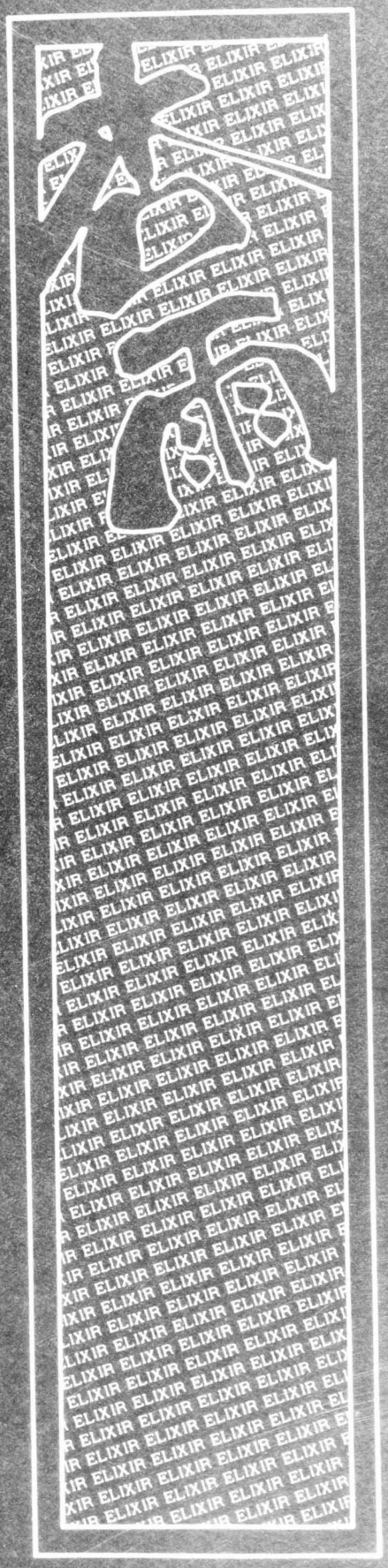
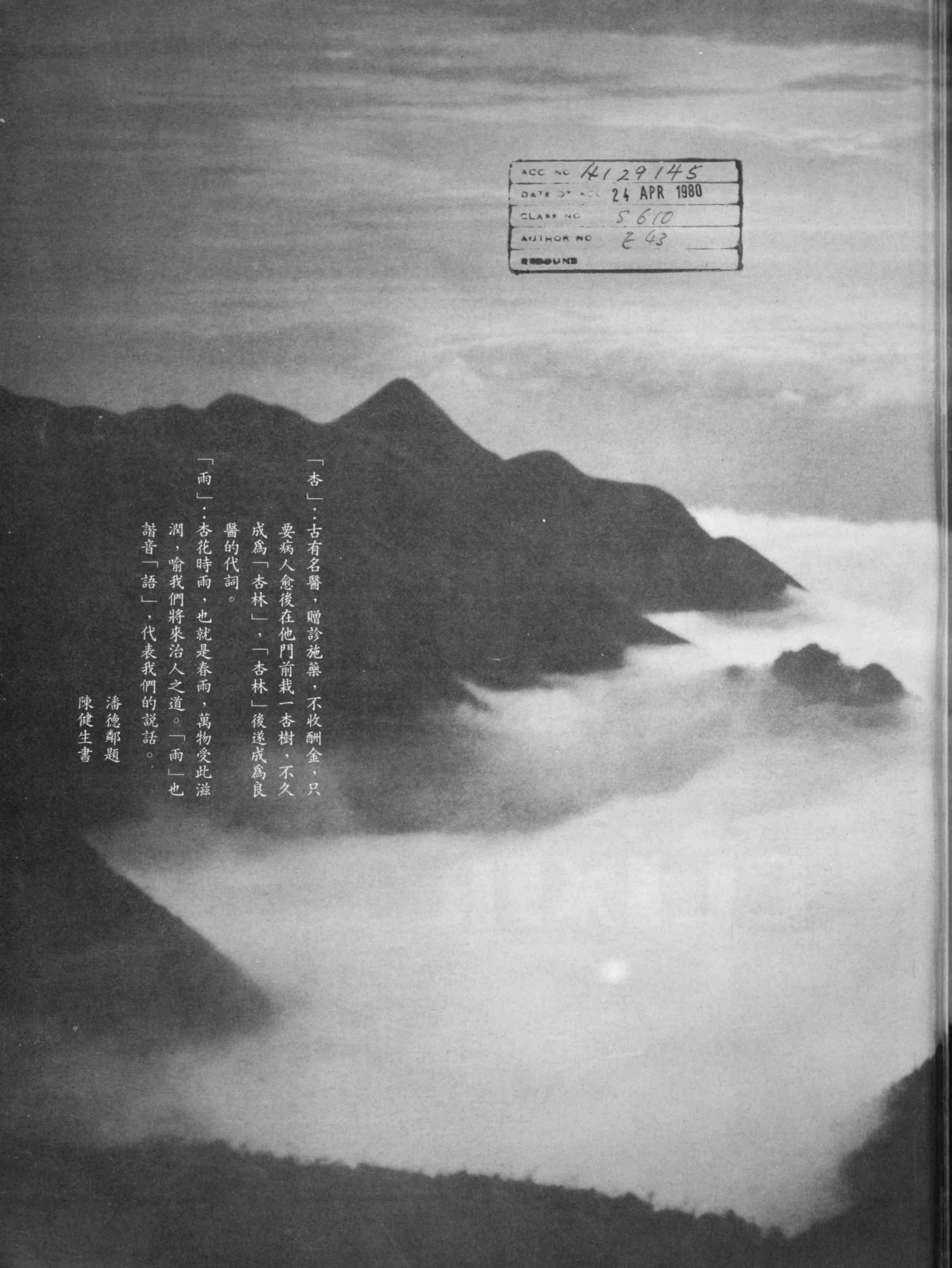


ELIXIR

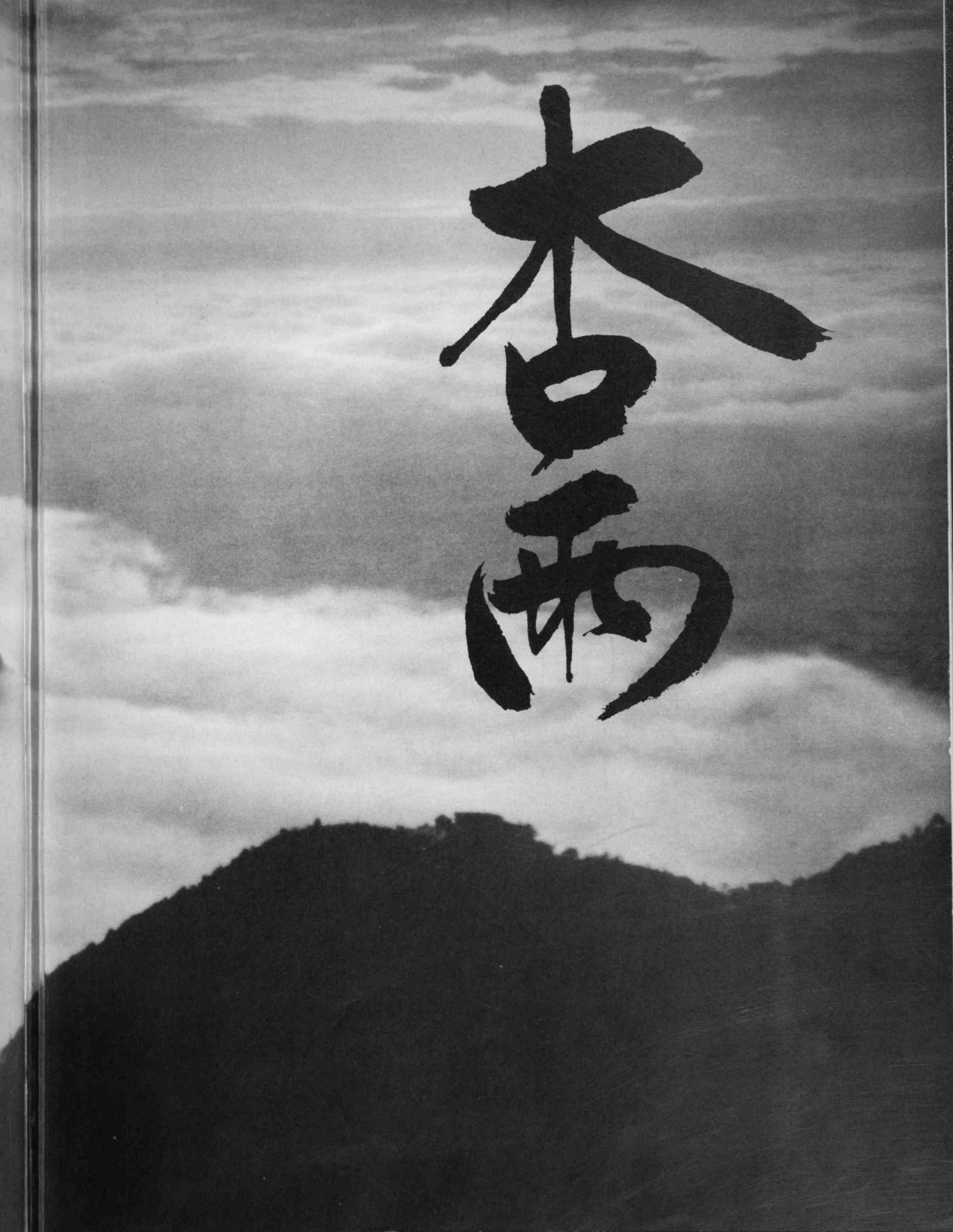
Official Annual Journal
Of The Medical Society
HKUSU
78-79



「杏」：古有名醫，贈診施藥，不收酬金，只要病人愈後在他門前栽一杏樹，不久成爲「杏林」，「杏林」後遂成爲良醫的代詞。

「雨」：杏花時雨，也就是春雨，萬物受此滋潤，喻我們將來治人之道。「雨」也諧音「語」，代表我們的說話。

潘德鄰題
陳健生書


杏雨

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Elixir: "A substance held especially in the Middle Ages to be capable of prolonging life indefinitely.
It means any of a class of sweetened aromatic preparations that contain variable percentages of alcohol and are used either for their medical ingredients or in treatments for their flavoring quality."*

Hence, as Elixir is supposed to make medicine taste better, so is it going to be a journal entirely

by the student
for the student
of the student.

This still remains the Editorial policy of this 38th issue of Elixir, since its inception in 1951. This journal will serve two main purposes; firstly to record the events of each session of the Medical Society, and secondly to serve as a bridge between doctors and students, and amongst students themselves.

In our editorial work, we have been far from problem-free. As pointed out by previous Editors, a journal which appears once a year cannot be a very effective means of communication and of expression of opinions, especially on more controversial topics and fast-progressing events happening in the year. In this respect, Caduceus probably could do and is in fact doing a better job. Nonetheless, we believe that Elixir does have its part to play in giving an overall annual picture of Medic Life.

We have been faced with other problems too. With the uprocketing rate of inflation, there has been a forty % rise in the printing cost compared with Elixir, 77-78, while more money is needed to include more journals and articles. Moreover, income from advertisements has failed to catch up with the rising cost of printing, and central funding from the Medical Society is rather limited. Therefore starting from this year, subscription is open to all General Practitioners. This has helped the financial situation to some extent, but of more importance is the fact that it provides a channel of communication and support from the General Practitioners, who are mostly our sisters and brothers of previous years. A contribution of $2.00 has also been asked of each medical student, but the general response has not been too satisfactory.

Since this is an annual journal, many students will probably not appreciate its existence till the moment it is distributed. Nevertheless, it is always hoped that students would contribute more to Elixir because this journal belongs to our own! Besides, as preparatory work lasts long and is often slow in the first few months, it is sometimes difficult to upkeep even the enthusiasm of members of the Editorial Board. However, a genuine interest and a deep sense of responsibility have times and again heightened the morale of the Editorial Board and pushed it to finish its otherwise unfinished task.

Chinese and English being both official languages, it would be so much better if we could have our journal printed in both languages. This is not yet possible because of our limited budget and manpower. Notwithstanding, the Editorial Board has chosen a Chinese name (杏雨), in an attempt to make this year's issue a more special one and to arouse more attention from both doctors and students alike.

Finally, it is unfortunate that communication between members of successive Editorial Boards is often inadequate, especially in this year. Since sharing of experience and feelings should and must be one important reason for our participation in student activities, it is earnestly hoped that this shortcoming will be improved in the future.

* Webster's Third International Dictionary

MESSAGE FROM THE DEAN

HEALTH FOR ALL

An invitation to write the "message from the Dean" presents the opportunity to give some ideas outside the general run of the medical curriculum. I think it is worthwhile looking rather further afield than enlarging on the usual subject of "work hard and be kind to your teachers by passing your exams".

Hong Kong is a small place with a large population. Practically every facet of life in Hong Kong is atypical of what is going on in nearby countries. There are many similarities between Hong Kong and other industrial cities but most of these cities nearby are closely connected with a rural hinterland. Singapore certainly has similarities, in spite of its different political system (and its control over what might be called unnatural increase of population). However we can certainly learn from studying what is being done in Singapore to solve medical and health problems.

Students, including medical students, should be interested in everything in the world around them, especially students in Hong Kong, which depends so much on its relations with the outside world. But this is a medical journal and this message should have at least a medical flavour. So ..... students especially medical students should be aware of the medical affairs of the countries nearby.

Over the past few years there has been a powerful campaign, spearheaded by the World Health Organization, to rethink the health service requirements of mankind — and especially of those living in tropical rural areas, of which most of the countries of South East Asia are very typical.

The new major aim of the World Health Organization has become "Health for all by the year 2000". This is "catchy" but if you think of the WHO definition of health rather unlikely. You do not need to be a pessimist to doubt whether there will be social well-being for all in twenty one years time. The slogan seems now to have been reshaped by WHO into the much more reasonable "An acceptable standard of Health Care for all by the year 2000".

Is this concept relevant to Hong Kong? Whether directly relevant or not, medical students should understand and think about what is proposed by WHO for the medical welfare of the greater part of the world's

population.

What exactly is "an acceptable standard of Health Care"?

Actually the central idea is not very complicated though its achievement is not at all simple; the intention is that everyone should have "primary health care" which is defined by WHO as including at least:

Promotion of proper nutrition.

An adequate supply of safe water.

Basic sanitation.

Maternal and child care including family planning.

Immunization against the major infectious diseases.

Prevention and control of locally endemic diseases.

Education concerning prevailing health problems and the methods of preventing and controlling them.

Appropriate treatment for common diseases and injuries.

It might seem that these fields bear little relation to what we perceive as the health needs of Hong Kong. The first five can be said to be already reasonably satisfactory. Health Education is being developed, though it is a term with a very wide meaning; what about locally endemic diseases and appropriate treatment?

The preventable diseases that we worry about in Hong Kong to-day are not the communicable diseases of rural Asia but include accidents, degenerative diseases, such as heart disease and cancer, and various physical and mental disabilities. Many are dependent on a style of life rather than faults in the direct physical environment.

Appropriate treatment is a wide term, open to many interpretations. For most of Asia it means the provision of simple medical care, often by subprofessionals in the first instance.

For Hong Kong we have rather different ideas. People want much more sophisticated treatment whenever it is required, as well as effective primary care, which must be readily and cheaply available. At least that is what the medical profession thinks they want; perhaps we should take more active steps to find out if it is really so. We may even take the dangerous attitude that we know better what people ought to want and should then set out to persuade them that we are right (one aspect of Health Education?) There is no doubt that we cannot provide a perfect curative health service — a recent survey of the U.K. National Health Service noted that to satisfy everybody would use up the whole of the G.N.P.

This emphasis by WHO on Primary Health Care is obviously correct for many countries in the world. In Hong Kong we seem much more concerned with the secondary or hospital care. We might even find that some of the methods of providing "appropriate treatment for common disease and injuries" being developed elsewhere are, after all, applicable in Hong Kong. Certainly we should look critically at the present system and not be afraid to explore other solutions.

The objective of this forward is to try and start some thoughts about the place of Hong Kong, from the medical and health point of view, in the wider world in which we live. Is this a waste of time when it is difficult enough to get students to take seriously anything outside the curriculum? I can sympathise with this narrow mindedness but will continue to try and break it down.

Perhaps we should not be too self centred. We already have achieved the acceptable standard of health which is hopefully being sought for many of our neighbours by the year 2000. Should we do anything about this? If so, what?

What is the objective of this message? To think rather more broadly outside the Hong Kong situation and possibly come to the conclusion that it is not so irrelevant after all.

M.J. Colbourne,
Dean, Faculty of Medicine.

PRESIDENTIAL ADDRESS

The Diagnostic Process & Its Simulation with the Computer

The Computer

Assuming most medical students do not know much about computers, I will begin by describing in very simple terms what is a computer (fig. 1). A computer is an electronic device which can process information. In order to do this, it must have **Input Device(s)** connected to it so that information may be passed into it. The common input devices are tape readers, card readers or typewriter terminals. The computer also must have **Memory** which allows it to store information. The brain of the computer is termed the **Central Processing Unit** (CPU), which controls the whole computer (the Controlling Unit or C.U.) and also performs the arithmetic and logical decisions (the Arithmetic & logical Unit or A.L.U.). Finally, after having processed the information, the result is communicated to the external world via **Output Device(s)**. The common output devices are line printers, card purchers, cathode-ray-tube terminals and typewriter terminals. Memory is divided into **Main Memory** and **Auxillary Memory**. Main memory or internal memory is usually built into the computer and is used to hold the instructions (or programme) and data needed for immediate work. The power of a computer is often expressed in terms of its throughput time or how fast it can work and also how much main memory it has. The unit of measurement of computer memory is byte, and 2^{10} or 1024 bytes is often also known as 1K. A typical computer main memory is usually between 100K and 1000K or 1 megabyte. Auxillary memory is usually in the form of magnetic tape or magnetic disc and the cost per unit of auxillary memory is much much less than that of main memory.

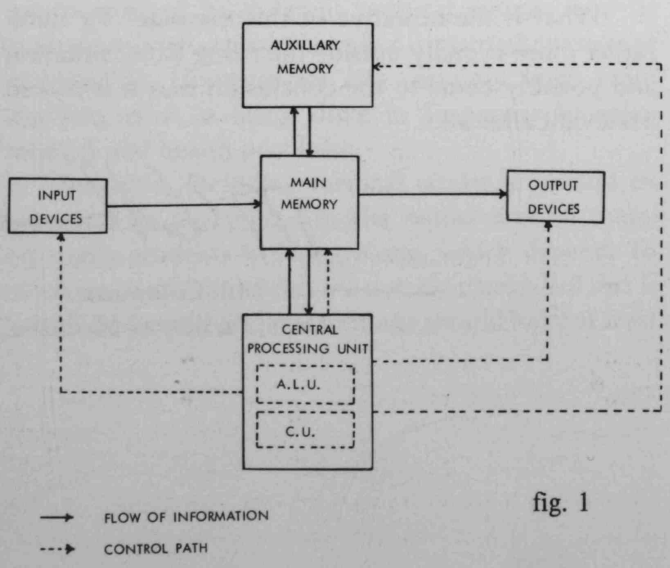


fig. 1

All this might sound very confusing to you, but the following human analogy might make it clearer. The brain with its memory, capacity to think and controlling function over the body is equivalent to the CPU of the computer with its main or internal memory. The eyes, ears and other sensory organs are equivalent to the input devices. The hands, legs, fingers etc are the output devices. What about the equivalences of the auxillary memory unit? Books, journals, notes etc. are the auxillary memory units.

This analogy can be carried one step further. the instructions which we give a human being to do certain things are known as programmes to a computer. Just as there are many languages in the real world and each language may have a number of dialects, there are also many computer languages together with different dialects.

The first all purpose, all electronic digital computer, the ENIAC, was built in 1946. It has about 10,000 vacuum tubes. In the late fifties, the second-generation computers which used transisters in place of vacuum tubes were born. 10 years later, in the late sixties, the so-called third generation of computers which used integrated circuits were marketed. In 1971, microprocessors came into being. A microprocessor is a single chip of silicon on which is etched the entire CPU. With the advent of the microprocessor, prices of computers have tumbled so much that it is now possible for individuals to buy and own a microcomputer.

You all know of the first industrial revolution which was brought about by man's understanding and harnessing of some of nature's power and energy, and thereby extending man's physical power and control over certain aspects of nature. We are now in the midst of the second industrial revolution which is brought about by microprocessors and computers which extend man's mind. This revolution will touch each and every one of us.

Computer diagnosis by Bayes' Theorem

There are two main approaches to computer diagnosis. The earlier approaches were mainly based on mathematics and more recently models based on heuristics were tried.

Most of the mathematics models are based on Bayes' theorem.

In simple mathematics, the theorem is:

$$p[D_1/S] = \frac{p[S/D_1]\,p[D_1]}{p[D_1]p[S/D_1] + p[D_2]\,p[S/D_2] \ldots + p[Dn]\,p[S/Dn]}$$

where $p[S/D^1] = p[S_1/D_1]\,p[S_2/D_1] \ldots\ldots p[Sn/D_1]$

$p[D_1/S]$ = probability of [Disease 1] given symptoms [S]

$p[D_1]$ = a prior probability of [Disease 1] in the population under consideration

$p[S_1/D_1]$ = probability of [Disease 1] having [Symptom 1]

To make this clearer with concrete examples, let us use a few biochemical results in the calculation of probability for three types of liver diseases.

As an example; let

Virus hepatitis = Disease 1 (D_1)
Chronic active hepatitis = Disease 2 (D_2)
Carcinoma of liver = Disease 3 (D_3)

By studying a large number of patients with this disease it was found that the probability of patients with virus hepatitis having a bilirubin level of 70($p[S_1/D_1]$) is 0.383 and for chronic active hepatitis $p[S_1/D_2]$ is 0.298, and for CA liver $p[S_1/D_3]$ is 0.061

With SGPT = 200 (S_2), the probability of patients with virus hepatitis having that particular SGPT level i.e. $p[S_2/D^1] = 0.117$, for CAH $p[S_2/D_2] = 0.285$, and for CA liver $p[S_2/D_3] = 0.205$

Similary for A1k phosphatase of 120 (S_3)

$p[S_3/D_1] = 0.314$
$p[S_3/D_2] = 0.399$
$p[S_3/D_3] = 0.302$

and for Albumin level of 29 (S_4)

$p[S_4/D_1] = 0.011$
$p[S_4/D_2] = 0.359$
$p[S_4/D_3] = 0.289$

The probability of the three diseases having those particular biochemical findings will be:

$$p[S/D_1] = p[S_1/D_1]\,p[S_2/D_1]\,p[S_3/D_1]\,p[S_4/D_1] = 0.383 \times 0.117 \times 0.314 \times 0.011 = 1.548 \times 10^{-4}$$

$$p[S/D_2] = p[S_1/D_2]\,p[S_2/D_2]\,p[S_3/D_2]\,p[S_4/D_2] = 0.298 \times 0.285 \times 0.399 \times 0.359 = 1.217 \times 10^{-2}$$

$$p[S/D_3] = p[S_1/D_3]\,p[S_2/D_3]\,p[S_3/D_3]\,p[S_4/D_3] = 0.061 \times 0.205 \times 0.301 \times 0.289 = 1.091 \times 10^{-3}$$

Assuming the prior probability of any one of these diseases occuring is the same i.e. $p[D_1] = p[D_2] = p[D_3]$ then

$$p[D_1/S] = \frac{1.548 \times 10^{-4}}{1.548 \times 10^{-4} + 1.217 \times 10^{-2} + 1.091 \times 10^{-3}} = 0.01$$

$$p[D_2/S] = \frac{1.217 \times 10^{-2}}{1.548 \times 10^{-4} + 1.217 \times 10^{-2} + 1.091 \times 10^{-3}} = 0.91$$

$$p[D_3/S] = \frac{1.091 \times 10^{-3}}{1.548 \times 10^{-4} + 1.217 \times 10^{-2} + 1.091 \times 10^{-3}} = 0.08$$

In other words, considering the possibility of only three diseases, if a patient has a bilirubin level of 70 umol/1, SGPT 200 and Alk. phosphatase 120, and Albumin 29, then he has a 91% chance of suffering from chronic active hepatitis, and 8% chance of suffering from carcinoma of the liver and 1% chance of suffering from acute viral hepatitis.

Recently, Dr. K.C. Lam, Dr. W.C. Leung and myself have constructed a model for the interpretation of abnormal liver function tests. The disease classes are: acute hepatitis, chronic active hepatitis and macronodular cirrhosis of the liver, carcinoma of the liver, alocholic liver disease, gall stones, biliary diseases, heart failure and a category classified as "not primary liver disease". The last category was put in because often septicaemia and many other conditions can cause abnormal liver function tests. The biochemical tests which were used for the model were : Albumin, Globulin, Bilirubin, Alkaline phosphatase, SGOT, SGPT and γ GTP. The data from about 450 patients were used. The diagnosis in these patients had been either verified by histology or in the case of viral hepatitis, the clinical picture is typical of it. Using these seven parameters alone, and taking the diagnosis with the highest probability as THE diagnosis by the computer, the accuracy was 61%. By pure guess work alone, the accuracy should be 1 in 9 or 11%, so the model is better than pure guesswork by 6 times. But then 61% accuracy in diagnosis is really abysmal. The progam was making some silly mistakes such as diagnosing "Normal" in a patient who has cirrhosis of liver with ascites & splenomegaly but who happened to have fairly normal liver function tests.

Because the computer has not been taught to recognise ascites or other clinical features, it was making silly mistakes which even a junior clerk wouldn't make.

Subsequent models were then constructed which included clinical features such as hepatomegaly, splenomegaly, ascites, alcoholic consumption, RUQ pain previous history of chills and rigor, jaundice and drug history. Two more laboratory tests, namely the white cell count and the platelet count were added. Certain heuristics principles were incorporated as well but the main backbone of the system is still Bayes' conditional probability theorem. The latest model now has a diagnostic accuracy of around 90%. Though formal competition between this model and senior clinicians has not been conducted, there have been occasions when the computer diagnosis was correct and that of the clinician wrong. Though I must admit the opposite situation has also occurred.

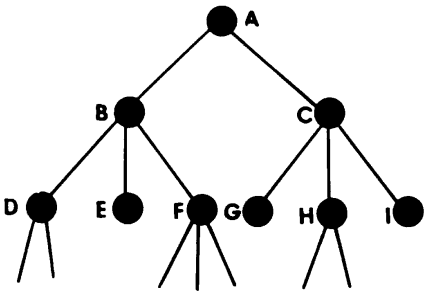
The major difficulty with this sort of mathematical approach is the need for a large & reliable database. The larger the database the more accurate would be the diagnosis. However the calculations involved increase exponentially with the increase in the number of diseases to be considered. The second problem is, the model is probably applicable to the particular centre from which the database was created but not elsewhere. As an illustration, our model would probably not be able to perfrom as well in European countries where the pattern of liver disease is different as they have more primary biliary cirrhosis and less hepatoma; and even their hepatoma are probably more associated with alcoholic cirrhosis than with HBsAg.

One final point which makes most doctors instinctively unwilling to accept this model is the glaring fact that doctors do not arrive at a diagnosis this way. Doctors do not go around carrying the conditional probability of different laboratory tests and physical findings in their heads and then perform computations to arrive at a diagnosis. Similarly no doctor ever collects a whole set of all possible characters from the patients before making a diagnosis. This model is then a plausible model for computer diagnosis but does not actually simulate the human diagnostic process.

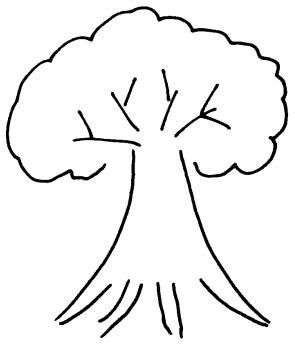
Computer Diagnosis by non-Mathematical Model

The earlier non-mathematical models utilise a tree-search technique. A tree in computer science is somewhat different from a biological tree. The root is usually pictured on top with the leaves and nodes below (see figure 2)

The idea is that at "A" a symptom or sign is looked for and depending on the presence or absence of that



AN INFORMATION TREE



A REAL TREE

fig. 2

sign or symptom, the enquirer, which here is the computer, moves onto to B or C. From this point further information is looked for and again depending on the response the enquirer would go on to D/E/F or G/H/I as the case maybe. This process then goes on till a diagnosis is reached.

Except for some very well defined groups of diseases, such as patients with erythrocytosis, this model is highly unsatisfactory and unrealistic. I don't know which is more difficult to master, the diagnostic process or to play a good game of chess. However, experience from writing programmes to teach the computer how to play a reasonable game of chess has taught us that the tree-search technique is of limited use only and there must be other ways of teaching the computer to make "good" decisions.

By observing how clinicians arrive at a diagnosis and by introspection, Pauker, Gorry et al (1) constructed a program for the diagnosis of patients with oedema. To my mind this programme most closely simulates the workings of the minds of clinicians.

The computer first began to ask a few questions and the user would type in the answer. An example of the dialogue would be something like this:

Presenting Problem: A young man with Massive Pedal Oedema

1A Is Pedal edema, which is massive,

1. for days?
2. for weeks?
3. for months?
4. for years? >>1

(>> means answer)

1B Is it
1. first-timed?
2. infrequent?
3. occasional?
4. frequent? >>1

1C Is it
1. without temporal pattern?
2. worse in morning?
3. worse in evening? >>3

1D Is it
1. Symmetrical?
2. Asymmetrical? >>1

2 Well, is there dyspnea >>No

3 Is there heavy alcohol consumption >>No

4 Is there .....

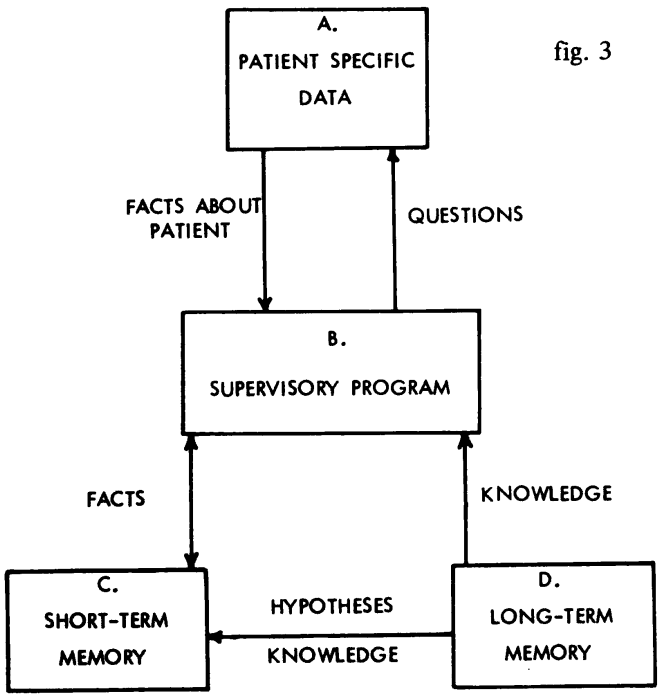


fig. 3

and so on until a "diagnosis" is reached when a "case summary" will be printed. A case summary would look something like this:

Presenting Problem: A middle aged man with ascites pedal edema.

The case can be summarized a follows:

This is a middle-aged man who has ascites. He has pedal edema, which is not painful, not-erythematous, pitting, symmetrical. 4+, worse-in-evening, occasional and for-months. He has social alcohol consumption. He has hepatomegaly. He does not have jaundice. He does not have palmar erythema. He does not have spider angiomata. He does not have parotid enlargement. He does not have gynecomastia. He does not have testicular atrophy. He has normal bilirubin. He has normal prothrombin time. He has normal SGPT. He has normal SGOT. He has chest pain which is relieved-by-sitting-up, without-radiation, moderate, occasional for-seconds and sharp. He has exertional dyspnea. He has orthopnea. He does not have paroxysmal nocturnal dyspnea. He has elevated neck veins. He has Kussmaul's sign. He has pericardial knock. He has distant heart sounds. He has pericardial-calcification-on. Normal-heart-size-on, clear-lung-fields-on. Chest X-ray.

The leading hypothesis is constrictive pericarditis.

Figures 3 illustrates the computer programme organisation. Clinical data (A) are presented to the supervisory program (B) which places them in short-term memory (C). After consulting the two memory states, the supervisory programme then generates hypotheses and the facts associated with these hypothesis are then moved from long-term memory (D) to short term memory. The supervisory program then asks for additional patient-specific data relevant to these hypotheses. At every stage, each hypotheses is evaluated by the programme to determine whether it should be rejected, accepted or considered further.

The knowledge that's stored in long term memory is organised into packages called frame. Frames might be about diseases (e.g. systemic lupus), clinical states (e.g. nephrotic syndrome) or physiological states (e.g. Na+ retention). The frames are connected with each other such as the nephrotic syndrome clinical state is connected to SLE the disease because nephrotic syndrome may be caused by SLE. The nephrotic syndrome clinical state is also connected to constrictive pericarditis clinical state frame, as well as to cirrhosis and renal vein thrombosis because these are common differential diagnosis for patients with ascites and ankle oedema. The operation of the programme thus goes through cycles of characterising the findings then zeroing in on the presenting problem, checking on the validity of the data (i.e. such as information of wt. gain of 50 lb per day must be wrong), generating and testing hypothesis and finally asking questions for further information before repeating the cycle again.

At the hypothesis testing stage, the programme first of all considers whether there are any features which would exlcude the hypothesis under consideration, such as the absence of proteinuria would exclude the hypothesis of nephrotic syndrome permanently. It will also check for any features which would cause it to

accept the hypothesis such as the presence of massive proteinuria and oedema for nephrotic syndrome. Most of the time it will apply a scoring process to the hypothesis and check on how well the hypothesis can explain the features at hand, in other words it will check on how many features in the patient are unexplained by the hypothesis as well as how many features in the hypothesis do not fit the patient's data. When the data from the patient fit the hypothesis to a preset level, the hypothesis will be accepted. If the data do not fit the hypothesis to again a preset level then it will be rejected and a new hypothesis will be considered.

How then do the frames of diseases etc reach short term memory to be evaluated as hypothesis. Initially, the short term memory is devoid of frames. When certain facts from the patient fit certain features of a frame, the frame is moved into short term memory as a hypothesis. It is now said to be ACTIVE. You would remember that each frame has a number of other frames connected to it. These connected frames then become SEMI-ACTIVE. In a human analogy, these semi-active frames would be equivalent to those thoughts "at the back of one's mind". So if certain facts from the patient then fit a semi-active frame but not the active frame, then the semi-active frame would become fully ACTIVE and the hypothesis associated with it would be the hypothesis under consideration.

Finally, there is one more striking feature of this programme, and that is its ability to apply the "Principle of Parsimony". If in the course of evaluating the hypothesis of "Nephrotic Syndrome" a positive ANF result is known, it will generate a diagnosis of "lupus erythematosis with nephrotic syndrome".

The Human Diagnostic Process

What is a "DIAGNOSIS"

According to the late Prof. McFadzean "A diagnosis is the disease which can explain best the **available** data and is not necessarily the disease from which the patient is suffering". To Lord Cohen, "a diagnosis is only a tentative guide to action".

Figure 4 illustrates the most probably strategy for diagnosis which we use. Substituting the word "Diagnosis" for "Hypothesis" and you can see exactly what Prof. McFadzean meant. When one looks at both "searching for further information" and "applying a solution" as "further action" then the diagram is also an illustration of Lord Cohen's dictum. What is even more amazing, it is virtually the same blue-print for the Pauker, Gorry, Kassirer and Schwartz model which was described above.

The next question is how do we organise the vast store of medical information in our minds and how do we generate hypotheses for testing?

According to Miller (2), and this is now well accepted by most psychologist, the span of immediate memory in man is limited to approximately seven items. Note again the similarity to the Short Term Memory of the Pauker et al Model, which can only evaluate a few hypotheses at any one time. The vast store of information is organised in a hierarchical structure such that each level of the hierarchy consists of 5 ± 2 items. The reason for this organisational structure is due to the limiting effect of the span of our memory. These informations thus grouped and categorised are used to generate hypothesis. These information are also related to each other in our minds. Wortman (3) studying physicians at work found that in general when the number of features confirming a hypothesis versus features against a hypothesis is more than 5:2 the hypothesis is accepted. Irrespective whether this figure 5:2 is operative or not, we do apply exclusive rules and look for pathognomonic features in out patients and when these are absent we would weigh the evidence for or against a hypothesis. Again the Pauker et al model simulates this activity.

According to one estimation (1) there are about 200,000 facts in Beeson & McDermott Textbooks of Medicine. In addition there is about another 200,000 facts from the basic sciences and 100,000 facts from the real world which is needed for the practice of medicine. To allow for underestimating the total no. of facts which are necessary, one doubles all those figures which would give us a grand total of 1 million facts. If one adds in the number of facts from specialist textbook such as Wintrobe's Clinical Haematology as well as

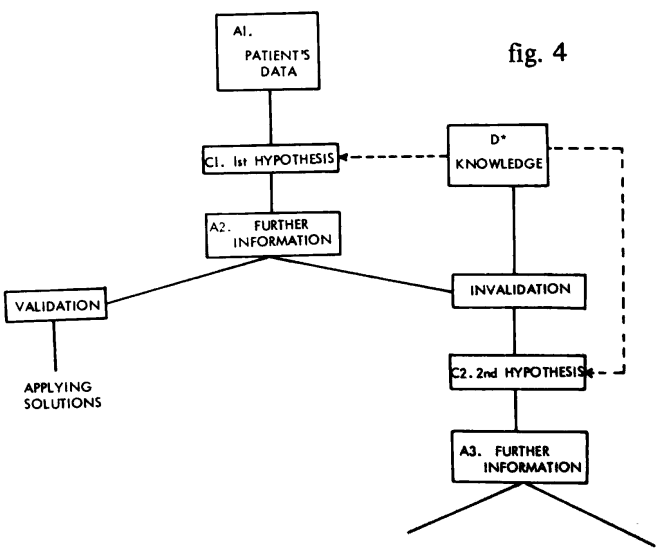


fig. 4

others, the total would be 2 million facts. At the moment, no computer in the world can process this vast amount of information. However, given the present rate of advancement of computer technology it is not difficult to see that soon it can be done. Can the computer replace the human being as a consultant physician? The answer to that question lies in this limerick:

A robot complained to the staff
that whenever he'd sorrow or laugh,
whatever the shade
of emotion displayed,
It came out in the form of a graph

To be a doctor means more than technical competence. There must be compassion and a feel for one's patients as well. Even if & when a computer can be programmed to function as a better diagnostician than a doctor, it is nevertheless just a diagnostician & not a doctor because it cannot show compassion or care. Medicine is derived from two traditions, the scientific tradition and the humanistic tradition. Without science, medicine would be reduced to quakery. Without a heart, medicine would be reduced to cybenetics & robotics. Therefore the computer can never replace the doctor. But, having said that, systems of Computer Aided Diagnosis might become a reality and future generations of doctors might have to learn about computers.

REFERENCE

1. PAUKER, S.G., GORRY, G.A., KASSIRER, J.P., and SCHWARTZ, W.B. Am. J. Med. 60 : 981, 1976
2. MILLER, G.A. Psychol. Rev. 63 : 81, 1956
3. WORTMAN, P.M. Computer and Biomedical Research, 5 : 315, 1972.

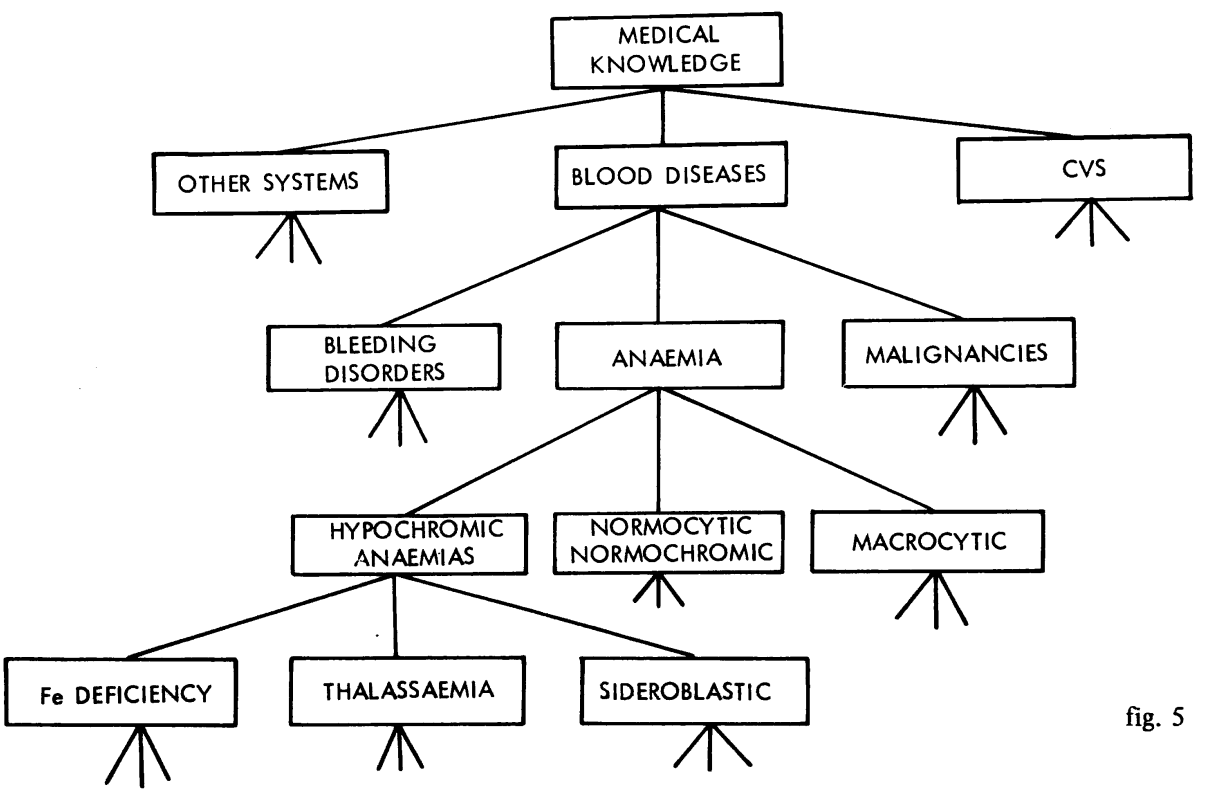


fig. 5

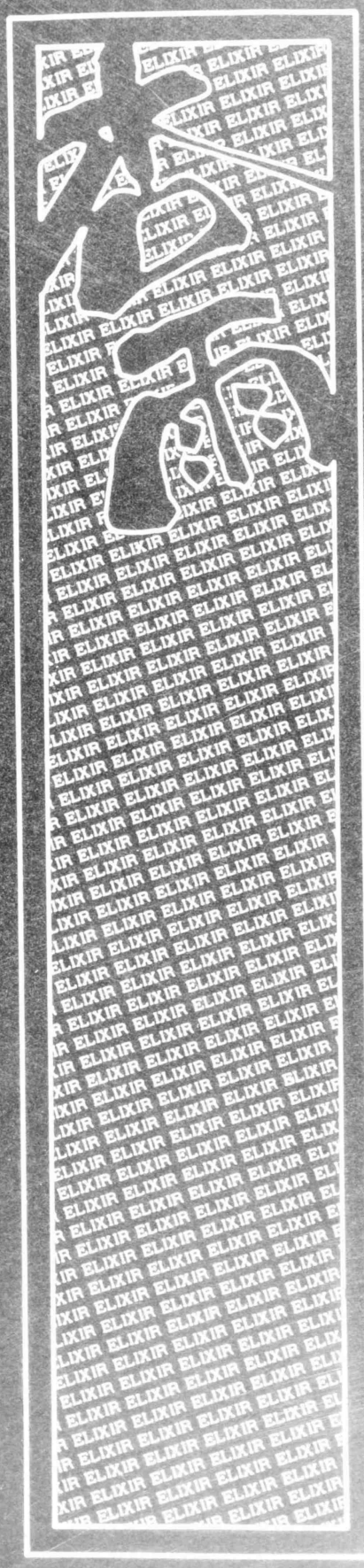
MESSAGE FROM THE CHAIRMAN

Professor Abel—Smith has emphasized repeatedly in his *Value for Money in Health Services* that for the improvement of the health of peoples and for the proper functioning of any best-laid plans in health care, "ultimately what matters is not just the financial incentives operating on those working in health services, but their ethos and their commitment to serve not only individual patients but the health of the community as a whole"; and it is important that this latter idea can be imparted on medical students being trained. What else can I better claim the role of our Medical Society than for what Professor Abel—Smith says; and I really dare to do so.

Thus we learn our values and sense of social commitment through actual organizations and participations: the summer health project in Ping Chau, the mobile health exhibition from City Hall to the Ocean Terminal, Aberdeen, Tai Wo Hou and Kwun Tong, the large scale study on health care in October, the social service in Aberdeen, as well as the bits and pieces of efforts spent for community health programmes and exhibitions organised by other groups and societies; not to mention the persistent effort of our Caduceus people in arousing interests and creating good discussion atmospheres among the fellow students. More important, however, is perhaps the enthusiasm behind all these hard works, the passionate concern between each other participants. The Medical Society is never anywhere near its ideal; but every year we are improving, which is something beyond all doubt.

Yet I would not be fair if I do not mention the support we have received from the whole medical profession, both in terms of finance and the valuable advices. We must also never forget our seniors for without their shoulders, we would have nothing to stand on. By the time this volume of Elixir is published, we will have already entered another decade in the Twentieth Century. I should, on behalf of all office-bearers in the session 78-79, only hope that the Medical Society should continue its pace of improvement; as well as that one day health will be a property and right for all.

Fung Hong



FROM THE CLASSES

medic 80

一生裡有幾回春幾回冬，
我們只感受時序的輪替，
感受不到人間規定的年齡。

啊，一次別離，一次降生，
我們担負着工作的苦辛，
把冷的變成暖，生的變成熟，
各自把個人的世界耕耘。

我們招一招手，隨着別離，
我們的世界便分成兩個，
身邊分成兩個，眼前忽然遼闊，
像剛剛降生的兩個嬰兒。

爲了再見，好像初次相逢，
懷着感謝的情懷想過去，
像初悟面時忽然感到前生。

相遇

MEDIC 81

邀宴食街、飛觴共醉、齊謝恩師親切指導、繼而進修各該系科目、課程繁複、同學倒覺興趣盎然、年中、從偷得半天空閒、來個茶敘玩々遊戲、難得梨口大笑一場、淺水灣灘頭、边游泳边開野火会、春砂角扎營、聽浪声、數星々、浪声不絕、星々數不完、開过跳舞盛會、柔揚音樂聲起、但覺舞影翩々、再也看不真了。医学節中敏班同学器具音樂天才、傾力陶醉演出、而奪鰲頭。至於医学會别項活動如田徑水運等也悉力以赴，來年分科上課、見面時總覺朦朧々離情繁、只想一日重逢各述陳情新知、不亦樂乎。八一

FAMILY PHOTO

1978~79

頌 二 八

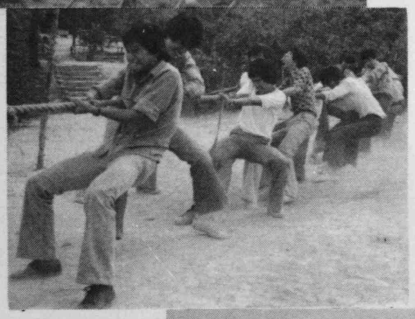
聚龍虎，會羣英
八二同學敢自稱
學醫習術沙宣道
逆水行舟事非輕
同舟共濟互守望
唯冀他朝業有成

多健兒，有英雌
滿目鴻儒無白丁
音樂歌舞有奇才
泳速球技人嘆驚
練功習武不乏人
琴棋書畫未遜色

鴻鵠志，鐘鼓聲
日後濟世又扶傾
羣策羣力禦難艱
雨打風吹杏益馨
但願八二常八二
青山常綠水長清

同求學問群體歡樂八三添

共謀理想你我本是一家人



Medic 83

回顧七九年

一月：「你的一週」—齊探索，齊實踐。

二月：團年飯—打邊爐大會，人人盡興。
新春大嶼山旅行。

三月：仲春行大運。

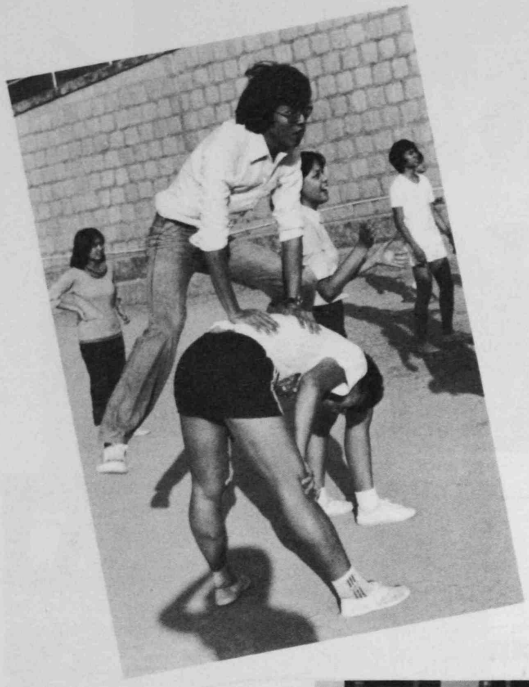
四月：班際球類、運動會—男子組均勇奪亞軍。

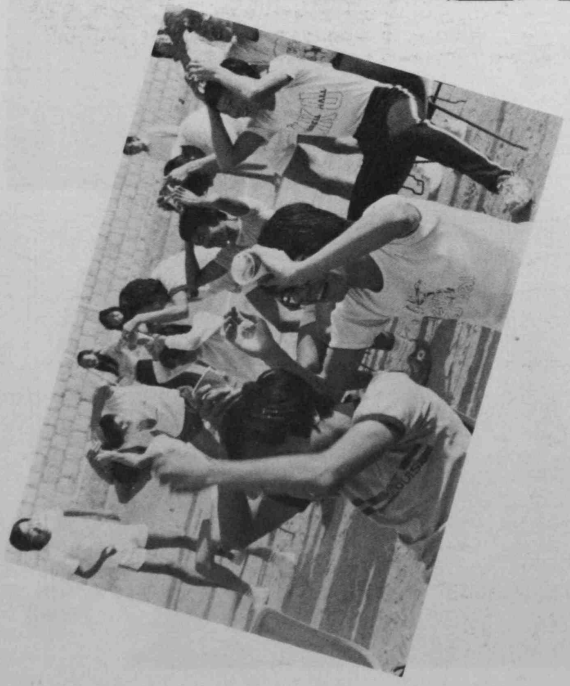
八月：與八二合辦「健康的坪洲」暑期服務計劃。

十月：暑期旅遊滙報、交流經歷。
班際泳賽男子組蟬聯冠軍。
再取醫學生節遊戲項目總冠軍。
野火大會，七十位同學齊聚於大潭。

十一月：勇奪班際運動會男子組冠軍。

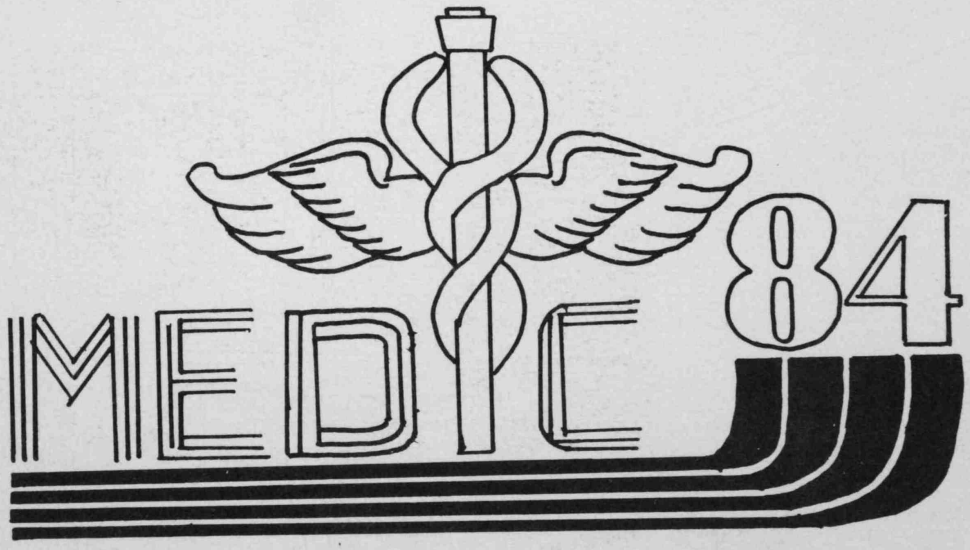
十二月：組際越野賽。
支援柬埔寨飢民越野跑籌款。
期終聯歡會。





八四精英，
勇往前征！

八四精英，
石破天驚！



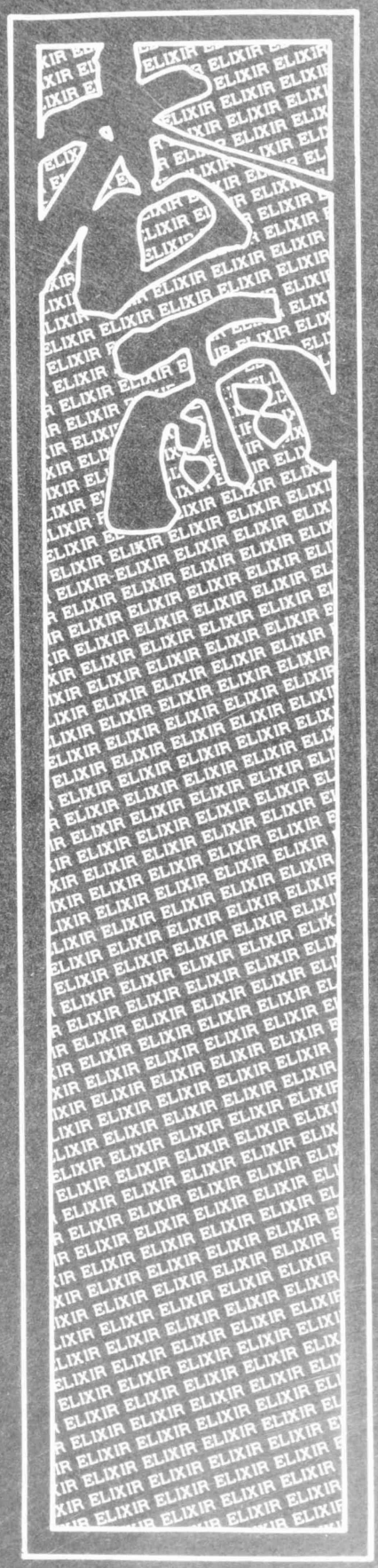
八四好波，

八四士氣多，

八四獎牌一籮籮！

A banker is a fellow who lends his umbrella when the sun is shining, and wants it back the minute it begins to rain.

— Mark Twain



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Medic '84.
Mr. Lam Shun Chiu (79 — 80)
Miss Chiu Kit Yee, Sherlianne (79 — 80)

THE COUNCILLORS

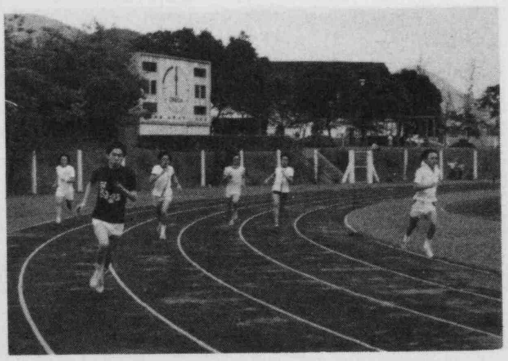
CALENDAR

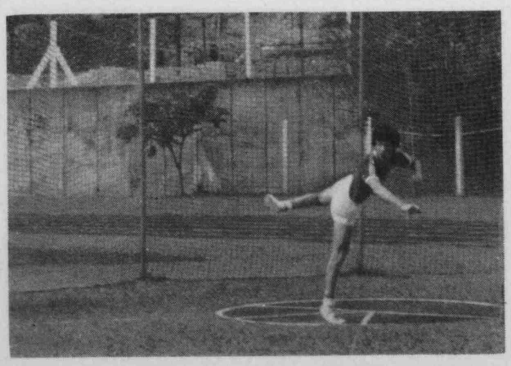
December 1978

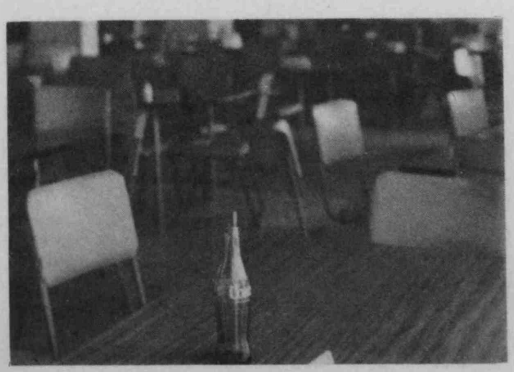
1 Executive Committee (78-79) comes into office
2 Inter-faculty Athletic Meet (heats)
6 Forum — 'Review on Know China Activity in the previous years'
8 M.B.,B.S.: Second Examination (part II)
9 Inter-faculty Athletic Meet (final)
15-16 Health Exhibition (Smoking and Drinking) at Castle Peak
15-22 Tour to Chung Shan Medical College, Canton
23 Christmas Carolling
26 Christmas Party

January 1979

1 Health Committee, Fraternity Committee, Elixir Editorial Board, Caduceus Editorial Board come into office
2 Second term begins
3 Report on the survey on Medical Students Canteen
4 Paraclinical Orientation
15-19 Soliciting phrases, poems on Fraternity
18 Sing along — *organised by Fraternity Committee*
23 Lunch Time Concert — *organised by the Fraternity Committee*
25 Panel discussion on various tours to China
28 Chinese New Year Holiday begins







February 1979

7 Participation of Medical Society in the Chinese New Year Gathering organised by the Students' Union

8 Forum on the 'Boat People'

10 Project organised by Health Committee at Aberdeen begins

13 Bridge Tournament — *organised by the Fraternity Committee*

26 General polling of the Senator and the students representatives to the faculty board

27 Book exhibition and film show — *organised by Fraternity Committee*

28/2 —6/3 Participation of Medical Society in Union Festival

March 1979

1 General polling for popularly elected councillors
Book exhibition and film show — *organised by Fraternity Committee*

2 Film show — *by Fraternity Committee*
M.B., B.S.: Second Examination (part II) begins

5 M.B., B.S.: First Examination (old) begins

6 Book exhibition and film show — *organised by Fraternity Committee*

8 M.B., B.S.: Second Examination (part I) begins

13-14 Visit to Refugee Camps
14-16 Academic Orientation — *organised by HKUSU (participation by Medical Society)*
18 Gala Premiere 'Buddy Holly Story' at Lee Theatre
19-30 Social Service Project at Ping Chau — *organised by Medic 82 and Medic 83*

April 1979

2 Third term begins
21 Inter-year Athletic meet
27 MB.,B.S.: Final Examination begins

May 1979

2 Inter-year Sports Presentation Day

June 1979

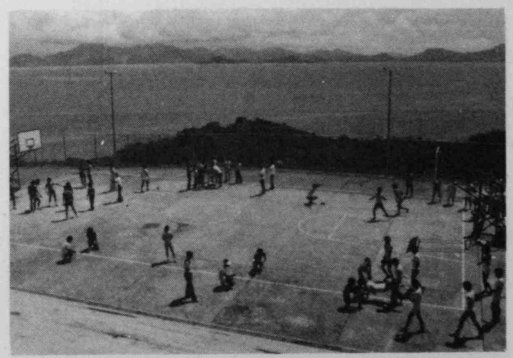
5 M.B.,B.S.: First Examination and Second Examination begin

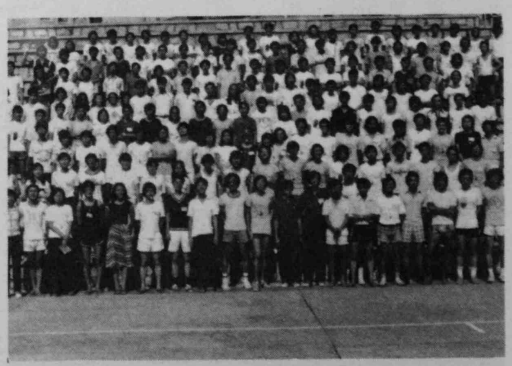
July 1979

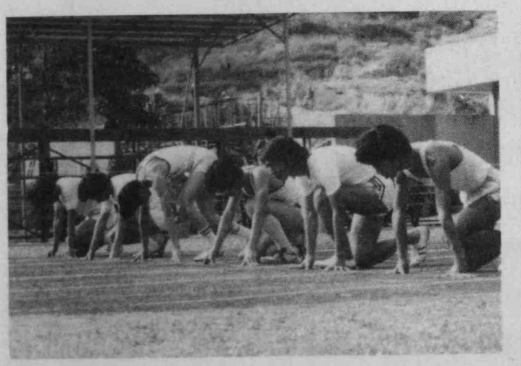
7 Matriculants Day

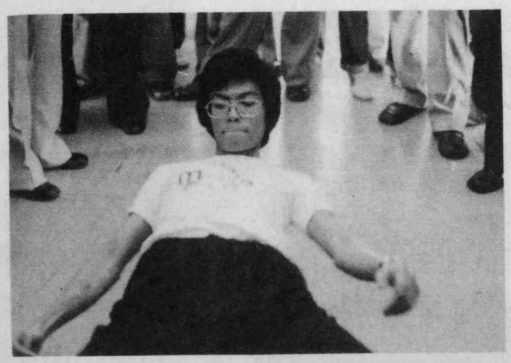
August 1979

4-8 Participation of Medical Society in 'Child Health in Hong Kong' Exhibition at City Hall
17-19 Orientation tutor camp — *organised by Fraternity Committee*
29 Freshmen Welcome Day
31/8 —2/9 Health Exhibition 'Drugs: Safe and Effective Utilisation' at Ocean Terminal









September 1979

3	M.B.,B.S.: Second Examination (New) and Second Exation (part I) begins
4-6	Fraternity Camp
8	Second Hand Book Sale
10	Term begins for 3rd, 4th, and final years students M.B.,B.S.: Final Examination begins
11-14	Health Exhibition '79 at Tsuen Wan
15-17	Health Exhibition '79 at Aberdeen
18-22	Health Exhibition '79 at City Hall
24	Term begins for 1st and 2nd year students
29	Medic Launch

October 1979

1-10	"神州十日" — *organised by Caduceus*
2	Inter-year Aquatic Meet
15-22	Medic Festival
17	Inter-faculty Aquatic Meet — heats

November 1979

10	Inter-year Athletic Meet
17	Inter-faculty Aquatic Meet
22-23	Annual General Meeting
23	General polling of Ex-co
27	Presidential address Blood Donation

December 1979

1	Executive Committee (79-80) comes into office

中山醫學院專業參觀團

鄧遠懷

時值七八年聖誕假期，我們一行三十位同學(二、三、四年級），本著「認識中國醫療制度、醫學教育現況，和國內同學溝通、增進互相了解」的目的，遠征廣州，用了前後八天時間，訪問了中國南方有名的中山醫學院。行色匆匆，收獲卻不少。

× × ×

中山醫學院是由以前光大、嶺大和中山大學醫療系合併而成。在去年全國教育工作會議上被定爲全國五間重點醫學院之一，是一間担負起教學、醫療、科研任務的高等專科學校。

整個學院分爲醫療、衞生、葯學、口腔四個系，而以醫療系學生人數最多。共有五間附屬醫院—三間綜合醫院、眼科醫院、腫瘤醫院。共有病床二千多張，每日門診大約六千人。

中山醫學院現時共有教職員四千人，學生二千多人，分別來自全國各地和其他十七個第三世界的國家。現時入學必須通過全國統一高等考試，首先根據他們學業成績，再考慮政治表現、體格各方面，由學院擇優取錄。

現時學制是五年（文革時是三年半）。前大半年是一般基礎課，包括外文、醫用物理、化學、生物等等。醫學基礎課（解剖、生理、生化、病理、葯劑等等）佔去前期二年多時間。醫學臨床課佔去一年多。最後一年是在醫院當見習醫生，一般要當過內、外、婦、兒四科，才能成爲正式醫生。

文革中一度廢除的考試制度，現時恢復了。每一年級都要經過考試合格才能升班。考試不合格則要補考或留班。大部份的課程正在從新編訂，糾正過去十多年輕視基礎理論的錯誤，加强基礎理論課程，也注重理論和實際結合。

此外，中山醫學院還準備引進先進的技術，特別是電化教學方面的儀器。又準備和日本、美國的大學建立聯繫，互相交流，吸收先進經驗，提高教學水平。

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我們在十二月十五日下午到廣州。翌日隨即展開我們的參觀活動。首先是中山醫學院領導人簡介學院狀況和校園遊。跟著數天我們旁聽了兩次課—二年級是上神經解剖，生化實驗；三年級上內、外科的臨床課；在第二附屬醫院參觀了兩個手術—針刺麻醉甲狀腺腫瘤切除和心膈膜修補（ＶＳＤ）；訪問了腫瘤醫院；參加一些學術報告會，內容包括針灸其原理及近期發展、斷肢再植，風動開顱器的介紹，還觀看了一些自製的教學電影。此外我們還參觀了廣州近郊的羅岡人民公社，訪問了公社衞生院和赤脚醫生座談，了解中國農村的醫療狀況。我們還有機會和廣東省衞生局負責同志暢談了一個晚上，使我們對現時衞生工作情況，有較詳細的了解。

比較特別的是我們安排了一次包括國內同學、醫生、老師的聯歡會。會上有各種表演、土風舞，氣氛融洽熱烈。還有一個晚上我們到他們的宿舍探訪他們，親身體驗了他們日常的生活，了解他們的思想。交流溝通的目標在輕鬆活潑的氣氛中達到。

我們還趁著星期天的方便，遊覽了風景優美的植物園，富有紀念價值的烈士陵園和黃花崗等等風景名勝。晚上的文娛很豐富：包括話劇「於無聲處」，有中央樂團、鋼琴家、小提琴家演出的音樂會等等。

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現時來說，中山醫學院的種種設備是比較簡陋

的。課室缺乏擴音設備、高枱投影機、幻燈機。一般都是利用掛圖及由老師在黑板上繪圖來解釋講授的內容。生化實驗中所用電泳儀器是老師利用糖果盒改裝的。雖然如此，同學們學習的熱情和老師的責任心都令人十分感動，給我們留下深刻的印象。

老師們教學態度認眞，善於將課程內容重點、提綱挈領，以同學能理解吸收的方法講授，而不會像輸送資料入電腦一般，教完所應教的就了事。他們除了教學外，還要編寫教材，帶研究生，還有自己的研究。工作是辛苦的，責任是重大的。但他們卻不以爲苦，都是幹勁十足，總希望在國家邁向現代化的過程多作貢獻。因此他們贏得了學生的尊敬和熱愛。

文革十年路綫的偏差令到教育質量普遍下降。這情況在外語方面尤其顯著。我們所接觸的同學都十分珍惜現時求學機會，非常用功讀書。每晚宿舍關燈後（下午十時半），他們就藉著路燈的燈光繼續溫習。他們也非常虛心，總渴望多接觸一點先進的知識技術。每次他們都有很多問題提出：像香港一般情況，我們的生活，特別是我們課程內容、教學方法、設備、學習的心得等等。尤其他們渴望掌握英文，常要求我們學習英文的方法，以英文來通訊等等。

學生年齡差別很大，由十多歲到三十歲，這是由於實行上山下鄉的政策的緣故。思想方面，一般來說並沒有太高的政治理論水平，對事物也有不同的看法。但是他們國家的觀念是很重的。

由於是新學制的第一批學生，要担負起填補文革以來培養人才的空白。他們所感到的壓力是很大的。但是他們精神愉快，信心滿懷。

在第二附屬醫院，外科的何教授負責向我們講解手術的過程。攀談之下，發覺我們一位團友的父親是他以前的大學同學，曾經一起參加過學生運動。何教授非常推崇我們學院的王源美教授，認爲他技術水平高、思維具邏輯性。又表示在他數次到中山醫學院講學。使他們學習了很多先進的東西，得益不少。

我們醫院的一些教授、講師在中山醫學院的知名度是很高的。例如在腫瘤醫院他們常提及何鴻超醫生，並說到他在中山醫學院合作研究鼻咽癌的成果。我們幾位團友遇到了他們中學的舊校友——現時生化講師。此外中山醫學院許多講師都有他們的同學在我們醫學院任教。他們都表示希望有機會能夠和舊同學、老朋友，互相探訪叙舊，交流學術、經驗，以致共同研究。

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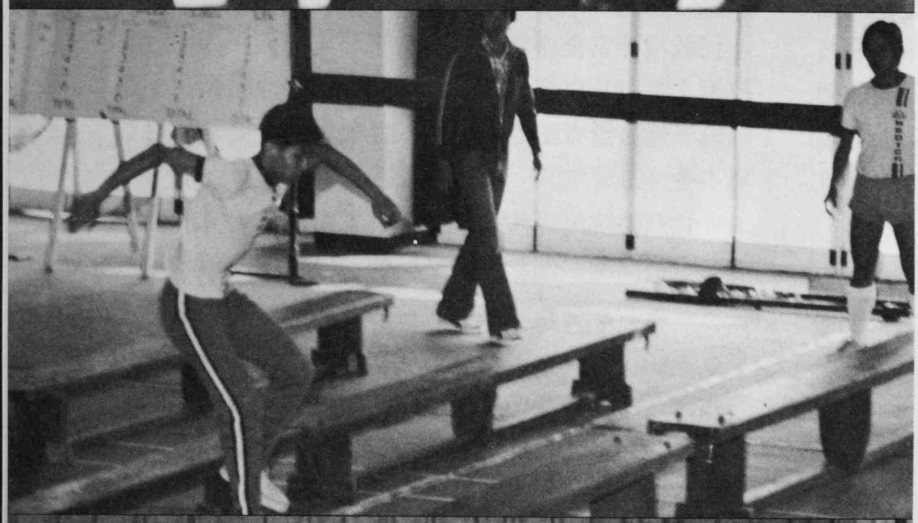
整次參觀訪問過程中，大家都採取開放、主動的態度。整個團氣氛輕鬆活潑、親切而不拘形式，大家暢談自己的見解。因此比較成功地達到互相了解、增進友誼的目的。八天很快的過去了，我們滿載著中山醫學院同學、老師的熱情和友誼回到香港。他們的熱誠、滿懷的自信、苦幹的精神，對前途的希望，深深感染了我們的團友。願他們在前進的道路上，衝破一切困難險阻，擺脫落後的狀況。

後記：我們相信現時的接觸，只是友誼的開始，隨著兩院校校方、老師和同學之間友誼的建立，必然有更廣泛、更進一步的交流和合作，也就能夠互相促進，取長補短，共同提高我們大家在學術和服務的水平。

我們希望中山醫學院能派人回訪我們，看一看我們的實際情況，更深入了解我們、我們的醫學院。

這日子，看來不會遠了！



UNION FESTIVAL

Medical students had had a good time participating in the Union Festival organised by H.K.U.S.U. Unfortunately, the senior students missed a great deal of fun since they were preoccupied by their examinations.

As usual, the programme consisted of a variety of social and cultural activities including music, dance, drama, debate, painting, photography, bridge and games — as many as you could think of.

We received a thunder of applause during a conjoint performance with the Science students. Our praiseworthy efforts in the various competitions were ultimately rewarded by a glorious cup for the Champion. Last, but not least, it is the devotion and enthusiasm of our fellow students that we find most invaluable.

聖誕七八

Joy to the World, the Lord is come·····
Oh come, all ye faithful·····
·····we wish you a Merry Christmas,
and a Happy New Year.

陣陣的聖誕歌聲，從音樂室裏傳出，飄逸在白文遜樓內，大家都猛然醒覺，聖誕節又來了！

一夜之間，玻璃窗上多了一些雪花，天橋上出現了一張紅色的橫額，耀目的「普世歡騰」使人精神爲之一振，五個孩子臉的聖誕老人一齊揮手微笑，像是對著我們說：「噫，老兄，不要再呆在圖書館了，聖誕節都來了，快出來玩個飽吧！」

不錯，聖誕對我們來說，代表著Term Break、假期，是喘息、「追書」和旅遊的好機會，也是安排報佳音、聖誕舞會的時候。

參加報佳音的同學大部份都不是基督徒，其實是不配去「報」甚麼「佳音」的，但大家都覺得無論基督存在與否，聖誕已成爲一個普世歡騰的節日，我們很應該把歡樂和別人分享。當夜我們在電筒光下分別探了幾位講師和老人院。我們的歌聲大受Lecturers讚賞，但因時間急迫，他們一早準備的橙汁、糖果、電視，我們也無福消受。我們很晚才去到老人院，大部份的老人都上牀休息了，但是他們聽到歌聲，都紛紛在牀上和我們招手，有些還和我們一齊唱起來。我們唱得興起，在巴士上也唱起來，意外的是巴士上竟然沒有乘客理會我們。

幾部有關流行舞的電影在香港掀起了一陣Disco狂熱，所以今年的聖誕舞會也特別多人參加。正是「醫護人員一家親」，來賓大都是護士學生；但我們到會同學的動機都很不同，有些是爲興趣而來，有些是大夥兒一起來趁趁熱鬧，開開眼界，有些則是人情難卻，被迫來充撐場面，有些就採取「觀望態度」，但最有趣的，還是一些年年參加，年年「過」的同學，因爲不想破例而來。但無論如何，寬闊的陸佑堂當晚也顯得有點水洩不通；在紅、藍的燈光下，男男女女跟著音樂起舞，有此舞姿美妙，有些則敷衍了事，不管它是甚麼音樂，那一種舞，但求痛痛快快玩一晚。

聖誕就在Christmas Carols, Disco Music中過去了，明年的聖誕你又會怎樣渡過呢？在圖書館、教堂、還是睡房?!

健康的坪洲

李樹堅

「健康的坪洲」——從名字看來，這似乎是去年「健康的大澳」的延續。不錯，在形式上或服務的本質上皆與年前的暑期服務計劃大同小異，所不同之處乃是今年由一、二年級的同學共同組織及推行這項計劃；我們承接了往年的經驗，亦試圖在一些地方作較新的嘗試。

財源問題總是最傷腦筋的，這是籌委會在決定坪洲爲目的地外需要面對的首要問題。今年幸獲離島理民府青年事務署的贊助，加上醫學會的支持，已能夠解決部份問題，更有部份熱心同學發起籌款運動，一次別開生面的環島跑步以及八二班宴中的一些項目籌得不少款項，除卻這次計劃的開銷，還可供將來同類型的服務使用。

經過連串的籌備工作，在計劃正式推行前一個星期，我們亦舉行了一個籌備營，地點在坪洲志仁小學，即我們計劃進行時的大本營。是次籌備營之目的是讓各參加者有機會先熟習當地的情形，及了解整個計劃的詳情，可惜只有少數參加者出席了該次活動。

計劃推行的日子終於到了，七月十九日，大夥兒便開入坪洲，經過一天的準備工作，正式地打响了頭一炮——健康知識展覽會，同場亦爲參觀者量血壓，驗血型等，於當天晚上，我們舉行了一個名爲「歡樂在坪洲」的晚會招待坪洲的居民，並向他們宣傳我們的服務。

同學們每天都過着頗有規律的生活，清早起床，吃過早點後便開始一天的工作，有些出外宣傳或家訪，其餘的留在志仁小學裏爲展覽做講解員，或負責領導一些興趣小組。同學亦得輪流充任廚師爲大家燒飯菜；中午時，外出的同學都陸續回來了，大家又聚在一起同進午膳。

午餐過後，各人稍作休息又繼續工作。有時我們會分成小組，出外到較遠的地方替居民量血壓及傳播健康知識。黃昏時，我們又團敍於一起了，由於該所學校沒有浴室的設備，吃過飯後大家都趕緊到附近的公衆浴室洗澡，因爲開放時間有限，慢一步便關門了。

晚上的時間亦沒有讓它白白溜掉，我們曾去造訪一些非英聯邦醫生，舉辦老人晚會及幻燈放映。每晚十時後，一天的工作便完了，同學們敍在一起檢討當日的工作情況，喫過宵夜後才睡。

在整段時間內，我們亦曾探訪了一些小型工場，包括燈泡廠，彩瓷廠等。除了這些家庭式的工業外，還有牛皮廠，及規模更大的鋼管廠，同學們除了增廣見聞外，對坪洲的認識亦加深了不少。

這個計劃的推行，同學的努力固然重要，但有不少地方是有賴於當地年青人的協助，在鄉委會的介紹下，我們認識了一羣坪洲社區青年服務團的團員，幫助了我們解決不少技術上的困難。在合作之餘，我們亦特地抽了一天晚上招待這羣熱心的青年人，通過「經驗小組」的形式，大家得以有更深的了解；於翌日還來了一場籃球友誼賽，僥倖地我們以兩分之微取勝。在離別的前一晚，原定有一個惜別晚會招待坪洲區民的，但碍於天氣轉變，終於改爲與那羣幫了我們不少忙的朋友共同分享已預備好的節目；晚會結束後，大家還留在學校裏暢談至深夜。

翌日在絲絲細雨中，帶着依依不捨的心情，收拾好行裝，離開這個我們已建立了感情的地方。

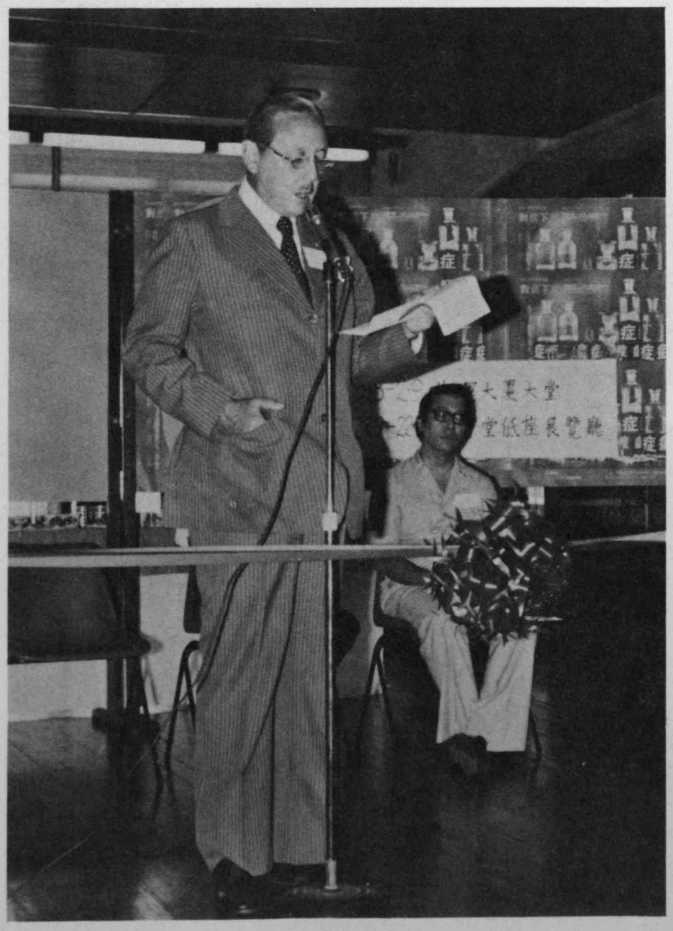
在關心社會的大前提下，同學們踏出了課堂，置身於人羣中去服務及學習，這對我們服務他人之心的培育是有其肯定的意義，若果能從觀察所得，加深層次去思考和討論亦會帶來一些對社會問題的認識。故此社會服務在適當的帶導下是值得在醫學院內舉辦的。

健展片語

陳家馴

吁一口氣，展覽終於結束了。作爲籌委會的一員，我不敢妄言今次展覽的成敗。但，一切事物的成敗得失，該從何角度去評價？又該由誰人去決定呢？

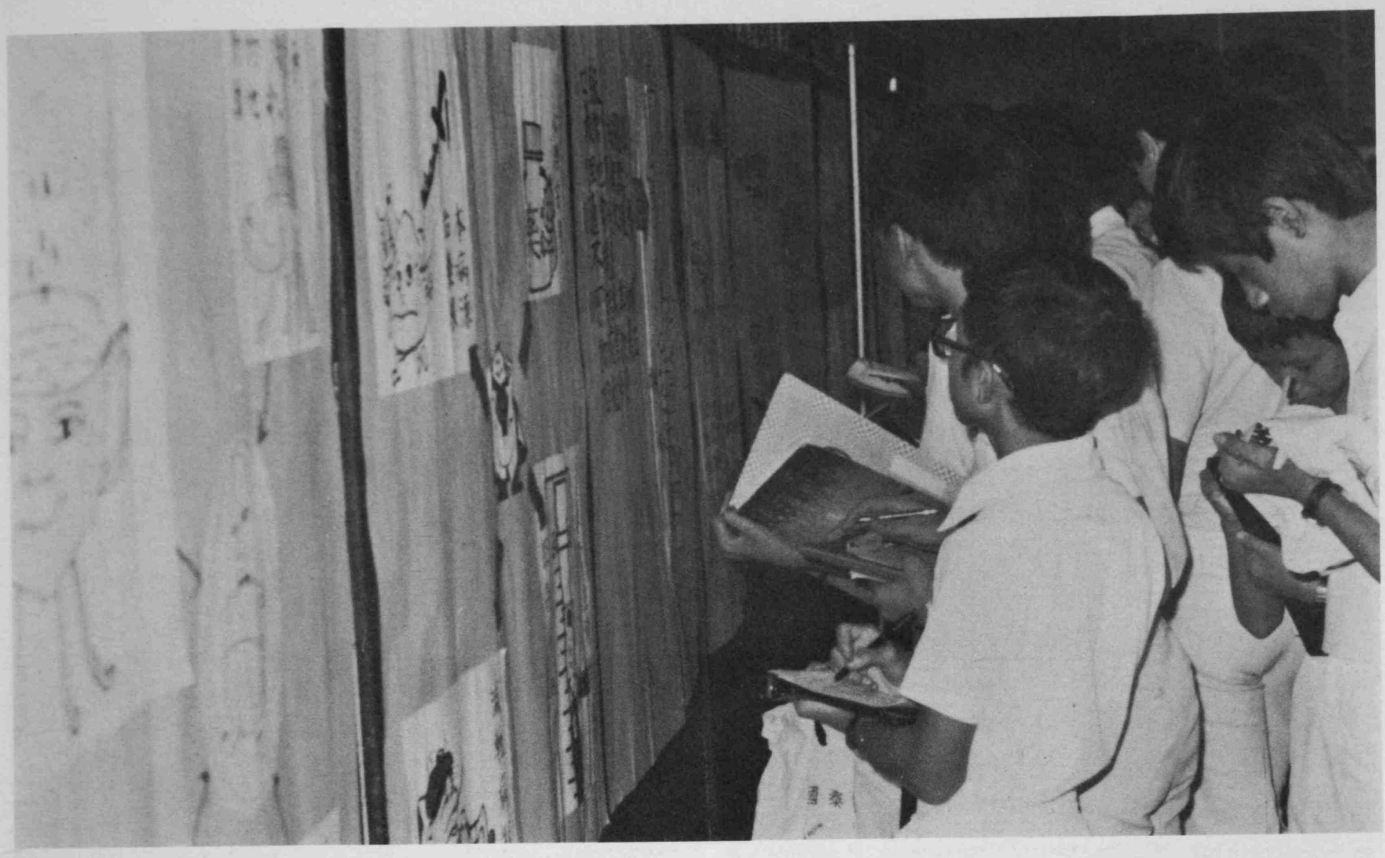
健康展覽一年復一年的舉辦，似乎已成了醫學會的例行公事。（更有甚者，某等機構好像已把「我們」的健展納入「他們」的財政預算，每年早已準備好若干數目以贊助展覽。）於是，每年便總會有那麼的一羣同學走出來開始各方面的籌備工作，實際上，也有這樣的一些市民，有心理準備的在每年九月前後便到大會堂走走，看看那些醫學生又弄了個什麼展覽出來。如是者，經過一連串的會議後，題目給定下了，贊助人請到了。籌欵的籌到經費，學術秘書們找到資料，宣傳的把展覽弄至街知巷聞。接着，參與工作的同學更多了——上數四、五年班的已忙得不可開交、頭昏轉向的師兄、師姊們，下至剛剛踏入醫學院大門的「新鮮人」小弟妹們，大家都來湊湊趣、幫幫忙。熱鬧了好一陣子，「擾攘」了一大番後，要參觀的來看過了，來遲一步的也望門輕嘆過了，展覽終於大功告成、功德完滿。也有一些同學又再檢討一番，爲來屆的展覽鋪路。



可是，在這整個過程的背後，我敢問一句，曾參與工作的、身爲贊助人的、捐過款的和參觀過的人，對於健展的意義瞭解又有幾許呢？而我們朝著這些方向所做到的又有多少呢？

肯定地說，每一次健展的籌委，在首數次會議時，必曾經討論過這問題。猶記我們第三次會議時論及展覽目的，也曾一口氣數出兩大綱領、八大要目的目標來。（當時正在做會議紀錄的我，差點兒給殺個措手不及呢！）一直以來，也不時有人大聲疾呼：請大家緊記健展的意義云云。然而，我有時也不禁懷疑——牢記了能否做得到？做到了便怎樣？做不到又怎樣？不爲什麼目標，純粹爲做展覽而做展覽又有何不可？說不定，就是這樣不知不覺地，我們便可以達到了一些所謂健展的目標呢！不過，我始終認爲健展有她一定的價值，循著一定的方向，我們也許能夠把她辦得更好。

爲了不要辜負一些同學曾徹夜思量，爲我們的「對症下藥——藥物常識展覽」定下了對外、對內洋洋八大點的目標，現在我特地把這幾點一一列出



，衆告周知如下：

對外：一、勸介市民，休要自我診斷。

二、澄清一些對用藥的錯誤觀念。

三、爲市民提供正確使用藥物的常識。

四、令市民認識清楚遵從醫生處方服藥之重要性。

對內：五、提高我們這一羣未來醫生於將來執業時對濫用藥物的警覺性。

六、提高醫學生的社會意識，作爲服務社會的一個機會。

七、增進各班同學之間的認識和感情。

八、作爲迎新的一部分。

「對外」的四點，我不知道我們做到了多少。但從約四萬的參觀人次，及（也不知是禍是福地）因展期遇上配藥員按章工作和配錯藥事件而引起某些報章上各種的輿論看來，今次展覽對社會人仕是曾作出一點影響的。

「對內」的四點中，第五、六兩點大家心裏有數，我無置喙之餘地。至於其他兩點，尚堪告慰的是八四新同學參與程度可稱踴躍，其他八零、八一、八二及八三各班同學出席率亦頗高。甚至曾有一位不知是何年畢業了的「超級大仙」到大會堂向我細問：「我哋醫學院嘅健展，今年搞成點呀？」大家關心和參與的熱情都很高。至於是否促進了彼此的友誼和給新同學作出了指引，則待日後可見。

最後，且讓我套用「是次展覽」的宣傳語句作一總結：

"We hold Exhibition for benefit, yet are liable to go astray!"

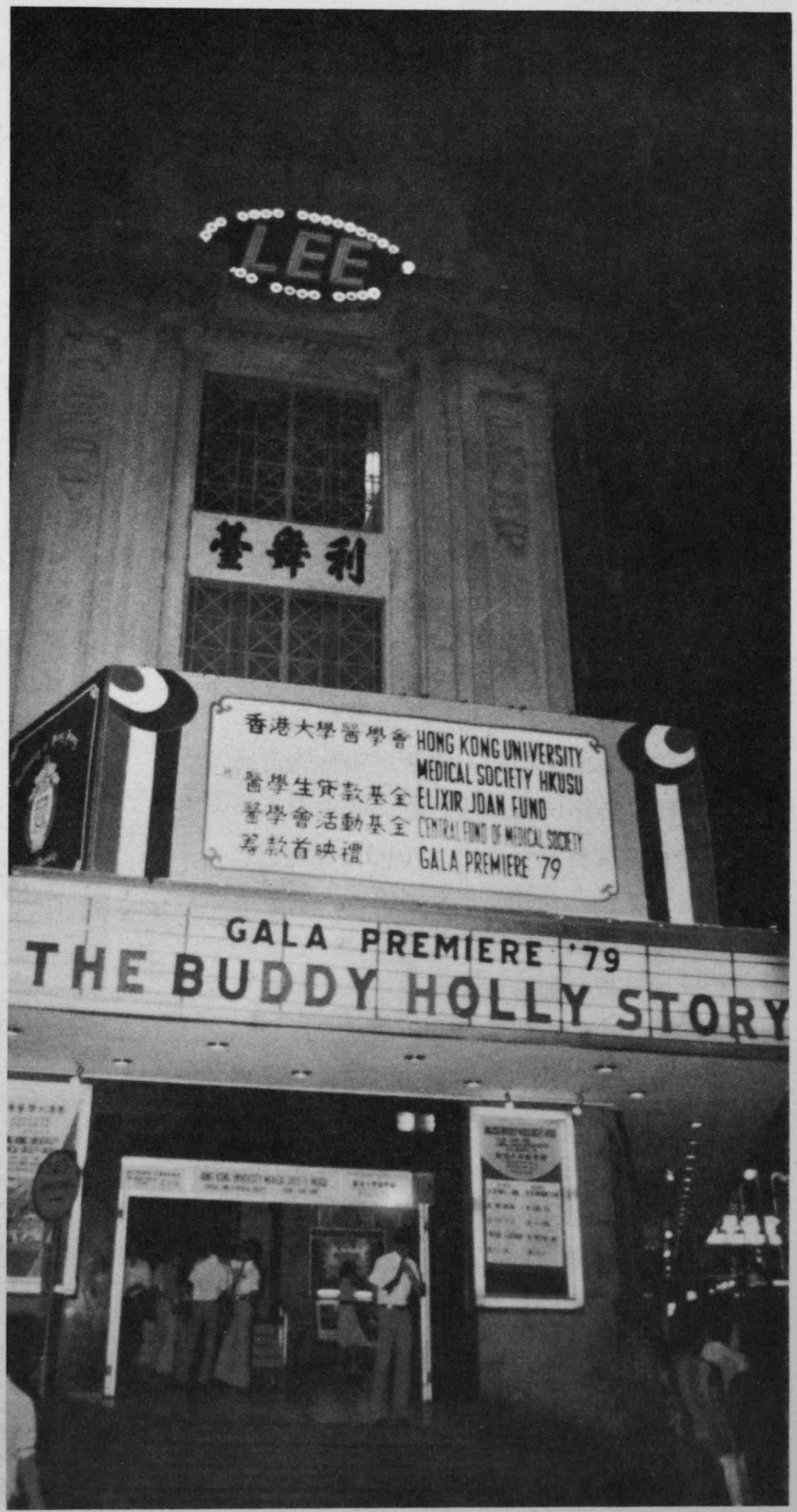
THE GALA PREMIERE '79

The Gala Premiere is a fund-raising project of the Medical Society, H.K.U.S.U.. This year's Gala featured "The Buddy Holly Story", starring Gary Busey, Don Stroud and Charles Martin Smith. It is the success story of Buddy Holly, a rock 'n' roll king in the late '50s.

The organizing committee started working since February, 1979. Our hard work was rewarded by having a near full-house on 18th July, at the Lee Theatre. This year's Gala raised more than HK$35,000.00, and the funds raised will contribute to the Elixir loan fund and also to the Central fund of the Medical Society to support various activities, e.g. the Health Exhibition, which takes place every year at the City Hall.

We had a lot of guests at the cocktail party at the Lee Theatre foyer that night. The President of the Medical Society, Dr. Ronald Ng, and the Chairman of the organizing committee, Mr. Tsui Hing Sum, each gave a speech; then came the presentation of souvenirs to our Patrons and Dr. Ronald Ng. The film show started shortly after this.

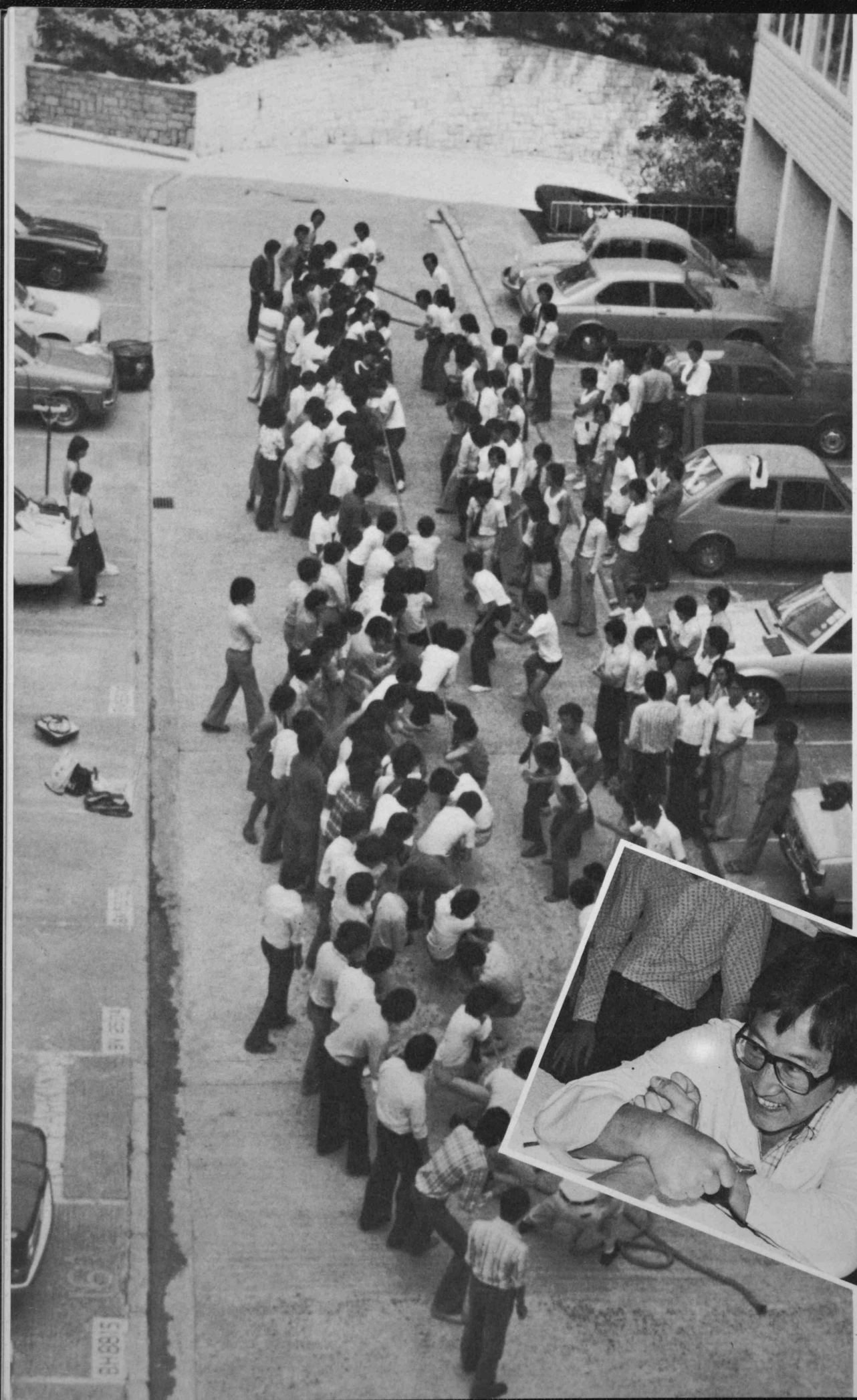
Besides being a fund-raising occasion, the Gala Premiere '79 had also succeeded in providing a chance for friends and members of the Medical field to get together and have some fun, which is in fact one of our aims.



MEDIC LAUNCH

Fifty of us enjoyed ourselves within a spacious launch on the 29th of September, 1979. It was supposed to be an occasion for greeting our new brothers and sisters. The purpose was defeated since the attendance was unexpectedly low.

However, nature had granted us an extremely fine weather; and very fortunately, no one was caught by a shark! We passed our time in a relaxing atmosphere — chatting, resting, fishing and bathing in the cool blue sea. It was a pity that many people could not share our fun.



MEDIC FESTIVAL '79

15th — 22nd October

So Lok Yee

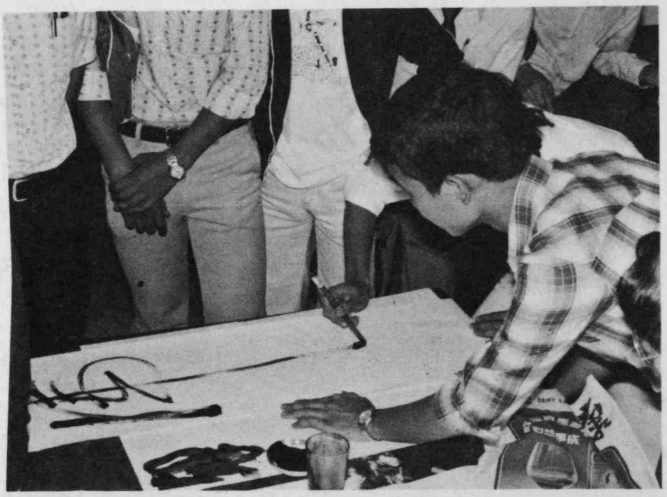
One was awaken in the midst of his studies when the Medic Centre was flooded with crowds, music, cheers and laughter. Needless to say, the Medic Festival was again on its way when you saw flags and banners flying around. The previous social secretary had started a new era in our social activities in introducing the Festival as many people anticipated the event this year. I am much indebted to him for the experience that had been passed on to me.

The aim of the Festival should be more than entertainment. As only a minority are concerned with the activities of the Society, it is designed to draw the attention of the members to their share in the Society. The programme is actually a "variety show" suiting people of different interests. The principle is to involve as many people as possible, whether in participation or organisation.

There is still room for improvement in organisation although the programmes ran smoothly on the whole. Many communication and technical problems have yet to be overcome. However, the Festival should not be assessed in terms of organisation. I would sacrifice the smooth running of programmes for recruiting more inexperienced workers.

The Festival received full attention from all years; I would like to take this opportunity to thank the Class Committees for their unfailing effort. We were particularly delighted when the final year students turned up in many of the programmes; it was a pity that they had tried but failed to form a choir. Finally, I must apologize for arranging the Festival in mid—October, instead of later (because of the 16th T.I.G.) since it proved to be a difficult task for the first year Class Committee in her urge for participation. It was happy to learn that their class spirit was elevated during the Festival.

In conclusion, the Medic Festival '79 was a success since its aim was reached, though to a limited extent.



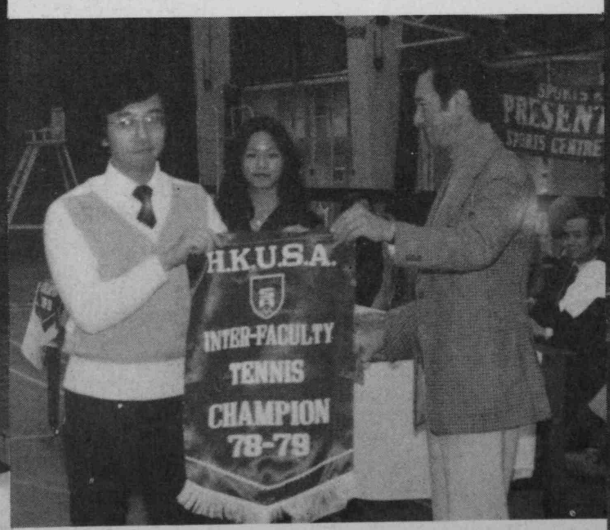
體育

每當同學們經過醫學生中心的 Common Room 時，相信都會留意到在走廊的兩面牆上，掛著大大小小、各種顏色的錦旗，也許仍然有很多人不知道那究竟是什麼東西；但這些旗幟，却是標示著醫學院的同學歷年來在體育方面驕人的成果。

那些大旗（和一些較小的），就是港大體育聯會每年所舉辦的（學）院際體育比賽的獎品，全年（學）院際總冠軍的學院，都可得到那一面大旗，名爲「亞米茄玫瑰盃」Omega Rose Bowl，較小的是頒與第二名的。比賽範圍包括各類球賽、田徑和游水等，經過一年的比賽，再將各項成績總結而定出名次，故此，每一面錦旗，都是醫學院同學幾經艱辛，在比賽中流汗、流血所爭取回來的。只是，除了曾經參與的同學外，又有多少人能夠明瞭到錦旗得來不易呢。

從錦旗的數目，大家都可以想見得到醫學院的同學在體育方面是出色的，特別是我們屢屢打敗勁敵工程學院而奪標。但在去年，我們保持了多年的優勢却被工程學院以不算少的比數取去了，而另一個令人担心的現象却出現了：在低年班同學中，對體育活動有興趣投入的並不多見，這種情況，在棍網球、壘球和曲棍球上尤爲明顯。這不禁叫人爲醫學院以後的體育活動憂心。再者，在比賽時，亦往往有球員缺席、遲到等。至於到場參觀和打氣的同學，更是絕無僅有的了，甚至於一些重要的決賽、水運會等，亦只有三兩個同學到場，或順道經過時叫喊一兩聲而已。

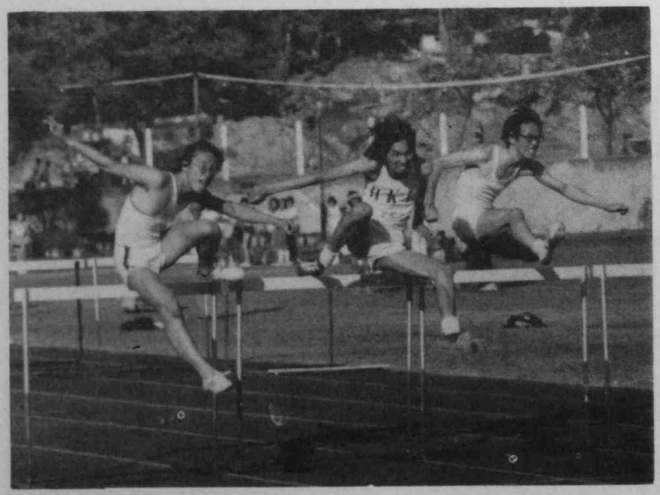
究竟是什麼原因令致出現這個危機的呢？也許，這是與醫學院的課程更改有關係，在「新臨床前

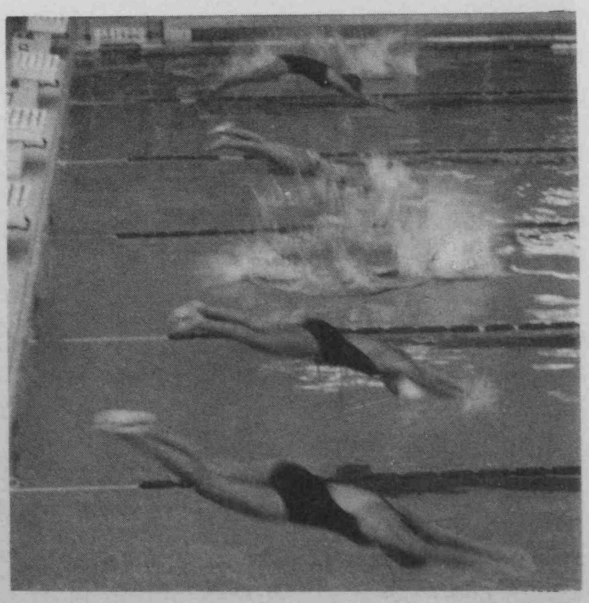


課程」推行之前，一年級的醫學生是無須考試的，故此同學們都能夠抽出較多的時間去參予體育活動，而當在第一年學會了各種球類和有所參予後，在以後的幾年，很容易就會繼續下去，發展這方面的活動。而且，醫學院的五年課程，更利於培養體育健將（這一點，在壘球、棍網球方面尤爲顯著，因同學多數均在大學裏才初次接觸這兩種球類活動）。於是，醫學生乃建立起在運動方面的聲譽。再說在新課程推行之後，一年級就有學位考試，新同學在進入大學之初，正想嘗試大學裏各種活動時，就被這個考試嚇怕了。讀書、溫習便取締了到體育中心的時間。這個習慣，若不能在低年級時培養好，隨著升上到高年班時，功課的增加就更加令同學不能去參加體育活動了。

也許，這個說法太悲觀一點，但低年班已較少參予體育活動却是事實。在這情況下，我們要重振醫學院在體育的威望就更需要大家同學的加强參予和關心，如有興趣於球類活動的同學抽更多的時間去練習，而其他的同學，亦應多留意體育的動態，在比賽時，到場爲運動員打氣。當然，這些是須要同學們在時間上作出安排的了。

另一點，相信也與這個現象有關的，就是近年來，醫學院的同學有很多都積極參予社會性的活動，如「認中關社」等，乃佔去同學不少的課餘時間。當然，課外活動的參予，是每一位同學本身的取斷，是以自己的興趣、能力和價值觀作取捨的。但是，一如大家熟識的一句話，「健全的精神，寓於健全的身體」，希望大家同學都能愼重考慮運動的價值，進而認識到在醫學院推廣運動的重要性，我們所珍惜的，不是那面美麗的錦旗，而是透過積極的參予，以普遍提高同學對體育的興趣，更平衡地發展各類課外活動；而最後，就是成爲一個身、心健全的好醫生。



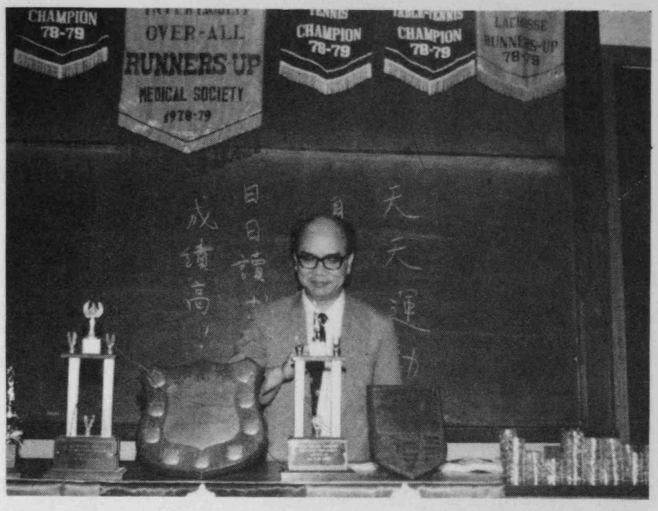


體育活動成績

A. 院際比賽：

我們在七八至七九年度院際體育比賽獲得亞軍。在各場比賽中，我們的運動員都很盡力，得到優良的成績。其中游泳、乒乓球、網球、壘球及壁球得冠軍，棍網球得亞軍而曲棍球、籃球、排球及田徑得季軍。

至於七九至八〇年度，在七九年十一月十七日舉行的水運會裏，我們已贏得男子冠軍、女子亞軍及總冠軍。



B. 班際比賽：

總冠軍(Dr. Frank Cheng Shield)：Medic 82

男子冠軍(Dr. T. K. Chan Trophy)：Medic 82

女子冠軍(Dr. H. Y. C. Liu Trophy)：Medic 82

總亞軍：Medic 81

網球冠軍(Dr. John Lawton Shield)：Medic 80

越野賽冠軍(Pharmacology Dept. Shield)：

Medic 82

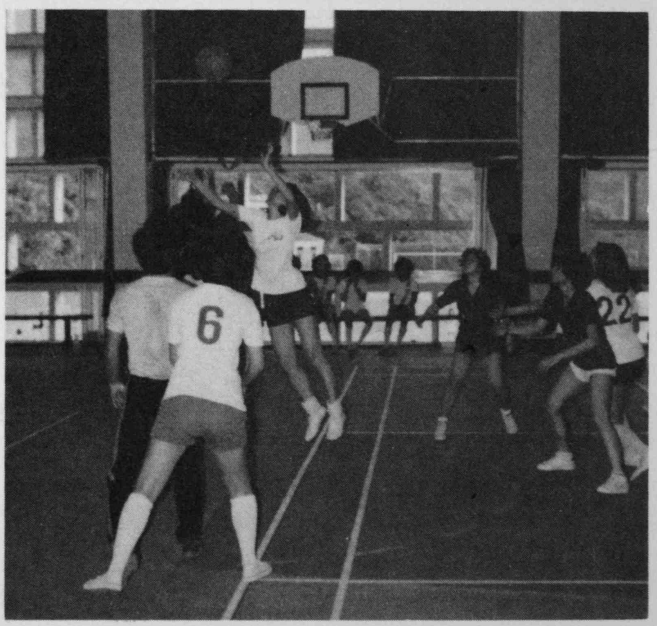
於七九年四月十二日舉行的班際田徑比賽是今年度新辦的，成績如下：

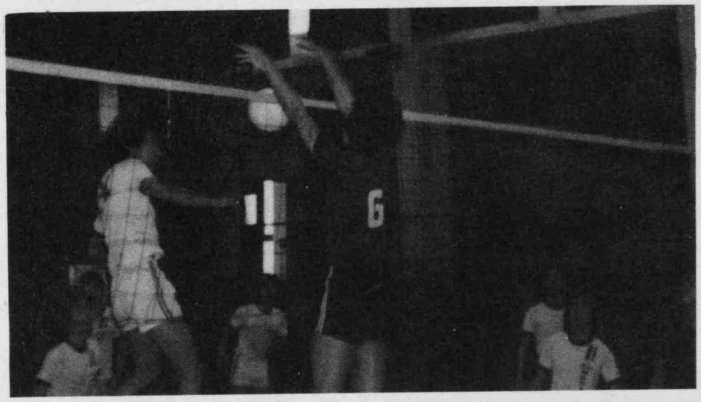
男子冠軍：Medic 82

女子冠軍：Medic 82

總冠軍　：Medic 82

總亞軍　：Medic 83






INTER-FACULTY
TENNIS
INTER-FACULTY
TABLE-TENNIS
CHAMPION
78-79

艇戶事件的早期及重整階段

七七年中，油麻地艇戶開始爭取本身權益，向社會人仕吐露居住環境的惡劣情況，及希望政府能安置上岸居住。港大學生會下數個屬會曾發動了一次社訪，以瞭解艇戶居處的實際情況。七八年初，學生會組織了一次大型的調查及一次「一人一船」的簽信運動，希望政府能夠正視這個問題。

在此之後，支持艇戶上岸的行動開始冷却下來，並且重新進行組織工作，成立「支持艇戶爭取上岸聯合委員會」。港大學生會的艇戶調查報告在暑假發表，曾在這寂靜的時刻引起了輿論的一點漣漪。至七八年底，政府發表公佈攻擊艇戶要求上岸是「打尖」的行爲及指責艇戶其中有不少是非法移民。聯委會方面也作出反應指出政府公佈不符事實。十月二十四日，艇戶及「聯委會」決定到港督府請願，中途被警方攔截，並且警告如果不立刻疏散而堅持要進行請願的，便會被拘捕及控告，當時，請願行動被迫取銷。一月七日，艇戶準備再到港督府請願，由於有上次的經歷，所以這次請願是很有可能在冒着被捕的風險下進行的，結果艇戶及支持艇戶爭取上岸的各界在出發途中被捕。

其實，自從七八年學生會組織艇戶調查的計劃以來，醫學院已有不少同學參予關心艇戶爭取上岸的工作。因此，對整件事件是早有較深入的瞭解的，而且從來也只有通過親身的參與，才能夠建立一股對低下階層深厚的感情，也祇有這樣才能產生無窮的熱誠，爲爭取艇戶上岸而努力；也祇有這樣才能言行更趨一致，與居民一同進退。

被捕事件以後

在一月七日事件發生以後，在醫學院內曾組織了一次座談會及一次電影放映，學生會方面也組織了一次社訪，以便一般同學能夠對事件有進一步的掌握。雖然一月七日的被捕事件能夠重新喚起了同學對艇戶問題的關切，但是普遍仍有一種傾向就是靜待事物發展的態度。這時候，艇戶問題進入了一個雙線發展的階段，一方面是艇戶的繼續爭取上岸，另一線是這次被捕所涉及的市民的和平請願權利問題，這兩個主線，在判決以後繼續發展及鞏固下來。二月十三日，法庭宣判七十六人全部罪名成立，艇戶代表不留案底，另外十一人包括神父、醫生、社工及大專學生被重判留案底及簽保守行爲十八個月。

在這事件中，可以看出政府對居民爭取權益運動所採取的手段，就是要努力操縱及設法打擊。現存的公安條例賦予政府無窮的權力去操縱及打擊居民的集體行動。另外便衣警察亦主動「探訪」艇戶，以達到恐嚇及分化的作用。同時，海事處的驗艇工作，也可以將一些有利於政府的數字源源不絕地公佈。二月十三日這個政治性的判決，是要告訴支持艇戶爭取上岸的人士不要再和窮者及受壓逼者連結在一起。

法庭宣判以後

法庭的宣判，惹起了社會的强烈反應，在同學之中，所喚起的不再是冷眼旁觀的關心，而且要求起來行動，在一次討論會中，余德新醫生表達了一個親身參予者的感受，指出了每個人在社會的責任及使命。

同學的反應，出現在飯堂外的大字報裏，在敢思的艇戶特輯裏及評議會所發表的聲明中，可惜的是這股熱烘烘的氣候，祇能維持在這段期間內。

縱然，學生的力量有限，要針對政府的政策每有力有不逮的感覺，但是艇戶帶起了對房屋政策、法律問題、市民權利等方面的討論，加深了對社會規律的看法。雖然曾經與艇戶共進退的人不多，但却製造了機會讓他們的感受與別人溝通。

中文運動

周樹立

中文運動的發展始於一九七〇年，當時曾引起社會各階層人仕團結一致，共同爭取中文應有的地位，成爲自六七暴動後一次大規模的社會運動。雖然當時聲勢頗爲浩大，但行動的形式則甚爲溫和，而在政府推出「公事上應用中文問題研究委員會」成立後，運動便逐漸平靜下去。

到去年五月間，考試局公佈有關高等及高級程度會考的投考資格，新制實行後，中文變成選修科目，中文及格與否，對兩個考試的投考資格毫無影響，如果新制獲得實行，肯定會加劇香港重英輕中的畸形趨勢。

十一月間，港大學生會成立一專責小組，開始走訪各單位。這時，校內有不少大字報討論中文地位問題，其中不少是醫學院同學所寫的，總算在開學不久的時間內，引起校園一陣討論社會問題的氣氛。

中運能夠引起校內廣泛的反應，由於本身有一定的羣衆基礎，其中有關心中文問題的、有關心社會問題、有專修中文的，這樣便能夠聯成一條陣綫，而普遍的同學也感覺到中文本身在香港受歧視及中文水平有日漸衰落的趨勢，能夠重新提高中文地位，提高中文水平，成爲一種比較切身的要求。

中運的目標之一是要爭取中學使用母語教學，這裏，有不少熱心人仕曾作過研究，指出外語教學使學生在吸收知識、思考、表達創作力各方面都受阻碍，而且只有少數學生能適應英文教育。

事實上，提高中文地位並非貶低英文的重要性，而研究所指出的就是中文教學能更有效地使學生受益，另一方面，也使英語的教育更有效地發揮她的功能。學生輔導處的白爾斯先生曾在交流中著文挑惕港大同學的英文水平及對英文的態度，自然迅速受到同學的駁斥。

中運也曾提到「自强」的意義，所謂「自强運動」，就是要求我們自己對中文加以重視，平時說話，寫文章多點留心。那時候，大家都似乎多留意中文，大家報中的錯字，經常被人看出及要求改正，可惜「自强運動」並沒有進一步內容。

在同學中當討論到中學使用母語教學時，都覺得這是最有價值的，不過仍需待專家制訂具體的辦法，方有實現的可能。不過，既然母語教學的價值已肯定，而且政府也曾表示英文授課，增加了學生在學習上的負担，却又不積極去改革語文教學？單憑熱心人士利用他們工餘的精力去研究，而袖手旁觀，這是甚麼態度。

本來，對於社會不平，申張正義，從整個社會來看，大學生有可能成爲一個積極的階層。但是，在香港能進入大學的是社會中的少數，也是社會的既得利益者，也由此造成大學生的保守性。再加上種種理由，中運的前景仍要待熱心人仕的發掘。


ILSHU-FAN

SOCIETY PHOTOGRAPH

啟思

香港大學學生會醫學會刊物

CADUCEUS

HKUSU Medical Society Publication

在今年學期初的時候，我們曾以資料册方式介紹啓思編委會內的一切給新同學，這樣子介紹常務委員會確是前所未有，方法不錯，只可惜印費不輕，現想借杏雨之珍貴版面，公諸其部分內容出來。

一、辦報的理想：

啓思不只是編委會的報紙，更是七百五十位醫學生共同的報紙，我們辦報，不是爲編委而辦，而是爲服務同學而辦的。我們爲同學辦啓思，是有我們的理想，理想中希望達致：——

（一）增加同學、老師之間，高低班之間的溝通，使不相熟的同學能從啓思這橋樑得到互相了解大家的生活、理想和讀書的情況。

（二）提高同學對社會（尤其醫療制度）、國家的認識，使同學作爲一個醫學生，也同時是一個生活在這個時代的人，對這個時代盡一點了解的責任。

（三）鼓勵同學參加醫學會的活動，在歡樂羣體之氣氛下對未來的責任共同探索。

我們當然不贊成啓思成爲同學們茶餘飯後的消遣品，我們希望能在團結的氣氛下攜手互勉，爲印證理想而努力。

二、編委會內的共同精神：

參加編委會，不是出來「打份牛工」，在一個有相當人數的團體裏，是需要有不同程度的精神和事物，作爲集體的維繫力；「各適其式，各盡所長，建立友誼，團結進步」，就是大家的一個起碼的共同精神。

「各適其式，各盡所長」，就是使編委能發揮個人潛能，發展個人之獨立思考；「建立友誼」，了解自己，加强與別人溝通，建立友誼，爲追尋理想而努力；「團結進步」，爲探索我們未來服務社會的責任而共同邁進。

三、選稿時之處理方法：

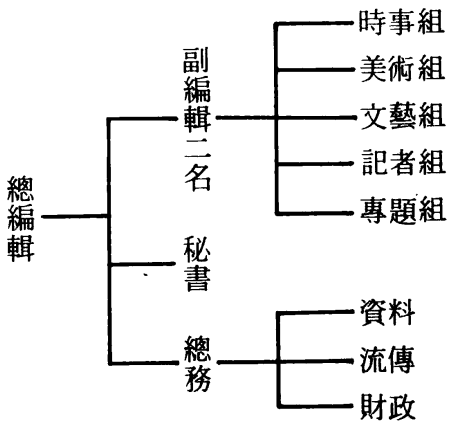
我們的選稿原則，可見於報章上，這裏要提的是在處理稿件時，根據原則之下的一些處理方法。

基本上來稿大多數會照登的，遇上一些具討論性質，或內容論據而未爲大多數編委所瞭解，或我們從本身的經驗和認識範圍內發覺文章列舉的與事實不符，或有人身攻擊之嫌，我們都會經編委會討論及議決登或不登載；當然，做編輯會（在情理上，並非稿例上）向作者解釋不刊登之原因。

要一提的是當文章的觀點、立場與編委會相左時，我們從辦報的態度一定不會以此爲基礎對文章加以扣壓，除非作品本身犯上稿例之原則等。

四、編委會的內部組織：

因參予會務的同學不少，所以我們已採取了分組的工作模式，而以共同精神及集體性活動爲全會之內部維繫，相信在未來的歲月中，分組爲大勢所趨，結構會更細緻。

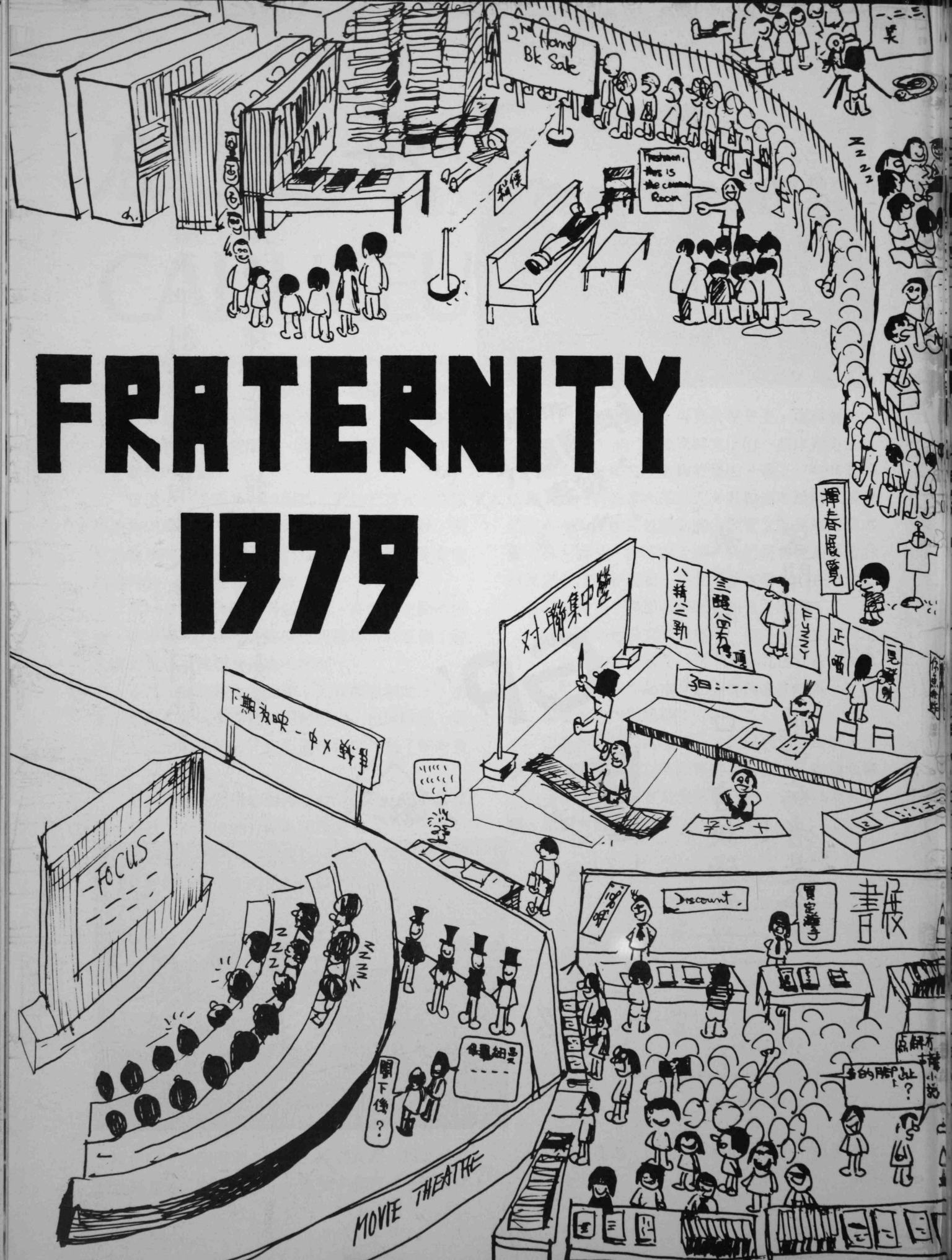


（此外，還邀請一位老師爲顧問，並有一名去屆代表。）

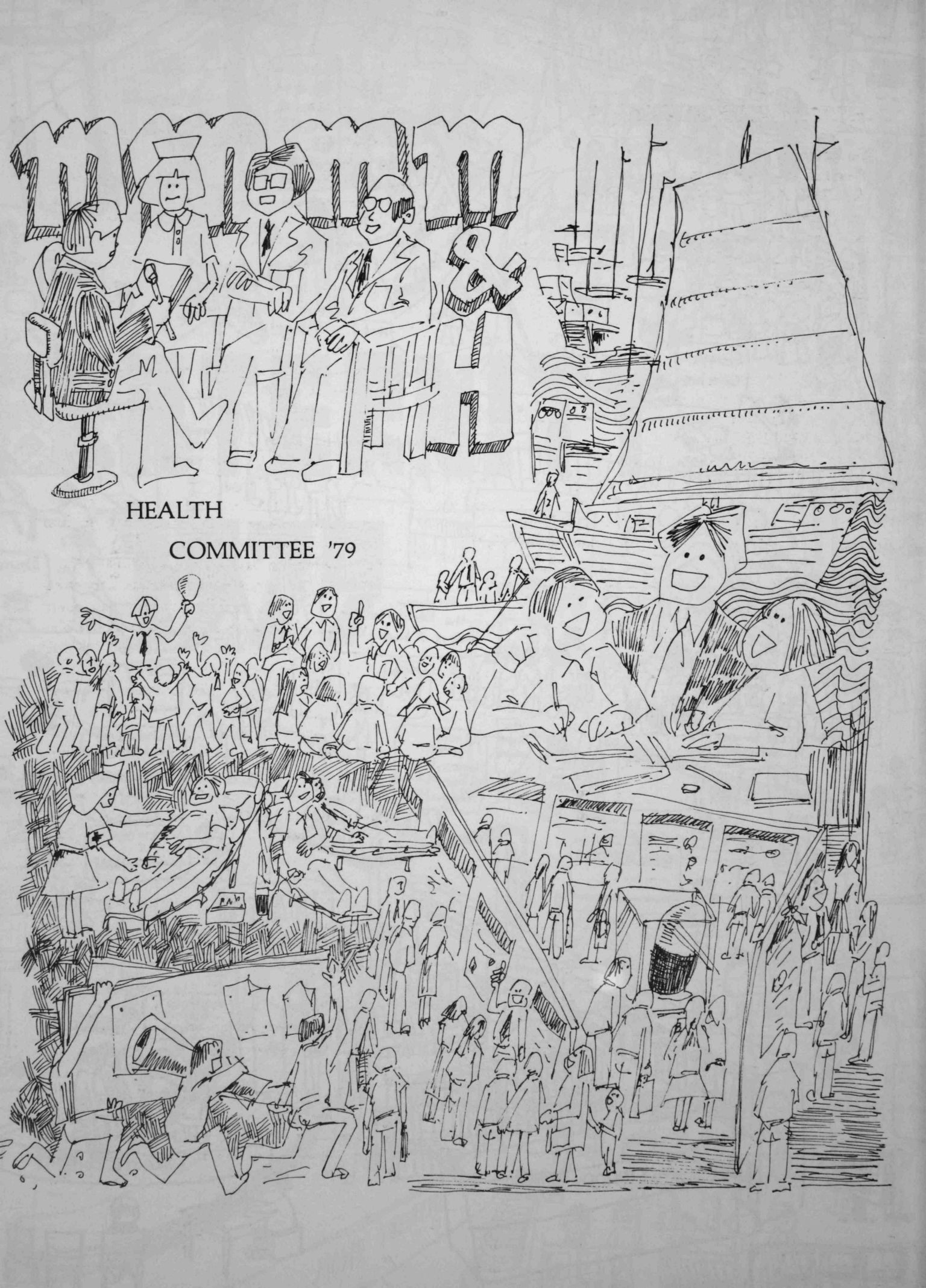
療

啟后承平創新頁，馬壯人精心同往；
思潮湧溢揮妙筆，龍吟虎嘯氣如虹。

放認關爭，口裡言談皆實話；
望聞問切，眼中病者是全人。


2nd Hand Bk Sale
Freshman: Here is the common Room
FRATERNITY
1979
FOCUS
MOVIE THEATRE
Discount


Bingo!
FRATERNITY CAMP
Talent show
GroupA come here
* Sigh *
Toilet
Film
Slide
Dear Freshman, this is the Patrick Mansion, that is X building etcetc.
Film & Talk for you mathematics
Mathematics Day
you need partner, lesson, Bloom & Faucett & Olympus Mic.
T-shirt sale
Hey, come & get your MBrisk Card
TIPS INCLUDED !!!
A card in need is a card in dead
Excuse me Can you tell me where the library is
I don't know either
LIBRARY
Library tour
LUNCH TIME CONCERT
LUNCH BOX
Music is good to your health
Down N
ALONG


HEALTH
COMMITTEE '79

HEALTH COMMITTEE '79

Structure:

Based mainly on three units:

A. Study Group on Hong Kong Medical and Health Service
B. Social Service Group
C. Health Exhibition Organising Committee

Study Group on Hong Kong Medical and Health Service

Activities include:

(i) Study group meetings with discussions on
  — "Assessment of the needs of medical and health service in general";
  — "The structure of the Hong Kong Medical and Health Service" and
  — "Community Health Concepts".
(ii) Visits: to Dr. Denny M. H. Hwang, Professor
(iii) Project: "An analytical study of medical and health care concepts and their application to the Hong Kong situation" (香港醫療專探)
(iv) A study on the Government Nurses Salary Affair

The Social Service Group

(i) Social Service Project at Aberdeen
  (a) **Nature:** a joint function with the Aberdeen Kai Fong Association Community Centre.
  (b) **Aims:** 1) To launch a brief survey of the needs for health care in Aberdeen as an example of a small community.
  2) To give social services related to "Community Health" to Aberdeen residents.
  (c) **Activities:**
  1) Regular tuition given on every Saturday to secondary school students in the Community Centre from January to April.
  2) Talks on "Hypertension", "Smoking and Drinking", "Sex and Health" with a blood pressure measurement service and a film show on "Sex and Health".
  3) Quizes: "健康常識問答比賽"in April and May.
(ii) A brief study on the concepts of "Community Health" and visit to the Kwun Tong Community Health Project.
(iii) A re-assessment of the feasibility and needs for a "Social Service Unit" in Medical Society was made in October.

Health Exhibition on "Drugs: Safe and Effective Ultilization"

The Exhibition took the form of a mobile exhibition at:

(i) Ocean Terminal (31.8.79 to 2.9.79)
(ii) Tai Wo Hau Community Centre (11.9.79 to 14.9.79.)
(iii) Aberdeen Community Centre (15.9.79 to 17.9.79)
(iv) City Hall (18.9.79 to 22.9. 79)

The content of the exhibition was divided into 3 major sections:

(i) General pharmacokinetics
(ii) Proper usage of some common drugs
(iii) Proper usage of drugs in special periods of life: infancy, pregnancy and senescence.

The number of visitors totalled 43,000.

Miscellaneous activities

(i) **Preview Camp** at Cheung Chau.
(ii) **Sex Education (May, 1979)**
This was given to the F.4 & 5 students of Rev. Holm Glad College. A talk was given by medical students and group discussions held;
(iii) **Blood Donation Arrangements (April, 1979)**
(iv) 腎臟常識展覽 **and Kidney Donation Campaign (May, 1979)** organised by Peninsula Jaycees in collaboration with Hong Kong Society of Nephrology, with assistance from Medical Social HKUSU. Venue of Exhibition: Ocean Terminal.
(v) **Assistance to Tai Wo Hau Community Health Project (June to September, 1979)**
Assistance given included general advice, talks and group discussion on aspects of health; training of volunteer workers for and conduction of blood pressure measurements and urine test.
(vi) **Exhibition on Child Health in Hong Kong (August, 1979)** organised by Hong Kong Paediatrics Society, in collaboration with Hong Kong Dental Association and Medical Society HKUSU.
(vii) **Freshman Orientation (April to September, 1979)**
(a) Representatives from the committee participated in the planning and preparatory work of the orientation.
(b) A tea-gathering was organized jointly with the Caduceus Committee in late September.
(viii) **Assistance to Elderly Health Sector of** 九龍城寨家庭生活週 **Project (July, 1979)**
Functions included slide shows, group discussions and blood pressure measurements.
(ix) **Blood Donation Campaign (November, 1979)**
(x) **Assistance to the preparation of the Wanchai Health Day (September to December, 1979)** organised by the Wanchai City District Office.

成長中的醫學院合唱團

一九七七年：醫學院合唱團終於正式成立，並隸屬兄弟會。但是，除了幾位熱心的高班同學之外，當時的合唱團其實與八二的班合唱團無異。

一九七八年：在迎新營中，通過十數位合唱團團員的演出，亦察覺到合唱團的成立。因自己對歌唱亦有少許認識，毫不猶疑便加入了合唱團了——合唱團從此亦不只是八二的世界了。

開課不久，爲了準備在 MUSIC NITE的演出，合唱團亦展開第一次練習，到了音樂室，已認得幾張相熟的面孔，對當時的環境亦不覺陌生。可是，經過第一次練習，實在覺得有點失望。因合唱團的水準，與自己在中學時參加的合唱團比較，實在有一段距離。但既然參加了，亦要硬著頭皮唱下去。經過指揮的悉心誘導，及各團員努力合作，結果在MUSIC NITE 中亦有相當的表現，更受到評判的讚許，對合唱團從此亦開始產生信心。

爲了聖誕節報佳音，合唱團亦展開第二階段的練習，記得其中有一首歌曲(MERRY CHRI－STMAS）難度相當，實在有點懷疑合唱團的能力，但經過各團員努力嘗試，亦終於把困難克服，以前的顧慮亦覺多餘。

午間音樂會過後，我們便把全副精神放在港大學生節上。通過指揮及各聲部的努力，除了充份表現出我們的合作精神，更促進各部的感情。練習之餘，大家有說有笑，氣氛融洽，已除去班級的隔膜。大家對合唱團在院際比賽的表現覺得很滿意，雖然不能奪魁，大家實在也不怎在乎，因其中我們已領略到一點歌唱的樂趣。

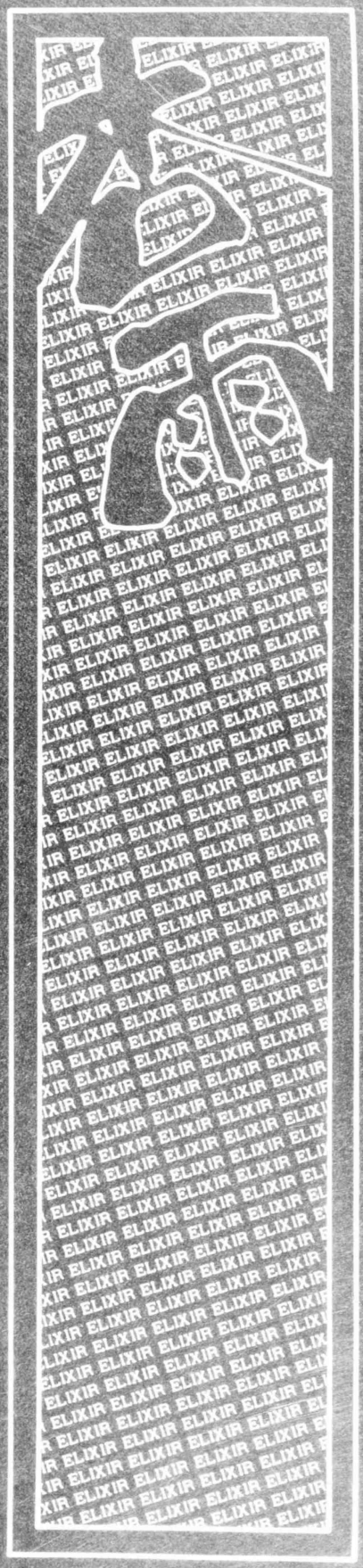
學生節過後，我們都面臨考試大關，有段時間，眞恐怕合唱團就此瓦解。可是，經過試後的聚會，已肯定來年的合唱團的前途，我們已有一定數目的支持者，我們的目標，就是希望招收更多的團員。

一九七九年：各團員在迎新營的努力，終於得到成果。在營中報名參加合唱團的八四同學，爲數三十多人，踴躍程度前所未見。八三大部份的女同學，亦相繼加入。

現在，合唱團已是八二、八三、八四的天下了。雖然聲勢浩大，但亦要抱著勝不驕，敗不餒的精神，一同邁向新的旅程，盡量作多方面的嘗試，以增加大家對歌唱的興趣，務求同學們在功課壓力下得以喘一口氣。

最後，要强調一點的，就是我們醫學院合唱團是爲所有對歌唱有興趣的同學而設的。整體的質素固然重要，但最終目的，都是希望同學可藉著自己的興趣，去盡量發展、伸延。「我恐怕唱得不好」已不是一個不參加合唱團的理由了。

一九八零年：？



DEPARTMENTAL SURVEY

DEPARTMENT
OF
OBSTETRICS & GYNAECOLOGY

Professor Ma Chung Ho Kei
M.B.,B.S. (H.K.); F.R.C.O.G.; J.P.

"Busy people actually have more time!"

Professor Ma was born in H.K. and was educated at St. Stephen's Girls' College. After obtaining the degrees of M.B.,B.S. at this University in 1958 she worked at the Queen Mary & the Tsan Yuk Hospitals until 1959 when she joined the University as a Clinical Assistant. She was appointed Assistant Lecturer in O. & G. in 1960. In 1962 she was awarded a British Commonwealth Scholarship & for the following two years was attached to University College Hospital & Hammersmith Hospital, London, & the University of Birmingham.

In 1964 she returned to H.K. & the Department of O. & G. as Lecturer. She spent the years 1966 to 1968 in the United States as Buswell Research Fellow & Instructor in O. & G. at the State University of New York at Buffalo. She was appointed Senior Lecturer in 1968.

Professor Ma became a Member of the Royal College of Obstetricians & Gynaecologists, London, in 1963 & a Fellow in 1971. From July 1, 1972, she has been appointed Professor of O. & G.

Concerning medical students in H.K., she feels that they are far too book and examination-orientated, passive & quite reluctant to work more on their own. This has been due to a number of reasons. First, the educational system in H.K. has been too examination-orientated, often neglecting the development of students' genuine interest in their studies. Secondly, probably owing to over-population, competition has been too keen so that a student can easily lose his preferred choice of future work once he makes a slip-up. Moreover, in H.K. the doctor's profession has been too elevated both with respect to its income & its status, so that students may often lose their true sense of future orientation.

Professor Ma also thinks that medical students should learn to be more social-conscious. "They need not necessarily go on strikes, but they should at least show some concern for Society," she said.

With reference to the new medical curriculum, she hopes that by reducing the time spent on systemic lecturing, students can spend more time on practical work in their clinical years, with the time of contact with patients being increased. The new curriculum also aims at decreasing finer details of a subject, with a view to enabling students to have a more lively & integrated understanding of principles & their applications. New courses such as Behavioural Sciences, moreover, intend to help us discover better the sociopsychological component of a disease, and this can often increase a doctor's competence in the treatment of a particular disease process.

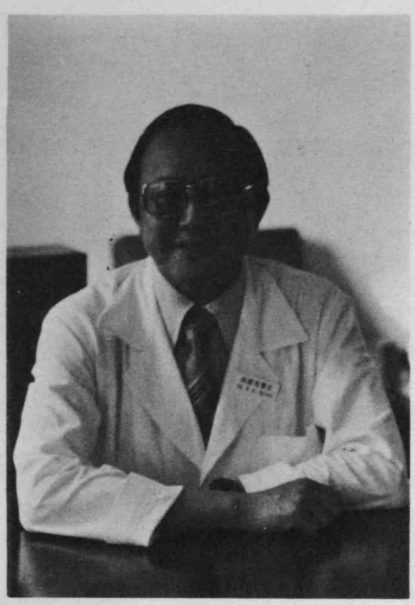
Regarding medical system in H.K., Professor Ma thinks that it is quite satisfactory. But the general public have not been sufficiently informed of health services in H.K.; hopefully this will improve as people's general educational standard improves. In addition, she finds it difficult to say whether the number of doctors is sufficient in H.K., because this depends on the specialty concerned, & that redundancy amongst General Practitioners in private practice is not uncommon, while sufficiency of the number of doctors is measured with respect to the number of vacancies in government Hospitals only.

On the subject of the admission policy of the Medical Faculty, Professor Ma is of opinion that there is no completely satisfactory selection method for admission in any country over the world. Although various methods such as aptitude test, study of personality profile, consideration of Principal's recommendations & interviewing have been tried in different countries, these all have their obvious shortcomings. In brief reality, the present policy in HK is the only practically feasible & objective method.

Insofar as the aims of University Education are concerned, she thinks that the University has done well in the inculcation of information, but has achieved relatively little in building up the student to be a complete person. For this, the present system of primary & secondary education is, of course, also to blame.

The policy of the Department, Professor Ma said, has been to provide adequate training not only in the technical aspect but also in the humanistic aspect. It also encourages research work on various subjects, so that continuous advances can be made.

Although her present post involves treating patients, administrative work, teaching as well as research, Prof. Ma puts the treatment of patients as her first & foremost aim in being a doctor. Understandably, she is greatly devoted to her work both in respect of time & mentality. However, she enjoys her work and said confidently that "Busy people actually have more time!"



"Housemanship offers an excellent chance to ....."

Dr. K.K. Yeung
M.B.,B.S., (H.K.); M.Sc. (Mich); F.R.C.O.G.

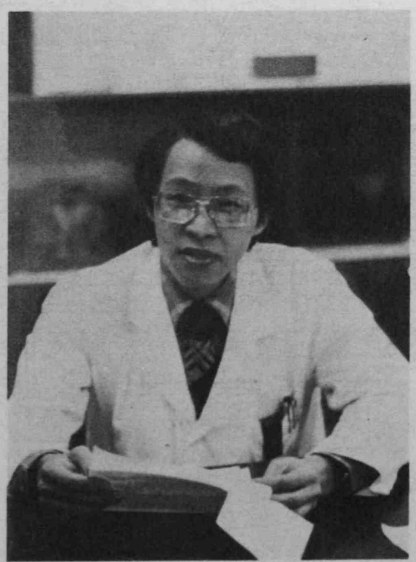
Dr. Yeung received his secondary schooling at Queen's College and graduated in Medicine in 1960 at the University of Hong Kong. He joined the department in 1961 as a Medical Officer for his training in O & G. In 1967, he went to England for his high degree and upon his return, joined the Department as a Lecturer in 1968. Between 1971 and 1972, Dr. Yeung spent his study leave in Ann Arbor, Michigan, U.S.A. and was awarded M.Sc. by the University of Michigan.

Dr. Yeung's primary interest is in the field of human reproduction. He has spent many years in the care of patients with infertility problems. Recently, he has completed with Dr. Christina Wang of the University Department of Medicine a WHO study on the effectiveness of cyproterone acetate as a male contraceptive. Taken orally by the male, this drug did effectively reduce both the count and motility of the sperms. However, it also at the same time decreased the level of circulating testosterone, resulting in a lowering of the sexual activity and enjoyment of its users. In Dr. Yeung's opinion, cyproterone acetate certainly is not a perfect male contraceptive by itself but further research on this drug used in combination with another agent, for example testosterone to counteract its antiandrogenic effect, may promise a new contraception for the male.

Concerning medical students in Hong Kong, Dr. Yeung is of the opinion that although they generally perform quite well in examinations, they are relatively lacking in initiative and rely too much on lectures and teaching from their tutors. This point is of particular relevance to the new medical curriculum, which has substantially shortened the total time of lecturing (in the O & G Department it has been reduced from about 55 to 25 lectures). As a consequence, subjects can only be covered briefly in lectures and the students will have to study more on their own. This can be a potential problem for our students. As for lecturers, subjects not well covered in lectures will have to be given in tutorials or teaching clinics and repetition of the same teaching will become necessary; this will demand more manpower. However, Dr. Yeung is confident that the University will have ways and means to deal with these shortcomings in time to come.

Dr. Yeung strongly feels that Housemanship offers an excellent chance to practise what one has learned from medical school and believes that a Housemanship of two years will be beneficial to our junior doctors.

Regarding his family, Dr. Yeung has a son and a daughter and spends most of his very little leisure time with them. He is satisfied with his life as a medical doctor and finds it increasingly enjoyable with each passing day.



"Medicine has its limitations. But....."

Dr. C.H. Tang
M.B.,B.S. (H.K.)

Dr. Tang matriculated from Queen's College and graduated in Medicine in 1975.

He did his internship at Tsan Yuk Hospital. After working for two years as a medical officer, he began his teaching career at the Department of O. & G. Together with his present training, he is now very busy at work and prepares to sit for his M.R.C.O.G. Examination in May 1980. He hopes to specialise in Endocrinology in the future.

Dr. Tang admits that Medicine has its obvious limitations. But with continuous research work, further advances will be made towards the betterment of health. As with the antibiotic breakthrough, Dr. Tang feels confident that through intensive oncological research, a similar breakthrough to combat malignant diseases will be made in the future.

Dr. Tang is interested in reading and strolling.

Dr. Rosamond Wong L.C.
M.B.,B.S. (H.K.); M.R.C.O.G.

Dr. Wong received her secondary education at St. Paul's Co-educational College. She was one of the twelve females amongst the 70 graduates in medicine in the year 1959. Interest has been a major factor in her decision to join the University as a lecturer, though to some extent this is also a matter of opportunity.

She feels that medical students here have a good command of the theoretical background of knowledge and are industrious; but they often lack understanding & insight into the crux of a subject, and as such are relatively weak on the practical side. For this the educational system should probably take the biggest blame. Nowadays medical students have begun to step out of the cocoon of medical field & have shown increased concern towards community affairs.

In this connexion she gives us the following advice on what to do in our summer holiday — of course for those who like it — 'Never shut yourself in a room and study; try to participate in whatever businesses with an aim to understanding the difficulties of others.'

On the subject of the policy of admission into the Medical Faculty, she agrees that admission based purely on academic results is nonetheless the most objective method really available. And insofar as reliability is concerned, a 5 to 10 minutes' interview equally cannot guarantee the selection of the most suitable students.

Dr. Wong points out that a sound basic knowledge of preclinical subjects will greatly facilitate our further studies in clinical years. After all, enlightenment consists in a gradual buildup of knowledge. Besides, a course of Behavioural Science would greatly benefit students by enabling them to have a better understanding of the more appropriate ways to deal with patients in their entirety.

Dr. Wong thinks that a good doctor should be competent, be concerned about the patient, and be capable of inspiring confidence on them.

The life of a doctor is never ever easy for it is, so to speak, a job of 24 hours. There is no solid schedule of work. 'Once you get into the system, you are stuck with it.' Dr. Wong said. But after all these years, she has become more or less adapted to the system so that her role as a doctor has only the minimum interference to the other side of her life beyond the white gown.

"Never shut yourself in a room and study; try to ....."

Dr. So Luk Kan
M.B.,B.S. (H.K.); M.R.C.O.G.

A former girl of St. Paul Co-educational College, Dr. So graduated in medicine in 1971. Since then she has mainly worked in the O. & G. Department at Queen Mary Hospital.

Dr. So has interest in both teaching & clinical work, and actually finds the two inseparable. She feels that medical students in H.K. are too dependent on lectures and should have a more explorative mind so as to work more on their own. For instance, seeing more cases in the ward and talking more to patients will prove very fruitful to their future work and contacts with patients. Moreover, brief preparatory reading can greatly multiply what students can learn from lectures.

Dr. So thinks that a good doctor must have a deep sense of responsibility and should give patients a feeling of confidence. "Imagine when we ourselves are the patients, we surely do not want to be treated as no more than a simple disease process!"

Dr. So has done research on colposcopy, which is the endoscopic examination of vagina & cervix to detect, say, any neoplastic lesions. She is also interested & has worked on the field of Acupuncture.

Dr. So finds that a doctor's life is mentally quite demanding and often strips one of sufficient time to see to the family. She is also interested in music in general.

"A good doctor must have a deep sense of responsibility and should ....."

"All students should be strongly guided and influenced during their formative years."

Dr. Vivian Wong
M.B.,B.S. (H.K.); M.R.C.O.G.; M.R.C.P. (UK)

An 'old' girl from Diocesan Girls' School, Dr. Wong entered this medical school in 1964. After graduation and internship, she spent one year in Internal Medicine and three years in Obstetrics & Gynacecology, training with the University Units in Queen Mary Hospital and Tsan Yuk Hospital.

In 1974, she was sent by the Hong Kong Government to London for further training in order to specialize in medical problems in pregnancy. She worked under Dame Sheila Sherlock on various aspects of Hepatitis, an experience which stimulated her interest in research in this field, and on her return to Hong Kong she continued to elucidate the route of transmission of Hepatitis B from mother to foetus.

She joined the University as Lecturer in 1976, and when asked the reason behind this vital decision, Dr. Wong replied that it was due to her natural inclination towards teaching and her preference to work under the guidance of a dynamic professor.

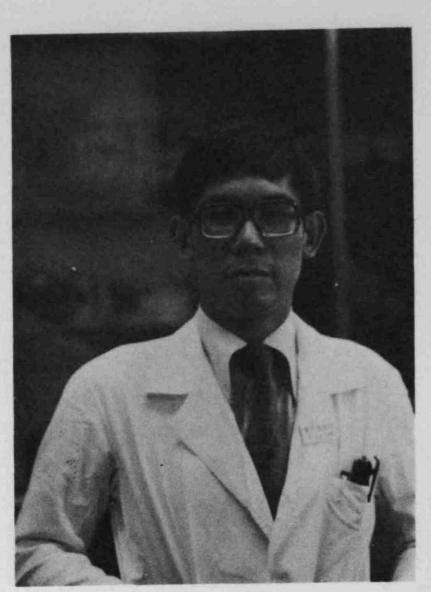
Dr. Wong points out that there have been dramatic changes in obstetric practice over the past two decades. Modern obstetrics stresses the importance of monitoring the baby, from the moment of conception to immediately after delivery. In fact, she is interested in the subspecialty now known as Perinatology, which studies the relationship between the mother and the foetus in various physiological and pathological conditions. She has also conducted research on the side-effects of steroidal contraceptives and recently on prenatal diagnosis of congenital abnormalities.

"Medical students in Hong Kong are becoming more social conscious, and less conforming. This obviously is a reflection of the psychographics of today's youth. On the academic side, students in general still prefer to be spoon-fed, and are usually despondent when left on their own. Quite often, simple bedside diagnostic methods are forgotten, and expensive diagnostic tools are used to replace them. This is the problem with teaching in 'centres of excellence' where the sophistication of the modern technological advances may attract the students' attention more than the traditional clinical approach to diagnosis and management. Some students can learn by heart all the ten possible causes of a symptom complex without knowing which is the commonest. However, with the new curriculum, there will be no systemic lectures for the Specialty Clerks, and students will have more time to participate in patient care, and hopefully better clinical acumen can be developed." Regarding the new curriculum in the preclinical years, Dr. Wong welcomes the introduction of courses such as Behavioural Sciences, but she feels that some students may find it difficult to appreciate the tightly packed programme during the first two years of their tertiary education.

As an undergraduate, Dr. Wong was active in student activities. Her experience ranged from subeditor of the "Undergrad", social convenor of St. John's College, Member of the Student Welfare Committee & Sports Association Council, to representation of the Medical Society to HKUSU Committee on Student Reform. As a teacher she is still interested in student activities, thus she makes a sympathetic Vice-President of our Society '79. Being an all-round sportswoman, she won the coveted title of "Sportswoman of the Year, HKU" in 1967. An ardent supporter of family planning, she plans to have children soon, after being married for seven year.

Finally, Dr. Wong cannot resist making the remark that with the increasing number of doctors in private practice nowadays, the medical profession must strive to guard against malpractice. "It is the responsibility of every doctor to maintain a code of ethics, and all students should be strongly guided and influenced during their formative years."

Dr. K.K. Chan
M.B.,B.S. (London); F.R.C.S. (Eng.); M.R.C.O.G.



"A doctor must uphold his moral integrity."

Born in Singapore, Dr. Chan graduated in Medicine at King's College Hospital, Medical School of London University in 1970. Afterwards he worked in England and came to H.K. to join the O. & G. Department of HKU in 1977.

Dr. Chan thinks that H.K. students are over-coached during their primary & secondary schooling and remain to be too academically orientated even in the University. This may have serious effects on their future development as doctors. The better medical students may soon overcome the problem, but the less bright ones will very probably remain as poor thinkers who may fail to react properly to any out-of-the-way situations in the future. Thus the present educational system in H.K. witnesses an urgent necessity for changes. To become a better qualified young doctor, the medical student should then make great efforts to strike a healthy balance suitable for himself.

Insofar as a good doctor is concerned, Dr. Chan believes that he should firstly care for his patients and secondly should be competent in his own particular line. Since the doctor as a special profession directly interferes with the physical quality of life, he must uphold his moral integrity. Moreover, young doctors should also be prepared for change if they find themselves being not suited to their training posts.

Dr. Chan is interested in O. & G. because it is a surgical discipline which also has plenty of room for development. His particular interest lies in gynaecological oncology and in the next few years his research will mainly be focussed upon ovarian cancer.

Dr. Chan enjoys his medical life. He is married and has a son. As for his interests, he likes ruby, squash, athletics, chess as well as bridge. (Note: Dr. Chan has now left for his home in U.K., where he acts as a senior lecturer and Honorary Consultant at Birmingham University.)

Dr. Sung May Lun
M.B.,B.S. (H.K.); M.R.C.O.G.

"A doctor must have adequate communication with the patients."

After matriculation from St. Paul's Co-educational College, Dr. Sung graduated in medicine in 1971. She did her internship at Tsan Yuk Hospital and in the year 1975 she joined the University as a lecturer of the Department of O. & G.

Dr. Sung enjoyed her present post very much because it involves relatively more academic work which enables her to keep abreast with the more recent advances. She is interested in the field of O. & G. because it is, so to speak, a combination of both surgical & medical disciplines and allows for more frequent contact with patients. Her research has mainly been centered upon endocrine disturbances & infertility.

Dr. Sung thinks that medical students here are quite devoted to academic work and some of them are often not social-conscious enough. She strongly feels that medical students should make efforts to see & experience more, so as to best prepare themselves for their future work.

In Dr.'s opinion, a good doctor should have good attitudes towards patients and should treat them as a whole, such as in seeing to their psychological make-up before & after an oncological operation. In this way post-operative morbidity & mortality can be minimized. Moreover, a doctor must ensure that his communication with the patient is adequate, so that all signs as well as symptoms can be made good use of.

As regards the new medical curriculum, Dr. Sung feels that in theory it is more integrated, but its real practicability in the clinical years still remains to be seen.

Dr. Sung is single and enjoys music in her very few spare hours.

"I am learning all the time....."

Dr. Evelyn Shiu S.M.
M.B.,B.S. (H.K.); M.R.C.O.G.

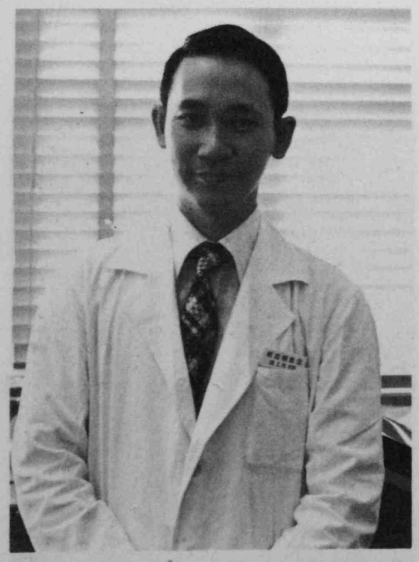
A former girl of D.G.S., Dr. Shiu graduated in Medicine in the year 1970. After her internship at Tsan Yuk Hospital and UMU, she entered the Department of O. & G. to act as lecturer.

She obtained Distinction for the subject of O. & G., and her choice of the present post has mainly been a matter of interest & suitability. Shifting amongst hospital work, lecturing and research work on clinical trials, Dr. Shiu finds her workload to be quite heavy but nevertheless enjoys it.

Regarding medical students in Hong Kong, she thinks that on the whole they are not mature enough. This has partly been due to their being over-protected in their secondary schooling as well as in their families which together probably constitute a 'greenhouse' for them. As a consequence, she believes that most medical students will experience a period of readjustment in their future clinical years.

In her opinion, a good doctor must make patients feel contented not only with respect to the pathological process involved but should also see to their feelings. She humbly said, 'I myself is still very immature and am learning all the time.'

As for her interests, she enjoys listening to music, watching films with a literary taste, reading, swimming as well as picnicking. She is single & is of opinion that after going into marriage, a doctor needs to achieve a proper balance in the use of time.



"Pre-clinical students should make good use of their time to enrich their lives."

Dr. C.M. Yim
M.B.,B.S. (H.K.); M.R.C.O.G.

An ex-student of St. Paul Co-educational College, Dr. Yim obtained his M.B.,B.S. in 1971. After one year of internship at both Tsan Yuk & Queen Mary Hospitals, he joined the Department of O. & G.

Dr. Yim has obstetrics as his field of choice because in it he deals mainly with physiological processes and the treatment is not just simple symptomatic relief as in some cardiovascular & lung diseases. In addition, his interest has also been extended to gynaecological oncology, in which he sees cancer at a different level, being a non-deadly disease highly curable with early treatment. Dr. Yim is also glad to note that it is now the departmental policy to treat patients as a whole, seeing to both their clinical & social backgrounds in the process of pain relief. Such policy will become increasingly widespread as the number of doctors increases and also as Hong Kong gets more & more affluent.

Dr. Yim went to New York twice to do his research work. He finds that medical students in the U.S. are different from those of H.K. Probably because they are mostly undergraduates, they seem to be more mature. Under a more lively educational system, they are better at the understanding of principles, have more incentive to go to references, & are on the whole more self-orientated. H.K. medical students, on the other hand, are good at book cramming & memorisation, but often are lacking in a sense of proportion of what they need to learn. Because preclinical students are usualy recently matriculated students who are often necessarily limited in scope & experience, they should, in a self-initiated way, make good use of their time to enrich their lives.

In Dr. Yim's opinion, a good doctor should have a basic level of competence and should care for his patients. He should also take account of the psychosomatic aspect, such as a woman's image of the uterus in regard to sex after operation to remove the uterus.

As regards his family, Dr. Yim is married, with two girls. He enjoys reading, music as well as badminton.

Dr. Tang, Grace W.K.
M.B.,B.S. (H.K.); M.R.C.O.G.

An ex-student of St. Paul's Co-educational College, Dr. Tang finished her M.B., B.S. course in H.K.U. in 1971 and then joined the Department of O & G.

Dr. Tang has particular interest in Obstetrics because it deals with physiological but not pathological processes, and as such is a more lively subject amongst other fields of Medicine. Moreover, Obstetrics to-day involves more active management, and scientifically foresees any possible difficulties, with a view to decreasing both perinatal and maternal mortality.

Dr. Tang is doing research work on Psychosomatic obstetrics and gynaecology, such as adlolescent menstrual patterns, abortion in single women and patient attitude in gynaecological operations.

She feels that medical students in H.K., being still too used to spoon-feeding, are often lacking in initiative and thus should take more active interest in their work. Although it is often hard to strike a healthy balance between academic work and extracurricular activities, Dr. Tang suggests that a good way for preclinical students to prepare themselves for their future career is to participate in social work. Through it, students can learn better the art of communication with people from different walks of life; this will proved of great use in their future contact with patients.

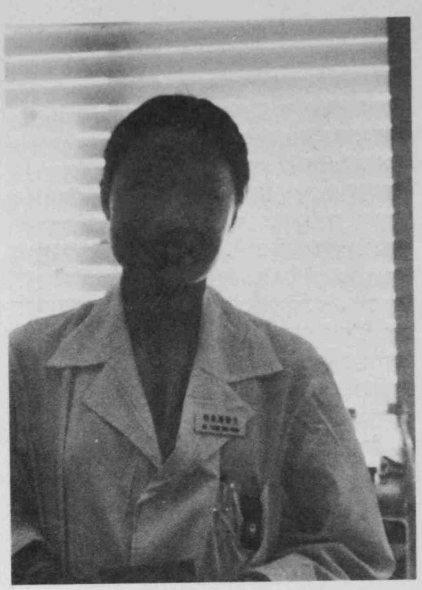
In Dr. Tang's opinion, a good doctor must first be technically competent and secondly should be able to treat the patient as a whole, for otherwise a doctor is merely a medical technician. Additionally, he must be decisive and project dependablility and confidence.

The present medical system, Dr. Tang said, witnesses a lack of both hospitals and medical staff, owing to the ever-increasing number of patients. To improve medical service in Hong Kong, the first thing to do is thus to increase the number of hospitals, as the number of doctors is already on the increase.

In view of the possibility of medical malpractice in Hong Kong, Dr. Tang thinks that a doctor should treat a patient only when he is sure of his own competence in that particular case. Thus, an obstetrician should not too easily do an appendicectomy or gastrectomy which it is perhaps better to refer to other more specialized medical practitioners.

Besides irregular and long hours, Dr. Tang finds that the greatest sacrifice of a doctor is the need to bear a constant and heavy mental burden, because he deals with matters of life and death and the possibility of mistakes is always present.

Regarding her interests, Dr. Tang was active in extracurricular drama activities and enjoys playing the piano.



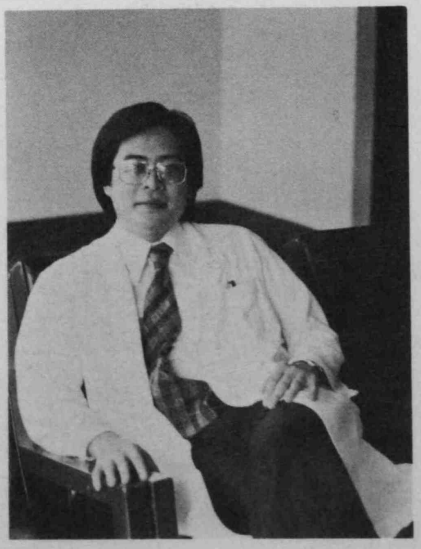
"Medical students in H.K. should take more active interest in their work."

Dr. Mao Kenneth
M.G.; M.B.,B.Ch. (Cantab.)

Dr. Mao was a former student of Diocesan Boys' School. After reading Medical Sciences at Cambridge University, he went on to Guy's Hospital, London, for his clinical training.

He feels that the medical curriculum is fairly good, with more emphasis on bookwork and less on practical experience as compared to England. The students are very knowledgeable & keen but are sometimes hindered by difficulties in expression.

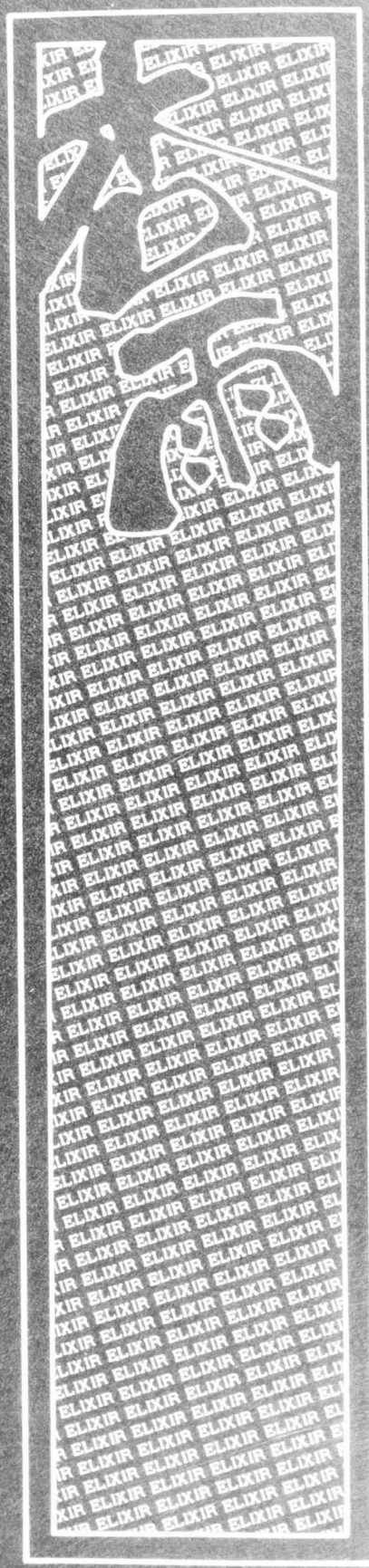
Dr. Mao enjoys music and also played tennis for Queen Mary Hospital. In addition, he is interested in medical herbary.



"The medical curriculum is fairly good,....."

Genius is one per cent inspiration and ninety-nine per cent perspiration.

— Thomas Edison



MEDICAL SERVICES

九龍灣健康中心
——愛心的學習

九龍灣康健中心義工*

經過一天在病房裏的辛勞，該是回家休息，或找尋各種娛樂，鬆馳一下的時間吧，但一羣醫生，護士卻老遠跑到九龍灣安置區的一所夜間診所，當起義工來……

「中心」簡介

九龍灣康健中心（以後簡稱「中心」，誕生於去年三月。該是兩年多以前的事了，剛成立了不久的香港基督徒醫學團契正在探索着一個社區服務及見證福音的途徑，碰上了有同樣抱負的幾個社會工作者和大專基督徒團契幹事，經過一番研究和調查，終於選定了居住在九龍灣安置區內的一萬名居民爲他們的服務對象。跟着是發動區內居民，向房屋司署申請一個安置區內的單位，作爲診所的基地。通過居民委員會的合作，終於如願以償，租得一間面積400呎的單位，義工們的努力就換來一間似模似樣的診所。

爲何選中九龍灣安置區？

九龍灣安置區位於牛頭角對開的一大片新填地，雖然有一萬名居民，卻沒有一間政府診所或註册西醫在其中執業。由於地理上及交通上的諸多不便，居民要長途跋涉，才能得到適當的醫療服務。一間位於他們當中的診所實在是很需要。加上居民的經濟狀況，教育水準和居住環境都比較差，就要需要人關心和幫助了。

義工來源

「中心」的工作人員，全都是基督徒，計有來自不同工作單位的22位醫生，9位牙醫，65位護士，輪流當值。還有二位行政人員，社會工作者，物理治療員，社康護士等等，實在是一支頗爲强大的社區醫療隊伍。正因如此，義工的聯絡，工作分配，就更加複雜煩瑣了。要脫離在死板的制度下分工，而達致靈活的互相配搭，各盡所能便只有靠那「愛心的包容」和基督的「不受人服事，而是要服事人」的信念了。

「中心」的理想

世界衞生組織對健康的定義包括生理、心理和社交三方面。「中心」之名爲康健中心，就是要達到這全人——包括生理，心理，社交，加上靈性—

*轉載自啓思十一卷第四期

—健康的目標。因此「中心」除了提供治療性的夜診服務外，還希望在預防和發動居民對健康的積極性兩方面盡力。後二者就帶出一系列的健康教育活動和社區發展工作。目前在「中心」內舉辦的健康教育活動，包括在中心內張貼海報，派發健康常識小册子，放映幻燈，及由專業人士負責的健康常識短講等。對象主要是每晚到診所求診的病人及其家人。社區發展方面就包括一些大型的活動，如睦鄰晚會，聯絡居民委員會，以增加居民自己的投入及反映他們的意見等。但社區發展工作的最重要一環，還是——家訪。家訪的對象是曾到「中心」求診的一些病人，因醫生發覺他們有身體、心理或家庭裏的一些問題，需要詳細討論和解釋，而被介紹給家訪的義工的。近期，一個較廣泛的家訪計劃正在進行，就是將家訪推展到每一個曾求診的病人，及由受過特別訓練的義工負責。這樣一個人力的投資，目的除了與居民建立良好關係外，更是藉此探討居民對健康教育的需求，作爲日後參考之用。

「福音」的見證

「中心」的成立，不只是本着「愛人如己」的目標，向居民提供服務，更希望藉着一些佈道會，個人工作及與附近地方教會合作，直接向居民傳講基督的福音。

「中心」的困難

義工們有同一的異象及緊密的聯絡，以達致合一的見證，是「中心」的理想之一。但由於醫護人員本身工作辛勞，加上在教會或其他宗教組織的參予，剩餘的時間有限，要達到這個理想，義工便要負上更大的努力和忍耐。

此外，搞健康教育往往是吃力不討好的。香港人茶餘飯後，除了看電視，打蘢將之外，便很難會對健康，或社區性的問題，拿出一點興趣，負上一份熱心。九龍灣安置區的居民亦不例外。加上他們當中，大部份成年人都是出賣勞力的打工仔，爲着生活，由朝忙到晚，又那裏來的精神去增廣自己的健康常識呢？香港人這種只看到眼前急事，卻看不到生活背後的意義的壞習慣，實在很難一下子打破。

結語

我們這一羣養尊處優，與社會大部份羣衆脫節的醫護人員，除了爲升職、加薪、或追求學術成就而奮鬥，爲追求安定，豐裕生活而籌算之外，又有沒有想到那臥在床上的病人，除了「牌板」上的診斷之外，還有很多問題，如對健康常識的無知，居住環境的惡劣，及數不清的家庭問題等等？它們在在需要醫護人員額外的心思和負担。

九龍灣康健中心，只是一個嘗試，一個學習，所能做到的，又是那麼微不足道。但它卻是一個開始，一個肯定！

社康

——一個你不太熟悉但比你想像中重要得多的項目

健委會*

觀念的起源

社康醫療服務發展至六、七十年代，已成爲社會運行上的一個巨大環節，醫院的宏偉，醫務隊伍的龐大陣容，使醫療服務的經費日益浩大。但這些增長是否表示人類在照顧身體方面已得到了滿意的服務？在落後或發展中的國家，無論在社會發展，科技研究各方面對比不上先進的社會，當然得不到如上述的服務。但即使在國民健康計劃那樣完善的英國，亦有人會懷疑龐大的國家醫療計劃是否一個大而無當的體系？是否需要在健康服務的觀念上來一個革新？

傳統的醫療服務觀念都是把照顧健康作爲醫務工作者的專利品。普通人甚至將照顧健康這個責任完全交在醫生手中，從這裏帶出了兩方面的問題。

在個人來說，健康知識的貧乏和對責任的忽視使人不能緊緊的照顧和重視自己的健康，對自己當然是個損失。

在社會整體而言，如何照顧組成社會的每一分子的健康確是一個大問題。市民對醫務工作者的完全倚賴對醫療健康服務做成沉重的負担，在某程度來說甚至是浪費。以香港爲例，加建醫院和增聘工作人手是個改善方法，但很難滿足需求；門診部和很多私家醫生的病例都只是一些輕微或不藥而癒的病症；有專科訓練的醫生很多時只診治普遍病症等等，一連串問題的癥結，除了政策和制度上的問題外，都和傳統的醫療服務觀念和市民對制度和健康的認識有莫大關係。

社康是甚麼？

「健康」，已不再是「醫治疾病」那麼簡單，根據WHO，「健康」的定義是個人在生理、心理和社會生活三方面的完整發展（A state of complete physical, mental and social well-being），而醫療健康服務的目標，除了治理疾病外，還要加上預防疾病和健康的建立，可惜的是很多醫務工作者仍是認爲健康服務是他們的專利品，尤其香港醫療界的傳統勢力很大。如何使醫務人員接受和嘗試新觀念，需要政府、醫學教育和社會意識的引動。

如何使市民投身社康發展中更是一個重要但困難的課題。除了把健康教育介紹給他們外，還要使他們主動參與和計劃。正如觀塘社康，計劃確算龐大，但經費亦是驚人，支出最大的是在僱用工作人員方面，可以說這只是將醫療服務稍爲擴散到市民當中去。

香港社康的展望

從觀塘社康計劃的成績與限制中，可看到「社康」的觀念逐漸成熟。很多社區和居民組織、社工人員都在各地嘗試推行。政府正如上面所說亦逐漸重視「社康」這個新的模式。相信將來會陸續有新的發展。但現時急需的是一個統籌組織，協助各界工作，和對以往的成果作檢討，政府的政策更形重要。

*轉載自啓思十一卷，四、五、六期

醫學生與社康

我們的醫學教育不會對「社康」作很詳細的介紹，所以我們需要自己去學習，以前亦有同學參與觀塘社康計劃做義工。健委會在香港仔推行的社會服務，亦用「社康」教育的形式，希望從實踐中去學習各方面的問題，甚至在香港仔一區內切實推行社康服務。這當然需要同學的參與和投身。

「Community」，就是指社會上的每一體系，包括國家、政府，各機關、服務團體及人民本身的共同參與和努力，使社會的運行和人民的生活能夠有所發展。總括來說，「社康」是以社會發展爲目的，而健康的改善是其中的一個途徑。

要明白的一點，「社康」不單是志願團體的工作；政府作爲社會事務的代理人，有全責照顧人民健康。

「社康」所强調的，是市民參予照顧本身健康的行動。醫療工作當然要由受專業訓練的醫生和其他醫務人員負責，但如何建立健康、預防疾病，甚至一些較簡單的診斷，處理或急救卻可以由市民自己來分担。這樣當然要在健康教育、醫療常識和對制度的介紹做好推廣工夫。這些不單只是政府、醫療工作者，社會工作者負起，市民更是最重要的動力來源。

香港的社康工作

「觀塘社康發展計劃」從七二年起即在香港實驗「社康」這個觀念。以聯合醫院和幾間社區健康中心爲基地，擴散至整個觀塘的65萬人口。現時整個計劃分六方面來推行：

▲社區發展和組織居民、義工；

▲健康教育，

▲社康工作者訓練，

▲保健計劃，包括幼兒、學童、工業、成人和老人健康；

▲醫療（包括牙醫）服務；

▲社康護理。

除觀塘之外，一些社區和區民組織都在推行或嘗試階段，如大坑東社康組、李鄭屋等。

政府方面除了資助少部份觀塘社康計劃的經費外，都抱一個觀望態度。不過已經逐漸加强對這方面的重視，如在四月後接管全港社康護理，和設立中央健康教育組等，但仍有待發展。

當「社康」這個觀念還是這樣新的時候，如何推廣和實踐自然遇上很多困難。政府的政策、經費來源和社會（社區）發展都是十分迫切的問題。醫務工作者（主要是醫生）的傳統觀念，可能仍是認爲健康服務是他們的專利品，尤其香港醫療界的傳統勢力很大。如何使醫務人員接受和嘗試新觀念，需要政府、醫學教育和社會意識的引動。

如何使市民投身社康發展中更是一個重要但困難的課題。除了把健康教育介紹給他們外，還要使他們主動參與和計劃。正如觀塘社康，計劃確算龐大，但經費亦是驚人，支出最大的是在僱用工作人員方面，可以說這只是將醫療服務稍爲擴散到市民當中去。

醫學生、醫生、醫療組

醫療組

醫療組（註，並不屬於任何醫學會）從埋下種粹到現在孕育成一株幼苗，已經有三年多的時間，當初的撒種人，亦由醫學生變成各大醫院的駐院醫生，組員方面亦由十多人增至四十多人矣。

成立醫療組的目標大致可歸納爲四點，㈠發揚醫學精神㈡增進醫學知識和技能㈢團結溝通㈣服務社會。在貫徹這四個宗旨的行動上，三年來舉辦過多次大大小小不同類型的活動，文娛康樂方面有旅行，宿營，游泳，聯歡晚會、羽毛球練習等。學術方面有醫學講座，大多數由組員主講，間中亦有邀請資深的醫生參加。社會參與方面則有去年的大澳兒童健康檢查，在明年初，將會在摩星嶺木屋區再作同一性質的兒檢，希望透過參與，使組員多瞭解一下貧苦市民的情況，同時亦爲一些缺醫的市民提供些少服務，檢查報告則轉達有關部門，以求改善。至於發揚醫學精神方面，由於比較抽象，所以難以安排甚麼具體的活動，惟利用在其他活動的時間間裏，組員之間，對於在工作上遇到關於思想上的困惑時，亦會提出來討論，以求達到互相勉勵的目的。

在慨括介紹完醫療組的活動後，各位或會覺得醫療組的發展是相當順利的。然而事實上，所遇到的困難可眞不少啊！首先醫院的工作委實太繁忙，當一個醫生當值完卅多小時後，身心實已疲乏不堪，往往工餘之時只希望能舒舒服服的休息一下，甚或找尋一點有刺激性的娛樂來發洩一下，同時踏足社會工作、不多不少也有點社交應酬，所以能撥出來的時間並不多，更大的問題還是在聯系方面、由於各人的工作地方分佈極廣，更兼且當值的時間又參差不齊、要安排一個適當時間的活動實在頗傷腦筋。雖云彼此都是醫生，可是各人所事的專科則並不劃一，所以在提高專業知識方面，各人的興趣很難一致，譬如一個做內科的很難會對骨折療法會有興趣，即是之故，學術講座在經過一年多的時間亦被迫擱置起來，不過在這方面各組員亦不會有所缺少，因爲其他醫學會時常都會舉辦公開的講座，大家亦會按著自己的興趣而出席。

相信各位在讀過這篇醫療組的簡介後，都會覺得這個組就是我們大學生活的延續，雖然醫療組的成員全都是醫生，但並不排除醫學生參與的可能性，然而更希望需學生們能放多些時間在學運的洪流上，這樣在畢業後，就能給醫學組不斷帶來新的冲激，使它能不斷改進，以能對社會作出更大的貢獻

配藥員的工作

何國榮

要了解配藥員的工作先要知道藥劑學是怎樣的一門學問。藥劑學是一門對藥物用途，服用方法，劑量控制，禁忌，副作用，吸收，反應及藥物所引起的變化；藥物製造，貯存與及調配的專門科學。其實藥劑學與醫學兩者最能代表理論與實踐相配合的一門科學。這兩種科學與其他專業不同，例如法律，測量與及會計學等，各有其固定的法規與公式，只要對理論及公式熟習實行準確計算便可發揮其最高之專業水平。但藥劑學與醫學便不同，無論任何一人對其專業理論多麼熟識或深入了解。例如一個藥劑師熟讀了抗生素的原理，或一個醫生對心臟病的病理如何的了解，但前者對個別最新的抗生素沒有認識便不能向醫生提供最適當之劑量及其治療價值，而後者缺乏了臨床斷症經驗便不能定出準確治療方法。所以兩者如未能將理論與實際經驗相配合就不能發揮彼此間之實用價值。加以藥物的種類繁多，日新月異，進步一日千里，既要記得舊的藥物也要認識新的出品，所以便有做到老學到老的說法。無論那一個也不能說他認識所有的藥物，自稱專家者亦只不過對個別藥物有較深入的了解而已！單以維他命或賀爾蒙而論，只就其中一種而言便可窮任何一位科學家一生的精力與時間亦不能學得完全。故所以內科專家、眼科專家、婦科專家亦只各自對他們慣用的藥物有較深入的認識，而對其本身專科以外的藥物的用途則所知有限，而藥劑師與配藥員亦僅是總其成及就其個別的修養與經驗提供專業智識或書籍上之資料給醫生參考而已！

配藥員（或配藥師）DISPENSER 一詞多年來大部份社會人仕對它均有不同的誤解，原因除新加坡以外全世界只有香港政府醫務衞生處有訓練及聘請配藥員。他或她們是不需在藥劑師之監督下去獨立管理藥房或配製藥物，在英美各國雖然也有聘用人員協助藥劑師執行配藥工作，但他們的職位各稱爲藥房技術員（PHARMACY TECHNICIANS）而且絕對要在藥劑師之監督下工作。有些人以爲配藥員的工作只是照單執藥及交給病人那麼簡單，而她或他對藥物則一無所知，更不需負任何責任，一切自有醫生負責。而另一些人如醫生及護士等則把配藥員與藥劑師混爲一談。其實兩者有其相同而各異的地方。相同的是兩者的日常工作表面上大致相同，而醫生，護士與配藥員日常的接觸及了解比與藥劑師則更多。香港的藥劑師絕大多數負責行政管理，檢查私家藥房及藥廠工作，而實際的製藥與配藥工作均由配藥員執行。不同的地方是兩者的訓練及出身不同。自一九五八年開始，藥劑師的訓練轉由大學或專門學院負責。畢業後經一年在職訓練或實習及經藥劑師管理局考試及格後便可成爲註册藥劑師。而配藥員則由香港政府醫務衞生處自行招聘中學會考畢業生，經三年在職訓練及考試及格便可成爲合格配藥員。藥劑師接受理論及學術性訓練較多，而配藥員則接受實際之工作訓練時間較長。

配藥員的訓練其實亦不簡單，他們的課程包括：生理學、藥理學、藥物製造學、微生物學、藥物化學，及另有實驗製藥課一百〇八個單位。上課時間達五百小時。實驗時間一百二十小時。隨着課程的增加，多年來招聘的學生配藥員大部份都是大學預科畢業生。此外實際工作訓練時間如下：以每星期工作四十小時計算一年共有五十二個星期，三年在職訓練時間超過六千小時始能參加考試，畢業後還要試用一年後才能成爲合格配藥員。而外國之藥

房技術員只需接受二年之在職訓練。所以香港之配藥員在學術和工作質量與責任上的要求差距極大。學生配藥員的訓練過程並不簡單，他們要知道藥物的用途，藥物的來源，副作用，禁忌，藥物進入人體的途徑，反應所引起的變化，吸收及排泄的過程。用了某種藥物過量所需的藥物治療，藥與藥之間及藥與食物之間之關係都需要清楚及了解，以及每種藥物每日最高服用限量等等。在藥物製造方面他們要對機械及儀器的運用，生產方法及過程亦要有深入了解。

至於配藥員日常之工作與責任更須詳細解釋。配藥員的工作最明顯的莫如配製藥方和派藥給病人的工作。這項工作看似簡單，其實亦絕非易事。別人看見他們稍爲向藥單一望便開始配製藥方上開列的藥物。其實這一看已包涵着多年之訓練與經驗。單就醫生之字體而言看得通已不容易。有時兩種藥物，從字體上極相似，如 PYRIDIUM 與 PYRIDOXINE 的草書，要決定那一種亦頗費心思。最重要的是這不是猜獎遊戲，猜不中亦不重要。更難爲的有時醫生將 TAB. LIBRIUM 寫成十足像 TAB. LUMINAL，配藥員根本沒有理由將藥單打回頭給醫生證實，只好將 TAB. LUMINAL 交給病人。那便會嚴重影響病人的健康。特別在時間少病人多的情況下更麻煩，工作壓力大，良心上之負担尤難受。若要做到絕對準確，除小心外更需要足夠之經驗與定力。調配藥方除上述情形配藥員更須對藥物用途、劑量、服用次數、藥與藥之間所產生的作用，禁忌等，要有敏捷準確的判斷才可應付每日龐大的配方工作及解答醫生對藥物的問題及決定醫生開出的處方是否有問題。通常處方上發生的問題多數是超出劑量數倍，或醫生記錯了每粒藥丸的份量、服用次數，將每日一次寫作四次（Q. D. instead of Q. I. D.）或從記錄咭上抄錯了藥名等。如果配藥員沒有足夠藥物知識和工作經驗向醫生取得聯絡及時糾正，相信損失一定是病人。相信很多病人也曾有過由藥房取回藥單給醫生更改的經歷。可見配藥員與醫生之間佔了極重要的地位。在製造藥物方面，政府藥房共製造七十二種內服藥水八十種外用藥水，五十種藥膏，一百〇三種針水，及九種藥丸。而製藥部門共有九個，全由配藥員或高級配藥員管理，雖然在行政上需要向主管藥劑師負責，但亦只就行政上而言罷了。在生產藥物方面配藥員需要懂得如何製造各種藥物技巧，更要認識各種藥膏、藥水、藥丸、針水所含原料之特性、份量、防腐劑、防氧化劑的用法和特有作用，更要懂得消毒的原理及各種殺菌方法和過程，各種消毒藥物不同的用途及劑量等。除此，配藥員更要懂得各式各類製藥機器的用途及操作過程，輕微修理等，例如高壓消毒爐、高溫消毒爐、打丸機，製造藥水藥膏的特種攪拌機及其他型式的機械。除了應付日常的製藥和調配藥方工作外，配藥員還要肩負其他更重要的工作，如行政管理，人手的調動，編假，藥房的管理和行政，開支及財政的預算，藥物的貯存及採購，藥倉管理，危險藥物及毒藥管理，會計工作，檢查藥物的有效日期，數量及保證能按時供應品質優良的藥物，其他如採購，及管理一切醫療器材的工作更需要憑長期工作中積累起來，就算藥劑師在大學課內亦不能學得到的寶貴經驗，此外配藥員亦要協助醫生試用新藥，及解答醫生對藥物及醫療器材所發生的各項問題。

最近有些人仕，特別是藥劑師方面批評政府不應任用配藥員獨立管理藥房及執行配藥工作。更指謫配藥員之專業訓練不足，惡意攻擊配藥員膚淺無知，危害市民健康。更進一步主張政府在所有藥房內增設藥劑師，監察一切藥房工作。而配藥員對這方面的反應爲，最重要的事實是要證明配藥員是否如所指之訓練不足及膚淺。他們的實際工作表現是否必須在藥劑師監督下才會有良好之工作表現及成績呢！從本文前一段介紹可證明配藥員所接受的訓練並非如所指之簡單。若單以理論與純學術的訓練而言配藥員絕對比不上藥劑師。但在調配藥方及製造藥物的技巧與經驗而論則由於配藥員絕大部份時間均花在實際配藥工作，所以便會比藥劑師更爲熟習。所以單就實用價值而言，兩者自有其同時存在的價值與需要，不容爭辯。目前全香港八十五間政府醫院及診所藥房，其中七十九間全由配藥員負責

管理及執行一切藥劑工作。又全港二百六十一名政府藥劑員中共有二百三十一名爲配藥員。在過去卅年以來，絕大部份政府之配藥服務均由配藥員担任。但從未有病人、醫生或護士投訴配藥員所管理之藥房服務欠佳或表示懷疑！這方面政府亦曾公開承認配藥員所接受的訓練絕對足夠與及極有效率地執行配藥服務。近年來香港政府大力推行及發展理工學院課程。其目的便是以最實用及經濟的方法訓練及聘請各種技術及專業人員。更成爲政府定下及推廣的政策。其實在先進國家，藥劑師的工作除在醫院及診所藥房執行配藥服務之外，還要在藥廠或實驗室內研究藥物的用途、藥品的製造及發明方法、品質管理的控制、售賣及指導市民服用藥物的方法。故需要接受較全面的藥劑訓練及需接受藥劑師管理局考試及註册。所需訓練時間也較長。師資的質素也要求較高，設備更要完善與昂貴。因此目前香港要全力訓練藥劑師實在應視乎以下之實際需求與特殊環境而決定：

（一）目前香港在生產或製造藥物方面並不發達而需求也不大。所謂生產藥物不外是採用入口之外國原料，加工配製或批發而已。故不需採用太高深之藥物製造技術。

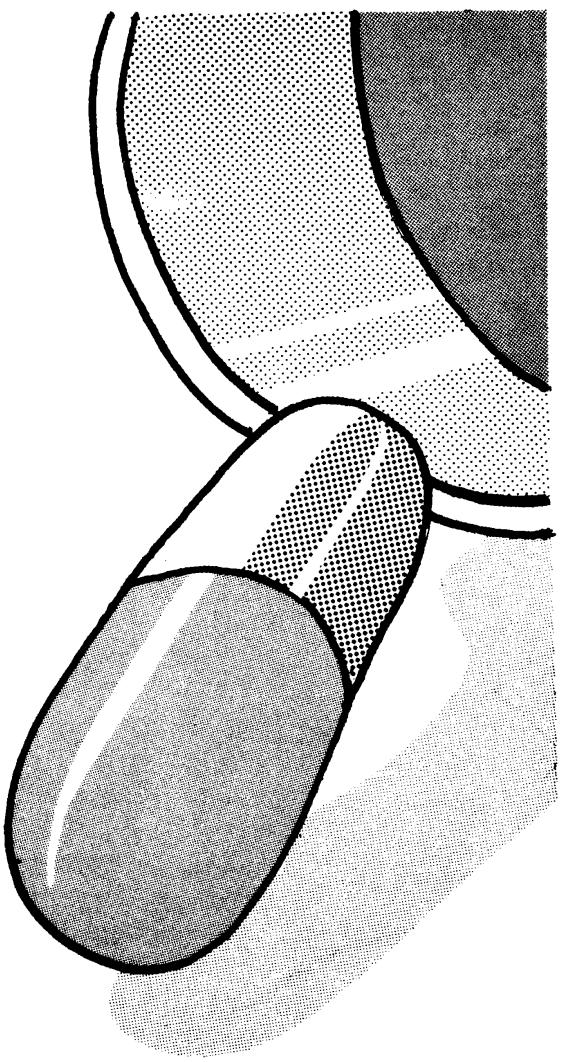
（二）目前香港所採用或售賣之藥物，九成以上均爲成藥。一切用途，服用方法，劑量及禁忌等均有說明書介紹。故醫生多能各自了解其用途與及特性。

（三）在香港私家醫生均自行配藥及派藥給病人服用，與及醫藥未能分家。而醫藥分家的辦法及概念亦未能爲市民大衆所接納。因此私家藥房的配製藥方的服務，名存而實亡。故所以社會上對藥劑師的需求不大。

因此目前若要政府及私家醫院、診所全部聘請藥劑師，實行起來絕非易事。而且極不化算。故所以大量訓練藥劑師必需注意其出路問題。近年來美國 OHIO 州之 CINCINNATI 大學及北歐國家亦開始訓練藥房技師 PHARMACY TECHNOLOGIST 執行配方及製藥工作，縮短了藥劑師與藥房技術員 PHARMACY TECHNICIAN 的距離。故在目前香港的社會環境及需求上而言，配藥員與藥劑師實有其同時存在的必要與價值。

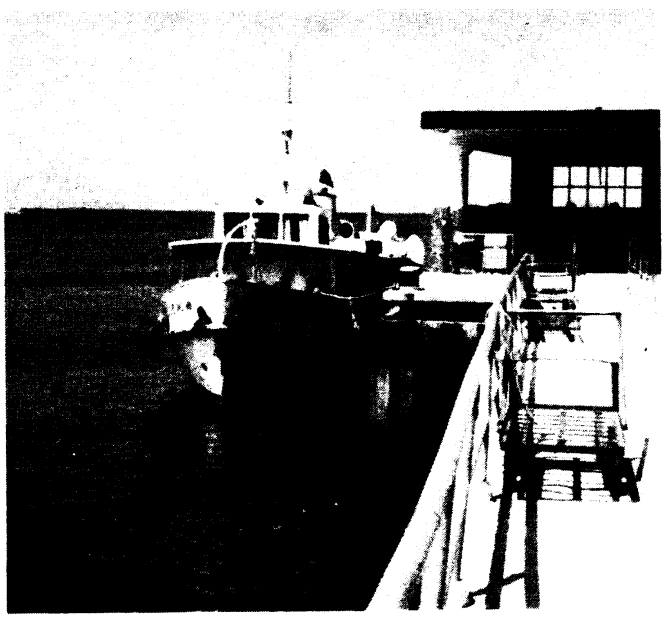
香港醫務衞生處藥劑職員會
主席：何國榮

一九七九年十月卅一日



FLOATING CLINICS —

THE COMPANIONS OF VILLAGERS



Hong Kong is made up of the Hong Kong Island, Kowloon, the New Territories and many outlying islands. The medical service has no difficulty to extend throughout urban areas. Remote areas are either served by helicopters or floating clinics.

The two floating clinics, 'Chee Wan' (慈雲) and 'Chee Hong' (慈航) of the Medical and Health Department serve mainly the uneasily accessible islands. The main area of operation for 'Chee Wan' is around the Tolo Harbour, while the service of 'Chee Hong' centres mainly around the scattered islands in the south-west of Hong Kong waters, e.g. Cheung Chau, Lamma Island etc.

The two floating clinics, donated by the Royal Hong Kong Jockey Club have been in service for about 20 years and are still going strong. As their names, in Chinese literary sense, mean to spread the mercy, the medical service provided by them is indispensable to those villagers living in remote islands.

For five and a half days a week, the two vessels set sail in the morning, to those remote islands to attend the sick. While 'Chee Hong' sets sail from Tsim Sha Tsui, Chee Wan begins her journey from Tai Po Hau. It is only during public holidays or when storm signal No. 3 or above is hoisted up that they are forced to take a break. The islands visited are according to the schedule so that the service is evenly allocated.

On arrival at an island, the vessel will pull a hooter to notify people. However, the villagers have already been waiting there because they are accustomed to the time table of the service. Some islands such as Lamma Island have their own clinics with only nurses attended. The doctors of the floating clinic go to attend the patients there. At some of the sparsely populated islands which have no berthing facilities, people have to row out to the clinics in their own spans.

The medical staff in a floating clinic includes a doctor, a nurse and a helper. The crew is provided by the Marine Department. The floating clinic is a miniature clinic, having necessary equipment to cope with common diseases such as influenza, fever, skin trouble, measles, chickenpox etc. They also provide vaccination when necessary. For the more serious cases requiring hospital care, the floating clinic will take the patients to town. The doctor on board will radio get an ambulance ready on shore. In the event of very urgent cases, helicopter will come to rescue.

The medical officer in charge of Chee Hong visited by us, is Dr. Chan. He is a man in his early fifties, who is very kind and friendly. He have been working there for 3 years and his past service of 8 years was in Sheung Shui. His predecessor, Dr. Mak, was in service in that ship for 7 years. Both of them have been enjoying their work. According to Dr. Chan, working in the floating clinic does not cause any incovenience. Sea sickness is accustomed by the staff. Meals are usually self-prepared though restaurants may be available in several places, e.g., Lamma Island. They even may avoid traffic congestion during rush hours.

Both vessels are docked for maintenance for a fortnight twice every year. During this period ships from the Marine Department will stand in to ensure normal services.

The Laboratory Animal Unit —

Improved Facilities for Laboratory Animal Supply and Research

(1) The Role of the Laboratory Animal Unit

Within Hong Kong there are no satisfactory commercial sources of laboratory animals and importation of animals from other countries is not only expensive but also impracticable. The demand for laboratory animals within the Medical Faculty of University of Hong Kong must, therefore, be met by home — breeding, and in the past this function has been carried out by the animal house in the Li Shu Fan Building. The new Laboratory Animal Unit facilities, although they have been designed for experimental use, will in the absence of any other source of animals have to carry on this function when the old accommodation is vacated in Easter 1980.

Animals are supplied for teaching and research, primarily to the Faculty of Medicine and eventually also to the Dental School. Small numbers of laboratory animals are also supplied to other departments in this University, and to Chinese University of Hong Kong, Hong Kong Polytechnic, the A—Level Examination Board and some departments in Hong Kong Government.

It is hoped that separate Animal Breeding Centre will be established in the near future to provide animals for this University, Chinese University and the Hong Kong Polytechnic as well as other users in Hong Kong so that the new Laboratory Animal Unit facilities can be used solely for experimental animal holding, for which the building was designed and intended.

However, in the interim period the new facilities will be used to breed high quality or specified-Pathogen-Free (S.P.F.) animals for teaching and research purposes.

(2) The New Laboratory Animal Unit Facilities

The new facilities consist of a six-storey building situated in Sassoon Road adjacent to the new Amenities Building. The Unit is broadly divided into three animal areas, with associated service areas:

(a) Breeding Area:

The breeding colonies that are being established in this area aim to provide S.P.F. animals under strictly controlled environmental conditions.

Advantages: In the old animal accommodation in the Li Shu Fan Building, animals are kept under conventional or non-barriered conditions with minimal environmental control and few precautions to prevent the entry of infection. Therefore, the animals supplied from these colonies harbour a variety of pathogens or potential pathogens which not only may affect experimental results and possible the validity of experiments, but also premature death and other disruption by clinical disease may interrupt research programmes causing considerable wastage of time and money.

S.P.F. animals are bred under sophisticated environmental conditions and with strict procedures to prevent the entry of pathogens or potential pathogens to the colonies. The types of control required are sterilisation of all diet, bedding, equipment and other materials entering the Unit as well as restrictions on personnel entering the area, which include showering and putting on a complete set of protective clothing. The physical environment is stable, with strict control of termperature, light, humidity and ventilation. The precautions taken are particularly important in preventing zoonotic infections, i.e. infections between animals and man, so that there is full protection for staff involved in animal work.

Will the S.P.F. animals be more susceptible to infection? The documented evidence indicates that this is not so. These animals, being bred under optimal conditions, reproduce better and show improved weight gain, and because of their improved physical condition appear to be more resistant to infection. Furthermore, lower dosages of anaesthetics have to be given and deaths during anaesthesia are much reduced as responses to drugs are more uniform and predictable. Therefore, instead of S.P.F. animals causing an increase in budget, they will in fact be of benefit both in terms of money and time saved and by their contribution to valid animal research.

(b) Experimental Area:

This area is also contained within the barrier, but as the primary responsibility of the Unit in the immediate future must be to supply laboratory animals, the extent of the facilities that can be given over to experimental allocation are unforunately much reduced. Eventually it is hoped that the whole building will be available for research purposes, thus providing far better conditions for animal experiments as a result of the facilities being purpose-built and having a fully controlled environment.

(c) Quarantine Area:

This area will be available to research workers for short term holding of laboratory animals, i.e. the experimental work will be carried out in other departments and the animals will only be returned to the Unit between experimental procedures. The Quarantine Area is not within the strictly controlled barrier and so there is easy access to these animals. Temperature, ventilation and humidity are, however, an fully controlled.

(3) Conditions in the Barriered Area

Temperature control: 22±2°C. in animal rooms.
Humidity control: 50—60% R.H.

Lighting: adjustable in animal rooms so as to avoid seasonal variation in breeding and, therefore, any fluctuation in animal supply.

Air — conditioning and ventilation system: apart from regulating temperature and humidity within the Barriered Area, this also maintains the animal rooms under positive air pressure compared with other areas within the barrier, which are in turn at a positive pressure compared with areas outside the barrier. This means that all air flow is away from the animal colonies, providing a further safeguard in preventing air-borne infection.

Sterilising system: two large autoclaves are used to sterilise diet, bedding, cage and all other materials that are not heat-sensitive. Items of equipment etc. that would be damaged by the autoclaving process are introduced into the barrier by dunk tank or by means of a low temperature sterilising cycle combined with formaldehyde fumigation.

(4) Diet

No satisfactory laboratory animal diets are available locally at present and so all rodent and lagomorph diet used has to be imported from either the U.S.A. or the U.K.

(5) Types of animals bred

(a) Mice:

One random-bred strain, CRJ:CD(ICR), as the standard white mouse used for most research purposes.

Three inbred strains, BALB/cA, DBA/2N and CBA/N, for experimental procedures that require genetic uniformity or for which the characteristics of a particular inbred strain are specifically indicated.

One mutant strain, the nude mouse — these animals, apart from having no hair, are also deficient in a thymus gland and any competent immunological system. They are therefore particularly valuable in, for example, tumour transplantation studies or parasitological studies, as they have no immune reponse and will not reject tumour cells or respond to infection. However, as they have no form of self-protection, they are highly susceptible to many infections that would normally not cause any problem. It is, therefore, essential that these animals, which are of increasing importance in medical research, are kept under S.P.F. conditions. Breeding under conventional conditions is not successful.

(b) Rats:

Random-bred rats (CRJ: CD(SD)) as the standard white rat used in medical research.

(c) Hamsters:

Syrian or golden hamsters.

(d) Guinea-Pigs:

Dunkin-Hartley guinea-pigs.

(e) Rabbits:

New Zealand White rabbits.

(f) Cats:

English short haired and crosses.

(g) Primates:

Common Marmosets — these are New World monkeys which only reach a size/weight of 3-400 gms. They find their major use in reproductive research and the colony is being established as a long term venture. Primates are becoming increasingly difficult to obtain and there is a pressing need to conserve these species in the wild.

Animals for which there is a significant deamnd within the University but which cannot be bred within the new Unit as the facilities are unsuitable, are dogs and primate species other than marmosets. Dogs are particularly required by investigators in the Surgery and Physiology Departments and in the past they have been supplied by the Agriculture & Fisheries Department. However, since September, 1979, dogs have only been supplied for terminal experiments, and after September,

1980 even this supply will stop. An alternative source of supply is, therefore, urgently required. In the longer term, a breeding colony of either rhesus or cynomolgus monkeys would be valuable as the supply of these primates from overseas is difficult and also extremely expensive.

(6) Staffing

The number of staff in the Unit at the present time is 20. Within Hong Kong, there is no course of training that is really applicable to laboratory animal work, although it is hoped that the Hong Kong Polytechnic will establish a part-time day release course within the next 2-3 years for animal technicians. The courses available at present are primarily intended for laboratory technicians and the animal - related component is small. Of the present staff, the Technicians have degrees in related disciplines such as biochemistry and micr-obiology and many of the Attendant staff are school leavers. As there is no formal course of training for these staff, knowledge can only be gained on-job training and experience.

Conclusion

With the opening of this new Unit within the Faculty of Medicine, a satisfactory source of laboratory animals for research and teaching purposes has been established and should be of considerable benefit to the Faculty. It is hoped that the establishment of a separate breeding centre will allow the Unit to provide more facilities for animal experimental work within the Faculty and up to the standards now expected for an animal research facility. Although the running expenses for this type of building are, of course, higher than for a conventional building, the increased funds required are provided by a special supplementation of the Faculty budget so that the cost is not a burden on other departments in the Faculty. As with any new facility, the justification for its establishment can only be shown by experience.

I believe that every right implies a responsibility;
every opportunity an obligation;
every possession a duty.

— John D. Rockefeller, Jr.

SOME PARAMEDICAL PROFESSION –

THEIR TRAINING AND THEIR WORK

Institute of Medical & Health care student Asso. c/o HKPSU.

The Institute of Medical and Health Care is a newly formed institute of the Hong Kong Polytechnic. It is aimed at producing competent workers to match the expansion of the various professions in the medical field. There are at present 3 higher diploma courses and 2 lower diploma courses.

Diploma in Medical Laboratory Science (M.L.S.)

This 2-year course enables a student to use various techniques to perform tests and analysis which are important to the doctor in the diagnosis of diseases and disorders, their treatment, progress and prognosis. Apart from that MLS also plays an important role in blood banking and public health laboratory services in the community.

The entrance requirement for this course is the attainment of grade 'E' or above in at least 5 subjects including English, 2 relevant science subjects and Mathematics.

The syllabus of this course includes MLS subjects, Physics, Chemistry, General Biology, Cell Biology, Mammalian Physiology, Biochemistry, Mathematics, Statistics, Biological Methods, English, General & Communication Studies and P.E. Besides, a student is also required to have 17 weeks of field training in government hospitals.

MLS subjects include Clinical Chemistry, Haematology & Serology, Histopathology and Medical Microbiology. Clinical Chemistry is concerned with the quantitative and qualitative chemical analysis of body fluids for abnormal constituents or normal constituents in abnormal amounts. Therefore, it helps much in the diagnosis of diseases which affect the metabolism of the body, with hormone and enzyme disturbances, with toxicological investigations and with control of treatment. Haematology & Serology is the study of blood and the various kinds of cells which it contains, involving blood cell counts, the detection of anaemias, leukaemias and clotting disorders. It also involves blood grouping, cross-matching of blood and other blood-bank work in the blood transfusion services. The study of antibody-antigen reactions belongs to the field of serology. Histopathology is concerned with the theory and techniques of fixation, sectioning and staining of human tissues in order to produce a proper slide which is examined under the microscope so that abnormal tissue can be identified. Medical Microbiology is concerned with the theory and techniques that are to be used in the isolation and identification of viruses, bacteria, parasitic worms etc. from patients, and the assessment of the microorganism's response to antibiotics.

There are four main areas of activities in the clinical pathology unit of a hospital in which persons engaged in MLS may be employed. These areas cover Haematology & Serology, Clinical Chemistry, Histopathology & Cytology and Medical Microbiology. Holders of the diploma may apply for jobs in government, government subsidised and private hospital laboratories. Employment opportunities also exist in schools, colleges, universities and pharmaceutical companies.

Whether the higher diploma course in MLS will be introduced to the Polytechnic is still a mystery. In the higher diploma course, students will specialise in one of the 4 main disciplines: Clinical Chemistry, Haematology and Serology, Histopathology & Cytology or Medical Microbiology.

Higher Diploma in Diagnostic Radiography

This 3-year course prepares student to become capable of preparing and carrying out diagnostic radiographic examinations. Although the common medium employed is x—ray, the utilization of radioactive isotopes and ultrasonic waves are becoming popular in these days. The aim of a radiographer's work is to produce a good radiograph having good contrast and revealing maximum details, so as to allow the radiologist to make a diagnosis.

The minimum entrance requirement is gaining a 'C' or above in 5 O-level subjects which should include Mathematics, Physics, Biology and English. However preference will be given to candidates with relevant 'A' - level passes.

The 3-year course includes the study of subjects like Physics, Foundation Biology, Anatomy & Physiology, Nuclear Medicine, Diagnostic Ultrasound, Psychology, The Care of Patient, English and P.E. Apart from attending lectures, students are also required to have a substantial amount of practical training. The training is carried out mostly in Government Clinics/Hospitals.

Radiographers are not only employed by x—ray department of hospitals, they are earnestly required by medical laboratories and clinics in the private hospitals. Due to the fact that the Polytechnic has just started offering this course, the higher diploma in Diagnostic Radiography is not yet recognised by overseas professional bodies. However, the forth coming legislature with regard to Medical and Health Care will render HD holders registable in Hong Kong. At present, the polytechnic is seeking recognition from the college of Radiographers (U.K.). On the other hand, students make look for specialization through further studies. Diagnostic Ultrasound and Nuclear Medicine are examples of these studies.

Diploma in Dental Technology

The dental technician is an essential member of this field. He works for the prescription of a dental surgeon, making all types of dental appliances. These include dentures to replace teeth, crowns, to replace teeth that are damaged by dacay and accident, appliances to correct irregularities of the teeth and jaws.

Dental technicians use a wide variety of materials like modern plastics and metals. Modern plastics are moulded for use. Both precious and non-precious metals are shaped, formed and cast into complicated designs with a high standard of precision. There is no repetitive work — each job is done to suit an individual patient.

The entrance requirement of the course is H.K.C.E.E. with grade 'E' or above in 5 subjects including English, Mathematics and 2 science subjects.

The special subjects include Dental Anatomy and Physiology, Dental Materials, Prosthetics, Complete Denture Prosthetics, Partial Denture Prosthetics, Science of Dental Technology, Orthodontic Technology and Conservation Technology. Other subjects like Mathematics, Physical Science, Material Science, General Communication Studies, English and P.E. are also studies. The students also receive practical training in the Dental Technology Building of the Hong Kong Polytechnic during the first term. In the first term, students are required to have four hours of laboratory training each week. In the second term, nine hours are required. Moreover to compensate for the insufficient training hours within the academic year, the students have to attend a summer practical training course in which a total of 120 hours is required. In the first two years, both theoretical and practical training will be given at the Polytechnic. While in the last year the students will work in a private dental laboratory or at the Dental Hospital of Hong Kong University for actual working experience. After qualifying, the students will become dental technicians.

A dental technician can work in the government dental laboratories, private/commercial laboratories or in dental hospitals. He may also work abroad as a dental supplier of sales representative. After the diploma course, further studies can be made in the following aspects, namely, Orthodontics, Crown and Bridge, Prosthodontics and Maxillo-Facial.

Higher Diploma in Physiotherapy

Although physiotherapy is a term quite new to many dwellers of Hong Kong, it has long been used therapeutically by our ancestors. Physiotherapy is the us of physical methods — say heat, ultrasound, electricity, exercise, manipulation, massage and water — to aid in the recovery of a patient. So even the rubbing of an itchy patch of skin after receiving a nasty sting from a mosquite is a form of physiotherapy.

Most physiotherapists have certain objectives of treatment. These are to improve the functional use of certain injured areas, to regain mobility, strength and co-ordination of parts according to their respective needs, to make full use of the remaining capabilities of the severely injured areas and to prevent any onset of complications.

There are many different forms of treatment available. One way by which treatment can be done is electrotherapy. Some forms of electrotherapy are ultrasound treatment, infra-red treatment, ultraviolet treatment, short-wave diathermy, micro-wave treatment and faradism. Most of these are a form of heat treatment while others like the ultrasound and the ultra-violet have in themselves therapeutic effects. Faradism makes use of different forms of current to stimulate the action of different muscle groups or individual muscles.

Another type of treatment is exercise therapy. A patient is either made to do exercises actively or passively. By action, it means that the patient makes an effort in performing the exercises. The physiotherapist can either assist or resist his action according to the state of the muscle. By passive, it means that the patient relaxes and every movement is done by the physiotherapist. Passive exercises consist of passive movements, massage, traction and manipulation.

Some patients can also benefit from hydrotherapy

which makes use of the buoyancy of water to assist or resist the action of a muscle.

The physiotheraphy section of the Institute of Medical and Health Care is at present recognised by the Chartered Society of Physiotherapist in Britain. (The minimum entrance requirement of this course is grade 'C' or above in 5 O-level subjects which should include English and Biology). This higher diploma course is to be completed in 3 years' time. The Syllabus of this course includes major subjects like Anatomy, Physiology, Kinesiology (a study of exercise therapy), Electrotherapy and Pathology. Other subjects like foundation Biology, Psychology, English and P.E. are also required. Besides attending lectures, students are required to receive adequate training hours in the various rehabilitation centres and hospitals to fulfill the demands of the syllabus.

Once graduated, a graduate can either work as a government servant or work in private hospitals. If one prefers working on his own he can also start a firm himself and be the boss.

Higher Diploma in Occupational Therapy (O.T.)

Occupational Therapy is a form of medical treatment which is concerned with people who are physically or mentally sick and are disabled temporarily or permenantly. Occupational therapists also design activities to promote the restoration and the maximum use of functions. All these are aimed at helping the patient to meet the demands of working a in social and domestic environments.

Occupational therapists play an important role in the rehabilitation of the physically handicapped, mentally retarded, burnt, psychiatric, paediatric and geriatric patients. The places where occupational therapists are likely to be found are reform institutes, rehabilitation centres, psychiatic unit, general hospitals, geriatric unit, special schools and clinics that provide rehabilitation.

In general, occupational therapy has five functions. Firstly, the residual capacity of a patient is found out by means of assessment. Then treatment objectives and planning will be set according to it. Secondly, occupational therapy functions as a means of restoring general health and function. Thirdly, it restores local function by means of specific treatment that mobilises joint, improves muscle strength, co-ordination and endurance so that the patient can function properly in activities daily living. Fourthly, the permanently disabled ones are taught to become independent. Fifthly, diseases are prevented by the maintenance of general health through exercises, the alleviation of over-introspection, boredom and anxiety of the patient.

Activities are the treatment media in O.T. and the activities frequently used are personal activities of daily living, expressive and creative activities, intellectual and educational activities, industrial and vocational activities, recreational activities and sensorimotor activities.

Besides activities other aids are used to a facilitate rehabilitation. These are the walking aids, the splints and the pressure garments.

If a patient is leigible for discharge, the occupational therapist will instruct the patient on how to adapt to the environmental conditions and make suggestions for the patient if he faces any difficulty.

The minimum entrance requirement for this course is gaining grade 'C' or above in at least five subjects in the H.K.C.E.E. which must include English and Biology. The syllabus includes O.T. Theory, Activities of Daily Living, Recreational Therapy, Activity Studies, Psychology, Anatomy and Applied Neuroanatomy, First Aid, Foundation Biology, English Workshop, Pathology, Sensori-motor Study, Psycho-Social Study and Clinical training.

After graduation, the graduate can work in treatment fields such as psychiatric hospitals, orthopaedic hospitals, rehabilitation centres, geriatric units, hospitals for the chronically ill, general hospitals, children's hospitals, special schools and home care programmes.

For the time being, the Institue of Medical and Health Care only has the above 5 courses, but in future more courses will be introduced to supply the Medical field with sufficient workers.

DENTISTRY

UNIVERSITY OF HONG KONG

In July 1974 the Legislative Council of Hong Kong approved a white paper on the development of Medical and Health Services which included proposals for the establishment of a dental school in the University of Hong Kong.

The need for a Dental School in Hong Kong had been raised on a number of occasions previously — but other more pressing needs had to be dealt with first from the resources available.

In 1976, a Dental Academic Advisory Committee (DAAC) was appointed to advise on requirements, in terms of staff, buildings and equipment, for a degree curriculum which would meet the requirements of the General Dental Council.

Following its meetings in July and November 1976 the DAAC submitted reports incorporating schedules of accommodation for a Dental Teaching Hospital, a programme of staff development, schedules of equipment and an outline curriculum. These were approved and the Hong Kong Government provided a site at Sai Ying Pun and authorised detailed planning and staff recruitment to proceed.

Yorke, Rosenberg and Mardall were commissioned as Consultant Architects by the Public Works Department. Their detailed "brief" was developed, in consultation with members of the University's "Planning Team", from the outline schedule of accommodation recommended by the DAAC.

There will be 228 clinical positions (161 in open-plan units with associated back-up facilities, 56 individual surgeries, 9 special demonstration surgeries with T.V. facilities) and two operating theatres (in the Oral Surgery Department).

Facilities for treatment under sedation, relative anaesthesia or general anaesthesia, together with recovery facilities, will be provided in the Department of Oral Surgery, and the other clinical areas will have access to these facilities when required.

Technical laboratories for students and technicians will be adjacent to or near the clinical areas and a general purpose laboratory position per student will be provided with easy access from the clinical areas: teaching laboratories will be provided with T.V. facilities.

Departmental seminar rooms will also be provided: each is to be equipped with appropriate audio-visual aids.

To attract first class teaching staff, facilities for dental research are provided.

Eight day-beds with an associated operating theatre suite will be provided in the Tung Wah Hospital (Po Yan Street).

Facilities for major and elective Oral Surgery including the treatment of maxillo-facial injuries are to be provided at Queen Mary Hospital.

Work commenced on the site in June 1978, the substructure was completed by May 1979 and it is expected that the Building will be completed in the summer of 1980.

It was not, and still is not, the Hong Kong Government's aim to provide a dental service for the general public which is equivalent to its medical service. The stated aim is to produce more dentists for Hong Kong (i.e. to improve the present dentist/population ratio of approximately 1:7000).

Nevertheless, the Government is proposing to commence a subsidised dental service for children who enter (Government) primary schools in and after 1980.

The "School Dental Service", which is due to commence in September 1980, will be, largely, staffed with Dental Therapists and the first intake of trainee Therapists is at present being trained at the Maclehose Dental Centre. The School Dental Service will entail some further expansion of the Government Dental Service establishment of Dental Officers to provide supervision and professional back-up. Some graduates of the Hong Kong dental school may therefore find employment with the Government but the present expectation is that the majority will enter the private sector.

The DAAC recommendations included a schedule of staff requirements and a proposed order of staff development which took account of "the need to establish

a development team' as soon as possible". The development team at present comprises: Professor G.L. Howe (Dean of Dental Studies and Professor of Oral Surgery & Oral Medicine); Professor C.E. Renson (Professor of Conservative Dentistry); Mr. J.B. Shaw (Senior Dental Technologist) and Mr. A.P. Walker (Senior Assistant Registrar). Professors Howe and Renson assumed full-time duties in Hong Kong in July 1978 and Mr. Shaw in September 1978. Initially the development team was chiefly concerned with the detailed planning of the hospital accommodation and its equipment and with a closer examination of the staff requirements.

In the course of this planning it was recognised that certain categories of ancillary staff were not likely to be available in the numbers required for the proper staffing of the Dental Teaching Hospital.

The problem was defined in respect of Dental Technicians in May 1978 and the Government's response was immediate. By October 1978, 32 students were admitted to a new full-time course of training for a Polytechnic Diploma in Dental Technology and by January new teaching laboratories had been designed and equipped on the same basis and scale as those designed for the Dental Teaching Hospital and brought into operation. The course, which is intended to be compatible with TEC guide-lines, extends over 3 years: the first 2 years of full-time instruction at the Hong Kong Polytechnic and the third year in the Dental Teaching Hospital. Mr. Shaw is actively engaged in the organisation and provision of this course in addition to participating in the planning work at the University.

The shortage of trained chairside assistants, and dental hygienists has led to the formulation of proposals for similar Polytechnic/University co-operation in the provision of courses for these and other ancillary workers. The proposals have not yet been formally adopted and the details have yet to be worked out but the basic concept is of a core curriculum which would provide Dental Health Instructors (6 months), Dental Surgery Assistants (12 months), Extended Duty Dental Surgery Assistants (2 years), Hygienists (3 years). At the completion of each stage the trainees would be qualified for a particular role but would have the prospect of further progress.

It is intended that the undergraduates will be trained as the leaders of dental health care teams and close support (four-handed) dentistry will be taught in all the clinical disciplines throughout the course.

Proleptic appointments have been made to three additional chairs:— Professor A.H. Brook to Children's Dentistry and Orthodontics; Professor R.K.F. Clark to Prosthetic Dentistry; and Professor W.I.R. Davies to Periodontology and Public Health. Professors Brook, Clark and Davies visited Hong Kong in February 1979 to participate in a Curriculum Conference; they will assume full-time duty in Hong Kong in January 1980.

The Curriculum Conference was extremely successful and has resulted in the formulation of Regulations and outline Syllabuses for the degree of Bachelor of Dental Surgery which are currently under consideration in the University Senate. The Curriculum follows the recommendations of the Dental Academic Advisory Committee in that it places great emphasis on prevention; the teaching will be organised on the basis of small groups and there will be a high degree of integration within the dental clinical disciplines and between 'pre-clinical' and 'clinical' studies as a whole.

The five clinical dental departments — Children's Dentistry and Orthodontics; Conservative Dentistry; Prosthetic Dentistry; Oral Surgery and Oral Medicine; Periodontics and Public Health — together with appropriate supporting 'divisions' or 'units' in Radiography, Anaesthetics, Dental Materials, Photography, etc. — will be wholly accommodated in the new Dental Teaching Hospital which is planned for an output of 60 graduates a year. Clinical instruction in Medicine and Surgery will be conducted by members of the University departments of Medicine and Surgery in the wards of the Tung Wah Hospital (which is almost adjacent to the Dental Teaching Hospital and which will provide day-bed facilities for the dental school). In addition to the clinical and teaching laboratory facilities the hospital will also include a library and facilities for research and for continuing graduate education.

The Dental Library will occupy some 380 square metres on the 6th floor of the Hospital Building. It will have a staff of one Assistant Librarian, five Library Assistants and three attendants, and will be provided with an ear-marked setting-up grant which will endable the ordering of books and journals to commence in mid 1979.

The first intake of 76 dental undergraduates will be admitted to the preclinical curriculum in September 1980. Instruction in pre-clinical subjects will be provided by departments of the Faculty of Medicine at Sassoon Road—some two miles away from the site of the dental hospital at Sai Ying Pun. The Medical Faculty accommodation at Sassoon Road includes the Medical Library, Faculty Office and the Pre-clinical Departments. By mid 1980 there will be a new student amenities building and a new animal house to serve the teaching and research needs of both medicine and dentistry. The clinical departments of the Faculty of Medicine are housed in the nearby Queen Mary Hospital where there

is also an Electron Microscope Unit which is available to all departments of the University. It houses a Philips EM 300 and a Cambridge SEM 150 B.

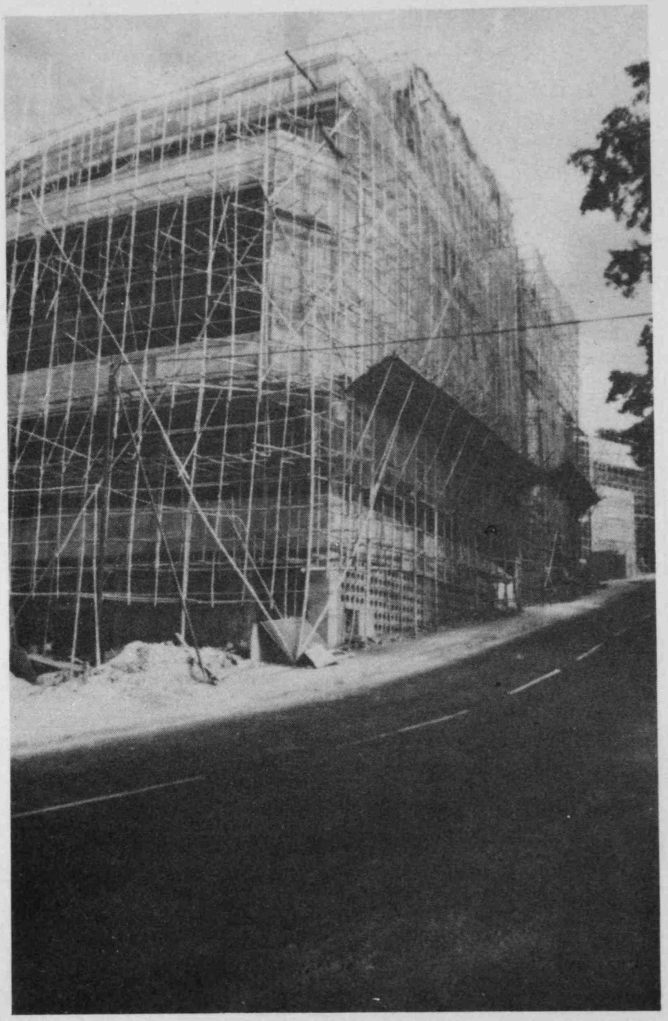
Computer facilities are available in the University which is a member of the Universities and Polytechnic Computer Centre (UPCC), a central organisation set up to co-ordinate computer services in the two universities and the polytechnic. UPCC is developing a ring type computer network with PDP 11/70 systems acting as nodes at each of the three sites. The main computer system presently available on the network is an ICL 1904S with 196K words of main store. Graphics facilities are provided by a CALCOMP 936 plotter, Tektronix 4010 displays and a GRAF/PEN digitizer. An IBM 3031 system is to be installed in the 1979-80 period.

It is anticipated that the Dental Hospital will be linked to the network in due course but that the initial development of systems for the computerisation of patient and student records, inventory and stock control will be undertaken by a separate project group comprising 1 Senior Systems Analyst and 2 Programmers.

The programme of staff development is phased to meet the expanding requirements to provide for the admission of dental undergraduates to the clinical practice of the hospital in and after September 1980.

The University is currently recruiting four Dental Technological Instructors, a systems analyst and a dental librarian and expects to advertise Senior lectureships in Public Health (Dentistry) and in Oral Surgery and Oral Medicine in the very near future (with a view to filling the post from January 1980).

In September 1979 the University will advertise a number of teaching posts in dental subjects with a view to having the appointees take up duty in August/September 1980. These will include Lecturer posts in each of the 5 dental clinical departments and Senior Lecturer/Reader posts in Radiology, Anaesthetics, Dental Materials, Conservative Dentistry, Prosthetic Dentistry and Children's Dentistry and Orthodontics.



At twenty a man is full of fight and hope.
He wants to reform the world.
When a man is seventy he still wants to reform the world, but he knows he can't.

— Clarence Darrow

JOURNAL

PERIPHERAL ARTERIAL DISEASE IN HONG KONG — A RARITY?

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Peripheral arterial disease in the form of atherosclerosis is regarded as uncommon amongst the indigenous people of the East. However, there has been no substantiation of this impression. Arterial diseases reported from these countries usually belong to the inflammatory types, such as Buerger's or Takayasu's disease. This apparent rarity of atherosclerotic arterial disease is even more remarkable when one considers the high proportion of heavy cigarette smokers in the male population.

Racial, dietary, and climatic factors have traditionally been thought responsible for the low incidence of this condition. It has also been assumed that the shorter life expectancy in these developing countries has excluded the population from acquiring this degenerative disease. This explanation is no longer tenable, as the present mean life expectancy in Hong Kong is over 70 years.

Other factors which may be more important in perpetuating the reported low incidence of overt vascular disease are: (i) the more stoical Oriental patient may not complain of claudication; (ii) the prevailing exercise pattern and low mean body weight may make claudication less severe; (iii) the low incidence of any thrombotic tendency may make progression to gangrene less common; (iv) there is a low index of suspicion on the part of the medical attendant in diagnosing symptoms of vascular insufficiency; and (v) there is a lack of trained personnel and facilities, so that fewer patients with vascular disease are referred for treatment. In order to document the pattern and incidence of occult and symptomatic peripheral arterial disease, two studies were conducted by the University Department of Surgery; these studies were designed to determine (i) the incidence of unsuspected peripheral arterial disease amongst surgical patients, and (ii) the types of arterial problems encountered in symptomatic patients.

(i) **Incidence of unsuspected peripheral arterial disease**

A total of 1,052 patients admitted to the University Surgical Unit in the Queen Mary Hospital were surveyed. All were Chinese. Only 12 patients who presented primarily with arterial disease in the same period were excluded from the study.

From each patient a cardiovascular history was obtained to include symptoms of limb ischaemia, and any history of ischaemic heart disease, hypertension, cerebrovascular disease and diabetes mellitus. Cigarette and alcohol consumption and narcotic intake were also recorded. Physical examination included measurement of blood pressure and full assessment of the peripheral arteries by palpation. The pulses examined were the superficial temporal, internal carotid, common carotid, axillary, brachial, radial, ulnar, abdominal aorta, external iliac, femoral, popliteal, posterior tibial and dorsalis pedis. Auscultation was performed over any major arteries which were palpably enlarged, weak, or absent.

Smoking was assessed on the number of cigarettes smoked per day. Alcohol consumption was graded as "occasional or social", "moderate" (two bottles of beer or one catty of Chinese wine or less per day), and "heavy" (more than two bottles of beer or one catty of Chinese wine per day). One catty of Chinese wine is approximately equivalent to half a bottle of whisky. Narcotic consumption was classified as either "occasional", or "regular" if the patient took narcotics daily.

The X^2 test with Yates's correction was used to test the statistical significance of the various findings.

Findings

1. Abnormalities of the major peripheral arteries. - These are listed in Tables 1 and 2. Twenty-four patients (with 31 affected limbs) were found to have abnormalities of the major peripheral arteries. All were males. The age distribution and the abnormalities found in this group of patients are shown in Tables 1 and 2 respectively. The vessels involved were restricted to the abdominal aorta and those of the lower

extremities.

Abdominal aortic aneurysms were detected in three patients. Their transverse diameters were between 5 and 6 cm. Aneurysmal dilatation of the femoropopliteal arteries was found in three patients, and the condition was bilateral in all three.

Aorto-iliac obstruction was encountered in two patients. One of these had severe claudication, although he presented with a duodenal ulcer. The other patient was asymptomatic, but had reduction of both femoral pulses and loud bruits in both groins.

Absent iliac and distal pulses in two further patients followed selective hepatic arteriography for hepatocellular carcinoma. Only the punctured artery was affected. Neither patient had any immediate acute ischaemic symptoms following arteriography, and the condition was detected during the survey when the patient was readmitted to hospital for assessment some weeks later. Both patients had developed claudication. These two patients therefore do not belong to the atherosclerotic group, but have been included in this survey because their abnormalities were not suspected.

Unilateral reduced femoral pulses and unilateral absent popliteal pulses were found in three patients in each group. Reduced popliteal pulses were noted in a further eight patients, in five of whom the finding was bilateral. Of these 14 patients, none complained of claudication even on going upstairs.

All three patients with symptoms were submitted to surgical arterial reconstruction, with a successful outcome in each.

Table 1
Abnormalities of Major Peripheral Arteries. Total 24, All Males

Age (Years)	Total number	Aneurysmal disease	Occlusive disease	Total	Percentage
10-19	31	0	0	0	0
22-29	58	0	0	0	0
30-39	62	0	2*	2	2.2 (1.6)+
40-49	104	1	2*	3	3.9 (1.9)+
50-59	165	2	4	6	3.6
60-69	162	2	6	8	4.9
70-79	79	1	3	4	5.1
80-89	14	0	1	1	7.1
	675	6	18	24	

* One patient had postarteriogram arterial thrombosis.
\+ Percentage after exclusion of postarteriogram arterial thrombosis appears in brackets.

Table 2
Abnormalities of Major Peripheral Arteries

	Patients	Limbs
Aneurysmal disease:		
Abdominal aorta	3	
Femoropopliteal arteries	3	6
Occlusive disease:		
Aorto-iliac	2 (1)	4
Absent iliac pulse*	2 (2)	2
Reduced femoral pulse	3	3
Absent popliteal pulse	8	3
Reduced popliteal pulse	3	13
Total	24 (3)	31

Number of patients with symptoms appear in brackets.
* Following arteriograpms.

2. Reduced or absent ankle pulses. - A total of 204 patients were found to have reduced or absent ankle pulses.

   Of 675 males examined, 141 (20.9%) had one or more ankle pulses affected. This figure was not significantly different from 63 (16.7%) of 377 females similarly affected. However, of 2,700 ankle pulses examined in males, 321 (11.9%) were affected, as compared with 119 (7.9%) of 1,508 ankle pulses examined in females. This difference is highly significant ($P < 0.001$).

   Thus although the number of patients affected was not significantly different in the two sexes, the number of pulses affected per person was different, being 2.27 pulses per affected male patient and 1.89 pulses per affected female patient. The proportions of weak or absent ankle pulses were approximately equal, and the posterior tibial and dorsalis pedis pulses were equally affected.

   An increase in both incidence and bilateral involvement was noted with increasing age in both males and females.

3. Reduced or absent ulnar pulses. - A total of 149 patients were found to have reduced or absent ulnar pulses.

   In 675 males examined, one or both ulnar pulses were weak or absent in 103 (15.2%). In the female patients, 46 (12.2%) out of 377 were similarly affected, and this figure was not significantly different from that in the male population. Of 1,350 ulnar pulses examined in males, 197 (14.6%) were affected. Of 745 ulnar pulses examined in females, 87 (11.5%) were similarly affected. The difference between the

sexes is not significant. The average number of ulnar pulse deficits per affected patient was 1.91 in males and 1.89 in females.

There was an increase in ulnar pulse deficit with age, but not of bilateral involvement, since approximately 90% of ulnar pulse deficits in both sexes were bilateral.

Approximately three-quarters of pulses in males and two-thirds in females were absent.

4. Personal habits. - These are summarized in Table 3.

The majority of males (76.6%) were smokers, and of these 73% smoked 20 or more cigarettes per day. In contrast, only 9.8% of females were smokers, and most of them (65%) smoked less than 20 cigarettes per day. Amongst male smokers, 29% smoked in the 10 to 19 year age group, 46% in the 20 to 29 year group, and from then onwards approximately 80% were smokers.

Of the males 62.8% drank alcohol, and in this group 63.2% were moderate to heavy drinkers. Only 9% of females drank alcohol, and 85.3% were social or occasional drinkers.

Twelve per cent of males used narcotics, and of these 80.2% were daily users. Only one female patient used them, and she was a regular user.

In contrast with the cigarette smoking habit, the maximum incidence occurred in the older age group.

5. Incidence of cardiovascular disease and diabetes mellitus. - There was no significant difference in the incidence of ischaemic heart disease, hypertension, cerebrovascular disease, and diabetes mellitus, between the sexes. There were 51 (7.5%) males with cardiovascular disease, compared with 26 (6.9%) females, and 21 (3.1%) males with diabetes, compared with 6 (1.6%) females.

6. Association of abnormalities of major peripheral arteries, ankle and ulnar pulse deficit, personal habits, cardiovascular disease and diabetes mellitus. - A summary of the statistical association between the above factors is shown in Table 4. A significant correlation was found between abnormalities of the major peripheral arteries and reduced or absent ulnar pulses, cardiovascular disease, and diabetes mellitus.

Reduced or absent ankle pulses were significantly associated with reduced or absent ulnar pulses, but neither were significantly correlated with the other factors examined.

Since abnormalities of the major peripheral arteries were found only in males, comparisons were made with the male population only.

Table 3
Personal Habits In 675 Males And 377 Females

SMOKING HABITS							
	Cigarettes per day					Total	Percentage
	5	10	20	30	40+		
Males	49	90	261	61	56	517	76.6
Females	14	10	11	2	0	37	9.8
						P < 0.001	

ALCOHOL CONSUMPTION					
	Occasional	Moderate	Heavy		
Males	156	152	116	424	62.8
Females	29	4	1	34	9.0
				P < 0.001	

NARCOTIC INTAKE				
	Occasional	Regular		
Males	16	65	81	12.0
Females	0	1	1	0.3
			P < 0.001	

Table 4
Association Table for Abnormal Pulse Findings and Other Relevant Factors Studied

	Reduced or absent Ulnar pulses	Personal habits	Cardiovascular disease	Diabetes mellitus
Abnormalities of Major peripheral arteries (Males only)	P<0.005	N.S.	P<0.05	P<0.01
Reduced or absent ankle pulses (Males and females)	P<0.05	N.S.	N.S.	N.S.
Reduced or absent ulnar pulses (Males and females)	-	N.S.	N.S.	N.S.

N.S. = Not significant.

Discussion

Abnormalities of Major Peripheral Arteries. - The overall presence of this abnormality in the total population studied was found in 24 patients out of 1,052, that is, 2.3%. If only males over 40 years of age are considered, and if one excludes the two

patients who developed occlusion following arteriography, then atherosclerosis as the probably cause of major arterial abnormalities occurred in 21 out of 524 patients, that is, in 4.0%. This figure is similar to the 5% — 7% estimated by Eastcott (1973) to have "recognizable" peripheral arterial disease in the middle-aged and elderly section of the general population. However, it is not certain whether or not these patients had symptoms. Widmer et alii (1964), in a similar study of 6,400 working subjects in Basle, Switzerland, found the overall incidence to be 1.6%, but in male patients over 40 years of age it was 2.6%. A similar rise in incidence with age was noted in both the present study and Widmer's series. One-third of Widmer's patients with occluded limb vessels were asymptomatic. Although the two groups of patients were vastly different, it appears that subclinical arterial disease in Hong Kong - at least as detected by palpation - is not uncommon, and not dissimilar to that recorded in European patients.

Of the 24 patients in whom the condition was so detected, only three had symptoms, and none complained of claudication, even in hospital and after a clinical history had been taken. The incidence of claudication in these 24 patients was still much lower than in similar patients reported by Widmer et alii (1964). If the two patients with postarteriography arterial occlusion are excluded, then only one patient out of 1,052 studied was symptomatic on the basis of atherosclerosis which was surgically remediable. It is possible that in our group of patients obliteration of the arterial system is not as extensive, or the collateral circulation is better developed, or superadded thrombosis on the affected arterial wall is less common, or the patients complain less, or the appreciation of these symptoms is different from that which occurs in European patients.

All patients with major peripheral arterial abnormalities were male, and highlight the difference between the sexes in this condition. A significant and surprising finding was the lack of association between cigarette smoking and major peripheral artery abnormalities.

Reduced or absent ankle pulses. - The incidence of impalpable posterior tibial and dorsalis pedis pulses was similar to that reported by Morrison (1933), Reich (1934), Silverman (1946) and Ludbrook et alii (1962).

Both the increase in incidence and in bilateral involvement with age, together with a significant association with ulnar pulse deficit, suggest that atherosclerosis is responsible for obliteration of these small arteries. No significant association was found between deficient ankle pulses and cigarette smoking, cardiovascular disease, and diabetes mellitus. There was, however, a highly significant difference in the number of ankle pulse deficits between the sexes, with a preponderance of males. Perhaps this is related to the higher proportion of heavy cigarette smokers in men.

It appears that little significance can be attached to the findings of a deficient ankle pulse if this is present in isolation, a conclusion also drawn by Ludbrook et alii (1962).

Reduced or absent ulnar pulses. - The high proportion (90%) of bilateral ulnar pulse deficits at all age groups would suggest that this finding is an anatomical variant. Lack of correlation with smoking habits, cardiovascular disease and diabetes mellitus lends support to this opinion. However, an increase in incidence with age and a positive correlation with abnormalities of major peripheral arteries both favour some degree of atherosclerotic involvement.

The overall incidence of absent ulnar pulses in this study is 9.8%, which is similar to the incidence of 6% reported by Little et alii (1973) of a functionally absent (and presumably impalpable) ulnar artery as detected by Doppler examination in a "normal" population. An impalpable ulnar pulse should therefore alert the clinician to the increased risk of digital ischaemia associated with procedures which may compromise the patency of the radial artery.

Personal habits. - Considering the weight of evidence incriminating cigarette smoking with peripheral arterial disease, the incidence of symptomatic major arterial abnormalities is exceedingly low in this population of male heavy smokers. Alcohol consumption and narcotic intake also appear to be insignificant factors. However, since major arterial abnormalities occurred only in males and since these are the heavy smokers, a causal relationship cannot be completely excluded in this population, but perhaps the effect is only minor.

(ii) Types of Arterial Problems in Symptomatic Patients

A total of 163 patients with various arterial conditions came under our care over a three year period from 1975-1978. In the same period approximately 35,000 adult general surgical patients were admitted to this Unit. The incidence of patients admitted with arterial symptoms is thus 0.5%.

Findings

The types of arterial diseases encountered, the number, sex, and age of patients in each category, and the treatment carried out, are shown in Table 5 and 6. Atherosclerosis as a cause of arterial disease was found in 52% of patients and is the commonest cause. Aneurysms (all due to atherosclerosis) was the single most common condition encountered, and 36 of the 46 aneurysms were located in the abdominal aorta. Nine of the abdominal aortic aneurysms were ruptured on presentation and were all operated on with 2 deaths. Fifteen elective abdominal aneurysmectomies were performed with 1 death.

For obliterative disease, surgery, where possible, carried little risk to life; although for distal reconstructions, there was a threat to limb if the operation was unsuccessful.

Buerger's disease is by far the commonest form of arteritis seen in Hong Kong, but unfortunately for those afflicted, direct arterial surgery is rarely possible. To aggravate their own condition, these patients usually cannot give up cigarette smoking. Takayasu's disease may cause renal artery stenosis or aorto-iliac obstruction.

Only one of 16 patients who had peripheral embolism had the embolus lodged in the upper limb. The rest were in the distal aorta, or, more commonly, in the external iliac or femoral arteries. The source of clot in 12 of these patients was from a heart affected by coronary artery disease. Embolectomy is a simple, quick and limb-saving procedure and can be performed under local anaesthesia.

Table 5
Peripheral Arterial Disease 1975-1978

	Patients	(M/F)	Mean Age	Range
Aneurysms	46	(41/ 5)	65.7	31-80
Atherosclerosis Obliterans	38	(27/11)	63.1	42-83
Arteritis	32	(29/ 3)	38.3	19-55
Embolism	16	(5/11)	58.4	17-81
AV Anomalies	13	(7/ 6)	32.3	18-69
Trauma	11	(9/ 2)	42.3	23-61
Others	7	(4/ 3)	42.1	18-65
	163	(122/41)		

Table 6
Peripheral Arterial disease. Conditions and Treatment

	Patients	(M/F)	Arterial Surgery	Other Operations	Conservative°
Aneurysms	46	(41/ 5)	33*	2*	12
Atherosclerosis Obliterans	38	(27/11)	17	4	17
Arteritis	32	(29/ 3)	5	10	17
Embolism	16	(5/11)	14	0	2
AV Anomalies	13	(7/ 6)	8*	2*	4
Trauma	11	(9/ 2)	9	1	1
Others	7	(4/ 3)	1	3	3
	163	(122/41)	87	22	56

° Including patients who refused surgery or defaulted follow-up
* One patient with both treatment

Cavernous haemangioma and arterio-venous fistula were the usual congenital vascular anomalies seen. Surgical excision is the treatment of choice although this is sometimes not possible because of proximity of vital structures.

Arterial trauma is relatively uncommon and always require urgent exploration. The common causes of trauma are catheterisation for arteriography, blunt injury and operative misadventure.

Other conditions seen are neurogenic claudication, popliteal artery entrapment syndrome, sclerodema and coagulation disorders.

Discussion

This study demonstrates that peripheral arterial disease and other arterial conditions that require treatment as seen in a large teaching hospital in Hong Kong were uncommon, but atherosclerotic patients still formed the largest group. Although subclinical atheromatous arterial disease in Hong Kong is not less frequent than in other Western communities, there appears to be a lack of progression of the disease. Perhaps the pattern of occlusion of arteries in more advanced disease is different in our patients from that seen in Western countries.

Jones et alii (1970) and Bouhoutsos et alii (1973) reported an interesting association between peptic ulcer disease and abdominal aortic aneurysm as well as with aorto-iliac occlusive disease. They found an incidence of 20% to 25% of peptic ulcers in patients with atherosclerotic disease affecting the major abdominal arteries. In one-third of our patients with a similar pattern of arterial disease,

chronic peptic ulcers were demonstrated. Although cigarette smoking had been suggested as the common cause for both conditions, Martin and Marston (1973) thought this unlikely, as this association was not present in more peripheral atherosclerosis.

Patients in Hong Kong accepts surgery readily if they have symptoms and if the symptoms are sufficiently severe, e.g. progressive claudication of recent onset. However, many patients with serious conditions, particularly abdominal aortic aneurysms, refuses surgery because they are asymptomatic. Understandably, it is difficult to convince an elderly patient the need for a major operation when he feels perfectly well. Unfortunately, this prevailing attitude accounts for our high proportion of patients who present with rupture.

Conclusion

Occult, peripheral arterial disease, as detected by palpation, is not uncommon in the Hong Kong Chinese, and is similar in incidence to that reported in European populations. Symptomatic peripheral arterial disease, on the other hand, is distinctly less common in the local population as compared to Western communities. The reason for this apparently contradictory finding may be because of different rates of progression of disease.

There is an understandable but unfortunate reluctance amongst our patients to refuse surgery for the asymptomatic but potentially lethal abdominal aortic aneurysm; patients with ischaemic symptoms, however, usually accepts surgery without reservation.

With greater awareness on the part of doctors in recognising and detecting peripheral arterial disease, and with appropriate counselling of patients, many patients with treatable conditions may be offered, and be convinced of the need for limb-saving and, at times, life-saving reconstructive arterial surgery.

Acknowledgement

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References

Bouhoutsos, J., Barabas, A. and Martin, P. (1973) Brit. J. Surg., 60:302.

Eastcott, H.H.G. (1973) Arterial Surgery, Pitman Medical, London: 2.

Jones, A.W., Kirk, R.S. and Bloor, K. (1970) Gut, 11:679.

Little, J.M., Zylstra, P.L., West, J. and May, J. (1973) Brit. J. Surg., 60:652.

Ludbrook, J., Clarke, A.M. and McKenzie, J.K. (1962) Brit. med. J., 1:1724.

Martin, P. and Marston, J.A.P. (1973) Peripheral vascular disease in Recent Advances in Surgery, edited by S. Taylor, No. 8, Churchill Livingstone, Edinburgh: 412.

Morrison, H. (1973) New Engl. J. Med., 208 : 438.

Reich, R.S. (1934) Ann. Surg., 99 : 613.

Silverman, J.J. (1946) Amer. Heart J., 32 : 83.

Widmer, L.K., Greensher, A. and Kannel, W.B. (1964) Circulation 30 : 836.

EPSTEIN BARR VIRUS (EBV) AND NASOPHARYNGEAL CARCINOMA (NPC)

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Factors Associating with NPC

There are about 1000 cases of nasopharyngeal carcinoma (NPC) in Hong Kong annually most of which occurs to Southern Chinese. This makes NPC only second to lung cancer as the most prevalent malignant disease. NPC occurs even more frequently in Canton where there are reportedly over 3000 NPC cases per year for a population of two and half million. Disease incidence is somewhat lower in other Chinese cities. Migrant Chinese in other countries are known to sustain a susbstantially higher incidence of NPC than the endogenous populations of these countries and where there have been mixed marriages with migrant Chinese, offsprings of these mixed marriages seem to show an incidence of NPC that is intermediate between those of the migrant Chinese and the endogenous populations. Among the other racial groups, NPC occurs more frequently in Tunisian and Eskimos while the disease is rarely seen in Caucasians.

The above suggests involvement of genetic and/or environmental factors in the pathogenesis of NPC. Indeed, NPC is known to aggregate in families. Ho showed that NPC is more likely to occur to family members of NPC patients than to those of patients with other cancers. In 60 sibships of NPC patients, it was found that siblings having NPC are distributed as though susceptibility to the disease is an autosomal recessive trait. Simons and his co-workers conducted extensive immunogenetic studies on Chinese NPC patients in Singapore and Hong Kong. These investigators reported a genetic disequilibrium with respect to HL—A haplotype of these patients as compared with control groups. These findings suggest that susceptibility to NPC is an inheritable trait determined probably by an autosomal recessive gene that is in linkage with the major histocompatibility gene complexes.

Henderson and others compared NPC incidence between first and subsequent generations of overseas migrant Chinese. These investigators reported a significant decrease in NPC incidence among the offsprings from that of their forbears which is believed to reflect a differential exposure to environmental carcinogen between the two groups: The older generation would have been exposed to the environmental agents before they migrated but their offsprings born in the new country are spared from such exposures. It is believed that diet constitutes an important source of environmental agents. Ho and others surveyed the dietary habits of Chinese and concluded that salted fish is one of the most likely of the food items containing environmental carcinogens. Subsequent studies by Fong, Huang, Ho and others revealed a high concentration of nitrosamines, a well established group of carcinogens, in salted fish. A life long consumption from infancy of salted fish is a unique dietary habit of Chinese and Ho believes exposure early in life to dietary carcinogens is important in the pathogenesis of NPC.

Epstein Barr virus (EBV), a ubiquitous virus of the herpesvirus group, has recently emerged as yet another possible causal agent of NPC. Early serological studies by Henle and colleagues revealed a close association between NPC and the virus. The genomes of the virus and certain viral antigens (EB nuclear antigens) are consistently detected in NPC cells. By treatment of NPC cells with halogenated nucleotide analogues, infective EBV had been recovered from NPC cells. These findings are significant in view of the now well established capacity of EBV to cause transformation of lymphoid cells in vitro and its ability to cause malignant diseases in primates. But the findings are somewhat curious, because as far as can be ascertained, EBV only affects lymphoid tissue of man and to some extent, also those of primates. Therefore the presence of the EBV genomes in NPC cells would represent an exception to the otherwise strictly lymphotropic properties of this virus. This raises a question as regards the origin of the virus in NPC cells; is it caused by direct infection of these cells by the virus or was the virus transfered there through fusion with EBV infected lymphoid cells?

EBV as a CAUSAL AGENT

From the foregoing, it may be concluded that NPC is associated with at least three factors of genetic, environmental and viral origins respectively. The nature of association with these factors in which lies the key to our understanding of NPC, remains however, unknown. It would be of interest to know for example, which one or more of these factors is the primary cause and which, the co-factors. For the causal agent, we would like to know the way by which it initiate the disease process and for the co-factors, we wish to determine how they facilitate the disease process. These questions are not only pertinent from a mechanistic standpoint but they are also relevant to our attempt at disease control. Attempts at answering these questions are likened to that at fitting pieces of gigsaw puzzle in which one must begin by putting a few pieces together and then expand upon the rudimentary pattern. In the following I shall describe our approach in which we begin by assuming EBV as the primary agent:

In singling out EBV among the three factors as the causal agent of NPC, we considered first the well documented oncogenic properties of the virus. Also considered were the scope for experimental verification if the other factors were the causal agents: Current technology in human genetics is not considered as sufficiently advanced to allow meaningful approach to test whether genetic factors may cause NPC. Environmental agents might well be a primary cause of NPC but definitive experiments of nature are already in progress in the different migrant Chinese populations abroad who are exposed to quite a different environment from that in China. Similar experiments are also in progress in Hong Kong where for better or worse, we are witnessing a rapid sociological change including our dietary habits. To these, we concede our own inadequacy in devicing an experiment that is anywhere near as comprehensive as the experiments of nature. But as pragmatists and for want of something to occupy our time, we embark upon our experiments based on the assumption that EBV is the primary cause of NPC. We do not feel that our approach and the experiments of nature are necessarily mutually exclusive.

In the first instance, we tested the nature of disease association against Koch's postulates to ensure in as far as possible, that EBV is indeed a causal agent of NPC. Thus, the consistent presence of EBV genomes in NPC cells would appear to satisfy the first Koch's postulate because it is clear now that it is the viral nucleic acid but not so much the viral particles, that is the principle infective agent. The second postulate of Koch's requires that the infective agent be retrieved from the disease tissue and propagated in culture. Indeed, EBV has been recovered from NPC cells and used to transform normal lymphoid cells. The transformed cells are being cultured and along with it, EBV from NPC cells are propagated. The third postulate is concerned with production of experimental NPC using EBV originating from NPC cells but there is yet no suitable animal model.

Huang and colleagues studied the effect of experimental EBV infection of tissue explants using biopsy specimens obtained from normal nasopharynx (NP) of 20 patients in whom neoplasm had been excluded on clinical and histological grounds. Also tested similarly were biopsies obtained from primary tumour sites of 10 NPC patients and 7 patients with other cancers and 9 tonsillar biopsies. In these experiments, 6 tissue fragments each from a biopsy were treated or not with an EBV preparation, washed and then cultured on glass cover slips. EBV infection was found to stimulate the rate of epitheliod cell outgrowth from the explants of all but one of the 20 NP biopsies. This stimulation was apparent by 12 days in culture following infection with EBV and by 15 days, the mean sizes of the stimulated outgrowth were up to 6 time larger than that of the corresponding uninfected control. This proliferation continued and by the 10th week, the outgrowths had extended to cover the entire coverslip and onto the petri dish. The uninfected control NP explants on the other hand, grew slowly in monolayers beginning to show signs of cell degeneration and detachment from the coverslips about 3 weeks after explantation.

The mean diameters of outgrowth from different tissue explants observed at the 15th day after EBV infection are shown in Table 1. For comparison of the stimulating effect of EBV infection on the growth of the different tissue explants, a value of 1.8 which is the ratio of the mean size of outgrowth from the EBV infected tonsillar explants to the mean size of the outgrowth from the corresponding uninfected control explants + 2 standard deviation, was chosen as the lower limit of positive stimulation. It is apparent that a positive stimulation of cell outgrowth, as defined, occurred significantly more frequently and to a greater extend in the EBV infected NP explants.

Apart from the NPC tissue, the lower susceptibility to the growth stimulatory effects observed with the other tissues is consistent with natural infection with EBV which, with the only exception as in the case of NPC, occurs only in lymphoid tissues. It is well documented that EBV infection of lymphoid cells already harboring the EBV genomes often activates the end-

Table 1 Growth of test and control tissue explants observed at the 15th day after infection with EBV

Tissue	No. of specimens	Mean growth diameter (mm ± SD)		Mean growth ratio infected/uninfected	No. with growth ratio ⩾1.8	P (X^2 test)
		uninfected	infected			
Normal Nasopharynx	20	12.3±2.9	34.6±14.8	2.8±1.2	19/20	–
NPC	10	15.7±3.2	20.3± 7.8	1.3±0.5	3/10	<0.001
Other tumours	7	14.0±4.2	23.0±13.8	1.7±0.9	2/7	<0.005
Tonsil	9	23.8±5.1	26.7± 7.4	1.1±0.3	1/9	<0.0005

Comparisons were with normal nasopharynx.
EBV obtained from culture supernatent of B95-8 Cell line.
(Huang, Ho, Ng & Lui. Br. J. Cancer, 35, 630, 1977).

ogenous viral genomes to an abortive replicative viral cycle and as a consequence, causes death of the cells. As NPC cells are known to harbor the EBV genomes, it seems possible that the lower susceptibility to the growth stimulating effects observed with the NPC explants may likewise be attributed in parts at least, to activation of the endogenous viral genomes in the tumour cells.

After infection with the virus preparation, the NP explants showed a marked change in cellular morphology. After the first week, the cells from the uninfected NP explants grew in monolayer consisting of predominantly polyhedral cells of relatively uniform morphology with a low nucleus-to-cytoplasm ratio and predominantly normochromatic nuclei. In contrast, the infected NP explants proliferate at a much higher rate, with foci of cell piling and disoriented cell distribution (Fig 1). The outgrowth from infected explants showed marked cellular pleomorphism, increased mitotic indices, abnormal mitotic figures, occasional presence of multinuclear giant cells, increased nucleus-to-cytoplasm ratio and nuclear hyperchromatia in many of the cells (Fig 2).

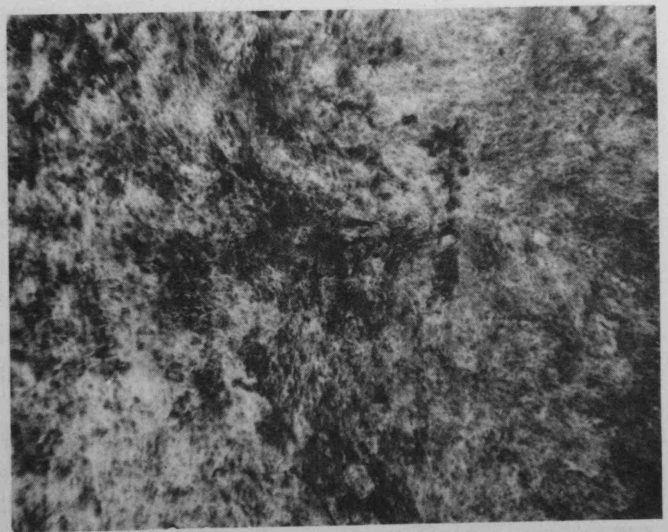

Fig 1 Low power view of outgrowth from an EBV infected explant from normal nasopharynx. Note foci of cell piling and disoriented cell distribution. (Huang, Ho, Ng & Lui. Br. J. Cancer, **35**, 630, 1977).

Fig 2 High power view of outgrowth from an EBV infected explant from normal nasopharynx. Note cell pleomorphism, high nucleus-to-cytoplasm ratio and hyperchromatic nuclei. (Huang, Ho, Ng, Lui. Br. J. Cancer, **35**, 630, 1977).

The rapid proliferation with foci of cell together with the changes in cell morphology observed with the EBV infected NP explants are some of the features of transformed cells. The findings that the growth stimulatory effect could be abrogated when some of the explants were pretreated with interferon, an antiviral agent, or were infected with EBV which had previously been reacted with antibodies to the virus would further suggest that transformation is mediated by EBV infection. Taken together with the apparent tissue specificity of

this effect, the present findings are significant in that the EBV infection of tissue explants may be potentially a useful experiment model for NPC. But before its application as such, it is essential that outgrown cells are further investigated by electronmicroscopy to ascertain that they are indeed epithelial and by passage in nude mice and/or growth in soft agar. The ability of transformed cells to grow under the latter conditions is considered as a reflection of their malignant properties.

Implications of Disease Association

In sum, the association between EBV and NPC satisfies the first and second postulates of Kochs. The only approach open at present to test this association against the third postulate of experimental production of NPC is by infection of nasopharyngeal cells with EBV. Although the results are compatible with NPC in that EBV infection of non lymphoid cells appears to be restricted to cells from the nasopharynx and that the transformed cells bear certain morphological resemblence to NPC cells, such an approach is not expected to provide an unequivocal verification of Koch's third postulate. Therefore, direct proof that EBV is indeed a causal agent of NPC is unlikely to be forthcoming at least for the near future. Whichever be the nature of association the consistent presence of EBV in NPC cells has allowed the application of EBV serology in diagnosis and early detection of the disease and this feature opens up the possibility of using EBV vaccines as a means to control the disease.

Recently, it was shown that a large preponderance of NPC patients (over 95%) has serum EBV IgA antibody (Table 2). This antibody is rarely detected in sera from different control subjects which included healthy subjects (none out of 89) and patients with other cancers (13%). More surprisingly, only a small proportion of the patients with the other EBV associated diseases. e.g. infectious mononucleosis and African Burkitt's lymphoma, show only low titre of this antibody. 21% of healthy family members of NPC patients however showed serum IgA antibody to EBV.

To further evaluate diagnostic application of the EBV IgA antibody test, 99 E.N.T. patients suspected of having NPC were investigated (Table 3). 41 of these patients were subsequently found to have histologically confirmed NPC of whom, 39 also gave diagnostic titres of IgA antibody to EBV viral capsid antigen (VCA). The remaining 58 patients did not show histological evidence of NPC and of these non-NPC patients, only 2 had diagnostic titres of IgA antibody to VCA. The other EBV antibodies also tested were IgG antibody to VCA and IgG and IgA antibodies to early antigens (EA) of the virus. Of these, the IgG antibody to VCA is the least discriminative for NPC followed by IgG antibody to EA. IgA antibody to EA affords a somewhat lower detection rate than IgA antibody to VCA but none of 58 non-NPC patients gave a diagnostic titre of serum IgA antibody to EA. These results clearly indicate the diagnostic value of EBV serology in NPC.

There were 4 NPC patients so far from whom presymptomatic sera were available and these sera some of which were obtained as far as 61 months before clinical onset of the disease, allowed an evaluation as regards the application of EBV antibodies in early diagnosis of NPC. A serum obtained from one of these patients eight months prior to clinical onset gave a diagnostic titre of IgA antibody to EBV of 10. The titre rose to 160 with clinical onset of NPC and then remained relatively unchanged for the next 12 months. The IgG antibody tire was high initially before clinical onset but did not change significantly in the subsequent months (Fig. 3). Table 4 shows results of serological studies with the other 3 patients. Presymptomatic sera obtained from one patient at 61 and 55 months re-

Table 2 Detection of IgA antibody to EB viral capsid antigens (VCA) in NPC patients before radiotherapy, the apparently healthy siblings of NPC patients, patients with other cancers (oc) and healthy subjects (H.S.)

Subjects	Number (%) with IgA anti-VCA titre × 10
NPC patients	121/126 (96%)
Sibs of NPC patients	28/133 (21%)
OC	6/48 (13%)
HS	0/89 (0%)

IgA anti VCA titre of 10 or above is considered diagnostic. (Ho, Ng, Kwan & Chau, Br. J. Cancer, 34, 635, 1976).

Table 3 Serum EBV antibodies in E.N.T. patients with and without histological confirmation of NPC

Tests	Diagnostic titre	No. of patients having diagnostic titres	
		NPC (41)	Non NPC (58)
IgA anti VCA	10	39	2
IgG anti VCA	640	33	20
IgA anti EA	5	32	0
IgG anti EA	80	33	3

(Ho, Kwan, Wu, Chan, Ng & Saw. Lancet. November 18, 1978. p. 1094).

VCA EBV viral capsid antigen.

EA : EBV early antigen.

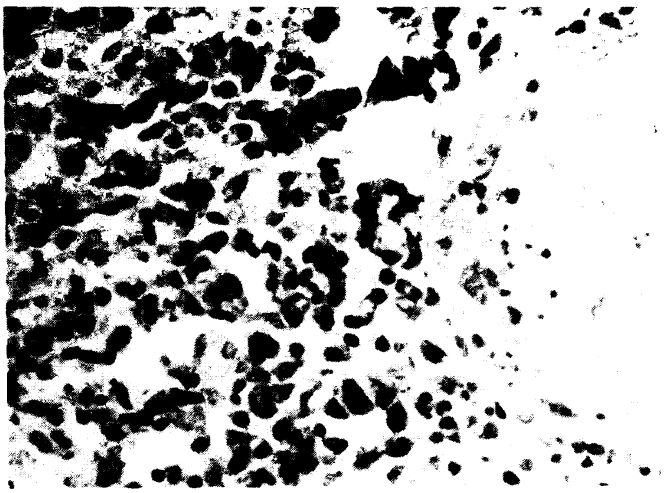

Fig 3 High power micrograph (x 500) of a paraffin embedded section of an NPC biopsy specimen reacted with ∝ chain specific antihuman immunoglobulin and PAP. Counter stained with haematoxylin. Note IgA plasma cells accumulating in stroma surrounding nest of tumour cells. (Ho, Kwan and Ng, Br. J. Cancer, 37, 514, 1978).

Table 4 Serum IgA antibodies to EBV before and after onset of symptomatic NPC

Sex	Age at onset	Before onset		After onset	
		months	titre	months	titre
M	37	61	5	2	80
		55	5		
M	45	30	20	0	40
				18	20
				43	10
M	47	35	80	28	80

(Ho, Kwan, Ng, De The. The Lancet. Feb. 25, 1978, p.436).

spectively before clinical onset did not show a diagnostic titre. But the sera obtained at 30 months before onset from one patient and 35 months from the other, gave high titre of IgA antibody to EBV of 20 and 80 respectively which are diagnostic for NPC. From the results obtained with the limited number of presymptomatic sera to-date, it would appear that EBV antibodies might indeed be useful for early detection of NPC. The simplicity of the tests would make it worthwhile to undertake a serological surveillance of population at high risk for NPC, ie., family members of NPC patients.

On the other hand, EBV has a ubiquitous occurrence such that the majority of us would have had prior infections with and, as a consequence, contain antibodies to the virus. These are however largely antibody of the IgG type and it would seem that the IgA antibody responses to EBV is a unique feature of NPC. Indeed, immunohistochemical studies revealed an intensive accumulation of IgA plasma cells in close proximity to NPC tumour cells (Fig. 4). Although the antigenic specificity of this phenomenon was not readily apparent from these studies, EBV IgA antibodies were detected in the saliva and throat washings obtained from a large preponderance of NPC patients but not in those from the control subjects (Table 5). It seems likely from these results therefore that the accumulation of IgA plasma cells observed in sections of NPC tumour biopsies might be due to EBV antigens in NPC cells and that the local immune response to these antigens might account in part at least, for the occurrence of IgA antibodies in sera of patients with clinical or perhaps even subclinical NPC. From the latter stand point, one

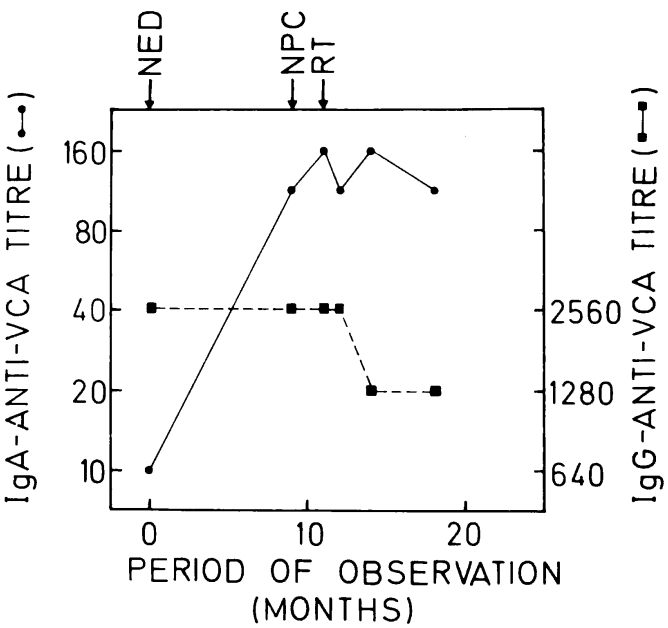

Fig 4 IgA (•) and IgG (□) anti-VCA titres in sera from NPC patient before and after clinical onset of NPC. NED, no evidence of disease; NPC, clinical onset of the disease; RT, radio-therapy. (Ho, Ng & Kwan, Br. J. Cancer, 37, 356, 1978).

Table 5 Frequencies of detection of IgA antibody to VCA in Saliva and Sera obtained from NPC patients and control subjects

Case	Number tested	Detection of IgA — anti VCA in number of specimens	
		Saliva	Sera
NPC	30	24	30
OC	20	0	0
HS	10	0	0

Saliva specimens were concentrated 20 fold and sera were diluted to 1:10 for testing (Ho, Ng, Kwan. Br. J. Cancer, 35, 888, 1977).

would wonder about the significance of detecting serum EBV IgA antibodies in the 20% or so of the healthy family members of NPC patients who are known to sustain a high risk for the disease.

The presence of EBV in NPC cells may lead to the occurrence of viral antigens on the cell surface. The topography of these viral antigens would make them an important factor in host surveillance mechanism against the tumour. The existence of these antigens are supported by results of in vitro cell mediated immunity studies and also by studies using antisera raised in rabbits against surface components of lymphoblastoid cell lines that harbor EBV. Attempts at purification of these antigens are being undertaken with a view to vaccination against NPC. Results to date from these studies however fail to reveal a unique physical entity that may be considered as a viral product. These studies suggest instead that certain host cell surface components, most probably the Ia and HL—A antigens, might have been modified following EBV infection and these altered host cell components may account for the results of earlier immunological studies. These findings are compatible with our current belief based on studies with a large variety of viruses that viral infection frequently causes modification of host cell surface components. Generally, however, these modified components are weak antigens and therefore the prospect of producing a vaccine with such components is not bright.

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MENTAL HEALTH OF UNIVERSITY STUDENTS

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Introduction

Whereas higher or tertiary education was only a short time ago the prerogative of the wealthy or the gifted and later became the entitlement of the able and motivated, it is now becoming a matter of course for many of our young people. At the same time, the number of university-age persons entering universities has been growing at a rate higher than the actual increase in the population and both the actual number and the rate will, to all intens and purposes, continue to grow. However, along with the increase in the size of student, his economic and emotional independence evidence to suggest that problems of students, be it personal, social, physical or psychological, are also on the increase, at a rate more than commensurable to the proportional growth of student population. The number of drop-outs, even well before the conclusion of the first year curriculum, does not seem to wane. Not a few attempt or commit suicide in the vale of depressive mood. As is true in western world, the abuse of drugs, in particular the addictive or psychedelic ones, comes to be a common phenomenon in the campus. Sexual morality has been displaced to take a much lesser weight among the students. Contraception is no strange practice, and accidental but illegitimate pregnancy is so frequent in some universities that the unmarried parents, often mothers, constitute a significant proportion of student users of the campus student health services. Against a world background of turmoil and of questioning, student unrest and political activism in the campus have escalated in universities in some western or Asian countries with whirls of discontent, protests, sit-ins, demonstrations, confrontations, marches, tumult, violence and revolts, often ensuing in casualties. Thus, needless to say, the student population warrants and deserves each and every attention, concern, and sometimes caution of ours, especially if we take into account that adolescents are our today's prime assets and the best lots of the academic intellectuals are presumed to come from the universities.

Student in Transition into University: Problems of Changes

Undoubtedly, most students are apprehensive upon first arrival at the college or university (Cauthery, 1973), for, till then, they may have much unfinished business insofar as attaining maturity is concerned. Yet, this is the period which society more or less arbitrarily assumes as reaching the commencement of adulthood (Farnesworth, 1966). The student is, therefore, simultaneously confronted with the continued acquisition of knowledge that will give him the academic and/or technical skills that he seeks from devoting his efforts to the university on one hand, and, on the other hand, with the remaining interpersonal & intrapersonal tasks of realizing his own selfhood (Glasscote and Fishman, 1973). What is recognized of the student, hence, is to effect a metamorphosis, perhaps, the most significant of his life, one which forecasts the future with remarkable accuracy and one which is critical for fulfilling the personal odyssey toward maturity (Impellizeri, 1968).

Needs and Tasks of University Students in Adolescence

Most, if not all, of our university students are still in the stage of late adolescence or young adulthood which is characterised by tensions and ambivalence — the desire to be like adults but occasional need to be like children. Childhood represents limits and restraints, but also safety and security; independence is challenging, but also threatening. In the case of university

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student, his economic and emotional independence has to be delayed in comparison with others of his age group, and the student has to accomplish the transitions of adolescence into adulthood through meeting a number of simultaneous abrupt challenges. Problems of independence, problems with authority and problems of identity must be coped with in an environment which offers relatively little adult support or guidance, and which imposes a high level of demand, while the role of student per se does not suggest any firm guidelines and is itself essentially transient. Simultaneously to coping with these problems and with the intellectual demands of his course, the student is likely to embark upon intimate relationships which test capacity to trust others.

On the whole, the student in university is largely on his own. He must organise his life, establish priorities, make or postpone career choices, utilise effective techniques. He must move among from his previous dependence on adults to a new independence; he must, in short, learn to become and to be himself. Often, at the same time that he is doing this, his sense of alienation and impersonality is heightened. This may come from a previous lack of feelings of acceptance, it is often due to the increasing size and complexity of universities. Among the milling throngs he will be at a loss and find it hard to find friends, to sort out values, to have personal contact with faculty and other trusted adults. In university, too, the student comes to encounter with the hard realities of political and social conditions which may undermine his previous belief in the importance and power of the individual, or lure him unwillingly to give up faith in the religious indoctrination and hope in the solution of social and cultural problems. Though his liability to breakdown is determined by genetic factors and by his family background, the chance of this liability being manifest in disability or illness while he is at university is obviously high.

Towards a Concept of Student Mental Health in a Positive Context

In the main, there is not a consensus for the definition of mental health, even amongst the professional workers. To date, the splendid description of Marie Jahoda remains one of the best and unparalleled. In 1958, in the report to the Joint Commission on Mental Illness and Health, she proposed six main categories, in an exhortative tone, for conceptualizing the positive, striking aspects of mental health:

"1. An attitude towards one's self in which self-inspection leads towards acceptance of weaknesses and pride in strengths; a clear image of what one really is and identity with it so that one is motivated toward inner stability.
2. Growth & development toward self-actualisation of one's potentialities; a blending of one's total personality toward achieving the best of what one might become.
3. Integration of personality involving a balance of psychic forces, a unified outlook on life, and some capacity for withstanding anxiety and stress.
4. Autonomy of action in which the individual determines behaviour from within instead of drifting with the impact of present stimuli-independence in the face of difficulties.
5. A perception of reality which is relatively free from what one wishes things might be and which involves his being attentive to and concerned with the welfare of others.
6. mastery of the environment through (a) the ability to love; (b) being adequate in love, work, and play, (c) competence in human relations; (d) capacity to adapt oneself to current circumstances; (e) ability to draw satisfaction form one's environment, and (f) willingness to use problem-solving approaches in life processes."

Thus it can readily be seen that mental health is not simply the absence of disease and certainly it implies more than a state of psychological well-being or happiness. The highest degree of mental health might, in point of fact, be described as that which permits an individual to realise the greatest success which his capabilities will permit, with a maximum of satisfaction to himself and the social order, and a minimum of friction and tension (White House Conference, 1930).

In the same vein, Nikelly (1966) construed to suggest a definition specifically related to students:

"The mentally healthy student accepts himself with his strong points and his shortcomings; he makes the best use of what he has, and he does not allow his personal weaknesses to interfere with his daily activities and his pursuit of long-range goals. If the positive factors in his personality and accentuated, the weaknesses, in most cases, will retreat from the foreground. The emotionally healthy student reaches a balance between his instincts and his conscience, coupled with the demands of his environment. He experiences little conflict between these feelings, and he can tolerate a moderate amount of inconvenience resulting from conflicts among drives, values, and the experiences of reality in the academic environment."

In similar terms, Bernard (1970) contended that the mentally healthy student is one who, justifiably, draws satisfactions from his achievements. Because he is effective and has satisfactions, he is cheerful about his work and

his associations. And finally, the mentally healthy student is one who can work for and with others as well as by himself. In Roger's words (1968), he is one who has learned fundamental skills of interpersonal relationships. It is, on the other hand, important for students to understand that mental health does not mean complete freedom from all anxiety, tension, or dissatisfaction (Williams and Kitzinger, 1963). Mental and emotional health exist when people can pursue their everyday affairs with reasonable satisfaction, unhampered by feelings of conflict either in themselves or with the world around them. In short, the central problem in mental health for every youth is the development of a system of values that will lead to some worthwhile achievement, some success that lifts life out of the rut of failure, some recognition by others of real effort made and honest purpose pursued.

Though it is salutary to find that half a century ago, which still holds true nowadays, Ruggles (1925) remarked that the average university student, men or women, has no mental health problem in the sense that he can make his adjustment without much difficulty; he can keep up with his classes, get along with the faculty, make friends among his fellows, and in general enter with a fair degree of success into the lift of the organization of which he has become a part, it can hardly be emphasized that many essentially healthy personalities may be (and clearly are) confronted from time to time with decisions, deficits, complicated life circumstances. Above all, there is a certain percentage normally longer than is generally realised, of boys and girls who are constantly struggling with some definite problem of adjustment at this stage of development that is both remarkably vulnerable and considerably treatable.

In this context, it would appear, in recent years, clinicians have grown increasingly reluctant to apply the standard psychiatric nomenclature to students. This is undoubtedly partly a manifestation of growing disinterest throughout the entire mental health field in diagnosis, in favour of an appraisal of the client's or patient's capacity to function. In part, however, it also obviously reflects the contention of the college or university mental health personnel that it is a difficult if not at times impossible matter to differentiate between "set" psychopathologies and the various maturational processes still at work in the college-age student. At the same time, there are students probably many in number, who exihibit problems in living that can be regarded as normal responses to their circumstances and do not call for urgent intervention from another person or agency and that would improve with lapse of time and development of maturity.

Comparative Epidemiology of Psychiatric Disturbance for College Students

Reifler reviewed the epidemiological aspects of college mental health and observed (1969) that the prevalence of psychiatric disturbed (however defined at the time of survey by the various investigators) had not changed much over the forty years (between 1920 and 1968) under study, and that apparently the prevalence of severe disturbance had not changed much either over the same period of time. He further concluded (1971) that about 12 per cent of college students are estimated to need mental health services each year. However, Farnsworth, a prominent worker in college mental health, considered (1974) that the widely accepted estimate, remarkably constant though they undoubtedly are, that 10 to 12 percent of all college students have emotional conflicts of severity to warrant professional help may be too conservative for institutions whose populations are relatively sophisticated about the nature of emotional conflict. Further, working from various data available, Farnsworth (1966) estimated that for every 10,000 students:

1,000 will have emotional conflicts of sufficient severity to warrant professional help.

300 to 400 will have feelings of depression severe enough to impair their efficiency.

100 to 200 will be apathetic and unable to organize their efforts.

20 to 50 will be so adversely affected by past family experiences that they will be unable to control their impulses.

15 to 25 will become ill enough to require treatment in a mental hospital.

5 to 20 will attempt suicide of whom one or more will succeed.

In the United Kingdom, despite differences in selection procedures, in services provided and in the criteria used, there is a surprising consistency in the estimates given for the rates of psychiatric disturbance for students similar to that in America (Baker, 1963; Kidd, 1965; Kidd and Caldbech Meenan, 1966). Serious psychiatric disorder affects 1-2 percent of students during their undergraduate career, while a further 10-15 per cent suffer some emotional or psychiatric disorder of a degree justifying at least some treatment. In Ryle's review (1971), it is noted that psychiatric illness is usually reported as being more common in female than male students, and the rates in Arts students tend to be higher than in Science students.

In the Hong Kong scene, over a period of three

consecutive years (1973-1975), Dan (1976) observed that a mean figure of 3.9% among the student users of the Health Service at the Chinese University of Hong Kong had expressed primary psychological distress and emotional disorder, though it is likely that it is more apparent than real. At the same time, an average of 7.4% for male and 9.7% for female respectively of freshmen on admission to the University admitted to have psychosocial difficulties. A breakdown analysis of the questionnaire for medical information revealed that over the period of 1972-1979, a wide-spaced range, 4.2-15.2% of male and 6.1-16.9% of female new students respectively answered in the positive with respect to the need for counselling and psychiatric help for their personal or emotional problems, with the female figures nearly always greater than the male counterpart. This is, therefore, in good keeping with the Ryle's findings, though there is reason to believe that the trend is on the increase over the years.

Mental Health Survey on the University Freshmen

In order to catch a glimpse into the status of mental health of the first-year university students, which is of doubtless value in assessing the probable vulnerability of their psyche and in predicting the future need of psychological intervention, a survey on them is conducted and a questionnaire comprising 31 questions (in 17 of which an answer of yes or no is asked for and in 14 of which a score from 1 to 4 is given to different standardised answers to each question) is distributed to each freshman who is registered to complete it promptly and to return it as soon as possible. Officers from the University Students' Union help to give out and collect the questionnaires at the spot.

Of the 1,186 freshmen enrolled to the Chinese University of Hong Kong, 607 students succeeded to return the questionnaires to the authors and this group constitutes about 51.2% of the sampling population, with the male portion slightly over half of the freshmen body and the female slightly under half. This is not unexpected because in Chinese society, men are presumed to be more expressive, less shy and more assertive.

Results of the Survey

Broadly speaking, the number of freshmen with definite emotional instability, as ascertained by our criteria (i.e. 85% or more of positive answers to the first 17 questions), is small, namely, about 1% of the sample. In other words, apparently, there is no urgent need for any psychological help to the vast majority of the freshmen. With respect to the recent history of probable emotional disturbance in the preceding 6 months, all save for 0.2% denied. Thus, on the surface at least, the freshmen can be said to have enjoyed good mental health, as far as the computerisation of the scores is concerned.

However, it does not necessarily follow that the freshmen are exempt from any symptom traits or uneasiness in the psychological respect. We can only be permitted to go so far as the statement that, generally speaking, the overall findings do not immediately suggest the presence of any formal mental distubrance, assuming with much reservation that the other half of the sampling population is as good and as stable as the respondent freshmen, though it may well be that a great number of disturbed freshmen will normally be motivated to conceal their mental status by noncompliance and unresponding. That is, in the student body admitted to the University this year, at best, only a few are so adversely dysfunctioned as to require intervention by the professional.

To complicate the issue further, let us look at the breakdown analysis. Some of the questions can be grouped under the heading of tension state of the students. 5.1% of them complained that "sudden noises made them jump or shake badly"; "they became scared at sudden movements or noises at night"; and "they often become suddenly scared or panickly for no good reason". In the last 6 months prior to the admission to the University, 14.5% had "been feeling nervous and strung up all the time" and another 17.3% did "feel constantly under strain".

As regards the questions that would reflect the existence in students of anxiety (which is defined here as a psychological state of apprehension, dread or fear in anticipation), 18.5% of them admitted to "sweat or tremble a lot during examination or questioning"; felt that "strange people or places made them afraid", and, for these students, "it was always hard to make up their mind". 14.8% reported that "every little thing got on their nerves and wore them out" and that "worrying continually got them down". In the past six months, many of them had "been perspiring a lot" (14.4%); "been too tired and exhausted to eat" (15.7%); "lost much sleep over worry" (11.1%); and "been having frightening or unpleasant dreams" (5.9%).

Depression is a common life phenomenon in mankind, more so in adolescents. University students are no exception. 5.5% of freshmen, to nobody's surprise, conceded that "they often cried"; "they wished they were dead and away from it all" and "they were always miserable and blue". Over the period of half a year, a significant proportion of the freshmen had "been finding life a struggle all the time" (33.7%) "felt themselves

dreading everything that they had to do" (8.2%); "been losing confidence in themselves" (13.7%); "not been able to face up their problems" (3.8%); "felt incapable of making decisions about things" (12.7%) (compared with the fact that 45.3% of them found it hard to make up their mind); "not been satisfied with the way they had carried out their task" (16.3%); "not felt that they were playing a useful part in things" (6.9%); and "found themselves waking early and unable to get back to sleep" (12.8%).

The area of anger feelings has been enquired about and 14.5% alleged that "it made them angry to have anyone tell them what to do", "they always did things on sudden impulse"; and "they flared up in anger if they couldn't have what they wanted right away". Admittedly, student impulsivity with problem of self-control and inability to delay the sight of success is a notorious observation everywhere (Farnsworth, 1969)

Lastly, the sensitivity of these freshmen was surprisingly high. As much as 32.8% of the sample freshmen replied that "their feelings were easily hurt"; "criticism always upset them"; "people usually misunderstood them".

In general, the Arts freshmen seemed to show greater propensity to have mental problems than those from other faculties, which might speak for their overall liability to emotional instability at a higher risk than their compeers. This is in concert with the Ryle's impression (1971).

Discussion

Summing up the findings, it does not take one too far to realise that, for all the apparent global homeostasis quite a percentage of freshmen has manifestation of symptom cluster, for instance, depression and anxiety. For the former, it is estimated to exist in approximately 10-15% of freshmen, while as high as 15% or even 20% of them might have been afflicted from depressive episodes. Although in some of the students, both types of symptomatology can be normal reactions to life stresses and strains in adolescence period, the occurrence in the remainder of the students is far from insignificant. Sleeping disturbance, for example, is not rare among the students. 5% to 15% of them had either difficulty to get into sleep or to return to sleep again after waking up in the little hours, or, if they were able to sleep at all, they would have nightmares that would disturb their sleep unless some form of professional service is at hand, it goes without saying that for some of them the psychological disturbance is likely to perisist through life or even become morbid. Whether many of the troubled students have been receiving treatment privately prior to admission is unknown, yet a kind of mental health consultation accessible by all students is obviously in order. Again, should we refer to the confession of 159 freshmen (14% of total admissions) in their health questionnaires in 1978 that they would need counselling or psychiatric help for their personal or emotional problems, we will come to see that requisition for a students' mental health service is not without rationale and ground. It is hoped that students can turn for help long before they cannot disentangle from the crisis and, in so doing, psychiatric morbidity can be reduced and mental health for students can be affirmed.

Conclusion

The health of university students has been a concern to the western universities for more than six decades, but for most an awareness of university students' mental health has only been recent. If we envisage our university students our prime and most precious assets, our concern for their mental health is not unwarranted. As with physical health, the most positive action for mental health is in the realm of prevention. Prevention will be best at work for those whose mental health is marginal, that is, those who are getting along but are revealing symptoms of stress. The preventive concern can be the thing that helps "pushing them over the brink" or adding the "straw that breaks the camel's back". If possible, every attempt should be made to restore the mental health to them well before a pathological life pattern sets in. In view of the rising cost of tertiary education, prevalence of student wastage and the demand for the graduate professionals, mental health consultation service will be eventually become a matter of necessity in the years to come.

References

Baker, R.W. (1963) 'Incidence of Psychological Disturbance in College Students' Jo Am. College Health Assoc., 13:352

Bernard, H.W. (1970) Mental Health in the Classroom: New York: McGraw-Hill

Cauthery, P. (1973) Student Health. London: Priory Press

Farnsworth, D.L. (1966) Psychiatry, Education and the Young Adult. Springfield: Charles Thomas

Farnsworth, D.L. (1969) "Psychiatric Services in Colleges" in "Evolving Concepts in Psychiatry" (Ed. P.C. Talkington & C.L. Bloss). New York: Grcine & Stratton

Farnsworth, D.L. (1974) "Mental Health Programmes in Colleges" in 'American Handbook of Psychiatry, Vol. 2' (Ed. S. Arieti) New York: Basic Books.

Impellizeri, I. (1968). "The Personality of the College Student" in 'The Counselling of College Students' (Ed. Mo Siegel) New York: Free Press

Jahoda, M. (1958) Current Concepts of Positive Mental Health. New York: Basic Books

Kidd, C.B. (1965) 'Psychiatric Morbididty Among Students'. Br. J. Prev. Soc. Med. 19:143

Kidd, C.B. & Caldbeck Meenan, J. (1966) 'A Comparative Study of Psychiatric Morbidity Among Students of Two Different Universities' Brit. J. Psych., 112:57

Lewis, G.F. (1966) "The New Breed — dissenting view" in 'The Aim of Higher Education: Social Adjustment or Human Liberation?' (Ed. E. Barnes) St. Louis: United Campus Christian Fellowship

Nikelly, A.G. (1966) Mental Health for Students. Springfield: Charles Thomas

Reifler, C.B. (1971) 'Epidemiologic Aspects of College Mental Health' J. Am. College Health Assoc., 19(3) : 159.163

Reifler, C.B. & Liptzin, M.B. (1969) 'College Mental Health' Arch. Gen. Psych., 20 (5) : 528-540

Rogers, C. (1968) 'Interpersonal Relationships: U.S.A. 2000' J. App. Behav. Sci., 4:265

Ruggles, A.H. (1925) 'College Mental Health Problems' Mental Hygiene, 9 (2) : 261-272

Ryle, A. (1971) "University Psychiatric Services in the United Kingdom" in 'Modern Perspectives in Adolescent Psychiatry' (Ed. J.G. Howells) Edinburgh: Oliver & Bryd.

White House Conference (1930) Preliminary Reports. New York: Appleton — Century — Cropis

Williams, J.F. & Kitzinger, A. (1963) Health for the College Student. New York: Harper & Row

MENTAL DISORDERS IN PREGNANCY

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INTRODUCTION

Pregnancy includes great physiological and psychological changes. The expectant mother is faced with psychological problems, for example, the baby may or may not be wanted, the mother's attitude may be affected by misinformation, superstitions and taboos and in the case of the first pregnancy, she is further faced with the fears of pregnancy, labour and delivery.

Although pregnancy itself is not a direct cause of major mental diseases, it may nevertheless act as a catalyst in the case of those who are psychologically vulnerable. The physical care of the expectant mother is generally good in Western societies, yet the psychological aspects of pregnancy is not always adequately attended to. In consequence emotional problems may arise. Neuroses such as anxiety, psychosomatic symptoms and puerperal depression are common and will be discussed in detail. Puerperal psychosis will also be examined.

Finally, the mental attitude to therapeutic abortion will not be discussed for the moral, social and legal values are variable bothein time and place.

NORMAL CHANGES IN PREGNANCY

1. Anxiety

All childbearing women have fears for themselves or their babies. (1) The principal fear is that of the unknown, even the fear of death. The Royal College of Midwives (2) (1966) showed that the most common fear of the unknown was that of having an abnormal baby. Factors such as the loss of personal and financial independence are important. There may be resentment of the imminent loss of attractiveness and the child may be seen as a potential competitor for the husband's love. The other major cause of anxiety is uncertainly of the fufilment of the parental role. Thus the obstetric team needs to provide information and advice regarding the pregnancy, the acceptance of the pregnancy and the child following delivery.

The emotional adjustments that may be required depend on personal, familial, social and cultural factors. Finally, her husband's support, the success of the marriage and their desire of a child will also influence the mental attitude of the expectant mother.

2. First, second and third trimesters, labour

The **first trimester** is associated with emotional lability like puberty and menopause when hormonal changes occur. The frequent mood changes sometimes go with **psychosomatic symptoms.** Anxiety symptoms need investigation since many may have a physical cause. Sleeplessness, breathlessness, palpitation and headache are common. Fainting may be due to the supine hypotension syndrome. Minor ache and pain are common and difficult to evaluate. Frequency, urgency and nocturia are more often due to urinary infection but may be anxiety induced. Ptaylism (excessive salivation) occurs; globus hystericus, the inability to swallow is however uncommon.

Morning sickness is frequent and may progress to **hyperemesis gravidarum.** This is likely due to hormonal changes. In cases of hydatidiform mole in which high level of chorionic gonadotrophins is recorded, vomiting is common. Vomiting as a symptom of neurosis is hard to define. Some authors report personality differences between those admitted to hospital and the control (3) while other authors report no such differences. (4). Chertok in 1963 (5) evaluated 100 primigravida female of whom 68 suffered from vomiting and concluded that vomiting is based on an ambivalent attitude of the mother towards the child, rejection conflicting with the joy and expectation of childbirth.

The **food craving** in pregnancy have been suggested as physiological, yet Yudkin in 1956 (6) felt that the psychological aspect was dominant. Harris in 1978 (7) analysed 991 food cravings from BBC listeners mostly in their first four months of pregnancy and showed for example, 261 cravings for fruits, 105 cravings for vegetables and 187 cravings for non-food substances (which include 35 for coal, 17 for soap and 15 for disinfectant). He also reported a dislike for coffee and alcohol.

In the **second and third trimesters** the patient feels fetal movement. This is exciting and satisfying for most

expectant mothers. The patient will have increased drive and will be emotionally more stable. Preparations for the birth will also be made. In the last three months, James in 1963 (1) described an increase in physical and emotional sluggishness. Tension increases as the expected date of delivery approaches. As stated before, the more factual knowledge the patient possesses, the less the fear.

Although childbirth is stressful, psychotic reactions rarely develop during **labour.**

3. **Prematurity**

Nearly half of all neonatal deaths are due to prematurity and in over 50% of these, the physical causes are unkown. Blau in 1963 (8) found that women having premature infants tended to be young, immature, with a dependency on a strong mother figure. He also reported that they tended to be narcissitically concerned with their appearance yet uncertained about their femininity and its development. Perhaps early identification of this at risk group may reduce prematurity and neonatal deaths.

PSYCHOPROPHYLAXIS OF CHILDBIRTH (9)

This aims to involve the mother and father more actively in the preparation and process of birth, with the mother entering labour relaxed and with confidence. Relaxation is taught for everyday living as well as for pregnancy, labour and the post-partum period.

Posture and pelvic floor exercises are emphasised. Breathing is taught at different levels and rates. At the first stage, as contraction becomes stronger, the patient breaths shallower and more rapidly, lifting her over the pain. Emotional support with one midwife or the husband is important. The goal is that childbirth should not be painful and with the prepared woman, the interpretation of 'the uterine contraction' is different, making it less threatening.

The dynamics of pain and labour as explained by Dick-Reed can be summarized as follows:—

1. Gravida + fear = marked tension
   Marked tension + aneamia, fatigue, discomfort and panic
   = severe pain
2. Gravida + abnormal pregnancy, poor integration and intelligence + previous obstetric disaster
   = severe pain
3. Gravida + normal pregnancy + confidence + relaxation
   = little pain and good labour

Early studies compared exercise with no exercise and detected no significant differences (10). However, Sharley in 1970 (11) showed less analgesic drugs and episiotomies were used with the prepared group. Also their children had higher Apgar scores.

MENTAL DISORDERS IN PREGNANCY

1. **Incidence**

The international statistical classification of mental illness refers only to puerperal psychosis. There is marked variation in the frequency of different types of mental disorders reported. Below is the classification by three authors. The general concensus is that severe mental illnesses and suicides are rare in pregnancy and of psychosis thought to be associated with pregnancy, the majority occurs in the puerperium.

	Boys (12) 1942	Brew (13) 1950	James (1) 1963
Affective disorder			
Depression	40%	41%	25%
Puerperal psychosis			
Schizophrenia	20%	51%	25%
Symptomatic exogenous causes	28%		
Clouding of consciousness			40%
Psychopathic reaction	11%		

2. **Affective disorder — depression**

Some authors have suggested that on or about the fourth day of the puerperium, nearly all mothers feel miserable and depressed. The fourth day 'baby blues' precipitates weeping with the most trivial stimuli or even with no apparent cause. The fears and anxieties of the early pregnancy are revived. The mother feels inadequate towards the baby. There may be problems with the infant's sleeping and feeding, lactation may be difficult and the perineum and the breast may be painful. Furthermore, the patient is no longer the centre of attention, now being shifted to the infant. Finally, she is away from her comfortable and familiar surroundings. It is interesting to note that the incidence of depression in home deliveries have been found to be much less than hospital confinements.

Depression due to a particular cause is known as exogenous or reactive depression. The sudden fall of hormone level from the placenta together with a rise of pitiutary activity (oxytocin and prolactin) have been incriminated. When no adequate reason or explanation is given, this is known as endogenous depression. Poor sleep and early waking is common. Difficulty in con-

centration with an inability to carry out normal tasks occurs. This is known as psychosomatic retardation.

There may be a family or personal history of depression. Psychologists analysed these personalities as overconscious, sociable and helpful.

Treatment: The treatment of reactive depression is to remove as many of the cause as possible. Explanation, demonstration and help with the baby and lactation should be undertaken.

The benzodiazepam group of drugs are widely used to ensure sound sleep. In cases of breast feeding, the milk : plasma ratio is 0.2 : 1 (15). It is estimated that only 10mg of Diazepam should be given. One breast fed infant in which the mother was given 30mg daily for 3 days became lethargic, lost weight and had EEG changes characteristic of sedative medicine (16).

Chloral hydrate enters milk in quantities sufficient to cause minimal sedation after feeds.

Of the tricyclic antidepressants, Imipramine has, but Amitriptylline and Nortriptylline have not been shown to affect breast milk (17).

The use of Monoamine oxidase inhibitor (MaoI) has declined as many food and drugs interact with MaoI to produce hypertensive episodes.

ECT may be used when all the above have failed. ECT with muscle relaxant may be given safely to pregnant women but it is advised to delay treatment until after the first three months to avoid causing abortions and not for the last two months to avoid premature labour.

3. **Puerperal psychosis**

Incidence: The number of psychosis starting in a pregnant woman is not greater than the control group (18). The incidence of psychosis during the period from conception to six months after delivery is about 1 to 2 per 1000. Of these only 10% occur during pregnancy and the rest in the puerperium (1). Recent figures by Jansson in 1964 (19) found an incidence of 6.8 per 1000 deliveries in Gothenburg, Sweden, of which 2.3 were admitted and 4.5 attended psychiatric clinic.

Aetiology: The aetiological factors include hereditary, emotional stresses and previous mental and puerperal illnesses.

a. **Schizophrenia**

The hallmark of the illness being disorder of thinking, feeling, conduct and contact with reality manifested with auditory hallucinations. The thought disorder is evident by thought blocking, ideas of references and delusions. Flattening of affect may be noticed with a general indifference. The physical state described with schizophrenia is thin and asthenic.

b. **Symptomatic exogenous causes, clouding of consciousness**

The incidence of physical causes has declined (see chart). Puerperal sepsis, eclampsia and severe haemorrhages are not so common nowadays. In 'organic syndrome', the predominant impairment is that of cognitive function, associated with impairment of consciousness, poor attention and concentration. In acute states overactivity and visual hallucination may occur. According to James (1963), clouding of consciousness follows physiological stress. Yet, Jansson (1964) showed that 30% of the total cases with mental disorder and 60% of the admitted cases showed a clouded sensorium with rarely any exogenous causes.

c. **Psychopathic reaction**

Psychopathic reaction or neurotic illnesses as defined by Boyd (1942) may present with depression, anxiety, irritability or restlessness. This may be associated with a psychopathic personality presenting with neuroticism, immaturity, instability and lability of mood. They react to the whim of the moment which may lead them into crime or drug abuses.

Treatment: After the thalidomide disaster, the use of drugs in pregnancy must now be examined in detail. Lewis (1960) (20) suggested the use of the well established drug like Chlorpromazine and barbiturates, when necessary. He emphasised the need to familiarize with the patient and her background prior to any treatment. The use of barbiturates in pregnancy has also been challenged recently (21).

The phenothiazenes are the most important group of drugs used for schizophrenia. Over the past 20 years, 60 breast fed infants whose mothers took chlorpromazine (up to 1250mg per day) have been studied and some followed up for 5 years. No physical or mental effects were seen and development was normal. Single dose studies showed that negligible amount was passed into milk (22) (23).

Lithium taken by manic depressant mothers up to the time of delivery has been associated with muscle flaccidity, cyanosis and heart murmur in the baby. Lithium level in milk is about 1/3 to 1/2 of the maternal plasma level.

Prognosis: Jansson's long term follow up of 8 years and 7 months showed 29.5% require further inpatient care, mostly the schizophrenic group, but only 9.5% require psychiatric admission associated with childbirth. This agrees with James (1963) who showed that 70% of the cases make a good recovery, the most unfavourable

ones being the schizophrenics.

Summary

The obstetrician is in an unique position to 'monitor' the psychiatric needs of a pregnancy and to reduce any tension during childbirth. In this advancing technological age, these aspects are sometimes forgotten. As a result, there is an attraction and trend towards 'natural childbirth'. Therefore, the obstetrician must be aware of the normal and abnormal mental changes during pregnancy.

Regular antenatal attendances allow adequate opportunities to identify those at risk, to advise the patients and to give any necessary treatment.

References

1. James GWB: British obstetric practice p1217 edited Sir A Claye Heinemann 1963
2. Royal College of Midwives: Preparation for parenthood London Royal College of Midwives 1966
3. Robertson GG 1946: Lancet ii 332
4. Coppen AJ 1959: Lancet i 172
5. Chertok L 1963: Psychosomatic Medicine **25** 1
6. Yudkin J 1956: Lancet i 695
7. Harries JM 1958: Br. Med. J. **ii** 39
8. Blau A 1963: Psychosomatic Medicine **25** 201
9. Dick-Read G: Childbirth without fear Heinemann 1951
10. Peel JH 1955: Physiotherapy **41** 105
11. Sharley CB 1970: Med. J. Australia vi 1159
12. Boyd DA 1942: Amer. J. Obste. & Gynec. **43** 148 & 335
13. Brew MF 1950: J. Nerv. Mental Dis. iii 408
14. Obstetrics by Ten Teachers p310 Arnold 1972
15. Brandt R 1976: Arzneium Fersch Drug Research **26** 454
16. Patrick MJ 1972: Lancet i 543
17. Rees JA 1976: Practitioner **217** 686
18. Pugh FF 1963: New Eng. J. Med. **268** 1224
19. Jansson B 1964: Act Psychiat. Scand. **39** suppl. 172
20. Lewis BVA: Price's textbook of Practice of Medicine Oxford University Press 1966
21. Gleiss J 1967: Germ. Med. Mon. **14** 202
22. Ayd J 1973: Internal drug therapy Newsletter viii 33
23. Blacker KH 1962: Amer. J. Psych. **119** 173

*SCIENCE, MEDICINE, AND SOCIETY AT THE APPROACH OF 2000 A.D.**

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— I —

Four periods may be distinguished in the history of medicine.

The first period was that of an endless childhood which extended over several thousand years. The therapeutic capabilities of a physician at the end of the XVIIIth century were scarcely greater than those of his counterparts practising three thousand years earlier.

The second period began in about 1860. In 1859, Darwin published the "Origin of Species" and suggested the theory of evolution. Between 1860 and 1865, the famous experiments of Pasteur refuted spontaneous generation. In 1865, the Moravian monk, Johan Mendel, discovered the laws of heredity and the basis of genetics. In the same year, 1865, Claude Bernard published the 'Introduction to the Study of Experimental Medicine.' These six years, from 1859 to 1865, for which it had been possible to suggest the name of the "glorious six", had more influence on changes of the future of mankind than the wars and battles which fill our history books.

The discoveries of 1860 led to the birth of bacteriology, physiology, hygiene and to a certain extent modern surgery and obstetrics. They made possible the prevention of certain diseases, but by a curious phenomenon had little influence on their actual treatment. At the time when I began my own medical studies — many years ago though not quite prehistoric — the number of truly effective drugs could be counted on the fingers of one hand.

The third period was that through which we had just lived. It began just before the last World War with the discovery of the sulphonamides. It had continued over a period of more than thirty years, marked by prodigious therapeutic progress. To measure this progress, let me take you on two journeys.

The first journey took place in 1930. In the medieval wards of hospitals for adults were to be found, side by side, the dead, the dying and a few rare survivors. These patients were in the delirium of severe septicaemia, that one was lapsing into diabetic coma whilst yet another was suffering from the agonies of terminal uraemia. A little farther on were the paediatric wards. A number of children, gently whimpering, with hands twisting in slow movements, were dying from tuberculous meningitis. Physicians were powerless, just as they had no means of dealing with cases of malignant diphtheria which swelled the neck and darkened the skin. Just beyond were infants suffering from gastroenteritis and who, whatever the treatment, would die, their eyes half closed and the face grey.

But here is the second journey. Let us enter the same hospital in 1975. Everything has changed. Severe septicaemia and acute meningitis could usually be successfully treated. Tuberculous meningitis, which previously killed all the children it affected, could then be cured. Problems of major glandular insufficiency could then be dealt with either. Pernicious anaemia was no longer pernicious. Surgeons could open up the brain, the lungs and the heart. The most extraordinary adventure was perhaps that of haemolytic disease of the newborn caused by Rhesus incompatibility. This disease was not recognised as a separate entity in 1930. Its signs were recognised in 1935; its mechanism was discovered in 1940; its treatment by exchange transfusion was proposed in 1945 and its prevention developed effectively. Thus in less than 50 years, this disease had been described, understood, treated and prevented. In France alone it used to be responsible for the death of 3000 newborn infants each year.

Thus the very shape of death has changed since at the present time its causes are virtually limited to diseases of the heart and vessels, malignancies or car accidents. Nevertheless, this remarkable period in terms of therapeutics was an empirical period. It could thus be said that the discovery of penicillin by Fleming was due to the fortunate combination of chance and genius.

But now, in recent years, we have entered a fourth period, which is a rational and logical period. Biology, after having long been considered as a mere tool for the purpose, for instance, of a laboratory examination, has

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become the key discipline of science, the fundamental discipline on which everything else depends. Physics and its progress dominates the XXth century. Biology and its progress will even more resoundingly dominate the XXIst century. The biology of our epoch is triumphant. The alphabet, grammar and syntax of creation have been discovered. The genetic code which governs the hereditary transmission of our structures has been defined. Its laws are simple. Study of diseases of haemoglobin raise the concept of molecular pathology. Diseases are no longer defined merely in terms of lesions of organs but also by changes in molecular arrangement. Neurobiology, long uncertain, has begun to approach essential questions of how information is assessed, transmitted, recorded and retrieved, how relations between instincts and acquisitions are established, and what is the true conception of this freedom, or rather degree of freedom, which is perhaps the feature of man and his nervous system alone. It is reasonable to suppose that this completely new orientation will greatly change, in the years to come, the prevention and treatment of disease. But, much more, its influence will be felt on numerous other problems essential to man and it is about all these future problems which I should like to explore with you, whilst making it quite clear that confusion must be avoided. The physician must in no way attempt to become a philosopher. He must leave philosophy to the logicians, moralists, sociologists and politicians. But he must offer solutions to all these honourable groups, provide information concerning recent scientific events which, as you will hear during this lecture, are to transform and totally alter the human condition during the next 50 years. I should also like to examine three major change processes, one of which is taking place at present and the other two of which are in view. Man is in the process of mastering three areas, and this process will be complete within the next 30 to 50 years: the mastering of reproduction, the mastering of heredity and the mastering of the nervous system.

— II —

Firstly, the mastering of reproduction. I shall make no mention here of methods of contraception which have been discussed widely over the past many years. The new fact is that individual methods of contraception, which have been the only ones used up to the present, will be replaced in the years to come by methods of collective contraception. This refers to recent progress in methods of vaccination against pregnancy. Research is pursued along two major paths. One is aimed at vaccinating against male antigens, the antigens of spermatozoa. This research met with certain difficulties at the outset, the initial results being such that vaccination was against the sperm of the husband only. It is easy to imagine the conseqences of this limitation. However, better definitions of these antigens are now available and the hope of vaccination against various sperm antigens is now possible.

The second path of research, perhaps the most fruitful, is that which links certain pregnancy hormones to a well known antitoxin, the tetanus antitoxin. Very important research is underway in different laboratories throughout the world. This has not yet resulted in complete success but it is reasonable to consider that in the coming ten years effective methods will be available, simple or free from danger, of vaccination against pregnancy. As in the case of all vaccinations, it seems likely that the effects of such a vaccination will be limited in time.

This leads to the kind of moral problem which I mentioned earlier. Imagine a country faced with enormous demographic problems. It may be imagined that the political leaders of such a country might decide, after democratic consultation with the population, to vaccinate all blonde haired women, or all women aged less than 25 or all women aged over 35. I have deliberately chosen arbitrary examples. This obviously indicates the possibility of a very grave conflict between the individual freedom which we feel to be fundamental and certain needs of the community as a whole. This merits reflection.

In this area of the mastering of reproduction, a second very important event is concerned with progress in methods of preservation of sperm. The French biologist, Jean Rostand, who has died recently, was the first, some thirty years ago, to show it to be possible to store the sperm of different animal species at low temperatures. In animal biology, in zoological techniques, artificial insemination plays a very important role. In recent years, these methods have been transposed in man, with relatively unsatisfactory results initially. A sort of sperm black market developed before a rational and controlled organisation was perfected. Even now, applications exist in medicine. Thus the treatment of Hodgkins disease, which as you know has transformed the prognosis of this grave illness, results in a certain number of cases in male sterility. It has now become usual practice to ask young male sufferers from the disease to provide sperm for the sperm bank before their treatment is started. From a more general standpoint, when sterility in a couple is due to the husband, it is possible to envisage either collection of a sample from the husband for insemination, or the use of sperm from an anonymous donor.

What is more important, and more widespread, is the phenomenon seen in certain countries where a large number of young men undergo vasectomy, after having previously left a sperm sample in the sperm bank. this offers them the possibility of unlimited sexual relations without procreation and at such a time as they may wish to have children, they can obtain their own sperm from the sperm bank. It is important to emphasise that this is a great event in the history of humanity since for the first time the act of love and reproductive function are separated. The consequence of this dissociation will certainly be considerable. The third aspect of the mastering of reproduction is known to all. The world's press has written widely of fertilisation in vitro, bizarrely described as "test-tube babies". The facts reported are important, but all the more so in terms of their implications for the future. Female sterility may be ovarian in origin or due to a defect of the uterus or uterine tubes. It may be imagined that in the future, the possibility will be offered of correcting one or the other of these types of sterility by either fertilising in vitro an ovum from a donor with sperm from the husband and reimplanting the fertilised egg into the maternal uterus, or by fertilising the ovum from the mother in vitro using the sperm of the husband and reimplanting it in the uterus of another woman who might be described as a "brood mother". We thus risk the possibility of seeing children with two mothers: an "ovum mother" and a "brood mother". Many events occur during pregnancy, many exchanges of hormones, of information affecting the nervous system and one can thus envisage very great and novel moral, psychological and affective problems in the future of these children with two mothers.

These, then, are the three aspects of our first chapter: vaccination against pregnancy, sperm banks with the dissociation of love and the function of reproduction, and the existence in the future of children with two mothers: an "ovum mother" and a "brood mother".

— III —

In the book "Brave New World", which was a great success some forty years ago, the distinguished English novelist, Aldous Huxley, brother and son of well known biologists, imagined a future world in which Man would be capable of regulating genetics at will and could produce at will children who would be a future dictator, a future great writer or a future long jump champion. Quite obviously, we have not reached such a point, but since the book appeared great advances have been made and at the present time biologists are capable of profoundly altering the genetic properties of lower organisms, bacteria. If these bacteria lived in a world other than our own, this phenomenon would be of no great importance, but the bacteria studied, for example Escherichia coli, are normal commensual organisms of our body and changes and recombinations imposed upon these bacteria are thus of great importance to man himself. These experiments were first given the highly unfortunate name of genetic manipulations, within the concept of the student working in a physics or biology laboratory, or in an even more pejorative manner the influence exerted by certain political groupings on opinion. It would not seem desirable to retain this term and preference is given today to notions of genetic recombination or of genetic technology.

I shall not digress on the technical details, but only the consequences of this research. It is possible at the present time to transform an Escherichia coli genetically sensitive to antibiotics into an Escherichia coli resistant to all known antibiotics. It is also possible by genetic recombination to transform an E.coli resistant to antibiotics and to render it once again sensitive to antibiotics. It is now possible, and the potential consequences may be seen as a source of great concern, to incorporate into an E.coli the molecules of an animal cancer virus, thereby greatly facilitating the dissemination and diffusion of the virus. By contrast, there is the much more desirable possibility of literally domesticating E.coli, forcing them to produce substances useful from a therapeutic standpoint. As an example, the first success here concerned insulin. It is clear that in the future insulin, rather than being extracted from the pancreas of animals after long and costly processes, will be manufactured by domesticated bacteria. A French team at the Institut Pasteur has in the same way recently been successful in causing E.coli to produce human albumin. Another team has obtained the production of pituitary hormones by an E.coli. Similar methods make it possible to envisage the preparation of a vaccine against viral hepatitis. Since the chief purpose of this lecture is to consider future prospects, I have been at pains to emphasise the importance of these initial results. It is reasonable to predict that the entire pharmacology of the XXIst century will be transformed by methods of genetic recombination.

What is the very great importance of these discoveries for the future? At the present time, their value lies in having for the first time stimulated an awareness of the problems posed by scientists themselves. In the past, and in the history of physicists, the discovery of radiation and nuclear fission provides an example, scientists were divided into two sorts: the first group

washing their hands of the problem who considered that the consequences of their discoveries, even very undesirable, were none of their affair, and the second group terrified by these consequences, to the extent even of abandoning all research. Neither of these attitudes would seem to be very satisfactory. The attitude adopted at the time of the first discoveries of genetic recombination by biologists is much more valid. Biologists were thus aware of a new event, and of the potential dangers which it implied. In the various laboratories of the world concerned, they decided to organise a moratorium, or in other words a period of waiting, to allow time for reflection, to assess the possible extent of the dangers involved and the measures necessary to limit or avoid them. This method proved to be very valuable, calming the emotional response which had begun amongst the population at large. It may be noted here that humanity has always had need of devils. The devils of our own era are cancer, nuclear radiation and, now, genetic manipulation. Nothing could be more absurd than this demonology. People are terrified by cancer but will calmly talk about the myocardial infarction they have had and which is sometimes far more serious than a cancer. At any event, the period of moratorium permits proper assessment of the situation, with the publication of rules and precautions, the extent of which depends upon the nature of the genetic recombination envisaged. The same rules are applied in all countries. Fortunately, it has emerged over the past few years that the fears were probably excessive, and in particular these bacteria manipulated in this way are much less vigorous than wild bacteria and if allowed to escape into nature would probably be subjected to the competition of wild bacteria and would tend to disappear. One danger nevertheless persists, that of the military use of these scientific discoveries. It would seem that up to the present time it is the fear of seeing these transformed bacteria returning to their own country which has limited modern strategy. From a more general standpoint, one very important fact must be emphasised: for the first time, science has shown itself capable of assuming the responsibility for the consequences of its discoveries in such a way as to derive maximum benefit for mankind and limit the dangers.

I have limited my view of the future to the next 30 or 50 years. Farther into the future, it is possible to consider that in the XXIInd century methods will be developed to enable the application of methods of genetic recombination in mammals and man — methods which at present can be used in bacteria only.

In the mid-term, perhaps between 50 and 80 years from now, there may be the possibility of passing from the bacterium to animal and human cells. Two chief applications may be envisaged even now.

Genetic manipulations of animal cells could be used to produce hybrids and thereby improve the conditions of breeding and raising bovine and ovine domestic animals. Above all, there is the hope of being able to modify life expectancy. The life expectancy of a given species is probably related to genetic properties. The programmed death of chromosomes has been spoken of. If this is a genetic factor, it is conceivable that it might be suppressed, by introduction into the egg an opposing factor. But where to find this opposing factor? Possibly in the nucleus of certain tumour cells, which have an indefinite capacity to multiply, thereby rendering them eternal in a certain fashion, or in bactera which for the moment do not show any evidence of aging.

What an open door into dreams, or at least the science of tomorrow.

Before leaving the topic of genetics, I should like to stress the importance for medicine and biology of the discovery made by Professor Jean Dausset in the Institute of which I have the honour of being the Director in Paris: the discovery of the system of tissue histocompatibility antigens, called HLA (Human Leucocyte Antigen). These studies, initially inspired by Dausset and now widely developed in many laboratories throughout the world, have led to knowledge of the extreme complexity of this HLA system, with the existence at the present time of almost 200 million combinations. If to the HLA system are added the other known systems of erythrocyte groups, etc., the remarkable conclusion is reached that not only is each living human being different from all other human beings, but that since men have existed, and as long as men continue to exist, there have never been and never will be two the same (with, of course, the exception of monozygous twins). The discovery of HLA system thus has three principal consequences:

The first consequence is valid for all time, being that just mentioned: the discovery of the biological definition of man, and it is this which is source of pride to the haematologists and immunologists of our own time, in having provided this biological definition of man.

The second consequence involves the past. Since the incidence of each HLA sub-system varies with different populations, it is possible to establish an HLA profile for each population through the thousands of years which have gone before. The discipline which Professor Jacques Ruffié and I myself have developed over almost 20 years and which is known as Geo-

graphical Haematology has found this to be a remarkably useful tool. The migrations of populations from Asia to America, the migrations of the Normans, the great Indo-Aryan migrations, may be reconstructed by study of the HLA system.

The third consequence is more important for the future. It is known that belonging to this or that HLA system sub-group predisposes the carrier to one disease or another. It is obvious that physicians have long been aware of predispositions to disease but for a long time they failed to understand the reasons for such predispositions and, in accordance with the secular habits of medicine, masked their ignorance by eloquence, inventing a series of terms: diathesis, underlying pre-morbid condition, idiosyncrasy, allergy ..., etc. It is now known that the fact of belonging to a particular HLA system predisposes to diabetes, another to diseases of the nervous system, etc. Future methods of prevention may thus be imagined. Prevention is one of the oldest dreams of medicine. The word prevention slips easily from the tongue of politicians of all countries. This prevention, in the past, was achieved by various methods, either epidemiological (quarantine, isolation of lepers) or vaccination, both methods being highly satisfactory. There have also been methods of routine examination of populations, which have failed to yield valuable results. It can already be understood that in future HLA histocompatibility groups will be determined early in life and general living conditions, diet, living in a dry climate will make it possible in one case to avoid the risk of diabetes or in another the risk of rheumatic disease, etc. Many errors in the diet and general health care of young children will thus be avoided. The incidence and severity of important diseases (diabetes, rheumatic conditions, arteriosclerosis) will thus be limited.

— IV —

Some years ago a twenty year old girl, admitted to a Paris hospital, was suffering from septicaemia and was in a very grave condition: deep coma, a temperature of 41° irregular pulse and respiration. Intensive therapy was begun. The pulse and respiration became regular, the fever reduced but the patient remained in deep coma. Several days passed, pulse and respiration remaining normal. A neurologist was called in consultation. He examined the patient for a long time, with the thoroughness typical of his speciality, and having finished, turned to his colleagues to announce: "Your patient has been dead for two days". When an autopsy was performed a little later, lesions affecting the brain confirmed the accuracy of the neurologist's diagnosis.

We now know that various respiratory and circulatory functions may continue when an individual is dead. Death is death of the brain. In many countries, official legislation has confirmed this definition: two flat electroencephalograms indicate that you are dead, well and truly dead, in accordance with the law.

Thus the brain now plays the fundamental role which through the ages has been played by the liver, the blood, the heart and the endocrine glands, each in their turn. Thus the most fundamental problem facing medicine and biology during the next fifty years will be that of mastering the nervous system. This area of research is extremely difficult since man is at one and the same time the subject and object: on the one hand it is his own nervous system which is being examined, whilst on the other hand it is man with his own nervous system who must carry out this examination.

Progress is already in sight. Neurobiology seems likely to dominate the XXIst century. In fact, the question is simple: mastery of the nervous system, equivalent to changing the brain. How can a brain be changed? Let us now examine the various methods, some bad, some good, which can be suggested.

The first method which may be considered is that of a transplant. We are capable of transplanting kidneys, the pancreas, the heart, the bone marrow — why not transplant the brain? Numerous experimental studies have been performed. They have succeeded in overcoming the majority of the technical obstacles. They also raise an objection, an objection described by one of my eminent neurologist colleagues at the time when development of such transplants was envisaged. At the very best, he told us, you may be said to have grafted a man onto a brain. This remark is of deep significance: since men define themselves by their brain, then by transplanting a brain into a man it is the man who is changed.

The second method, very different and of great interest, although not immediately applicable, has been suggested by embryologists. One of the most extraordinary mysteries of our life is that of differentiation. We all begin as a single cell, this fertilised egg which contains the potential of our pancreas, our white cells, our red cells, our brain and our kidneys. It has been possible in the laboratory to show that a certain number of substances act as inciters or stimulants, capable of accelerating the development of this or that element: the brain, the liver, the lungs. Progress is such that it is possible, at least in certain animal species, by starting with a single cell to direct differentiation towards the brain, liver, lungs. This has been done in the lower crustacean, shrimps. Shrimps are certainly far away from man. But it is reasonable to conceive that within fifty years, and this in order not to discourage the younger amongst us,

it will be possible to advance from the shrimp to man. This will thus offer the solution to the daunting problem of aging. In the past thirty years, great changes have occurred in the life expectancy of man. In about 1935, the life expectancy in Western Europe for a man was 60 years and for a woman 63 years. It is now 73-74 years for men and 76-78 years for women. However these old people may be divided into several categories: 1) those with diseased organs, and various types of treatment, organ transplants, kidney transplants, can correct these deficiencies; 2) the old with organs in good condition but a diseased brain. This is the graver situation. It may now be hoped that within fifty years it will be possible to restore an adequate nervous system in the old people. A certain number of undifferentiated cells from these individuals will have been kept in culture. When their brain begins to fail, various stimuli will be applied to incite these cells to remake the nervous system, to permit the development of a brain in good condition. The neurologist friend whom I mentioned a short time ago has once again raised an objection: at best, he says, you will give this individual the brain of a newborn infant. Already, that is not so bad.

The third method is surgery. Since the work of the great Portuguese surgeon Egas Monis around 1935, the surgical treatment of psychoses has been possible. Monis showed that by altering certain regions of the brain it was possible to restore normal balance in cases of psychiatric disturbance. This was a pioneering technique. But psycho-surgery has now been overtaken by advances in psychopharmacology, that is to say methods which may be used to change the mood, the change of psychological function by the use of drugs.

In the line from Othello, "I have very poor and unhappy brains for drinking". It has long been known that a few centigrams of thyroid extract can transform a calm and gentle lady into an agitated shrew. The complexity and diversity of the effects on the central nervous system of numerous chemical substances have been recently recognised. New methods have been developed for the study of the nervous system.

Two major research areas have been explored. The preparation and synthesis of chemical agents have provided physicians and psychiatrists with highly original, active and diverse drugs. The observation of patients thus treated and of diseases thus modified has provided very important information. The language of chemistry was soon necessary to describe these effects and changes. Severe disorders of the mind, pyschoses, rendering the individuals affected dangerous to themselves and to others have been transformed by these chemical agents.

Limited at first to severe disorders, these therapeutic advances were then applied to more moderate mental problems, to behaviour disturbances. The next step is the application of these psychochemical methods to healthy or almost healthy individuals, with the aim of modifying their character. This raises technical and ethical concerns. Limiting ourselves to technical concerns, emphasis must be placed on the recent nature of these drugs and the caution which must be exercised in their use, as long as their advantages and disadvantages have not been perfectly and completely defined.

However, the chemistry of the nervous system offers legitimate hope, since the chemical mediators which are the messengers of the nerve cells and which are responsible for linking one neurone to another and the nerves to the muscles and various other organs of the periphery are now known. It is known that the drugs which correct mental disorders interfere with the metabolism of these mediators. A new beginning may thus be seen in terms of the conception of mental diseases: it may be possible to master psychoses by chemical agents. It may be explained by changes in chemical mediators.

A few years ago, having been named Dean of my Faculty of Medicine, I envisaged, amongst the new chairs which I wished to create, the creation of a Chair of the History of Therapeutic Illusions. Predictable progress in psychochemistry and in psychopharmacology will no doubt soon make it possible to classify many methods used in psychiatry, from the hysteria of Charcot to psychoanalysis, amongst such therapeutic illusions. New drugs are capable of profoundly altering outlook and personality. In the hands of an irresponsible dictator, they could represent a formidable weapon, enabling him to transform his population into sheep or tigers according to the political needs of the moment. It would suffice to slip into the food supply of his people, surreptiously, a substance creating either agitation or lethargy. Such a fear is not confined to the realms of science fiction. The Swiss government, well considered though the measure may be, has gradually eliminated goitres by introducing a little iodine into foodstuffs, especially salt.

Even beyond such political problems, fundamental questions concerning the human individual have now been raised and even more will be raised in the years to come. What relationship should be established between the definition of neurologists based upon the brain and the definition of geneticists and haematologists based upon genetic markers? To what extent is the state of the brain dependent upon genetic or inherent factors, and to what extent on acquired factors. This once again

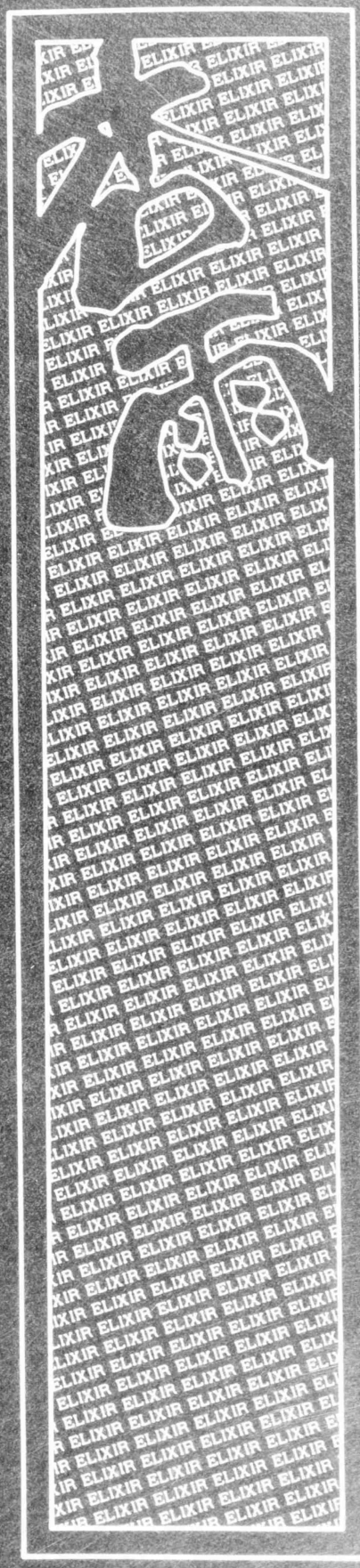
revives the old debate between inherited and acquired, which remains one of the great problems of our times. It is already possible to take a single undifferentiated cell and, in lower animals, produce a whole individual. It is conceivable, though obviously in the distant future, that it will be possible to produce a whole human individual from a single cell and thereby create a living being absolutely identical to the one which has just died. Identical with the exception of one characteristic: he would have the genetic characteristics but not the learning.

This fundamental difference is illustrated further by the notions suggested by Jacques Ruffié in his significant book: "De la biologie à la culture". The first story is that of an English lady in London High Society at the time of Darwin. When told "Man descends from the ape", she replies "I very much hope that that is not so, but if ever it should be ture, it should not be spoken about". The second story is more serious. If an atomic holocaust destroyed all the developed countries, with only a few tribes in New Guinea left alive, the world would suddenly find itself taken back 7000 or 8000 years. A complete new start would be necessary. But if young American, Russian, Chinese and French babies, children of the most eminent scientists and academics of the century, were saved from the disaster and brought up by primitive tribes, they would have to relearn and reinvent everything. The chromosomes given to them by their illustrious parents would be of little use. They would transmit aptitudes, not knowledge. But suppose that the same disaster destroyed all bees except for one fertilised female. Within a few weeks the hive would be reconstructed according to the same norms as in the past and within a few months would have given rise to daughter-hives constructed according to the same plan, containing insects with the same behaviour patterns, and within a few years the bees would have repopulated the world. This apologue illustrates the extraordinary difference which exists between animal species which have only their genetic properties and which have programmed everything for millions of years and man, who is at one and the same time biology and learning.

Thus, and I should like to conclude here, we are in the presence of events which are at one and the same time full of hope and to some extent awesome. There is a profound discord between the amazing advances in scientific and technical knowledge on the one hand and in much more uncertain progress in wisdom on the other hand. To measure this gap, it is sufficient to compare on the one hand the knowledge of Archimedes with that of the physicists of our own time, and on the other hand the wisdom of the ancient philosophers, of Plato, with that of our own philosophers.

Such discordances, such extreme separations, first sources of success, the unequal development of certain characteristics, are well known in the history of evolution. They may be fatal and account for the disappearance of a species. The great reptiles of the secondary epoch, the diplodocus, had an enormous body and a tiny brain: they disappeared.

According to whether we are pessimist or optimist, we must await in fear the consequences of the discordance, or on the contrary hope that progress in learning and culture will lead to the hoped-for desirable and fruitful outcome.



EXTRACTS FROM THE GAZETTE

HONOURS

Officer of the Most Excellent Order of the British Empire

Dr. Frederick Yong Koon Ong, M.B., B.S. (1957), Part-time Lecturer in the Department of Pathology *(Honorary)*.

By His Majesty the King of Malaysia:

Panglima Setia Mahkota (P.S.M.)

Professor G.B. Ong, O.B.E., M.B., B.S. (1947), J.P.

PERSONALIA

Drs. T. K. Chan and **Vivian N. Y. Chan,** Reader and Lecturer respectively in Medicine, attended the first Workshop of the IPPF—ESEAOR Panel on the Effects of Steroidal Contraceptives on Asians held at the University on September 3 and 4, 1978.

Dr. F. C. Y. Cheng, Reader in Surgery, has been admitted as a member of the British Society of Gastroenterology.

Dr. R. G. Choa, Lecturer in Surgery, has passed the Final Fellowship Examination of The Royal College of Surgeons of Edinburgh.

Professor M. J. Colbourne has been appointed Chairman of the Institute of Medical and Health Care Advisory Committee, Hong Kong Polytechnic.

Dr. D. Fang, Lecturer in Orthopaedic Surgery, has been elected a Fellow of the Royal College of Surgeons of Edinburgh.

Professor J.B. Gibson attended by invitation the Twelfth Congress of the International Academy of Pathology and the Third World Congress of Academic and Environmental Pathology held in Jerusalem from September 10 to 15, 1978, and presented a paper on 'The WHO Histological International Classification of Liver, Biliary Tract and Pancreas Tumours' and another paper (with F. C. S. Ho) on 'Gastrointestinal lymphomas in Hong Kong Chinese'.

Professors A. C. L. Hsieh and Rosie T. T. Young attended the conference on 'Biomedical Research Training in the Pacific-Southeast Asian Area' sponsored by the Fogarty International Centre, United States National Institutes of Health, and held in Honolulu from October 4 to 6, 1978.

Dr. S. W. K. Im, Lecturer in Microbiology, attended the Twelfth International Congress of Microbiology held in Munich, West Germany, from September 3 to 9, 1978, and presented a paper entitled 'Drug resistance and R plasmids in *Salmonella johannesburg*'.

Dr. K. C. Lam, Senior Lecturer in Medicine, attended the Inaugural Meeting of the Asian Pacific Association for the Study of the Liver held on August 11 and 12, 1978, and delivered a talk on 'The aetiological spectrum of liver cirrhosis in Hong Kong'. He became a Founder Member of the Association and was elected a member of its Executive Committee.

Dr. J. C. Y. Leong, Senior Lecturer in Orthopaedic Surgery, was invited by the Centro di Recupero Funzionale per Scoliosi—Fondazione Pro Juventute, Italy, to deliver two lectures entitled 'Anterior diskectomy and anterior spinal fusion for prolapsed intervertebral disc' and 'Surgical correction for fixed flexion deformity of the spine in ankylosing spondylitis' in Monteoriolo, Florence, in May 1978. He was also invited to visit orthopaedic centres in Rome, and the Primario Ortopedico Ospedale S. Corona, Divisione Deformita Vertebrali, Pietra Ligure, where he also operated on patients with spinal deformity.

Professor F. P. Lisowski delivered a lecture on 'The Olduvai foot' at the Institute of Vertebrate Palaeontology and Palaeoanthropology of the Academia Sinica in Peking and was presented with a cast of the *Gigantopithecus* mandible III, during July 1978. He also gave lectures on 'Medical educat on in the West with particular reference to anatomy' to the Peking Branch of the Chinese Anatomical Society, the Bethune Medical College

in Changchun, and the China Medical College in Shenyang.

Professor (Mrs.) H. K. Ma, organized and chaired the first Workshop of the Panel on the Effect of Steroidal Contraceptives on Asians in Hong Kong held on September 3 and 4, 1978. The Workshop was sponsored by the International Planned Parenthood Federation of the East and Southeast Asia and Oceania Region (IPPF—ESEAOR), Regional Medical Council. Professor Ma has been appointed Chairman of the Regional Panel on the Effect of Steroidal Contraceptives on Asians.

Dr. P. Nandi, Lecturer in Surgery, attended the Thirteenth World Congress on Diseases of the Chest held in Kyoto, Japan, from July 2 to 7, 1978, and presented a joint paper (with G. B. Ong) entitled 'Foreign body in the oesophagus — thirteen-year experience.'

Professor G. B. Ong attended the Fourth Annual Meeting of the Samson Thoracic Surgical Society, Western North America, held in Coronado, California, from June 4 to 7, 1978, and as guest speaker delivered a lecture entitled 'Factors influencing morbidity and mortality in oesophageal carcinoma'.

Professor D. Todd has been invited by the Roche Far East Research Foundation to be Honorary Advisor for Hong Kong for 1979.

Dr. T. F. Tse, Lecturer in Medicine, attended the first Workshop of the IPPF-ESEAOR Panel on the Effects of Steroidal Contraceptives on Asians held in Hong Kong on September 3 and 4, 1978, and presented a paper entitled 'Cardiovascular risks associated with oral contraceptive pills—a retrospective study in Hong Kong'.

Dr. Vivian C. W. Wong, Lecturer in Obstetrics and Gynaecology, attended the first Workshop of the IPPF-ESEAOR on the Effect of Steroidal Contraceptives on Asians held in Hong Kong on September 3 and 4, 1978. She presented a joint paper (with H. K. Ma, D. Todd, S. C. Tso, T. K. Chan and Vivian N. Y. Chan) entitled 'The effect of oral contraceptives on coagulation factors and venous thrombosis in Hong Kong'. She has been nominated Secretary of the Panel on the Effect of Steroidal Contraceptives on Asians, IPPF-ESEAOR Regional Medical Council.

Dr. W. Y. Chan Lui, Senior Lecturer in Paediatrics, was elected a Fellow of the Royal College of Physicians of Edinburgh.

Dr. F. C. Y. Cheng, Reader in Surgery, has been elected a Fellow of the Royal Australasian College of Surgeons.

Dr. S. P. Chow, Lecturer in Orthopaedic Surgery, attended by invitation the First Afro-Asian Conference of hand surgery held in Bombay, organised by the Indian Society of Hand Surgery from February 18 to 23, 1979, and presented a paper entitled 'Moulding press injury of the hand'.

Dr. P. C. Ho, Lecturer in Obstetrics and Gynaecology, was admitted as a Member of the Royal College of Obstetricians and Gynaecologists in January 1979.

Professor A. C. L. Hsieh attended a workshop on faculty development sponsored by the World Health Organization Regional Teacher Training Centre held in Sydney from February 4 to 16, 1979.

Professor J. H. Hutchison has been elected President of the Hong Kong Paediatric Society for 1979—80.

Dr. J. W. L. Kleevens, Senior Lecturer in Community Medicine, has been appointed a member of the Asian Advisory Board of *Modern Medicine of Asia,* and a member of the Management Committee of the Kwun Tong Community Health Project.

Dr. (Miss) H. J. Lin, Senior Hospital Biochemist in Pathology, attended the Twelfth International Cancer Congress held in Buenos Aires from October 5 to 11, 1978, and presented a paper entitled 'Abnormal composition of O-alkyl groups in the neutral O-alkyl glycerolipids of human hepatocellular carcinomas'.

Dr. H. C. Liu, Senior Lecturer in Anatomy, has been appointed Visiting Professor of Anatomy at the University of Oklahoma, U.S.A. from April 1 to August 31, 1979.

Professor M. B. Roberts visited the University of Malaya, Kuala Lumpur, from February 20 to 24, 1979, as External Examiner in integrated basic medical sciences (pharmacology) for the Second Professional Examination of its Faculty of Dentistry.

Dr. D. M. Scollard, Lecturer in Pathology, attended the Eleventh International Leprosy Congress held in Mexico City, in November 1979, and presented a paper entitled 'Cultivation of *M. leprae* from a human skin biopsy'.

Professor D. Todd has been elected a Fellow of the Royal College of Physicians and Surgeons of Glasgow, and invited to be a member of the Joint Panel of Examiners from Overseas for the Part II Examinations for the M.R.C.P. (U.K.). He has also been re-appointed a member of the Board of Censors of the Hong Kong College of General Practitioners by its Council.

Dr. P. Y. D. Wong, Senior Lecturer in Physiology, has been elected a Fellow of the Royal Institute of Chemistry.

J. L. Anderson, Lecturer in Medical Sociology, presented the following papers (with J.A. Thompson) to the British Sociological Association's Medical Sociology Conference held in York, in September 1978, and the British Psychological Society Conference held in Nottingham, in April 1979, respectively: 'Tell me about it : training medical students to communicate' and 'Patient preferences and the bedside manner'.

Dr. Flora M. Baber, Lecturer in Paediatrics, has been elected a Fellow of the Royal College of Physicians of Edinburgh.

Dr. K. K. Chan, Lecturer in the Department of Obstetrics and Gynaeology, presented a paper entitled 'Labour in different racial groups' at a scientific meeting of the Blair-Bell Society, held at the Royal College of Obstetricians and Gynaecologists in November 1978.

Dr. F.C.Y. Cheng, Reader in Surgery, has been appointed by His Excellency the Governor as a member of the Nursing Board of Hong Kong for three years from July 22, 1979.

Dr. G. Choa, Honorary Clinical Lecturer in Surgery, has been elected an Associate Fellow of the American Laryngological, Rhinological and Otological Society.

Professor G. L. Howe has been elected a Vice-president of the British Dental Association.

Dr. A. Koo, Senior Lecturer in Physiology, attended the annual meeting of the British Microcirculatory Society, and the scientific meeting of the Physiological Society, held in London, on April 6 and 7, 1979, and April 20 and 21, 1979, respectively. He has also been appointed Honorary Lecturer in the Department of Physiology, London Hospital Medical College, University of London, and Honorary Research Associate in the Department of Physiology, Charing Cross Hospital Medical School, University of London, for one year from April 1, 1979.

Dr. K. C. Lam, Senior Lecturer in Medicine, was elected an Associate Editor for the section on Gastroenterology in the *American Journal of Proctology. Gastroenterology, Colon and Rectal Surgery,* in May 1979. he was also elected a Fellow of the International Academy of Proctology at the same time.

Dr. J. C. Y. Leong, Senior Lecturer in Orthopaedic Surgery, was appointed Visiting Professor of Orthopaedic Surgery at the University of California, San Francisco, during his visit there in March and April 1979, on a China Medical Board Fellowship. He also visited orthopaedic centres in Boston, Wilmington, Toronto, Montreal and Los Angeles, where he delivered lectures. He attended the Sixth Congress of the Western Pacific Orthopaedic Association in Taipei from April 29 to May 4, 1979 and was Vice-Chairman for a session of free papers on spinal surgery.

Dr. Z. Lett, Lecturer in Surgery, has been admitted to the Roll of Fellows of the British Medical Association.

Dr. K. M. K. Leung, Lecturer in Community Medicine, was invited to the World Food Congress 1979, held in Cairo, Egypt, from March 23 to April 1, 1979, and asked to present a paper entitled 'Some aspect of nutrition education that deserves emphasis' which was chosen as one of the prize-winning essays. He also chaired a session on 'Food and population' during the Congress.

Dr. Anita M. C. Li, Lecturer in Paediatrics, has been elected a Fellow of the Royal College of Physicians of Edinburgh.

Dr. T. T. Loh, Lecturer in Physiology, was invited to attend the Fourth International Conference on Proteins of Iron Metabolisms held in Davos, Switzerland, from April 17 to 21, 1979, and presented a paper entitled 'Studies on the binding of transferrin to human placental microvillous membrane'.

Dr. R. P. Ng, Senior Lecturer in Medicine, attended the Fourth Meeting of the Asian-Pacific Division, International Society of Haematology, held in Seoul, Korea, from June 25 to 29, 1979, and presented a paper on 'Histiocytic diffuse non-Hodgkin's lymphoma'.

Dr. S. F. Pang, Lecturer in Physiology, was elected President of the Hong Kong Society of Neurosciences.

Lecturer, appointed Senior Lecturer in Surgery from July 1, 1978.

Tse Tak Fu, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), Lecturer, appointed Senior Lecturer in Medicine from September 15, 1978.

Christina Wang Chung Lun, M.B.,B.S., M.D. (Hong Kong), F.R.A.C.P., Lecturer, appointed Senior Lecturer in Medicine from July 1, 1978.

Patrick Wong Chow Lun, B.Sc. (New England), Ph.D. (Flinders), Lecturer, appointed Senior Lecturer in Biochemistry from July 1, 1979.

Patrick Wong Yee Ding, B.Sc. (London), M.A., Ph.D.(Cambridge), C.Chem., M.R.I.C., Lecturer, appointed Senior Lecturer in Physiology from July 1, 1978.

Florence Cheung Man Fung, M.B.,B.S. (Hong Kong), appointed Lecturer in Pathology from May 1, 1979.

Judith Evans, M.A. (Oxford), M.B.,B.S., M.R.C.S. (London), appointed Lecturer in Surgery from February 1, 1979.

James David Young, B.Sc., Ph.D. (Edinburgh), appointed Lecturer in Biochemistry from September 1, 1979.

James Lau Tai Twan, M.B.,B.S. (Hong Kong), M.Med. (Singapore), D.C.H. (London), F.R.C.S. (Edinburgh), F.R.A.C.S., appointed Lecturer in Surgery from May 1, 1979.

Mary Agnes Lung Kin Yum, B.Sc. (Hong Kong), Demonstrator, appointed Assistant Lecturer in Physiology from July 1, 1979.

Alan Henry Brook, M.D.S. (London), F.D.S. R.C.S. (England), appointed to the Chair of Children's Dentistry and Orthodontics from January 1, 1980.

Robert Kingsley Francis Clark, B.D.S., Ph.D. (London), F.D.S. R.C.P.S. (Glasgow), appointed to the Chair of Prosthetic Dentistry from January 1, 1980.

William Ian Rees Davies, B.D.S. (London), M.Sc., Dip. in Periodontics (Pennsylvania), F.D.S. R.C.S. (England), appointed to the Chair of Periodontology and Public Health from January 1, 1980.

Vivian Chan Nap Yee, M.Sc., Ph.D. (London), Lecturer, appointed Senior Lecturer in Medicine from July 1, 1978.

Chau Pak Yin, Ph.D. (Hong Kong), Dip. Med. (Shanghai), M.R.C.Path., Lecturer, appointed Senior Lecturer in Microbiology from July 1, 1979.

Anthony Koo, M.B.,B.S., Ph.D. (Hong Kong), Lecturer, appointed Senior Lecturer in Physiology from July 1, 1978.

Ronald Paul Ng, M.B.,B.S. (Hong Kong), M.R.C.P. (United Kingdom), Lecturer, appointed Senior Lecturer in Medicine from July 1, 1979.

Jen Ling Sun, B.S. (National Taiwan), M.Sc. (Ball State), appointed Lecturer in Anatomy from August 1, 1979.

Ong Say Gark, M.B.,B.S. (Malaya), appointed Lecturer in Community Medicine from August 1, 1979.

Grace Tang Wai King, M.B.,B.S. (Hong Kong), M.R.C.O.G., Honorary Clinical Lecturer, appointed Lecturer in the Department of Obstetrics and Gynaecology from August 5, 1979.

Ray Richard Lycette, M.D. (Otago), F.R.C.Path. (Australia and England), Clinical Pathologist, appointed Senior Clinical Pathologist in Pathology from July 1, 1979.

Chan Kwok Wah, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in Pathology from July 1, 1979.

Pang Sui Wah, M.B.,B.S. (Hong Kong), appointed Clinical Pathologist in Pathology from July 1, 1979.

Resignations

Dr. (Mrs.) Patricia M. Bannatyne, Lecturer in Pathology, from November 21, 1978.

Dr. C. F. L. Chui, Lecturer in Surgery, from January 5, 1979.

Dr. K. N. Lai, Lecturer in Medicine, from January 31, 1979.

Dr. A. K. Y. Lee, Senior Lecturer in Medicine, from September 14, 1978.

Dr. K. M. K. Leung, Lecturer in Community Medicine, from July 31, 1979.

Honorary and Visiting Professors

The following have been appointed Honorary and Visiting Professors:

Professor S. J. Joel-Cohen, M.B., B.Ch., F.R.C.S. (England), F.R.C.O.G., (Emeritus Professor of Obstetrics and Gynaecology, Tel Aviv University, Israel, Visiting Professor of Gynaecological Surgery at King's College, London and Honorary Consultant at Chelsea, Queen Charlottés and Dulwich Hospitals), as Honorary Professor in the Department of Obstetrics and Gynaecology in November 1979.

Professor Jeffrey Wong Tze Fei, B.A., Ph.D., Department of Biochemistry, University of Toronto, as Honorary Professor in the Department of Microbiology for the period June 1 to August 31, 1979.

Professor S.S.C. Yen, Professor and Chairman of the Department of Reproductive Medicine, University of California at San Diego, as the first Aw Boon Haw Visiting Professor in the Department of Obstetrics and

Gynaecology in November 1979.

Mr. G.L. Lloyd-Roberts, M.Ch. (Cambridge), F.R.C.S. (England), Orthopaedic Surgeon to the Hospital for Sick Children, Great Ormond Street, London, as M.B. Lee Visiting Professor in the Department of Orthopaedic Surgery from October 1 to 16, 1979.

Prize

The Hong Kong University Alumni Prize has been awarded to Dr. Mary Ip Sau Man.

APPOINTMENT

Peter John Preston,

O.B.E., F.R.C.P. (London), D.T.M.&H., D.C.H.

Dr. P. J. Preston, O.B.E., assumed duty as Director-designate of Postgraduate Medical Education on June 7, 1978 and as Director on September 1.

Dr. Preston retired from the Royal Navy where, as Surgeon Captain, he was previously Medical Officer in charge of the Royal Naval Hospital, Plymouth. No newcomer to Hong Kong, he was here as Consultant Physician at the Naval Hospital from 1955 to 1958, during which time he did some informal teaching at that hospital and at this University.

Dr. Preston received his medical training during the war and early post-war years at King's College and the Charing Cross Hospital Medical School, and obtained the Diploma in Child Health in 1964. In 1959 he was awarded the Diploma in Tropical Medicine and Hygiene from the School of Tropical Medicine in Liverpool. He brings to his appointment a wealth of practical and administrative experience gained in various civilian and naval hospitals in England, Sri Lanka and Malta (where he was also appointed Physician to the Governor of Malta) besides Hong Kong.

He has also maintained a teaching role in general medicine and tropical medicine. He was appointed an honorary teacher in the Faculty of Medicine at the Royal University of Malta from 1966 to 1969 and on return to England as Royal College of Physicians Professor of Naval Medicine, he was responsible for medical teaching and research in the Institute of Naval Medicine.

He also taught Tropical Medicine in Southampton University, Wessex and the South West Regions, being appointed Examiner in Tropical Medicine for the Royal College of Physicians from 1972 to 1978.

His publications include a variety of subjects including malaria, hepatitis, helminthology and isotopic scanning in pursuit of nematodes. He is the author of the chapter on medical emergencies at sea in the current edition of Birch's *Emergencies in Medical Practice.*

Li Kwan Ming

B.Sc. (Nanking), Ph.D. (Hong Kong)

Dr. Li Kwan-ming retired from the Department of Physiology on June 30, 1978, after twenty-five years of service to the University.

Dr. Li entered Nanking University in 1937 with the aim of studying marine biology. As with many of the young men of his age, the Sino-Japanese hostilities interrupted his studies. He participated in helping the University of Nanking to move to Chengtu. With China waging a full-fledged war of survival, the study of marine biology appeared to be quite irrelevant and Dr. Li entered the Air Force Academy. Having served his country for six years and achieved the rank of colonel, K.M. returned to complete his university studies in 1944. He joined the Department of Zoology of the University of Hong Kong as a demonstrator in 1952. In 1953 he transferred to the Fisheries Research Unit of the University of Hong Kong and in 1961 joined the Department of Physiology.

Dr. Li maintained his interest in marine biology and his doctoral thesis, submitted in 1966, was entitled 'Icthyosarcotoxins in fishes of the Pacific Ocean: With special reference to the mechanism of action'. In this work he demonstrated the anticholinesterase activity of the ciguatera fish poison and the effectiveness of protopam chloride in conjunction with atropine as an antidote. His work on fish toxins led to an invitation to join the Department of Pharmacology of the University of Hawaii in 1967. He returned to the University of Hong Kong in 1969 on appointment as Senior Lecturer in Physiology.

Although Dr. Li's main research interest was in marine biology, he very quickly adapted to the needs of a physiology department in a medical faculty. He lectured to the undergraduates on a variety of subjects, including the digestive system. His tutorials were always stimulating and well received. He brought to the Department the broader outlook of the trained zoologist and constantly reminded us that *Homo sapiens* is only one of many

species of animals. He participated actively in the affairs of the students and was elected president of the Medical Students' Society.

During his long service to the University he earned the respect of all those who came to know him and we wish him a long and happy retirement.

A.C.L.H.

Alan Henry Brook

M.D.S. (London), F.D.S. R.C.S. (England)

Mr. A. H. Brook has been appointed to the Chair of Children's Dentistry and Orthodontics from January 1, 1980.

Professor Brook graduated from the university of London (Guy's Hospital Dental School) and the Royal College of Surgeons of England in 1964 with the Degree of Bachelor of Dental Surgery and the Licentiate in Dental Surgery. He obtained the F.D.S. in 1968 and the Degree of Master of Dental Surgery in 1974. From 1969 to 1977 he served first as Lecturer, then Senior Lecturer (from 1973), and Honorary Consultant (from 1975), at the Institute of Dental Surgery, Eastman Dental Hospital. He was appointed Reader and Honorary Consultant of the London Hospital Medical College in 1977.

Professor Brook has contributed extensively to the literature. He is especially interested in the epidemiology and aetiology of dental anomalies, the control of tooth eruption and the diagnosis and treatment of oro-facial infections in children. He has played a significant role in the improvement of the dental care provided to mentally and physically handicapped children and those afflicted with acute anxiety.

Robert Kingsley Francis Clark

B.D.S., Ph.D. (London), F.D.S. R.C.P.S. (Glasgow)

Dr. R. K. F. Clark has been appointed to the Chair of Prosthetic Dentistry from Jan. 1, 1980.

Professor Clark graduated from the University of London (Guy's Hospital Dental School) and the Royal College of Surgeons of England in 1970 with the Degree of Bachelor of Dental Surgery and the Licentiate in Dental Surgery. In 1974 he obtained the Degree of Doctor of Philosophy from the Institute of Basic Medical Sciences of the Royal College of Surgeons of England, and in 1976 he obtained the F.D.S. R.C.P.S. (Glasgow). After serving as Registrar/Demonstrator at the Department of Prosthetic Dentistry, Guy's Hospital, for about two years from 1972, Professor Clark was appointed Lecturer in Prosthetic Dentistry at the Royal Dental Hospital of London, School of Dental Surgery. Since 1974 he has been Honorary Senior Research Fellow in Dental Neurology and Honorary Lecturer in Dental Physiology at the Institute of Basic Medical Sciences of the Royal College of Surgeons of England. In 1977 he was promoted to Senior Lecturer in Prosthetic Dentistry at the Royal Dental Hospital of London, School of Dental Surgery.

Professor Clark is particularly interested in neuromuscular mechanisms and control and has made important contributions towards the study of temporomandibular articular mechanoreceptors.

William Ian Rees Davies

B.D.S. (London), M. Sc. Dip. in Periodontics (Pennsylvania), F.D.S. R.C.S. (England)

Mr. W. I. R. Davies has been appointed to the Chair of Periodontology and Public Health from January 1, 1980.

Professor Davies graduated from the University of London (University College Hospital Dental School) and the Royal College of Surgeons of England in 1964 with the Degree of Bachelor of Dental Surgery and the Licentiate in Dental Surgery. After serving as House Surgeon and Assistant Lecturer at University College Hospital Dental School he was awarded the First Thouron Scholarship in the medical science and entered the University of Pennsylvania in 1966 where he obtained the Degree of Master of Science and the Diploma in Periodontics in 1969. He obtained the Fellowship in Dental Surgery in 1971 and one year later joined the staff of the Royal Dental Hospital School of Dental Surgery as Senior Lecturer in Periodontology. In 1974 he was appointed Director of the Department of Periodontology and Honorary Consultant Periodontologist of the Royal Dental Hospital.

Professor Davies has been an active member of the British Society of Periodontology, being a Council member from 1973 to 1976 and serving as Secretary of the Society's Teachers Section since 1975. Apart from being author of many articles in learned journals, Professor Davies has recently been appointed to a number of examinerships, including that for the Final Fellowship in Dental Surgery of the Royal College of Surgeons of England.

ELIXIR LOAN FUND, MEDICAL SOCIETY

Statement of Account as at November 30, 1979

Balance at Dec. 1, 1978		
Fund at Financial Office, HKU	25,937.62	
Fund at Medic Central Fund	3,625.00	
Cash	49.20	29,611.82
Less:		
Excess of Expenditure over Income		4,377.57
		25,234.25
Represented by:		
Fixed deposit with Wardley Ltd.		
(16.5.1979—31.1.1980)	2,000.00	
(18.10.1979—31.1.1980)	14,100.00	
(23.11.1979—31.1.1980)	9,100.00	25,200.00
Balance with HKU's Current Account		3.85
Cash		30.40
		25,234.25
Loans Situation:		
Outstanding on December 1, 1978	79,515.00	
Add:		
Loans granted in 1979	24,500.00	104,015.00
Less:		
Repayment balanced forward on Dec. 1, 78	3,625.00	
Repayment received in Session 78—79	18,170.00	21,795.00
Total Outstanding Loans		82,220.00

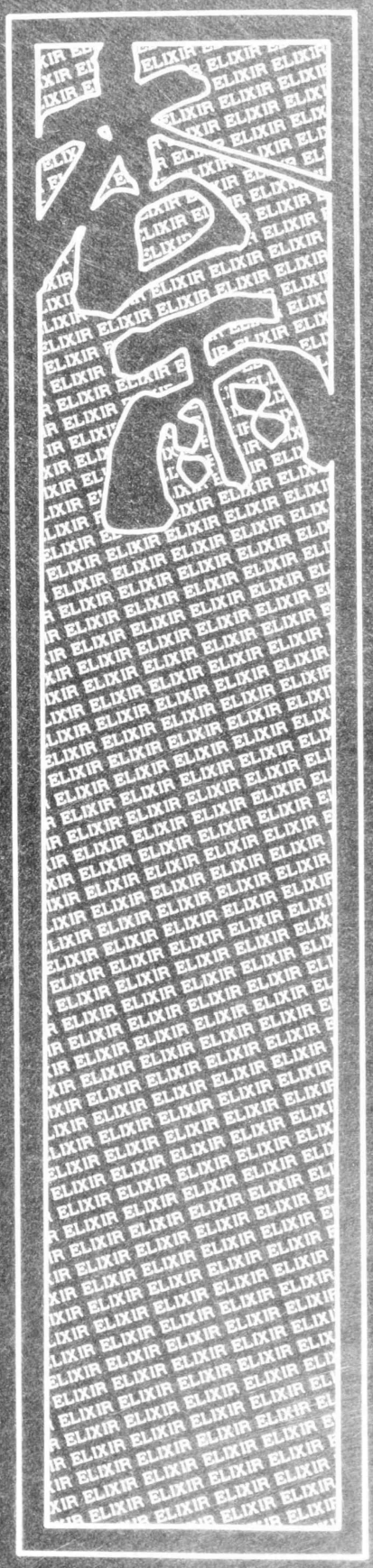
Income and Expenditure Account for the period from Dec. 1, 78 to Nov. 30, 79

Income	
Repayment received in Session 78—79	18,170.00
Transferred from Medic Central Fund	1,000.00
Associate Members Subscription Fee	200.00
Donation specified to ELF	100.00
Bank Interest received	674.23
	20,144.23
Expenditure	
Stationery, postage, photocopy	21.80
Loans granted in 1979	24,500.00
	24,521.80
Excess of Expenditure over Income	4,377.57

Prepared by:

Fung Hong, (Sd.)
Chairman, Administrative Board,
Elixir Loan Fund, Medical Society,
Session 1978—9.

Date: December 1, 1979.



CONTRIBUTIONS

"This frog has to jump out from the little well....."

A dreamer

My senior clerkship in Medicine ended last week. So there is only one more clerkship in Medicine to go before my finals. If I am to be honest, I feel very frightened. I don't seem to know a thing! It sounds sad, but the sadder still was that I did not realize it during my previous clerkships.

I was very satisfied and congragulated myself when I managed to make a correct diagnosis or to give a clever and accurate answer to a question being asked at the bedside. Sometimes I even nearly made myself and the others to think that I was smart. I thanked heaven when I was able to avoid things that I did not know. I felt glad when these questions were not directed to me. I did not mind when I made a wrong diagnosis, because I always told myself that I was still a student. Somebody would get it right! It all sounded so stupid but it happened, not too long ago, to me and I bet to many others. It was such a natural thing to do, it was such an easy mistake to make but too big a mistake.

Oh, I feel so scared, not that I am worried about the final M.B.,B.S. examination. I know I will graduate, I know that I will manage to get through, but so what? What am I going to use to practise medicine? What can I offer to the patients? How long will it be when luck leaves me? When I'll have to face things that I do not know, there won't be anybody else to make the diagnosis. There is no way to escape questions. No, I won't be lucky everytime. I need something more solid than luck that I can fall back on — knowledge. I really should make up from now on for what I foolishly ignored in the past year. I shall pick up the responsibilities of a future doctor but not that of a professional student working towards passing examinations. 'I want to see the whole forest but not just a small bush close by.' This frog has to jump out from the little well.

FEMALE

Somebody

'You will soon find that the CNS examination will come in reflexes, just like when you are driving a car unless you are a female.'

'You ladies have to try to make an effort to practice your percussion technique.'

'So many girls in your group!'

'You may support only 1 leg for the knee-jerk but the guys should be able to support both.'

'Girls cannot do Orthopedics.'

etc. etc. etc. etc. etc. etc. etc. etc. etc. .....

'Common things always occur more commonly.' Dr. H. C. Ho. So you bet I was very unhappy about all the above comments. However, rare things do occur and this is why Medicine is so difficult! You believe it or not, I was delighted to hear them. The reason is that I was recognised as what I was, a female.

Equality does not mean loss of identity. A female should be identified as one of her sex. Why should she be treated as a male when she is not? She is brought up to be what she should be. She cares about small things, she likes to be beautiful, she likes shopping, and many other things that help her to recognise her sex. There is nothing wrong with it and she should be proud of her own sex. Self-identity is important and one's sex is only part of it. To be equal to a male is not in the formalities and appearances but in the attitude.

The essence of equality between the two sexes lies in the respect that people pay to the members of either. Many people think that they can forget their manners by saying that the 2 sexes are equal. Manners are manners, they are part of civilization and have nothing to do with inequality as long as they are done in good faith. We may remain as what we are and at the same time be equal to the opposite sex.

The Doctor and His Mission

Peter Cheng Ming Chuen

The sun was setting. Her withering glory she emanates, carpeting the undulating blue sea with a path of glittering gold and gilding the wafting sheepy clouds each a brilliant lining.

On the nearly-empty shore stood a young statuesque man, his long shadow trailing on the golden sand. The picturesque and tranquill sunset scene lay vividly before his empty and emaciated eyes which seemed unmatched to his handsome figure and pleasant face. Indeed, even the most fascinating panorama would not charm him, now that his thoughts were so far, far away .....

He remembered once he had performed an operation on a patient who suffered from head injury. Though the situation was delicate, he could have saved his life but in the end every effort he strained was in vain.

At noon, while he was having lunch with his fiancee, Natalie, he could not hide his despondence and was gloomly silent.

'What's on your mind, Bob?' Nat noticed and asked him.

He told her somberly of what had happened that morning.

'Come on, Bob,' she said soothingly, "don't tell me you're such a melancholic kind of doctor.'

'But I thought that,' he replied, 'the operation had been a success. And then no sooner had he been taken back to the ward, he was gone.'

She paused for a moment.

'But you've tried your best, haven't you?'

Then they ate silently.

'Haven't you heard of the saying "I have come that you may have life and have it more abundantly."?' she quiried afterwards.

'Is this the word of God?'

'But that's also the mission He's given you, whether you succeed or not.'

From the time they met when Bob was only a medical student, throughout his internship up till that moment, there was many a time when he was thwarted, depressed and defeated in the course of his studies and his work; but Nat was there to share his worries, to relieve his burden and to rescue him from his sea of troubles. Sometimes he wondered what would happen if he were without her.

And then two weeks ago a damned, reckless driver knocked Nat down in the street and since then he felt all alone.

For a fortnight he had tried to drown his sorrow by burying himself inside his work, but his confidence seemed wrecked and being unable to concentrate in attending his patients, he took a week's leave from the hospital.

Unwittingly he had once again returned to the beach which Nat and he once haunted. The sunset view looked just as imposing as before, only that the eyes that once admired it would admire it no longer. Each rock on which were their footprints conjured up the wonderful time they had shared, whilst walking hand in hand and whispering the language of romance, caressed by the tender sea breeze. But now these memories merely added to his sorrow.

He, Doctor Robert Ryan, he thought painstakingly, who had backed his patients in battling and struggling with Death, was absolutely helpless in saving the only girl he loved. Or was it that Fate gave him no chance?

Tears came to his eyes as he could stand loneliness and emotion no more.

His eyesight became blurred by lacrimal fluid, but he could faintly hear the distant voice of someone yelling. As he swept his glance over the empty beach, he noticed that the boy who had been fishing on a boulder had fallen into the sea and was struggling from the watery grave. Instinctively he tossed off his shoes, ran forward, dived into the water, and swam as fast as he could towards the drowning boy. Reaching him, he dragged him out of the water by his hair and pulled him ashore. The child being unconscious, his lips cyanosed, Bob tried mouth-to-mouth resuscitation. Several minutes lapsed but there was no response. Bob did not give up. At long last his effort paid off and the boy restored consciousness.

The child was still feeble but Bob knew he had escaped from the fangs of Death. The wind chilled his soaked body to the spine, but he no longer felt cold and alone inside his heart. Carrying the pitiful child in his arms to his car, he felt Nat near him, and her words appeared in his mind: 'I have come that you may have life and have it more abundantly.' He knew that the road was long, winding and full of thorns and Nat had left him to walk it alone. But nevertheless he would complete the journey God had assigned him.

He grieves for the dead but lives for the live.

In this story 'elixir' is, as the word literally means, a substance that can prolong life indefinitely, but it was written to commemorate the publication of the magazine of the same name.

Spaceship HERCULES towered above the lonely, edgeless, level landscape of Titan, the largest moon of the giant planet, Saturn, its engine cooled to the surrounding temperature of -150°c and its shell scarred by micrometeorites. After a month's voyage, HERCULES had ultimately reached its destination.

All had gone well so far. As planned, HERCULES had blasted off from Earth, and travelled 900 million miles of almost empty space, propelled by its enormously powerful solar batteries. It had been launched into a transfer orbit round Saturn exploiting the planet's huge gravity to find itself finally amidst the dense atmosphere of Titan. There, using an intense electric field its crew had extracted a tank full of methane, the main constituent of Titan's atmosphere, compressed to a pressure of several hundred atmospheres. Earth now facing so serious a oil crisis, the gaseous fuel would not worth little. But in one chamber of the ship worthing much more than the methane was an unexpected harvest of a plant, called Rhodosida, better known as *'elixir' plants*, spotted by HERCULES' crew below a small overhanging cliff. First discovered during a space expedition, these plants *were found, by research experiments, to contain an extract that could slow down the aging process of human cells, and hence make a precious medicine.* But culture of the plants failed on Earth because terrestrial conditions were unsuitable. And subsequent expeditions to Titan failed to bring home more of them.

ELIXIR

David Walker and Thomas Lloyd, the two crew members aboard Hercules were ready to take off now that their task had been more than achieved. Scarcely had Walker pressed a button when the ship soared into space, through the methane atmosphere and up, up into the enveloping darkness — Titan was left behind.

Walker left the ship under automatic piloting and gazed into the boundless, gloomy vacuum outside. Pondering, he could imagine how happy Susan and little Dick would be when he brought home unexpected good news.

HERCULES was three-quarters way back to Earth after three weeks' voyage. Walker was sitting in front of the controls when Lloyd appeared from the radio-room, wearing a grave countenance.

"What's up, Tom?"

"Look at this yourself," Lloyd replied, handing his shipmate a relayed message which read:

EARTH HEADQUARTERS TO ALL SHIPS: Urgent and important. Vessels in flight in Sector X6Y4Z16 return to Earth at once. Solar flare due in 5 hrs. Entire tow fleet now to the rescue. Smith. Space Base Commander.

"The hell with it," Walker remarked as he noted the ship's position, "We're almost in the centre of the sector."

"Rescue team won't make it," Lloyd said, "It's impossible to find a damn thing in this pitch-black space. Besides our ship and theirs will be travelling at top speeds — "

"I've already switched to maximum power," Walker interrupted. "Still, we can't possibly get out of this sector on time. And with enough explosive gas aboard the ship to blow up the whole New York City, I don't

want any space rescuer to company us in a space catastrophe."

The two stayed speechless, thinking what they should do. Half an hour lapsed before Lloyd broke silence.

"I've got it," he said without enthusiasm as though he hadn't. "It's simple, Dave. Just let me go outside in a spacesuit and drill a hole in the wall of the tank. As the methane gushes out through the hole, the ship will be pushed towards Earth at a tremendous speed. It's just Action and Reaction — Newton's Third Law."

"Nonsense," Walker remarked after a little pondering, "the ship will make a Jump through millions of miles of space as soon as you make a hole in the tank. You can't possibly get back into the ship on time."

"But this is the only way out. We've only four and a half hours left."

"I won't let you do it," Walker insisted.

"Listen, Dave," argued Lloyd, "you have a family — wife and son — waiting for you at home. I haven't. We've spent so much time and effort on this expedition. We can't let our ship and our valuable findings turn into ashes."

"No, Tom, I would rather go out myself, or both of us stay and think of another way out. You are younger and have bright prospects."

They sat again in silence. Another 15 minutes passed. All of a sudden Walker felt a blow on his head and unconscious he fell.

When he came round, he could find Lloyd nowhere. Walker shouted, "Tom! Come back in. I want to speak to you."

But there was no answer. His head aching, Walker scrambled into his spacesuit. No sooner had he reached the inner door than the whole vessel took a tremendous thrust forward, hurling Walker to the floor. By the time he could stand on his feet again, he could guess what had happened. He noticed that the ship had almost evaded the sector under the solar flare warning. But now another crisis had arisen. The barometric pressure of the ship was dropping sharply and Walker could hear a faint hissing sound — somewhere air was leaking out into space. Some meteorite, he thought, must have hit the ship during its Jump and owing to the enormous velocity a leak had been created. Yet there is no time to hesitate. Walker knew the remaining air in the ship would soon escape into space and the trifling oxygen in the storage cylinder connected to his spacesuit would not last long. Instinctively he strode into the chamber where the 'elixir plants' had been placed, and turned on the air-tight device which would prevent any air from flowing out of the room. Sweat droplets still dripping on his forehead and his heart still beating hard, Walker suddenly realized that oxygen was plentiful in the room — the plants were giving out oxygen and taking in carbon dioxide like ordinary Earth plants.

Steered by its automatic controls, HERCULES shot through Earth's atmosphere heading straight towards the Rocket Base.

Benumbed, indignant and grieved, Walker could stand the emotions within himself no more, as tears ran down his cheeks. He knew the 'elixir plants' had extended his life though not in the usual way a medicine would. Still, the plants were worthless compared to the immortal friendship that Lloyd showed in sacrificing his life for him.

Peter Cheng Ming Chuen

旅程㈠

青斯

「嗚……嗚……」

「轟隆……轟隆……轟隆……」

已經是凌晨四時許。車廂內仍是一片煙霧瀰漫，人聲嘈雜；混濁的空氣使人昏昏欲睡。也許我該再盹睡多一會兒，經過了一整天的火車旅程，疲勞老是想把我再驅進夢鄉，再來一個甜甜蜜蜜的美夢，才去迎接黎明的使者。但是，我相信意志總能支撐得住沉重的眼皮，驅走一切疲倦：我要讓自己瞻瞻中國文化的發源地——黃河——的風采後，才能甘心。黃河，使我們中華民族爲自己感到自豪，我們引它爲榮。其實我該說它就是一本歷史課本，描繪着中華民族數千年來的奮鬥史。想到這裏，心中不期然地聽到冼星海先生的黃河大會奏……

火車已經到達花園口㈡，車頭慢慢地駛過黃河上的鐵橋了。窗外漆黑一片，除了在水中倒影出來的幾盞燈光之外，其餘的都埋藏在黑夜之中，待人把這塊黑幕扯掉之後，它就會一頁一頁地把沾滿了血漬和淚痕的辛酸史，告訴中華民族的子孫。我的心跳加速了，音樂聲也漸漸大起來。

是一陣婉然迴盪的音樂，多少含點憂傷，訴說着黃河的曲折迂迴，訴說着中華民族的悠久歷史；跟着是雄壯，清脆的琴鍵聲，佔有了我的腦海，一幕一幕的歷史顯現在眼前……

……在從前，我總覺得中國是一個遙遠的地方，而黃河也是書本上的名詞而矣。所謂民族感情，就只是歷史課堂內的產品，課堂之外，是不大存在的；一切都顯得很遙遠、很遙遠。誠然，近代中國史的確是黑暗的一頁。每一章，每一頁，不是外戰，列强侵略，就是內戰，互相殘殺；百姓不受外人欺壓，就是受着同種同族的剝削，生靈塗炭，民不聊生。倘若有人讀後不爲之感動，不立志要振奮的，我能對他有好的評價嗎？坦白地說我就曾經歷過這個階段，培養過一份課堂內的民族感情，質詢自己，作爲一個中國人的責任、使命；並且意圖打破課室的框框，走出象牙之塔，要爲中國貢獻自己的力量。

但是，「愛國家，愛民族」等口號，眞是談何容易呢？我們身處香港，身份証上填的是英籍，誰是自己的國家，也可能未弄清楚呢！怎能談得上民族感情呢？一份身處異地的無可奈何，再加上一個遙遠缺乏親切感的名詞——中國——就把一切都趕回課室內，剩下來的或者偶然會在字裡行間流露出點滴而矣。

當我第一次有機會嗅到祖國鄉土的氣息時，我才敢相信以前讀過的歷史不是虛構的；同時也隨着時間的增長，打破了自己對一些不知悉的東西所曾

作的美麗憧憬。誠然，當初當我相信我不是做夢的時候，心裏已感到無盡的喜悅，再加上每次踏在祖國土地上之時，那份「中國人」的感覺都會重新燃點起來，心底裏就更加覺得火一般的熾熱。尤其是當哼着遠航歸來的時候：「祖國的河山遙遙在望，祖國的炊煙招手喚兒郎……祖國，我們遠航來了……」，那份心情，不能言喻。在那個時候，在祖國裏所聽到的每一個故事，都是振奮人心的，不是知青談怎樣去爲國家，就是青年突擊隊談怎樣去克服艱巨的任務。黨、國家，就如身體的一部份一樣，共生共存。對一個異地的中國人而言，能夠去領略這顆死寂已久的心，都掀起一陣陣的漣漪。那個時候，的確有好些人視國內旅行團，爲重新灌注工作動力、生命力量的途徑之一。

腦海中印象比較深刻的一次旅行，我想要算是年前去長沙韶山㈢的那一次。雖然是短短的七天，而且多少帶點朝拜革命聖地的心理，但是參觀罷雷鋒紀念館，及韶山的毛主席舊居，舊居紀念館等地之後，總覺得有點羞愧之心。以雷鋒爲例，爲什麼別人可以不顧自己，貢獻自己，去幹一番不算是轟烈，其實可以說根本是平凡的、但是值得歌頌的事情，而自己卻偏偏選擇要安於本位呢？講解員講解的時候，眼淚一顆顆滴下來，圖把我最後的防線都溶化掉……。然而我似乎領悟了。那一次也是我最後一次參加旅行團。

我開始問自己，太過感性的認識是否有益處呢？我承認近代中國史是血淚的交織，而亦出現過不少的英雄烈士。他們的事蹟個個都可歌可泣，但是，這是否全部的民族感情的教育呢。他們的事蹟，雖然有點兒千篇一律，我們都應該知悉，因爲他們該成爲永世後人的典範；但是他們和我們都是不同時代的，除非中國仍是那樣的停滯不前，否則我們不能再直接選用他們獻身的方法，以之後效。階級教育是需要的，但是過時的階級教育很容易令人失卻親切感。而且，我們根本不知道那裏可以讓我們去獻身、去顯一下身手，這就是一切的教育所缺乏的。我好奇地問：「爲什麼中學的歷史課只能教中日七年抗戰呢？」

……

在不知不覺間，我再墮入夢鄉之中。

……

一覺醒來，耳目爲之一新。整個大地披上了一件白色的新衣。火車已經在河北省境內奔馳了。在熹微的陽光照耀下的雪景，別有一番新意，更加顯出它的皎潔，與及大地的廣闊，無邊無際。遠遠地只見到白色及蔚藍色，分不清那是雲還是雪呢！鐵道旁還見到不少的騾子、騾車，更加感覺到自己是身處北方了。江山如此多嬌呢！我想聞一多先生說的「我的世界自有更遼闊的邊境。」就是含意着中國大地的廣闊，無邊無際吧！

是的！廣闊的大地，何處不能容納我們去一顯身手呢？

……

火車慢慢地溜進北京火車站了。

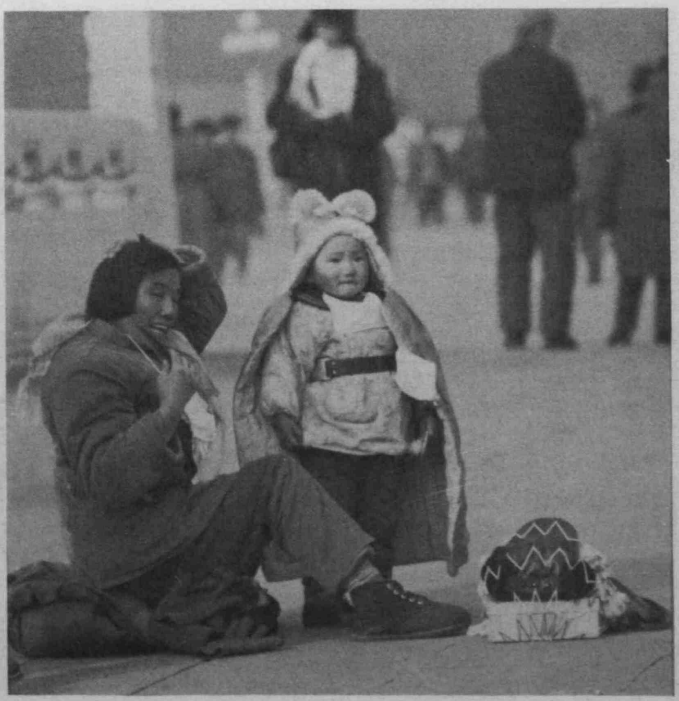
一九七九年九月廿五日

註：

㈠筆者去年十二月尾，乘聖誕假期之便，曾到北京旅遊數天。

㈡花園口在河南黃河岸旁，與省會鄭州相距不遠。

㈢長沙乃湖南之省會，韶山位於長沙之西南，爲毛主席之故鄉。



三年之想

陳仲謀

有人說快樂的時間是過得最快的，這話兒一點沒有說錯，這兩個年頭實在過得很快。想起兩年前剛考入醫科，心裏又是興奮，又是迷惘。興奮的是如願已償，迷惘的是不知道自己是否適合讀醫科。當時的心境曾以一篇「新丁雜感」，投稿於醫學院的年刊ELIXIR 之中，還記得最尾的幾句是：

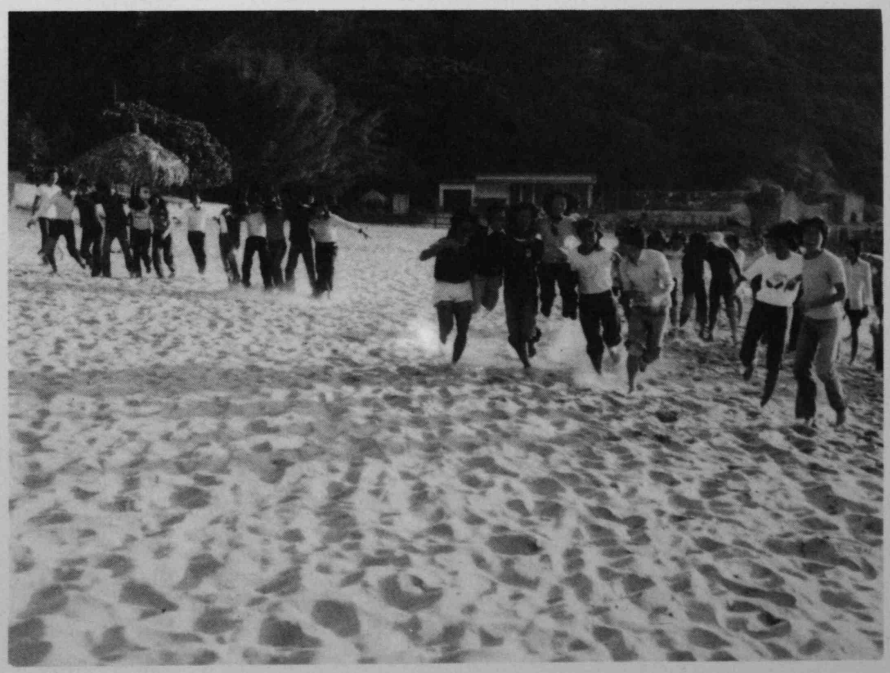
「七年中學悠悠，此時此地難再，憶往事，望前程，身在青黃之界；雄心萬丈，立志堅强，他日濟世爲懷。」

兩年後的今日，自己已經升上三年班了，究竟現在的想法和感受和兩年前又有何分別呢？

初入醫學院時，對醫科的情形很是陌生，心中「十五十六」，不知道有沒有選錯系，也不知道自己是否適合做個醫生，現在雖然已經讀了兩年醫科，但是對上述的問題仍沒有找到肯定的答案。

這兩年叫做PRE- CLINICAL YEARS ，上課的情形和在中學時沒有多大分別，只是上課時人比較多一點吧！換句話說，在兩年中，我們還未可以領悟到當醫生的眞正滋味，我們還未上過醫院，還未接觸過病人，所以醫生的生活是怎樣的，我們還不很清楚，對於是否適合做醫生，還未能下一個結論。

有時候覺得自己很傻，反正這個醫生大概是做定的了，幹甚麼還問適合不適合呢！況且興趣是從學習、工作和經驗中培養出來的，只



要自己悉力以赴，那麼不適合也會變得適合吧！

暫且撇下學業上的問題不談 ， 讓我們談談大學生活的其他方面吧！

憑良心說，這兩年的大學生活委實多姿多采。我一方面在班中認識了很多新朋友，另一方面，在宿舍內也認識了不少其他院系的同學，跟他們在一起，自己可以看到很多事物，增廣見聞，也可以從他們之中看到很多有關自己的東西，想來「以人爲鑑，可以知得失」，就是這個道理吧！

「八二」的同學眞是很好的，這句話說來很孩子氣吧，不過我着實想不到更好的形容詞。他們之中，很多不但「敬業」，而且「樂羣」，跟他們一起讀書 ，一起搞活動 ，一起玩耍，一羣年青人，無拘無束，熱情奔放，眞教人難忘。還記得一年班時，班會搞了一次沙灘旅行，當時正在舉行集體遊戲，那個遊戲叫五人六足賽跑，相信大家都知道怎樣玩的吧！當時我們的一組有三個「大隻佬」，一個「小姑娘」和一個「細隻佬」 ， 我們五人互雙一看之下，不期然計上心頭，實行「搏懵」，詳情請看照片，結果我們輕易取勝，可是裁判說我們犯了規，取消資格，令我們甚爲「氣結」。這祇不過是班中活動的一小片段，其他種種，不能盡錄，不過從同學們參加活動的熱情來看，「八二」不愧爲「八二」。

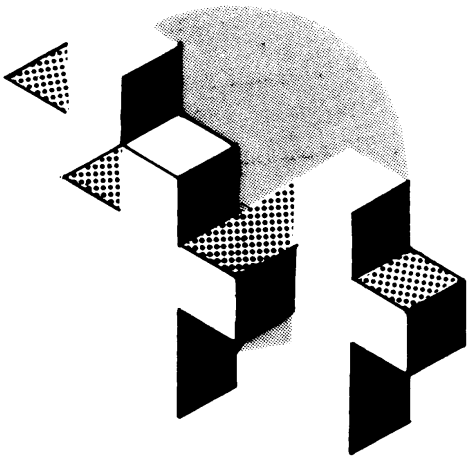
除了班中的活動之外，還有宿舍的生活呢！宿舍的生活也着實教人難忘。一羣年紀相若的年青人，一起生活，一起讀書，一起FUSSY，一起搞活動，一起宵夜，一起……，事事都是一番新的體驗，就連原本固執的我，也拗不過宿舍多姿多采的生活。下面是小記一則：

「復活節前後，春意闌跚，夜闌人靜，余手持醫書一本，俯而讀，仰而思，思而弗得，輒起，繞室而旋，忽而有呼余名者，乃開門一看，原來是隔鄰同學，其謂現時春意正濃，濕氣亦重，山頂必然別有一番風光，復邀余同驅車往觀之，余以其盛意拳拳，不便相卻，乃收拾書本，復邀三人同往。

時屆十一點，沿途煙霧迷漫，有如置身神仙之境，登山越高，霧氣越重，須臾，山頂漸近，霧氣亦漸減，鳥瞰香港全景，七彩繽紛，「東方之珠」之名，實非虛譽。有此雅興者，大不乏人，尤以情侶爲多。對此美景良辰，余等實流連忘返，至凌晨，始歸。」

以上是宿舍生活一小片段，以之略抒情懷。事實上，還有很多其他方面的事情，例如搞活動的滋味，宿舍中同學們的守望相助等等，就如班中的生活一樣，不能盡錄，只留待有機會住宿舍的同學自己去慢慢咀嚼吧！

想起來，現在自己還是處於青黃之界，只不過這已經不是那兩年前劃分大學和中學的界線，而是一條劃分成長與成熟的界線吧！



你認識我嗎？

「聽過基督徒這名詞嗎？」

「當然，我班裏不就有幾個嗎？」

「你怎知道他們是啊？」

「唔，我見他們去C.A.，又開甚麼Cell ，自然是基督徒啦。」

「知道他們去C.A.，去Cell 做甚麼嗎？」

「任何團體都有集會，他們自然不例外。」

或許你已不祇一次經過安靜室，聽到陣陣歌聲，在花園見到一些人，垂着頭，口中唸唸有詞，在圖書館溫習室發現幾個不同年級的人，研究一本黑皮紅邊，不像醫科教材的書。

你心底是否冒出「基督徒，C.A.，Cell」這幾個名詞。但他們有何意義呢？

基督徒，一羣由卑微、絕望變成尊貴、滿有盼望的人。一羣見到自己的罪，感受到與萬物之依歸的獨一眞神隔絕和失去人生目的和方向之苦、又深覺自己無能爲力的人，藉着耶穌基督的死，憑信心接受祂的救贖，與創造主回復關係，更因祂的恩典，成爲神的兒女。因爲聖經說：「凡接待祂的，就是信祂名的人，祂就賜他們權柄作神的兒女。」

C.A.，基督徒團契，就是一群基督徒的聚集，正如前面所說，基督徒是神的兒女，也就是兄弟姊妹同在一個家庭了。也因此在有人類歷史，有基督徒以來，屬神的人都感到一股無形的吸力，將他們聯爲一體。

Cell，細胞小組，簡單來說就是基督徒小組，在細胞核——神，的引導下，完成一些特定工作，以支持整個身體一團契一的生存及發展。

但究竟醫學院的基督徒在做甚麼呢？

或許你沒有留意，但在你周圍，在醫學院裏，有超過一百個基督徒，他們有不同層面和不同形式的相聚，有小組，有班內的團契，也有整個學院的聚會，還會和其他院系接觸。有午餐例會，圍圈圈的交談，排排坐的聽講，和退修的露營。內容有唱詩歌、祈禱、讀聖經、討論、聽道。目的在於敬拜神，更深認識祂以至將祂介紹給別人，與同學分享祂的愛和恩典。

藉著別人寫的詩歌，我們向神發出讚美、感謝，重溫神的恩典，

作出反省，也互相激勵向前進。

祈禱是人和神的交談，是在神面前安靜、反省，數算神的恩典的時刻，也是基督徒向神傾訴心事，支取力量的途徑。聖經中說：「應當一無掛慮，只要凡事藉著祈禱、祈求，和感謝，將你們所要的告訴神。」又說：「你們要將一切憂慮卸給神，因祂顧念你們。」

神向人的話又如何呢？人與神的關係不應只是單程路，只有人說的吧？不錯，神已將祂的話詳細的記在聖經裏。聖經着實是本奇異的書。它的寫作到現在已有數千年，卻仍是流傳最廣，有最多譯本的書，不但沒有被時代淘汰，反因其中預言的不斷應驗引起更多的研究，而基督徒更藉着聖靈（即三位一體神住在信徒心中的那一位）的指引，在聖經中找着生命的方向和奔走的力量。

爲了互相扶持，分享所得的恩典，基督徒就聚在一起唱歌、祈禱、研讀聖經、交談，討論一些切身問題，也邀請一些講員幫助我們更明白當走的路。

這一切好像都是基督徒的專利品，其實並非如此。

任何人找到自己珍貴的事物，都會渴望告訴別人，基督徒也不例外，何況我們找到的是每個人都要面對，各有一份，沒有人能多佔的。

人有罪是無可置疑的事實，人永存的靈魂也因罪與神分隔了，耶穌，神的兒子因愛世人，不願人留在罪裏，永遠受苦，就臨到世上爲人受死，爲世人償還了罪債，叫信靠接受祂的人在神眼中顯爲無罪。在將來耶穌還要再來，到時人要在祂台前受審，按着自己的選擇，或到神懷中安息，或到不滅的火湖永遠與神隔絕。聖經中提到末日的景況，與近年的世界大勢已有很多吻合之處，基督再來之日可能就在我們這世代。

同學們，我們着實爲你焦急，盼望你能在還可以選擇的時間接受這份特別爲你預備的救恩。所以我們也有一些聚會和查經小組特別爲你而設，盼望你在當中明白神的愛和祂救贖的計劃，而非迷信科學，迷信社會進化論，不經思索地否定神，否定人不能抗拒的末日來臨。

親愛的同學，無論你現在對神態度如何，神同樣盼望你的得救，我們在醫學院的基督徒着實願意和你分享這美好的訊息，也歡迎你參加我們的聚會，認識這天地的主宰，唯有祂能滿足你生命的追尋。

小妮子

緬

臘月的寒風總是那麼逼人，刮在面上使我睜不開眼睛，晚上十一時半的三號車上層就只有我一個一踏上歸途。

做了兩個月的幹事可不是好玩的，未「上莊」就已經幫手做飯堂問卷，又沒有經驗，行了許多迂迴的路。面對飯堂這個爛攤子，心目中就只有寄望攪好各方面的人際關係，輭硬兼施。課本丟開已經很久了，差不多每晚都十二時半至一時才回到家，對家人的面色、嘮叨早已麻木，雖已是隆冬時分，但也不想費時間煑水，洗個冷水浴便往被窩裏鑽，就睡他幾個小時，早上六時半又要一骨碌爬起來，回到課室未上堂便又睡熟了。一天最精神的時刻，可算是下課之後，可惜我只有一個去處——Medso 房，工作好像永遠也做不完似的：午飯時間做，放學做，晚飯之後再做，人已經變了機器，無暇看書、無暇上體育課、無暇與同學閑談——有的都是關於公事的，使我陷於孤獨……心裏不期然響起每晚在飯堂吃飯時聽到的電視主題曲：「無論歷盡幾次浪、無論受盡多少風霜……」

問卷調查總算做完了，飯堂知道做調查，就做足門面功夫。自己來往周旋無數次，工友和學生之間的爭吵總算和解了一些，後來發現若終止飯堂合約，則問題多多，所以在評議會交上報告的同時，也就提議暫且維持現狀。豈料評議員們來個「飯堂問題專責小組」，而事實上也是主要由我去做，分別只是做的更多了，心裏想：你們爲什麼不放過我？

逆境也得接受，聖誕假中山團放棄了，第一學期測驗肥了兩科，還要再出飯堂問卷，結果除了向同學作出一些交代之外，這「專責小組」的成果基本上與我自己做的無多大分別。

三月，搬了入Mini Hall，心情舒暢多了，時間也省回不少。飯堂剛穩定下來，大學的膳食系統又蠢蠢欲動了，幾年前的舊賬翻了出來，迫得我要熟讀數年文件才敢去開會，發現學生一方與校方經常是處於對立狀態，相互之間的利益衝突很難達成協議；後更驚聞大學評議會竟不顧同學意願，單方面決定將來飯堂的行政系統，使醫學會失去直接控制權，這使我清楚意識到大學之所謂民主，所謂替同學設想是什麼一回事。

大學此舉帶來很多後遺症，飯堂水準急劇下降，工友和學生之間的關係再度惡化，有工友自動辭職了，飯堂老闆以前的一副嘴臉一掃而空，立即減低服務質素，私自在某些食品上加價，並且違反合約，准許隔鄰地盤工友來進食，弄得飯堂骯髒擠迫，並以較高價錢賣飯給他們。當時大學估計新飯堂要十月才開業，所以要求飯堂老闆續約半年，使我們更處於被動的地位。在這惡劣的情況下，我一方面得沉住氣，希望寧願續約半年也比關閉飯堂好；而另一方面，則設法逼大學當局負責，希望有可能儘早實行大學接管，以免繼續受氣。可惜大學當局

根本不願意去負責，諸多理由，百般推搪，反而急急要辦續約手續，豈料一切就緒時，飯堂老闆又威脅要續約到三月，否則就不做了，滿以爲這可攻我們一個措手不及，其實在我看來，飯堂水準這麼差，就算不關閉也沒有同學去吃了。於是七月一日飯堂也就關閉了，後來發覺有些椅子不知何故竟被割爛了，雪櫃也壞了，火爐的一個小零件不見了，飯堂也有一兩個月沒交水費電費了。

在暑假期間，學生事務處居然賜函一封，竟說是校方依照醫學會的意願及要求不和飯堂老闆續約，以致飯堂關閉云云，莽圖把這由校方一手做成之惡果的責任完全推在醫學會上，於是幹事會立即回以顏色，雖然效果不大，但最少澄清立場，以免將來被人拿著痛脚也。另外又採取了一些行動去迫使大學當局作出重開飯堂的準備。

飯堂終於重開了，第一個月便虧了本，難怪同學們覺得水準不錯，至於以後有何發展，則要看現屆福利秘書及其他同學的努力了。

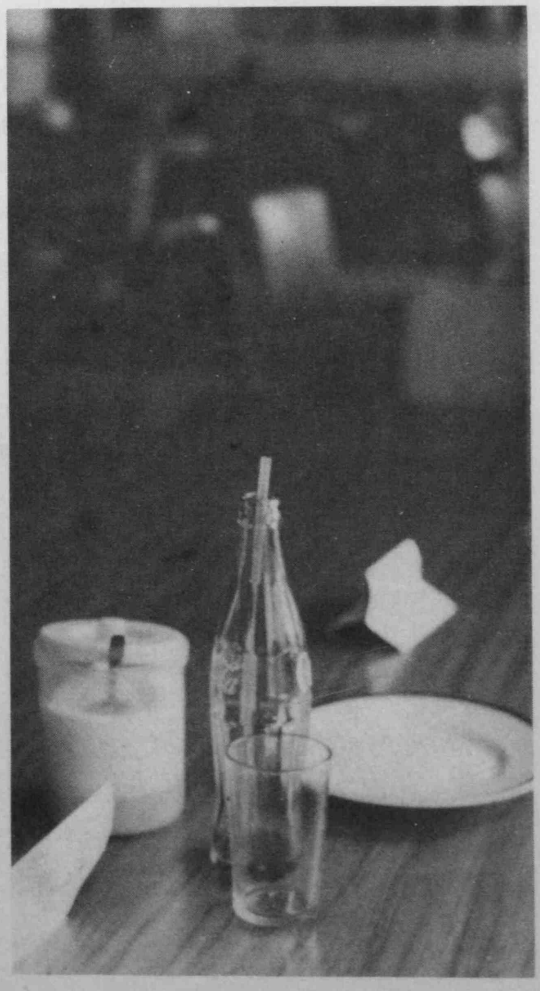
縱觀整年當中，瑣碎雜務佔據了我大部份的時間：貼海報、打理汽水機、油印服務、搬運貨品、售賣貨品，收錢等强迫性地成了我的習慣，剝奪了我的讀書時間。但在另一方面，我學會了很多人際關係的處理方法，事實上，能夠有機會周旋於飯堂老闆、工友、學生事務主任、副主任這班人之中去尋求一個勢力均衡，去認識矛盾，利用矛盾，去把握利益，提防圈套，從失敗沮喪之中汲取經驗，是一個很大的挑戰，是對我最大的訓練。而幹事會內部各幹事之間思想分歧之大，但終能坦誠開放，合作愉快，使我的接觸面擴大了，豐富了，對事物的看法成熟了些。

在週年大會裏，我們認爲幹事會較重要的貢獻—財政—並未受到應有的注重。當大家可以花上數小時對評議員通過某項撥款作出懷疑而糾纏不清時，大家似乎對財政報告沒有興趣，甚至有同學在剛開始討論是項議程時便毫無根據地想立刻通過。同樣地，幹事會曾大力推行的行政概念亦未能在同學心中佔據一個小小的地位。但最少我們開了頭，做了大量工作，花了數百工作小時去弄清幾年來的積賬——我們甘願做開路機！

過去一年並沒有白費，面對一個轉變著而紛亂的形勢，我曾嘗試去尋找出路，這尋找的過程充滿了矛盾、挫折，但我到底作出了耕耘，得到了收獲。以幹事會整體來說，我們或許少做了別人認爲我們應該做的，或許多做了別人認爲不該做的，無論如何，我們鼓吹了交流的重要性。若你問我「落莊」的感受如何？我會說：我滿足地完成了這一階段，並充滿信心去迎接新的挑戰。

七九年十一月廿八日

何兆煒



贊育日記片斷

盧維基

一月一日　星期一

剛從北京旅遊歸來，懷著興奮的心情來到贊育醫院；現今要面對的是一類新的「病人」、新的生命，倒又驚又喜。喜的是與病人的關係比前密切，不只是學生「咁簡單」；驚的是自己責任重了，我所做的會對孕婦和嬰兒的生命健康十分關切；這裡也是試驗自己怎樣做醫生的第一步。

一月二日　星期二

今天收了第一位孕婦，也不覺得什麼特別。

贊育的時間表也算鬆閒，希望能用多點時間和孕婦交談，幫助她們，最低限度也能幫助她們瞭解自己的情況，可以加强做媽媽的自信心，就算只是解悶也是好的。而且我也可以藉此多了解她們。

一月四日　星期四

今早收了一個羊水過多的孕婦，她似乎很緊張。我該讀讀「羊水過多」一課了。

一月五日　星期五

原來她前一胎也是羊水過多，胎兒未出世就死了；難怪她那末緊張。今天抽了些時間和她聊天，還算投契。

一月六日　星期六

她問我爲什麼會羊水過多，我可以對她說什麼呢？只好說原因不太清楚（書說有不少是idiopathic 的），暫時安慰她吧。但是一看牌板，才知道她前一胎是一個水胎（Hydrops foetalis），可能是Haemoglobin-Bart's；看來今次都是與此有關。

一月八日　星期一

她要到十六日才可以照超音波，她似乎等不了，很想早些知道胎兒的情況，我也何嘗不是？但是超音波機不足，奈何？

一月九日　星期二

她的肚子越來越漲，腰圍一天增加一公分，體重每天加半磅，情況不大好。我也不懂怎樣解除她的憂慮，反而每次跟她談及她的病情，就令她更加焦慮和緊張。惟有和她談談其他方面的事。

一月十二日　星期五

她的情況更加嚴重，開始有胃漲的感覺（子宮太大了），雙脚浮腫，晚上又失眠了；除了一些安慰鼓舞的說話，我也不知說什麼，也不知說了這些話對她有何影響。

一月十五日　星期一

我越來越感覺不安，我的存在究竟對她有沒有幫助，抑是增加她的焦慮？我似乎很難再去找一些新的話題，除非我去面對她的內心世界和負起那後果。眞有些兒想逃避她。

一月十六日　星期二

她今天終於接受了超音波檢驗。我不大想見她，連她住的那個病房我也沒有進過。

一月十七日　星期三

我嚇了一跳。

當我打開牌板，赫然看見超音波結果—水胎—我幾乎不能接受，縱然我知道這是一個很可能的事實。

我不知該怎樣做，我見她時可向她說什麼？倘她問我胎兒怎麼了，我該怎樣回答？

我立刻轉身離開病房。她沒有看見我。

但我始終要面對她。

一月十八日　星期四

今早硬著頭皮去見她。

「早晨，照過超音波了麼？」

「是的，醫生說是一個水胎。」她說著，並沒有什麼特別的表情，似乎她很能接受事實。

她沒有繼續問我什麼，我也不多說話。

剛好是我組醫生巡房，我跟了去。

巡房時，宋醫生說：「I'll discuss with her after the round.」

原來她還不知道水胎是什麼一回事。

當宋醫生向她解釋病情時，她雙眼突然轉紅，淚水從她眼角掉下來。她不斷地發問，希望醫生能救回她底嬰兒的性命。

半小時後，我隨著宋醫生離去。但當我走到病房門口，她「嘩」的哭了出來，轟動了整個病房，其他孕婦都擁到她身旁，企圖知道事情底蘊，嘗試安慰她。

我再去看她時，她睡了。

一月十九日　星期五

就只四份一機會，但徧徧兩次懷孕都是這四份一。

她仍然對孩子的生存有很大的期望。

我向她解釋水胎的成因後，她很希望孩子能早點生下來，給他輸血以保持生命。我說輸血也是很難有效的，況且孩子難道要一生不停接受輸血嗎？她不大理會，依然堅持要快些救活孩子。我不願意告訴她孩子是一定沒有希望，因爲讓她仍然留有一絲希望對她餘下懷孕的日子也許是好的，或可提高她的士氣。

一月廿日　星期六

她的情緒比較穩定了，但仍有一些憂傷；知道她心裡可能對自己有些自責（雖然宋醫生和我都解釋過水胎的遺傳因素是夫妻雙方的），惟有再解釋一次。中國女性似乎都有這種傾向。

她的胃口很不好（心情和子宮過大都有影響），我勸她爲了孩子和自己身體緣故，多吃一點吧。

一月廿二日　星期一

我和另一位孕婦談話時，知道她覺得我也很關心她，而不只是關心她的「病」。想起主說：「誰給這小子一杯水喝就是做在我的身上了」，總算「老懷開慰」。

幸好她現時情緒相當穩定，否則我會不知所措。

一月廿三日　星期二

她終於分娩了。

她在產房大聲哭叫：「我要我的孩子！我要我的孩子！」聽者能不動容！

很多同學聽聞她要生產，都擠進產房來。平時孩子生下來時總是熱哄哄的，但當她的孩子用產鉗生下來，整個產房卻鴉雀無聲，大家都悟然。

她也停止了叫喊，也許從我們的反應已知道她底孩子的命運。

水胎的樣子實在恐怖，我們不敢給她看到孩子的面孔，只讓她看看肚子及雙腿便算了，她也不要求什麼。

她靜靜地躺在產床上，我也不打算說什麼話。

一月廿四日　星期三

我去看她時，她多數是睡了，但她蒼白的面孔及眉頭卻帶著一束愁結。

一月廿五日　星期四

我見她時，她向我微微笑了一笑，但笑容隨即消逝了，表現得似乎若無其事，但她心靈裡果眞平靜如鏡面？她眞能接受事實？她怎樣面對以後的生命、家庭及再次懷孕的挑戰？

主啊，賜我智慧與愛心。

一月廿六日　星期五

……

三年雜憶

修記

TB 菌的平均生殖時間爲廿四小時，假定它能不停地分裂，那麼三年便可產生1095代的TB菌。常言道「人生七十古來稀」，那麼假定我只能活到六十歲的話，三年乃等如一生的廿份之一。可見人總不能和TB菌相比。

大學三年只是短暫的歷程，不過正因爲這歷程是一生的黃金時間和思想的成熟期，而大學內外又提供了讓我們接受衝激，使我們成長的機會，我反更珍惜這短短的三年。如今腦海中縈懷着這三年逝去的點滴。但過去的總要過去，在這裏，我只試回懷三兩，好作日後的雪泥鴻爪。

× × ×

大學預科時，我和一班同學固然孜孜不倦地讀書，做生物解剖也絕不苟且，正是「想當年金戈鐵『剪』，氣『劄老鼠』如虎」，頗有點辛棄疾的遺風；無它，爲的是要踏上大學的階梯。

不過，最記得入大學之前，一位我敬愛的外籍老神父對我告誡——「Be cautious of the Left！」他把大學生活形容得十分複雜和政治化，要我時刻在意，莫受他人利用；「老頭子」和「老媽子」更不厭其煩地作類似叮囑，尤其當電視螢幕上顯映着一群所謂大專學生，「呢度去嗰度去」抗議時，他倆便顯得格外緊張，叫我千萬別學人「攪事」，以附合「衆人地莫企，衆人事莫理」的哲學。

那時我根本不清楚，祇有唯唯稱是，心中難免有所戒心；然而卻有點兒不甘心，當眞這般少覷自己嗎？我難道不能獨立思考嗎？抱着「初生之犢」的心情，我反要見識見識一下。

× × ×

中學時也算是活躍份子，當時的目的是要舒暢心情，一方面可以廣交朋友，另一方面又可以「學到嘢」，但究竟學到什麼也就不甚了了。

最初入到大學，我感覺的是一個截然不同的世界，裏面的大學生所關心的事物和舉辦的活動，對我來說是前所未聞，什麼認中、社訪、荷花池之夜、舍堂生活……等，都使我大開眼界。此外是尖銳的人際衝突，各走極端的思想，百樣米養的百樣人，當然他們也有共同點，例如說話較有條理組織，往往長篇大論而面不改容，也都相當友善熱誠，常常主動地告訴你各種概念——如「狗佬」、「毛佬」等不一而足。透過參加學生會和醫學會迎新、學苑、中週……等活動，我逐漸認識到這種種特徵。

就以學生會迎新爲例，校園便掀起了軒然大波，相對現在一少撮人在荷花池之夜擾攘所引起的紛爭，可謂「小巫見大巫」。

那時候迎新節目中也有認識中國一項，形式是數人主講的講座，他們說了什麼我倒沒有印象，但當時作爲講者之一的學生會會長，爲了紀念剛去世的毛澤東主席，而請在場的同學起立默哀，參與其會的我卻沒有依言而立，其實不爲什麼，主因是自己太睏了，而又坐在後排，沒有人注意到，其次是我那時只知道毛澤東是共產黨的人物，總覺得不是什麼好東西，不起立也表示一點不服氣，事後卻有人聯同指責會長，罪名是「强姦民意」——一個相當新穎的名詞。

此外「大學教育」一項中，有幻燈放映，還記得內容涉及不少學生運動的資料，當幻燈放映完後，說時遲那時快有個人跳上台來，宣稱幻燈片只是一位學生會幹事的「個人傑作」，並不代表幹事會的意見；事後傳單滿園飛，爲的是追究責任，終於開了個「鋤會」（Forum），各方各說各的，沒有什麼結論，今後也就不了了之。

這一切一切令我瞠目結舌，熱熾的爭辯不但沒有把我嚇倒，反更刺激起我的求知慾——究竟誰擺事實？誰講道理？

× × ×

七六年的中國週激發起我從未有的思潮，當時參加主要是由於好奇心的驅使，還加上一些高年班的慫恿；就我所見，節目多采而具規模，份量最重的要數大會堂的展覽，題目是「祖國建設社會主義

的道路」，參加的院校同學非常踴躍，我不禁被那熱烘烘的氣氛所感染。使我印象至爲深刻的是醫學生負責的部份，內容講述中國農村血吸蟲爲患的歷史，和新中國如何透過各種方法解決問題，從而使廣大農民得免「大肚症」之苦。

憑良心說，初時我總有點不以爲然，覺得身爲香港人是沒需要認識中國的，談國事便等如談政治，談政治則是相當危險的。

但當我多次接觸這班參予的同學時，我逐漸感受到他們對自己作爲中國人的醒覺，對國家民族的感情；我開始試圖了解國家的近代史，開始曉得爲苦難的中華唏噓。

中國週雖未能給我對中國的全面理解，但她至少給我一個起點和一把勁，我醒覺到單靠一知半解道聽途說的「知識」，我決不能長期地做「認中」的反對派。

今年中國週已沒有舉行，她似乎已完成它底歷史使命而「壽終正寢」，但這不表示我們已無需再關心中國，反之新的問題接踵而至：中國如何實現「四化」？民主運動往何處去？如何面對蘇聯的威脅？這新的世紀付予我們新的使命！

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七六年來，校園內的激爭因學生會大選而至極端白熱化和政治化，當時是兩閣競選，宣傳上各展奇謀，互相攻揭，在那洶湧浪潮中，想「明哲保身」而不可得，事物的發展迫使人作出抉擇，投票額亦爲歷年之冠。

然而跟着的七七年卻是沉寂的，原因之一是國內四人幫倒台，以往的一套思想理念開始瓦解，而新的一套又未能建立，導致好些活躍和從前以國內提倡爲圭某的同學靜默下來，或反省、或退卻；其二是社會經濟矛盾的逐漸磨平和香港政府諮詢性民主的實踐，以致社會危機的相對消弭；其三是學生會在方向和活動上未得到廣大同學的支持，屬會反而紛紛發展。

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在這平淡的七七年，卻閃爍着不平凡的星火——金禧。年中金禧師生爲了斂財事件第一次在校內靜坐抗議；而校長梁燕芬修女亦於年底被檢控。

風波未因此而平息，反之埋下了更大的計時炸彈，爆炸時間是翌年四月，烈性炸藥是新校長關慧賢所施行的一連串措施，如取消學生會、分隔高低班、釐定苛刻的教師守則等，而最令人髮指的是關校長竟誣蔑靜坐教師中有「革馬盟」份子，示意另一位教師向報界發展，以圖破壞教師的形象。這計時炸彈的導火線則是學生被毆打。爆炸的地點不在金禧，而是主教府；五百金禧師生再一次坐下來，要求一個較佳的學習環境。

失望得很，教育司竟用迅雷不及掩耳的手法將金禧關閉，滿以爲一了百了，誰料到師生家長們卻無限期地靜坐下去，萬人集會和七九大請願顯示支持群衆的日益擴大；終於根據黃麗松校長的建議，教育司署另開五育中學，而仍然保留金禧，任由金禧學生選擇其一。這個成果全賴金禧師生和家長堅忍不撓的精神，他們放棄家中溫飽的日子，日以繼夜地靜坐請願奔走，我們又怎能用一句「攪事」將他們一棍子打死呢？

早在第一次靜坐時大專界便開始關注，如出特刊、討論會等；而我亦因某種機緣加入了他們的行列。金禧給了我既悲且喜的經驗：悲的是教署的高壓手段，歪曲的輿論和袖手的人！喜的是我能作事件的見證！

× × ×

最後想提，艇戶，不想贅叙他們的要求和慘況，因爲這兩年已說得太多了，只見他們一批人被政府拒絕了，忽旋踵另一批人又來請願，但始終沒有成果，反而更被檢控非法集會，支持的人越來越少，政府的態度也越强硬！只覺得這就是現實，而現實往往是叫人沮喪的。

× × ×

當眞要對這三年「雜憶」起來，我還有說不盡的體會。這三年的認識、摸索和實踐，使我曾經理想化，也曾使我承認現實，而現實與理想似乎永遠存在着不可塡補的差距！不過存在差距仍是好的，因爲ＴＢ菌只有現實，沒有理想！

跟着又是另一個三年——兩年臨床和一年實習，今天的我當然不同於三年前的我，但至少我還須堅持三年前的一點「初生之犢」的心情！

愛之掠影

曾有人這般問說，
眞愛何處得覓。
勞碌的老實人，
以爲愛在天涯，遠不可及。
穩重的大商家，
深信愛難保值，不切實際。
落泊的傷心人，
卻道愛已死滅，難望再現。
然而——
那疑惑的人，
卻在身旁路邊，
找著愛的痕影。

*　　*　　*

春雨。

雨絲緩緩地飄落在大地的臉龐上，是那樣的靜悄悄，是那樣的輭綿綿，彷彿情人底溫柔而輕拂。

春天的日子，雨中的散步——這該是何等的詩意？

在環繞草地的小徑上，走著一對年輕的戀人。淡紅色的小傘，緊靠的肩膀，天地似乎都縮處傘子之下！喁喁的低語，輭輭的甜笑，世界似乎都瀰漫著喜悅。

走著，走著。來到路旁的一張綠色的、濕轆的長椅前，女孩抬頭說道：「我累了！」

就是那樣的毫不猶豫，就是那樣的不假思索，青年把雨傘交給女孩，迅速地脫下外衣，平舖椅上！朝女孩一望，他底眼神好柔和，好溫暖！

女孩頓時呆住了，面下又是訝異，又是感激。

兩對手兒緊緊地互握著，淡紅色的雨傘斜躺路旁……

*　　*　　*

七月天。

午後。

熾烈的陽光無情地儘往大地投射。緩步在斜長的蒲飛路上，身體裏每一個細胞都給陽光害苦了！額上冒著汗，心裏冒著火。

「該死的天氣！」——嘴在咀罵著。

驀地，路的那旁傳來陣陣歡快的叫喊聲。隨而一幅悅目的，跳動的畫面便映入我底眼簾——一個穿著潔白運動裝的年輕人，正在興冲冲地往斜路上跑。隨在他身後的一頭牧羊狗，進在邊搖著尾，邊跑動著。青年人不時回頭替狗兒打氣，狗兒底脚步也就愈發起勁。那樣一前一後的奔跑，在酷熱的天氣裏，倒也顯得輕鬆愉快。

看著，看著……不對！

那狗兒——它竟是跛了一條後腿的「小拐子！」

大熱天，跑步。

年輕的主人，跛腿的牧羊狗。

——我猛地明白過來！

陽光仍是熾烈如前，我底心頭卻漲滿了喜悅！

*　　*　　*

十月的風，送來絲絲寒意。

片片落葉，散發點點秋思。

夏日的驕陽一下子便逃得無影無踪，匆忙中竟忘了給人們打個照應。馬路旁的大榕樹，也一下子抖落得遍地黃葉，只剩微呈禿態的枝椏。

秋來了——又是加衣的時候！

靜坐在靠窗的椅子上，她正在聚精會神地編織著一件毛衣。淺棕色的毛冷球，不住地在她脚旁的小袋內滾動。一針接著一針，她雙手底動作既配合，又起勁，毛衣很快便成了形狀。

忽然，活動中的手停住了。

輕輕地撫著微隆的腹部，她似乎感覺到肚內的生命底有節拍的心跳。拿起未完成的毛衣，看了又看，這才發現毛衣竟比預算的寬大多了！

「噢，這毛衣！寶寶怎麼用得著？」

或許毛衣寶寶用不著，可是它卻編進了一顆慈母的心。

*　　*　　*

風，是冷峻的北風。

身子雖然給厚厚的大衣裹著，可是仍免不了斷續的哆嗦。冬天，果眞是難熬的季節。光禿的樹枝，疾厲的寒風，瑟縮的人兒——大地蕭索得可以！

拐過一個小路彎，在不遠的樓梯角落，我看見一個顫抖的生命。

那年老的流浪漢，靠著樓梯而坐，兩手緊抱著膝，身子抖動得像在北風中亂舞的枯葉。

略爲遲疑了片刻，我便決定上前去看看究竟可幫他點甚麼。

忽而，一個手抱著毛氈的婦人從樓梯上走了下來——原來是送氈的好心人！

老人接過毛氈，不住地點頭道謝。驚喜、感激，寫滿了他的臉。

「世界有的是溫情，宇宙有的是愛！」你說呢？

惠惠

大德曰生　育我贊育

又木

每個醫學生都需要長駐在贊育十個星期，既是學習，又是服務。作爲適應一種新的生活，這段日子不算長，但它留給我們帶來不少衝激，思索及回味。

我們在這裏扮演着一個特別的角色。以前入病房，主要是學習，所謂STUDY PATIENTS IN THE WARD，病人與我們可謂兩不相干，我們也不會在處理病情上做到些什麼；如今可不同了，我們都有名下的產婦要照顧，打從收她入院，住院，接生，產後到出院，我們都可爲她們服務，如臨床觀察、接生等，也開始感到學有所用，也換來一些服務後的滿足感；與此同時，我們却不是正規醫生，沒有許多常規工作，於是有較多時間去了解孕婦各方面問題，實踐把病人看作一個人，而不是一個病症，實踐怎樣去當個好醫生。

我們到贊育實際上幹些什麼呢？學習方面，除了一星期兩節臨床課，一節TUTORIAL，數節下午課及街症外，其餘都是帶服務性的學習，如抽血，臨床觀察（CLOSE OBSERVATION），以及廿四小時隨傳隨到的收症和接生。不要以爲入贊育就只是學「執仔」，事實上基本理論及臨床處理病例却是最重要，但無可否認，「執仔」確往往給我們留下深刻的印象。

談到接生，就要抖抖精神，一想到小生命的誕生，一想到一點疏忽或亂子足以影響他的一生及孕婦本身，這心情可謂又驚又喜。接生又一次顯示「知」並不等於「行」的道理，當初數次接生，無論理論多好，總是紙上談兵，一上戰綫就是手忙脚亂，幸虧各醫生及助產士在旁指點，才算穩定大局，漸上軌道。其間剪開會陰及嬰兒露面的一刹那，尤爲緊張，試想，把好好的會陰剪上一刀，應剪多深，角度怎樣，什麼時候剪，怎樣縛傷口，怎樣減少失血，再想，嬰兒頭部出來了，應助他轉向什麼方面，怎樣助他身子出來，怎樣提防窒息，這類問題，都會令同學忐忑不安一段時候。回想許多時，進贊育後最急於做的是能接到第一個嬰兒，可是「老闆」總要我們耐心學習足夠及有醫生在場才可讓我們如願，但是我們總會蠢蠢欲動，不過，病人及嬰兒的安危是第一件重要的事，這念頭也就打消了；個人就見過一位「同學」企圖這樣做而被助產士制止，心想，若出大錯，你能過得意嗎？接生的苦事也有不少，每次我們都要先消毒，然後穿上厚厚的衣服及手套，再爲產婦消毒，之後就是期待，偶爾遇到第一胎，或慢產的，等數小時也不爲奇，加上天氣炎熱，餓着肚子，或渴睡的時候，很不好受，但且看，最不好受的還是產婦的本身。

臨床視察就給我們超乎足夠的時間去體會產婦的掙扎。這項工作又是怎樣的呢？某些產婦因過期未產或本身有病如高血壓，糖尿等需要用藥催生，有些却過早子宮收縮而要用藥制止，這些藥都要靜脈滴注，而份量則視乎臨床情況而決定，我們也就派用場了。我們需要爲她每十五至三十分鐘量度血壓、心跳，嬰兒心跳及子宮收縮的頻率及時間，以防有變，其間當然，從實際中學到不少，但由於生產過程可長可短，有的就要守候十數小時，精神及體力的疲勞不在話下，最不幸的是我們眼巴巴看着產婦抵受着陣痛的煎熬，身體像小蟲般蜷縮，憔悴的臉容，豆般大的汗珠，因極度痛楚而只能發出無力的呻吟，甚或叫苦連天，上吐下瀉，頗不好受，除了一些無效的安慰及鼓勵，和那時常不足的止痛劑外，我們只能如方木般呆着，驚訝母親的偉大，或女人的不幸。由於這份工作壓根兒不好受，有些同學便埋怨這是廉價勞工，學不了什麼，又影響其他學習機會，同學間也容易在當值問題上產生爭執，有的借意不工作，有的別人做到死了也不加援手，也有因工作多了而脾氣差了，諸如種種，都是他日生活的縮影。幸好我組同學較少這種情形，大家多想點產婦的安危，拍拍心口，互相幫助，事情也就好辦了。

談過苦差，也該說些樂事——與產婦談話。她

們大多來自低下階層，話語間可以了解到社會及生活的更多方面，也可討論她們心目中許多醫學上的疑問，鼓勵她們用母乳餵嬰兒，遇上年紀相約，興味相投的，更是天南地北，從旅遊，繪畫，音樂，電影，宗教，國內生活，談個不休，甚至可談及戀愛，夫婦關係，生活瑣事，避孕，育兒等問題，而事實上，她們獃在醫院也很無聊，樂得跟你聊天。此間，也會遇到些需要學習處理的情況，如病人的胎兒流產了，或是胎死腹中，或是遇上個未婚媽媽，我們又該說些什麼呢？總而言之，這裏也是個學做人的好地方。

十星期容易過去，也見到一些問題，願與同學分享，或藉此抒發。

當初入住贊育，最不習慣的就是那個廣播傳呼系統，每天由早上八時至晚上十時，全院各醫生及醫學生的傳呼都經分佈各層樓的揚聲器廣播，聲量或大或小，做成聲浪污染，也使人精神緊張，最可憐還是那些晚上沒有睡而要日間尋夢的學生，睡夢中還要受那廣播的驚嚇呢。希望有關方面能改用無線電傳呼就好了。

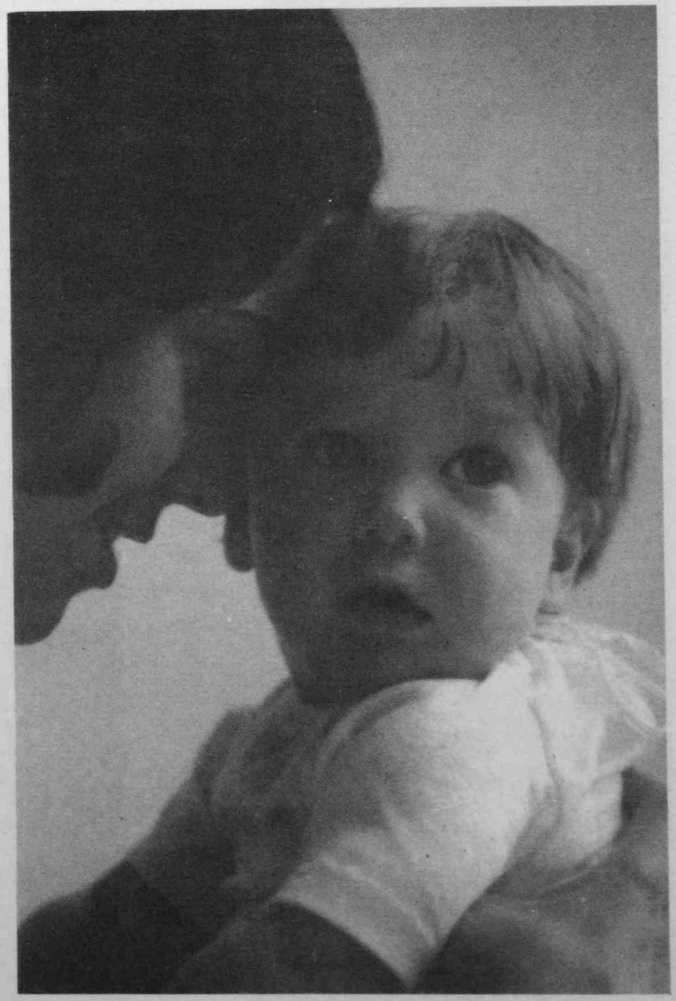
除了同學間關係外，與助產士的關係也是一大課題。平日工作上可能會產生磨擦，如我們想上課，便想找她們代爲臨床觀察，但她們又因人手不足而不願爲之，偶然又會遇上一兩個脾氣較差而對病人呼喝的，幸好，大部份都很友善，閒來 FUSSY 一番，她們又樂於給我們品嘗可愛的小吃，如南乳花生、話梅等，也會說些小人小事。

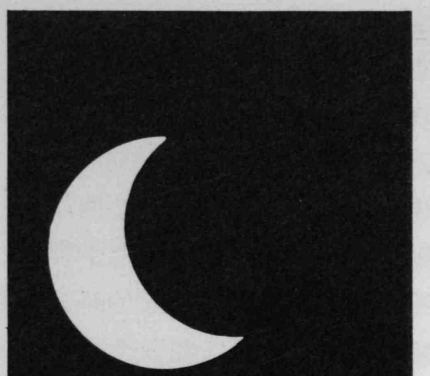
贊育是一個小天地，生活在產婦、同學、醫生、助產士之間，不期然每天講的就是什麼病房的什麼事，或是某君的某事，閒來玩玩乒乓球，生活着實平淡，與外間的隔絕，也做成兩耳不聞天下事的現象，這也算是他日生活的寫照，幸虧組內還有興味相投者，才不致悶死。

這地方確實太少了，太多的孕婦埋怨苦悶，沒有一片空曠的地方，沒有樹木花園，要運動嗎？爬那一層層的樓梯吧，乘凉嗎？開風扇或到正門站站吧。她們和普通人無大分別，終日却要關在這小床位和梯間，也難怪她們叫苦連天，要求早日出院，其實建一個小小花園也不算過份。

無可否認，人手是要增加的，但也應改善孕婦的產前及產後的護理及育兒教育，側聞已着手在電視播出這些知識，這是一大喜事，但可否利用住院期間那漫長的空虛來填一點知識給她們嗎？例如專人集體教授產後運動，這似乎在那打素醫院中實行，贊育又爲何不能呢？利用產前檢驗候診的時候灌輸有關知識，也屬實際。最近已在印製及改編了有關小册子，也是推廣知識的有效辦法，值得一讚。

總覺得這是一段有意義而難得的時間，是踏入醫療隊伍的試脚石，可以看多一點，想多一點。經過這段日子，更體會到醫生的不少經驗是從錯誤中學到，不犯某項錯誤，可能也不會在那方面格外留神，但往往病人是犧牲了。但我們不該爲這而羞愧，應承認錯誤，尋求正確做法，推而廣之，才對得起病人，才能正確地爲更多病人服務。





夜車

懷

夜幕低垂了，淡黃色燈光照着車站的一角，候車室內只有那三兩人，昏暗的月台還是一片漆黑，更加顯得四周冷落、寂靜。在時間分秒逝去裡，脚步磨亮了車站內每一格方磚。如同燈塔守候着歸帆般，這一份執着而又眞誠的等待，就是爲了要坐那最後一班的夜車。

終於，耀目的强光射進月台，火車蹣跚地從西邊駛進站來，疲倦的機車拖着一列長長的車廂慢慢靠近來，我大步迎上前去，心情高興得難以自已，緊握着梯子扶手，我爬進車裡，啊，今晚的夜車將帶我回到那可愛的故鄉。

挫頓一下，列車開動了，戴着我的興奮和喜悅，滑過凉風陣陣的田野，越過唱着輕歌的小溪，穿過黝黑的山洞，飛過萬家燈火的小鎭。窗外景色急速拋落在後面，火車轟轟向前奔去。

我忽然感到，現在，我的旅程再不孤單了，破舊的車廂剎那間變得溫暖，四周那東倒西歪的乘客，也都變得親切起來。一切都是那麼熟悉，再過幾個鐘頭，我便要回到我的故鄉。

月光灑在車廂外，份外明亮，今夜的月色也比任何時刻更令我心醉。隨着火車有韻律的擺動，感覺中有如一輛輕快的馬車，在遼闊的原野，踏着柔軟的青草，盡情地馳奔，得得的啼聲，洋溢着多少歡樂呢！

火車喘着氣停靠在一個古老的小站，站前街燈下，擺着冒着熱氣的簡陋小吃攤。人們坐在長條的木櫈上，是那樣悠悠自得，那樣無拘無束地吃着宵夜、淺飲小酌。在這個小地方，是沒有都市的緊張繁忙，他們與世人無爭，只有簡單和悠閒的生活。

在南方的一個小站，你也可以看見同樣的情景，那個小站比這個站更簡陋、更古老。那個古老的小站便是我要下車的地方，那是我童年生長的地方。到了那個小鎭，你是會喜歡那裡的一切。那裡沒有車聲攙人聲的煩燥，也沒有令人喘不過氣的汽油味；有的是一片安靜和祥和的鄉間景色，還有一張張純樸而可愛的笑臉。

火車一站又一站的繼續向前奔馳，窗外陣陣的晚風，透着一股凉意，吹在我臉上，閉上眼睛，迷迷糊糊便睡着了——夢中，我躺在瓜棚架上數着天上的星星，又躺在竹林樹木中聽鳥語風聲——今晚的月色太美了。

結廬在人境
而無車馬喧
問君何能爾
心遠地自偏

謝紀超題 己未年仲秋

閒談生活

我是到要創作的時候，才體會到目前生活的貧乏。前陣子音樂老師叫學寫樂句，說要從生活中尋找動機。我於是處處留心，聽清楚每一位病人的呻吟，看清楚每一晚星星的明暗；終於仍是沒有什麼收穫。最後還好憑日記中的一點鱗爪，拾回些以前的趣味，才交成功課。然而，即使近來的日記也不像樣了；斷斷續續，不過是些表面的歡呼慨嘆，每天由上午七時至另一天零晨一時的程序。似乎沒有更無聊的了。

不是說醫學課程令人沉悶。事實上我一直都喜歡着以前和現在的各個學科；更何況自上病房以來，往往又從和病人的交談中得到許多樂趣。我永遠忘不了我的「第一位」老伯。他年青時因家貧失學，後來有個機會學會了做洋服。不幸又因戰亂流落到香港，不名一文。他說：「我從中環走到西環，再由西環走回中環，不知道該到那個地方容身，這樣地來回走了三遍，才給警察抓着。」那時候灣仔是上海洋服師傅的集中地，所以他也聚到他的同鄉同行里去。「我當時年青不懂事，有錢便花掉，待年紀大了才知錯。」但是，他畢竟還能把根基紮好，成家立室。「我們沒用了，你們年青有爲，現在可要好好學習，將來做群好醫生啊！」好老伯！可是，因爲課程的緊迫，加上自己又在醫學會中負責些活動，這樣的交談終歸是少。與其說是生活的一部分，許多時候視之爲意外倒反適合些。

所以，歸根到底仍舊是簡單的上課、問病歷、坐圖書館、游泳、跑步、吃飯、睡覺的生活。這樣的日子本來亦很快活；但無論怎樣加起來都不能稱之爲豐富。最令我吃不消的是身上沒背着任何責任，什麼也做不成。像有時候問病歷問到病人傷心的地方，他（她）哭了；我徬徨地無言以對，似乎怎麼樣的安慰說話都很虛假。我於是想：「如果我眞的是醫生就好了，至少可以爲她盡些微力。」另一方面，我在醫學會倒負上點責任。然而這又不是使我太高興的。我總覺得這會內大家說得太多、太理想，却不太切合實際；而許多的理論斟酌，也叫我受不了。我無疑還會視醫學會是個很好的學習和培養自己的地方。總而言之，有些食物本來就沒有味道，醮上醬油不過使入口時大家過癮一點；因此，我其實不太怪自己近來寫的那些日記。

或許，我應該多花點時間創作；又或許，我根來不該住在薄扶林道。

鳳元

秋興五首

楚橘

其一

日在山西雲似紗　遠城燈射近漁家
風搖透月青松葉　浪搖連營白岸沙
結伴青春歌炙火　隨懷夢興惜英華
自陶秋色聽蟲語　問月幽人亦望些

其二

記得春雷第一霆　曾將死水付滂聲
蔭新鳴囀不無意　雨密煙重亦有情
萬卉安排新發蕊　千般計就有遊京
風雲變幻常難測　一線微瀾歸杳冥

其三

孤軍血淚向誰多　斜葉碧雲偏插梳
無酒蹣跚人自醉　掩藏清淚故狂歌
枕殘驚夢爭忘所　書掠浮光竟爲何
敢信丹心囚不住　暫將豪杰慢消磨

其四

醉裏狂書梁父吟　詩沈紙脆筆如針
飢鴻振羽臨窮海　病馬蹄踭嘶久陰
今夜梗知泊何處　明朝蓬問轉幾林
相逢劫後應隔世　車走犬猖深夜深

其五

鵾鵬原是雲中鳥　當自披創不畏弦
一再周旋長汗額　幾多寒暑矮胸肩
危旌斑駁知鏖戰　極目風雲任少年
亦合新秋栽綠葉　更追餘夏浴金天

竇娥冤

漢家

「爲善的變貧窮更命短，造惡的享富貴又壽延。

天也，做得個怕硬欺軟，却原來也這般順水推船。

地也，你不分好歹何爲地？天也，你錯勘賢愚枉做天。」

竇娥臨刑前滿腔憤恨，唱出了激動人心的歌。她被人陷害，地方官又受人收買，被苦打成招，於是在臨刑前許下三願，第一，殺頭後血不落地，卻濺在旗槍上的白布上；第二，六月飛霜；第三，就是楚州地方三年苦旱。在關漢卿的筆下，這些當然一一實現了。最後當然就是清官出現，天理昭昭，「王法不使民冤」。

自古以來，包公這一類清官已成爲家傳戶曉，萬民景仰的人物。而「天」這個虛無的概念，亦是一般平民百姓祈求順境福蔭的泉源。士大夫看到日月運轉，萬物榮枯，委實是會想到可能有一個超乎萬物的力量存在。在老百姓而言，「天」這個概念之深入民心，亦絕非偶然。農民祈求五穀豐收，人生長壽，當然是反映了古時科技之有限，人未能和自然力量對敵，更不能控制之，因而自然要將希望寄託在這個「天」身上，希望他大發慈悲，平民亦以各式祭祀物品爲報。可悲的是一般人竟不能保証自己在這個人的社會中，平安地生存，要是出了事，輕者受到欺負，重者則可能性命家產不保，甚至禍延後代和親朋。如果社會狀況不變，竇娥冤這類故事還是會繼續流傳於後世，作家亦因而受人愛戴。只是，讀完這些故事後，黑暗便會過去了嗎？

中國歷代的政治，權勢和財富利益都是一個固不可破的結合體。有財有勢，官家當然要多給面子，或是來個官商勾結，一同發財，就算只有點人事關係，亦易辦事得多了。一般人受着欺凌，便投訴無門，唯有呼天搶地，希望天公有眼，或是有清官爲他們出氣，亦即是，除了「天」這個無甚作爲的「東西」外，他們的希望，就只有寄託在「好官」的身上了。

天下烏鴉一樣黑，現代社會還不是一樣。美國號稱自由民主的明燈，可是漂亮白紗的背後竟是團團的黑暗和血汚！總統和財團的關係人所共知，又或者是將剝削壓迫的對象伸展到外國，到一些非洲、南美、東南亞的落後國家去。美其名曰世界警察，其實是欲以保護自己在彼邦利益。只是，時代進步了，這「進步」不單只包括科技生產的進步，人民思想亦發展了。教育水平的提高，交通的發展，使人們能團結起來，爭取自身的權力和條件的改善。西方式的民主不是一蹴即可，當然亦不是上天所賜，（自然天亦不會「錯勘賢愚」），而是有其歷史及社會背景的。

不能說中國人民愚昧和儒弱。歷代開國的帝王臣子，大抵都是英明的，現實就是，權力會慢慢地消磨大部份人的意志，特別是當他們和人民的利益有衝突，甚至對立起來的時候。於是，漸漸地當人民無路可走時，便會像梁山泊的好漢一樣，揭竿而起，更多更多的人民起來了，這個王朝自然要壽終正寢，而末期的歷史，自然要由下一個朝代的御用文人來修。雖然新的皇帝是在平民起事的條件下得了益處，但他們準是害怕自己會遭到前朝帝皇的同一命運，便「先下手爲强」，罵起事的平民是流寇、盜賊、大逆不道。在歷史家的筆下，末代帝王自然會被稱呼爲廢帝或哀帝，其實，只是他們不能抵擋得過歷史的巨輪而已。

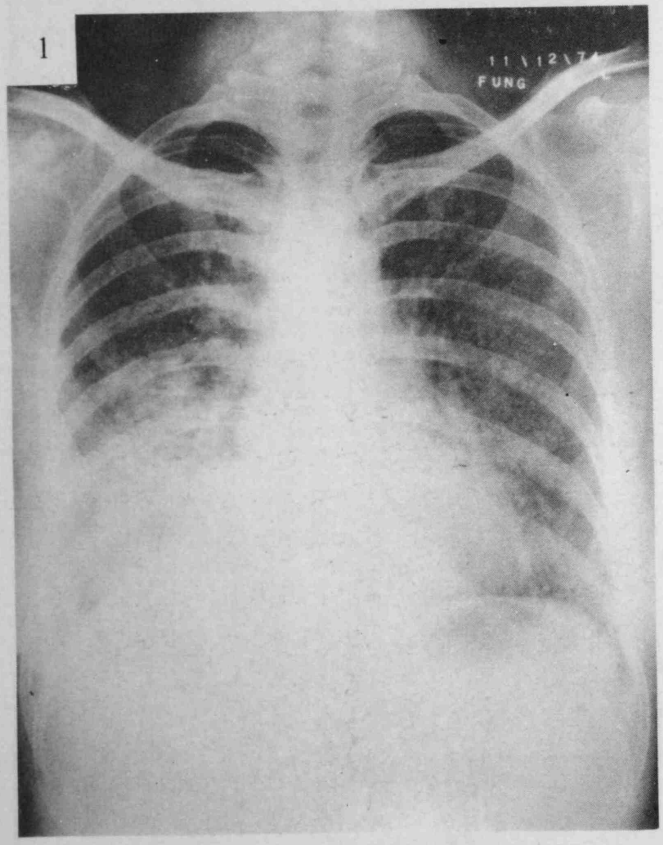
Happy is he who has no serious consequences of his erroneous diagnosis to regret.

— Howard Marsh.

WHAT IS YOUR DIAGNOSIS?

Thanks are hereby expressed to the Department of Medicine for her kindness in lending us these photos.

1



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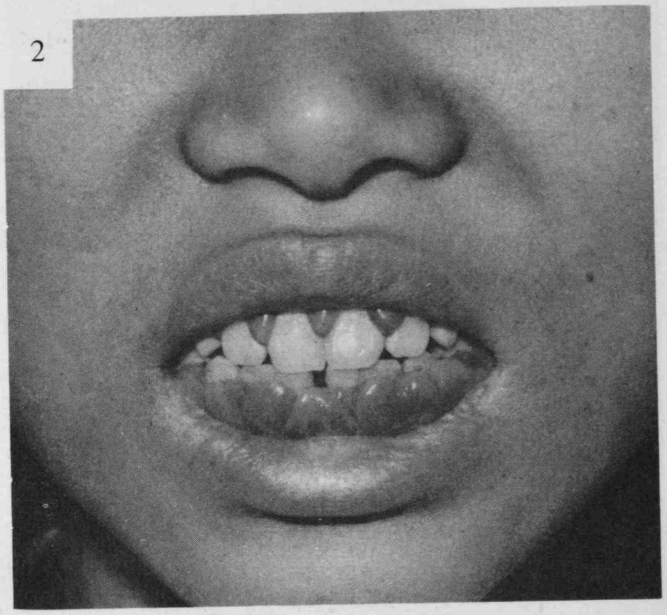

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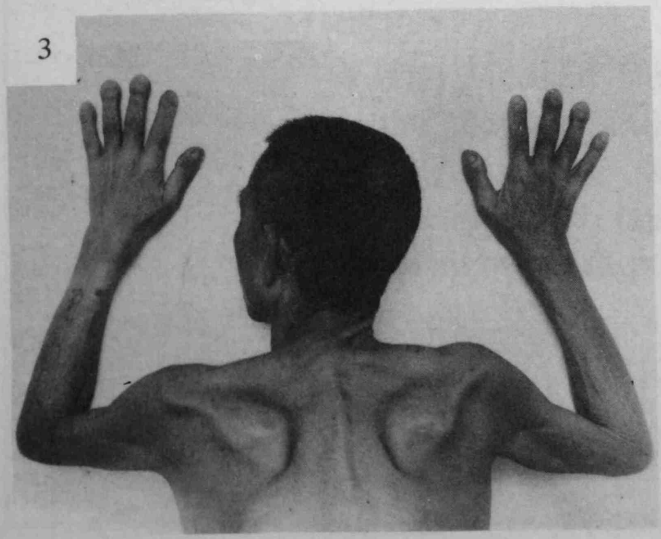


QUESTIONS

1. A 55—year old lady complained of progressive dyspnoea for one month, associated with copious amount of mucoid sputum and marked weight loss. She was afebrile. Physical examination was unremarkable. Sputum for AFB was negative.
   What is the most likely diagnosis?

2. a) What is the abnormality?
   b) Name two causes.

3. a) What is the abnormality?
   b) Suggest one possible cause.

4. This patient has carcinoma of the prostate.
   Name the abnormality and its cause.

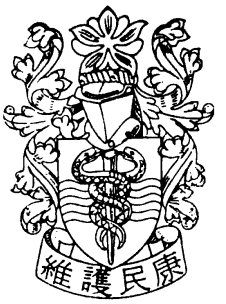
5. This girl is referred to the dermatologist for cosmetic advice.
   a) Name the abnormality.
   b) What two common neurological complications may arise?

5

4

ANSWER

1. Alveolar cell carcinoma
2. a) gum hypertrophy.
   b) Dilantin therapy and leukaemic infiltration.
3. a) There is marked clubbing of fingers and wasting of proximal muscles of upper limbs.
   b) Bronchogenic carcinoma with myopathy.
4. Gynaecomastia of left breast, due to oestrogen therapy.
5. a) There is rather extensive skin pigmentation (café au lait) with multiple subcutaneous nodules (neurofibromas). The picture is suggestive of neurofibromatosis (von Feckling Laucen's disease).
   b) Neurological complications include:
      i) spinal cord compression by tumours of spinal nerve roots (dumbbell tumours).
      ii) deafness and signs of cerebellopontine angle lesion due to acoustic neuromas.



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"Labetalol is a useful anti-hypertensive agent for patients with all grades of hypertension and the present study would suggest that an additional advantage is the rapid fall in blood pressure when the drug is given by mouth."

(Serlin, M.J. et al, *Brit. J. clin. Pharmacol.*, 1979, **7**, 165)

Even in patients resistant to other antihypertensive agents

"The results of this study indicate that labetalol is an effective antihypertensive drug, particularly in view of the fact that the majority of the patients were uncontrolled on other antihypertensive drugs or drug combinations."

Bolli, P. et al, *N.Z. med. J.*, 1977, **86**, 257)

The onset of antihypertensive action is rapid . . .

"The hypotensive effect of labetalol was apparent within 2 hours of drug administration and was maximal by 4 hours."

(Breckenridge, A.M. et al, *Brit. J. clin. Pharmacol.*, 1977, **4**, 388P)

Side effects are rarely a problem and usually transient

"The total number of side effects attributable to labetalol were small and none prevented an increase in dosage."

(Pugsley, D.J. et al, *Brit. J. clin. Pharmacol.*, 1979, **7**, 63)

. . . Which simplifies individualisation of optimal dosage

"Good blood pressure control was obtained easily and the treatment regimen was simpler than that with previous therapy received by the patients. Few incremental changes in dosage were required and all but 6 (10%) patients were controlled by labetalol alone."

(Harris, C., *Curr. med. Res. Opin.*, 1978, **5**, 618)

Patients feel better on Trandate and the treatment does not restrict activity

"It is therefore particularly encouraging that 74% of patients in this study reported that they were much less tired, more energetic, more active physically and more mentally relaxed than when on their previous antihypertensive therapy."

(Scott Manderson, W., *Practitioner*, 1979, **222**, 131)

Trandate Injection provides rapidly effective control of hypertensive emergencies

As a bolus injection . . .

"Labetalol given intravenously is highly effective for the acute reduction of blood pressure. In this series no serious side effects were encountered and the drug seems particularly suitable for use in hypertensive emergencies."

(Rosei, E.A. et al, *Clin. Sci. mol. Med.*, 1976, **51**, 497s)

Or as a continuous infusion . . .

"Labetalol, given slowly by graded intravenous infusion, with continuous monitoring of arterial pressure, is our current treatment of choice in hypertensive emergencies."

(Brown, J.J. et al, *Lancet*, 1977, **i**, 1147)

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- **When side effects are causing problems**
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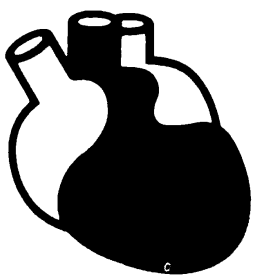

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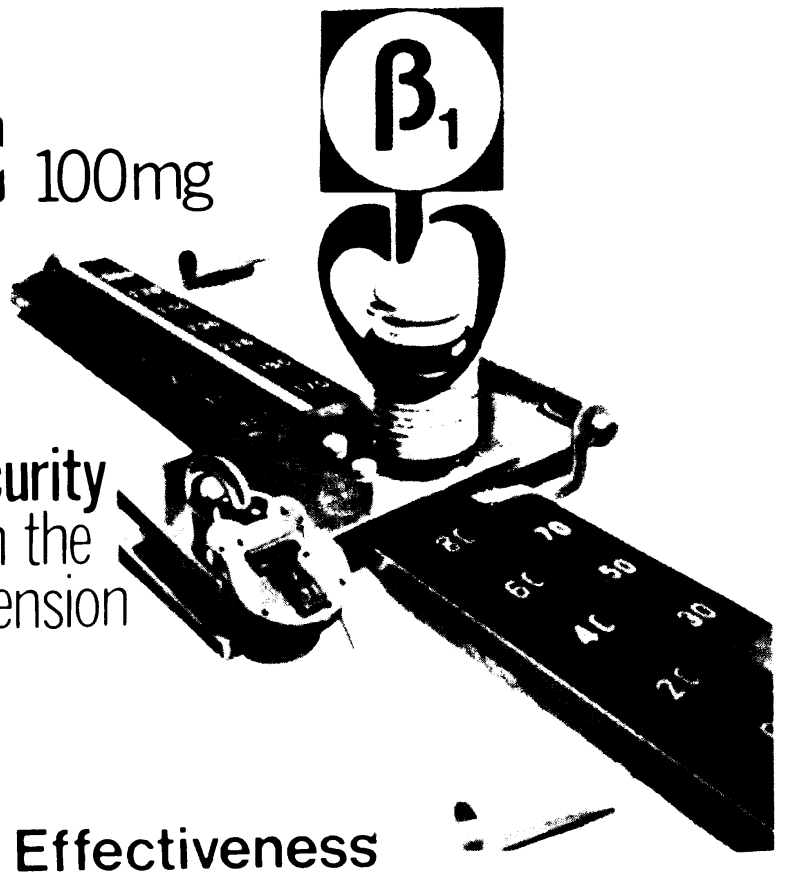

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DUODENAL ULCERATION. WHAT COMES NATURALLY?

'Tagamet' has been shown to be unequalled in the short-term treatment of duodenal ulceration, inducing early and dramatic symptomatic relief, rapid healing and subsequent remission.[1,2]

In addition, 'Tagamet' has been shown to prevent relapse during longer-term maintenance therapy;[3-5] the only drug so far proven to have this property.

However, experience to date tends to suggest that for many patients the natural history of the disease remains unaltered despite medical intervention[6] and the question inevitably arises – will patients with a severe condition require medical treatment for the rest of their lives?

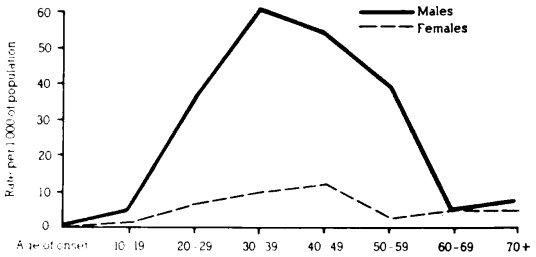
This can only be answered when the natural history of duodenal ulcer disease is fully understood. Some aspects of the natural history of the disease, however, have been well recognised for some years.

It is a naturally relapsing condition; in fact, it has been estimated that 75-80% of patients have at least one recurrence within 5 years of the initial episode,[7] some relapsing several times in one year.

The onset of duodenal ulceration is related to age, as shown in Figure 1. The initial episode is most likely in the 30-39 age group for males and slightly later in life for females.

Of greater interest is the natural development of the disease following its onset. Figure 2 demonstrates how the disease tends to 'burn itself out' after a certain period of time.[8] In a group of duodenal ulcer patients who were followed for 15 years, the symptoms tended to peak in severity

Figure 1 The Onset of Duodenal Ulceration[8]

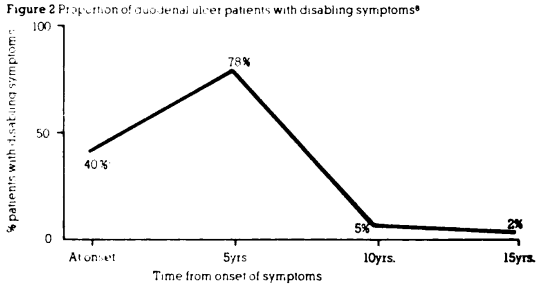


after 5 years and then progressively remit until at 10 years no more than 5% of patients had severe symptoms.

This finding has been recently substantiated by workers in Denmark who found in a retrospective study that the disease is present for a finite time.[9]

The workers concluded "...most patients with duodenal ulceration will need only intermittent or continuous cimetidine treatment for a limited period."

Figure 2 Proportion of duodenal ulcer patients with disabling symptoms[8]



References

1 Oral cimetidine in severe duodenal ulceration. (1977) Lancet, i, 4
2 Cimetidine in the treatment of active duodenal and prepyloric ulcers (1976) Lancet, ii, 161
3 Maintenance treatment of recurrent peptic ulcer by cimetidine (1978) Lancet, ii, 403
4 Prophylactic effect of cimetidine in duodenal ulcer disease (1978) Brit med J, 1, 1095
5 Cimetidine treatment in the management of chronic duodenal ulcer disease (1978) Topics in Gastroenterology (In Press)
6 Cimetidine for duodenal ulcer (1978) Lancet, ii, 1237.
7 The natural history of duodenal ulcer disease. (1976) Surg. Clin. N. Amer., 56, 1235.
8 Peptic ulcer a profile (1964) Brit med. J., 2, 809.
9 Long-term prognosis of duodenal ulcer follow-up study and survey of doctors' estimates. (1977) Brit med J., 2, 1572.

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