構中，擔當一個對外社會服務團體的角色，個人認爲亦有很多有利條件，第一，醫學會幹事會和其他常委會，日常有很多職務，這都是在憲章中清楚列明的，他們纏身其中，可能難以抽出時間兼顧社會服務，只有健委會，並沒有規定的工作，而只有兩項目標，都和社會服務有關；第二，健委會作爲一個常設委員會，可以有系統地計劃整年社會服務的安排，聯絡及事後檢討等工作，第三，在資料保存方面，一個常設委員會肯定可以做得更好，而這些資料，對日後同學展開類似工作或遇到困難的時候，可以有很大的幫助。

根據以往健委會的作風，工作通常都是集中於醫療方面，但考慮到以上三點，可能的服務對象頓爲之擴大，心目中就有老人、青年、兒童、弱能人士、社會福利，輔助醫療服務等，而筆者基本的信念是，醫療不可以與整體的社會福利制度脫節，要做一個好醫生，除了醫術和醫德之外，必須顧及病者的其他方面，要做到這一點，就必須了解不同病者的不同社會需要和各種社會設施所能提供的服務，因爲一個醫生畢竟時間有限，不能每事都親力親爲；而透過直接參予其活動，亦是了解上述兩方面最有效的方法。可惜本年度這方面所做到的，實在有限，如果未來的健委會能在這方面繼續努力，實在是令人鼓舞的。

醫學會舉辦社會服務，亦有客觀的局限條件，主要就是高年班同學太忙，很難抽出時間參加，而低年班的同學對醫學上的問題，又往往一知半解，所以在籌辦服務的時候，我們實在希望不太過涉及醫學問題；可是醫學會畢竟是醫學會，如果服務活動完全和醫學扯不上關係，可難免令服務對象失望，所以這些活動實在是兩面不討好，惟有希望高年級的同學甚至畢業後的醫生以後能給我們更大的支持和鼓勵。

最後，誠如上述第一個目標，健委會要提高醫學生的社會意識，首要就是提高同學對健委會的認識，本年度開始籌辦的健委通訊和啟思「醫療事」專欄，亦以此爲目標；此外亦可提供一個園地讓同學思考和抒發自己有關醫療和社會服務的意見，更可爲日後留下一些記錄和心得，希望可以繼續下去。

健展八三「癌症知多少」

鍾漢平

狂風怒號，波濤澎湃，十號烈風訊號經已懸掛，此刻離健展原定的展期還不足半天，籌備了九個多月的健康展覽會否因此而功虧一簣呢？

幸好颱風「愛倫」很快便離去，健展八三終於在九月十日揭幕，雖然已經延誤了寶貴的一天，但還餘下三天的時光，各籌委亦算舒了一口氣。

大會堂展覽

展期因颱風襲港而由四天改爲三天，自九月十日至十二日假大會堂舉行，在短短三天中，共有七千多人來臨參觀，成績已十分理想。

今年的健展保留了不少往年的特色，除了簡化精美的版面外，還安排播映幻燈，電影及電視錄影帶，盡量利用不同的方法，把知識帶給市民。此外，還印製了一些資料單張，免費派給市民，作爲市民的備忘，也好讓這些知識能更廣泛流傳。今年的一項突破，就是得到「香港八三」的幫助，把「及早察覺，及早治療」的訊息，嘗試以一輕鬆的手法帶到市中民去。

新世界中心重展

今年的健展原先並未計劃在大會堂展覽後移師別處重展的。適逢一名加拿大人仕Mr. Stan Guiguard在他的環球防癌籌款活動中途經香港，籌委會覺得此項活動意義深長，亦監於展期因颱風影響而縮短，很多市民未能得益，同時剩餘了少部份物質，例如場刊、單張等，所以便主動接觸Mr. Stan Guignard，決定在九月廿四日、廿五日在新世界中心重展，並協助他爲本港癌病者籌募善款。是次展覽中央籌得六千多元，並把這些款項轉交香港防癌會。今年健展能爲癌症病患者盡點綿力，也不枉花了的一番心血。

同學的參與

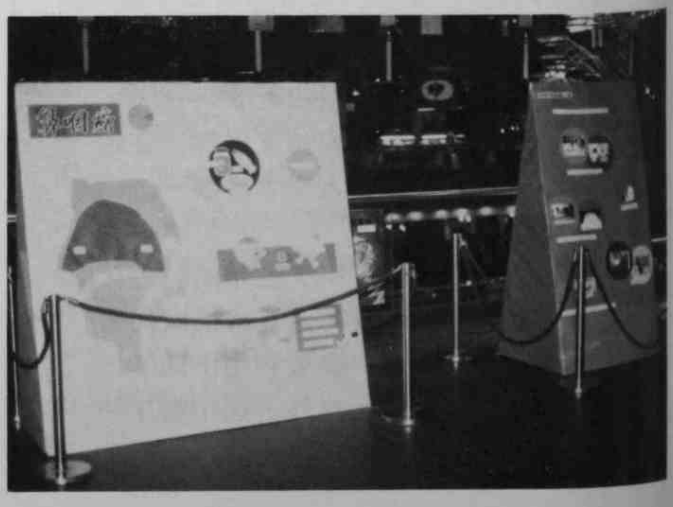
在整個健展過程中，同學的反應可分爲兩個階段：

在展覽前，同學們的參與普遍冷淡，自一月成立籌委會後，很多工作都是由籌委成員獨自充當的，人手短缺等問題，歷屆健展如是，因此在構思整個展覽時已再三思索，作出了最保守的估計，盡量利用現有的資源，以減少各籌備同學的負擔，畢竟健展的工作量並非十餘同學所能應負，面對種種問題時，只好憑着爲市民服務的心志來各自默默耕耘，努力解決，至於什麼分工合作，互相學習，互相幫助的理想，亦非期望中那麼完美。有時眞懷疑健展是屬於醫學會各同學的，還是自己那一小部份籌備的同學呢？

直至八月尾，得到八八新同學的加入，的確爲籌委分擔了不少負擔。最令人鼓舞的就是在颱風襲港期間，有不少同學都問及健展的情況，可能就是這一句短短的慰問，便足以爲籌備工作的各同學帶來無限滿足。而在展覽期間，亦有不少高年班的同學來臨助鎮，高年班人數之多，眞可媲美低年班的同學，對於低年班的同學，特別是八八新同學們，猶如打了一支强心針。

健展意義何在？

「爲廣大市民服務，提高市民對健康的認識，重申健康的重要」是健康展覽的主要目的，相信每個同學都知道，但除此之外，健展還有沒有其存在價值呢？



其實健展可說是醫學訓練中重要的一環，如何去了解市民的需要，如何把醫學知識從書本中抽取出來，經整理後灌輸給市民，如何使他們明白健康的重要，認識達到健康的途徑，又不至濫用或誤解其中的要旨等，這都不是輕而易舉之事。而從書本中是絕對學不到的，沒有臨床經驗的低年班同學往往不能了解一般市民的需要，什麼要說，什麼不用說，以求達到健康教育的目的，這全不是低年班同學能力所及，但高年班同學卻因功課煩重，不能挺身而出籌備健展工作，由此可見，高低年班的合作是必然的。

從第一年做講解員，第二年做籌委，第三年或以上做資料搜集及分析，這正是一個理想的學習途徑，每一階段都有其存在的價值，有其學習的重點。對於整個健展來說，這三個階段是不相伯仲，同樣重要的。希望曾參與健展的同學能朝着這三個階段自我奮鬥，努力學習吧！

展望將來

隨着醫學會活動不斷澎漲，單是暑假期間便有電影籌款及迎新兩項大型活動，再加上健展，人手短缺可說是一個不能輕易解決的問題，有人提議將健展改爲兩年一度，這畢竟可算是解決人手不足的辦法，而且健展只是健康教育的衆多方法之一，縱觀近年亦有不少團體組織舉辦，類似的展覽，如果醫學會能在暫停健展之年間，以一個創新的方法來推動健康教育，相信市民的得益亦會遠勝健展。但新的方法是什麼呢？相信不是一兩年間能計劃出來的。無論如何，要籌備健展或推動健康教育的熱心同學，先要作好準備，以服務市民，自我學習爲自己的座右銘，面對這重重的挑戰。最後，祝你們在來年再創一高鋒。

ORIENTATION 迎新八三

王志方

「迎新」是醫學會每年度的大型活動之一，亦是醫學會迎接一羣新同學的第一個活動。爲了迎接這一羣「醫科八八」的同學，一羣「八六」和「八七」的同學早在二月的時候，已開始組織迎新籌委，一同計劃和籌備各迎新活動。

今年度的迎新活動包括預科生日、學術迎新、組長營，歡迎日、迎新營、賣舊書和迎新雙週。

預科生日 (MATRICULANTS' DAY)

預科生日是迎新的第一項活動，在七月初舉行、主要目的是在放榜前向預科生介紹醫生和醫學生的生活，希望可以藉此幫助一羣預科生作出明智的選擇。當天參加的同學有百多位，我們除了請來一位醫生和一位醫學生來分享他們的感受外，還有幻燈和分組討論。與「準八八」同學的第一次接觸，在愉快的氣氛下結束。

學術迎新 (ACADEMIC ORIENTATION)

在放榜前後數天舉行的學術迎新，是學生會舉辦的活動。目的是希望向預科同學介紹各院系的情況。醫學會的同學是負責介紹醫學院裏一部份。學術迎新包括展覽和講座兩部份。展覽部份主要向預科同學介紹醫學院課程、收生制度和以往收生的一些資料統計等。在講座中，我們邀請了醫學院副院長和數個學系的講師向同學解釋收生政策和各學科的課程等，並解答各同學的問題。

組長營 (TUTOR CAMP)

組長營在八月初在明原堂舉行，我們邀請了學生輔導處爲我提供一些簡單組長訓練，另外，我們亦藉此機會將四十多位組長聚在一起，一方面討論迎新營的主題和內容等。另一方面，大家也可藉此機會彼此熟落起來增加默契。

迎新日

於八月二十五日舉行，我們邀請了新任醫學院院長楊紫芝教授和醫學會會長麥利菲菲教授向八八同學致詞，此外，我們亦爲新同學安排了校園漫遊、一年級書籍和顯微鏡介紹等活動，藉此幫助同學適應未來的醫學生生活。此外，迎新營的組長與各組員亦於當日作初步的認識。

迎新營 (ORIENTATION CAMP)

迎新營是迎新活動的重頭戲。在八月二十九至九月一日在北潭涌渡假營舉行。除了營地的活動和一些分組比賽外，迎新籌委還特別籌備了兩個項目，來配合我們迎新營的主題：「未來的醫生、醫生的未來。」

第一個特別項目是是迎新籌委傾盡人力物力製作的三套幻燈。今年度迎新舉行幻燈有兩大特點。第一、三套的幻燈是可串連爲一完整故事、講述兩個醫學生在畢業前的理想，畢業後在工作上和家庭中所受到的壓力，在社會制度的不健全，以至香港前途的不明朗底下，他們內心的矛盾和掙扎。 第二個特點是首次嘗試採用兩部或三部幻燈機於同一時間播放，以不同的畫面配合來產生更佳的效果，同時我們在錄音和配樂上的要求亦十分嚴謹，以求達到最佳的視聽效果。

第二個迎新營特別項目是長達六小時的角色扮演。我們將市政局選舉這社會事件在營內重演了，這是一個很大胆和創新的嘗試，相信所有同學也從沒嘗試參與過如此大型（包括了一百五十多人），而又長達六小時多的角色扮演。故此，一般同學的反應都很好。

在迎新營的最後一晚，有許多高年班同學甚至是已畢業的醫生來探營，在迎新晚會上，各班都有精彩的表演。最後以醫學會的會歌和口號結束。

迎新雙週

迎新雙週是今年度的新嘗試，在初開學的兩星期內舉行。主題爲「醫學生的第一步」。活動包括高桌晚宴，座談會，午間音樂會等。

今年度迎新雙週的期間，恰巧有「學生會致信戴卓爾夫人」事件和MERC REPORT，在這兩件事件的影響下，迎新雙週的反應未如理想。但迎新雙週的部份目標已透過這兩件事達到。

第二次預科生日和學能迎新

迎新八三的活動，可說是歷年以來最多的。第二次預科生日和學術迎新是在十月初舉行。因爲大學收生制度的改變，所有八四年度的預科生，須於八三年十月中投報大學，爲了使八四年度預科生在投報醫學院前對醫學生及醫生的生活有一些了解。迎新籌委於十月初再舉辦了預科生，並且亦參與學生會的學術迎新。醫科八八的同學，雖然剛剛進醫學院，但已經積極參與是項活動的籌備工作，這亦可算是今年度迎新的特點。預科生的出席空前踴躍約有五百多人，把醫學院的兩個演講室都擠得滿滿的。

結語

迎新八三雖然基本上與以往的迎新活動相似，但我們亦作了許多新的嘗試，有成功的，亦有不如理想的。但總括來說。

迎新的成功或失敗，是我們所沒法衡量的。我們並不會去斤斤計較我們付出了多少，我們所希望的是盡我們的力量，使新同學收穫更多。

Calendar of Event
82 ~ 8

S 19

S 20

M 21

* Presidential Address '82
  Dec. 2
  – by Dr. T.H. Lam

T 22

* Medic 溫情百萬行
  Dec. 5

W 23

* Christmas Card Design Competition
  Dec. 8

T 24

* 4th M.B., B.S. Examination
  December

F 25

* Christmas Ball
  Dec. 26
  – at Lok Yew Hall

S 26

* 黎青龍盾中文辯論比賽
  Jan. 24 to Feb. 4
  – Champion: Medic '86

S 27

* Medical Society 1st High-table Dinner
  Feb. 1
  – at Pauline Chan Bldg.

M 28

* 沙宣道挑戰盾
  February

T 29

* Union Festival '83
  Feb. 21 to Mar. 4

W 30

* Farewell Party for Prof. Gibson, Prof. Hsieh and Prof. Lisowski
  March 17

T 31

* Interyear Sports Competition
  Feb. to May

F 1

* Final M.B., B.S. Examination
  Apr. to May

S 2

* Video-tape Show: "Superman II"
  May 10

S 3

* Presentation Day '83
  May 13
  – Interyear Sports Champion: Medic '85
  – 麥列菲菲盾時事常識問答 Champion: Medic '86

M 4

* 1st, 2nd and 3rd M.B., B.S. Examination
  June

T 5

W 6

T 7

* Gala Premiere '83
  Aug. 3
  – at Lee Theatre

F 8

* Orientation '83
  Jul. – Oct.

S 9

* Joint School and University Project
  Jul. – Aug.

S 10

* 「活力香港、松柏長青」老人健康檢查服務
  Jul. – Aug.
  – in collaboration with TVB

M 11

* First-aid Course
  August

T 12

* Health Exhibition '83
  Sep. 9-12
  – at City Hall
  Sep. 24-25
  – at New World Centre

W 13

T 14

* Medical Society 2nd High-table Dinner
  Sep. 23
  – at Pauline Chan Bldg.

F 15

* Interyear Aquatic Meet
  Sep. 30

S 16

* 「致戴卓爾夫人信」事件
  十月廿五日　學生會非常全民大會，逾千五同學出席。
  十一月　　舉行全民投票，結果信件須收回。

S 17

* Friendly Basketball Match with the Chinese University Medical students.
  Oct. 29

M 18

* Medic Festival '83
  Oct. 24 – Nov. 2
  Interyear Champion: Medic '86

T 19

* University Open Day '83
  Nov. 5-6

W 20

* 37th Annual General Meeting
  Nov. 24

T 21

* Presidential Address '83
  Dec. 2
  – by Prof. F. Lieh-Mak

F 22

* General Polling for EXCO session 83-84
  Dec. 7

S 23

* Extraordinary General Meeting
  Dec. 8

– P. Lau –

CHILD BATTERING IN HONG KONG

Felice Lieh-Mak, MD, MRCPsych., MRANZCP
Chung See Yuen, MB,BS

Department of Psychiatry
University of Hong Kong
Hong Kong

This work was carried out at the
Department of Psychiatry, University of Hong Kong

Abstract

A short historical background of child battering in China is given. The prevalence and incidence of child battering reported by the police, social agencies and the Against Child Abuse Centre in Hong Kong were cited. The low prevalence reported may be due to absence of relevant legislation regarding compulsory reporting, social sanction for harsh discipline, subordination of children's rights to that of the adult, the preservation of the kinship support system. Socio-cultural factor which put children above age 6 at risk were also discussed.

Key Words
Child
Abuse
Battering
Chinese

Introduction

The phenomenon of child abuse cuts across all races and cultures. Each culture has its own particular form of abuse and in this respect China is no exception. The aim of this paper is to study the prevalence of child battering in a Chinese population against the background of a long history of child abuse, harsh discipline and the denial of children's rights. We will also compare the prevalence and the nature of child battering in Hong Kong with that in the West and will attempt to explain such differences if it exists.

Infanticide is the worst form of child abuse. In China, this was commonly practised in the rural areas especially during periods of famine or war. The earliest mention of infanticide was made during the Chin Dynasty (221-206 B.C.). In the book entitled, Essays on Governing the Family by Yen Shi, infanticide was reported to be most rampant during the South and North Dynasty (420-589 A.D.), the Southern Sung Dynasty (1127-1129 A.D.) and the Yüan Dynasty (1271-1368 A.D.). Inspite of laws passed forbidding infanticide in the Yüan Dynasty (1271-1368 A.D.) and in the Ching Dynasty (1644-1912 A.D.), the practice continued up to the time of the establishment of the Republic (1912-).

Since females were considered "goods upon which one loses money" by the Chinese, a large proportion of female infants were killed. Couling[1] mentioned that 20 per cent of female infants were destroyed in the Fukien province. Missionaries in Kwangtung provinces reported that in some districts only one in three female infants were allowed to live. Ball[2] claimed that in some localities female infanticide was so prevalent that local girls could not be obtained for marriage.

The usual methods employed in infanticide were: drowning, smothering, burying alive or by abandoning the child to the elements.

Infanticide was also employed as a means of curbing the growth of a family. Li Yüan-Kang[3] reported that in Fukien, families usually stopped having children when they had four sons. The second or third daughter was usually destroyed. During delivery a bucket of water was kept nearby and as soon as the infant was born he or she would be drowned immediately. This practice was euphemistically called "bathing the infant". In the Sung Hui Yao[4] a practice called "harrowing the progeny" was described. It consisted of killing all the children born after the inheritance had been divided among the sons.

Superstitutions also played a part in perpetuating infanticide. Granet[5] reported that male infants who were born on unlucky days like the fifth day of the fifth month, first day of the fifth month were destroyed. For it was believed that these children were destined to kill their fathers. Malformed children were considered to be harbingers of ill-fortune and were therefore destroyed.

The custom of foot-binding was a form of physical cruelty inflicted on female children. The process consisted of binding the foot tightly with bandages until all the toes excepting the big toe were turned on to the sole. The bandaging was usually began at the age of five to six years old. The object was to make the feet so small as to achieve the ideal of "3-inch golden lilies". Foot-binding was reported to have originated in the Sung Dynasty (960-1279 A.D.).

It is not an exaggeration to say that there is nothing in the history of mankind that can be compared to the agonies and sufferings of the millions of female Chinese children subjected to the cruel custom of foot-binding over the centuries. Macgowan[6] gave a good description of their sufferings. The best personal account was written by Hsieh Bing Ying in her book, Autobiography of a Female Soldier.

Another area in which Chinese children may be abused is in the implementation of harsh discipline. Chinese adhere to the dictum of "Spare the rod, spoil the child" strictly especially when the act is construed to be an unfilial one. The doctrine of filial piety is the basis of Chinese ethics. In the complicated relationships among men, filial piety forms the most fundamental unit of mutual connection between two or more persons from which benevolence towards other human emanates (Hsieh).[7] From this one can understand why Chinese parents demand absolute obedience and love from their children. It also explains the strict hierarchical structure of Chinese families.

Filial piety also formed the theoretical base underlying the articles of the Code of Tang[8]. This Code dominated Chinese criminal legislation for 1,300 years. As regards to crimes against the person, the Code prescribed more punishment for the junior offender, thus it was considered a great cime if a son were to strike his father, while a father who trounced his son may not be committing any crime at all. In the Code certain crimes were considered so heinous that they were especially listed under Article Six, entitled "The Ten Abominations" and the lack of filial piety is listed here.

In Chinese families the father had absolute authority over his children and it was not until the Han Dynasty (202 B.C. – 220 A.D.) when it was considered illegal for a father to kill his son. But the power of a father to punish a disobedient son was sanctioned by law and society. In fact the character for father " 父 " is formed by a hand holding a stick. The Family Instructions of Yen stated that, "If beating and anger are abandoned in the family, the faults of children will immediately appear; when punishments are not properly administered, the people do not know how to move hand and foot. To rule a family strictly should be the same as to rule a nation".

Material and Results

This study was conducted in Hong Kong. Hong Kong, according to the recent census" has a population of 5 million of which 1.3 million (26.6%) are aged 15 and below. Hong Kong, with a land area of 1,061 square kilometres, is one of the most densely-populated places in the world. The overall density per square kilometre is 4,729 with the metropolitan

areas reaching a density of 25,400 (Wood)[10]. The majority of the population is engaged in light manufacturing industries or commerce. The predominent religions are Buddhism and Taoism.

The data regarding child battering were taken from three sources: the police records, survey done by the Hong Kong Council of Social Services and the Against Child Abuse Project. The criteria used in labelling the child as being battered was "non-accidental physical attack or physical injury, including minimal as well as fatal injury, inflicted upon children by persons caring for them".

The number of physically abused children reported to the police from 1972 to 1979 is shown in Table 1. The age distribution of reported cases in 1979 is shown in Table 2. Over the past 8 years there were consistently more male children being battered compared to female children. An average of 53% male children were battered compared to 47% of female children. As regards degree of injury of the cases reported in the past 8 years, 34% were considered serious (fractures, damage to internal organs, severe burns or scalding, death), 66% were considered slight (bruises, welts, minor burns or scaldings).

Based on a population of 1.3 million children below age 15 in 1976, Hong Kong has an incidence rate of 24.6 reported cases per million.

The second source of figures on battered children was the study conducted by the Hong Kong Council of Social Services[11]. This survey included all active cases of abused children under the care of all social agencies in the period between September 1, 1978 to February 28, 1979. The agencies' survey included: all medical social workers, family services, volunteer services, the probation services, the Samaritans, and the Social Welfare Department. There was a total of 777 cases of child abuse reported of which 201 cases were victims of physical abuse. Based on these figures the prevalence rate was 154 cases per million. Table 3 shows the age distribution of the cases. The types of physical injury stated in the report are shown in Table 4. The sex distribution of the victims was: 55.6% males, 44.4% females.

As a result of the publicity on child abuse a "hot line" service called Against Child Abuse was formed in June 1979. The service reported a total of 154 cases of child battering for the year June 1979 to May 1980, giving an incidence rate of 118 cases per million. The age distribution of the cases are shown in Table 5. 58.4% of the victims were males and 41.5% were females. As regards the extent of injury 126 (82%) were considered not serious and only 28 (18%) were considered serious enough to need hospitalization. None of the children died as a result of battering.

There was no attempt to obtain the number of battered children that were admitted to hospital because these were included in the survey done by the Hong Kong Council of Social Services.

All the cases reported by the police and social agencies were Chinese.

Implications

The different criteria used for child battering has made it difficult to compare figures obtained by different agencies in the same country and more difficult to compare incidence or prevalence rate between different countries.

Our study shows a discrepancy of about 400% between the cases reported to the police and cases reported to the Against Child Abuse Centre. Nagi[12] in a survey of community agencies estimated that about 54% of cases were unreported. Bourne[13] stated that the incidence of abuse increases with self reports. This seems to be the case with the Against Child Abuse Report whose study indicated that 64% of incidences were culled from self reports by parents.

In Hong Kong other factors exist to account for the discrepancy:

1. The absence of legislation for the mandatory reporting of child abuse cases.
2. The reluctance of the Chinese population to be involved with the police. Generally speaking, most people regard the whole process of reporting a case and appearing as witness a tedious process to be avoided at all cost. The fact that the

laws in Hong Kong are largely adopted from the British Legal System and is therefore alien to the local population may serve as another obstacle.

3. The law is viewed by most Chinese as a punitive agency while social agencies are considered helping organizations. Therefore, it is not surprising that the population should turn to the Against Child Abuse Centre for help.
4. The lack of family or juvenile courts to deal with cases of child abuse may also deter certain professionals from reporting such cases.

Taking the upper figure of 154 cases per million, the prevalence of child battering in Hong Kong is still low compared to 380 cases per million reported by Kempe[14] in the U.S.A., 598 cases per million in Great Britain and Germany (Lukianowicz[15]).

Known cases of child battering may be low in Hong Kong because corporal punishment in child rearing is sanctioned and strongly encouraged in Chinese society. Most of the population regard that the parents have an inalienable right to punish their children and no one should interfere with this right. Solomon[16] reported that 79% of the persons be interviewed recalled having been beaten with boards, whips, rulers or received other forms of physical punishment in their childhood. In fact, Chinese law exonerated a father or grandfather who killed his son or grandson unintentionally when chastising him (Lang[17]).

The low prevalence rate may also be due to a lack of awareness by the public and a low index of suspicion by the medical profession. In 1977 a few cases of child abuse were reported in the press, subsequently the phenomenon of child abuse received wide publicity. The 84% increase in cases reported to the police from 1977 onwards was probably due to this. Hence, we think it is important to keep a close watch not only on police figures but also on figures reported by social agencies.

Hong Kong has many conditions like: overcrowding, cultural justification for the use of force against children, long working hours, poverty, rapid social changes, cultural subjugation of children's rights in favour of parental rights, which are conducive to child battering. Yet, the prevalence of serious battering resulting in death or disfigurement is uncommon. This may be due to the fact that the support system is still relatively intact. The relevance of a support system to the dynamics of child abuse was developed and elaborated by Caplan[18], Garbarino[19] considered the absence of potent support systems as a necessary condition for child abuse. In Chinese society the main support system is the extended family and the kinship system. The kinship group has been the focus of economic and social relationship in the Chinese way of life since ancient times. Although immigration and the acute housing problem in Hong Kong has to some extent disrupted the kinship structure of Chinese families, the ties are still strong. Millar's[20] survey revealed that 24.3% lived in a large extended family, 73.3% belonged to a "nuclear family" and only 2.4% lived alone. He found a high frequency of interaction with family members who do not live together and a majority of the respondents in his study expressed strong feelings of solidarity with the family. In his Biosocial Survey, Millar[20] mentioned that strong family solidarity may to some extent counteract the detrimental effects of urban Hong Kong's extremely ecodeviant environment. That family ties remains strong in Hong Kong may also be reflected in the low divorce rate (0.26/1000). Single parent families which is often mentioned to be associated with child battering is still virtually unknown in Chinese society.

Most early reports on battered children commented on the young age of the victims. Gil[21] reviewed various reports and postulated that the younger age group was over-represented because most of the studies were conducted in hospital settings where because of the function of the setting, more severely battered children were seen. In a later review by Smith[22] a similar explanation was given. These claims were supported by Gil's[23] epidemiological rather than clinical study that 50% of victims were aged six or above. Lynch[24] found that 51% of the abuse cases occurred among children aged 6 – 17 years. She claimed that these children may have been beaten but managed to survive the high risk years. Bergstrand, Forsland and Stibner[25] reported a pronounced increase of abuse cases involving older children in Malmö. They attributed this to increased public awareness of the problem.

Our findings show that most of the victims were 6 years old or above. This may be

partly due to the fact that our figures were not limited to hospital cases. However, there may be a socio-cultural explanation. The upbringing of children is to a large extent influenced by social expectations and what behaviour is tolerated at what age. Chinese parents are remarkably tolerant of helplessness and dependency behaviour in young children. In the ancient primer on child care, The Way of the Thousand Golden Wings, parents were admonished to anticipate and indulge the child's needs before the child is aged 6. Solomon[16] claimed that this "golden age" of childhood dependency is rooted in the Chinese tradition of filial peity. The Twenty-Four Models of Filial Piety stated that "the hope of the parent and the obligation of the filial offsprings was to bring life's full circle to those in old age, so that the pleasure of having one's needs effortless fulfilled would usher life out as the parent had in similar fashion ushered life in for the child".

Generally speaking, Chinese parents find dependency behaviour easier to cope with than assertive and independent behaviour. This is probably the result of a long tradition of dependency and submission to the hierarchical structure of the extended family system. In such a system dependency, material or emotional or both, tends to be infinitely prolonged. This view is supported by the finding of the Against Child Abuse Centre. They reported that majority of parents who ring up for help wanted advice on how to control and discipline their children. In fact, a large percentage of the cases of battering was related to the administration of discipline.

In her study on child training, Wolf[26] reported that the father's relationship with his son is both affectionate and informal until the boy reaches the age of six. Before six, the child's disobedience or misbehaviour is often viewed with amusement or tolerance. Osgood[27] in her study of a Hong Kong rural community observed that parents punished children only when they were older and younger children were often spared from harsh physical punishments. At age six which is usually considered to be the age of reason by Chinese parents social pressure and discipline is applied on the child.

An additional factor which may contribute to harsh discipline at the age of six and above is schooling. All Hong Kong children start formal schooling at the age of six. Chinese society regards educational achievements with great importance. This is in part due to the Confucian tradition of scholarship and in part due to the intense competition for university places. For the upper social class education is a means to maintain their prestige. For the lower social class it is often a passport to upward social mobility. Hong Kong's two official universities can admit only about five thousand students and there are perhaps about seven thousand students attending overseas universities. This total of twelve thousand students represents less than five per cent of the population aged 19 – 23. Inevitably the competition is stiff and parents have to start preparing their children as soon as they enter school. As a result of these factors parents invariably put great demands on their children for successful scholarship and often harsh discipline is implemented to achieve this goal.

The sex distribution of the victims of battering in Hong Kong is similar to that reported in the West. Although Chinese society still value male offsprings more than females, the discipline meted out to male children are often stricter and harsher.

Conclusion

Child battering is a universal phenomenon. However, the causes are multifactorial and complex. China, with its long history of infanticide and denial of children's rights could be a fertile ground for child abuse, yet, the prevalence of child battering is low compared to Western reports. The most obvious reason is under-reporting. However, factors like the preservation of the kinship support system and sharing of the responsibilities of child care may contribute to an actual lower prevalence.

Socio-cultural influences may put different age groups at risk. It is therefore important that in studying the phenomenon we should look at children of all ages and cull our information from as many sources as possible.

This study serves as an overview and more detailed research into specific characteristics and trends will have to be pursued.

REFERENCES

Couling, S. *The Encyclopedia Sinica.* Shanghai, Kelly & Welsh, 1917. 249-250.

Ball, J.D. *The Chinese at Home or The Man of Tong and His Land.* London, Religious Tract Society, 1911. 74-76.

Li, Yüan Kang (end of 12th century) *Hou Te Lu Shuo Fu* LXXI (in Chinese).

Sung Hui Yao, Hsing Fa (Chin-Yüeh) *A Report to the Emperor Dated 9th Day of the 5th Moon of 1109.*

Granet, M. *Chinese Civilization.* New York, Alfred A. Knopf, 1930. 321-322.

Macgowan, J. *Sidelights on Chinese Life.* London, Kegan Paul, Trench, Trübner & Co., 1907. 59-62.

Hsieh, Y.W. Filial piety and Chinese society in *The Chinese Mind: Essentials of Chinese Philosophy and Culture.* Moore, C. (ed.) Honolulu, East-West Centre Book, 1967. 172-173.

The Tang Code translated by Johnson, W., Princeton University Press, Princeton, New Jersey, 1979. 31-32.

Hong Kong By-Cencus. Hong Kong, Hong Kong Government Press, 1976.

Wood, D. *Hong Kong 1980.* Hong Kong, D.R. Rick Government Printer, 1980. 206-207.

Report on the Study of Child Abuse Cases prepared by The International Year of the Child Coordinating Committee (Welfare Section/Working Group) on Child Abuse Study. Hong Kong Council of Social Services, 1979.

Nagi, R. Child abuse and neglect programs: a national overview. *Children Today* 4 (May – June): 13-17, 1975.

Bourne, R. Child abuse and neglect: an overview in *Critical Perspective on Child Abuse.* Bourne, R., Newberger, E.H. (eds.). Lexington, Massachusetts, Lexington Books, 1979. 5-6.

Kempe, C.H. Pediatric implications of the battered baby syndrome. *Archives of Diseases in Childhood* 46:28, 1971.

Lukianowicz, N. Battered children. *Psychiat. Clin.* 4, 257-280, 1971.

Solomon, R.H. *Mao's Revolution and the Chinese Political Culture.* Berkeley, University of California Press, 1971. 50-51.

Lang, D. *Chinese Family and Society.* U.S.A., Archon Booms, 1968. 26-27.

Caplan, G. *Support Systems and Community Mental Health.* Behavioural Publications, New York, 1974.

Garbarino, J. Human ecology of child maltreatment: a conceptual model for research. *Journal of Marriage and the Family* 39:4, 1977. 722-735.

Millar, S. *The Biosocial Survey in Hong Kong.* Canberra, Australia, Australian National University, 1979. 135-240.

Gil, D. Incidence of child abuse and demographic characteristics of persons involved in *The Battered Child.* Helfer, R.E., Kempe, C.H. (eds.). Chicago, University of Chicago Press, 1968. 21-39.

Smith, S.M. *The Battered Child Syndrome.* London, Butterworths, 1975. 47-48.

Gil, D.G. *Violence Against Children.* Cambridge, Massachusetts, Harvard University Press, 1970.

Lynch, A. Child abuse in the school age population. *Journal of School Health* 35(3), 1975. 141-148.

Bergstrand, C.G., Forsland, M., Stibner, I.B. Child abuse in Malmö: a comparison between the periods 1967 – 1974 and 1975 – 1978. *Acta Paediatr. Scand.* Suppl. 275, 1979.

Wolf, M. Child training and the Chinese family in *Studies in Chinese Society.* Wolf, H.P. (ed.). Standford, California, Standford University Press, 1978. 221-245.

Osgood, C. *A Study of a Hong Kong Community.* Tuczon, Arizona, University of Arizona Press, 1975. 80-81.

Table 1

NO. OF BATTERED CHILDREN REPORTED TO THE POLICE FROM 1972-1979

YEAR	NO. OF CASES
1972	22
1973	13
1974	23
1975	14
1976	22
1977	42
1978	30
1979	32

Table 2

AGE DISTRIBUTION OF CASES REPORTED TO THE POLICE IN 1979		
AGE	NO. OF CASES	%
0-3	4	12.5
4-6	8	25
7-9	17	53
10-12	2	6.3
↑13	1	3.2
TOTAL	32	100%

Table 3

AGE DISTRIBUTION OF BATTERED CHILDREN BASED ON THE HONG KONG COUNCIL OF SOCIAL SERVICES REPORT		
AGE	NO. OF CASES	%
0-2	22	10.9
3-6	42	20.9
7-9	58	28.9
10-12	53	26.4
13-14	26	12.9
TOTAL	201	100%

Table 4

TYPE OF INJURY OF CASES REPORTED BY THE HONG KONG COUNCIL OF SOCIAL SERVICES

TYPE OF INJURY	NO. OF CASES	% OF CASES
Injury resulting in death	2	1
Bruises, welts, minor burns and scalds	157	78.1
Injury to internal organs	1	0.5
Disfigurement	19	9.5
Others	22	10.9
TOTAL	201	100%

Table 5

AGE DISTRIBUTION OF CASES REPORTED BY THE AGAINST CHILD ABUSE SERVICE

AGE	NO. OF CASES	%
0-3	14	9
4-6	40	26
7-9	64	41.5
10-12	20	13.2
13	16	10.3
TOTAL	154	100%

EXTRACT FROM GAZETTE 83

Two Congregations were held on Wednesday, November 16, 1983, at the Queen Elizabeth Stadium. The following degrees were conferred by the Vice-Chancellor, Dr. R. L. Huang, C.B.E., D.Sc., J.P., at the One Hundred and Nineteenth Congregation held at 10.30 a.m., and by the Pro-Chancellor, the Hon. Sir Albert Rodrigues, C.B.E., E.D., LL.D., Chev.Leg.d'Hon., Kt.G.C.(St. Syl.), O.Ord.Christ, J.P., at the One Hundred and Twentieth Congregation held at 3.00 p.m.

DEGREE OF DOCTOR OF MEDICINE

Professor Chan Tai Kwong
Dr. Chen Wai Chee, Walter
Dr. Ho Wat Chi Suk, Faith
Dr. Lai Kar Neng
*Dr. Wang Yu Ching, Rebecca

DEGREE OF MASTER OF PHILOSOPHY

(Miss) Hung Kit May, Beatrice
(Community Medicine)

DEGREE OF MASTER OF MEDICAL SCIENCES

*Dr. Chan You

DEGREES OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

1983

Honours List

Kwong Yok Lam (Distinctions in Anatomy, Physiology, Pathology, Medicine, Surgery, and Obstetrics & Gynaecology)

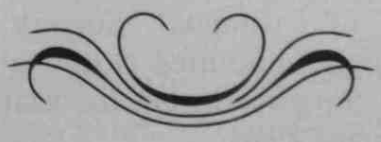
1982

Chan Ka Po
Chau Hung King, Eddy
Chong Chung Wah, Joseph
*Ho Kau Chung, Charles
Lau Yuk Kong
Lee Youn Sue
Leung Lai Man, Raymond
Lin Hin Wu
Lo Shing Shun
Ma Chan Chung
*Mak Kin On
Ng Kin Pong
Ng Kwok Kwong
Poon Tak Lun
*(Miss) Tam Lai Fan, Gloria
Tse Kai Fat
Wan Wai Chuen, Andrew

1983

Chan Chi King
Chan Chi Sang, James
Chan Hin Biu
Chan Hiu Ming, John
(Miss) Chan Ka Soon
(Distinction in Pathology)
Chan Kin Wing
Chan Nim Chung, Gerard
Chan Wai Hung, George
Chan Wing Sun, Vincent
Cheng Kin Keung
Cheng Ming Chuen, Peter
(Miss) Cheung Cheuk Yuen, Cath
Cheung Kwai Kit, Alan
Cheung Siu Cheong, Steve
Cheung Siu Ching, Philip
Cheung Tak Hong
Cheung Tze On, Benson
Cheung Wai Lam
Cheung Yuk Tong
Ching Kai Chuen
Chiu Chap Fai, Johnnie
Chiu Kwok Hing
Chiu Sik Chung
Chiu Sik Ho, Bonba
Choi Sze Kwong, Victor
Chong Kwan Yin
Chow Chun Chung, Francis
(Distinction in Physiology)
Chow Kin Chung
Chow Kwok Hung
Chow Wai Wah, Paul
Chu Kwan Ling
Chung On Ming
Chung Wai Ming, William
(Distinction in Physiology)

Iss) Dunn Lai Wah, Eva
ng Kin Kong
h Lung Cheung
istinction in Physiology)
Chu Leung
Hon Fai
Sheung Tung
Shiu Wei
Wing Yun, Francis
am Chak Wah
Miss) Khoo Lai San, Jennifer
wan Ho Yin, Patrick
wan Wing Kwong
wok Po Yin, Samuel
wok Sek Keung, Peter
wong Wai Kay
wong Yun Tak
ai Hin Wang
Distinction in Bio-chemistry)
ai King Shing
Lai Shiu Ming, Jimmy
Lam Kin Yui
Lam Siu Leung
Lam Wing Yin
Lau Kam Shing
Lau Kwok Kwong, Dominic
Lau Wing Choi
Law Kim Wan
Law Sai On
Lee Chi Chiu
Lee Siu Lung, Joseph
Lee Yat Wing
Leung Chi Chiu
(Distinction in Anatomy)
(Miss) Leung Fung Ming, Angela
Leung Kaa Kei
Leung Kwan Kui, Terence
Li Chi Kwan
Li Chi Yin
Li Chow To
Li Hin Chung, Richard
Li Kam Tao, Philip
Li Pui Ki, Lawrence
Lin Che Kit
Lo Tak Lam, William
(Miss) Low Hui Peng, Caroline
Lui Yiu Wing
Ma Chi Nam, Leo
Mak Kwok Hang
Mok Yun Wing, Thomas
Ng Kwok Keung, Tommy
Ng Man Ho
Ngan Kai Cheong, Roger
Pang Chung Pui
Pang Seung Chiu
Pun Ting Chung
Shek Chi Chung
Sin Chung Yau
So Hing Yu (Distinctions in Anatomy, Physiology, and Pharmacology)
Suen Wai Sing, Alan
Sung Jao Yiu
Tam Cheuk Wah
Tam Po Chor
Tang Sek Ying
Tang Shun Cheung
Tang Tak Sing, Allen
(Distinction in Pathology)
To Tak Shun
Tong Cheuk Yan, William (Distinctions in Pathology, Microbiology, Community Medicine, and Obstetrics & Gynaecology)
Tong Hon Kuan
Tsang Hon Kuan
Tsang Hon Keung, Andrew
Tsang Kwong Wing, Alfred
Tse Kin Wah
Tse Shing Lam
Tsoi Chi Wah, Danny
Tsui Hing Sing, Robert
(Miss) Tsui In Ling
(Distinctions in Physiology)
Tong Wai Kit
Wong Chow Ming
Wong Kit Fai
Wong Kong Chiu
Wong Tak Cheung
Wong Tin Chui
Wong Wai Chung
Wong Yin Ming, Hector
Woo Kong Sang, John
Wu Siu Wan
Wu Wing Cheung, Stephen
Yam Heung Wing
*Yau Kwok Wai
Yeung Kam Tong
Yu Kwok Chiu
Yu Wai Hong, Anthony
Yuen Ming Keung
Yuen Po Wing
(Miss) Yuen Wah Fun, Nancy
Yung Chun Kuen



** in absentia*

Appointments

Richard Lo Kwong Yin, M.S. (Virginia), M.D. (California), L.M.C.C. appointed Lecturer in the Department of Surgery from October 1, 1983 to September 30, 1984.

Samuel Ngan Yum Kay, M.B.,B.S. (Hong Kong), appointed Lecturer in the Department of Surgery from November 1, 1983.

Honorary Clinical Professors

Professor Christopher Ian Pogson, M.A., Ph.D. (Cantab), Head of the Department of Biochemistry, University of Manchester, appointed Honorary Professor in the Department of Biochemistry from December 28, 1983 to March 23, 1984.

Honorary Clinical Professors

Dr. John Ho Hung Chiu, O.B.E., M.B.,B.S., M.D., Hon.D.Sc. (Hong Kong), F.R.C.P. (London), F.R.C.R.(D.&T.), Hon. F.R.C.R.A., Hon.F.A.C.R., F.R.A.C.R., J.P., Consultant in charge of Radiology and Oncology at the Medical and Health Department's Institute of Radiology and Oncology, Queen Elizabeth Hospital, appointed Honorary Clinical Professor in the Department of Surgery from September 1, 1983 to August 31, 1986.

Dr. Henry Ngan, M.B.,B.S. (London), D.M.R.D., M.R.C.S. (England), F.R.C.P. (Edinburgh) (London), F.R.C.R., Consultant Radiologist in charge of the Radiodiagnostic Division of the Institute of Radiology and Oncology, Queen Mary Hospital, appointed Honorary Clinical Professor in the Department of Surgery from September 1, 1983 to August 31, 1986.

Visiting Professors

Professor Barry George Firkin, B.Sc., M.B.,B.S. (Sydney), F.R.A.C.P., F.R.C.P.A., Chairman, Department of Medicine, Monash University Medical School, Alfred Hospital, Melbourne, appointed the fifth Lions Club of Tai Ping Shan Visiting Professor in Medicine during his visit to Hong Kong in January 1984.

Professor Andrew Patrick McEwen Forrest, B.Sc., M.B.,Ch.B., Ch.M., M.D. (St. Andrews), Hon.D.Sc. (Wales), F.R.S. (Edinburgh), F.R.C.S. (Edinburgh), (England), (Glasgow), Regius Professor of Clinical Surgery, University of Edinburgh, appointed G.B. Ong Visiting Professor in Surgery during his visit to Hong Kong in January 1984.

Professor P.H. Joubert, B.Sc., M.B.,B.Ch. (Witwatersrand), M.Med.Sc., D.M. (Orange Free State), F.C.P. (South Africa), Professor and Head of the Department of Pharmacology and Therapeutics, Medical University of Southern Africa, appointed Visiting Professor in the Department of Pharmacology from January 3 to March 17, 1984.

Professor John Miles Little, M.B.,B.S., M.S., M.D. (Sydney), F.R.A.C.S, Professor of Surgery, University of Sydney, appointed G.B. Ong Visiting Professor in Surgery during his visit to Hong Kong in January 1984.

Professor Brian McKibbin, M.B.,Ch.B., M.D. (Leeds), M.S. (Illinois), F.R.C.S. (England), Professor and Head of the Department of Traumatic and Orthopaedic Surgery, Welsh National School of Medicine, appointed the eleventh M.B. Lee Visiting Professor from November 20 to 30, 1983.

Prizes

The following prizes have been awarded:

John Anderson Gold Medal: Kwong Yok Lam, William Tong Cheuk Yan (*proxime accessit*)

Belilios Medical Prize: Hobby Cheung Kwong Yu and Cheung Tak Fai

Chan Kai Ming Prize: Kwong Yok Lam

Digby Memorial Medal: Kwong Yok Lam

C.P. Fong Gold Medal in Medicine: Kwong Yok Lam

C.P. Fong Gold Medal in Pathology: Lo Chung Mau

R.M. Gibson Gold Medal in Paediatrics: Kam Chak Wah

The Nesta and John Gray Medal in Surgery: Kwong Yok Lam

Ho Fook Prize: Stephen Shiu Yuen Wing

Ho Kam Tong Prize in Community Medicine: Angela Poon Ming See

Hong Kong Medical Association Prize: Dr John Ngan Hin Kay

C.T. Huang Gold Medal in Microbiology: Franklin Ling Chi Kin

Gordon King Prize in Obstetrics and Gynaecology: Kwong Yok Lam

Li Shu Fan Medical Foundation Prize in Biochemistry: Stephen Shiu Yuen Wing

Li Shu Fan Medical Foundation Prize in Pharmacology: Hobby Cheung Kwong Y

Li Shu Fan Medical Foundation Prize in Physiology: Philomena Tse Wan Ting

Sir Patrick Manson Gold Medal: Dr. Donal Yu Yu Chiu

t McClure Kilborn Prize in Physiology ad Biochemistry: Philomena Tse Wan Ting
Gold Medal in Psychiatry: Tsang Hon eung
Ci Hing Prize: Stephen Shiu Yuen Wing
Far East Prize: Florence Lee Mun Yau, tephen Shiu Yuen Wing and Philomena se Wan Ting
n Ai-Ti Gold Medal in Behavioural ciences: Philomena Tse Wan Ting

ignations
Dr. W.K. Chan, Temporary Lecturer in the Department of Medicine, from October 15, 1983.

Dr. W.W.C. Chen, Lecturer in the Department of Medicine, from December 31, 1983.

Dr. J.T.K. Lau, Lecturer in the Department of Surgery, from October 14, 1983.

Dr. R.P. Ng, Senior Lecturer in the Department of Medicine, from December 31, 1983.

Dr. P.T.K. Wu, Lecturer in the Department of Obstetrics and Gynaecology, from October 8, 1983.

FELICE MAK-LIEH

M.D. (Santo Tomas), L.A.H. (Dublin), M.R.C.Psych., F.R.A.N.Z.C.P.

Dr. Felice Mak-Lieh, Reader in the epartment of Psychiatry, has been ppointed to the Chair of Psychiatry from ugust 1, 1983.

Professor Mak-Lieh received her degree of octor of Medicine from the University of anto Tomas in the Philippines in 1964 and, or a short spell, she was Resident in the niversity of Santo Tomas Hospital before ursuing a course in neurology at the Institute f Neurology. From 1965 to 1967, she was House Physician and House Surgeon in arious hospitals in Lancaster, Bournemouth, London and Oxford. From 1968 to 1969, she as Medical Officer in Psychiatry at the Castle Peak Hospital, Hong Kong. In 1971, Professor Mak-Lieh joined the University of Hong Kong as Lecturer, was promoted to Senior Lecturer in 1978 and Reader in 1981. Professor Mak-Lieh has been Head of the Department of Psychiatry since 1980.

Professor Mak-Lieh was admitted to membership of Royal College of Psychiatrists of the United Kingdom in 1973 and of the Royal Australian and New Zealand College of Psychiatrists in 1978. In addition, she is affiliated to various professional organizations and learned societies. She has been a member of the Committee for the Rehabilitation of the Mentally III since 1980, of the Board of Occupational Therapists since 1980, and has been the Psychiatric Consultant of the Hong Kong Council of Women since 1982. She was President of the Hong Kong Medical Women's Association, 1978-1980, Honorary Adviser to the Mental Health Association of Hong Kong, 1982-83, Member of the Hong Kong Medical Association Ad Hoc Committee on Homosexuality, 1982, a Fellow of the World Association of Social Psychiatry, 1981, and a Member of the Committee on Psychiatric Education of the World Psychiatric Association, 1982-83. She was elected Fellow of the Royal Australian and New Zealand College of Psychiatrists in October, 1983.

Professor Mak-Lieh has a wide range of teaching, clinical and administrative experience. She has contributed extensively to professional journals and has attended numerous international conferences. Her current research interests are on child abuse, effects of different kinds of medications on chronic schizophrenics, after-care services for the mentally ill, social adjustment of patients on chronic haemodialysis and psychological problems of chronically ill children and their families.

CHAU PAK YIN

Dip.Med. (Shanghai), L.M.C.H.K., Ph.D. (Hong Kong), M.R.C.Path.

Dr. P.Y. Chau, Senior Lecturer in the Department of Microbiology, has been appointed Reader from August 1, 1983.

Dr. Chau graduated in 1957 from the Shanghai First Medical College, China with the Diploma of Medicine. Upon graduation, he remained with the Shanghai First Medical College as a demonstrator until 1960 when he joined the Nanking Medical College as clinical tutor in the Department of Infectious Diseases and Epidemiology and was responsible for the supervision of the Bacteriology and Serology Unit of the Central Laboratory. He joined the Department of Microbiology as Demonstrator in 1969, became Lecturer in 1971 and Senior Lecturer in 1979. In 1976, he was awarded the degree of Doctor of Philosophy by the University of Hong Kong and was admitted to membership of the Royal College of Pathologists of the United Kingdom. For half a year until March 1977, he was visiting lecturer at the Department of Bacteriology of the University of Bristol and senior registrar at the Bristol Royal Infirmary.

Dr. Chau is a member of the International Association of Biological Standards, the New York Academy of Sciences, and various other international and local societies. His research interests for the past twelve years have centred around the bacteriology, epidemiology and control of salmonellosis. Under the sponsorship of the World Health Organization, he has collaborated in recent years with the Center for Vaccine Development, the Swiss Serum and Vaccine Institute and other academic institutions in the United States and Australia in the study of typhoid immunity. Dr. Chau's other research activities are related to his services to clinical microbiology. These include the development of methods for rapid diagnosis, the study of bacterial drug resistance, the assessment of newer antibiotics and the investigation of hospital cross-infections. He has received grants awarded by the World Health Organization, by pharmaceutical companies and by the University to conduct research projects, the findings of which have been presented at international symposia and published in professional journals of good standing.

JAN WILLEM LODEWIJK KLEEVENS

M.D. (Amsterdam), D.Soc.Med. (Netherlands), M.F.C.M. (R.C.P.) (United Kingdom), D.P.H. (Malaya), D.T.M. & H. (Amsterdam), F.R.S.H.

Dr. J.W.L. Kleevens, Reader in the Department of Community Medicine, has been appointed to the Chair of Community Medicine from June 1, 1983.

Professor Kleevens graduated from the Medical School of the University of Amsterdam in 1955 and in the same year, obtained the Diploma in Tropical Medicine and Hygiene from the Royal Tropical Institute, Amsterdam. In 1960, he obtained the Diploma in Public Health from the University of Malaya in Singapore and since 1968, has been Registered Specialist in Social Medicine in the Netherlands. In 1972, he was awarded the degree of Doctor of Medicine by the University of Amsterdam for a study on 'Housing and health in a tropical city', a selective study carried out in Singapore. In 1981, he was admitted to membership of the Faculty of Community Medicine of the Royal College of Physicians of the United Kingdom, and elected to Fellowship of the Royal Society of Health of the United Kingdom.

After a short spell of duty in the Royal

Netherlands Air Force Medical Corps, Professor Kleevens' career began in 1956 as a Government Medical Officer in the then Netherlands New Guinea, where he worked for seven years on medical and public health programmes and coordinating training courses and programmes for auxiliary personnel. In 1963, he left New Guinea and joined the University of Singapore as lecturer in Social Medicine and Public Health. In 1969, he returned to the Netherlands and there, until 1978, served as Deputy Director, epidemiologist and coordinator for health research at the Department of Tropical Hygiene, Royal Tropical Institute, Amsterdam. During his tenure at the Royal Tropical Institute, he initiated and was involved in research projects and consulting assignments that took him to East Africa, Indonesia, Egypt and Singapore. Professor Kleevens joined the University of Hong Kong in 1978 as Senior Lecturer in Community Medicine, and was promoted Reader in 1980.

Professor Kleevens is affiliated to various professional organizations and learned societies. He is a member of the Royal Society of Tropical Medicine and Hygiene of the United Kingdom, the Netherlands' Society of Tropical Medicine and Hygiene, the International Epidemiological Association and the Hong Kong Society of Community Medicine. Further, he is a member of the Expert Panel on Plague of the Hong Kong Medical and Health Department, the Sub-Committee on Treatment and Rehabilitation of the Government Action Committee Against Narcotics, the Sub-Committee on Drug Abuse of the Hong Kong Association of Pharmaceutical Industries, and Vice-Chairman of the Royal Society of Health, Hong Kong Branch. Professor Kleevens is also Editor of *The Bulletin*, the Journal of the Hong Kong Society of Community Medicine.

Professor Kleevens has contributed extensively to international professional journals in the field of community medicine, with particular reference to the major communicable diseases, medical and health problems of the urban environment, infant gastroenteritis, accidents, and occupational injuries.

VALEDICTORY

ARNOLD HSIEH CHIA LOH
B.Sc., M.D. (St. John's), D.Sc. (Hong Kong)

Professor Arnold C.L. Hsieh retired on June 30, 1983. He was appointed to the Chair of Physiology in 1976 and elected Dean of the Faculty of Medicine in 1980.

After graduating M.D. from St. John's University, Shanghai, he came to Hong Kong as a Ship's Surgeon with Butterfield and Swire Limited in 1947. He joined the University of Hong Kong as a Temporary Demonstrator Grade II in the Department of Physiology in 1953. Two years later he was awarded a China Medical Board Fellowship to do research under the famous physiologist, Dr. Loren D. Carlson at the University of Washington. This was the beginning of his long and distinguished research career. On his return to Hong Kong he was appointed Assistant Lecturer in 1957. His meteoric rise in the hierarchy of this University in the next ten years or so was legendary. He was promoted to Lecturer in the same year, Senior Lecturer in 1960 and Reader in 1966. He left Hong Kong in 1968 to take up the Associate Professorship in Human Physiology at the University of California, Davis and became its full Professor in 1972. When the Chair of Physiology of this University fell vacant in 1976, Arnold Hsieh decided to return to offer his service once more to Hong Kong. His appointment as Professor of Physiology was one of the best this University had made since it reopened after the war.

It is impossible to enumerate in full or to arrange in priority the achievements of a man who has enjoyed such a long and distinguished career as a teacher, research scientist and an administrator. Fortunately, the task is made much easier for me by his inaugural address delivered on November 7, 1977, which is a literary classic by itself. There one can get a glimpse of the inner man, his lifelong philosophy, principles and aspirations as well as the highlight of his achievements till then. It also foreshadowed the successful leadership he provided to the Department of Physiology since 1976 and the Faculty of Medicine since 1980.

To the students he taught, he introduce physiology as a scientific discipline, inspire enthusiasm in the subject and cultivated i them a lifelong zest for learning. He set by h own example high ethical standards whic would influence the behavioural pattern o students, making them not only competen but also compassionate doctors. From th staff in the Department of Physiology, h demanded their dedication and efficiency a teachers but at the same time encourage initiative and diversification in their researc To the colleagues in the Faculty of Medicin he used tact and persuasion to convince the that they should look beyond their individu departmental interests to make an overa positive contribution to the development an well-being of the Faculty.

In addition to his ex-officio status as Senate Member and Dean, he has served on many important committees of Senate and Council and was Chairman of the Committee on Media Resources, *Interflow* Editorial Subcommittee, Committee on the Use of Liv Animals, and the Working Party on Breedin Facilities. The functioning of this University has benefited much from his wisdom, discretion and fairness for more than two decades.

To Arnold Hsieh, who is a modest man by any standard, all the above appears common place and nothing more than what a senior member of the University should have done in the line of duty. But even he will admit that being the first Doctor of Science of this University (1965) and Public Orator for honorary degree congregations for a total of five years are unique accomplishments unprecedented in this University. The former, awarded to him for his work on the effect of low temperature in animals and man, with special reference to the role of the thyroid gland and sympathetic nervous system in the phenomenon of cold adaptation was a recognition of his ability as a scientist. The

ıtter was a tribute to his talent, eloquence, ɔt and humour as a student of the English ıguage and as a public speaker.

Those who have known Arnold Hsieh and ɔ wife Emily for years could not help but ɔy their matrimonial bliss, their mutual espect, admiration, care and affection. Retiring to California, their bliss will be enhanced by the company and devotion of their only daughter Sylvia and her family.

In his inaugural address, Arnold Hsieh asked 'What shall I do with my life?', 'What am I doing with my life?' and 'What have I done with my life?' Very few among us can answer the last question with greater satisfaction and pride than he could on the eve of his retirement.

R.T.T.Y.

JAMES BLACKBURN GIBSON, O.B.E., Hon. D.Sc. (Hong Kong), M.D. (Western Reserve) (Edinburgh), M.B.,Ch.B. (Edinburgh), F.R.C.P. (Edinburgh), F.R.C.Path., F.R.C.Path. (Australia)

Professor James Gibson retired from the University on April 2, 1983. He held the Chair of Pathology from 1963 until retirement and was for several years the University's senior professor. He served as Dean of Medicine for six years, from 1972 to 1978, and as Pro-Vice-Chancellor for two separate periods. His contributions to the University as a whole and to the Department of Pathology in particular have been immense and his influence will be felt for years to come.

Educated at Dundee High School then Fettes College, Edinburgh, he won an entrance bursary to the University of Edinburgh where he studied the classics (a more common preliminary to medical studies in those days than now!). In 1941, at the height of World War II, he travelled to America as a Rockefeller student to study medicine at Western Reserve University, Cleveland. In 1943 he graduated with the degrees of M.D. from Western Reserve and M.B.,Ch.B. from the University of Edinburgh. Only a few months later he joined the Royal Navy in which he served for two and a half years as a Surgeon Lieutenant. In this capacity he was part of one of the great historic events of this century, the Normandy Landing; his ship was stationed off Omaha Beach where some of the worst carnage was suffered by the American troops. There is little doubt that the disciplines of navy life taught him much of value which he carried into his later professional life.

In 1946 he entered the Department of Pathology, University of Glasgow. He must have developed a certain liking for Glasgow, because he remained there for seven years (Glasgow, he has hinted, is the Hong Kong of Scotland). In 1954 he was appointed Lecturer in Pathology at Queen's University, Belfast where he rose to consultant status. He gained his M.D. 'with high commendation' from the University of Edinburgh in 1958. Two more years, 1960-61, were spent at Western Reserve as a Visiting Professor and soon after that, in 1963, he was appointed to the Chair of Pathology in this University.

In his inaugural lecture Professor Gibson said 'medicine without the audit of pathology is medicine neglectful of standards' and he quoted Confucius: 'If when I give the student one corner of the subject he cannot find the other three for himself, I do not repeat my lesson.' In clinical service and teaching, he took these principles and put them into practice with energy and determination. It is indeed a daunting task to try to summarize his main achievements over the span of twenty years, but they would appear to be in the following three areas: pathology services, technician training, and postgraduate teaching and training of young pathologists.

It is hard to imagine that in 1963 Pathology had a professional staff of about half a dozen; now there are approximately thirty. The Clinical Pathology Building stands as a monument to the upgrading and expansion of the Queen Mary Hospital laboratory services, funded by an annual government subvention but administered through the University. Professor Gibson did almost all the detailed internal planning of this new building, opened in 1972; the standard and scope of laboratory services within it have continued to improve steadily since then so that now, without question,

they are unrivalled in Hong Kong.

Soon after taking up his post in Hong Kong, Professor Gibson was made Chairman of the Management Committee of Extramural Studies and from this vantage point he pioneered the in-service training of medical laboratory technicians, which led to the establishment of the Ordinary Technician Certificate and Higher Technician Certificate courses (equivalent to Ordinary National Certificate and Higher National Certificate in the U.K.) and eventually facilitated the passage of an Ordinance to regulate the practice of Medical Laboratory Technology in Hong Kong (Supplementary Medical Professions Bill, 1980). Places in these courses are highly sought after and have contributed to the continued improvement in laboratory services in government, subvented and private hospitals throughout Hong Kong.

When he became Dean of Medicine, Professor Gibson recognized clearly the need to develop postgraduate medical teaching throughout Hong Kong. He was the prime mover in establishing the Unit of Postgraduate Medical Education and, subsequently, in the setting up of the Hong Kong University/China Medical Board Fellowship Scheme. Through this scheme, one hundred and eight Fellows from Southeast Asia have studied in Hong Kong and it was particularly pleasing to Professor Gibson that, in the last two years, it has proved possible to offer Fellowships t teachers in medical schools in China. He a played a major role in establishing th Licentiate Committee system (through th initiation of the Holmes Report) for the loc qualification of graduates from Mainla China. By his own admission, Profess Gibson gained most satisfaction from th training of young pathologists. He regard Pathology as the centrepiece and the logic basis of medical science. Armed with th philosophy, and with a thorough period o training behind them, his junior staff, almo without exception, have succeeded in the specialist examinations.

James Gibson has an impressive range o appointments, membership of professiona associations, external examinerships an medical consultancies. He has approximatel sixty publications to his credit and w principal author of the W.H.O. book *Histo logical Typing of Tumours of the Live Biliary Tract and Pancreas* (1978). In 197 the Queen awarded him the O.B.E. Outsid medicine he had wide-ranging interests (as squash player, his skill was surpassed only b his ferocious demeanour). His favouri pastime is undoubtedly hill-walking which h will be able to enjoy to the full during h retirement in the highlands of bon Scotland.

J.W.M.

FREDERICK PETER LISOWSKI

L.R.C.P.I., L.R.C.S.I., L.M. (Rotunda), Ph.D. (Birmingham), F.R.A.I., F.Z.S.

Few will take Peter Lisowski for an Irishman by birth, but that is the case. He was born in Berlin, however, 61 years ago, his father being of the roving kind of engineer, and he did his schooling variously in Germany, England and the home country.

The Royal College of Surgeons in Ireland is a most remarkable institution, quite different from its counterparts in London, Edinburgh and Glasgow, firstly because it has preserved its title in republican Ireland and secondly because it is the largest medical school in that country whereas in mainland Britain the corresponding colleges are purely postgraduate institutions. Following a distinguished undergraduate career, literally distinguished in that he obtained distinctions in many of the subjects of the curriculum, and during which he served as a student demonstrator of Anatomy, he then proceed to obtain experience of clinical work hospitals in Liverpool, and in general practi before returning to the academic fold. He w Demonstrator of Anatomy at Trinity Colle Dublin, and then moved to the University Liverpool where he remained from 1950 1954 before taking up a Lectureship in So Zuckerman's department at Birmingham, t hothouse of British Anatomy for the l half-century. Shortly after his promotion Senior Lecturer in the same department accepted secondment for three years to h found the new medical school at Addis Aba in Ethiopia and it was a visit to Eastern A at the end of that period which led to invitation to the Chair of Anatomy here succession to Professor Francis Chang, invitation taken up in 1969.

Very much a classical anatomist, Peter Lisowski's principal research interests have been in functional anatomy, with a spin-off into the evolution of humans and other primates. In recent years he has devoted himself to developing contacts with colleagues in China, making numerous trips which have brought great benefits to some of the more isolated universities there. Within this University, too, he has demonstrated an unusual breadth and range of interests, having served, among other things, as Chairman of the Committee of Management of the Centre of Asian Studies, and recently on the Committee of the Hong Kong University Press.

Peter Lisowski leaves behind him a strong and thriving department in which the development of newer fields of interest in research have not been neglected. To anyone who knows him, it would be a surprise to learn that he intended to retire from academic pursuits, and he doesn't. Indeed, from several possibilities his choice has fallen on an appointment in Hobart which will give him more time to continue his own research interests with colleagues in both Australia and the United States. It is impossible to doubt that we will hear more of him.

T.R.C.B.

ZOLTAN LETT

M.D. (Czechoslovakia), F.F.A.R.C.S. (England) (Ireland), F.F.A.R.A.C.S., D.A. (England), R.C.P.S. (Ireland)

The development of anaesthesia in Hong Kong did not occur until after the arrival of Dr. Zoltan Lett. Before World War II and immediately afterwards, there was no organized anaesthetic service in Government hospitals, including the Queen Mary Hospital – the teaching hospital of Hong Kong University.

At that time most operations were carried out under spinal anaesthesia which was administered by the surgeons themselves. A year or two after peace was restored, demobilized medical officers with no training or experience were made to act as anaesthetists.

However, in 1954, Dr. Zoltan Lett arrived in Hong Kong to take up his appointment as an Anaesthetist Specialist. Most people would have despaired at the poor state of the art and science of anaesthesiology that confronted them – not Dr. Lett, for he settled down to tackle the problems. He was based at the Queen Mary Hospital but visited other Government hospitals including the Kowloon Hospital.

Being a friendly person, he very quickly won the trust of the postgraduates from the Chinese medical schools. He organized and subsequently encouraged them to sit the examination for registrable diplomas.

At the same time he attracted some of our own graduates to join the anaesthetic service. He demonstrated his leadership by founding the Society of Anaesthetists of Hong Kong and ever since has been actively participating in the activities of this organization.

It was mainly due to his demonstration of the importance of anaesthesiology in modern medicine, that he was appointed a part-time lecturer in the Department of Surgery. As a part-time lecturer, he introduced a planned curriculum to teach undergraduates and he managed to acquire the assistance of his, by now, numerous junior colleagues.

His activities were not confined entirely to the University but also the anaesthetic services of all major Government hospitals. He started this service in 1954 and by 1977 when he retired as Government Consultant in charge of anaesthesia, anaesthetic cover was provided by him and his colleagues to such hospitals as the Tsan Yuk Maternity Hospital and even the Tung Wah Group of Hospitals. In 1977, he became a full-time lecturer in the University and in 1980, was promoted to a Readership.

Dr. Lett received numerous honours – all from abroad. In addition to wartime honours, he was recognized by his anaesthetists peers. He was awarded Fellowships of the Faculties of Anaesthetists of England, Ireland, and Australasia and was one of the few to be awarded the highly regarded Pask Certificate. The British Medical Association entered him into the Roll of Fellows in 1979 – a unique honour for Hong Kong.

Dr. Lett will be retiring from the University service which he has served with devotion and distinction. We wish him a happy retirement.

G.B.O.


PROFESSORIAL

八四精英

石破天驚

同心協力

勇往前征


4th M.B.
SPO
START
1st M.B.


F.R.C.S.
M.B.B.S.
M.R.C.P.
功奇立要誓心齊五八衛簡
勇夠又智有學同五八勇


Pauline Chan Building
沙宣道
MEDIC 86 精英主錄


MEDIC 86
Sports Centre

精英盡錄　舉世矚目
團結互勉　八六一家

活力常在

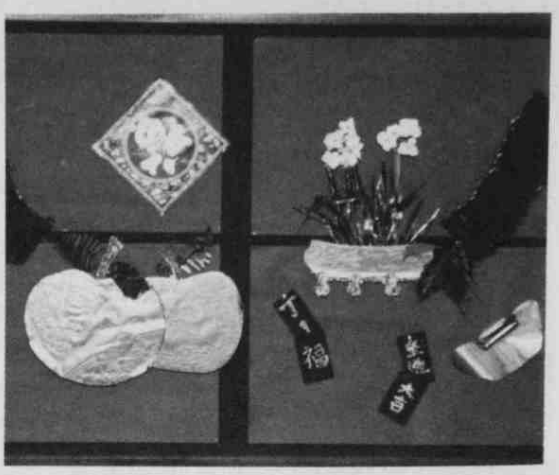
臨床學習的頭一年，多少代表繽紛的課餘活動，將由璀燦漸轉平淡。八六同學，却未呈一絲老態，依舊是活力充沛，衝勁十足，無論在班內班外，都爲八六迭創高峯。可記得醫學生節、中文辯論、時事問答、班際體育比賽？又有否忘掉聖士提反灣燒烤、團年飯、「杏蕾」的出版、幻燈放映……？

同學們在比賽中的熱心支持，對活動的積極參與，班委成員的衷誠合作，始終如一，亦是活力常在八六的關鍵。一腔熱誠，勝過卓越才能。只要人人尚有一顆赤子之心，我們一羣同學，對於八六的將來，仍懷信心、希望！

播放Pre-lecture Concert

Class Comm. 成員
辦事落力，玩時HAPP

一分耕耘，一分收獲



影相緊要過食嘢！
（聖士提反灣 Beach Party）

醫科八七

MEDIC '87

八面玲瓏・七竅皆通

八七英勇・大顯威風

自我初初結識你…

COME. COME, COME, ...

分屍

an introductory practice of dissection

EIGHTY-EIGHT .....

1983年度88班最＿＿男士：

(A)英明神武 (D)喜歡打吹

(B)風流倜儻 (E)不知所謂

(C)舉足輕重

四目＋二目相投＋相對無言＝？

ord to maintain neutrality,
. of ale singer must = no.
fem e singer, and no. of
ale j lge also = no. of female
dge.

黑人牙膏
最啱燒烤後用

邊個傻佬
掛住映相呢？
佢一陣實冇
嘢食。

讓我歌唱！

大個仔啦！
不如衣香鬢影一下……

WE ARE TIGER,

WE ARE GREAT

DEPARTMENTAL SURVEY

RESEARCH IN THE DEPARTMENT OF COMMUNITY MEDICINE UNIVERSITY OF HONG KONG

Introduction

As an academic university department we are committed to teaching and research. These two activities need to be seen in the context of a developmental policy. In that policy three definite roles can be recognised.

(a) to deepen the understanding of community health problems and to find solutions to control/eradicate them;
(b) to participate in local regional working parties to elucidate pressing problems in community health, and in initiating them if such working parties do not already exists;
(c) to upgrade professional and public awareness of and knowledge about the most important community health problems and indicate possible solutions.

Type of Research

Community Medicine is by definition a discipline that requires community orientation from staff working in this field. Consequently most research need to be community-problem oriented. This type of research, in turn, needs a team-approach and cannot usually be efficiently carried out as single-man research. Community health problems are usually complex problems, involving pathology, environmental hygiene, mass-management, demography, politics, etc. and nobody can be expected to be an expert in all these fields. The community medicine specialist can best be seen as an "expert generalist" or an "community-problem analist".

There is also a need for population-based epidemiological information in Hong Kong, particularly on morbidity.

Research Programmes/Projects

Each academic department should have one or more long-term research programmes fitted into its developmental policy. A programme delineates broad areas of research objectives and within these objectives projects need to be designed. These projects are usually described in terms of specific objectives and have a limited duration (2-5 years). A further subdivision of projects into studies may sometimes be necessary.

This construction of programmes divided into projects has the following advantages: academic freedom (so highly treasured in the academic world!) is safeguarded to a large extent because programmes cover wide enough areas to fit most relevant projects and yet the programme limit the scope of research within the boundaries of departmental interests. Long-term programmes have also the advantage of being less vulnerable to staff changes as recruitment of new staff can be geared towards programme needs and material can be more fully utilized. Furthermore, studies will achieve greater depth, and this in turn will give increased credibility to the staff and consequently make funds more easily forthcoming.

The Department is now engaged in the following research programmes/projects:

PROGRAMME: MAJOR CAUSES OF DEATH IN HONG KONG

Project – A study into person and place variables in Hong Kong patients suffering from selected heart diseases.

Project – Case-control studies of Chinese female lung cancer patients in Hong Kong.

Project – Comparative study of lung cancer patterns in the Asia-Pacific Region: an international collaborative study including Japan, China, Hong Kong and the U.S.A.

Project – The studies on mortality and morbidity in Hong Kong.

PROGRAMME: MORBIDITY EXPERIENCE AT THE HOUSEHOLD LEVEL & THE UTILIZATION OF AVAILABLE MEDICAL & HEALTH FACILITIES

Project – Morbidity experience and illness behaviour in household etc. of random samples of subscribers to the HK – Telephone Company.

Project – Morbidity experience and illness behaviour of a well-defined population of households through house-to-house interviewing and self-reporting.

Project – Social-economic factors in paediatric admissions in a major hospital in Hong Kong.

PROGRAMME: ANTHROPOLOGICAL & BEHAVIOURAL DETERMINANTS OF HEALTH, DISEASE AND UTILIZATION OF SERVICES

Project – A descriptive ethnomedical study on local (Hong Kong) concept of disease symptoms, causation, treatment and prevention.

Project – An epidemiological survey on bowel habits among Chinese in Hong Kong and China compared to populations in California.

Project – A food composition analysis of Chinese diets in Taiwan and San Francisco (in collaboration with University of California, Berkeley and San Francisco.)

PROGRAMME: OCCUPATION LINKED SICKNESS IN HONG KONG

Project – Prevalence of byssinosis and obstructive airway disease in cotton textile workers in Hong Kong.

Project – Occupational hand injuries in Hong Kong.

Project – Occupational contact dermatitis in Hong Kong.

Project – Compressed air work and decompression sickness in Hong Kong.

Project – Physical and mental health and work stress in white collar workers in Hong Kong.

Project – Health status, work environment, occupational health and safety services in small scale industry: an international comparative study involving Japan, Philippines, Singapore, Korea and Hong Kong.

These projects have already generated many papers published in local and international journals.

Professor J. W. L. Kleevens

M.D. (Amsterdam), D. Soc. Med. (Netherlands), M.F.C.M. (R.C.P.) (United Kingdom), D.P.H. (Malaya), D.T.M. & H. (Amsterdam), F.R.S.H.

Professor Kleevens joined the University of Hong Kong in 1978 as Senior Lecturer in Community Medicine and was promoted Reader in 1980. From June 1, 1983, he has been appointed to the Chair of Community Medicine.

Professor Kleevens is glad to see that the appreciation for Community Medicine in Hong Kong is beginning to grow. Departmental development is rather slow but this has nothing to do with the lack of interest in Faculty for Community Medicine. It is rather the difficult time in terms of finance that the University is facing now that has stunted all development within the HKU. "At present we have only a total of five academic posts for CM. To satisfy students' teaching and staffs' research needs we could easily absorb another five academic posts." However, he does not wish to complain. "Compared to many other Universities in the region we have a good curriculum and wide opportunities for research. We lack only in research funds." This is partly due to the non-glamorous status of CM, compared for example to Surgery, Medicine and Paediatrics. It is difficult to find donors for research and the Universi Funds are rather meagre and piece me

What is Professor Kleevens' impressio of medical students in Hong Kong?

His impression is that medical studen in Hong Kong are very hard working an attentive. However, out of necessity – th curriculum is heavy – they seem only t have time to work for class tests and examinations. Most of them are not well- informed about what is going on in Hong Kong, the region and the world. This may in part be true for medical students o other medical schools because of the heavy and technically oreinted pro grammes they have to follow. "As most students will eventually become general practitioners it is useful that they, at least, know and understand what is going on in the Society they serve." According to Professor Kleevens, the standards of written examinations of medical students in Hong Kong are ranking high, but the oral examinations are not so good. This may be a reflection of language problem and perhaps of the unsufficient training to express their ideas and thoughts orally.

Professor Kleevens is affiliated to various professional organisations and learned societies. He is also editor of The Bulletin, the Journal of the Hong Kong Society of Community Medicine. He has contributed extensively to internationa professional journals in the field of com- munity medicine.

Mr. John L. Anderson

Department of Community Medicine,
Behavioural Sciences Unit.

M.A. of Sociology
University of Aberdeen, Scotland.

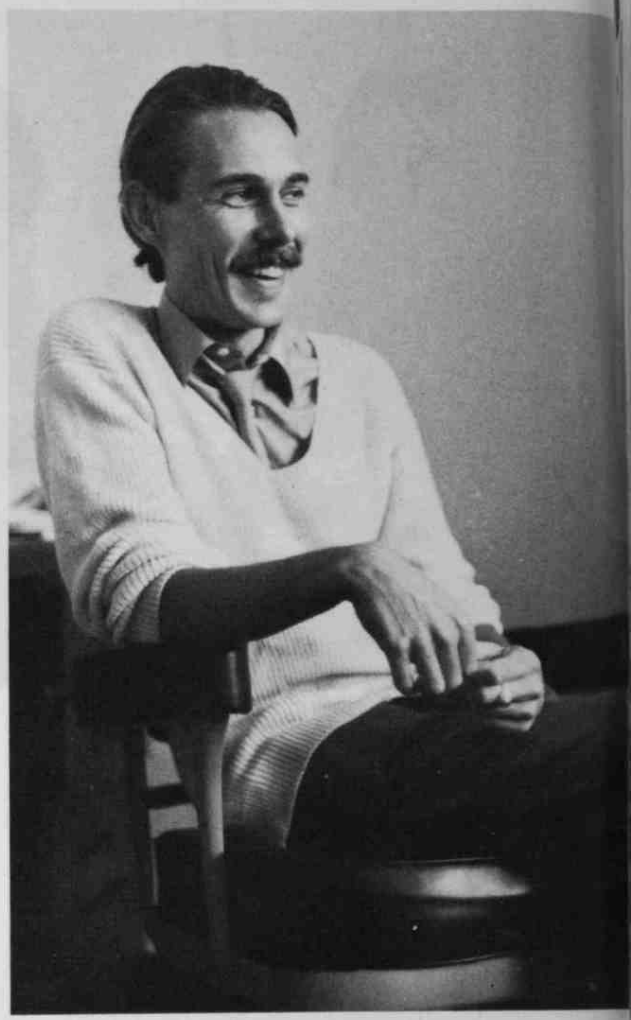
Mr. Anderson was born in Aberdeen, Scotland and finished his university studies (majored in medical sociology) there. Afterwards, he worked, doing research and teaching in London for 10 yrs. In 1978, he came to University of Hong Kong.

Mr. Anderson was impressed by students in Hong Kong as they are nice, friendly, warm and hard-working. Besides, they show great concern for their future career and their potential contribution to society.

However, some students (a minority) do not consider Sociology important in clinical application. The reason, according to Mr. Anderson, may be due to the lack of clinical experience and the difficulty in realizing the direct relationships between Sociology, psychology and medicine. The appreciation of the contribution of these subjects to medicine requires understanding, time and experience.

Mr. Anderson has been working in this field for 14 years. To him, Sociology is an interesting as well as important subject. Moreover, he finds people interesting.

Mr. Anderson's most favourite hobbies are fishing, photography and playing with his young son.



Mr. Fielding

Mr. Fielding graduated from the University of London in 1974 after completing a 3-year course in Psychology and Zoology. In 1977, he completed his clinical training obtaining a Diploma in Clinical Psychology.

Mr. Fielding joined the University in December, 1982, as lecturer in medical psychology. He had worked as a clinical medical psychologist before this. He has always been fond of Chinese culture and in this respect, was rosy-eyed about Hong Kong. However, he soon learned that Hong Kong is a very different place to China.

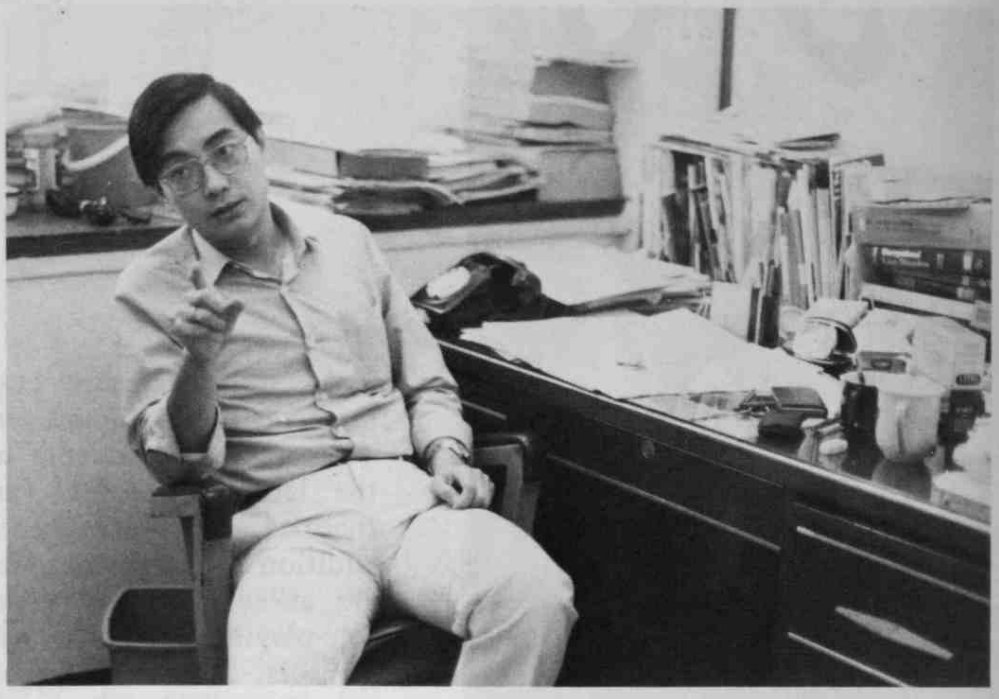
As a full time lecturer, he misses the clinical contact he had with his patients in his former job. However, he acknowledged that there may be differences between the problems experienced in the West, some of which he is familiar with, and those experienced by people in Hong Kong. This, as well as the language barrier to a non-Cantonese speaker, may make clinical work more difficult with Chinese.

To Mr. Fielding, students in Hong Kong are far less critical of what they are taught. This presents a problem for him in evaluating the impact and comprehensibility of his teaching. "Feedback improves performance – for both teacher and student. The students here are bright and polite, but shouldn't allow their politeness to make them accept things that could do with being questioned."

His favourite hobbies are swimming, reading, photography and chattering. His fiancée is a nurse in England.

Linda C. Koo, Ph. D.

As well as being based on science, medicine is an art and a service profession. To increase the students' understanding of the latter principles, various facts and theories are presented in teaching. In addition to the standard lectures, students are asked to apply their knowledge in role-playing, problem solving, investigative projects, etc. so that digestion and incorporation of learning takes place. For example, to increase the student's awareness of the importance of feelings and beliefs of significant others on the efficiency of health care delivery, studies on the role of the doctor, patient, nurse, mother, medical-social worker, etc. can increase their awareness and sensitivity to the different motivations of others. It is always easy to express the platitude that a good doctor-patient relationship is important, without realizing its consequences. Certainly victim-blaming is all too frequent an excuse to cover-up for poor communication patterns. Such phenomena as "doctor-shopping, patients asking for and getting unnecessary injections and pills" are only symptoms of the past experiences of the community with various doctors. In the therapeutic setting, the essential role of the doctor in determining the quality of the interaction (not necessarily related with expenditure of time) and health education cannot be over-emphasized – especially for doctors in Hong Kong. And finally, I think it is important to point out the mutual relationship of doctors with society. Society has financed some 95% of the costs of university education for medical graduates of this university. In return, there is the responsibility of each doctor to provide quality service for the community. In this way, the status of the profession can be truly elevated.



Dr. Lam

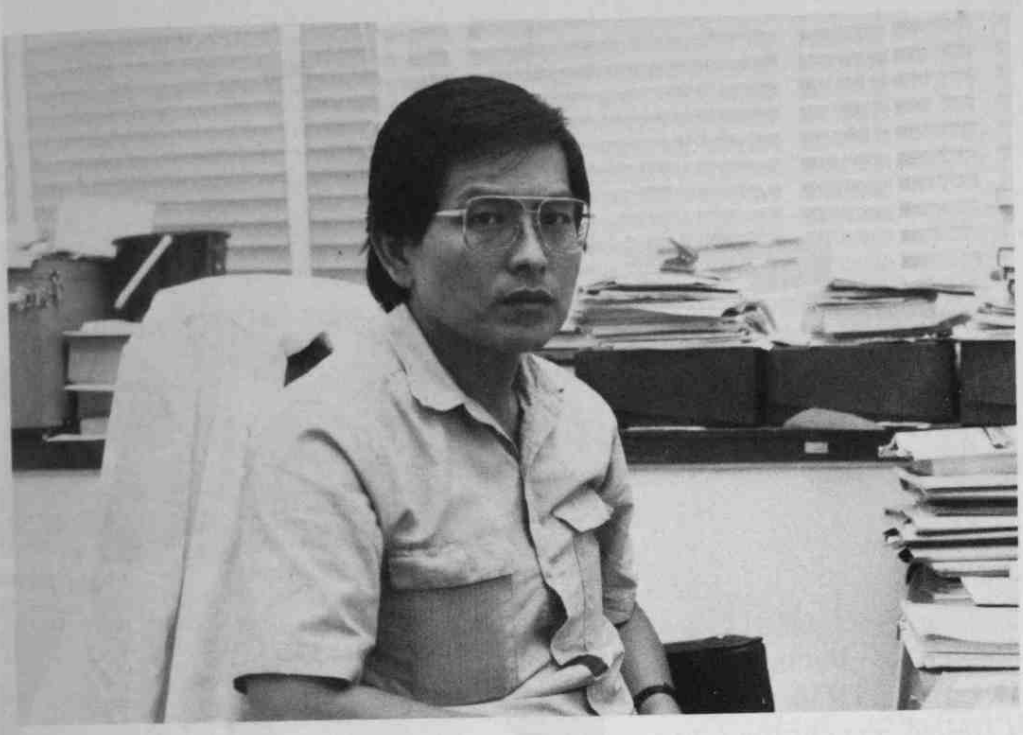
Dr. Lam was an old boy of Queen's College. He was educated in H.K.U. and obtained his degree of M.B.B.S. in 1975. After graduation, he became the houseman in the University Surgical Unit of Queen Mary Hospital for the first half year and in the Medicine Department of Nethersole Hospital for the next half year. Then Dr. Lam joined Community Medicine Department as a lecturer. After serving there for three years, he left Hong Kong for further training in London for 2 years. During this period, he obtained a M.Sc. degree in Occupational Medicine*. Then he came back to H.K. and continued his work in Community Medicine Department till now**. Dr. Lam has the following reasons for work in this department: He is not content with the traditional image and function of a doctor and is more interested in the whole community, particularly the workers. Joining the Community Medicine Department gives him a chance to look at the medical and health problems in the community from the epidermiological perspective. Also, he is interested in teaching medical students and research in occupational and community health.

Dr. Lam has married for 3 years and does not have children now. He has been involving in drama for 15 years and is a well-known playwright and dramatist in Hong Kong. He thinks that the medical students active and creative in spite of their heavy work load in their studies.

His research includes: Byssinosis, occupational hand injury, work stress, decompression sickness lung cancer of women, cardiovascular disease, and household morbidity.

*He was awarded the Society of Occupational Medicine Prize for the best student in the M.Sc. Occ.Med. course.

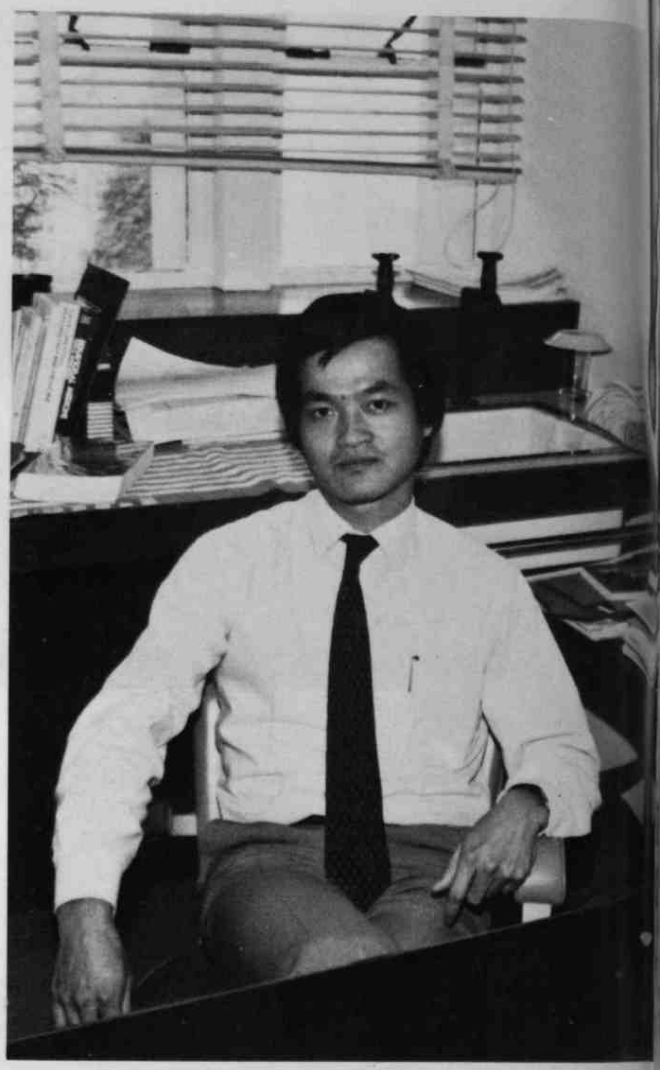
**In 1983, Dr. Lam was elected Associate of Faculty of Occupational Medicine in U.K. (A.F.O.M.) and Foundation Fellow of Australian College of Occupational Medicine (F.A.C.O.M.).



Dr. S. G. Ong

"Student should be eager to learn" Dr Ong thinks that medical students are not middle school students. They are already adults and should know what to do and spend the appropriate time on study. He feels the performance of the students is quite good and satisfy the requirement. He would not ask for too much as the work load of the students is already quite heavy.

Dr. Ong is married. He is a good father and spend quite a lot of time in taking care of his young children. In his spare time, he likes to play all kinds of ball games such as tennis and badminton.



Mr. Peter Lee

Mr. Lee got a degree of Bachelor of Social Science (HKU) in 1976 and a master degree in Clinical Psychology in 1979.

Mr. Lee joined the department in 1980 and worked as lecturer of behavioural science. He is also a lecturer of clinical psychology in the Department of Psychiatry in Queen Mary Hospital.

In 1980, Mr. Lee left for U.K. to study in the Institute of Psychiatry and the Taristock Institute for 1 year. He rejoined the department in 1981.

Mr. Lee believed that the study of behavioural science can help medical students develop the right perspective in the treatment of their patients.

He has done research work on male contraceptive, psychopathology of Leukemic children and is now completing a project on the correlation between children's speech development and their behavioural problem. Another programme is the investigation of the prognosis of Schizophrenic patients and their response to medication.

Mr. Lee is working happily in the department as his job ranges from the clinical aspect to teaching and research work.

Mr. Lee praises the solidarity of the medical students in the faculty and hopes that it can be maintained.

He also believed that excessive anxiety before examination can be relieved through mutual assistance and group support from other fellow students.

Miss Beatrice Hung

Miss Hung received her secondary education at the St. Paul's Convent School and Obtained the degree of Bachelor of Social Sciences at the University of Hong Kong in 1979. Thereafter, she was awarded a postgraduate studentship in the Faculty of Medicine and had obtained the degree of Master of Philosophy in 1983. Now, she is working as a demonstrator in the Behavioural Sciences Unit.

The academic interest of Miss Hung is focused on the application of Psychology to Medicine. In particular, she is interested in applying psychological principles in medical settings e.g. preparing mothers for pregnancy, labour and the postnatal period, and understanding patients' reaction to illness and treatment.

Miss Hung is married. Her leizure activities include reading, listening to music and especially shopping. She is particularly interested in the relationship between cultural values and fashion designs.

Miss Hung is, at present, working with the University Health Service on a project which studies Breastfeeding and Bottlefeeding in Hong Kong. Her other research interests includes mother-infant interaction, lay concepts of pregnancy and labour, and postural depression.

Miss Hung points out that the medical students now show more enthusiasm towards Behavioural Sciences. In her opinion, the medical students are overloaded with work. Though they are excellent in terms of academic achievement, some are deprived of the opportunity for all-round development. They may sometimes face with problems and have no one to talk to. Miss Hung thus suggests that each student should have an emphathetic tutor, so that academic or emotional problems can be attended to satisfactorily.

Miss Hung thinks that the Behavioural Sciences course should be spaced out over the five years of medical education. The Unit, however, is now facing the problem of inadequate resources. She comments that the working places for staffs are insufficient. She hopes that this problem can be solved in the future.

Finally, Miss Hung stresses that besides studying medical students should also try to understand themselves. This would affect their future career and how they meet their patients.

Mrs. Griffin

After having obtained her joint degree in History and Psychology in the University of Melbourne, Mr. Griffin took a Certificate of Psychology in the University of Hong Kong in 1980. In 1982, she started working as a demonstrator in Behavioural Science, Faculty of Medicine.

When she was a student in the University of Hong Kong, she found the students mutually supportive and the competition between the students was not keen. The medical students, in her opinion, seem to be overworked and to have an excessive load. However, a good standard is maintained in the faculty.

As a foreigner, she sometimes feels it to be inappropriate to teach Chinese students Western theories and Western research without reference to the Chinese culture of Hong Kong. There is very little local material that could be used for teaching purposes. However, from a cultural point of view and a language point of view, local teachers may be preferable. She regrets not having learnt to speak Cantonese as it may be helpful in communicating with the students. However, she considers that most of the students speak very good English.

Mrs. Griffin is now involved in a research on the psychological experience of Pregnancy. Being a woman herself, she is particularly interested in women's psychology and issues. The Psychological experiences of childbirth and postnatal depression are the subjects of her next research.

Reading is the major hobby if Mrs. Griffin. She likes to read all kinds of creative writings – poems, novels, plays and so on. She likes to go to the theatre – an exciting places with its dramas and operas. Wouldn't it be nice to see live performance right before one's eyes?

Mrs. Griffin suggested that the course on Behavioural Science should be extended to 2 years and even into the clinical years in the light that the 1 year's course is sometimes seen as too compact by the students.

Mrs. Griffin suggested that a good doctor should be sensitive and interested in what the patient expects from him/her. *May all of us live up to her standard.

*The doctor should respect the patient, and always see him or her as a human being, rather than just another 'case'.

Miss I. Sharp

Ms. Sharp left England two years ago, following graduation from University, and came to Hong Kong seeking new pastures and employment. Initially she taught English in a private institute, and then moved into journalism, working as a magazine editor in a local publishing company and also doing some freelance work for a medical newspaper.

She has only been teaching at HKU since September and, she says, is greatly enjoying it. "My degree was in Human Sciences, which shares much in common with the Behavioural Science course, and I find the whole area fascinating." She feels that one of the problems some of the medical students encounter in the Behavioural Science course is coming to grips with social sciences when they have previously been trained purely in the so called 'hard' sciences. But she believes that the course helps bring to the students a greater understanding of social and individual differences in ill health.

Ms. Sharp is interested in the doctor-patient relationship, and in particular in the way that sex differences can influence this relationship. She feels it is a valuable area for study in Hong Kong, where the burden on available resources is high and the pressures affect doctor-patient interaction.

Ms. Sharp lives in Discovery Bay. "I have lived on Lantau since I came to Hong Kong," she said, "and really love it. I prefer the countryside to the city."

Mr. Y. H. Cheng

Having completed the matriculation course in Lingnan College, Mr. Cheng entered the Faculty of Social Science of the Hong Kong Shue Yan College. After graduation, he served society by working as a social worker for more than one year. He was then engaged in a research project, working with a consultant orthopedics surgeon. The project, which was conducted in a hospital for more than 2 years, sparked off his interest in medical sociology. Then, he joined the Hong Kong Council of Social Science and devoted his time to research. After the summer of 1981, he went to Britain for study Medical Sociology. He came back at the end of 1982.

Promoted by his pursuit of knowledge in medical sociology, Mr. Cheng joined the Department in March, 1983. In the beginning, he worked with Mr. Anderson on doing a research on 'Doctor and Patient Communication' which will soon be finished. In the first term of this year, he began working as a demonstrator in the Behavioural Science Unit. In the near future, his research topic will probably be about physical disability.

In addition to his academic interest which mainly centres on medical sociology, Mr. Cheng likes various kinds of ball games, swimming and photography. Also, he is fond of reading and movies, particularly Japanese ones. Besides books of his academic field, his reading includes economics and philosophy. He enjoys travelling very much and found Paris and Rome most impressive.

Mr. Cheng has the general impression of the medical students here as having great enthusiasm in the academic course.

強睜睡眼看人間

『本報訊：約有百多名九龍灣臨時收容中心居民在房屋署門外靜坐，反對遷入大埔船灣臨時房屋區。』

✣✣人人都說世上沒有一件事情是完美的，我也相信。爲什麼我連一個祈待已久的美夢也不能圓滿地結局呢？那個沒有人性的鬧鐘總是担當着最醜惡的角色。在你最不希望它出現的時候，它偏要走出來嚇你一大跳。算了吧！這是「自作孽」，誰叫你偏喜歡它持重的外表，它辦事的精確和它堅定不移的個性呢？別了，我夢中的可人兒，別了！我這溫暖的被窩。

草草吃完早餐，穿戴整齊，挽起書包，以患得患失的心情跑到街上，爲着要趕及那班從不遲到的巴士。同一的時間，同一的地點，懷着同樣的心情做同樣的事，生活就是這樣一天天地過去了。「糟糕！忘了買報紙。」我又如常地醒覺，如常地埋怨自己。算了吧！歷史是循環不息的，昨天的事，明天也會再發生，我們又何必焦急呢？

——————————————————

『本報訊：政府發言人表示不排除用武力手段迫使靜坐中居民離去的可能性。』

「今天不是讀書天。」可是除了讀書外又有什麼事情可以做？中學時代的什麼「七君子」，「四人幫」，早已各散東西，「在遠份日親」這句話，只不過是極度消極中的一服解慰劑吧！還記得在一篇文章裏，有人作了這樣的一個譬喻：「我們週圍的人就像圖書館書架上的書，有些在我們眼前匆匆掠過，根本吸引不住我們的目光，但是有些卻不知怎地，叫我們禁不住停下步來。一種無法解釋的衝動，驅使我們伸出手去拿着它，以充滿好奇而戰慄的心情去揭開它的第一頁。」究竟它是一個什麼的故事呢？反正未看到最後一頁，誰也不知道結局是什麼。可是我們一生又可以看得完幾本書呢？

「噢！又在圖書館發白日夢了。」枱上放着的幾本書還是那樣端正地躺着，只看看那鋒利的書角，便知道我根本沒有揭開過他們。整個下午都是懶洋洋提不起勁。「難道我眞的衰老得這樣快？」

晚上，我又拿着中學時的相片仔細地看着。雖然燈光是那樣的昏暗，眼睛是那樣的疲勞，但我仍可以在人叢中發現自己。「這個人眞的是我嗎？」我第一次感到這樣疑惑。

——————————————————

『今晚新聞的主要內容是：在房屋署門外靜坐的災民開始了絕食行動，只進食流質，婦孺將不會加入……』

窗外的北風吹得正緊，但面對着那扇緊鎖着的窗門，她也是無可奈何。外面的東西進不了來，裏面的東西也同樣逃不了去。「早點兒睡吧！今晚天氣很冷呢！」母親在背後輕聲地說。不是麼，剛才新聞報告說氣溫只有十度呢！

夜深，風刮得更厲害了。我隱約覺得她已經從窗門的夾縫中鑽了進來，也許有了沸騰的熱血便不會感到寒冷，但我沒有。街上，行人愈來愈少了。除了那被風捲着，飛舞着的紙屑，就像一對對眨着的眼睛，爲這平面的空白點綴了一點兒色彩外，餘下的就只有寂靜，無休止的寂靜，這樣的一個晚上，有誰會跑到街上去呢？是

…，這樣的一個晚上，是不會有人自願跑到街上的。

「九龍灣事件不是一件孤立的事件，而是千萬個香港面臨的社會問題中的一個例子。」

生理實驗是很有趣的遊戲，遠遠勝過那些呆板和沉悶的講座和導修課。正當大家都埋首用刀片割開自己的手指的時候，久違了的光突然從門外氣呼呼的衝了進來。

我並不太熟悉光，因爲我和他根本沒有什麼交談的機會。上講座時你從來找不到他的踪影，上實驗課更是絕無僅有，要麼就只是在你面前匆匆一掠，在你能捕捉他的眼神前他已經跑得遠了。一次跟他打招呼，總有着久別重逢這一種感覺。每一次的遭遇都是短暫的，說不上幾句話便各散東西，因此也更叫人珍惜。但一個令人留下印象的聚會是不在乎時間的長短的。我對光並不太陌生，他是校內的活躍份子，院會的中堅，談起認中關社，談起九七、血書，總是不期然聯想起他，沒有機會聽見他發表什麼講話，也沒有機會看見他的名字出現在校報上或傳單上。只記得有些時候他會傻傻的跟別人開玩笑，捉弄別人，但過不了許久卻見他披着一頭散亂的頭髮，帶着疲乏的眼神，在路上獨自徘徊。光就是個這樣的人。誰都知道光進來不是爲了上實驗課，見他神色凝重的樣子，想必又是爲「公事」而來了。他搶着吸了幾口空氣，便跑到實驗桌旁拉了那個正在玩得興高采烈的敏出來。只看見敏用她不常見的嚴肅的眼神用心地爲聽着光，他們絕不是在說故事吧！「哎唷！」我竟然忘記了自己正拿着那塊刀片，一滴鮮紅的血緩緩地從指頭滲了出來，滴到枱面上。我竟然浪費了它。

「我們覺得作爲一個好醫生，除了要有豐富的專業知識外，同樣重要的是我們應該有强烈的社會意識……」

看見敏正朝着這邊走來，面上沒有掛着她一向的笑容，代替了的是一臉子的忽忙和緊張，「琦，今天晚上我們去房屋署慰問那些在絕食的災民，你也一起參加吧！」「我們在什麼地方集合？」眞不知道我爲什麼不假思索便答應了她，這不像我一向做事的作風呀？難道是爲了好奇？難道是爲了我尋刺激？還是因爲她來問我……「幫我去找多些同學參加吧！」耳畔響起了她說的一句話。帶着一點茫然，我的脚步已不覺走向周圍的同學當中。

很久沒有說這麼多話了。從來只覺得「君子」要「話簡而精」，但發覺在實踐的時候卻難免變成「話雜而繁」，更何況我根本就不是君子呢！要向別人解釋一件事情，可眞是吃力而不討好的工作。「你們的動機是什麼？」「有什麼背後的目的意義？」「什麼團體發起的？」「你們有沒有立場？」當你提出了一個問題，你就得準備回答數以十計的問題。然而我早就知道他們的回答不外是，「噢，今天晚上不行，明天可以嗎？」「我想我還是要用功讀書了。」「我不打算支持任何一方的。」「政治？不合我的胃口。」「努力吧！我在精神上支持你。」但是爲什麼我還是這樣努力地回答每一個問題，不顧一切地到處碰釘？我感到一片茫然。

想不到在這個寒冷的晚上，竟然在一個那樣熱烘烘的地方渡過。房屋署外架着的帳篷，分隔着兩個不同的世界。裏面密密麻麻的擠滿了百多人，有年輕的母親和她襁褓中的嬰孩，有舉目無親的單身漢，更有流落在香港的印尼、緬甸華僑。在一個較黑暗的角落，疲乏的人倦縮在一起，身上裹着厚厚的棉被，已是進入了夢鄉。但在另一個角落卻不時傳來陣陣嬰兒的啼哭聲，也許他是一生中第一次睡在街頭，有點兒不習慣吧！有些睡不着的成年人聚在一起，組成了十來個大大小小的圓圈。他們有些在玩撲克，有些在聽收音機的廣播，有些在談天說地來打發時間。但在這裏顯得最忽忙和緊張的，卻是那些纏着臂

章，到處傳遞茶水和拿着播音器講話的人。少不了的當然是在旁戒備的警察和像我們一樣到來「慰問」的人。隨着那漸漸到來的深夜，人羣也慢慢變得稀疏。那些來慰問的人們，想來也是歸心似箭，趕着回家罷。只有那些露宿的人沒有離去的迹象，因爲他們連一個可以歸的家也沒有。

回家的路並不算長，但我卻花了比正常多出一倍的時間才能走完。也許刺骨的寒風能令人更加清醒，更能令人平復激蕩的心靈。一連串找不着答案的問題老是徘徊在我的腦海中。我本可以告訴自己：「你的能力根本微不足道，又怎能改變這一切？」「你的責任是好好地讀書，不要浪費寶貴的光陰在這些無謂的事情上。」但我眞的不甘心這樣的欺騙自己：

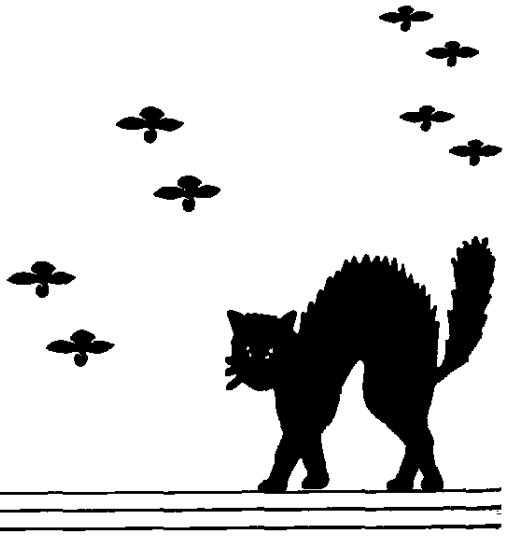
『在事件發生初期，港大學生會中央仍未有確定的立場，因此我們可以有更大的自由去探索事件的眞相。』

「鈴…鈴…」電話又響起來了。我模模糊糊的醒過來正準備接聽，卻看見敏已經比我快了一步拿起聽筒。這已是今晚接聽的第七個電話了。加上我們打出去的，絕不少於二十個，只見敏吃力地說：「我是二年班的王慧敏，九龍灣災民絕食已第三天了，我們希望高班的醫科同學可以組織一支急救隊到房屋署，一方面可以幫助有病的災民，一方面也可以盡醫生救死扶傷的本份，不知道你可不可以參加呢？」整個晚上，我和敏都留在光的宿舍裏忙着打電話聯絡高班的同學。數天睡眠不足已使我的眼皮睜不開來，但今天晚上是萬萬不能倒下來的。敏放下電話，滿意的笑了一笑：「琦，又多了一個生力軍。」還記得這天早上，我們三人到處打聽有關照料絕食者方法的資料，當我們正滿腔熱誠地在餐廳裏詢問一位教授時，得來的答案卻是：「Please don't disturb my lunch。」那份沮喪的心情還是第一次嘗到。

『九龍灣事件尚未結束，而無數類似九龍灣的事件亦會接踵而來。』

數天連續不停的工作和每晚四小時睡眠的調劑，使我們所構想成爲了現實：一份四千多字的大字報終於出現在眼前。望着那疊二十多張的大字報紙和枱上的十多枝用乾了的箱頭筆，不禁深深的舒了一口大氣。那份滿足更是不自禁的湧上心頭。心想：「這也許是停下來休息一下的時候了」每次打從大字報欄前走過，看見圍觀的人羣，心裏便有一種異樣的感覺。我好像看見他們看的不是那份大字報，而是活生生的自己，一個沒有掩飾，赤裸裸的自己。

考試、測驗、讀書、這些名詞已成爲了醫學生的座右銘。你愈對它們恐懼，它們就愈跟你糾纏不清。生活的節奏就是考試的節奏，生活的規律就是考試的規律，這些都是醫科不變的定理。「唉！幹嗎又發牢騷呢？還是快點合上眼睛睡覺吧！」睡眠對我來說只是爲了應付明天的工作的一種工具，是一種難得的奢侈品。「睡吧！明天還有許多事情等着做呢！雖然我們每天都要强睜着睡眼，但我們還是可以看清楚我們這個既殘酷而又眞實的人間的」



評議會——舌戰比武場?蓋功工場?

評議會，在熟悉醫學會活動的同學看來，它是一項馬拉松式競技，（其中有長達二十小時的一次會議），但一些不大熟悉醫學會活動的同學可能連評議會是什麼一回事也不清楚。那麼評議會是否一隻只會吞吃評議員的時間而又毫無貢獻的大怪物？

實際上，除了評議會主席之外，我就是每次評議會必須出席整個會議的人了。雖然身爲評議會名譽秘書，但假若評議會眞的是那麼多餘的一樣東西，我所受的害處也不比其他人爲少，也無需站在所謂官方立場，給評議會堆砌什麼豐功偉績了。

憲章上賦予評議會決策的權力，那麼評議會應該是一個決策的架構吧。然而，在決策的過程中，討論和諮詢是不可缺少的。再者，評議會也要作出了的決策付責任，例如，評議會委任了某些人作爲一個活動的籌委會，它也應當對籌委會工作的進展起一個監察作用。換句話說，評議會既有決策的作用，因而亦有諮詢以及監察的作用。我也嘗試在這裏對我這屆評議會就這三方面作出評價。

對於評議會在這一年裏所作出的決策，大致上我都認爲是合理的。致於諮詢及討論方面，雖然用於開會的時間算是不少，但在某個程度上，我仍然覺得諮詢及討論是不足夠的。我想原因不是在於議會主席沒有給予評議員足夠討論時間，而是在於評議員對於一些基本資料未有充份掌握。

原則上每份會議文件都應該在會議前數天交到評議員的手中，實際上，除了會議議程之外，根本大多數的文件都不能預早派發給評議員。有時候，甚至當會議進行到有關議程時，會議文件才會忽然出現，評議會並非超人，又那有能力在這麼短的時間內完全掌握文件內容以及作出分析呢？在此我並非要怪任何人，我自己身爲名譽秘書，亦要承担大部份的責任，但無可否認，有許多事情並非我們能夠控制的，而且，我們也不過是學生，難道同學要爲了這個評議會而使自己的學業蒙受影響嗎？

至於監察委員會工作方面，我以爲這一屆的評議會是不過不失的。但在個別事件中，它卻有時候被人稱爲「鋤人」之地，又或者相反地成了一部通過動議的機器。這兩種情形的出現，都是反映出評議會的運作並非時常理想，雖然這些都難以避免，但仍希望來屆的評議會能夠盡量減少這些情形。

評議會的運作是否合乎理想，是決定於許多因素的。假如我們把它們比諭作「天時、地利、人和」，那麼，制度只是其中的「地利」，而「天時」則是一年裏學院中發生的大小事情，往往，評議會花了許多時間在這些事情上討論，卻又不能達至任何結論，另一些需要討論的事情也不得不因時間關係而草草了事。另一個因素，就是所謂「人和」，評議員來自不同的班級，各有不同的背景，也担任着不同的角色，不難想像到大家的觀點與角度有所分別。事實上，正因爲大家有不同之處，討論才有眞正的意義；然而，成功的討論有一個先決條件—開放的態度，否則，所謂討論只是正反相方各自推銷自己的一套，然後以投票，那個偉大民主的方式，來給他們決一勝負，根本無討論的餘地。一

當我們論及「人的因素」時，不其然地，我們便會想評議會主席如何帶導討論，無疑，這是相當重要的；另一方面，每一個評議員的投入，對討論中的事情的關心和認識，大家對民主精神的尊重，對其他評議員的尊重也足以影響整個議會的運作。

要達到理想的運作，以上三個因素是不能缺一的。然而，現實總是現實，又那有十全十美的呢？面對着這堆不理想的條件，我想我們應該做的事情，除了設法致善各個因素之外，也應該面對現實，在各種限制下仍努力去幹，成就也未必可以限量呢。

林煥兒

八二至八三年度

醫學會評議會名譽秘書

基督徒團契

基督是一個醫療靈魂和肉身的治療者；我們這羣習醫的人，是基督的追隨者。

沒有統計過醫學院有多少天主教徒，但估計每班大約有二十位左右。正如人的性格各異，興趣不一，大家都在醫學院內過着不同形式的生活：有飛身撲出爲醫學會、班會等博盡；有在運動場上，音樂室內盡顯才能；有願意爲衆人的相聚團結而獻身；當然也有勤力苦幹、埋首苦讀的圖書館常客。

我們自覺有着同一信仰，但藉此而相聚，卻頗有困難。基本上，醫學院每班都有一個細胞小組，作爲同班天主教同學相聚分享的核心。但基於種種原因，很多兄弟姊妹都沒有利用這機會。但願意投入這小團體的同學，都覺得藉此可在信仰的路上，更清晰、更有信心地前行，爲着面對將來的醫療工作——一項神聖的使命——打好更鞏固的基礎。

雖然交通不便，時間不足，但我們卻沒有因此忽略，我們也是港大天主教同學會（Katso）的一份子。我們反而更關心Katso的活動及發展，故此歷屆Katso幹事會要員，都有醫學院的同學。也有不少同學，並未因成了醫學生，而減少對堂區活動的參與，反之，隨着知識領域的開拓，信仰體驗的加深，他們更加熱心的投入堂區工作，爲世界的改善，天主國度的實踐而努力。

醫治病人將會成爲我們的使命及責任，但是要怎樣去醫治呢？醫學院的課程提供了解答，但卻不是答案的全部。爲着使答案更完滿，我們籌劃參與種種活動，如醫療倫理課程——使我們更了解醫療的意義，人的價值；又如在與公教醫生分享的聚會裏，我們得悉行醫者親身的體驗，面對的困難和制肘，亦發覺很多人都沒有向現實低頭，繼續在自己的信念下工作，做個好醫生……藉着這些相聚和學習，認識和分享，我們希望能充實自己，改善自己，將來能成爲一個認眞的，負責任的醫者。

在此，願我們一同祈求：希望所有醫療工作者（現在的或未來的），能夠以人的尊嚴，人的身心健康爲第一目標，繼續盡己所學竭盡所能，衷誠合作，使醫療工作更能爲人類帶來神聖的祝福。

社康一日

社康護士學生

這是傾盆大雨的早上，路上不尋常的死寂。除了往日街市喧嘩場面不復見外，連平日最繁忙阻塞的馬路，今天特異的稀疏，似乎每個人都正躲避這場豪雨，讓它儘情地刺虐這空間，儘管如斯惡劣的天氣，仍阻不着黃姑娘趕往木屋區中獨身的六婆，爲她注射胰島素。還有徙置區中的張伯，他那因割除膀胱癌腫的外科傷口，是必須每天要清洗，出生數天的嘉翠昨天面色漸黃，思睡，且吃奶很慢，恐怕她是……。這些無數看似簡單，其實十分重要的工作正等待着她。這是社康護理服務其中一個上午的縮影。

在稠密人口的香港，雖然醫療服務正不斷改變及發展，醫院牀位仍存在供不應求的現象，未能應付本港需要醫護療理的病人。爲了照顧家居的病者、傷殘者及老年人，社康護士逐毅然肩負起這個沉重的擔子，到社區及家庭中去料理需要幫助的他們，社康護士更與其他醫療人員和社區資源負責人合作，共同努力地把醫院爲中心的醫療展開到社區及每個有需要的家庭中，並從治療工作伸展至教育及預防疾病，以達到眞正之健康。

社康護士除經過正式護理訓練外，也須接受社康護理的特別課程和督導。每次的探訪，除施行一般性的護理工作，如量血壓、傷口、換症、拆線、肢體運動，和產後護理外，還需與家人建立良好的人際關係，以機智靈活的頭腦，直接或間接解決那些足以影響病者康復的問題，並積極地鼓勵及促進病者獨立能力，使其能適應家居的生活環境。同時，在護理過程中，更盡力推行個人及家庭健康教育，並給予有關機構的聯絡、介紹，例如社會服務中心，志願服務機構，社會福利部等。在探訪病者的過程，事前須聯絡有關的醫生，物理治療師，社會工作者等，並在病者出院前探望病人，解釋日後的工作，探訪後還須作簡明的記錄及報告，並有需要時跟其他醫療隊伍成員討論，以求改善的治療方法，這是社康護理服務的範疇。

每位社康護士，每天平均有五至八個個案待料理探訪。不管風吹雨打，寒風刺骨，抑或是烈日當空，酷熱迫人的天氣裏，工作總是繼續地進行，也無所不到。縱使汗流夾背，制服濕了又乾，乾了又濕，肩膊發酸的時候，笨重的護理袋仍要背起來。有的時候，無電梯設備的十層舊樓，梯間堆滿污穢雜物，要一口氣跑上去可眞是苦！或者，攀上崎嶇的山路到偏僻的木屋探訪，脚筋力實在鍛鍊了不少。當懷着一顆熱誠的心志，努力地料理中風的老伯，竟給然家人冷漠的回應，反感而不合作的態度，怎不叫人心傷？在這富挑戰性的工作上，個中滋味，實非筆墨所能形容，這實發揮那爲病人服務的南丁格爾精神。

On Being a Christian Medical Student

M. Wong

I was born to be a man discovering myself as a Chinese, growing up and living in Hong Kong; and found myself started committing to the Christian way of life in my teens and later chose to be trained as a doctor. Recently, when confronted with the issue of 1997, like other people in the Colony, I am forced to face the fact of being a Chinese. I have to decide on my identity of being a Hong Kong citizen. As a doctor-to-be, the role of being a member of the intelligentsia and of the helping profession is to be clarified. As a Christian the reality of God and the relevance of Christian values has to be contemplated on and as man I cannot escape the fundamental issue: How to be a man and to relate with others?

With all these queries at hand, how should I start? I am part of the generation which people regard as rootless. Our parents are apathetic and suspicious towards social and political issues. Our pre-university education has deprived us of our ethnic identity. We are ignorant of our cultural heritage, apathetic towards political rights and duties, 'devoted' to sitting examinations and contented with good academic performance. Our university education, being technical and professional, continues with the process. For those who are dissatisfied with the situation, many are, however, cynical. Our society is, on the whole, permissive and norms and values pragmatic.

Having said all this and being well awarded of the complexity of the issue it may be more appropriate for me to begin with the two identities that I have chosen for myself voluntarily – Christian and medical student. The fact that many of my teachers and colleagues are practical atheists leads me to ask: can one be a good christian and a good doctor or doctor-to-be at the same time? Indeed I can see at least three motives which have impelled people to question God.

First of all, God is being thought of as intellectually superfluous: to bring in God to fill the gaps of our science or to deal with life at the point at which things get beyond human explanation or control is intellectual laziness or practical superstition. Man can cope with all questions of importance without recourse to God as a working hypothesis.

Secondly, God is being regarded as emotionally dispensable: it is a dangerous illusion which can prevent man facing reality and shouldering responsibility. It leads to debilitation, superstition and fatalism – an emotional crutch which men must have the courage to discard if they are to grow up and shake off the sense of helplessness which religion both evidences and sanctions.

Thirdly, God is being seen as morally intolerable. The modern secular tradition which derived from Feuerbach and ran through Nietzsche, Camus to Satre has their dictum as 'If God did exist, we should have to abolish him' while the marxists say, 'God must die if man is to live' so that the justice, meaning and freedom which God, the great 'blood-sucker', has drained away can be returned. Religion is disgusting. God does not solve the problem but magnify them.

In the mind of many people, God was 'sentenced to death and is dead'. But *post-mortem dei,* what? How do men do without God? Many solutions have been attempted. For the doctors or doctors-to-be, Profession takes the place of Dei. The operational scheme of the profession sets the norms and values. The role of professionals is well portraited – professionals should care better, serve better and be more dedicated than non-professionals; but for those who are so enthusiastic as to mythologize professionals the ability and right of non-professionals in coping with problems themselves is denied or down-graded. On the other hand, the development of a specialised language and terminology and the trend of technologicalization and procedurism has brought about precision, effectiveness and efficiency in the provision of service but at the cost of alienation with other professions or laymen and the fragementation of men's need, which deprived man of being cared for in a wholistic way. Moreover the stress that is placed on professional confidentiality and autonomy has achieved freedom for creativity and innovation but the readiness for objective self-review and criticism is, at the same time, jeopardised. Last but not the least, the professionals tend to process fact, derive meanings and infer values from

specialised and technical viewpoints and very often lack a comprehensive worldview.

Indeed, the God 'who was sentenced to death' is being materialised or 'reincarnated' according to men's need and taste in many forms – Professionalism is one of them – and these all require commitment from their followers though they are in no sense, free of intellectual, emotional or moral issues. In this sense my non-christian colleagues are no less 'religious' than I am. On the other hand, though paradoxically, I also find myself a practical atheist, like my colleagues, in the sense that I also reject a God who is brought in just to fill the gap of our knowledge, to be an emotional crutch or to take away the burden of the disturbing evil of our world. At this stage I see being a christian and being a doctor not mutually exclusive at all. In fact during the training of medicine I am compelled further to admit the reality of God and claim myself to be a christian. What do I mean? By this I mean I no longer take the pure mechanistic materialist's view, regarding the reality, whether natural or social, at the level of mathematical regularities, as nothing more than a collocation of atoms, or a piece of social engineering. In other words no longer use the instrumental approach to life seeing man and his surroundings as things which are just to be used, controlled or manipulated. Besides I do not side with the humanists, whether scientific, romanticist, existentialist or marxist, who think nothing finally is absolute or unconditional and for whom all is a means (though not merely a means). In other words I am not using a functional approach to life either. Rather, when I acknowledge the reality of God, I mean, through the mathematical regularities and functional values, I am met with a grace and a I-Thou relationship which is just like that experienced when I am responding to a person in love and trust, just for his or her own sake, though the former I-Thou experience is much more profound. In other words I am using a personal approach to life and find the reality of God through nature, through the claims of artistic or scientific integrity, through the engagement of social justice or of personal communion. In short a Christian is one who does not confine oneself to the instrumental or functional mentality but also allows the personal approach in dealing with the issue of God. He is unwilling to deny our sense of wonder or mystery encountered during our search of knowledge by simply attributing it to mere temporary intellectual ignorance or inadequacy nor by taking God simply as a factor to make our system work. A christian is more open-minded in seeking to construct an exact version of the reality. Moreover he refuses to use God as an emotional crutch but through the acknowledgement of the fatherly reality of God by claiming sonship, the discovers the terrible freedom of love which requires the courage of faith that leads one to confront with the creative probability in every situation, which cannot be destroyed by any event. Finally he discovers God not as an absentee controller who allows sufferings but as a crucified figure who actually bears the sufferings and took the responsibility for human evil – transforming and victoriously.

So, to be a christian, as Bonhoeffer puts it, is not simply an intellectual exercise or a process of maximising benefits for the greatest number of people but a commitment 'to range oneself with God in His suffering' i.e. to rediscover the I-Thou relationship between man and God through the understanding of the world-physical, psychological and social- and in response to this understanding to identify with God in his sufferings by taking up ourselves the responsibilities of human sufferings and follows God's way in resolving the sufferings. Following this discussion not only do I see no conflict between accepting the Christian faith and working as a doctor but also do I discover the possibility of being liberated from the mythology of Professionalism so that we can fulfill the role of doctor in a more human way. Besides I find myself unable to indulge any more in escapism in the form of intellectual cynicism, professional ritualism or socio-economic pragmatism but accept the terrible freedom and power together with its accompanied responsibility and challenge to re-implant our roots in the Chinese heritage, to bear our unfortunate historical burden and to take the pain to find out how we can utilise the properity, knowledge and technology for the betterment of quality of life of people in Hong Kong and reflect how man can really be man, not just an object or a means to an end but one who is sacred and free.

THE EFFECTS ON HEALTH OF CIGARETTE SMOKING

Dr. W.K. Lam,
University Department of Medicine,
Queen Mary Hospital,

and

Dr. S.C. Leung,
Central Health Education Unit,
Medical and Health Department,
Hong Kong.

"Smoking or Health - the choice is yours"

This is the theme of World Health Day 1980. It is now generally recognised that cigarette smoking poses great hazards to our health. This communication attempts to summarize the important effects on health of cigarette smoking.

SMOKING AND CANCERS

Lung Cancer. Basing on large retrospective and prospective epidemiological studies, postmortem studies and experimental animal studies, it has now been irrefutibly established that cigarette smoking is the most important factor for the present epidemic of lung cancer in the world, and the risk increases with the amount of cigarettes smoked. A British study has demonstrated that the risk factor is about the same as the number of cigarettes smoked a day. Cigarette smoke contains over a thousand separate chemicals, and the polycyclic aromatic hydrocarbons in the tar fraction are thought to be the main carcinogens responsible. It has been claimed that low-tar cigarettes could reduce death rates due to lung cancer, but recent research in the UK has shown that the assumed health advantages of switching to low tar cigarettes may be largely offset by the tendency of smokers to compensate by increasing inhalation and the number of cigarettes smoked.

When a smoker gives up smoking, the risk of lung cancer would decline such that after about 10 years' abstinence, the ex-smoker's risk would approximate that of life-long non-smokers. It has been estimated that if the whole population gave up smoking, deaths from lung cancer would decrease by 80% worldwide within twenty years.

Of the major histological types of lung cancer, epidermoid and small cell carcinoma (types I and II, WHO Classification) are strongly associated with smoking. The relationship between smoking and adenocarcinoma of the lung is less clear.

In Hong Kong, lung cancer is the commonest lethal malignant disease in both males and females, and accounted for 30% of all male cancer deaths and 24% of female cancer deaths in 1981.

Other Cancers

Cancer of the buccal cavity, pharynx, larynx and oesophagus have all been shown to be

associated with smoking, with a risk factor estimated to be from 5 to 10 times that of non-smokers. Cancers of the month and throat have a relatively high cure rate, and smokers who stop smoking after treatment of these cancers are less likely to have recurrence than those who continue to smoke after treatment.

An association between smoking and cancers of the urinary tract and pancreas has also been demonstrated, albeit not as strong as the above mentioned cancers.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Epidemiological, clinical and postmortem studies have demonstrated a clear dose-response relationship between smoking and chronic bronchitis and emphysema. Pathologically, the effect of smoking on the respiratory tract can be summarized in Fig 1. Hypertrophy of the mucous gland, decreased ciliary activity and proneness to chest infection are all features of chronic bronchitis, while destruction of alveolar wall is a feature of emphysema. The effect of smoking on proteases is of special interest in the light of recent knowledge of al-antiprotease (al-antitrypsin) deficiency. Smoking stimulates release of proteases from alveolar macrophages and polymorphs that cause alveolar destruction. Normally, protease inhibitors (e.g. al-antiprotease) counteract the effect of proteases and preserve alveolar structure. Cigarette smoke causes functional inhibition of protease inhibitions, and in patients with al-antiprotease deficiency who smoke, severe alveolar destruction (emphysema) would occur at an early age.

When a patient with COPD stops smoking, he would not regain his lost lung function, but his subsequent fall in lung function with age would approximate that of a non-smoker instead of following a steep curve as in those who continue to smoke.

CORONARY ARTERY DISEASE (CAD)

Large scale studies have shown that smoking is a major factor for myocardial infarction and death due to CAD. The risk is directly related to the number of cigarettes smoked per day: under the age of 65 years, moderate smokers are about twice as likely to die of CAD as are non-smokers, and heavy smokers about 3 times as likely. Stopping smoking decreases the risk of CAD mainly in men under the age of 65 years, and after about 10 years, the ex-smoker's risk becomes just slightly greater than that of a non-smoker. Giving up smoking after a heart attack also halves the chance of another.

The cardiovascular effect of smoking is mainly due to nicotine and carbon monoxide (Fig. 2). It may be appreciated from Fig. 2 that nicotine increases the work of the heart and myocardial oxygen requirements and contributes to coronary atherosclerosis, while carbon monoxide reduces the amount of oxygen available to the myocardium at the time when the work of the heart has been increased by nicotine.

PEPTIC ULCER

It is generally agreed that there is a greater prevalence (about 2-fold) of peptic ulcer in smokers than in non-smokers, and a positive correlation exists between the amount of cigarette smoked and be prevalence of ulcer disease. Smoking is also associated with a decreased rate of ulcer healing. The mechanism is thought to be due to nicotine which decreases pancreatic biliary bicarbonate secretion and thereby reduces acid neutralization in duodenum. There is however some controversy as to whether smoking is a direct cause of peptic ulcer or not.

SMOKING AND PREGNANCY

The babies of women who smoke during pregnancy have lower birthweight than those of non-smoking mothers due to retarded growth, and this effect of smoking is greatest in the latter half of pregnancy. Spontaneous abortion rate and perinatal mortality are both increased in mothers who smoke, and this increase is correlated with the number of cigarettes smoked. The mechanism is thought to be due to nicotine which cause narrowing of the blood vessels of the placenta, and carbon monoxide, which becomes concentrated in

the baby's blood and diminishes the amount of oxygen which the blood can carry.

If a smoking mother gives up smoking before the fourth month of pregnancy, the risk to the foetus can be greatly diminished.

PASSIVE SMOKING

Passive smoking is also known as second-hand smoking or involuntary smoking, and its possible harmful health effects on non-smokers have recently aroused much public concern.

Foetus being affected by a smoking mother is one form of passive smoking and has been discussed above.

Tar, nicotine and carbon monoxide are all found in greater concentrations in the side-stream smoke (given off between puffs) than in the main stream. Side-stream smoke is also more irritant as the smoker who inhales would filter some of the irritant substances of the smoke before breathing it out. The acute irritative effects of indoor cigarette smoke upon the eyes, throat and respiratory mucous membranes on non-smokers are well known. Babies whose parents smoke are more prone to bronchitis and pneumonia in the first year of life than those of non-smoking parents. Chronic exposure to cigarette smoke in the work environment is also harmful to the non-smokers, and significantly decreases small airways function. Slight increase in carbon monoxide level in blood of healthy passive smokers usually does not lead to any significant health hazards, but can be harmful and even dangerous for those suffering from coronary heart disease because of decrease of oxygen-carrying capacity of blood. Much of the recent public consciousness regarding passive smoking is related to the possible association with lung cancer. The Japanese study by Hirayama found that lung cancer mortality rates among married women were lowest for wives of non-smokers, intermediate for wives of light or ex-smokers and highest for wives of heavy smokers. Although subsequent studies have been inconclusive, they do raise concern about a possible serious public health problem.

CONCLUSION

Cigarette smokers, taken as a whole, have greater mortality (about 30 to 80% excess) than non-smokers. This excess mortality rises with increasing cigarette consumption, and is greatest in those who inhale and who start smoking at an early age. When smoking is given up, the mortality rate decreases progressively until after about 10 years when it would approach the level found in non-smokers.

"Smoking-related diseases are such important causes of disability and premature death in developed countries that the control of cigarette smoking could do more to improve health and prolong life in these countries than any other single action in the whole field of preventive medicine." Such is the conclusion of a report on smoking and its effects on health by a World Health Organization Expert Committee. Studies in England have revealed that doctors are in a unique position to motivate their patients to give up smoking – 80% of the patients said they would stop if their doctors told them to do so. Medical students, the future doctors and health workers, should appreciate the magnitude of the problem and play their vital role in this area of health education.

FURTHER READINGS

1. Smoking or Health: The Third Report of the Royal College of Physicians of London, 1977, Pitman Medical.
2. Smoking and its Effects on Health: Report of a WHO Expert Committee. Technical Report Series 568, World Health Organization, Geneva, 1975.
3. The Health Consequences of Smoking. 1973, Washington D.C., US Public Health Service.
4. Wynder EL, Hoffmann D. Tobacco and Tobacco Smoke. Seminars in Oncology 1976, 3:5-15.
5. Hirayama T. Non-smoking wives of heavy smokers have a higher risk of lung cancer: A study from Japan. Br Med J 1981, 282:183-5.
6. Lam WK, Leung SC. Answering some commonly asked questions on smoking and health. The Hong Kong Practitioner, 1983, 5:544-550.

Involutional Osteoporosis

urrent Concepts on Pathogenesis and Treatment

e Kwok Wai, Albert
'th January, 1984

Involutional Osteoporosis:

In 1940, Albright clearly defined the distinction between two metabolic bone disorders – osteom alacia and osteoporosis.[1] Furthermore, he also recognised two subgroups in the osteoporotics. If the condition began after age 65, he termed it senile osteoporosis, which occurs in both sexes. Another group which he termed postmenopausal osteoporosis is characterised by occurrence in women shortly after the onset of menopause commencing in the fifth decade of life. These two conditions together are known as involutional osteoporosis. Clearly, involutional osteoporosis need not be a single clinical entity, nevertheless, one common factor which prevails is the process of aging. Perhaps, the significance of involutional osteoporosis can be reflected from epidemiological data on the fracture of the proximal femur.[1 3] Incidence of fracture doubles in each decade after the age of 50, with a female to male ratio of 2 : 1 to 4 : 1 among different races.

Osteoporosis is a disease of skeletal biomechanical incompetence in a bone-deficient (osteopenic) skeleton. It is to be distinguished from osteopenia, implying a subnormal absolute bone volume, and osteomalacia, a disease due to subnormal mineralization.

The clinical picture of involutional osteoporosis is well-known to every clinician. Typically an elderly woman who is otherwise healthy presents with an acute onset of pain due to fractures, often occuring after minimal trauma. The lumbar and thoracic vertebrae, the neck of the femur, the upper end of the humerus and the lower end of the radius are the commonest sites of fractures. Repeated episodes of similar attacks may result from multiple fractures occuring over a period of time. Where vertebral collapse occurs gradually over months or years, the patient may remain asymptomatic or present with kyphosis and loss of height. Radiological examination demonstrates loss of bone density especially in the axial skeleton, reduction of trabeculation and thinning of cortex. Vertebral bodies may become biconcave or with anterior wedging due to collapse. Biochemically, serum level of calcium, phosphorus and alkaline phosphatase are normal, though the latter may be raised in patients with acute fractures.

No doubt this common and important condition, causing much morbidity and mortality among the elderly, has attracted great interest in the medical field. Enormous effort has been made by various workers to unravel this problem. Over the years, various new radiological techniques have been developed to study the bone changes in osteoporosis[2 0,2 2] and advances are made in its treatment and prevention. Nevertheless, there still remains areas that are uncertain or untouched as will be evident in the discussion to follow. I shall concentrate on the recent development of medical treatment of involutional osteoporosis and the underlying concepts and rationale.

Endocrine Aspect of Involutional Osteoporosis

*Endocrinological Changes and Pathophysiology

Obviously, the high incidence of osteoporosis in postmenopausal women suggests a deficiency of estrogen as a triggering factor for the entire process. Nevertheless, there are only minimal differences in estrogen and other sex hormones levels between clinically osteoporotic and age-matched controls.[2 3,3 4] Estrogen deficiency alone cannot account for the whole picture.

Biochemically, the accelerated bone loss in osteoporosis is associated with normal ranges of serum calcium, phosphate and alkaline phosphatase in most patients. More important findings are a low serum level of 1,25 – dihydroxycholecalciferol (1,25 – DHCC) and impaired ability to absorb calcium while 25-hydroxycholecalciferol remains at a normal level.[16] Moreover, the two abnormalities are reversible in about half the patients by estrogen replacement. To explain these observations, Heaney postulated that estrogen normally exerts inhibitory effect on the skeletal action of parathormone (PTH).[19] In a state of estrogen deficiency, the bone become more sensitive to the action of PTH with increased turnover giving a slightly raised plasma calcium level. This in turn feedback to cause a fall in PTH release resulting in decreased synthesis of 1,25 – DHCC and impaired calcium absorption.

This hypothesis, however, fail to account for the findings of decreased calcium level, elevated phosphate and PTH level in about 10% of patients.[2] Once again two postulations are put forward for explanation. First, there is a rise in the renal tubular reabsorption in the postmenopausal state, which is reversible by estrogen administration. Subsequent hyperphosphatemia inhibits the conversion of 25-HCC to 1,25 – DHCC resulting in impaired calcium absorption, decreased plasma calcium level and secondary hyperparathyroidism. Second, the conversion of 25-HCC to 1,25-DHCC may be directly dependent on a regulatory action of estrogen. In this case, the elevated phosphate is only a reflection of impaired renal function in the elderly.

The importance of calctonin has also been studied in relation to involutional osteoporosis. Basal level of calcitonin and calcitonin response to elevated calcium tend to be lower in women than in men and tend to fall with increasing age in both sexes.[21, 33]. In 1980, Morimoto et al described a link between estrogen and calcitonin[27]. In elderly postmenopausal women estrogen therapy has no direct effect on the basal calcitonin levels. However, the response of calcitonin secretion due to elevated calcium level is augmented to nearly 4 times by estrogen. Apparently, estrogen deficiency limits the calcitonin activity and result in lessening the tonic inhibition of bone resorption and/or allow more ingested calcium to be excreted in the urine.

There may be other changes in the aging process that contribute to the development of involutional osteoporosis. Intestinal absorption of calcium may decrease as part of the age-related depression of intestinal function. Renal conversion of 25-HCC to 1,25-DHCC may also be defective due to mechanisms other than those mentioned above.[2] This is illustrated by one study on long term 25-HCC therapy in patients with postmenopausal osteoporosis.[35] 7 of the 12 subjects responded clinically with increased 1,25-DHCC levels while the remaining 5 did not respond together with persistently low 1,25-DHCC levels.

From the above discussion, one can see that the current knowledge about the pathogenesis of involutional osteoporosis is still limited. This is summarised in figure I. With this scheme in mind, treatments using estrogen, calcium and vitamin D are more readily understood.

***Estrogen Treatment in Osteoporosis**

Starting in the fourth decade of life, skeletal mass declines. This decline is accelerated at the time of menopause and then gradually tends to slow down later on. The rate of bone loss is about 10-25% per decade in the postmenopausal years in the absence of exogenous estrogen administration[24,26,31]. This is about twice the rate of bone loss compared to the premenopausal period.[19] The effectiveness of estrogen administration in prevention of osteoporosis by inhibiting bone loss is shown in various studies. Rate of bone loss after starting estrogen therapy is reduced to 50% about equal to that in the premenopausal period[19,26,31]. Recently, Nordin showed that untreated patients with osteoporosis the rate of bone loss is higher than age-matched controls with estrogen treatment[28]. The risk of fracture can also be reduced, and the effect of estrogen administration is even more pronounced when calcium or vitamin D supplements are given together. With estrogen treatment, intestinal absorption of calcium is increased by about 25% and calcium requirement for zero balance is reduced from 1.5 gm/day to 1.0 gm/day in postmenopausal women.[15,17]

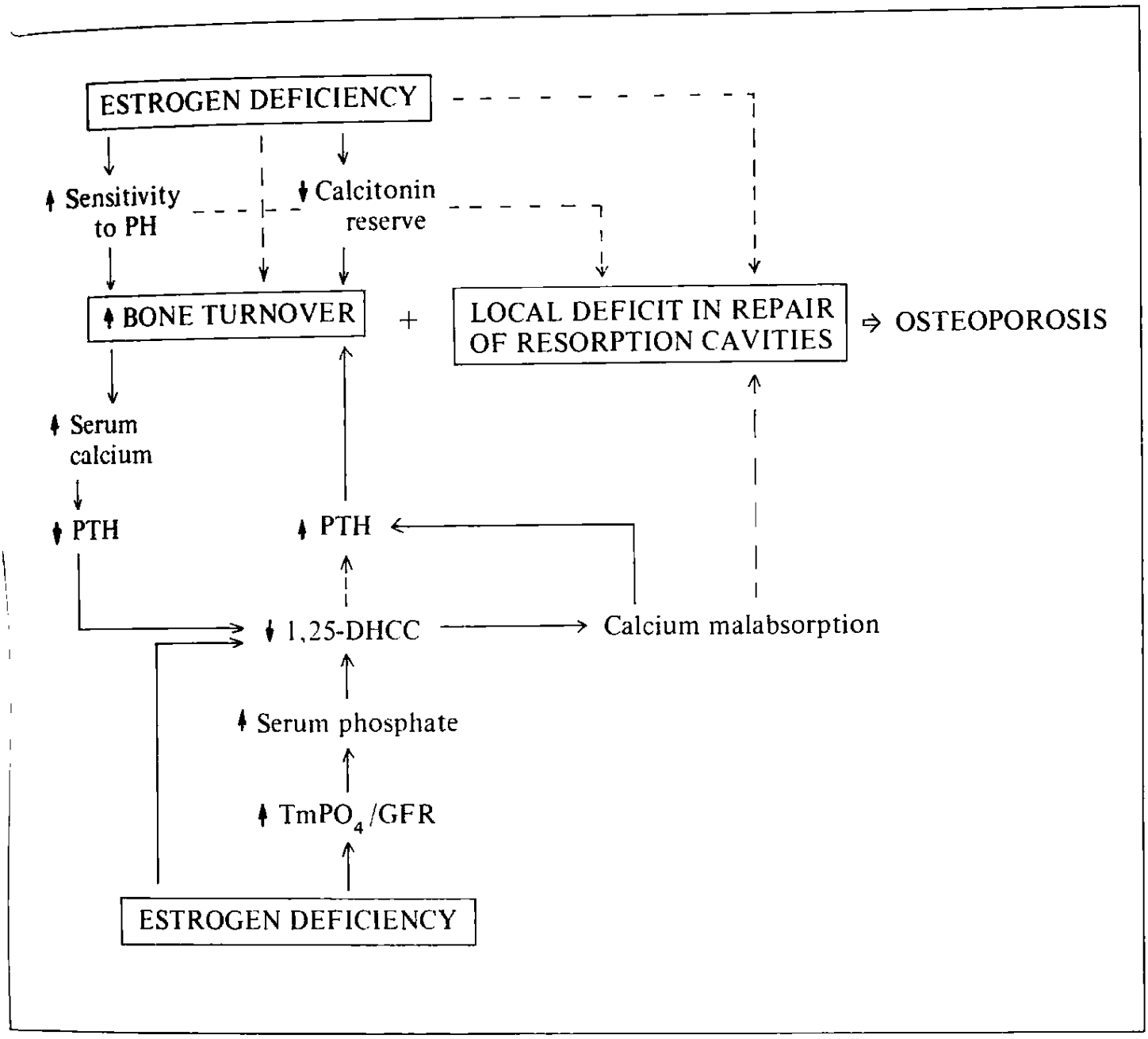


Figure 1. Indirect effects of estrogen deficiency leading to osteoporosis. Probable pathways are solid lines, and possible pathways are interrupted lines. Much more is known about the pathogenesis of increased turnover than about defective repair. PTH-parathormone; 1,25-DHCC-1,25-dihydroxychole-calciferol; $TmPO_4$/GFR-tubular maximum reabsorption of phosphate per unit of glomercular filtrate.

There are shortcomings in estrogen treatment in osteoporosis. First of all, the effective mechanism of estrogen is only to slow down the bone losing process without a positive effect to increase bone tissue. In established cases of osteoporosis with severe osteopenia, simply inhibiting further loss certainly falls short of the therapeutic ideal – to replace bone tissue. Estrogen treatment is more widely accepted as a form of prophylaxis of postmenopausal osteoporosis than as treatment of established cases. The second problem is the side effects of long term estrogen administration. The most important complication is a 2 to 15 fold increased risk of endometrial carcinoma. Other serious complications include hypertension, thromboembolic phenonemon and biliary tract diseases. Preventive measures should be to avoid estrogen treatment in high risk patients, to minimize the dosage, to follow a cyclic regime of estrogen and gestagen treatment, to monitor the condition of the

patient during treatment and to withhold treatment when risks seems to outweigh the expected benefits. Thirdly, the optimal duration of treatment is not yet determined However, evidence accumulates that an accelerated phase of bone loss follows the withdrawal of such treatment[6,26], much the same as the onset of menopause. Hence, if estrogen administration is at all considered, it will probably be for life.

The dosage usually used in postmenopausal women for preventing age-related bone loss is 0.625 mg per day of conjugated equine estrogens or its equivalent. It is given in a cyclic manner of 3 weeks on treatment and one week off, with concomitant use of a gestagen during the third week, such as medroxyprogesterone acetate 10 mg daily. Endometrial biopsy is performed prior to treatment and vaginal bleeding as well as other side effects should be reported.

***Calcium in the Treatment of Osteoporosis**

Like estrogen, dietary calcium supplements alone or in combination with estrogen have not been shown to increase bone mass. Nonetheless, it is reasonable to administer calcium supplements based on the following points.

1. Calcium supplements do reduce bone loss in osteoporotic patients by 30%-40%, slightly less effective than estrogen.[31]
2. Calcium treatment is effective in reducing fracture rates by 50% and if combined with estrogen, by 75%.[32]
3. Intestinal malabsorption of calcium is at least partially overcomed by increasing dietary calcium.[31]
4. Risk involved in the use of calcium supplements is minimal.
5. Oral calcium supplements can be used as a form of treatment in cases where estrogen treatment is contraindicated or undesirable.

Elemental calcium intake of 1 gm per day is adequate. Periodic clinical examination at intervals of a few months is necessary. One should check the blood pressure, renal function, serum and urine calcium level and watch out for hypercalcemia.

***Vitamin D in Treatment of Osteoporosis**

The mechanism of action of 1,25-DHCC, the active form of vitamin D, on bone is not clear. It is not certain whether 1,25-DHCC acts directly on osteoblasts to cause them to form matrix and mineralize, or whether it acts indirectly by raising the calcium concentration in extracellular fluid high enough to allow mineralization to occur, matrix formation having been uninfluenced.

The rationale for using vitamin D in osteoporosis is to improve calcium absorption resulting in high calcium level which inhibits excessive PTH secretion and bone resorption.[17,35]

Various agents used include 1,25-dihydroxycholecalciferol (1,25-DHCC), 1 α – hydroxycholecalciferol (1 α – HCC) and 25 – hydroxycholecalciferol (25-HCC). Provided the conversion systems in the body are intact, 1 – HCC is converted to 1,25-DHCC in the liver and 25-HCC is converted to 1,25-DHCC in the kidney. Theoretically, administration of any one of them is equally effective.

Nordin et al have demonstrated that 1 α – HCC given in combination with estrogen to postmenopausal osteoporotics inhibits bone loss and decreases fractures.[28] In another study, long term 25-HCC resulted in two distinct groups of responders and non-responders.[35] The renal conversion system seems to be impaired in the non-responders. This illustrates the possible role of vitamin D metabolism in the pathogenesis of involutional osteoporosis.

Early finding by Gallagher et al on using 1,25-DHCC in osteoporotic patients are encouraging. Intestinal absorption of calcium is increased by 12%.[17] Further investigations are required to establish its efficacy. Meanwhile, it is reasonable to ensure an adequate level of vitamin D in patients by administration of about 400 units daily. Similar precautions as in administration of calcium supplements are to be taken. Side effects are minimal.

Fluoride in the Treatment of Osteoporosis

*Some Observations

Fluoride induced osteomalacia was described in 1912 and its prevention by dietary calcium was observed in 1933.[7] Burkhart and Jowsey, in 1968, again reported that adequate intake of calcium and vitamin D can prevent the formation of excessive unmineralized bone in animal.[5]

Fluorosis, occuring in certain regions of the world where the water fluoride content is high, is associated with radiological evidence of osteosclerosis. Furthermore, epidemiological studies comparing subjects living in areas of high water fluoride level with subjects living in areas of low water fluoride level showed greater bone densities in the former groups.[3]

These observations indicate that fluoride is involved in bone metabolism and prompted the possible value of fluoride in the treatment of osteoporosis.

*Fluoride Therapy

Numerous clinical studies have provided evidence to the following points:

1. Short term administration of large doses of fluoride improved calcium balance apparently by reducing urinary calcium excretion while serum calcium, phosphourus, alkaline phosphatase remained within normal range.[4]
2. Clinically, bone pain was reduced are completely absent in about 70% of subjects during 2 years of treatment.[7]
3. In studies done for at least 1 year bone mineralization was increased whether measured by roentgenogram, neutron activation or photon absorptiometry.
4. Histological evaluation of bone biopsy showed increased trabecular bone volume often with increased osteoid and irregular calcification of the newly formed bone.[4,5,7]
5. One study lasting for at least 2 years indicated a significantly decreased incidence of fractures in the fluoride-treated groups compared with controls.[3,2]

One of the many regimes in fluoride therapy is as follows: 25 mg of sodium fluoride twice daily for one month. Afterwards the same dosage is taken together with 8000 IU vitamin D_2 and 1 gm of elemental calcium daily. The optimal duration of treatment is still under investigation.

Side effects of fluoride therapy include gastric irritation with nausea, vomiting and even bleeding, periarticular pain due to ligamentous calcification and synovitis. Perhaps even more important is the formation of morphologically and structurally abnormal bone, whether this overthrown the use of fluoride in osteoporosis requires further study.

*Mechanism of Fluoride Therapy

The mechanism of fluoride therapy and its effect on skeletal tissue are not completely known. One likely hypothesis is that traces of fluoride combine with calcium hydroxyapatite of bone, changing its physical and chemical properties with increased crystallinity and decreased crystal surface area and solubility.[4] At the same time, fluoride also stimulates bone remodeling process, both bone resorption and bone formation activities are accelerated. However, because of altered physiochemical properties of bone tissue, it becomes more resistant to resorption. There is a resultant net bone formation instead of the normally balanced bone turnover.

Fluoride therapy has the advantage of actually increasing bone tissue rather than only inhibiting bone loss by treatment with estrogen, calcium and vitamin D.

Bone Remodeling Mechanism and ADFR Treatment

* The BMU

In 1963, H.M. Frost et al recognised that lamellar bone turnover in adults occurs in discrete packets, or Basic Multicellular Units (BMU). Certain stimulus activates a new BMU

which then undergoes a stereotyped sequence of events. After activation the new BMU enters a phase of bone resorption by osteoclasts for about one month. The osteoclasts then disappear followed by emergence of osteoblasts in the same place and a phase of bone formation lasts for about two months. Each BMU turn over approximately 0.1 mm^3 of bone tissue without necessarily changing the local architecture or the total quantity of bone present. Rasmussen and Bordien suggested the cellular basis of BMU which starts off as a focus of osteoprogenitor cells differentiating first into osteoclasts, later into osteoblasts and finally into osteocytes.[29] The action of BMU can be summarised as "Activation – Resorption – Formation" (ARF) and this forms the basis of bone remodeling process in adults.

Another characteristic of the BMU is its coupling property. Clinical, pathological and experimental evidence indicates that agents which exert stimulation or depression on either osteoclasts or osteoblasts in an artificial situation exert the same kind of action on the other cell type. Hence the two cell types remain coupled and it is yet to find an agent with decoupling action.

***Envelopes and ΔB.BMU**

Adult skeleton can be classified into four compartments or envelopes. These are the periosteal envelope on the periosteal surface, the endosteal envelope on the endosteal surface, the haversian envelope which lies inbetween the former two envelopes, and the trabecular envelope which extends into the marrow cavity.

The BMU within these envelopes have different characteristics. In the periosteal envelope, the BMU remove less bone in the resorption phase than they deposit in the formation phase. Using the symbol ΔB.BMU to denote the net gain or loss of bone per BMU, averaged over 100 randomly selected BMU on one skeletal envelope, it is obvious the B.BMU has a positive value for the periosteal envelope. In the haversian envelope, the bone removed equals that deposited, that is ΔB.BMU is 0. The endosteal and trabecular envelopes behave similarly with bone removal greater than deposition, thus ΔB.BMU is negative. With such envelope-specific ΔB.BMU characteristics, it is not difficult to visualize that with time the adult bone will increase both its internal and external diameters with preservation of cortical thickness but progressive decrease in marrow trabeculation. All these changes contribute to alteration of biomechanical properties of adult skeleton. The envelope-specific ΔB.BMU characteristics may also partly explain why the thoracic and lumbar vertebrae, being mostly trabecular bone, are the commonest site of affection in involutional osteoporosis. Supporting evidence is provided by the finding that trabecular bone resorption rate is twice that of the cortical bone in oophorectomized patients.[9]

*** BMU Theory**

Based on the established physiological properties of bone, H.M. Frost designed the BMU Theory which helps to explain and predict the dynamics of bone remodeling. In the adult skeleton, new BMU are being constantly activated while old ones terminate their action. This is represented on a "ladder graph". (Refer to figure II) At any point in time, one may find in a sample of bone, BMU at different stages of the ARF sequence. This is represented by the intersections of "time line" with the "BMU lines" on the ladder graph. Hence, temporal incoherence characterizes the unchallenged bony skeleton.

Consider a activating stimulus, which is given during the period t_1 to t_2 (Refer to figure III). Provided the $t_1 - t_2$ period is a small fraction of the mean duration of resorption (σ_r), an increased number of BMU will be in a more or less similar phase of the ARF sequence. This results in temporal coherence of BMU. If no more external influence is exerted on the BMU, there is a phase of accelerated bone resorption lasting from t_2 to t_3 (duration equals σ_r). Following this is a phase of equally enhanced bone deposition making up for all the excess loss. Net change in bone tissue (ΔB) is zero.

*** ADFR Treatment**

Making use of the BMU theory a new form of therapy for osteoporosis has been

designed, aiming at increasing the absolute bone volume. Following the initial "pulse activation" for 5-7 days (t_1 to t_2), a depressor is administered for a period that lasts the mean duration of resorption (σ_r), normally about a month. At the end of the σ_r period, the depressor is removed, allowing the subsequent formation phase to proceed normally.

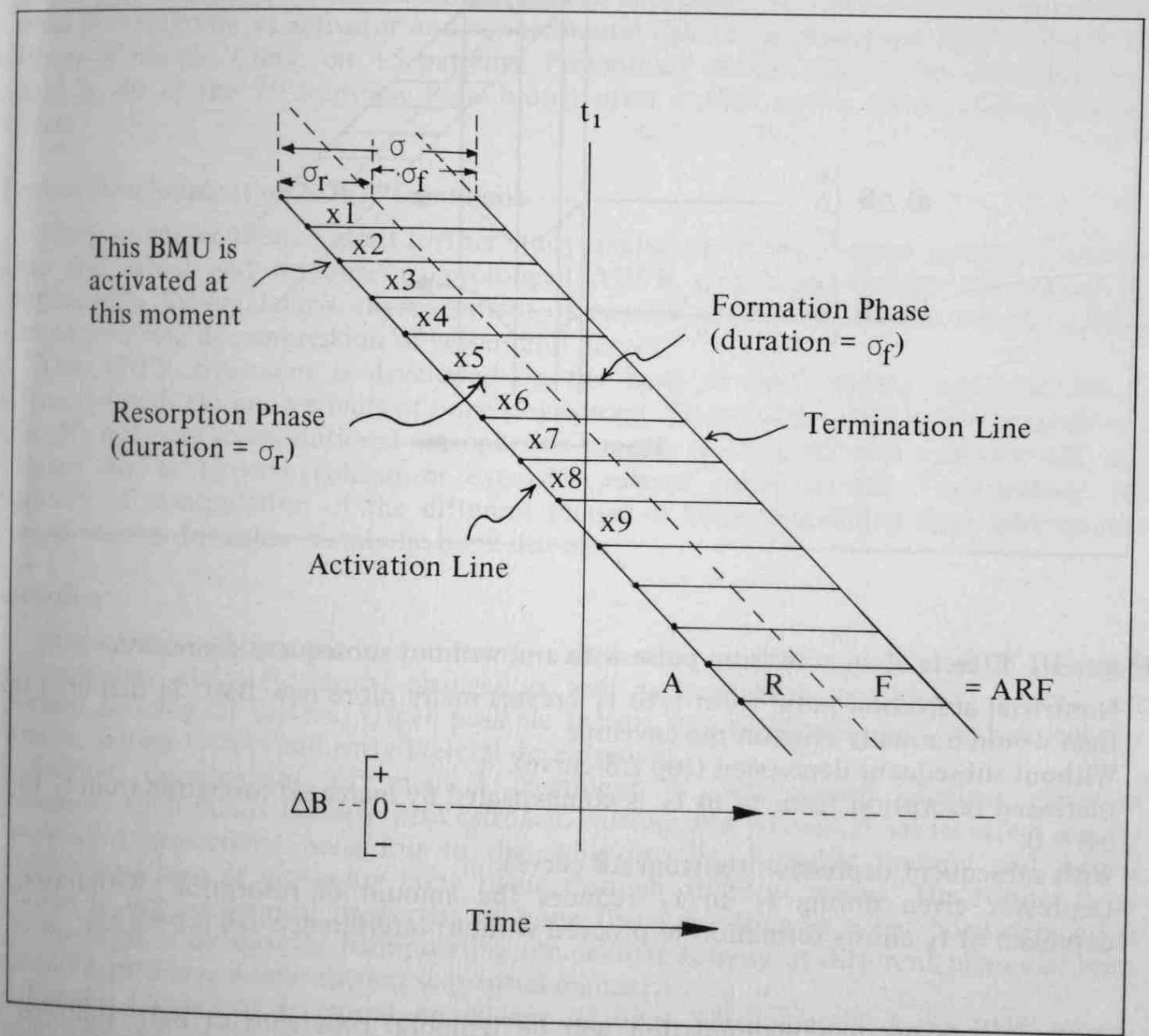


Figure II. Ladder graph and time line.

- x1 to x9 horizontal lines represent individual BMU.
- Left oblique line is the 'Activation line'. Right oblique line is the 'Termination line'. Dotted oblique line inbetween represents the switchover from resorption to formation.
- σ_r = duration of resorption phase
  σ_f = duration of formation phase
  σ = total duration of resorption and formation phase
- Vertical line t_1, the 'time line', forms the graphic equivalent of a biopsy done and analyzed at that moment. Time progresses from left to right on this graph.

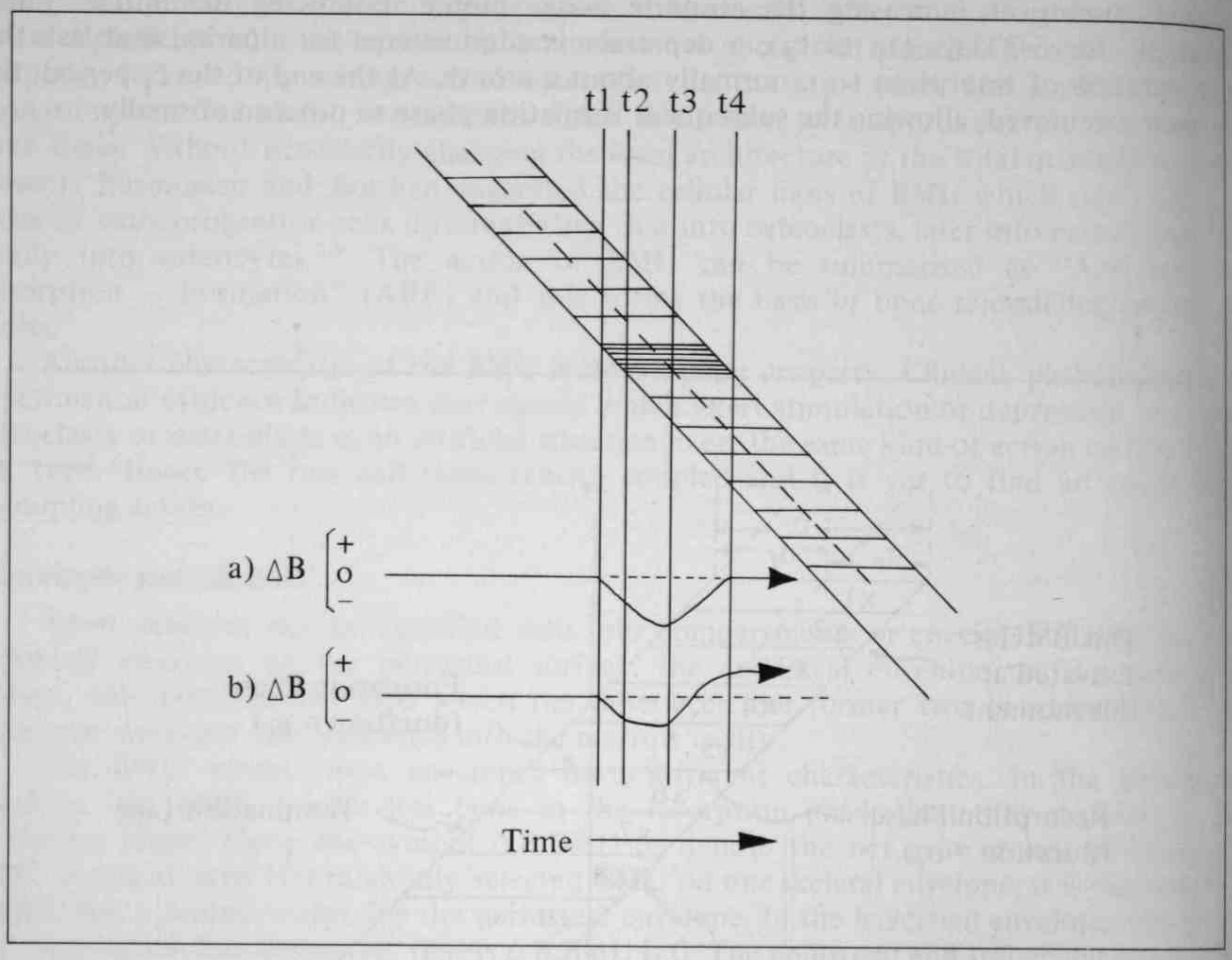


Figure III. Effects of an activation pulse with and without subsequent depression.

- Nontrivial activation pulse from t_1 to t_2 creates many more new BMU in that brief time than would normally arise on the envelope.
- Without subsequent depression (top ΔB curve).
  Increased resorption from t_2 to t_3 is compensated by increased formation from t_3 to t_4. $\Delta B = 0$.
- With subsequent depression (bottom ΔB curve).
  Depressor given during t_2 to t_3 reduces the amount of resorption. Withdrawal of depressor at t_3 allows formation to proceed without interference. ΔB is positive.

The result of such manipulation will be temporal coherance of BMU followed by suppressed bone resorption and subsequent increased bone formation. ΔB has a positive value. This manipulation can be repeated after the accelerated bone formation has stopped, a period equal to the mean duration of formation (σ_f), normally about 2-3 months. Each repeat would add a new increment of bone to any and all earlier ones. The sequence of manipulation is "Activate-Depress-Free-Repeat", hence known as the ADFR treatments involving intermittent, sequential administration of activators and depressors.

*** Activators and Depressors**

Agents that are potentially activators include parathormone, growth hormone, thyroxine, adrenal corticosteroids, certain vitamin D metabolites, regional trauma, elevation in temperature and some electrical and mechanical effects. Possible depressors include diphosphonates, ethane hydroxydiphosphonate (EHDP), dichlorophosphonate, calcitonin, supplemental dietary calcium, some sex hormones and depressed temperature. Other

activation depressors that should be avoided in the pulse activation phrase are estrogen, continuous adrenal corticosteroid administration, prostaglandin inhibitors (such as salicylate, indomethacin, phenylbutazone and ibuproten) and thymidine synthesis inhibitors (such as methrotrexate and mithramycin).

*** Results of ADFR treatment**

Since the initial description of ADFR treatment, experimental work in dogs have shown significant increases in trabecular bone volume in 60% of a total of 40 subjects. P. Meunier in 1978 also described increased trabecular thickening in 4 patients who had naturally activated skeleton subsequently received depressors. In 1980, a clinical trial using a vitamin D metabolite as activator and supplemental calcium as depressor was started at the Southern Colorado Clinic on 15 patients. Preliminary results showed an increased bone density in 40 of the 75 transiliac bone biopsy after 2 ADF cycles, 31 no change and 4 a decrease.

*** Future Development of ADFR Treatment**

Many unknown factors await further study, including timing, dosage, optimal choice of agents and effect and response to prolonged ADFR treatment. Possible side effect are hypercalcemia, hypercalciuria, encroachment of marrow cavity and stenotic effect on bony foramina resulting in compression of vessels and nerves.

The ADFR treatment is developed on the basis of BMU theory which in turn is constructed with the known facts of bone physiology. Theoretically, the ADFR treatment is applicable not only to involutional osteoporosis but also in other types of osteoporosis, such as those due to hyperthyroidism or excessive adrenal corticosteriod. Furthermore, the possibility of manipulation of the different phases of bone remodeling shed light on new forms of therapy for other metabolic bone diseases.

Conclusion

Involutional osteoporosis is a common and serious condition, yet its pathogenesis is not completely clear. Hormonal changes as well as local bone remodeling process are important aetiological factors. Other possible factors not mentioned here include genetic influence, dietary factors and early skeletal development.

Current development of medical treatment in osteoporosis involves different mechanisms. Continuous therapy with estrogen, calcium and vitamin D has its effect mainly in preventing accelerated bone loss in the aging process. Fluoride therapy and ADFR treatment both aim at increasing bone tissue through different means. The former is by alteration in physiochemical properties of bone tissue resulting in a net bone deposition while the latter is by directly manipulating the cellular activity at different phases of bone remodeling process in a intermittent sequential manner.

Finally, the recent increased knowledge of bone physiology and the BMU theory provide new outlook in the understanding of pathogenesis and in the treatment of other types of metabolic bone diseases.

Reference

1. Albright, F., Smith, PH and Richardson, AM : Postmenopausal osteoporosis JAMA 116 : 2465, 1941
2. Berlyne, GM; Ben – Ari, J; Kusheleusky, A, et al : The aetiology of senile osteoporosis: secondary hyperparathyroidism due to renal failure Q J Med 44 : 505, 1975.
3. Bikle, DD : Fluoride treatment of osteoporosis : A new look at an old drug Ann Inter Med 98 : 1013, 1983.
4. Briancon, D and Merinier, PJ : Treatment of Osteoporosis with fluoride, calcium, and vitamin D Orthop Clin North Am 12 (3) : 629, 1981

5. Burkhart, JM and Jowsey, J : Effects of variations in calcium intake on the skeleton of fluoride-fed kittens
J Lab Clin Med 72 : 943, 1968
6. Christiansen, C; Christensen, MS and Transbol, I : Bone mass in postmenopausal women after withdrawal of oestrogen/gestagen replacement therapy.
Lancet 1:459, 1981
7. Cohen, P : Nichols, G L, Jr and Bank, HH : Fluoride treatment of bone rarefaction in multiple myeloma and osteoporosis
Clin Orthop 64 : 221 : 1969.
8. Courpron, P : Bone tissue mechanism underlying osteoporoses
Orthop Clin North Am 12 (3) : 513, 1981
9. Dalen, N; Lamke, B and Wallgren, A : Bone-mineral losses in oophorectomized women
J Bone Joint Surg 56A : 1235, 1974
10. Frost, HM : Treatment of osteoporoses by manipulation of coherent bone cell populations.
Clin Orthop 143 : 227, 1979
11. Frost, HM : The evolution of osteoporosis therapy.
Orthop Clin North Am 12 (3) : 603, 1981.
12. Frost, HM : Coherence treatment of osteoporoses
Orthop Clin North Am 12 (3) 649, 1981
13. Gallagher, JC; Melton, LJ; Riggs, BL; et al:
Epidemiology of fractures of the proximal femur in Rochester, Minnesota
Clin Orthop 150 : 163, 1980
14. Gallagher, JC; Riggs, BL and DeLuca, HF :
Effect of long term treatment with synthetic 1,25 – dihydroxyvitamin D_3 in postmenopausal osteoporosis
Clin Res 28 : 777A, 1980
15. Gallagher, JC; Riggs, BL and Deluca, HF:
Effects of estrogen on calcium absorption and serum vitamin D metabolites in postmenopausal osteoporosis
J Clin Endocrinal Metab 51 : 1359, 1980
16. Gallagher, JC; Reggs, L; Eisman, J, et al: Impaired intestinal calcium absorption in postmenopausal osteoporosis: possible role of vitamin D metabolites and PTH
Clin Res 24 : 360 A, 1976
17. Gallagher, JC; Riggs, BL: Eisman, J; et al: Intestinal calcium and serum vitamin D metabolites in normal subjects and osteoporotic patients
J Clin Invest 64: 729, 1979
18. Heaney, R D; Recker, RR and Saville, DD: Menopausal changes in calcium balance performance
J Lab Clin Med 92 : 953, 1978
19. Heaney, RP; Recker, RR and Saville, PD: Menopausal changes in bone remodeling
J Lab Clin Med 92 : 964, 1978
20. Heath, H, III: Progress against osteoporisis. Ann Inter Med 98 : 1011, 1983
21. Heath, H and Sizemore, GW: Plasma calcitonin in normal man
J Clin Invest 60 : 1135, 1977
22. Johnston, CC, Jr and Epstein, S : Clinical, biochemical, radiographic, epidemiologic, and economic features of osteoporosis.
Orthop Clin North Am 12 (3) : 559, 1981
23. Kleerekoper, M; Tolia, K and Parfitt, AM : Nutritional, endocrine and demographic aspects of osteoporosis.
Orthop Clin North Am 12 (3) : 547, 1981.
24. Lindsay, R; Aitken, JM; Anderson, JB; et al: Long-term prevention of postmenopausal osteoporosis by oestrogen.
Lancet 1 : 1038, 1976.
25. Lindsay, R; Hart, DM; Forrest, C; et al: Prevention of spinal osteoporosis in

oophorectomized women
Lancet 2 : 1151, 1980
26. Lindsay, R; Hart, DM; Maclean, A; et al: Bone response to termination of oestrogen treatment
Lancet 1 : 1325, 1978
27. Morimoto, S; Tsuji, M; Okada, Y; et al: The effect of estrogens on human calcitonin secretion after calcium infusion in elderly female subjects.
Clin Endocrinol 13 : 135, 1980
28. Nordin, BEC; Horsman, A; Crilly, RG; et al : Treatment of spinal osteoporosis in postmenopausal women
Br Med J 280 : 451, 1980
29. Rasmussen, H and Bordier, P : The cellular basis of metabolic bone disease.
N. Engl J Med 289 : 25, 1973
30. Recker, RR : Continuous treatment of osteoporosis : Current status
Orthop Clin North Am 12 93) : 611, 1981
31. Recker, RR; Saville, PD and Heaney, RP : Effects of estrogens and calcium carbonate on bone loss in postmenopausal women.
Ann Intern Med 87 : 649, 1977
32. Riggs, BL; Seeman, E; Hodgson, SF; Taves, DR and O' Follow, WM : Effect of the fluoride/calcium regimen on vertebral fracture occurence in postmenopausal osteoporosis
N Engl J Med 306 : 446, 1982
33. Shamonki, I M; Frumar, AM; Tataryn, IV; et al: Age-related changes of calcitonin secretion in females.
J Clin Endocrinol Metab 50 : 437, 1980
34. Thompson, DL and Frame, B : Involutional osteopenia : Current concepts
Ann Inter Med 85 : 789, 1976
35. Zerwekh, J E : Sakhaee, K; Glass, K and Pak, CYC : Long term 25-hydroxyvitamin D_3 therapy in postmenupausal osteoporosis : demonstration of responsive and nonresponsive subgroups.
J Clin Endocrinol Metab 56 : 410, 1983.

Acknowledgement

I am grateful to Prof. R. Young, Drs. C. Wang, J. Ma and K. Lam for their guidance during my elective period in endocrinology.