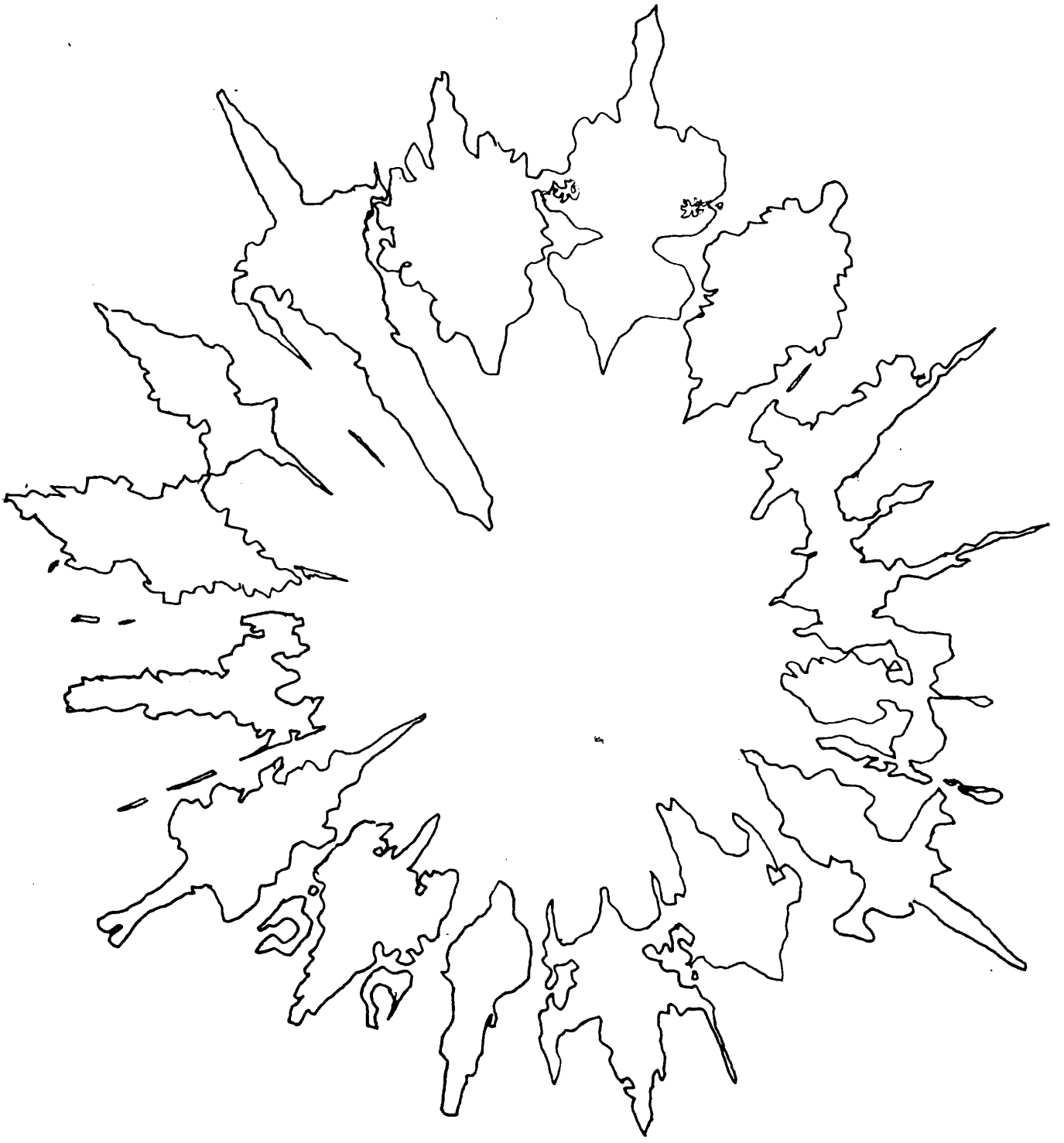
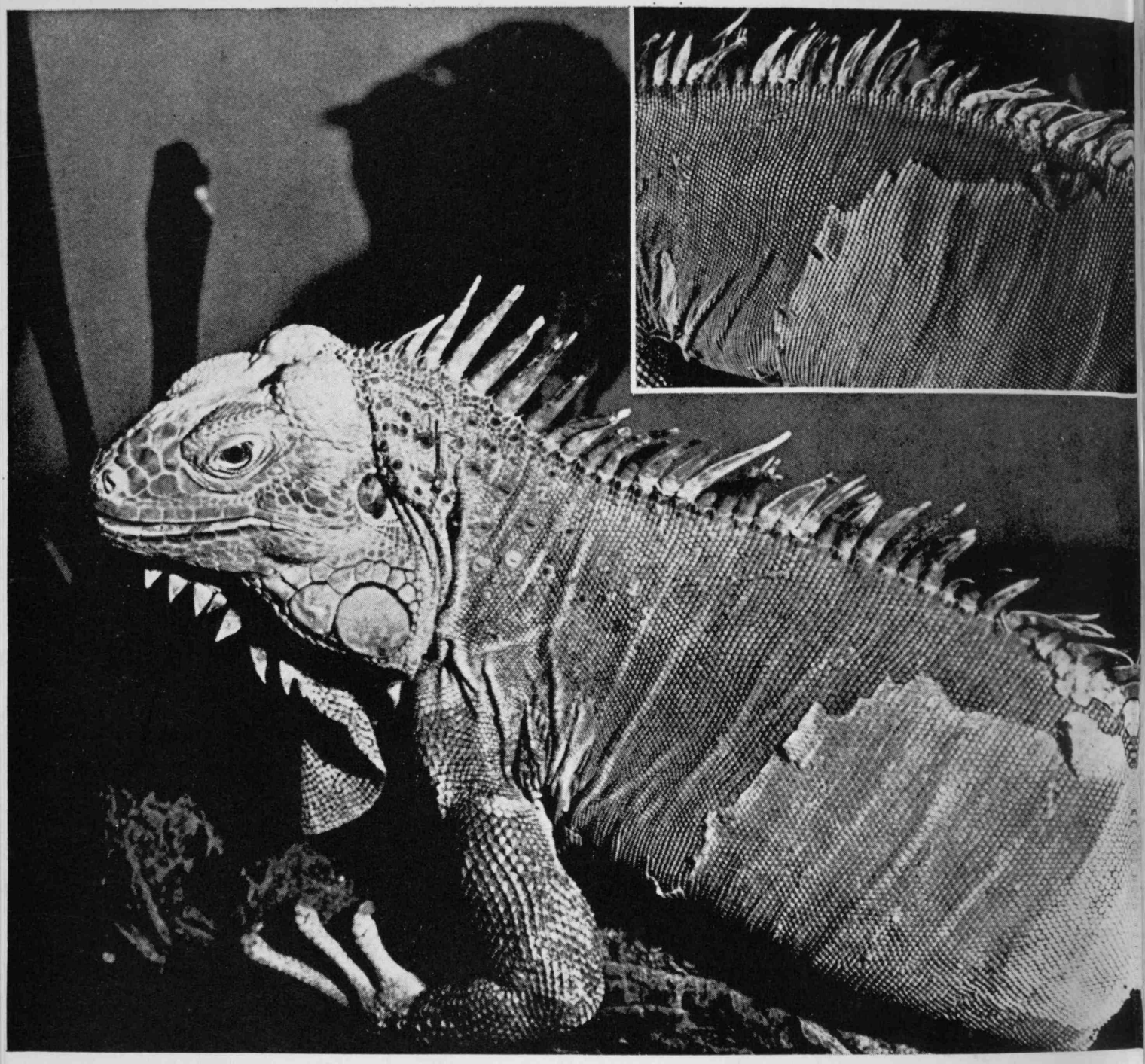
Elixir



Autumn 1973



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Acta Dermatovener, Suppl. (1972), **67**, 64–65

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Practitioner **205**, 671 (1970)

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ELIXIR

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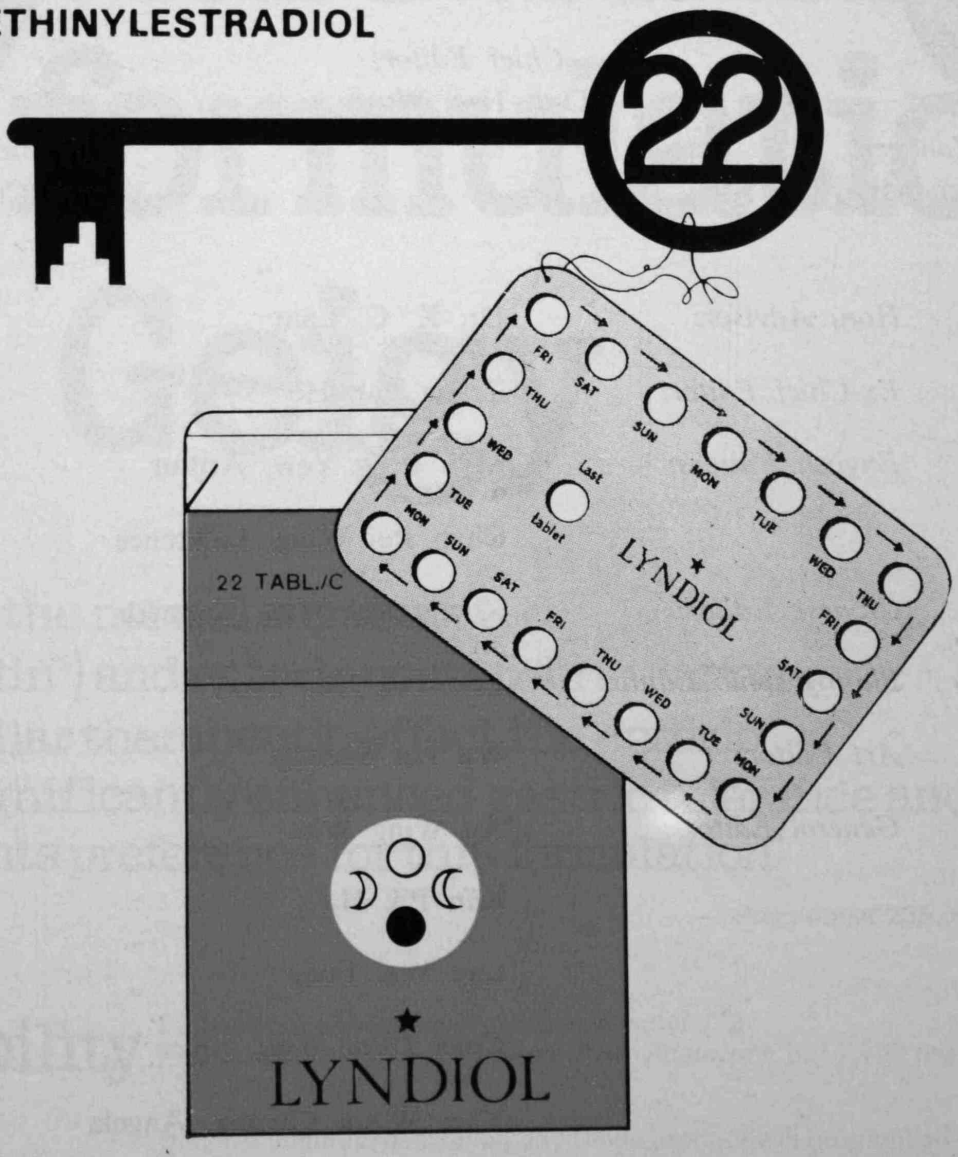

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CONTENTS

ACKNOWLEDGEMENTS:

The Editorial Board is very much indebted to all those who have contributed, in one way or another, to make this issue a success. We wish to express our sincerest thanks and gratitude to all of you.

優美的傳統
日航「747」
空中庭園噴射客機

日航747「空中庭園」噴射客機，一如日本文化傳統之絢燦綺麗，古意盎然，充滿典雅純美的風味。機內各式陳置鋪設，柔和悅目，閣下置身其間，自覺輕逸開朗，胸懷盡暢。

日航秉承一貫傳統服務精神，款客彬彬，意重情隆，閣下乘搭日航班機，自可享受最佳服務。中西美點佳餚，任君品嘗，身歷聲音響裝置，播送柔和音樂。此外日航所有飛越太平洋及北極線之班機，加放電影，空中旅程，倍覺多采多姿。

日航747「空中庭園」噴射客機，較諸其他客機更寬敞舒適，搭客坐立，伸展自如。請即乘搭日航747客機，親自體驗日本文化的美麗傳統。

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EDITORIAL

"The final aim of our Editorial policy is to publish a magazine that is entirely by the Students, for the Students and of the Students"

Elixir Editorial Board 1951

Looking back into the history of ELIXIR up to its present moment, this aim set by the Elixir Editorial Board of 1951 has yet a long way to be achieved. The amount of humble contributions from the students fluctuated widely from issue to issue. In fact, contributions from the staff formed the astronomical portion by comparison. What then is wrong with our Medical Students?

Medical students in Hong Kong (as well as those in overseas Medical Schools) are often criticised for their bookwormish, narrow-mindedness and lack of outside interest. Are these criticism made on erroneous and bias informations? No doubt the Medical Profession is envived and respected by the Society, young and old alike. But to make such a criticism as such is only half-truth! Nevertheless, the answer to the above is not for others to give. Only we, as Medical students, can supply the answer .....

What then is the purpose of a Medical magazine? A record of Medical life as a student? Our magazine is likened unto a mirror, reffecting the numerable events, auspicious or otherwise, that have taken place in that Academic year. It is a memior of the ups and downs in the life of medical students. It is also a bridge spanning the seemingly wide distance which is usually present between the staff and the students. As a matter of factly, it is a magazine that fosters a better understanding and friendship among the staff-student and student-studing and friendship among the staff-student (senior and junior) relationships.

Hence, in order to keep up the good work, students should play a more active role in responding to the 'call' of ELIXIR, be it contribution or otherwise. The *could-not-care-less* attitude of the students must be erased, once and for all, from their minds and a more responsible outlook implanted. ELIXIR is our magazine — our responsibility and we should be proud of it.

Let us hope that the support given to this issue will continue to merit the enthusiastic patronage of greater number of contributions among staff and undergraduates and be fully represtative of the Faculty and Departments.

H. W. ONG

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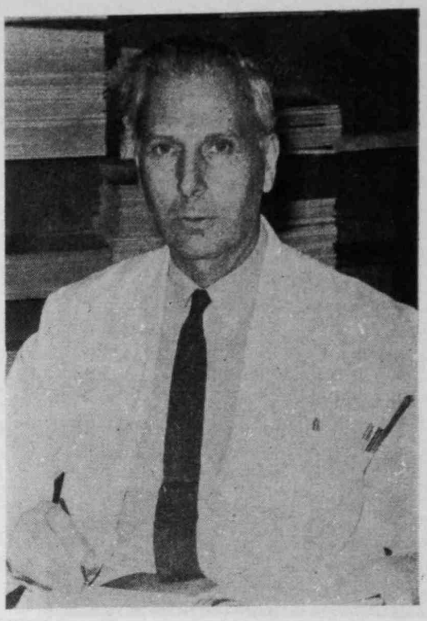
MESSAGE FROM DEAN FOR ELIXIR

An elixir is "A clear, sweetened, usually hydroalcoholic liquid containing flavouring substances and sometimes active medicinal agents used orally as a vehicle or for the effects of the medicinal agents concerned". To persuade readers to swallow the dose, then, your editors must write with good flavour, sweetly and clearly.

In past years our Elixir has also been a looking glass in which one and all are permitted from time to time to see themselves. Pictures in the looking glass are not always as flattering as we hope, but if the hydroalcoholic mixture is rich enough in good spirits, the shock is subliminal. Good luck then to Elixir for another year! I'm sure it will be a vehicle for some active medicinal agents and continue in its lively fashion to promote the community health of our Faculty.

J. B. G.

MESSAGE FOR ELIXIR



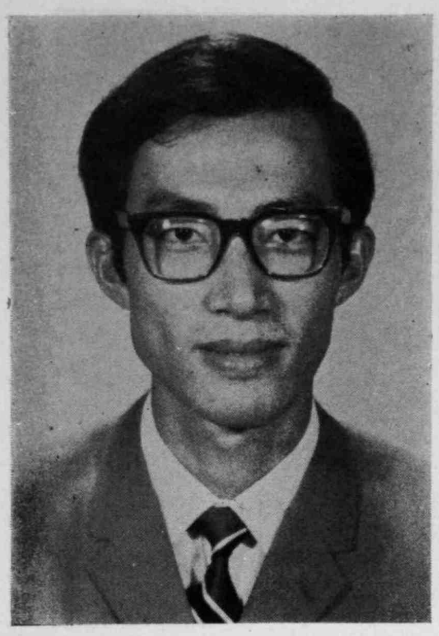
As President of the H.K.U. Medical Society, one soon becomes aware of the many useful extracurricular activities in which medical students involve themselves, and quickly realises the enormous amount of enthusiasm, organisation and hard work that go into their ultimate success. These activities range from ambitious educational projects to windswept barbecues on the roof of the new Medical Students' Centre. Council Meetings of the Society are conducted with great formality and devotion to protocol, and though in my experience they seem to go on for a mighty long time the ratio of wisdom to waffle is gratifyingly high. Already this year, medical students have planned and executed Health Projects and Public Exhibitions on Drug Abuse in H.K. and on Cancer Prevention, sent delegates abroad to attend meetings of ARMSA and IFMSA and debated in a moderate and balanced way the burning question of student representation on the Faculty Board.

Another important activity of the HKUMS is the publication of Elixir, and I am very pleased to welcome this new issue, the first to appear since Spring 1972. Elixir has always seemed to me to be an excellently produced magazine, with many articles of great interest and high quality. This edition, eagerly awaited, will, I am sure, maintain these high standards.

However, if Elixir is to aim once again to be published twice a year, the editors must depend on a continuous supply of good material from staff and students. Here, then, is my message and my plea to student readers of this copy of Elixir. It is *your* magazine and you can be justly proud of it; but to ensure its future success and viability, please inundate the editors with a varitable torrent of contributions of every kind!

Finally, I would like to express my congratulations to the Editorial Board of Elixir for bringing out this excellent issue, and I look forward to many more to come in future years.

M. B. Roberts.



MESSAGE FROM THE CHAIRMAN

It is my great pleasure to see the ELIXIR comes in print once again. During the past few months the ELIXIR Editorial Board especially the Chief Editor, the General Manager and the Financial Manager, had put much effort in securing advertisements to cover the printing cost, and this combined issue of the Elixir is the result of their untiring efforts.

The Ex-Chief-Editor received a memorandum during his session from the University Registrar on the system of procuring advertisements for student publications. The Editorial Board found that it could not find enough revenue to cover the printing cost if it were to honour the University policy. Negotiations with the University were attempted by the Ex-Chief-Editor without avail. Lacking sufficient financial resources, the Editorial Board could not produce the magazine although most of the manuscripts were ready. The matter was further complicated by no one taking over the posts of the Editorial Board at the end of the session.

It was almost by chance that I mentioned the case to the present Chief-Editor in June and he accepted the challenge. In the production of this issue of ELIXIR, the Editorial Board has honoured the memorandum from the University Registrar and they have been able to produce the ELIXIR within six months. This has come out as a combined Spring and Autumn issue because of the shortage of time for preparation. However, we hope that two issues would be published during the next session.

The ELIXIR Loan Fund Selection Board distributed just over HK$10,000.00 to some 10 medical students this year. For the ELIXIR, the Elixir Loan Fund and the Medical Society of the University of Hong Kong we hope that contributions and advice will continue to come from graduates, members of the teaching staff and the local medical practitioners.

SO PING CHAM,
Chairman,
Medical Society,
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THE INNER MAN

Examinations are formidable even to the best prepared, for the greatest fool may ask more than the wisest can answer.

— Chaules Caleb Colton —

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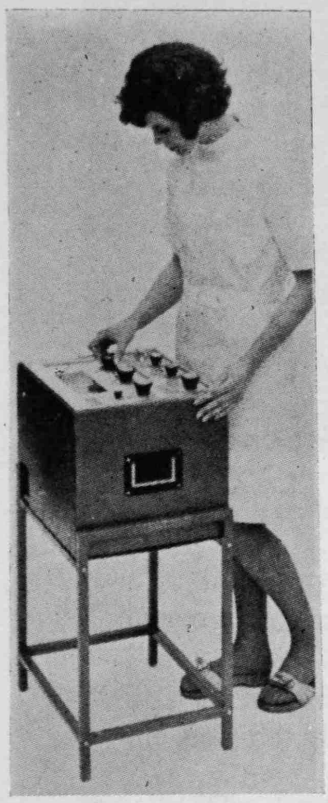

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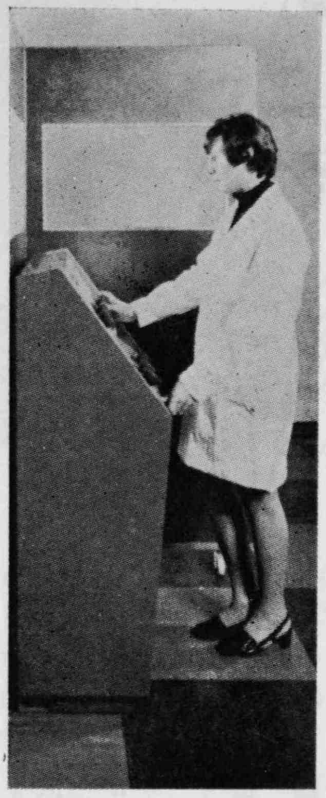

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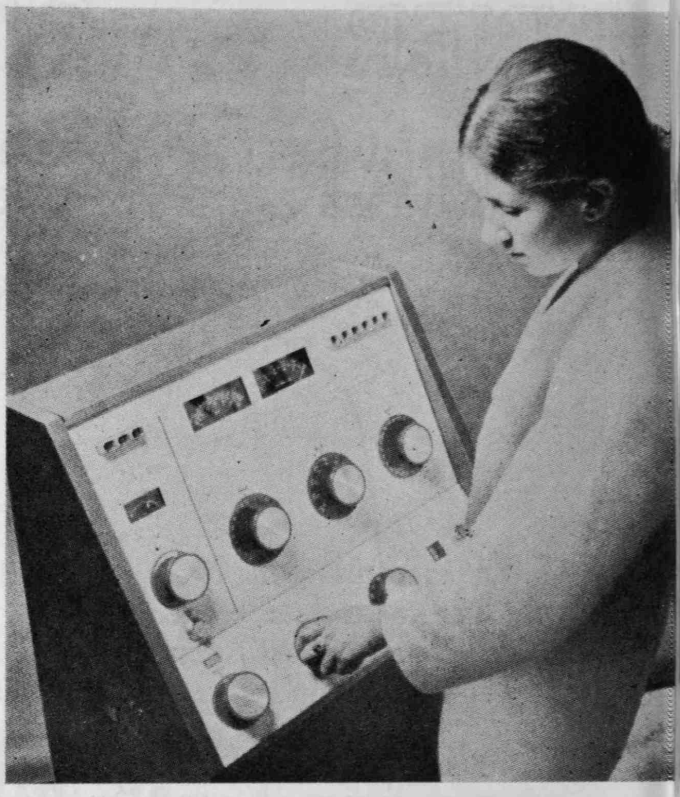

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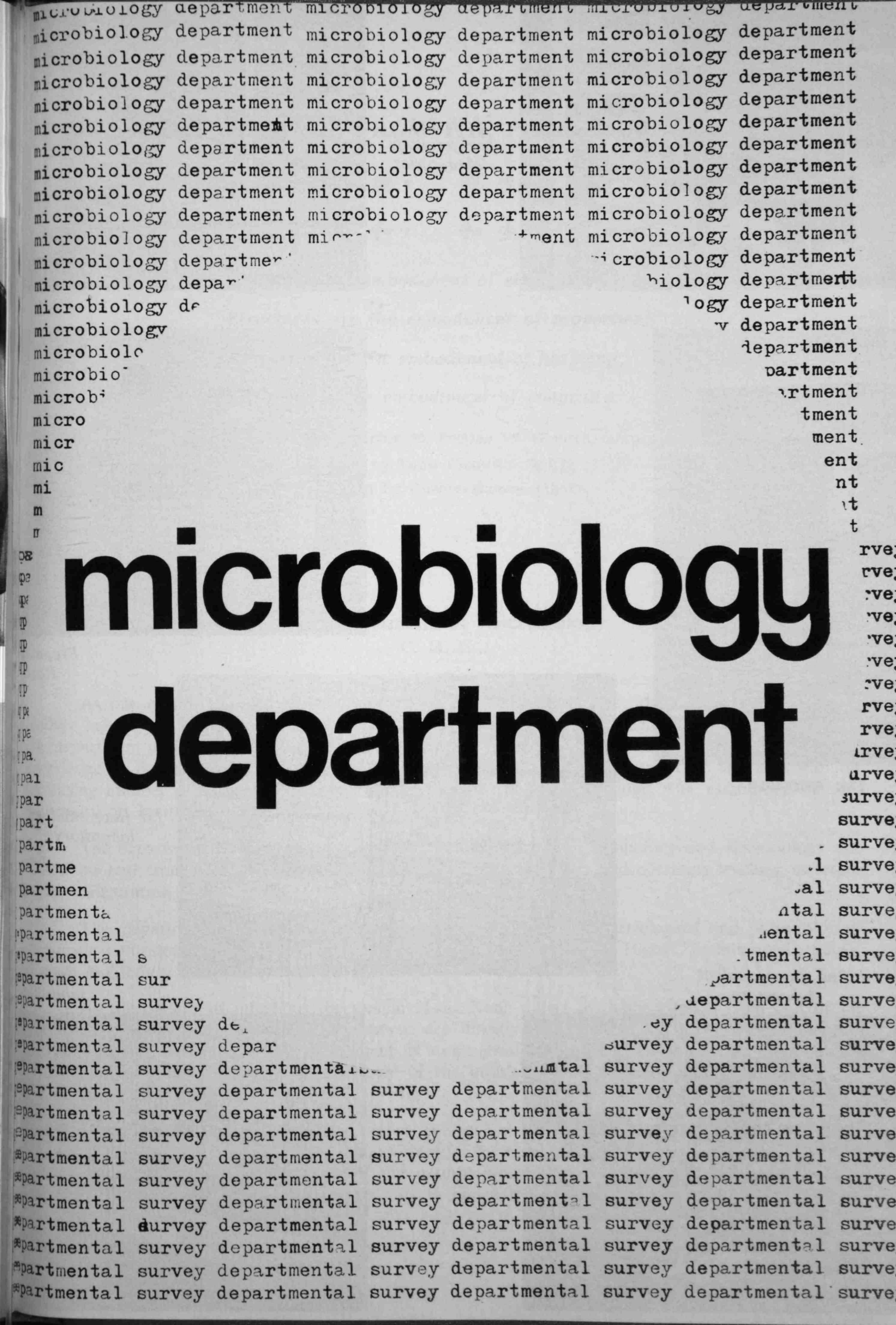
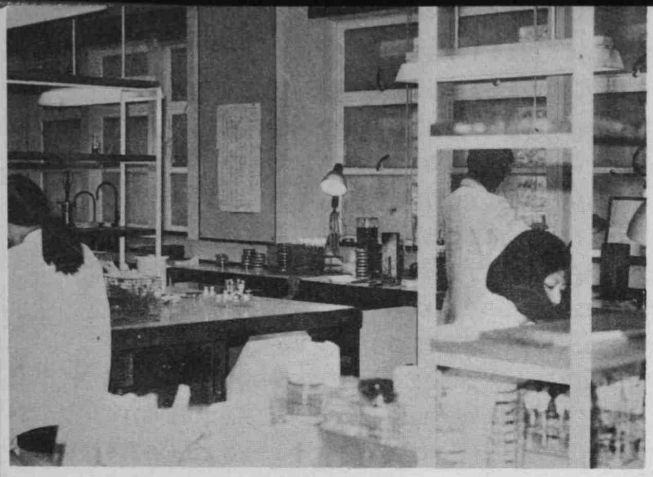

microbiology department



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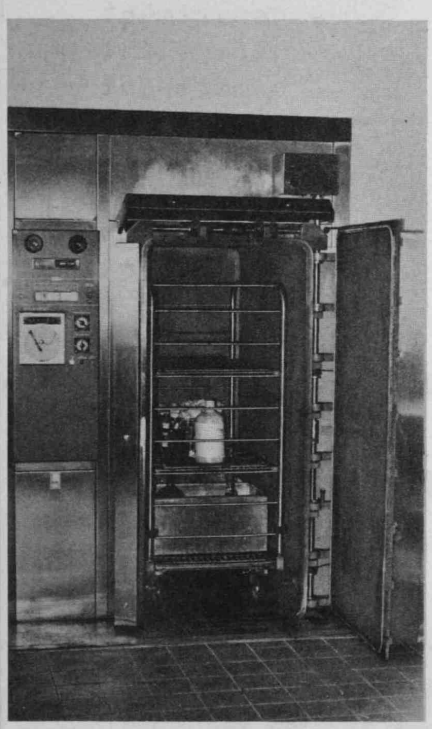

The autoclave

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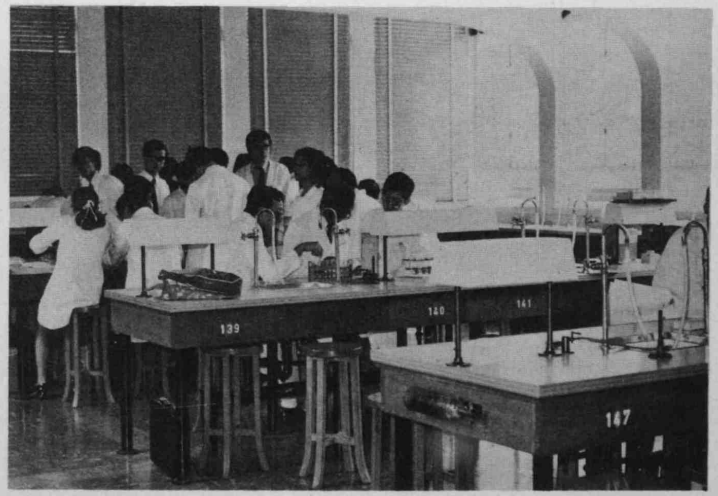
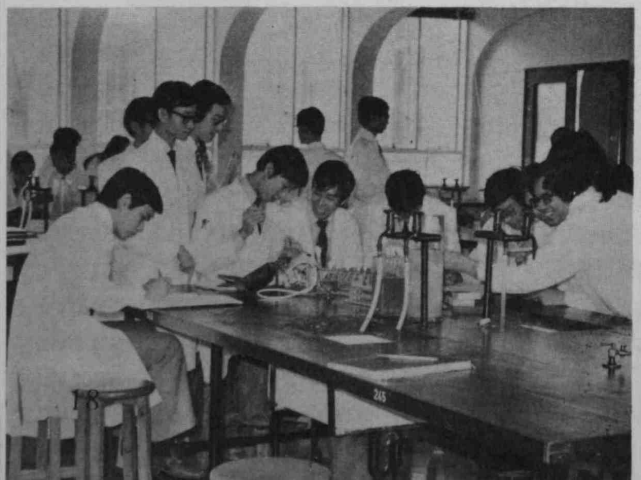
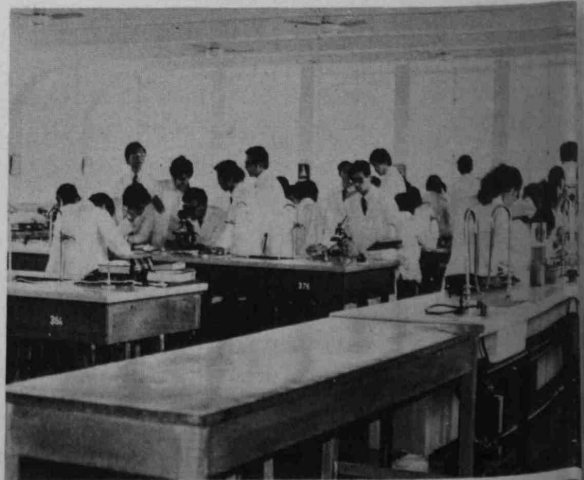


1st floor student laboratory

2nd floor student laboratory



3rd floor stud laboratory



MESSAGE FROM THE PROFESSOR

實 生 於 理， 理 生 於 德，

德 生 於 和， 和 生 於 當。

Reality is the embodiment of structures;

Structures are the embodiment of properties;

Properties are the embodiment of harmony;

Harmony is the embodiment of congruity.

From Kuan Tsi 管子 Chapter 55, Section IX (Fourth century B.C.)
Written by Ts'ao T'ien-chin 曹天欽
Translated by Gustav Haloun (1951).

The Department of Microbiology

C. H. C.

As one of the youngest departments of the Faculty of Medicine, the Department of Microbiology has only a brief history. Nevertheless, Microbiology had been taught along with Pathology in one department until 1968 when, with the expansion in research work and the tremendous increase in knowledge in the fields of bacteriology, parasitology, mycology as well as virology, and also with the increasing number of students to teach, a new department of Microbiology was established in this University on January 1, 1968.

The department was in fact an offshoot of the Department of Pathology and Bacteriology and it had no real trouble in recruitment of staff, training of technicians and obtaining teaching materials in its inauguration.

The department also serves the teaching hospital with its bacteriological and parasitological diagnostic laboratories and takes part in the training of technicians for Higher Technician Certificate Course in Medical Laboratory Technology.

As the pattern of infectious diseases in Hong Kong differs in many respects from that of the west, the research activities of the department are directly mainly to those which are prevalent in the community. At present the department is concentrating on the development of teaching and research in Virology. It is hoped that some of the problems concerning local viral diseases can be elucidated in the future.

The scope of Microbiology is enormous even when the sphere is reduced to Medical Microbiology. There is no practical limit to opportunities for microbiologists. Being a basic and growing science underlying all the complexities of the natural world, Microbiology will inevitably grow in importance, and in demand of man-power. It is hoped that more intelligent young people can be attracted to the field.

Professor C. T. Huang

Professor Huang was born in Hong Kong. After completing his secondary school at King's College, he went to study medicine at the Lingnan University and graduated in 1942. He started his career in microbiology soon after graduation. He began to work as an assistant in bacteriology and parasitology in Lingnan University and as an instructor at the Chung Cheng Medical College. After the Second World War he returned to teach in the Lingnan University for two years before taking up a fellowship to do post-graduate work on viruses in the Department of Bacteriology and Immunology at the Harvard Medical School. He came to this University as an assistant lecturer in the Department of Pathology and Bacteriology in 1949, was promoted to lecturer in 1952 and senior lecturer in 1959. He spent the years 1957-59 at Leeds University where he was awarded the Ph.D. degree. When the Department of Microbiology was established in January, 1968, he was appointed to the Chair.

Professor Huang's association with this University started long before his appointments here. In 1939 when the Japanese occupied Canton, Lingnan University moved to Hong Kong to resume classes in the premises of the University. Professor Huang and his class-mates were admitted as guest students to receive clinical training at the Medical Faculty in Queen Mary Hospital. For this, he still has many pleasant memories. When Hong Kong fell to the Japanese in 1941, some of the H.K.U. medical students went back to China to continue their education and some of them were admitted to the Medical School of the Lingnan University which was then moved back to Kukong, the war-time capital of Kwangtung. During this period, Professor Huang had the opportunity to teach bacteriology and parasitology to many of them. He always cherishes the close relationship of the two universities and with the medical faculties in particular.

When he was a student Professor Huang intended to become an internist but ended up as a microbiologist with no regret. He said that microbiology had not only taught him to understand the relationship between microbes and man but had also convinced him of the philosophy of "to live and let live".

When asked what he thought of the medical faculty after his long service in this University, he said that the medical school had expanded and developed very rapidly and the most encouraging thing was that the standard had been kept high all the time.

He had been Honorary Treasurer of the Medical Society twice and had been the President in 1969. He was appointed Pro-Vice-Chancellor of the University in July, 1971. He is a very busy man now, sitting on many committees, but he still finds time to give a number of lectures, tutorials and whenever he is free he supervises the practical classes. He said that he enjoyed teaching and that closer communication with the students to hear their views is the duty of a teacher.

He relaxes himself by listening to classical music and reading Chinese novels. Although he has never played the game he is an enthusiastic soccer fan. His favourite sport is swimming.

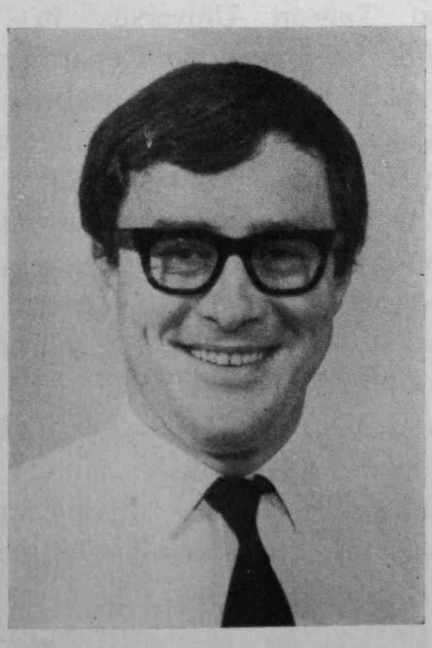
Dr. C. H. Teoh-Chan

Dr. Teoh-Chan has, since her graduation from the Lingnan Medical School, Canton, China in 1952, been a member of the Department of Microbiology. In 1959 she was awarded a Sino-British Fellowship Trust Scholarship which enabled her to do post-graduate work and obtained the Diploma of Bacteriology in the University of Manchester, England. She received her Ph.D. from this University in 1967 and was appointed to senior lecturer in 1969.

Dr. Teoh-Chan is especially interested in various aspects of tracing the sources and methods of controlling hospital infections. She has worked out the typing schemes for tracing *Pseudomonas aeruginosa* and *Shigella sonnei* infections here. In addition she helps to supervise the research students studying for their higher degrees. Her current research is mainly on the K antigen of *Escherichia coli* in relation to pathogenicity and bacteriophage-typing of *Ps. aeruginosa* and the interaction of *Ps. aeruginosa* on the growth of *Cryptococcus neoformans.*

She likes teaching and has been elected President of the Medical Society in 1971. Her hobbies include reading, listening to music and collecting curios.

Dr. K. F. Shortridge



One of the most recent members of our staff, Dr. Shortridge, senior lecturer in virology in the Department of Microbiology, hailed from Australia when he graduated in 1963 with a B.Sc. in Microbiology from the University of Queensland. During a two-year period as a bacteriologist at the Brisbane General Hospital, his interests centered on the quick and effective laboratory diagnosis of Salmonella infections.

His attention turned from bacteriology to virology in 1965 when he was appointed to a lectureship at the University College Hospital Medical School. There he gained his Ph.D. studying aspects of virus structure but for the most part his research interests lay in the interaction of virus particles with serum and colostral proteins. He considers coming to Hong Kong to be an excellent opportunity to study "on site" current topical virological problems. He is a happy father of two children. He enjoys Chinese food and likes playing squash and cricket. At present he is learning to speak Cantonese.

Mrs. Grace Chou

Mrs. Chou was born in Ayr and was educated in Townsville and Brisbane, Queensland. She received her B.Sc. with honour from the Queensland University in 1960. After serving as a research fellow in the Commonwealth Serum Laboratory at the Medical School of Queensland University for one year, she joined this University as a demonstrator in Bacteriology. In 1965 she was promoted to lecturer. In 1970, she was awarded M.Sc. by the University of Hong Kong. Her research works are mainly on anaerobic bacteria and the use of continuous culture to observe its effect on the growth of these bacteria.

She has now settled down happily in Hong Kong with three children. She has a wide variety of hobbies including reading, piano and Ikebana.

Dr. W. T. Wong

Dr. Wong was brought up in Hong Kong and he graduated with M.B., B.S. from the National Taiwan University in 1966. Soon afterwards he joined the Department of Microbiology as a demonstrator and became a lecturer in 1970. Dr. Wong's research interest lies in the serological and immuno-chemical studies of *Escherichia coli* causing urinary tract infection and recurrent pyogenic cholangitis in Hong Kong. This research project will form part of his dissertation for the Ph.D. He is keen on teaching and is willing to do a great deal to help the students and his junior colleagues. He is a proud father of three girls. Dr. Wong's non-medical interests include painting, driving and swimming, and he is an active member of the Royal Life Saving Society.

Dr. Joseph P. H. Fung

Dr. Fung was born in Hong Kong and studied in Wah Yan College. In 1954 he emmigrated to Canada and obtained his B.Sc. and M.Sc. degree from the University of Manitoba and then received his Ph.D. from Cornell University, U.S.A. in 1968. While he was in Canada he served in various capacities at the Animal Diseases Research Institute, the Ontario Agricultural College and was the Chief Research Microbiologist in the Medical Research and Development Laboratories, Canada Packers Ltd.

Dr. Fung came over to Hong Kong as a lecturer in Microbiology. His works are mainly on immunochemistry and biochemistry of cell wall synthesis of Vibrio foetus food poisoning pathogens, diseases of poultry and large animals, pathogenesis and phage-typing of *Staph. pyogenes* and vibrio species of murine origin.

He is a happy father of two children. His interest in student activities was reflected in his being elected as student representative and sports convenor for a number of years while he was attending the University of Manitoba. He was appointed a don by the University.

Dr. Fung's hobbies include swimming, badminton, reading and light classics but presently his main hobby is the bringing up of his children.

Dr. P. Y. Chau

In 1957, Dr. Chau graduated from Shanghai First Medical College. Since then he had worked in the Shanghai First Medical College and later in Nanking Medical College. His main interest during that period was the laboratory diagnosis of infectious diseases and the study of enteric pathogens.

In 1966, he came to Hong Kong and three years later, he joined the department. In 1971, he was appointed to lectureship. The study of enteric bacteria is his special field of interest and now he is working on the effect of dye and metal salts on the behaviour of salmonella for his doctorate degree.

He likes playing table tennis and listening to classical music and is well known to most of us as a very generous person.

Dr. M. H. Ng

Dr. Ng is another recent member of the staff of the Department. He was born in Shanghai and educated in Australia. After receiving his B.Sc. in Microbiology and Biochemistry, he went to New York in 1965 for post-graduate study and obtained his doctorate degree from the New York University Graduate School of Arts and Sciences. Being a research scientist of the Department of Microbiology, New York University School of Medicine, his research activities have been directed towards the elucidation of the mechanism involved in the biosynthesis of interferon and its antiviral action and on membrane biochemistry. A considerable number of papers on these subjects were published by him.

Dr. Ng is married with a baby boy whose arrival gave him great satisfaction.

Microbiology for the Future

P.H.F.

The above is the title of a feature article published in the *American Society for Microbiology News,* vol. 38, No. 1, January, 1972. It is a report of the Microbiology Training Committee of the National Institute of General Medical Science, National Institute of Health, U.S. Public Health Service. Its contents should obviously be of interest not only to microbiologists but also to those who are interested in all aspects of biology and medicine. The following is an abridged version to which I would like to call their attention.

Microbiology is an immensely practical science that makes important contributions to medicine, industry, agriculture, and environmental control. In addition, the small size and simple organization of microorganisms make them most effective subjects for studying life at its most fundamental level.

The microbiologists are teaching in medical schools and universities, and doing research in general and medical microbiology. This segment of the microbiological population is expected to increase in the 1970's, but there will probably be an even larger increase in the number of microbiologists working for non-educational employers engaged in food production, pest control, waste disposal and other aspects of environmental control, and production of drugs and other chemicals by microbiological techniques. Thus, larger and larger proportion of microbiologists will be using microbiology for the direct and immediate benefit of mankind.

There will be an increased demand for teachers of microbiology in the next decade, particularly in schools of medicine and paramedical sciences, in community and junior colleges and universities.

The present shortage of trained clinical microbiologists in the diagnostic laboratories of hospitals and clinics will grow worse with continued expansion of medical care. The coming of the antibiotic era has seen, not as one might expect, a decrease in the number of specimens submitted to microbiology diagnostic laboratories, but instead a great increase. There is, at this moment, a shortage of adequately trained clinical microbiologists. There is a particularly pressing need for clinical mycologists, people trained to diagnose human diseases caused by pathogenic fungi.

Up to now diagnostic microbiology has meant almost exclusively diagnostic bacteriology. The routine diagnosis of infectious diseases caused by viruses has not usually been attempted. The basic knowledge and practical methodology for successful laboratory diagnosis of viral diseases is already available. What holds it back is chiefly a lack of properly trained diagnostic virologists. Here is an entirely new role for microbiologists, and when clinically useful drugs for treatment of viral diseases become available in the next few years, good diagnostic virology will be required for their effective use, and the demand for diagnostic virologists will increase enormously.

Increasing concern over environmental deterioration will create many new opportunities for microbiologists trained to deal with problems of pollution prevention and control. Biodegradable wastes do accumulate on our land and in our lakes and streams, mainly because big cities produce them in such enormous amounts that microorganisms cannot break them down fast enough. Sewage disposal is the job of the sanitary engineer, the only microbiologist who so far has given much thought to microbial waste disposal. It is clear that in the immediate future we shall need more sanitary engineers with the ability to look at the pollution problems as something more than one of sewage disposal. A new breed of microbiologists, broadly trained in biology and with a reasonable grasp of the pertinent social sciences as well, will be needed to participate in such planning to see that microbiological considerations are not ignored.

Microbiologists will continue to use microbes for studying the basic properties of life, to use microorganisms and microbiological methods to attack many practical problems such as cancer and infectious diseases, protection and augmentation of food supplies, and the production of antibiotics and other useful drugs. The increased demand for microbiologists is apparent.

When the going is tough and the challenge is on,
when reserve of strength has been drained from his body and the summit is still not within sight,
Then the quality to look for in a man is neither great strength nor quickness of hand;
but a resolute mind firmly set on its purpose, never to let his body yield or rest.

— Edward Hillary

Keflin® I.V.

sodium cephalothin

2 Gm.* in 100-ml. ampoule

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in surgery, in medicine, in urology... since the introduction of Keflin, the susceptibilities of commonly encountered organisms, as measured by in-vitro methods, have not changed significantly.

Lilly

CLINICAL PHARMACOLOGY: THE PRESENT STATE OF PLAY

Professor M. B. Roberts

"Cur'd yesterday of my disease,
I died last night of my physician."

Matthew Prior (1664-1721).

On November 23rd, 1971, I was delivered of an Inaugural Lecture entitled, with some intent to provoke, 'The Pharmacologist as Guide and Mentor in the Therapeutic Jungle'. I was not a little amazed to discover afterwards that its arguments, which would barely have raised an eyebrow in Britain or the U.S.A., were regarded here as revolutionary, almost subversive. One or two non-medical listeners described me as 'the man who hates doctors'. This, of course, is a libel; some of my best friends are doctors. Another unexpected result was a persistent and widespread rumour that I had recently undergone a cholecystectomy, an impression no doubt fostered by my introducer's rather long drawn-out metaphor on the significance of large gall-bladders. I hasten to affirm that my viscera are to this day untouched by surgeons' hands, and long may they remain so! (But, of course, some of my best friends are surgeons.)

To return to the basic message of my Inaugural Lecture, this was quite a simple one. I tried to emphasise, and give evidence in support of, the concept that the enormous increase in the output of potent drugs by the Pharmaceutical Industry has made obligatory the development of a new discipline. No one knows quite what to call this new discipline so as to be both accurate and to avoid stepping on people's toes, but the favoured term is *"clinical pharmacology"*, though some prefer *"human pharmacology"*. I take the liberty in this article of quoting certain relevant passages from the Inaugural, and then I shall comment on them in the light of my present views and of any progress made in the past two years to implement some of my suggestions.

First of all, I attempted to define clinical pharmacology. ". . . . . in recent years, we hear more and more about the rôle of clinical pharmacology, a term which can be criticised but which none the less does indicate the physicians' need today for some guidance through the therapeutic maze. What then is this elusive subject, clinical pharmacology, and how is it related to basic pharmacology and to therapeutics? These questions require careful thought, and the whole issue is not a simple one. First of all, clinical pharmacology is *not* . . . . and I apologise to a well-known and excellent textbook . . . . applied pharmacology, an undesirable term which might suggest the wholesale and uncritical application of results obtained with animals to the human situation. This . . . is precisely what we cannot, and must not, do; and doing so in the past has led to some therapeutic disasters." I would add that the term human pharmacology can be misleading, too, as animal experiments can, and should, play an important part in the overall study of the clinical pharmacology of a drug.

I then pointed out: ". . . in days not so far off the armamentarium of effective drugs available to the physician was pitifully small. Some that did little good at least did little harm. Others were given in such heroic dosage that the patient was cured, at the cost of his life. *"A physician"* wrote J. H. Gaddum sardonically, *"Felt his greatest triumph when his diagnosis was confirmed . . . at post mortem."* Without the *vis medicatrix naturae* and the placebo effect, the physician would have had few real therapeutic victories. Even today, a very high proportion of minor illnesses is fortunately amenable to the

suggestion-laden aura of the confident practitioner; and the therapeutic means he employs, whether the latest product advocated by the persuasive detail man or some quaint therapy from the fringes of medicine, need have little or no real efficacy. For diseases more resistant to suggestion and the placebo, the physician has undoubtedly a far wider range of really effective drugs at his disposal today, yet the greater potency of these drugs inevitably carries with it greater toxicity, and greater dangers for the patient."

"How, then, can we help the physician, the clinician, to make his therapeutic tasks easier, so that his triumphs may be more frequently shared by his patients restored to health and still alive? The ultimate answer is, I think, for there to be far more collaboration between the medical scientist and the clinicians, either in departments of medicine, paediatrics and surgery, or in departments of pharmacology, or even in special departments of clinical pharmacology, clinical physiology and the like. It is this pooling of skills and backgrounds, the eclectic approach of minds trained in different disciplines and utilising all the available techniques of science and medicine, that is important. And that is why it is so difficult to define a clearcut meaning for the term clinical pharmacology, for it is not in any sense a new subject but a meeting place and a melting pot for many established disciplines whose ultimate goal is the improvement of drug therapy in all its aspects. Indeed, there have always been clinical pharmacologists, or pharmacological clinicians, if you like; some of the best research-minded clinicians of the past (Sir Thomas Lewis or Chassar Moir, for example) made important contributions to clinical pharmacology before the term was popular. But today, clinico-pharmacological studies are essential, they cannot be left to the chance man of genius and vision. There must be the deliberate and planned organisation of a favourable environment so that clinical pharmacology can grow and flourish. The tempo of the times demands it. The well-being of the community and the health of its individuals depend upon it."

I then gave an elementary explanation, familiar to those who attend my student lectures, of the importance of studying drug metabolism in man and animals, and how such investigations can help us to evaluate and improve our therapeutic measures. I concluded: "I hope that it is now clearer why there is the urgent need for Departments of Clinical Pharmacology today, and also what clinical pharmacology itself involves. The work done in such departments would not simply be clinical trials of recent drugs, important as these are. Clinical trials could be done in such an environment, and indeed would probably be better done there than by some young and enthusiastic registrar in the wards "*trying out*" a preparation for a Drug Firm, a situation which all too often becomes a sad case of the blind leading the double blind. Drug metabolism, modes of drug action, interactions of drugs through enzymic and other mechanisms must also be investigated on animals and on human subjects (sick and healthy) by clinicians, pharmacologists and scientists of every description. Clinicians would have access to, and advice about, modern methods of pharmacological research . . . and not only pharmacological, but biochemical, physiological and so on. In this two-way traffic, the progress of therapeutics, and of pharmacology in the broadest sense, could be accelerated for the maximal advantage of the human patient, who is, after all, the main intended beneficiary of these developments."

What progress has been made since 1971 on the Hong Kong scene? All too little, I fear, though things move slowly. I want now to try and explain what we aim to do in the future, and why we still have so far to go.

Before we can achieve the long-term aim of a separate Department of Clinical Pharmacology, or even a Sub-Department of Clinical Pharmacology in (say) the Department of Medicine, it is essential to initiate more contacts between the clinical departments and pharmacology, and for there to be combined efforts to integrate and streamline the teaching of pharmacology and therapeutics to medical students. This sort of thing is taken for granted elsewhere, but in Hong Kong collaboration between clinical and preclinical departments has been rather limited, for

reasons which I do not wish to go into here. This is a pity, especially since the Department of Pharmacology is fortunate in having an unusually high proportion of medically qualified graduates on its staff, who would welcome more contact with the clinical departments in the Queen Mary Hospital and would willingly take part in therapeutics teaching. Furthermore, by 1974 two staff members will have worked for a year in Departments of Clinical Pharmacology abroad; Dr. Lucas Chang in the States and Dr. Clive Ogle in St. Bart's Hospital, London. These two, at least, will almost certainly wish to initiate research with a clinical bias, and to collaborate with physicians on drug studies of various kinds in patients.

I strongly feel that this is the essential first step . . . our joining in the teaching of therapeutics in the later clinical years. Any lesser degree of *ad hoc* collaboration, e.g. the occasional appearance of a pharmacologist at a clinical conference or on a ward round to expound on the drugs being prescribed would not, in my opinion, be satisfactory or rewarding for staff, and only minimally so for students. But before we can join in the teaching of therapeutics in a systematic manner, we would have to reduce or at least streamline in some way our present teaching commitments in the second and third years. This raises the vexed question of the reorganisation of the whole medical curriculum in Hong Kong. This is long overdue, for many reasons. Without such a reorganisation, we in Pharmacology are too occupied with our year's course to do justice to an incursion into therapeutics and clinical teaching programmes. Ideally, as I have often said, I would prefer to have a shorter course in the basic principles of pharmacology, somewhat more integrated with courses in physiology and biochemistry. At the moment, we do include in our course, in a rather haphazard way, certain clinical aspects of pharmacology and cover topics such as chemotherapy much of which would be better left until the later clinical years.

If a complete reorganisation of the medical curriculum is to be postponed for many years (as one could be forgiven for supposing), then the only possibility that remains (it seems to me) is for the Department of Pharmacology to shorten its course unilaterally and to hold the Final Examination in Pharmacology at an earlier time and independently of Pathology, say in December or January. This would release teaching hours which could then be utilised for our contribution to the therapeutics lecture programme. Whether such unilateral changes would be accepted by the Faculty can only be guessed at.

The question of research in clinical pharmacology is a topic which may not seem of much direct interest to students, although in the long run students do benefit by the more stimulating teaching which tends to be associated with a department strong in research. So I think that it is worth a few comments. There is no doubt that clinical pharmacology is a discipline of growing importance in medical research, and the more enlightened of the Drug Firms (there are some!) have endowed many new chairs in the subject in Britain and the U.S.A. These Firms and their Medical Directors are very well aware (unlike some clinicians) of the real nature of clinical pharmacology, that it involves investigations into the whole field of pharmacokinetics, pharmacodynamics and pharmacogenetics; that it requires cooperation between physicians, pharmacologists, biochemists, statisticians and other brands of scientist. I have met Medical Directors of Drug Firms who realise all this, would like to see clinical pharmacology established in Hong Kong and are prepared to give such developments financial support. I suspect that if they visited the Department of Medicine, they would get a very dusty answer. But this, I think, would be a mistaken reaction, for reasons already mentioned. There is another point which I did not mention. I referred in my Inaugural Lecture to the need to investigate ethnic pharmacogenetic variations in the handling of drugs in the body. The worldwide dissemination today of the increasingly potent products of the Pharmaceutical Industry makes investigation into this vitally important, but almost unexplored, field absolutely mandatory. The large, fairly homogeneous, Cantonese population in Hong Kong would make this an ideal place for such work on ethnic variations in drug metabolism, and how this would affect the therapeutic and toxic

properties of drugs in clinical use here.

So these are my present views on desirable future developments in pharmacology here. Hong Kong may be in the van of progress when it comes to excessive urbanisation, pollution, traffic jams, petrochemical complexes and inflation. In the cultural and academic areas, it shows a depressing poverty of progressive planning and vision. This all-pervading atmosphere of pusillanimous conservatism, in a city living on 'borrowed time', inevitably influences all its educational institutions. We must make every effort to ensure that it does not hamstring the healthy growth and development of our Medical School. Admittedly, to start late is better than not starting at all, and may help one to avoid some of the mistakes of the pioneers. But start we must, or our Medical School will fall sadly behind in medical progress, both in teaching and research, in the years to come.

ELIXIR CURRENT CONCEPTS FOR STUDENTS

Approach to The Problem of Hepatitis

By K. C. Lam

Ideally diagnosis of a disease should be based on the association of a distinct clinical pattern with isolation of the causal agent. In the broad group of hepatitis at the present stage of medical knowledge the causal agents have been identified in only a small proportion of cases while clinical patterns are varied and inter-blending. Therefore approach to the problem of hepatitis is much more difficult compared to better defined conditions like bacterial infections.

Clinically the diagnosis process includes 4 aspects:

1. *Recognition of the broad category of hepatitis*

This is based on clinical and laboratory evidence of hepatocellular disease. *Lassitude, malaise, anorexia, nausea, vomiting and jaundice form the main symptoms.* Significant hepatitic activity persisting for more than a few weeks may produce vascular spiders, palmar erythema, masculinization of the female or femininization of the male, fluid retention, low blood pressure, cyanosis, foeter hepaticus, and hepatic encephalopathy.

The chief laboratory abnormality is elevation of serum transaminases. To warrant a confident diagnosis of hepatitis transaminase levels of over 500 Cabaud units are required. Since biliary obstruction may produce transient hyper-transaminasaemia, lower levels are taken as supportive but not diagnostic evidence of hepatitis provided that their levels are maintained for more than two or three days. Hypoalbuminaemia is usually present in chronic hepatitis but the interpretation of a single reading of serum albumin level is difficult because recent experiments showed a very complicated mechanism of control.

2. *Definition of the clinical pattern*

Essentially this follows the progress of hepatitic activity with time. Each pattern forms a clinical syndrome and may be caused by different agents. The following trends may be recognized.

2.1 Short history, rapid downhill course to hepatic coma or death within a matter of days — the syndrome of fulminant hepatitis.

2.2 Progression of clinical features for days followed by gradual recovery in a matter of weeks — the syndrome of acute hepatitis. This is the commonest pattern encountered in clinical practice.

2.3 Acute hepatitis pattern with disease process persisting at varying levels of activity for longer than a few weeks — persistent hepatitis. In most instances this is either due to delayed resolution of acute hepatitis or represents a manner of presentation of chronic hepatitis.

2.4 Active hepatitis irrespective of onset persisting for more than a few weeks but less than 6 months — subacute hepatitis. Many hepatologists do not consider this as a distinct clinical syndrome.

2.5 Long history and prolonged course for more than 6 months — chronic hepatitis. This type may have any mode of onset and is usually associated with portal hypertension. In any stage of disease acute exacerbations may be superimposed on the background of smouldering hepatitic activity.

It is important to note that cirrhosis of the liver denotes only a late pathological state of the liver and is an incomplete diagnosis in itself.

3. *Determination of the causes*

A combination of clinical features, laboratory data, and in most instances liver histology is required. The common causes and their methods of diagnosis may be outlined as below.

3.1 *Infections.* As a group this is recognized by the presence of constitutional symptoms

and confirmed where possible by isolation of the microbe. The better documented microbes include hepatitis "viruses" (vide infra), the viruses of infectious mononucleosis, yellow fever, rebella, cytomegalic inclusion disease and herpes simplex, typhoid, and leptospira. In most of these cases hepatitis occurs as part of an overall syndrome of infection by the organisms, e.g., hepatitis occurs in a mild form in association with fever and atypical lymphoid proliferation in infectious mononucleosis. The large majority of cases of hepatitis seen in our wards, however, are caused by the "hepatitis viruses". As these viruses cannot be isolated with existing techniques the diagnosis is generally based on a typical acute hepatitis pattern, the dominance of the clinical picture by hepatitis, the onset of jaundice when fever has already begun to subside, a curious aversion to smoking, a history of exposure to known carriers or patients, and a typical histological picture. It must be emphasized that without isolation of the hepatitis virus diagnosis of this condition is always open to doubt. In fact diagnoses are frequently made in retrospect.

Differentiation between the two types of hepatites caused by "hepatitis viruses" is of prognostic importance. Help may be gained from table I.

TABLE I: Differences between short incubation-period hepatitis and long incubation-period hepatitis.

	Short incubation-period hepatitis	*Long incubation-period hepatitis*
Incubation period	short (30-38 days)	long (41-108 days)
Onset	acute	insidious
Skin rash	—	+/—
Arthralgia	—	+/—
Duration of ↑SGOT	< 21 days	35-200 days
Mortality	0.4%	12%
Au antigen	—	+ (13.7%*)

* Hongkong figure.

3.2 *Hepatotoxic substances.* Incrimination of a chemical as the cause of a particular case of hepatitis depends on a history of exposure to the agent, a compatible clinical and histological picture, subsidence of disturbances on withdrawal of the chemical, and recurrence of symptoms on re-exposure. The agents to note in our patients include antituberculosis drugs like pyrazinamide, hydrazines like iproniazid, halogenated hydrocarbons like halothane, oral contraceptives, cytotoxic drugs, antipyretics like paracetamol, and laxatives containing oxyphenisatin.

A special hepatotoxic agent which is not commonly considered a drug by patients is alcohol. Caroli discovered that hepatotoxicity is not caused by an intake of less than 80 grams of alcohol per day and those people taking more than 160 grams every day are at high risk of suffering hepatic damage. Alcoholic liver disease presenting as a hepatitis has been described over a decade ago but is still not widely known. The accepted ultimate criterion of diagnosis is histological.

Recently Wilson's disease has been reported to present as a chronic hepatitis, and it may be classified under this category with the assumption that copper deposition is the cause of liver damage in these cases.

3.3 *Unknown causes.* These account for the large majority of our patients who present late in their disease course with posthepatitic cirrhosis. Diagnosis is by elimination of the known causes of hepatitis.

A special category under this heading is active chronic hepatitis. Numerous names — including chronic aggressive hepatitis, lupoid hepatitis, autoimmune hepatitis — are used by different centres but they probably all refer to the same category of patients. This group may be recognized by such extra-hepatic manifestations as arthritis, skin rash, Cushingnoid appearance, carditis, pneumonitis, serositis, hyperglobulinaemia and "auto-immune" phenomena on serological testing. The most important diagnostic feature comes from histology. It is noteworthy that among Caucasians this disease is most common among young females but apparently in this locality males of middle age are more commonly affected.

4. *Assessment of disease activity and prognosis*

In general hepatitic activity is gauged by the degree of elevation of transaminase levels. The two exceptions are (a) fulminant hepatitis where the lack of cellular output of transaminase prevents its serum level from going very high, and here the best assessment is derived from determination of the prothrombin time, (b) very low-grade chronic hepatitis where transaminase levels fall within normal limits, and in this situation assessment of hepatitic activity by determining the transport-maximum in a double bromsulphthalein infusion study has recently been suggested.

Prognostically liver histology provides the best adjunct to a sound knowledge of the natural history of individual hepatitis. The degree of structural damage at the time of biopsy indicates both the risk of cirrhosis after recovery and the amount of recovery expected when the primary injuring agent is removed. Of special significance is destruction of periportal areas of hepatic lobules. This is called by some as *"piece-meal necrosis"* and named by others in a more specific form as *"bridging necrosis"*. Both features, irrespective of the amount of damage already present at the time of biopsy signifies relentless progression to cirrhosis and carry a high mortality rate. It also indicate that corticosteroids may be helpful in those patients. In the absence of this change, however, and in the absence of collapse of reticulin framawork of the hepatic lobules, the prognosis is excellent.

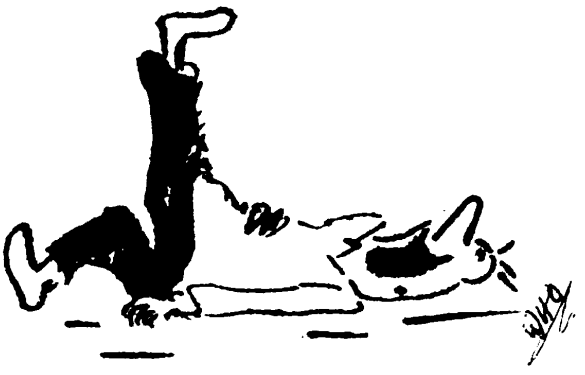
Considerable confusion has arisen over the relation among viral hepatitis, active chronic hepatitis, cirrhosis and carcinoma of liver. Historically, viral hepatitis was first named as a definite cause of cirrhosis in 1958 after a serial histological study on a handful of patients. There has never been doubt that postnecrotic cirrhosis of liver predisposes to development of carcinoma of liver. In 1967 and 1968 active chronic hepatitis was defined as a separate group distinct from typical viral hepatitis and the patients affected were traced subsequently to development of cirrhosis. Another study traced viral hepatitis patients to complete recovery in all cases. Doubt then arose over whether the viral hepatitis patients described in 1958 actually had viral hepatitis or active chronic hepatitis. In the last few years the finding of a higher incidence of *Au* antigenaemia in all conditions named at the beginning of this paragraph as compared to a control population spurned the suggestion that these clinical syndromes might represent different manifestations of the same disease, and one investigator went so far as to suggest a familial predisposition to carcinoma of liver because of familial clustering of *Au* antigenaemia. The main causes of difficulty are the lack of a pathognomonic test for viral hepatitis and the assumption of *Au* antigenaemia being synonymous with long incubation-period hepatitis. A large number of later publications with conflicting incidences of *Au* antigenaemia in these conditions, different methods of interpretation of results and different approaches to the classification of hepatitis leave the field totally chaotic.

Until the causal agents of viral hepatitis, active chronic hepatitis, carcinoma and posthepatitic cirrhosis have been identified, this problem with hepatitis remains unsolved. It may be simplified if one approaches a case according to the four steps suggested above. This approach is also relevant to institution of therapy.

* * *

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

Laughter, the Best Medicine®



A young and handsome houseman was posted to a certain hospital where the nurses were well-known for their mischevious deeds. One day, four nurses planned to play some jokes on the houseman. A few days later these four nurses gathered together to discuss the jokes that each of them had played on the poor houseman.

Nurse A: "I purposely misplaced the patients' case-reports under his care."

Nurse B: "I added some salt to his coffee."

Nurse C: "I saw a packet of contraceptives in his drawer and I put a pin through them."

Nurse D: Fainted.

A well-known Professor was travelling around the world with his chauffeur. Every university or country he visited, he was paid to deliver his series of famous lectures. One night, while they were travelling alone in the car, the chauffeur told his master saying, "Sir, you have a very easy living. You are well-paid for those simple lectures of yours."

Master: "If you think that it is so easy to deliver those lectures, well, how about you delivering them for me."

Chauffeur: "I would like to have a go, Sir."

So, during the following delivery of lectures, the chauffeur took the Professor's prepared lectures and did a very good job of it. When it was time for the questioning period, the chauffeur told his audience, saying, "The questions which you are going to ask are too simple and easy to answer. So I would like to call upon my 'chauffeur' to provide you the answers to your question".

On Second Thought

Medical Students' Notice Board.

'Would the student who insulted me by offering $700.00 for my $1500.00 Germany-made microscopic contact me please.

..... CHANGE MY MIND — WILL ACCEPT'

How Deep ... Do you want .....?

One fine afternoon two students were heard talking.....

Student A: "Why do you always keep on talking about getting a beautiful girl and then settling down after graduation? You know dawn well that beauty is only skin-deep."

Student B: "I'm tired of all this business and nonsense about beauty being only skin-deep. That's deep enough. What do you want — an adorable pancreas or kidney?"

History repeats itself

Schoolgirl, reading report card, to friend: "History does have a habit of repeating itself. I've failed again."

A shipping tycoon, having difficulty in sleeping, visited his doctor. The doctor prescribed several different sedatives, but none did any good.

Then one day, the tycoon visited the doctor again and told him, "My wife had some women in last night and they were talking about twilight sleep. Do you think that would help me?"

"No," said the doctor. "Twilight sleep is only for LABOUR."

The typcoon was very angry and banged his fist on the table, "That's the trouble with this colony," he exploded. "Never have anything for the MANAGEMENT."

Same Ordeal

The Surgeon who performed surgery on the patient asked him two days later, "It wasn't so bad, was it?"

The patient assured him that it was okay and he sighed with relief, saying, "Good, I'm having the same operation next month."

Italian Goolash

Once there was an Italian couple who owned a Fish & Chips shop. They had been married for a number of years and their marriage was full of intimate warmth and happiness except for one flaw — no child. So one day, the wife went to see a G & O specialist. After examining her, the specialist said, "There are a

lot of *fissures* in your womb. If you can give birth to a child, it will be a *miracle*."

When the wife went home and the husband asked her, "Darling, what says the specialist this morning?"

The wife replied, "Well, I have a lot of *fishes* in my womb and if I ever have a baby, it is likely to be a *mackeral*."

Logical Confusion

During a heavy monsoon rain, a doctor's basement drain was clogged and the basement was flooded. The doctor put on his boots and was starting down the stairs to open the drain when he realised that the water was too deep for the boots. The wife piped in with a startling solution to the problem.

"Let me put the boots on," she said, "I'm shorter than you are, so the boots come up higher on me."

Jackpot?

"For a thousand dollars," asked the jolly quiz-master," who was the first man?"

"Adam!" gushed the lovely young contestant.

"Correct! And for two thousand dollars, who was the first woman?"

"Eve!" burbled the girl.

"Correct again! And for four thousand dollars, what was the first thing that Eve said to Adam?"

"Gee, that's hard," said the girl, frowning.

"Jackpot!" shouted the quiz-master.

A chap generally considered to be a confirmed swinger visited his doctor to complain of impotence.

"You, of all people!" said the astonished medical man. "Why, you have a reputation as long as my arm."

"But what good is a reputation" asked his patient plaintively, "if it won't stand up?"

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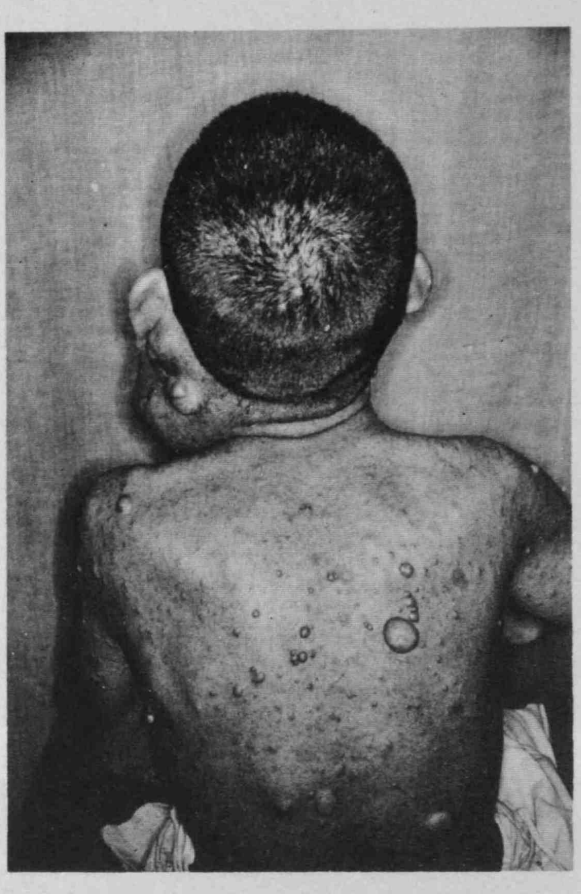
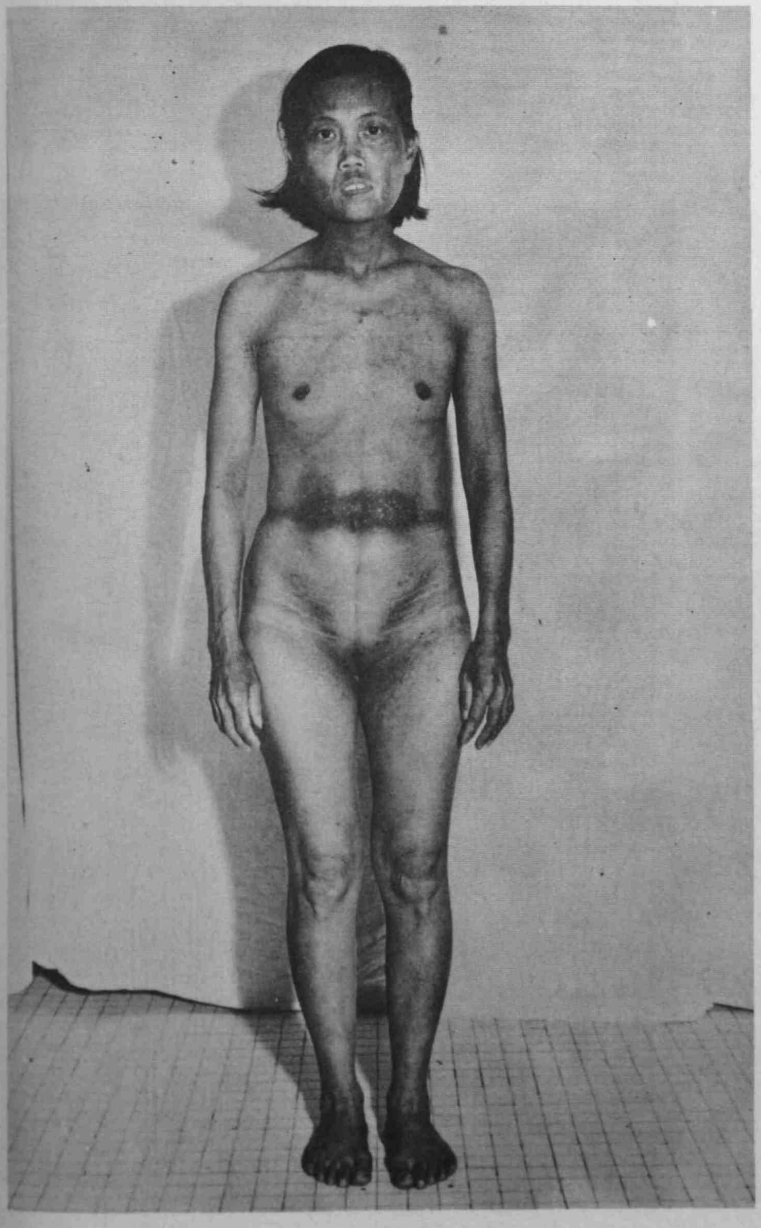
(Answers on p 67)

A





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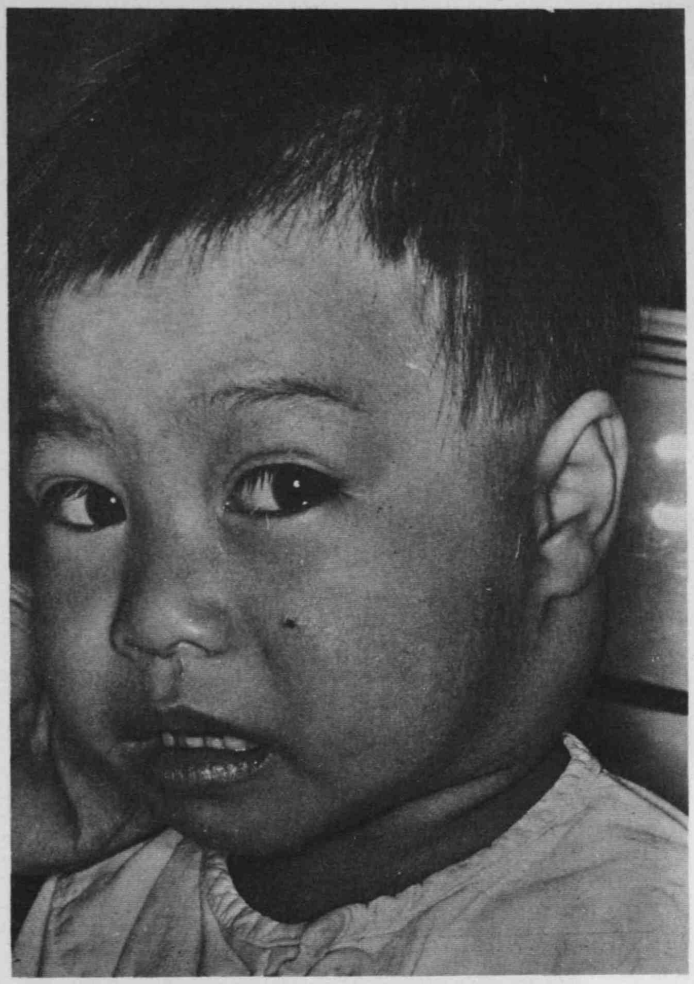

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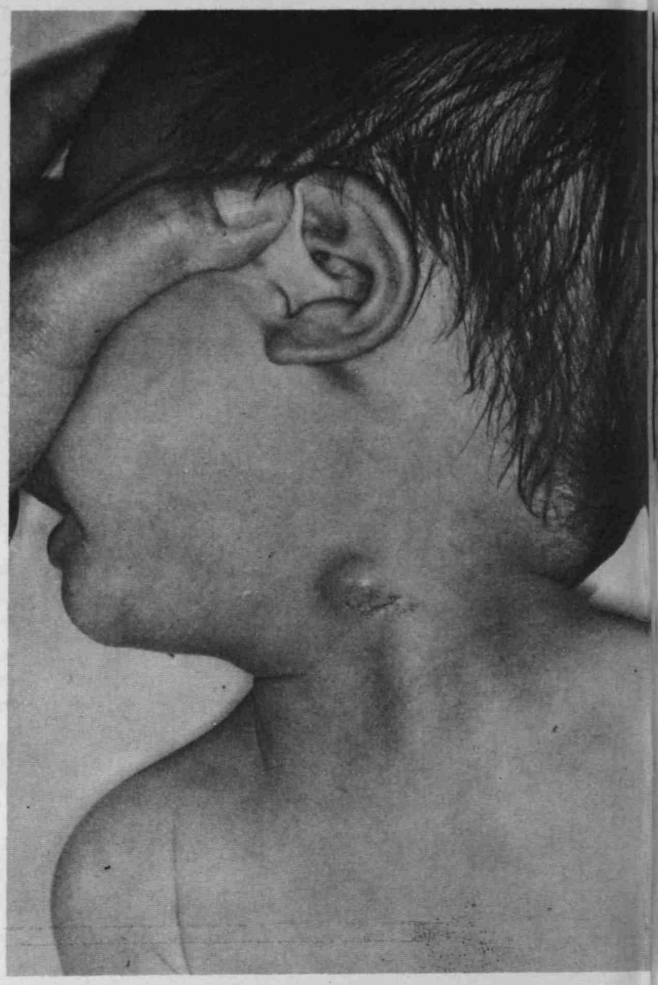

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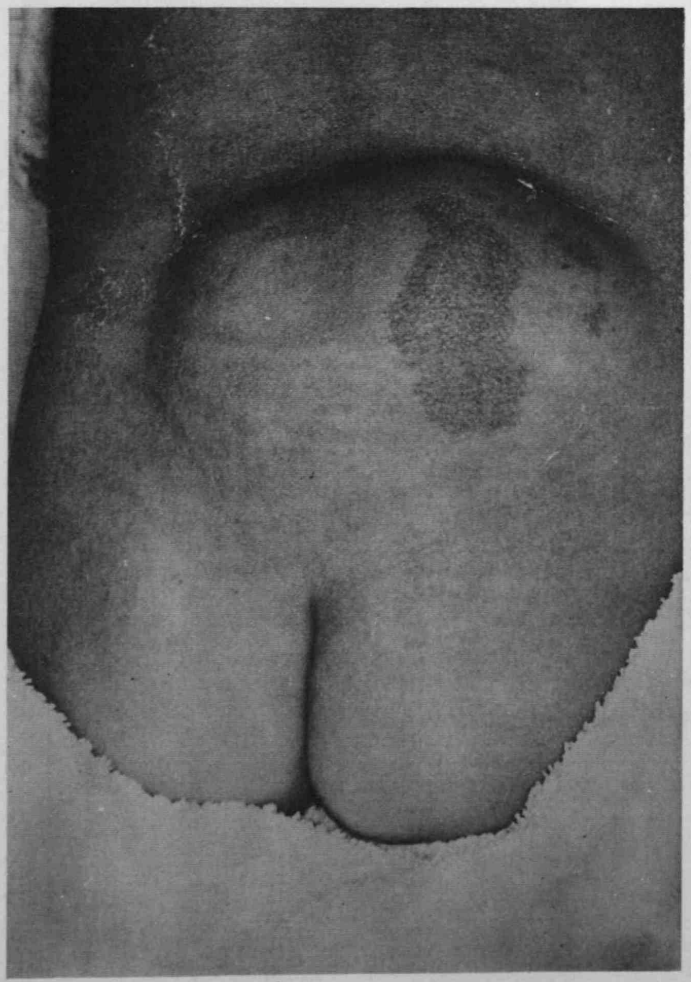

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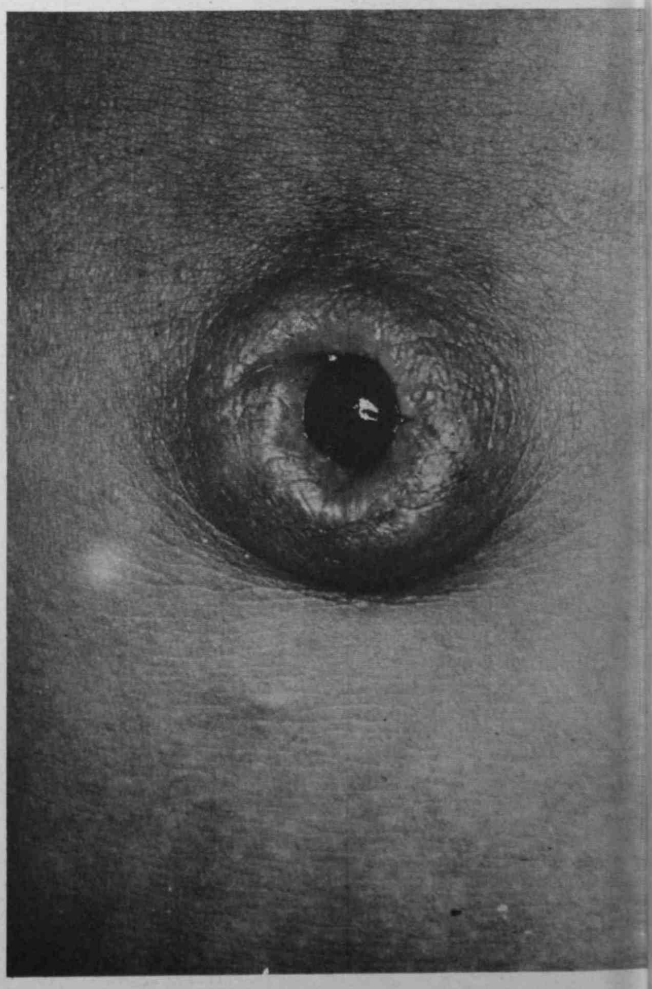

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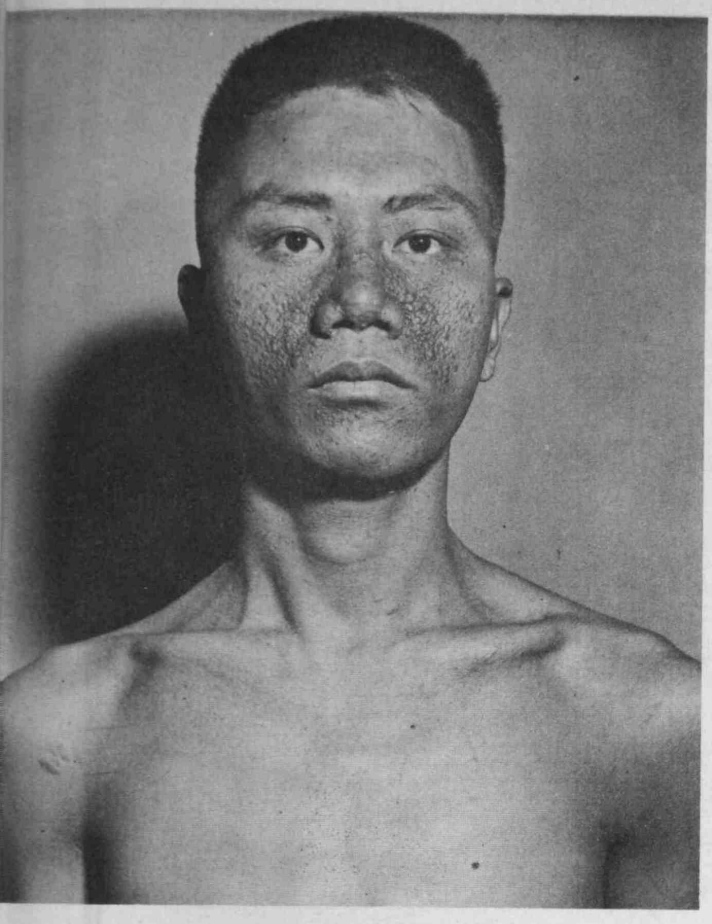

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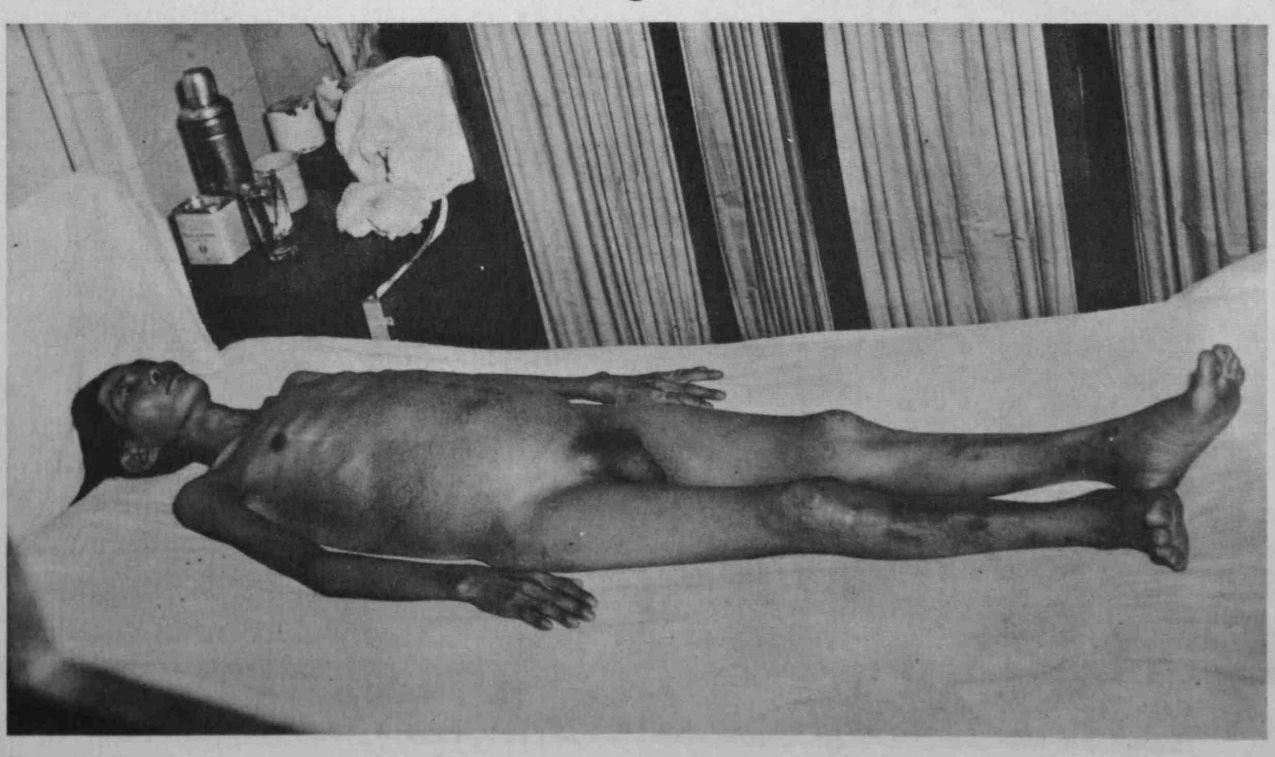

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AUTOPSY OF 2,100-YEAR-OLD FEMALE CORPSE PROVIDES ABUNDANT SCIENTIFIC DATA

Chinese scientists recently carried out an autopsy of a 2,100-year-old female corpse and found that its internal organs were fairly well preserved and its main diseases could be identified. The corpse was unearthed in April 1972 from Mawangtui Tomb No. 1 of the Han Dynasty (206 B.C.—220 A.D.) in Changsha, Hunan Province.

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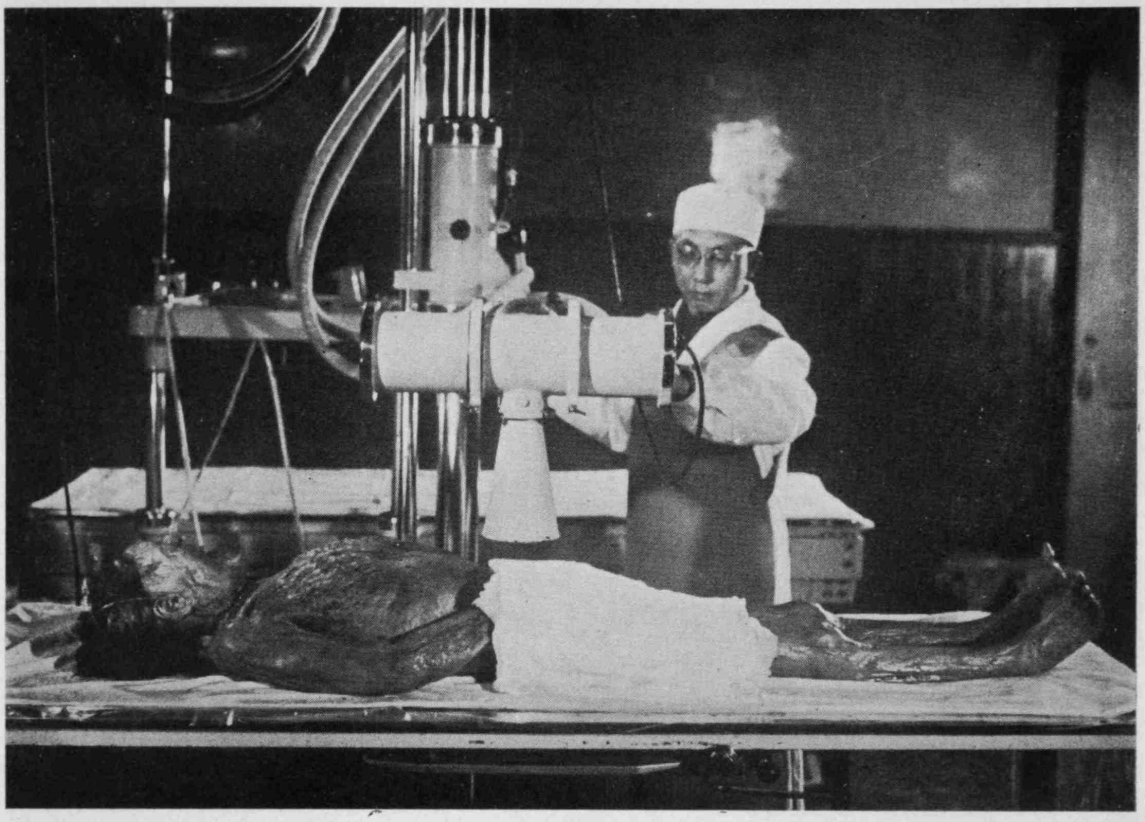
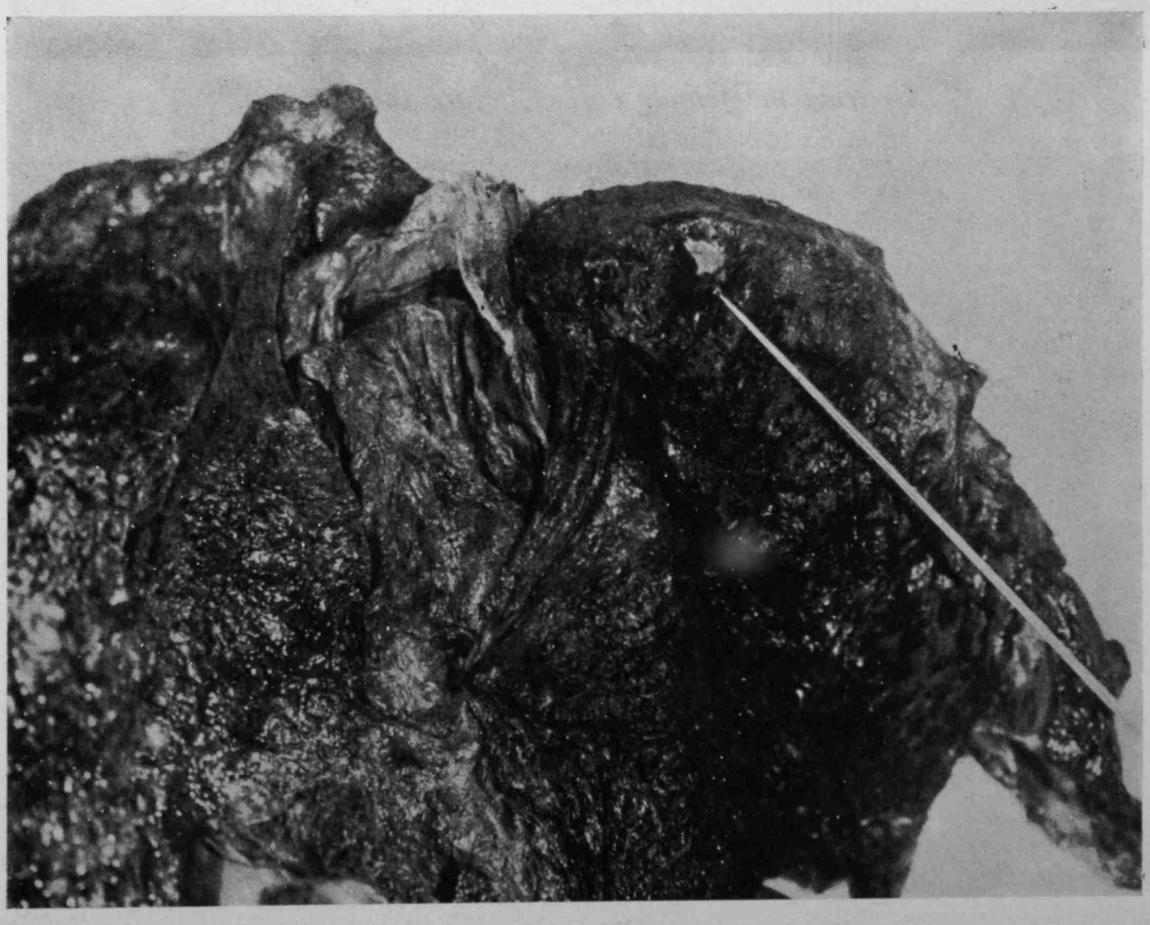
The corpse still maintains its original external appearance after the autopsy. Both the corpse and the specimens of the internal organs have been treated with preservatives and kept properly.



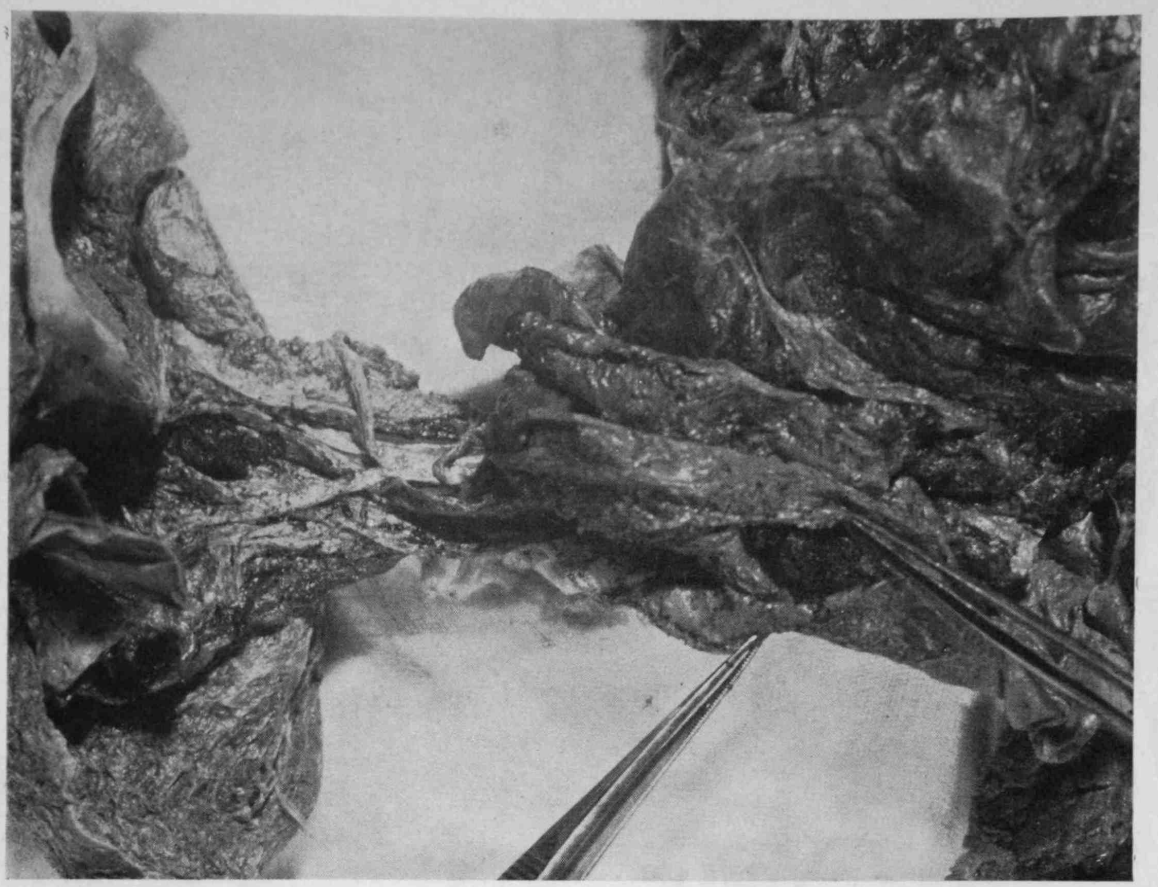
X-raying the female corpse before the autopsy.

The abdomen of the female corpse is cut open to disclose its internal organs.

The brain is visible after the dura mater is cut open.

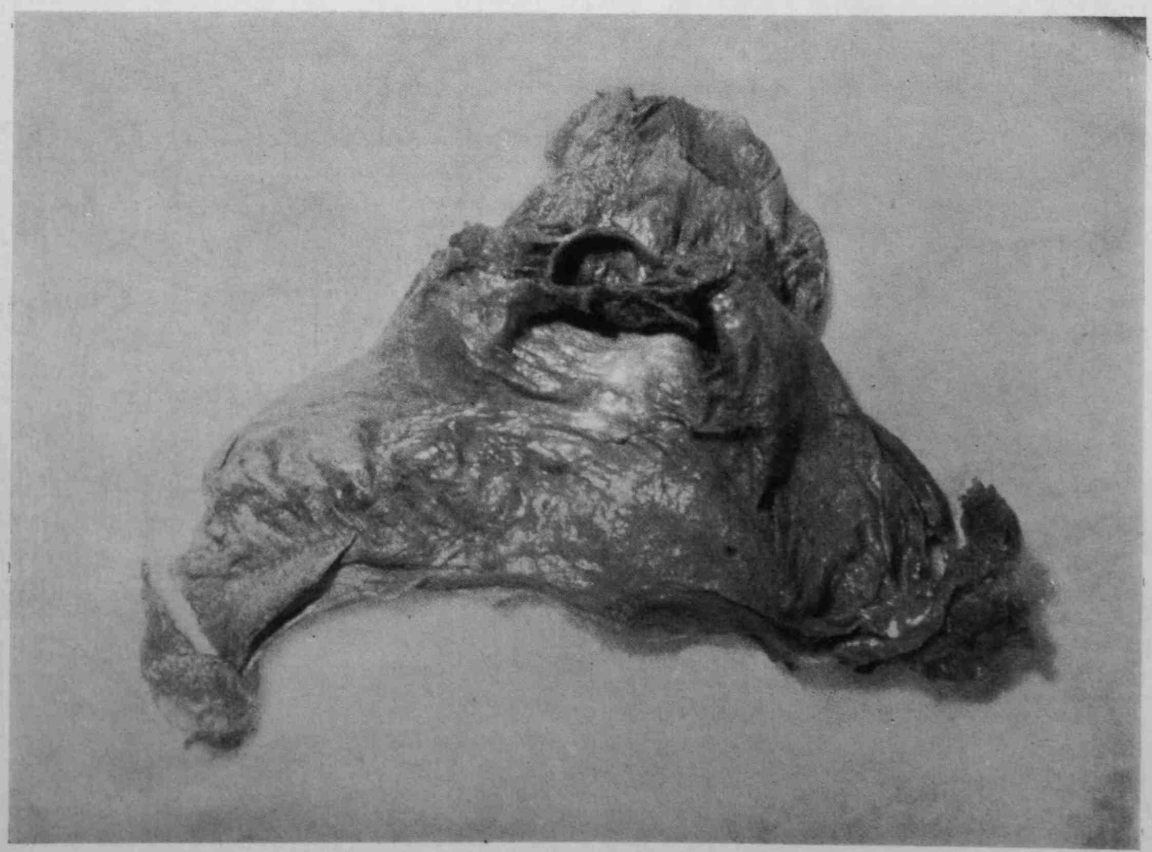


The pointer indicates a calcified foci of tuberculosis in the left lung of the female corpse.



A bile stone about the size of a broad bean is lodged inside the common bile duct.

The internal organs from the chest and abdomen of the female corpse.



Uterus, oviducts and ovaries of the female corpse.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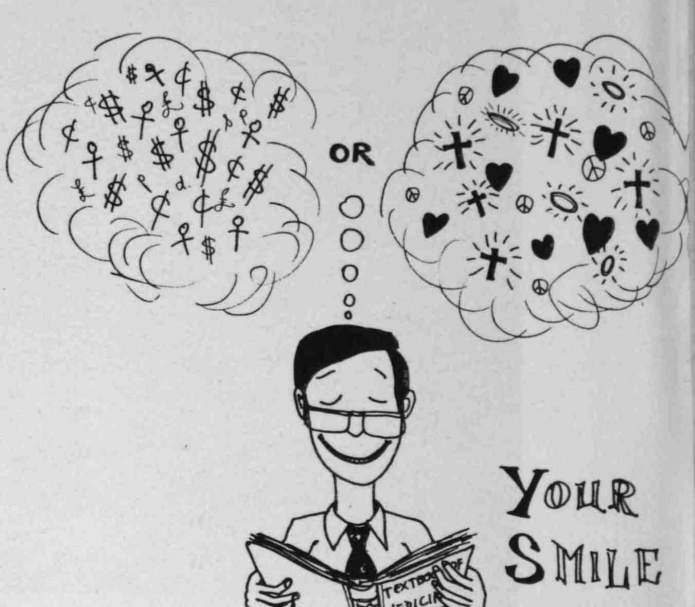
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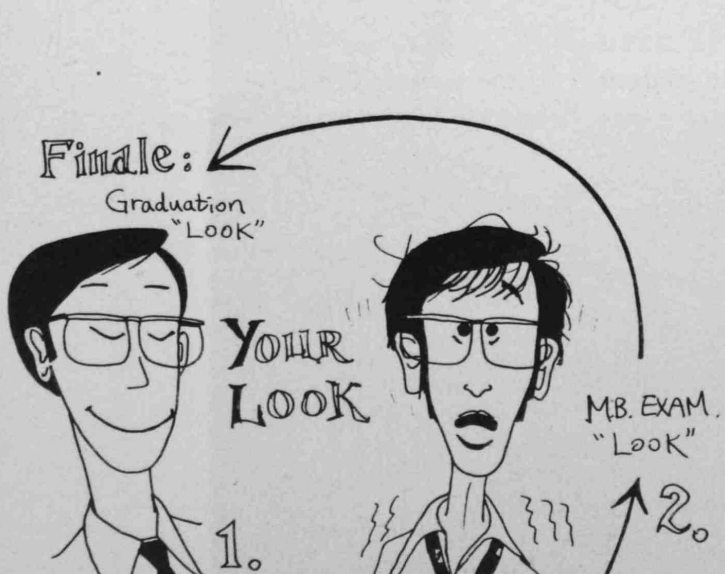
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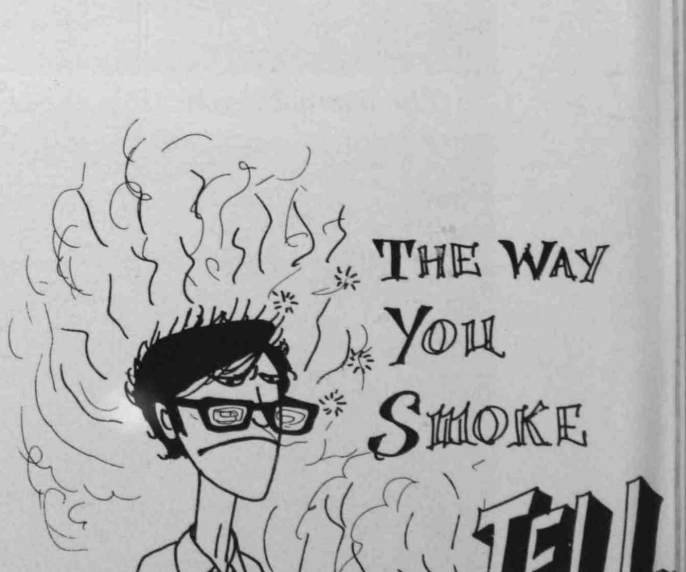
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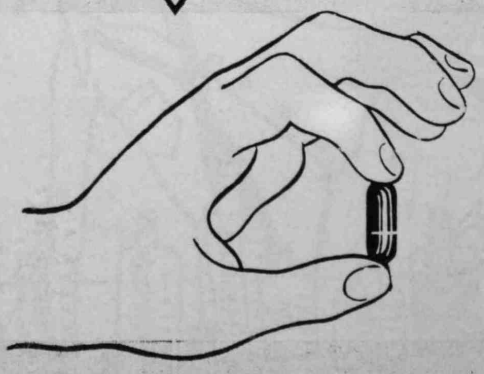

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IS A SECOND MEDICAL SCHOOL NEEDED IN HONGKONG?

Speech given by Dr. L. K. Ding
on the 17th of Dec. to the Rotary Club, Island West.

Shortage of doctors in Hongkong has been a topic for public discussion off and on during the past several years. In order to meet this shortage one of the solutions proposed is the establishment of a second medical school, perhaps in the Chinese University. Proponents of this idea advanced the argument that since there is a shortage of doctors the obvious solution is to train more doctors to meet the shortage and in order to train more doctors it will then be necessary to establish a second medical school. It has also been contended that there should be a medical school for every one million population in order to meet the increasing demand for more sophisticated medical services. However before examining the pros and cons of the proposed solution let us first of all examine the premise which is: Is there a shortage of doctors in Hongkong at present or will there be a shortage in the foreseeable future?

Proponents for a second medical school use the doctor to population ratio to support their contention that there is a shortage of doctors in Hongkong. They pointed out that the doctor population ratio in New York City is 1:450; in London 1:700; in Tokyo 1:800; in Taipei 1:900; in Seoul 1:1950 and in Hongkong 1:2200. The question is then: Is this comparison relevant? The 1:2200 doctor to population ratio for Hongkong has been arrived at by dividing the total number of *registered* doctors into the total population in Hongkong. At present the total number of such registered doctors is 2160. Taking the round figure of 2000 after making provision for some who have migrated to other countries but still retained their names in the local registry the ratio will be then approximately 1:2000. It is my contention that this comparison with other cosmopolitan cities mentioned above is not relevant for the following reasons:—

1. In Hongkong, besides the *registered* doctors there is a large group of so-called non-registrable but permitted doctors (like the permitted teachers in the educational profession) who obtained their medical training in the mainland of China and a few from countries such as Germany and France. In 1964 over 400 of these doctors, after being screened by a panel of specialists and given an oral examination, were permitted to practice medicine in as many registered clinics spread throughout the length and breadth of the colony. Those who did not pass this examination either changed their occupation or set up practice under the guise of herbalists. Not a few, I suspect, practice the so-called "black-market" medicine.

2. In another very important aspect the city of Hongkong is quite different from other cosmopolitan cities and that is the reliance on and confidence in traditional Chinese medicine on the part of a large segment of the Chinese population. In 1969 the Chinese Medical Association, in cooperation with the Census and Statistics Department of the H.K. Government, made a survey to determine the number of people engaged in the practice of traditional Chinese medicine. The results obtained are both of great interest and informative. These showed that there were then 3251 herbalists of various kinds, 1008 bone setters

and 247 acupuncturists. All these people are engaged in the practice of medicine and are delivering medical care to the people. Thus in arriving at the doctor to population ratio can this group of practitioners be completely ignored?

It is very well-known that all these forms of traditional Chinese medicine are popular with a large segment of the population. The common pattern is for a sick person to consult a herbalist after he has failed to recover with a few doses of self administered herb tea which he can pick up from the herb shop. If he still does not recover after a few visits to the herbalist who has prescribed more doses of herb medicine he will then consult the "western" medical doctor. The reverse is often true i.e. he will switch back to the herbalist after having failed to recover in the hands of the "western" doctor — a sort of ping-pong match. It is also a well accepted fact that in Hongkong the majority of Chinese people with sprains and fractures will consult the bone setters in preference to scientifically trained orthopedic specialists. This is also true with the large group of highly educated Chinese who, otherwise, are westernised in both education and outlook. Recently the head of a well-known English school (a Westerner) sustained a sprain of the ankle. After several weeks of treatment by the Western method and feeling no better she was urged unanimously by the many Chinese teachers in her school to seek help from a bone setter. When I met her, she was on her way to a bone setter. Choice of the different brands of medicine is not dependent on cost as both herbal medicine and bone setter's fees are by no means cheap. On the contrary the high cost of herbs has compelled a certain number of the sick to seek the more economical western medicine, who would otherwise use traditional Chinese medicine. With few exceptions patients suffering from stroke will consult the acupuncturists sometime during the course of their illness. With news of the use of acupuncture in place of the usual anethetics being practised in the mainland of China, it will not be hard to imagine that this form of treatment will become even more popular in the future.

The conclusion one is forced to draw from these facts is that the day will not likely come when the Chinese population in Hongkong will become solely dependant on scientific medicine. This situation is certainly quite different from that in London or New York city.

3. Another point one must not forget the reason why in the large cities mentioned above has a high concentration of doctors is partly due to the large number of medical doctors engaged in the many research and teaching institutions. These doctors are not actually involved in the delivery of medical care to the people. In fact the goal of the National Health Service in United Kingdom is to provide one doctor for every 2500 people. If we were to take this figure as our goal the present ratio of 1:2000 looks very favourable indeed. Remember that we have not taken the permitted doctors and the traditional Chinese medical practitioners into consideration.

The question of doctor shortage in Hongkong is therefore more apparent than real. It is really a problem of unequal distribution of doctors between the private sector and the government medical services. Approximately one third of the 2160 registered doctors work for the government and two thirds are in private practice. The public is naturally more sensitive to the shortage in the public sector. This unequal distribution is a problem in all countries of the world for doctors tend to concentrate in large and economically more wealthy cities. Thus in USA where the national average is 1:850 doctor to population ratio, there are many areas where there is one doctor for more than 10,000 people.

In Hongkong the private sector is now oversaturated with doctors. A few years

ago the Chinese Medical Association made a survey of its members to see how many would participate as part-time doctors in government medical clinics. More than 200 responded. The total number of hours they could contribute was equivalent to 50 full time doctors. According to recent information from the Medical and Health Department there are 59 vacancies in government medical services. Of these 20 will be filled by medical officers who are now abroad for additional training. Thus considering there are only 39 actual vacancies out of a total of over 700 medical officers in government service the situation certainly does not call for the setting up of a second medical school. Furthermore these present vacancies can be filled if and when the part-time doctor scheme can be implemented.

What about the future? By future I mean the coming 20-30 years for nobody can plan beyond that date. Certainly the proposal for a second medical school is mainly aimed at producing more doctors to meet future demands of the increasing population. According to a recent statement by the chairman of the Hongkong Family Planning Association the population of Hongkong in 1981 will be in the region of 5.3 million compared with the present 4.1 million representing an increase of 1.2 million. As far as the production of new doctors in Hongkong is concerned we know that by 1974 the H.K. University Medical School will have 150 students in the graduating class, as the enrollment of freshman students into the medical faculty has been steadily increasing in the past several years. Even allowing for "brain drain" it is quite evident H.K. will gain more than 2000 doctors in the next 20 years to meet the demand for more doctors by population growth. By that time the overall doctor to population ratio will be well below 1:2000. In fact there has already been a gradual increase of doctors in the past 5 years averaging 100 per year as revealed by the following statistics:

Year	*No. of Registered Doctors*
1966	1507
1967	1584
1968	1730
1969	1892
1970	1975
1971	2160

It has been further suggested that in the future, with the general elevation of the standard of living and education, demands for more sophisticated forms of medical services will increase. Here I think we can learn a great deal from what is happening in the most affluent country in the world i.e. USA. There the average doctor to population ratio is 1:850. There are now 108 medical schools (not one medical school for every million population) with an annual enrollment of 12,000 first year students. In that country leaders of medicine, realising that it will be well nigh impossible to provide the number of doctors to cope with the demand, are now making various innovations. Since a large portion of the patients' complaints are of a minor nature that do not demand the personal attention of trained doctors, many centers in the USA are making increasing use of trained assistants such as pediatric, medical and surgical. In this way the expertise of the doctors can be directed to those cases that are really in need of their attention. Another way to meet the situation is to shorten the length of medical training. Another program that is receiving increasing attention is the Health Maintenance Program, where emphasis is placed on health rather than on illness, keeping people healthy so that the demand for medical attention will be less necessary. All these merit our careful attention and study.

I have said earlier that I do not see the time will ever come when the Chinese people in Hongkong will rely solely on scientific medicine. Based on this fact I think what Hongkong needs now is a *College of Chinese*

Medicine, the establishment of which will offer many advantages. It can be a research center for many Chinese herbs that have curative value. It can be a center where comparisons of scientific and traditional medicine can be made. For example, we have recently learned about the result of treatment of fractures based on traditional Chinese method alone and Western method alone compared with a combination of both of these methods. Results showed the combination of both methods is superior to either method used alone. The college can also make a study on the use of acupuncture in place of anesthetics which is being practised in the mainland of China. At present, being unsure or even skeptical of the claims, no one in Hongkong will be brave enough to use it. Practice of traditional Chinese medicine can be more standardised so that the public can be protected from the quacks and chalartans. With increasing interest in Chinese medicine on the part of practitioners in the Western countries, this college can serve as a center for demonstration and observation. Hopefully this will serve as another bridge to close the gap between East and West.

TRAINING ON FORENSIC PATHOLOGY

Graeme Roberts M.B. Ch.B.(N.Z.) D.M.J. M.R.C.Path.

Senior Forensic Pathologist.

The concept of someone being a forensic pathologist conjures up visions of an autopsy room in the minds of many. Unfortunately, in many respects this is true, and may define the sole interest of any particular medico-legal pathologist. And the reason is simple to see, for the forensic pathologist may only be investigating cases of sudden unexpected death from a department which may well be divorced in geographical terms from his clinical and anatomic pathology colleagues. This represents a dichotomy of common interest, which I believe is not in the interest of the forensic pathologist or the public he serves.

It is only in recent years that in England the value and worth of competently trained forensic pathologists has been recognised by the professorial appointment of eminent medico-legal pathologists. This late recognition of exceptionally competent men reflects in many ways the "poor brother" relationship that the forensic pathologist has long had with his other colleagues in pathology. But let us not be too hard on the forensic pathologist, for after all, the pathologist (speaking in general terms) has only in recent memory become what one might call a "respectable" doctor. This respectability has been created by the efforts of many men, such as Arthur Purdy Stout in America, who became dissatisfied with the efforts of surgical pathologists and left the ranks of surgeons to become a dynamic surgical pathologist himself. This brought honour not only to him, but created an awareness amongst clinicians of an expertise they had not previously had, and with it the realisation that a highly trained pathologist could contribute immeasurably to the clinical care of patients. A similar role to that of Stout was played by Rupert Willis in the British Commonwealth. These were two men who through diligent application defined clearly the exceptionally valuable role competent histopathologists can play.

With the advent of technological knowledge, clinical pathology in many respects is barely recognisable as the subject taught in medical schools only a couple of decades ago. There has been a vast recent proliferation of clinical scientific knowledge, and with it the days of the clinician — pathologist have obviously passed. Clinicians now expect a very clear definition of a patient's particular problems in so far as the pathology laboratory can offer. And so there came into being a concept of acceptable educational standards in pathology, and with it, in the British Commonwealth, the Royal College of Pathologists and the Royal College of Pathologists of Australia became examining bodies with the authority to define acceptable standards of education in pathology. And similarly, Board Certification defined similar standards in America.

How did all this affect the forensic pathologist? Often it didn't as he may well in many circumstances have become a medico-legal expert (with varying expertise) on the basis of an accumulated autopsy experience, and may well have not had the advantage of a wide ranging experience and training in general and specialised clinical and anatomic pathology which after all is his bread and butter. There is no doublt whatever in my mind that the acquisition of medico-legal expertise is based on long and arduous training. And rightly this should be so, if the forensic pathologist is to be highly regarded in the eyes of his pathologist colleagues.

The question of what is appropriate for a sound education in Forensic Medicine arises. This is particularly important, as pathology (as we know it now) being what one might call a "relatively young" subject, the forensic patholigst has in even later years in many cases arrived on the scene through various routes of training, and which I feel has not always been well guided and positive education in forensic medicine. And naturally, in day to day work, this simply must

provide considerable problems to those who have been inadequately trained. I am firmly of the belief that a more precise international definition of acceptable medico-legal education can do nothing but enhance the status of the forensic pathologist in the eyes of his colleagues.

It has been well expressed that the law and medicine have long been uneasy partners, and which probably reflects the unease lawyers and doctors have in considering problems related to the other profession. However, it is true to say that both medicine and law can offer a tremendous amount to each other. It is in this offering that the *well-trained* medico-legal pathologist should be in a position to play a pivotal role, and which has been admirably broached by Keith Simpson in his "Doctors' Guide to Court," and which can be read with great profit by barristers and doctors as a book containing a wealth of information of essential and practical importance. The obligation and application of medicine and science to the needs of the law, and their application to the needs of law enforcement are equally important.

A corollary of all this is that a competently trained forensic pathologist can reasonably, on the basis of accumulated expertise, be considered a medico-legal expert. In this context, it is easy to see that as well as being prepared to give opinions in pathology which affect his specialty, he must also base his responses on a broad clinical experience. Then, his opinion will be respected as it must be, having been based on a wide experience which in my opinion should be international. Acquisition of such experience is not easy. It involves time, of which people seem to have so little. None-the-less, it is essential if the forensic pathologist wishes to enter the ranks of the highly trained expert.

Supposing you have accepted the concept of a wide ranging education in forensic pathology to be able to be an effective expert, then one should consider the means of attainment of such an end. The granting of graduate degrees in medicine presupposes a basic knowledge and discipline, and subsequent to which, the laws of most countries require a variable period of post-graduation clinical experience before registration. A minimum experience is not enough. It must be broadly based on medicine, surgery, obstetrics and gynaecology, orthopaedics, paediatrics and the other specialties that the busy houseman will find his lot. Perhaps two years in a busy multispecialty hospital will provide this experience. As an adjunct to this, the post-registration houseman will find his clinical training and his interpersonal attitudes well tested in a year or so of general practice, by which time he has a solid basis to begin his training in pathology. Perhaps too long a post-registration experience some might say, and those who object no doubt have cogent argument, but one thing which is certain, is that a pathologist who has had such training will have a sufficient clinical basis on which to interpret pathological fact. Unfortunately, it is at this point, or often much sooner that the embryo forensic pathologist may enter the world of mayhem without any training whatever in pathology and begin a long slow process of self education in the general principles of pathology, but at the same time feeling qualified to give an opinion on sudden death, whether natural or unnatural. Of course this is undersirable, and can do nothing to enhance his professional stature. And it surprises me that courts will hear such inexpert evidence. So, much better to become a registrar in pathology, or in America to enter a residency programme, and painlessly be well versed in the fundamentals of clinical and anatomic pathology on which the forensic pathologists working life is based. For unless he does, he can *not* with any justification call himself a pathologist, let alone a forensic pathologist.

The Royal Colleges of Pathology in their rules and regulations clearly define required training before sitting final examinations (and which embraces a period of five years), and a choice is open to the potential forensic pathologist as both Colleges offer a final examination in forensic medicine. But even here, I suspect those pathologists who have been finally examined in morbid anatomy and histopathology feel they have a distinct advantage over their hapless colleague who has done his in forensic pathology. I agree with this point of view, because acquisition of a membership in morbid anatomy at once

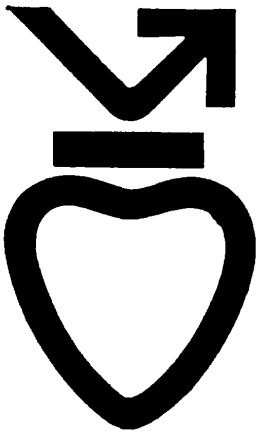
defines competence in a subject which is equally the ambit of the forensic pathologist. And besides, for a medico-legal pathologist to look as though he grew up with a microscope does much for his ego, as well as raise his colleagues' eyebrows. Well, from where is the forensic pathologists forensic experience going to come. Quite simply, on the basis of an apprenticeship to a master, such as Simpson and Teare in England, Gormsen in Denmark, and Helpern in New York to name a few, but *only* on the basis of an adequate prior training in pathology. Of interest, is that Board Certification in Forensic Medicine in the United Statec requires prior Board Certification in Anatomic Pathology. In England, an examination in Forensic Medicine for the Diploma of Medical Jurisprudence is offered by the Society of Apothecaries of London. Preparation for this may be undertaken at the same time as that for the Membership, at the same time taking advantage of the many courses offered in London and to include those in serology, haematology, biochemistry, microbiology and histopathology, for the forensic pathologist must have a disciplined knowledge of all these.

An American experience is well in order for some residency training in forensic medicine. For example, the Medical College of Virginia, in Virginia Commonwealth University, offers a Fellowship in Legal Medicine, and which incidentally, will give a rapid experience in the devastating effects of the American hand-gun. Anyway, such overseas experience will contribute to the international experience I feel is necessary for any young doctor in training today.

It requires no training in pathology at all to say that death has been caused by a .38 bullet or a knife, but, it requires *considerable* training to define the cause of death in the most difficult of all cases — the unusual natural death. A description of morbid anatomical appearances is not sufficient, it must be complemented by adequately prepared and interpreted histological sections. In my opinion, it is only then that forensic pathologists will be generally recognised as being specifically trained experts in pathology. At least, the days of the forensic pathologist who views a body, and somehow magically gives a cause of death without the benefit of an autopsy will be numbered. And this must be so, if forensic medicine is to advance with any basis of science at all in the years to come.

The point I am making is that a forensic pathologist must be a highly trained specialist in morbid anatomy and histopathology first, and on the basis of which he can build his experience in forensic medicine and which will ultimately lead him to expertise. To train any other way I well remember a teacher once saying is rather like learning ballet before one can walk. Hopefully, by now I have made my plea for appropriate training quite clear, and have not dissuaded those of you who might have had visions of training in forensic pathology as being straight-forward.

The views in this paper are those of the author, and do not necessarily represent the views of the Medical and Health Department of the Hong Kong Government.



Eraldin

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provides long-term protection against coronary insufficiency

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University of Birmingham, Department of Psychiatry

THE IMPORTANCE OF PLACEBO IN PSYCHIATRIC TREATMENT — A PSYCHOLOGICAL ANALYSIS

F. L. Leung,

Assistant clinical psychologist,
Department of Psychiatry,
Queen Elizabeth Hospital,
Birmingham University,
Birmingham,
England.

It is true that we like to think our treatments are rational . . . . ., this is a conviction which we probably share with practitioners of magic. Our claim can only be justified if, at the same time as using empirical remedies, we take the trouble to submit them to rigorous, critical evaluation.

Carstairs, 1965.

The many varieties of psychotherapy and physical treatment now employed are being required to show their credentials, and reliance upon unchecked clinical experience for their appraisal is surely a dying illusion.

Sir Aubrey Lewis, 1963.

Speaking from personal experience, one interesting thing about being a Chinese in the west these days, is often being asked by western friends: 'Is acupuncture only a placebo therapy?' Sometimes, I really feel that I know too little Chinese medicine to answer such a question. However, it surprises me when I learn from my western colleagues how little they know about the placebo effect of many current psychiatric treatments in their day-to-day practice.

The placebo response is not just unique to medical research and practice. It takes the form of 'Rosenthal effect' in experimental psychology and the famous 'Hawthorne effect' in industrial psychology. Most definitions of placebo are confined to its pharmacological usage, e.g. Dorland's Medical Dictionary (1965) defines placebo as 'an inactive substance or preparation, formerly given to please or gratify a patient, now also used in controlled studies to examine the efficacy of medicinal substances'. Shapiro (1971) tries to expand the definition further to include procedures other than the conventional dummy tablet. 'A placebo' in his terms 'is defined as any therapy, or that component of any therapy, that is deliberately used for its non-specific, phychological or psychophysiological effect, or that is used for its presumed specific effect on a patient, symptom or illness, but which, unknown to patient and therapist is without specific activity for the condition being treated'. He goes on to make several points explicit: a) both psychotherapy and the placebo effect function solely through a psychological mechanism, b) any therapy may be used with or without knowledge that it is a placebo, including treatment given in the belief that they are placebos but which actually are by objective evaluation, c) the placebo may be inert or active and may include, therefore, all medical treatment, no matter how specific or how administered, and d) a placebo may or may not result in a placebo effect, and the effect may be favourable or unfavourable—that is, positive or negative. It seems that Shapiro's is a more inclusive and acceptable definition because as Beecher (1962) points out that it is not only drugs but even a procedure like surgery can also have placebo effect.

After so much has been written on placebo, so little is known about it. Shapiro (1971) who is a leader of placebo research in the United States, admits that the placebo effect is a 'multi-dimensional phenomenon that is not yet understood'. His modest statement echoes what Sir Aubrey Lewis (1963) once remarks that 'the barrier to conspicuous advance in psychiatric research lies in the inherent toughness of the problems'.

It is quite common to find that once the discussion of placebo touches upon the 'therapist-patient' relationship, it is instantly assumed that such relationship will yield non-specific, non-contingent, ubiquitous or unknown influences, 'placebo' is often used as an epithet for the physician knowingly giving the form but not the substance of the treatment. Some physicians do strongly deny that they ever deliberately give something 'worthless'. Shapiro (1959) reports that physicians and researchers are far more likely to find placebo effects in the work of others than in their own work. He finds three times as many physicians who believe they use placebos less frequently than their colleagues as those who believe

they use them more frequently. Moreover, there has been suggestive evidence to show that experience in clinical practice does not enhance placebo effect. Truax and Carkhuff (1967) observe that more experienced psycho-therapists show no greater ability to induce or facilitate constructive change in patients than less experienced ones.

In a way, is it difficult to conceive of non-specific influences in patient-therapist communications, because each expression by the patient elicits some type of response from the therapist, and this response inevitably creates a specific reinforcement contingency that has a specific effect on the patient's behaviour. Studies (e.g. by Ayllon and Michael, 1959) of therapist-patient interaction processes conducted within the framework of social learning, show that the therapist's interpersonal responses have specific and predictable effects on their patient's behaviour. By altering the amount of interest, attentional and solicitous concern displayed by the therapist toward the deviant activities, we can easily manipulate deviant behaviour. Likewise, Truax and Carkhuff (1967) have explored the diadic interaction between the therapists and patients by manipulating patient- and therapist- variables. The crucial point is that improvement does not depend on the therapeutic relationship per se, but on what is done with it.

Studies of placebo response have made an important contribution in the evaluation of the efficacy of many medical treatment methods. They have become more and more important in view of the proliferation in the production of pharmaceutical products on the market. Some pharmacologists have alerted us and lamented the confusion in this therapeutic jungle (Roberts, 1972). Aureomycin, which at first was used to treat atypical peumonia, has demonstrated by controlled studies to be no more effective than a placebo. Isoniazid, which was supposed to have a euphoric effect, was later shown not to produce euphoria by itself. The patients only got 'merry' as a reaction to the therapist's manifested attitude. The same is true in a number of tranquilizing drugs, the effectiveness of which is positively correlated with the physician's enthusiasm. Insulin coma treatment is increasingly thought of as a complex placebo treatment (Shapiro, 1960). In an evaluative research on the effectiveness of perphenazine reported by Eisenberg (1961) on the intra-institutional behaviour of a group of committed delinquents, the favourable outcome cannot be ascribed to specific pharmacological actions. It appears to be related to the positive expectancies aroused in the subjects and the caretaking personnel! It is likely that the enthusiasm surrounding the introduction of a new therapeutic agent in an understaffed and under-stimulated institution is in itself therapeutic.

On the other hand, as far as other physical methods of treatment in psychiatry are concerned, we have only extremely sparse information about electro-convulsive treatment and leucotomy. In Sargant and Slater's (1963) classic text, there is not a word mentioned about placebo. Shapiro (1960) also finds that there is a paucity of references to placebo in psychiatric literature. Brothwood (1972) points out that about the usefulness of these two methods of treatment, there is a lack of consensus on the part of the practising psychiatrists, e.g. we have no data whatso-ever about the long-term effect of E.C.T. Professional opinion on leucotomy ranges from those who never use it, to those who employ it frequently and could not envisage clinical practice without it. Baker et al. (1970) also write: 'there is no doubt that inherent in an operation (with head shave, anesthetic, transient post-operative confusion, intensive care, etc.) is a great deal of suggestion, whose effect could be determined only by a double-blind study which included sham operations'. In a word, the efficacy of both treatments has not been investigated in relation to the powerful placebo effect.

Rosenthal (1964) who explored the outcome-orientation effects in clinical practice finds that the therapist's expectancy is crucial. The fatality rates of delirium tremens have recently not exceeded about fifteen per cent. However, from time to time new treatments of greatly varying sorts are reported to reduce this figure almost to zero. Grune's (1958) work in Sweden summarised by the Quarterly Journal of Studies on Alcohol Editorial Staff (1959) showed that any change in the therapy would lead to a drop in mortality rate. One interpretation of this finding is that the innovator of the new treatment expects a decrease in the mortality rate, an expectancy which leads to subtle differential patient care over and above the specific treatment under investigation. One thing we emphasize too much and really study too little is the so-called differential patient care! This expectancy can also be subtly communicated to the patient with the resulting influence on the patient's psychobiological response. At the moment, we still do not know how. Perhaps our colleagues who are studying biological feedback mechanisms in controlling autonomic nervous functions would soon offer a more plausible explanation (Miller, 1969). Shapiro (1960) once cites the well-known admonition: 'You should treat as many patients as possible with new drugs while they still have the power to heal' (Pp.114). It seems that such a statement sounds very humanitarian. However, we wonder if it helps to put modern therapeutics on a solid rational ground. Any new innovation is bound to be efficacious so long as it remains a novel stimulus. It is, therefore, of public concern and scientific interest to study more rigorously the underlying mechanism responsible for changes when new methods of treatment are introduced.

Shapiro's (1971) approach has led us on the right path in placebo studies. He has delineated several variables which are important for investigation like the mechanism of interest in the patient, mechanism of interest in results and mechanism of interest in treatment. However, his method of collecting data and interpretation are open to criticism. He uses subjective and impressionistic notions like empathy, integrity and warmth. These constructs are difficult to define operationally and measure quantitatively. His studies tend to ask for patient's perception of these qualities rather than to test the physician or quantify these qualities. Perhaps, it is the author's prejudice for being more concerned about rigorous methodology and quantification. Sir Dennis Hill (1964) comments that 'clinical psychologists, being reared on a diet from the generalizing sciences' tend to avoid 'all phenomena they cannot measure' (pp.513). Is it true to say that placebo falls within this category of phenomena?

It is a professional desire (almost an illusion) for clinicians to identify those who would respond from those who would not respond to placebo. Contrary to expectation, all attempts to find potential placebo reactors have failed (Honigfeld, 1964; Shapiro, 1971). No definitive personality traits exist. Ullman and Krasner (1969, Pp.79) put forward another argument that 'under the appropriate set of contingencies (i.e. what is reinforcing to them) most people will enact the role of the placebo reactor'. Instead of finding who is and who is not a placebo reactor, we should set out to find the environmental stimuli that make the placebo response most likely.

Western trained psychiatrists tend to have the perennial bias that non-western methods of treatment practised by indigenous witch doctors and shamans are of no more value than that of placebo therapy. It is not entirely true. Carstairs (1965) has made the observation that 'all over the world, at the present time, many more psychotics are being treated by exorcism than by electroshock therapy and tranquilizers'. Spiritual healing has two striking advantages over supposedly scientific

reliance upon physical treatments: first, the patient is not exposed to the undesirable side-effects of many of the newest psychotropic drugs; and second, spiritual healing requires the participation of other persons in addition to the patient and thus helps to reintegrate the patient with the rest of his community from whom he has become estranged (Carstairs, 1969, Pp. 409). On another occasion, Yap (1968) has discussed the cultural bias in psychiatry and mental health. Folk medicine, faith healing and rites of exorcism can be as efficacious and rational as the western methods of psychiatric treatment. Kiev (1964, Pp.10) is aware that 'Although primitive therapies are fundamentally magical, that is, non-rational attempts to deal with non-rational forces, they often contain elements of rational thereapy'. In fact, Lambo (1964) has already made unorthodox collaboration with traditional healers and witch doctors in the treatment of psychiatric patients in Nigeria. Lambo's method has proved to be a great success! It is true to say that the rationality in psychiatric treatment is very much tied with the cultural acceptance of the treatment method in a particular society. In western societies, the physician happens to be enacting the role of a healer. He is looked upon as a placebo administrator. Placebo serves as a discriminative stimulus because of its previous associations with curative agents (Ullman and Krasner, 1969). It can be a pill or a totem, as prescribed by the culture.

Any individual who goes to see a physician or a shaman has some expectation for change. As early as 1892, Sir William Osler has recognized the function of expectancy in treatment on the part of the patient and the role of a healer enacted by the physician. In any given therapeutic situation, there are implicit and explicit cues affecting an individual's role enactments. These cues may be manipulated to obtain a target behaviour, e.g. the patient's verbal behaviour of getting better, which can be quite independent of the objective signs of physical ailment. In Wolf and Pinsky's (1954) experiment, when subjects were given a placebo (lactose), they recorded a greater improvement rate on the subjective side than the objective signs of anxiety such as tremulousness, sweating and tachycardia Orne (1962) coined the term 'demand characteristics' of the situation. Put it in mundane terms, prescription of the same drug under two different situation (e.g. by a dogooder round the corner of the street or by a Harley Street consultant) would differentially affect the therapeutical outcome owing to the different demand characteristics of the situations.

To recapitulate, the studies of placebo effect alert us to its omnipresence. 'Awareness of placebo effects will enable clinicians better to evaluate the effects of therapy, contribute to the development of more flexible and appropriate procedures, and make therapy more comprehensive, resourceful, and effective' (Shapiro, 1971, Pp.463). They do suggest that the so-called non-specific effects are amenable to analysis and manipulation just like other aspects of human behaviour.

CONCLUSION

From a medico-philosophical point of view, since Rene Descartes has divided human functioning into PSYCHE and SOMA; hitherto medical sciences have made great advances in studying the Soma but neglected the Psyche (Dubos, 1968; Pp. 84). Disciplines like molecular biology, materia medica, physiology, anatomy and biochemistry have made substantial contribution in explaining and discovering new therapies in medicine. Such a reductionistic trend of investigations is well-exemplified in Pasteur's and Koch's concept of one-microbe-one-disease view (Beecher, 1962). This self-imposed limitation gives medical scientists a general tendency to study man as non-thinking and non-feeling entity. Sir Dennis Hill (1964) wrote: 'In fact medical man, with a few notable exceptions; had little

interest in what we now call psychiatry. This activity was carried on by scholars and philosophers'. Even up to now, any relationship established between a therapist and his patient is mystified as 'Art of Medicine', 'Faith in healing', 'Non-specific effect' or 'Placebo' because we have no method within our repertoire to analyse it. It is true to say that, to a great extent, studies of placebo have revolutionalised this conservative outlook. Undoubtedly, placebo studies have suffered from methodological inadequacies themselves. Consequently, we do not have as much information as we should have in understanding placebo and its relationship to respective therapies. It is likely that with the readiness of the clinicians and the behavioural scientists to take up the problem and to sharpen their tools of investigation, they should be able to know more about the placebo effect and to put therapy on a more sound and scientific basis.

FOOTNOTE

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GOODBYE GOODBYE

T. Kwan

Why
Why are we born to die
Do we live to walk to the end of the line
Some people walk fast
While others walk slow
But why I'm amongst the first ones to go
I asked my mother the reason why
She said
I love you Son
And began to cry

I like
The friends I have known all these years
When they knew they all bursted into tears
But dear old friends
Please excuse me
I'm the first to leave these worries and fears
I asked my dear friends the reason why
They said
We'll meet again
With tears in their eyes

I'm glad
I've tasted the pains of love
It makes me happier to die
I'm glad it's over and I'll suffer no more
Heartbreaking moments I'll stop to recall
I said to my lover good-bye good-bye
She watched
And sighed
Then ..... walked on by

FAIR SHARES FOR ALL

Let's share the food, my brother,
Let's share the fruits of the earth,

Steak for me, but rice for you,
Eggs for tea, the devil take you;
It's nice for me, and rice for you;

Fruit and wine, milk and jam,
Cheese and pickles, and fish and ham, For me;
And a little rice, just a little rice,
(if you're lucky) for you.

Let's share the pain, my brother,
You shall have more than you share,

Pains for you, and pills for me;
Germs for you, and jabs for me;
Though you die young, long life for me;

Tranquillisers, deep X-Ray,
Penicillin, and nothing to pay, For me;
And a little clinic, just a mobile clinic,
(per hundred thousand people) for you.

Let's share the world, my brother;
Apartheid means equal shares.

Your land for us, and mine for me;
Sand for you, and soil for me;
What's left for you, the best for me;

Schools and bridges, roads and trains,
Oil and tractors, libraries, planes, For me;
And a nice reserve, yes a nice reserve,
(when your working life is over) for you.

Let's share the war, my brother,
Let's share the horrors of war.

Peace for me, napalm for you;
Trade for me, but raids for you;
"Away" for me, "At home" for you;

Cripples, orphans, refugees,
Villages burned, no leaves on trees, For you;
And a little pang of conscience, just a little twinge,
(not very often) for me.

Let's share our wealth, my brother,
Let's share all that you have.

Gold for me, and beads for you,
Christ for me, and devil take you;
There's two for me, but none for you;

Bingo, bombs, and drugs and booze,
Money to burn and waste and lose, For me;
And a little aid, just a little aid,
(when we can spare it) for you.

J. E. Stringfellow.

ANNUAL MEDIC BALL, 1973

The Annual Medic Ball was held on 16th June, 1973 at the Hyatt Hotel. Patrons of the night being Sir Albert Rodrigues, Dr. R. L. Huang, Prof. J. B. Gibson and Prof. P. H. Teng. The occasion being attended by about one hundred couple. An outstanding feature of this year is that we have two first prizes; one is an Air-Trip ticket to Australia and Europe and the other is two Sea-Trip tickets to South East Asia. The Organizing Committee would like to thank Prof. M. B. Roberts, Dr. C. W. Ogle and Dr. J. C. C. Hwang for their advice and unfailing support in making this occasion a success. A profit of HK$3,477.50 goes to the Elixir Loan Fund. Finally the Chairman would like to express his best wishes for a much more successful evening next year.

ANSWERS TO SPOT DIAGNOSIS

A) Neurofibromatosis

B) Addison's disease

Note the pigmentation in exposed areas (face and hands), sites exposed to friction (belt area) and sites normally pigmented (nipples).
(belt area) and sites normally pigmented (nipples).

C) Varicose veins

D) Cystic hygroma

E) Branchial sinus or cyst

F) Lipoma of cauda equina

G) Cherry adenoma

H) Tuberous sclerosis

Note the adenoma sebaceum (fine wart-like lesions in a butterfly distribution over the cheeks).

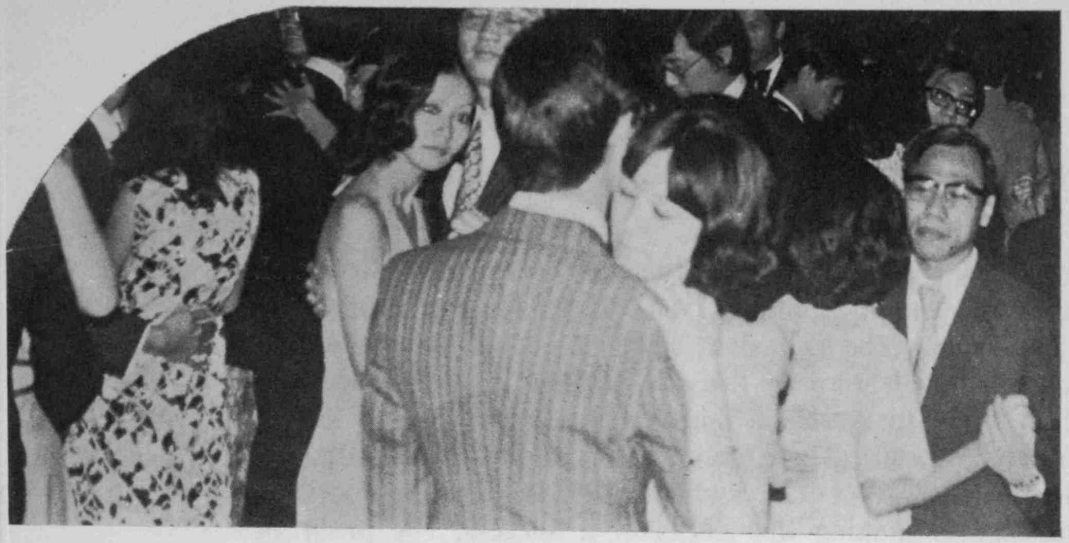
I) Acromegaly

Note the increase in the size of the bones and soft tissues of the hands, supraorbital ridges, sinuses and lower jaw. The skin is thick and coarse.

J) Cirrhosis of liver

Note the ascites, ankle oedema, dilated veins over the abdominal wall, pigmentation and ulcers over the legs.

Grand Mec



"What are you thinking, Lover?"

Three is a crowd

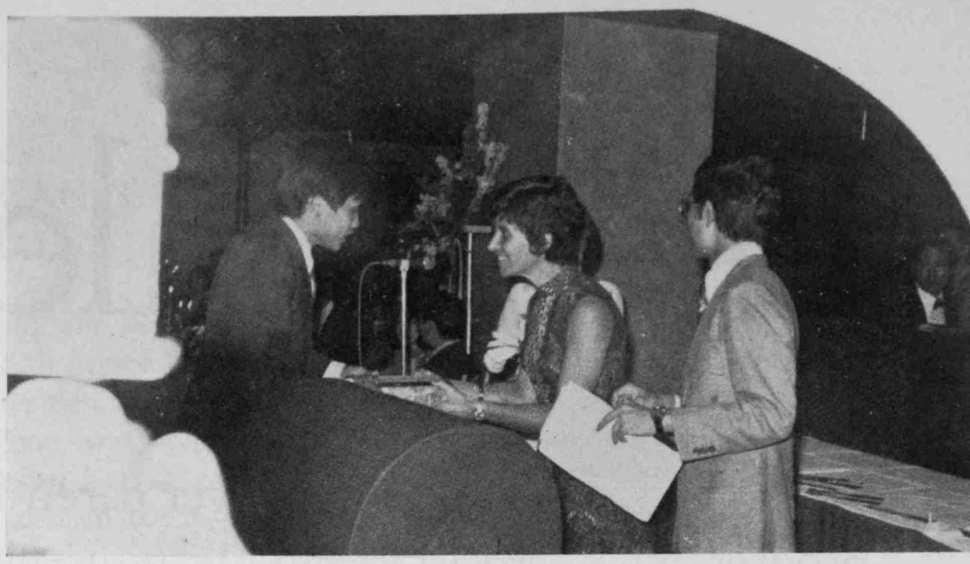
A friendly chat

"Don't be so serious, Mr. Chairman. Let's go for a swing."

A bouquet for Mrs. Roberts

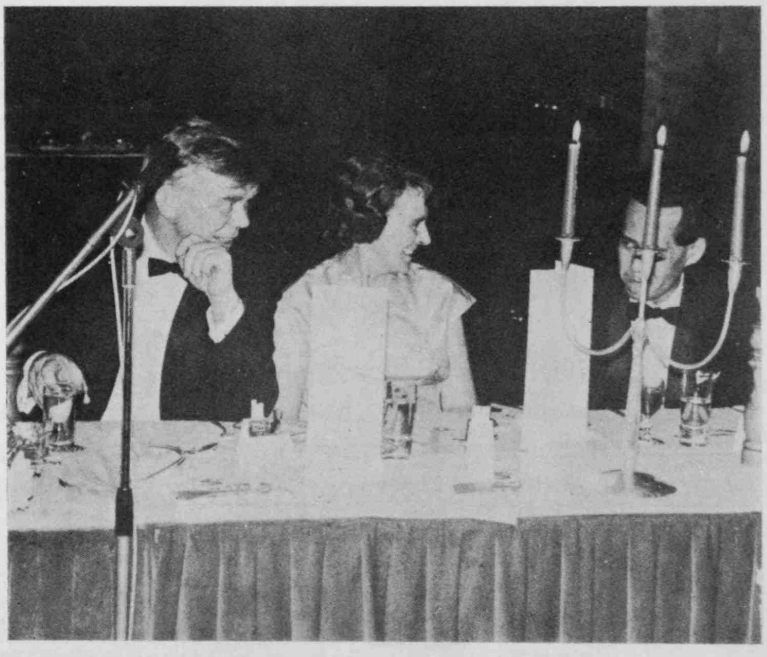
nual Ball

3

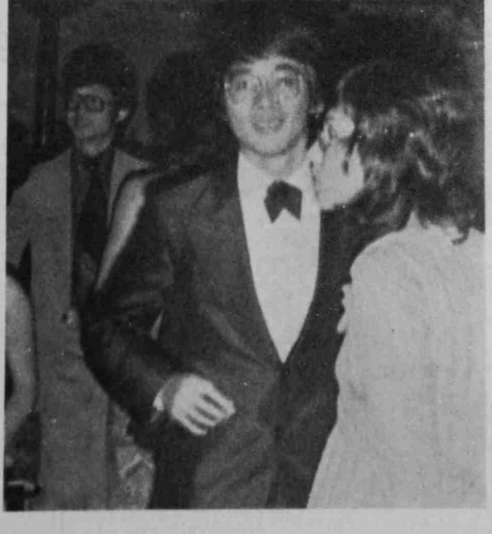


Mr. First Prize

Our V-C and his charming wife



"Come on, Dr. Olge, let's share the secret."



Our sports secretary in active motion

"Prof, What are you staring at?"

Essentiale® Capsules/Ampoules

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progressive necrosis. Essentiale® normalizes specific liver
functions. Essentiale® regenerates the liver cells.
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ANTI-CANCER EXHIBITION

The Anticancer Exhibition was sponsored by the H.K.U. Medical Society. It was held on 19-20th September at Queen's College and on 22nd-23rd September at Queen Elizabeth's School. Dr. Rayson Huang, the Vice-Chancellor of the University of Hong Kong, was invited to perform the opening ceremony. The organising committee consisted of 1st to 3rd year medical students. Students from secondary schools were also invited to participate in our project. The H.K. Anticancer Society and some Departments of the Faculty of Medicine, University of H.K. were very willing in offering help and valuable advice. Furthermore, they were most generous in supplying the exhibition with illustrations and photographs.

This exhibition was aimed at giving the general public, especially secondary school students, some basic knowledge about cancer and to encourage early diagnosis and treatment. The goal was to educate rather than to frighten the public. The exhibition programme was divided into three parts: part I — "Cancer in general"; part II — "Common Types of Cancer in Hong Kong"; and part III — "Progress of Research on Cancer" A set of slides on these subjects was prepared and the public is welcome to borrow it.

Through the cooperation of the press and the mass media — RHK, CRHK, RTV and TVB, the exhibition was greatly publicised. More than ten thousand people came to the exhibition. The majority of visitors were students and middle-aged people. Pamphlets and leaflets of the Anticancer Society and exhibition programmes were distributed free to the public.

On the whole, the exhibition was quite successful and stimulating. The public responsed favourably and the comments from the visitors were very encouraging indeed. Many people found it enlightening and instructive especially "cancer in general". They suggested that this kind of exhibition concerning public health should be held regularly. Some even asked for an extension of the exhibition pointing out that four days of display was far from enough while others proposed that it should be staged on television.

Although the participants had to spend much time and energy in preparing for this exhibition and had to make considerable effort in explaining to the visitors during the exhibition, they felt that it had all been very rewarding and worthwhile.

Organizing Committee of the Anticancer Exhibition.

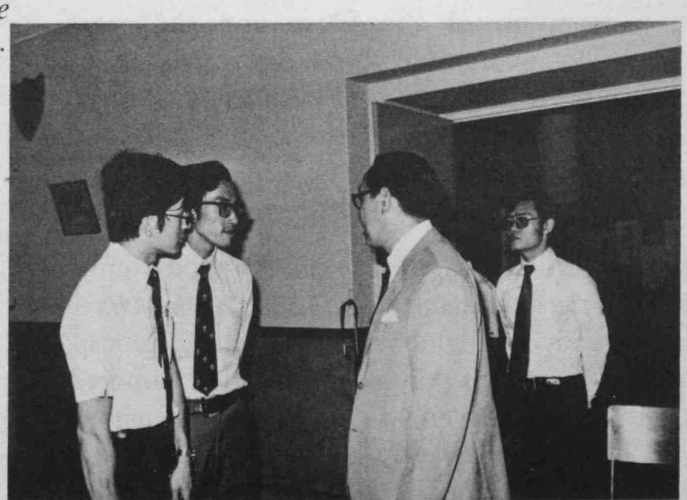
ANTI-
EXHI

The opening ceremony

Showing the V.C. around — tryin some multiple choice questions

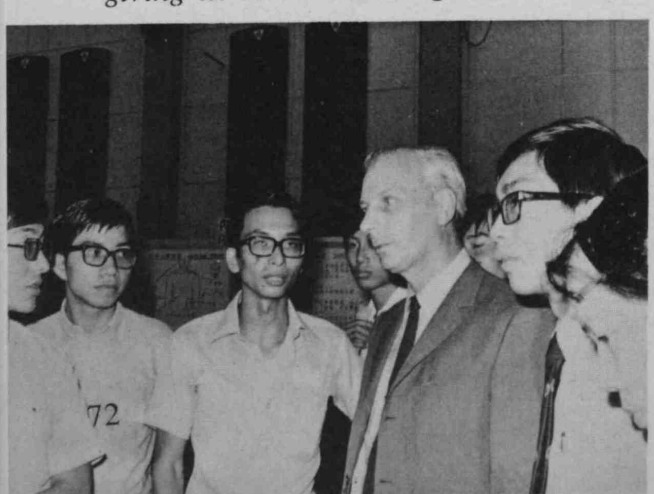
The tea-party — 'You know, I've also done me research on carcinogens .

The V.C. left his mark

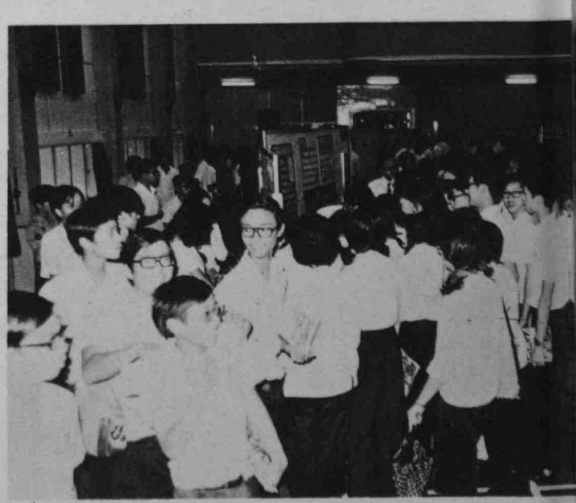


Dr. Rudy Khoo — 'Well done, lads!'

Prof. Roberts — giving us some encouragement



A scene at Queen's College 'Human Congestion'

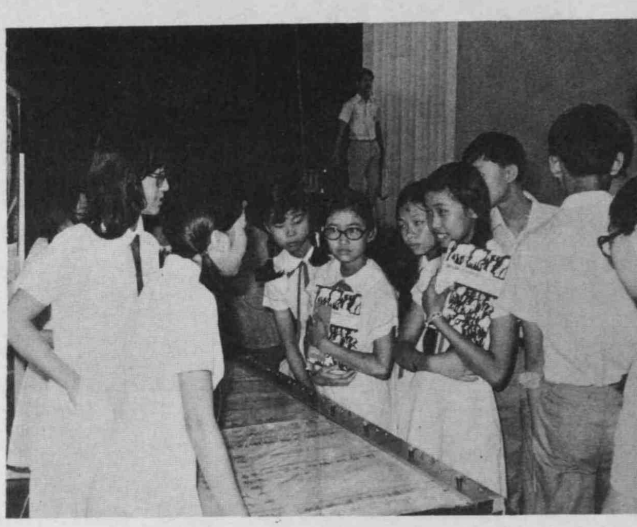


NCER
ION

T. H. Lao

Behold! one of our best commentators

Happy to be enlightened ! !



Some budding science from Sacred Heart Canossian College enlightening the younger ones

Our man with the sore-throat, and some ladies with spell-bound eyes

'The carbon particles an tar in inhaled cigarette smoke will be deposited o the ciliated pseudostratifie epithelium of the bronchioles, as shown in those diagrams, and lead to . . .'

"Cancer" means the crab'

A scene at Queen Elizabeth's school- 'all men have equal chances of getting cancer . . .'

Class Report

FIRST YEAR (1972-1973)

Join our hearts together, fill our class with spirit,

Together in harmony, successful in our career.

We heard the explosive echoing of our lovely class song on a few of the solemn and impressive occasions. We sang our farewell to Dr Glen-Bott before she left us in December. We expressed our ever increasing unity and never diminishing hope in our Class Song in the Annual Dinner which marked the end of our Freshman-ship.

Medic '77

Join our hearts together, fill our class with spirit,

Faithful and hardworking, is the watchword for us.

Join our hearts together, fill our class with spirit,

Humble and merciful, serve our fellowmen . . .

Medic Seventy Seven, sing out loud,

Medic Seventy Seven, we are proud.

Our Class Annual Dinner, held in Pak Lee Restaurant, was really an effective 'relaxant' after a nerve-breaking period of exhausting tests at the end of the third term. Professor Lisowski and Dr. J. C. C. Hwang were among our honourable guests who told us jokes, humour, and ghost-stories. The light entertainment we had that night, including a number of hilarious plays, were no less attractive and enjoyable than those in the Intergroup Drama Competition held in February. The latter had not met with satisfactory support from the class, but did prove to be most

rewarding to all those present. Dr J. C. C. Hwang was our Hon. Adjudicator. He was so much absorbed by the plays that he could not help giving a solo performance at the end of that exciting occasion.

Other Intergroup activities were the Games Day and the Intra-Class Annual Debate. The former in particular was most exciting and successful with an all-ladies vs ten-strong-men tug-of-war highlighting the rejuvenating games at the Sports Centre. The X-X genotype seemed to be the stronger combination.

Indeed, the girls, who accounted for less than one fifth of our total population, turned out to be five times more enthusiastic in supporting the class, in studying and in many others. We just should not forget that the only comfort we had in the Braga Cup series of competition besides the victory in the cross-country Race was the Women's Netball championship!

The Talent Hour was one of the most stable and quiet time we had together apart from the normal lectures. Many musicians revealed glamourously their talented potentials.

Our activity reached its first Zenith in December when we spent three days in Cheung Chau. We exhausted every minute that we spent in our Christmas Camp and our glycogen and lipid storage were definitely drained unsparingly at the end of the three days.

We really had lots of fun when we came together. We were also ready to serve and to share our experiences with others. Our first attempt in social service was to conduct a course on hygiene for the teenagers and under-educated in Yuen Chau Chai, Tao Po. Our social consciousnees is arising and increasing involvement in this field can be anticipated.

Above all, we do not forget our studies, our professors and lecturers. We had a few precious opportunities to meet the Staffs from each of the three Preclinical Departments. The number of tests and vivas ranked more than it used to be, and fortunately or unfortunately, multiple-choice type of questions were increasingly used.

Finally, with deep regret, we record the passing away of our friend and classmate, Kenneth Mak Kim Kan on 4th April, 1973.

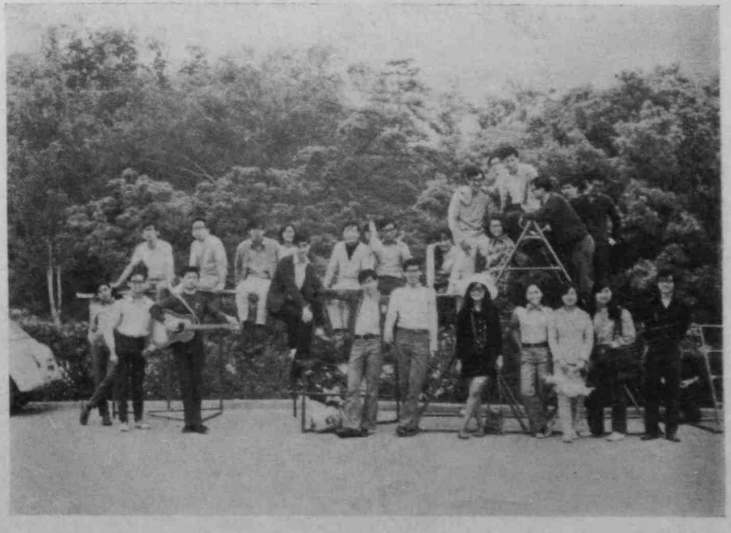
Medic '77 — humbly and hopefully, we wait for the year of 1977.

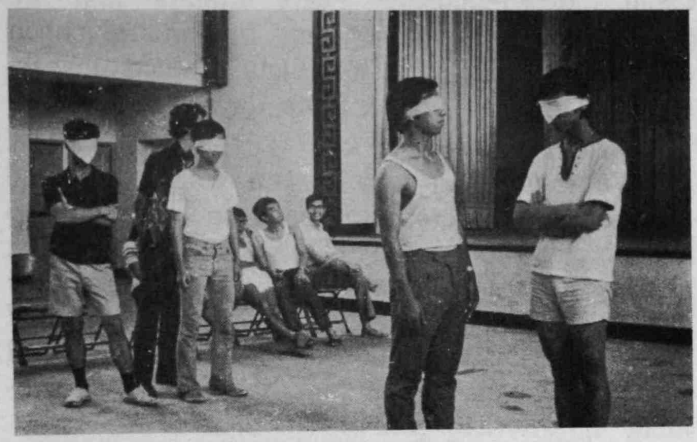
SECOND YEAR (1972-73)

During the summer vacation, a folk night was organised by the class. It was well attended by over 100 classmates. Intergroup folk-song and folk-dance competitions were held and we were very impressed by the talent of our classmates. After the intergroup competitions, there was mass dancing. The delightful evening ended at 11.00 p.m.

A summer camp at Wu Kai Sa and a launch picnic to Clear Water Bay were also held in the vacation.

At the beginning of the academic year, everyone had to work hard for the first M.B. examination. Nevertheless, the Social Secretaries managed to organise a hiking to the peak, a Christmas gathering and a joint barbecue with





We were fortunate to have Father Deignan as our guest speaker on the topics 'Psychological differences between the two sexes' and 'Toward Adult Love' on two occasions respectively.

This year, we had done very well in the Intrafaculty Games. We managed to enter final in 9 items out of 13. Throughout the games our players showed high fighting spirit and good sportsmanship. Our class was very unlucky to lose the Champion to third year by a few points.

our first year colleagues. The occasion was especially unforgettable. We enjoyed the company of our junior students very much and, without doubt, we promoted understanding between our classes, which was particularly lacking in the Medical Faculty.

The first M.B. examination was held from February 21st to March 10th.

Immediately after the examination, there were a picnic to Sai Kung and a cycling picnic to Tai Po. The former was cancelled due to lack of participants because perhaps, everyone was anxious to wait for the result of the first M.B. examination to come out.

The Class Dinner was held on April 17th at the Excelsior Hotel. We were much honoured by the presence of 8 staff members from the 3 preclinical departments.

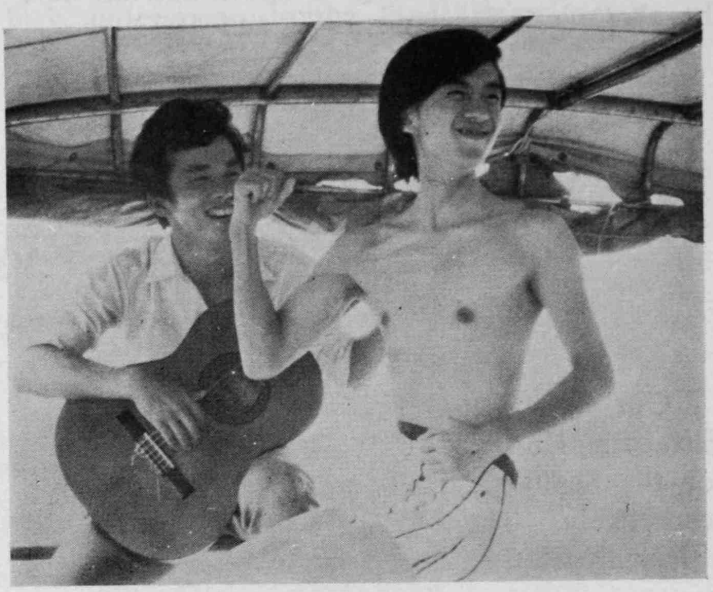
The term has come to an end and we are not sad to say goodbye to it as we have passed such a memorable year. 'We are not afraid of tomorrow as we have seen yesterday and we love today'.

THIRD YEAR (1972-73)

From Third Year Medical Students' Association

1972-73 has been a most eventful and fruitful year for the Third Year Medical students.

Social activities were held frequently. There were 4 social gatherings, with guests invited from secondary schools. During the summer holidays, the class organized a launch picnic, 2 cycling tours, and some folk-dance parties. A work camp was also held as a joint function with the Medical Society Fraternity Committee. Participants of the camp included members from the 1st and 2nd Years as well as from our class.



As something out of the ordinary, a Chinese New Year Gathering was held on the fifth day of the Lunar New Year. The class gathered together in the Medical Centre Students' Common Room, having fun with mahjong, ping-pong, Chinese billiards, etc.

The most important social event of the year, the Annual Class Dinner, was held after the 2nd MB Examinations, in which 4 members of our class were awarded with distinctions. We were honoured by the presence of the 3 Professors, and most of the staffs of the 3 Paraclinical Depts. Programmes of the evening included performances and games. Probably the most exciting item was a quiz-game which was participated enthusiastically by both staff and students. All present had a most enjoyable evening.

The class proved to be abundant in fine sportsmen. Laurels were won in plenty, and the much coveted Champion Shield was captured by our class for 2 years in succession. Our sportsmen also took a most active part in the Inter-Faculty matches, and contributed towards winning the Omega Rose Bowl for our faculty. In spite of the heavy schoolwork, some nine classmates also managed to find time to bring back medals from the BIG Games held in Singapore last October.

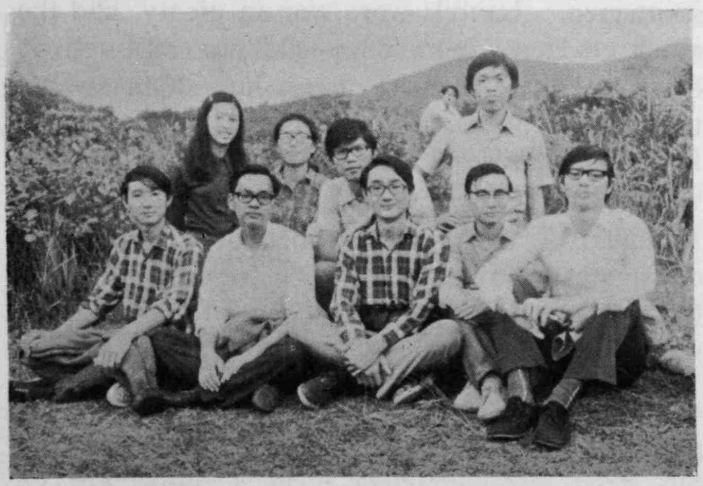
27th October, 1972 was an important day on our class-calendar. It was on that day that our class very proudly broke the record of many years by beating the Final Year and winning the championship of the Medic Nite.

The Inter-Year Debating Competition, organized by the Medical Society, was participated by our class with great spirit, and we were the champions for both 1972 and 1973.

Last but not the least, a Class Constitution was set up last summer. Its aim is to help in the better functioning of future Class Committees. with this and with the co-operation of our fellow classmates, may our class experiences yet more eventful and fruitful years in the future.

FOURTH YEAR (1972-73)

Our class acted as pioneer to the Queen Elizabeth Hospital and Kwong Wah Hospital for the Senior Medical and Surgical clerkships respectively. There we learned a lot and enjoyed a friendly staff-student relationship.



The beginning of 1973 marked the breaking up of the class into five specialty groups. We were fortunate to reside in the new Medical Students' Centre, where we had bigger rooms and more facilities than previously. As usual the Surgical and Medical clerks stayed there for 10 weeks, whereas the Paediatrics and Gynaecology clerks were provided with call-rooms for their call periods.

Though splitting up into so many groups, we managed to meet frequently through morning lectures and intergroup sports activities. Our intergroup sports activities were held regularly every Saturday and Sunday from January to March. We aimed at developing a closer relationship between group members rather than scoring points. We congratulated heartily to our champion group — Group II.

The highlight of our sports activities was the swimming Gala held at the Sir Stanley Smith Swimming Pool on one fine Saturday afternoon. We were proud to be the first class to hold such a function in the pool. It attracted more than half of the class to participate in the gala. We would like to thank Miss Wong Tze Ping who honoured the occasion by presenting the self-made "gold" medals to our winners.

In the Braga Cup competition, our class also managed to capture a few champions.

We also held a wide variety of social functions, hiking, camping and film-shows etc. to satisfy such a diverse interest of all the classmates.

With much joy and fun, we all entered into our final year and are now preparing for the Final M.B. Examination. A tough time will be in stall for everybody but eventually the effort will be richly paid off.

Therefore the final message to all the classmates is — Wishing everybody the best of luck and success in the Final Examination —

SPORTS REPORT 1972-1973

Medical Faculty Interyear Sports Competition:

Our traditional Interyear Sports Competition held between April 25 to June 5 was a great success through the help and co-operation of all the staff and students involved. This year, we have included a six-men cross country relay (from Medic Centre to Sports Centre and back again) into our Champion Shield competitions. Besides, we also have our first Interyear Swimming Competition held on October 3rd with the Champion Cup donated by our Dean, Professor J. B. Gibson. Though this was the first of its kind held, it turned out to be an enormous success with full support from students of all five years.

The overall results are as follows:—

Interyear Sports Competition — Third Year (1972-73)
Interyear Swimming Competition — Second & First Years (1973-74)

Interfaculty Competition —

Through the efforts of our representatives (to whom we express our sincere thanks), the Medic team has proved once again to be the unbeatable winner of the Omega Rose Bowl this year for the last five consecutive years. The results of the Competition are as follows:—

Results of the Interaculty Games are:—

	Med.	*Eng.*	*Sc.*	*Arts*	*Law*	*So. Sc.*	*Arch.*
Aquatic Meet	3	15	8	11	1	5	0
Athletic Meet	15	8	11	3	0	1	5
Football	7	2	0	4	0	10	0
Lacrosse	7	10	0	2	0	0	4
Badminton	10	0	7	2	0	4	0
Basketball	0	7	10	2	0	0	4
Lawn Tennis	7	4	0	2	7	0	0
Softball	10	4	0	2	7	0	0
Table Tennis	4	7	10	2	0	0	0
Volleyball	7	0	10	4	0	2	0
Squash	10	4	0	0	0	2	7
Hockey	7	4	0	2	10	0	0
TOTAL ...	87	65	56	34	26	24	22

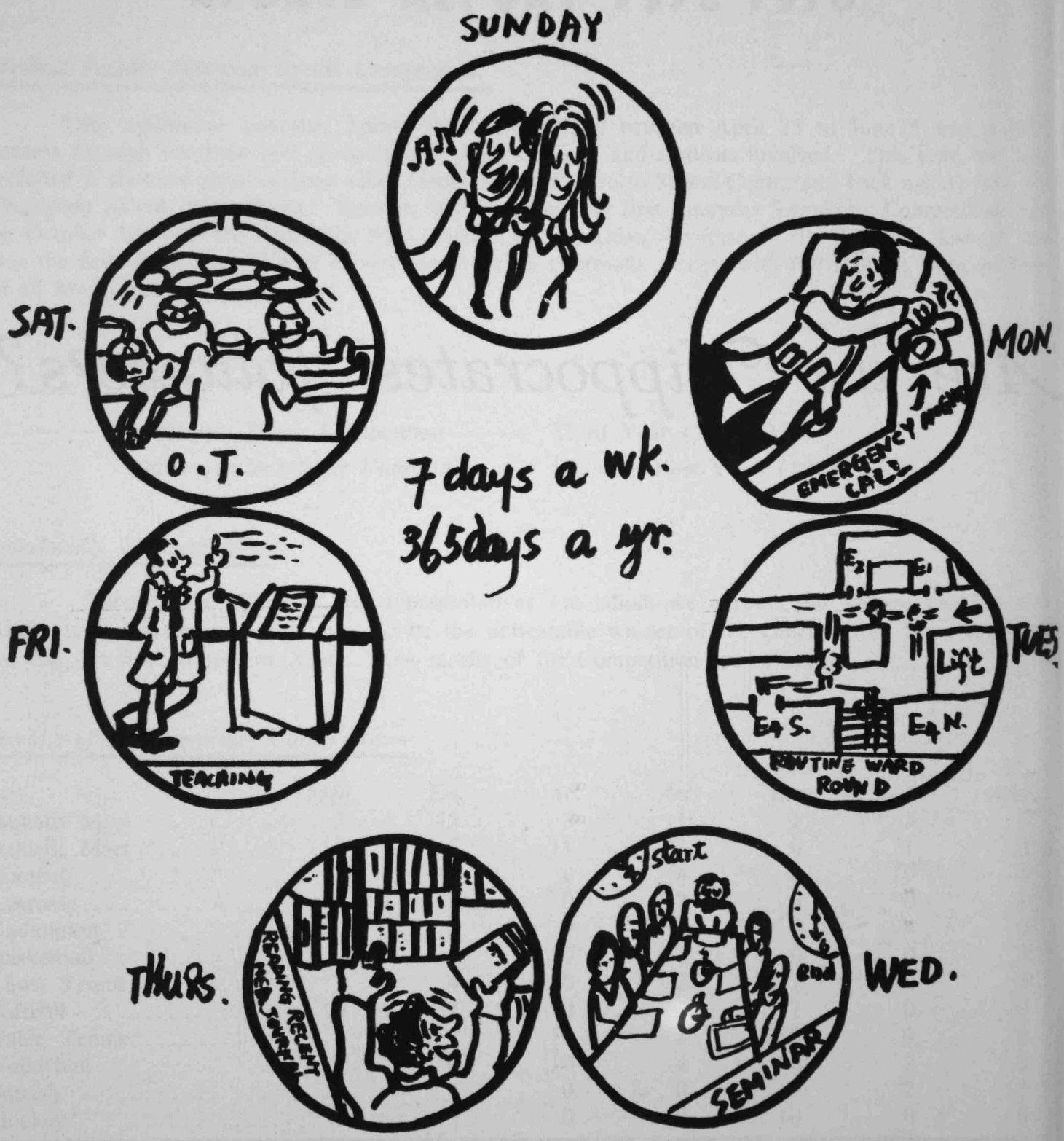
Overall Champion: Medical Society (Owner of the Omega Rose Bowl for the last five consecutive years!)

Overall Runner-up: Engineering Society.

Keep up the good work, Medics ! ! !

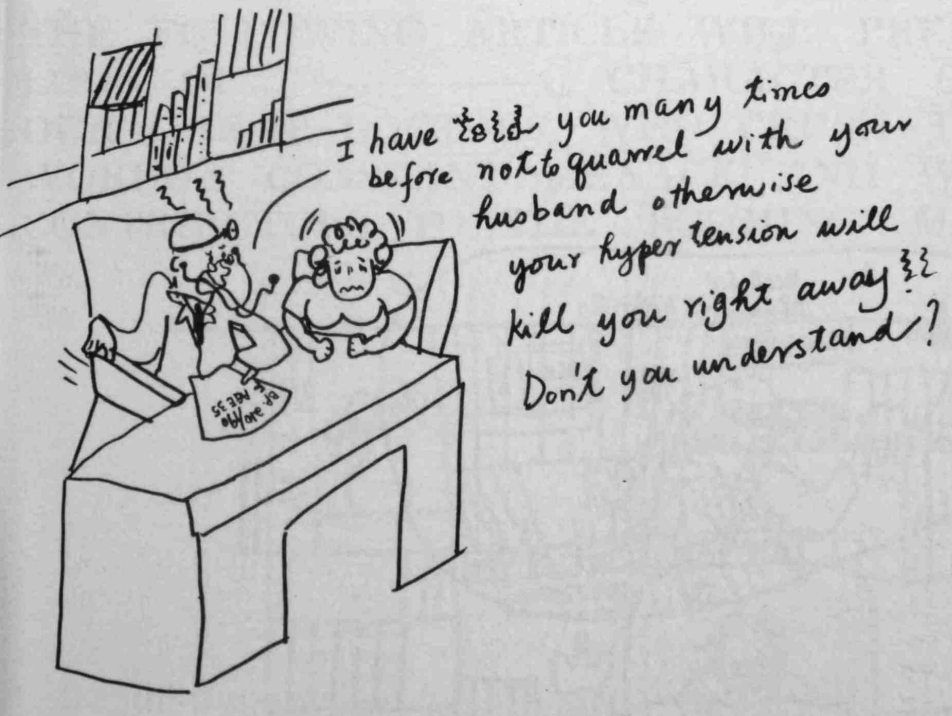
Are we Hippocrates' followers?

By Amy Tong



It's a circle game!

Once a life, now a mere biological specimen.



A Doctor is someone who has to poke into a stranger's family affair at times.

Our doctors who have battled through years in obtaining M.B., B.S., M.R.C.P., M.R.C.O.G. . . etc. are defeated now by a simple 'viva' put forward by their little darling!

. . . At first, father cat loves mother cat, then they live together and produce little knittens . . . . . .

A Doctor is someone who doesn't advocate Chinese Traditional Medicine and yet he himself . . . . . .

Hm., he's knowledge-able, brave, humorus, full of affection, logical

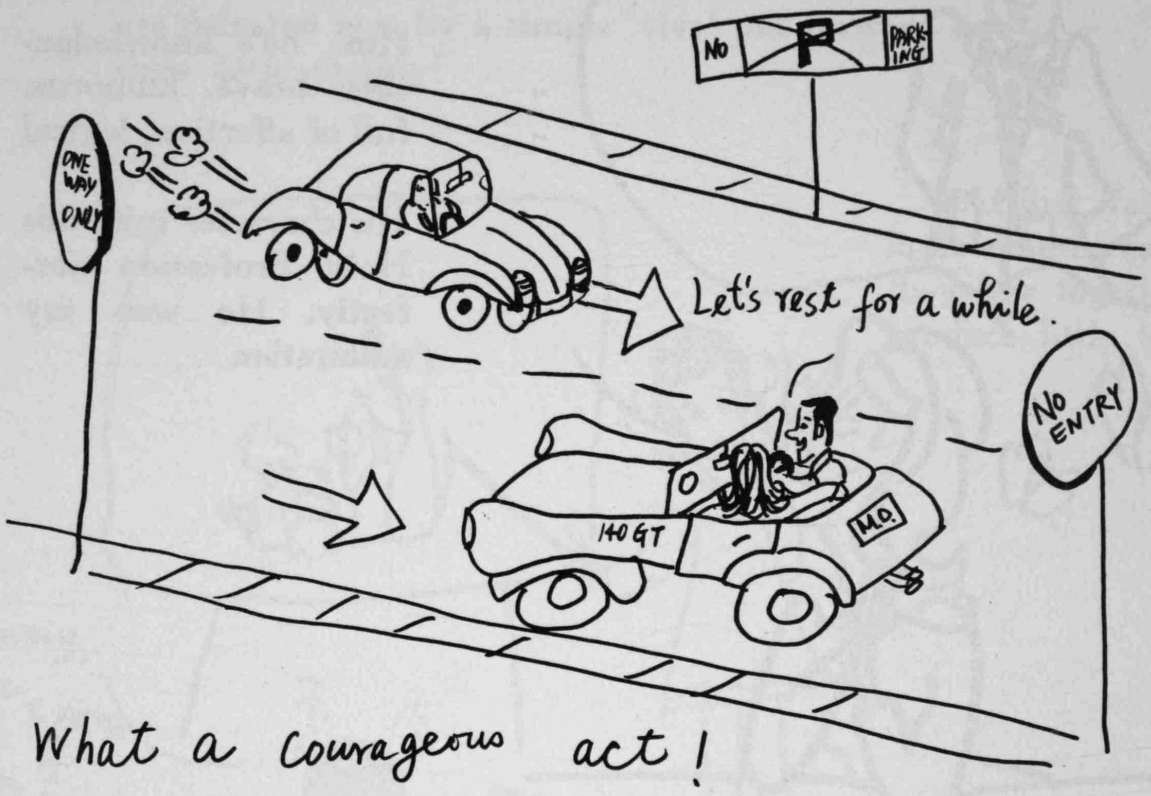
. . . . . .

His character suits this Holy Profession perfectly. He won my admiration. . . . . .

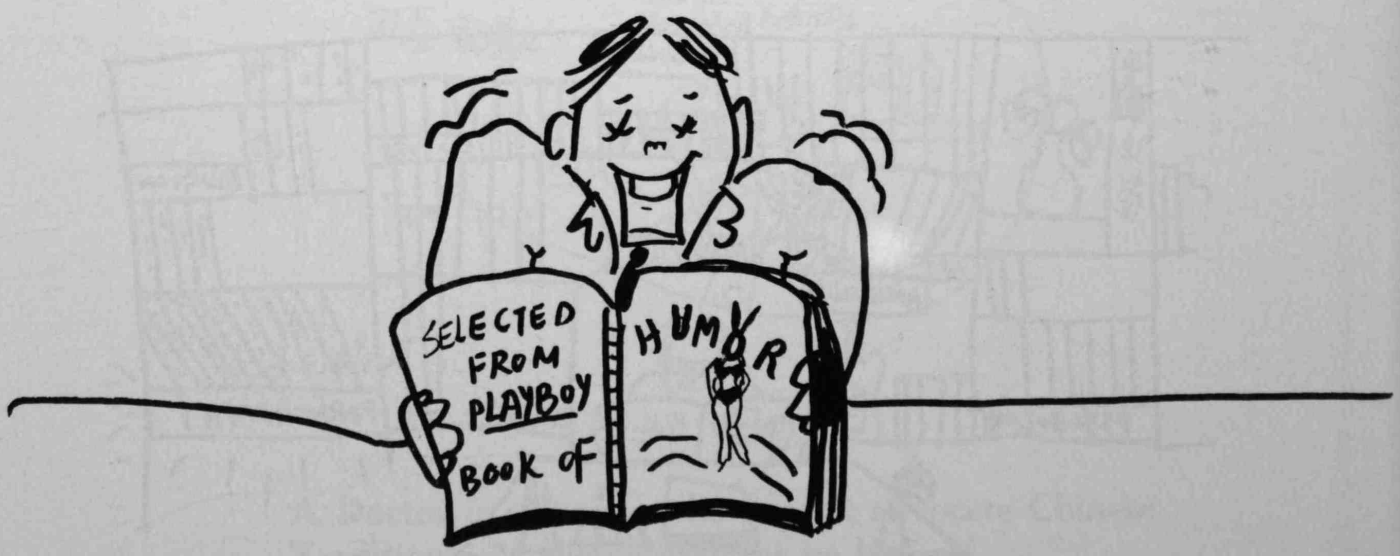
CHARACTER REVIEW

THE FOLLOWING ARTICLE WILL PRESENT A BACKSTAGE LOOK OF (————————) CHARACTER OF OUR **SUPER-MAN**, OUR GREAT DOCTORS, WHO CRUSH TRIUMPHANTLY OVER WORLD'S CONSTANT MENACE AND WHO ARE THE SOLE CONTRIBUTORS TO THE 'BOOMING' MEDICAL PROFESSION.

Really well-equipped with knowledge



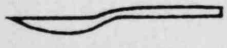
Here comes the
'Humorous Jokes appreciation hours'



A Welcome with warmest affection!

FERRUM Hausmann

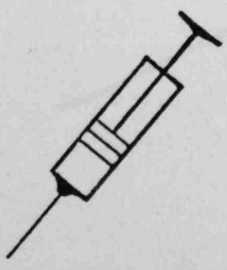
for IRON



FERRUM Hausmann SYRUP
with 10 mg Fe/ml as Iron (III)-hydroxide Polymaltose and Vitamin B6 and B12

FERRUM Hausmann TABLETS
with 40 mg Fe/coated tablet as Iron (III)-hydroxide Polymaltose and Vitamin B6 and B12

FERRUM Hausmann DROPS
with 50 mg Fe/ml as Iron (III)-hydroxide Polymaltose



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CHORIOCARCINOMA IN HONG KONG*

by Daphne Chun and H. K. Ma

Department of Obstetrics and Gynaecology, University of Hong Kong

I am deeply indebted to the Faculty of Medicine of the University for the privilege and honour of being invited to deliver this Digby Memorial Lecture this evening. I am particularly mindful of this honour when I realize that as a mere gynaecologist, I have been invited to pay tribute to a great surgeon and an outstanding teacher. In addition, I am proud to be the first of Professor Digby's students to have been accorded this honour.

Not only is Professor Digby's name well known to all of us in Hong Kong, but he is also renowned throughout the medical world through his many contributions to the Journals of Medicine. You may recall that in Professor Digby's days, blood transfusion was virtually prohibited, and sulphonamides and antibiotics also were unknown. Yet due mainly to his surgical skill, meticulous hemostasis and aseptic technique, he achieved such success that would be difficult to match in this age of unlimited transfusions and powerful antibiotics.

My main reason for the choice of choriocarcinoma for today's talk stems from my student days when I witnessed the successful operations performed by Professor Digby and the Professor of Gynaecology. I was particularly impressed by such combined effort to procure remission in cases of choriocarcinoma with isolated nodules of metastases in organs outside the pelvis when the primary uterine lesion had been effectively treated. Thus since the early days of this university, co-operation between surgeon and gynaecologist was quite firmly established and is now being further consolidated by Professor Ong and the Department of Gynaecology.

* A Digby Memorial Lecture delivered by Daphne Chun.

My other reason for choosing this subject is because, while this disease is quite rare in the West, it is comparatively common in the Far East. Professor Eastman of the United States, one of our visiting professors, once remarked that the gynaecologists in his country, saw only one or two isolated cases of choriocarcinoma in their entire lifetime and envied us with the great wealth of material available in Hong Kong. Professor Gordon King (1956) reported that he treated 15 cases in the post war years. Since then we have had 100 cases. Through our clinical and biochemical research we have been able not only to reduce the mortality rate of this highly fatal disease from 80 per cent to 24 per cent in recent years, but also to prevent its occurrence.

Let us now briefly trace the life history of the trophoblast from which choriocarcinoma originates:

After fertilisation of the ovum, the diploid number of chromosomes is established in the zygote, its sex is determined and cleavage or segmentation at once begins. The nucleus of the zygote divides to give two cells which continue to divide by binary division through 4, 8, 16, 32 — cell stages to form a solid cluster or globe of cells called a Morula. When fluid is accumulated in the centre of a Morula, a blastocyst is formed. Differentiation now takes place so that the cells become grouped into a central or inner mass of large cells and a peripheral layer of small cells. The inner mass is known as an embryonic cell mass and does not concern us to-day. The peripheral or trophoblastic layer takes no part in the formation of the embryo but is solely responsible for embedding and villi formation to make up the bulk of the placenta.

Thus the trophoblast is one of the first two types of tissue to become identifiable in the ovum within a week following fertilisation in the Fallopian tube. On about the 9th day the blastocyst arrives in the uterine cavity and its trophoblast has already differentiated into two parts; one called the syncycio-trophoblast, consisting of nucleated protoplasmic buds and reticula in which no cell outlines can be distinguished and the other called the cyto-trophoblast, consisting of definite cells.

One of the inherent properties of a normal trophoblast is invasion. This erodes the endometrium and opens up blood vessels, thus enabling the ovum to be partly attached to the endometrial tissue for embedding and partly to lie free in a pool of maternal blood so that absorption of nutrition, disposal of waste products and gaseous exchange can take place freely between the maternal blood and the developing embryo.

The rapidity of the growth and differentiation of the trophoblast with a 15-fold increase in volume in four days from the 9th to the 12th day was recorded by Hamilton et al. (1962). With the development of a central core of blood vessels from the embryonic cell mass, the trophoblast arranges itself in the form of villi.

Associated with the invasiveness and in the course of erosion, some villi become detached and are deported via the systemic circulation to the distal parts of the body, the most frequent of which is the lung. Trophoblastic embolism to the lungs was recognized as early as 1893 by German pathologists. Veit (1902) took the view that deportation of the trophoblast was a normal process but that it was more frequent in abnormal pregnancies. Similar findings were also reported by Attwood and Park (1961).

At term, the placenta is expelled and the trophoblast in ectopic sites undergoes resorption without notable infiltration. It has been shown (Kirby 1965) that after term delivery, the trophoblastic cells appear to be quite temporary and hormone production falls to an undetectable level.

Thus it can be seen that the normal trophoblast possesses some of the characteristics of malignancy such as invasiveness, rapid growth and embolisation. Hence the distinction between a normal and malignant trophoblast is only marginal. With any disturbance, congenital or acquired, a normal trophoblast readily turns malignant.

The natural history of choriocarcinoma

Choriocarcinoma originates from tissues consisting of trophoblast such as the trophoblastic layer of the early developing ovum the villi of the placenta, the vesicle of hydatidiform mole or the trophoblastic emboil anywhere in the body. Both the syncytial and cyto-trophoblastic epithelium are involved. Through the microscope, columns and sheets of anaplastic trophoblast can be seen invading the muscle and blood vessels in a chaotic manner. Haemorrhage and coagulation necrosis are constant features and villi are almost invariably absent. The uterus is the most frequent primary site, but the tumour may start in any of the ectopic sites even without the uterus being involved. It usually metastasizes early and extensively leading to a rapidly fatal corse. Spontaneous regression, though seen rarely, is a more frequent phenomenon with this tumour than any other malignant tumours of the body. This is probably due to the fact that choriocarcinoma, like a normal trophoblast, is not genetically identical with the host tissue and is therefore treated as a homograft, immunity having been developed against it.

An analysis of 115 cases of choriocarcinoma treated by us over a period of 23 years (1948-1970) yielded much information concerning the natural history of the disease. The incidence of choriocarcinoma to de-

liveries was 1:17,705 in our present series. Its incidence in the world literature (Table I) varied from 1:496 in Taiwan to 1:53,333 in England and Wales. The average age of our patients was 33 with the youngest 19 and oldest 48. The average number of pregnancies was 4.85 in Chan's and 4.46 in present series. Table II shows that there was not much difference in the age or gravidity of those described by the Joint Project for Study of Choriocarcinoma in Asia (1959). However, the patient in both the United States and the United Kingdom were younger and had fewer pregnancies.

The most frequent preceding pregnancies were hydratidiform mole which was found in 57 per cent of our cases. Term deliveries and abortions constituted 21 and 22 per cent respectively. Table III shows that hydatidiform mole was the most frequent antecedent pregnancy found in the world literature.

TABLE I

Incidence of Choriocarcinoma

	Incidence/Deliveries
Wei & Ouyang (1963) Taiwan	1 : 496
Acosta-Sison (1967) Philippines	1 : 1,148
Joint Project (1958) Asia	1 : 250–3,708
Schumann & Voegelin (1937) U.S.A.	1 : 13,850
Yen & MacHahon (1968) U.S.A.	1 : 40,000
Registrar General (1955-1960) England & Wales	1 : 53,333
Present series (1948-1970)	1 : 17,705

TABLE II

Age and Gravidity

Country	*Mean Age*	*Mean Gravidity*
England & Wales	27	2.31
United States	28	2.4
Asia (Joint Project)	33	4.8
Hong Kong (Chan)	32	4.85
Hong Kong (Present Series)	33	4.46

TABLE III

Antecedent Pregnancies

Country	*No. of Cases*	*Mole %*	*Abortion %*	*Delivery %*
U.S.A. (Novak & Seah-	74	39	38	23
U.S.A. (Hertz et al.	63	46	30	24
Taiwan, Wei & Ouyang	26	50	27	15
Philippines, Acosta-Sison	105	60	23	11
England & Wales, Bagshawe	164	66	15	19
Hong Kong	115	57	22	21

TABLE IV

Interval Between Antecedent Pregnancy and Choriocarcinoma

	< 6 months	*>6 months*
Hong Kong	53%	47%
Taiwan (Wei & Ouyang 1963)	27%	73%
United States (Hertz 1965)	87%	13%
United Kingdom (Bagshawe 1969)	46%	54%

TABLE V

Symptomatology

*Symptom**	*No.*	*Per cent*
Vaginal bleeding	94	82
Respiratory symptoms	31	27
Abdominal pain	9	8
Cerebral symptoms	7	6
Others	3	3
No symptom	8	7

* More than one symptom in some patients.

The time interval between the last pregnancy and the diagnosis of choriocarinoma varied between two weeks and four years. Table IV shows that more early cases were diagnosed in the United States than in other countries due to the readily availability of sensitive gonadotrophin assays.

Table V shows that vaginal bleeding, continuous or irregular, varying from two days to one year occurred in 94 (82%) cases, respiratory symptoms such as cough, haemoptysis, chest pain, etc. in 31 (27%), abdominal pain 9 (8%), cerebral symptoms such as headache, paralysis, etc. in 7 (6%) and rare symptoms including anorexia, anaemia, dysuria, haematuria, mass protruding from vagina or in the abdomen, abdominal distension and intraperitoneal haemorrhage in a (3%). There were no symptoms in 8 (7%).

The uterus had already been removed in 14 cases. Of those with intact uterus, there was no evidence of lesion in 20 (17.4%) cases. Hou and Pang (1956) found an absence of lesion in the uterus in five out of 24 necropsies on choriocarinoma in Hong Kong. In the United States and the United Kingdom, the incidence of absent lesion in the uterus was 12 per cent and 10 per cent respectively.

Table VI shows the sites of lesions in 115 clinical and 33 post-mortem cases. Because of the advanced stage of the disease at post-mortem, metastases are more evident then. The low incidence of the primary lesion in the uterus in the post-mortem cases is due to the fact that 11 of the 33 cases had had hysterectomy. In clinical cases however, the uterus was the most common site and was found in 81 cases, 14 had had hysterectomy before

TABLE VI

Sites of Lesions

Sites	*115 Clinical Cases (1st admission)*		*33 P.M. Cases*	
	No.	*Per cent*	*No.*	*Per cent*
Uterus	81	70	12	36
Tubes &/or ovaries	7	6	4	12
Vagina	12	10	7	21
Lungs	56	69	32	97
Brain	4	4	25	76
Gastrointestinal tract	0	0	13	39
Kidneys	0	0	11	33
Subcutaneous	2	2	5	15
Others	2	2	14	42
Unknown	16	14	0	0

onset of choriocarcinoma and no lesion was found in 20.

The lungs were the most frequent metastatic sites in both clinical (49%) and post-mortem cvases (97%). Next the brain but only 4 per cent is shown in clinical cases against 76 per cent at post-mortem due presumably to the inability to detect silent lesions.

Treatment of choriocarcinoma

Prophylaxis: Because of the high mortality associated with choriocarcinoma, attempts have been made from time to time to prevent its occurrence. Although choriocarcinoma may result from normal pregnancies, the post molar patients have a 2,000 — 4,000 times higher chance of developing it. Therefore, in an effort to prevent its occurrence, attempts have been concentrated on the use of prophylactic chemotherapy in the management of cases of molar pregnancy. Satisfactory results have been reported in recent years by Chun et al. (1970), the International Union Against Cancer, Trophoblastic Neoplasia Study Group (1969) and Goldstein (1971).

Between 1967 and 1971 we conducted a study of 79 consecutive cases of hydatidiform mole of modifying the previous methods of terminating the mole and by the selective use of chemotherapy. Braga and Chun (1968) found that the incidence of choriocarcinoma and other trophoblastic disease is related to the management of the hydatidiform mole. Table VII shows that among 50 patients treated with syntocinon, five subsequently developed choriocarcinoma and eight other trophoblastic disease giving an incidence of overall trophoblastic disease of 26 per cent. The incidence was 16.7 per cent in the 24 cases terminated by hysterectomy with mole in situ. The lowest incidence of three per cent was found in 32 cases where the mole was evacuated spontaneously. It was possible that the higher incidence in the first group was due to increased dissemination of vesicles consequent upon aggravation of uterine activity by the use of syntocinon and in the second group, due to the handling of a large uterus filled with the mole during the operation.

TABLE VII

Incidence of Post Molar Trophoblastic Disease in Relation to Treatment

Method of Treatment	*No. of Cases*	*Chorio-carcinoma*	*Other M.T.D.*	*Total* No.	*Per cent*
Syntocinon drip	50	5	8	13	26.0
Hysterectomy with Mole in-situ	24	0	4	4	16.7
Spontaneous expulsion followed by evacuation and D. & C.	32	0	1	1	3.1

While attempting to evacuate a uterus for an abortaion with a suction tube, Brandes et al. (1966) emptied a uterus of an undiagnosed hydatidiform mole. So impressed were they with the rapid evacuation, minimal blood loss, short term of anaesthesia and good uterine contractility that they adopted it for all cases of hydatidiform mole. We have confirmed the reliability of this method and have also used it to replace all others. It is now too early to assess the result but the incidence of post molar trophoblastic disease is not expected to be higher than that occurring in spontaneous evacuation.

Regarding chemotherapy for hydatidiform mole we selected 60 out of our series of 79 consecutive cases for this treatment. The factors (Table VIII) influencing the selection were elderly patients, H.C.G. levels of over one million i.u./24 hours, use of syntocinon in connection with evacuation of the hydatidiform mole, hysterectomy with mole in situ, histologically proven cases of infiltrative mole, pulmonary hypertension etc. all of which were known to carry a higher incidence of post molar trophoblastic disease.

TABLE VIII

Indications for Chemotherapy

Indications	*No. of Cases*
Over 40 years old	11
H.C.G. > 1,000,000 i.u./24 hours	14
Syntocinon drip	10
Hysterectomy	12
Infiltrative mole	5
Metastatic mole	3
Pulmonary hypertension	1
Miscellaneous	4

Drugs used: The initial drug used for all cases was methotrexate; only three patients at the commencement of the present study received it by the oral route and the rest by systemic administration as toxicity was found to be more severe especially in the gastrointestinal tract with the oral route. The number of courses given varied from one (one case only) to over 10 courses and the interval between courses was two weeks to allow the toxic effects especially those of the bone marrow to pass off.

The treatment was discontinued only when the H.C.G. was persistently below 50 i.u./24 hours. Though 6-mercaptopurine given in addition to methotrexate did not increase drug toxicity, it did not make any difference in the response and we therefore abandoned its use after giving it to only 18 patients. It is important to observe the response by charting H.C.G. levels weekly in order to spot cases resistant to methotrexate. In three patients, the H.C.G. levels failed to drop after repeated courses of methotrexate in one and methotrexate together with 6-mercaptopurine in two other cases. All these three patients responded promptly to actinomycin D following the discontinuation of the primary drugs used.

Results: Table IX shows that in this series of 79 cases of hydatidiform mole, there was only one case of choriocarcinoma and four cases of malignant trophoblastic disease, giving an incidence of 1.3 per cent and 6.3 per cent respectively. With further treatment, all the cases of malignant trophoblastic disease went into complete remission, and the only case of choriocarcinoma could have been prevented. This patient was a case of malignant trophoblastic disease following evacuation of hydatidiform mole but she refused chemotherapy. Four months later when she started to have vaginal bleeding and radiographic nodules in the chest, she still refused treatment. She died 25 months later from extensive metastatic choriocarcinoma. Thus, after adjustment, the incidence of choriocarcinoma was zero per cent. Comparing these results with those of our previous series (Braga &

TABLE IX

Trophoblastic Disease Following Hydatidiform Mole

	Present series (79 cases)		*Braga & Chun (1968) (104 cases)*	
	No.	*Per cent*	*No.*	*Per cent*
Malignant Trophoblastic Disease	4	5.0	8	7.7
Metastatic Trophoblastic Disease	—	—	5	4.8
Choriocarcinoma	1(0)*	1.3(0)*	5	4.8
Total	5(4)*	6.3(5.0)*	18	17.3

* When adjusted.

TABLE X

Incidence of Post-Molar Choriocarcinoma in Hong Kong

Period	*No. of cases of mole*	*Per cent*
1948 — 1953 (June)	64	9.4
1953 (July) — 1961	265	8.6
1962 — 1965	104	8.0
1966 — 1967 (June)	34	11.8
1967 (July) — 1971 (June)	79	1.3*

* 0 per cent when adjusted.

Chun, 1968) (Table IX) we have been able to reduce the incidence of overall trophoblastic disease from 17.3 per cent to 6 per cent or 5 per cent when adjusted. In the case of post-molar choriocarcinoma (Table X) the incidence has been brought down from the highest of 11.8 per cent to 1.3 per cent or zero per cent when adjusted.

Chemotherapy for choriocarcinoma

Choriocarcinoma has proved to be the first human cancer which can frequently be cured by a systemically administered cytotoxic drug. The survival rate of cases treated before the chemotherapeutic era was between 6 and 20 per cent. With chemotherapy, this figure has been brought up to between 48 and 76 per cent. This dramatic improvement in the results can be seen by tracing our 115 cases of choriocarcinoma using different regimens (Table XI over a period of 23 years:—

a) In King's (1956) series of 15 cases of choriocarcinoma, seven were treated by surgery and eight by palliative treatment. Twelve were dead and three survived at the time of the report giving a mortality rate of 80 per cent. The pregnancy test employed was Gallimanini's frog test.

b) In 1960 when chemotherapy became available, 12 out of the 41 cases reported by Chan (1962) had been treated with methotrexate. Of the latter, five were dead at the time of report and four died subsequently, giving a mortality rate of 75 per cent. In his remaining 29 cases not treated with chemotherapy, 15 were dead at the time of report and eight died subsequently giving a mortality rate of 79 per cent. Thus the mortality rate of the methotrexate treated cases was only slightly lower. The pregnancy test used was still Gallimanini.

c) In 1967, Chun et al. reported a series of 21 cases of choriocarcinoma with an overall mortality of 52 per cent. Eighteen of the cases were treated with chemotherapy and nine died giving a mortality rate of 50 per cent. The remaining three cases were treated by hysterectomy and two died giving

TABLE XI

Results of Treatment

Period	No. of Cases	Primary Treatment			Mortality Rate					
		Chemo.	Surgery	Misc.	Chemo. No.	(%)	No Chemo. No.	(%)	Total No.	(%)
1948-1953 (June) (King, 1956)	15	—	7	8	—	—	12	(80)	12	(80)
1953 (July)–1961 (Chan, 1962)	41	12	19	10	9	(75)	23	(79)	32	(78)
1962–1965 (Chun & Braga, 1967)	21	18	3	—	9	(50)	2	(67)	11	(52)
1966-1970 (present)	38	38	—	—	9	(24)	—	—	9	(24)

a mortality of 67 per cent. The better results obtained during this period were due to the introduction of latex and hemagglutination tests for detection of H.C.G. which are more sensitive than the frog tests. Thus a relatively earlier diagnosis was made and the chemotherapy was better controlled.

d) In the last series, all 38 cases were treated between 1966 and 1970 using similar drug regimen as for hydatidiform mole described previously, which was very carefully monitored with sensitive gonadotrophin assays. There were nine deaths. Thus the mortality was markedly reduced from 52 per cent to 24 per cent. This was undoubtedly due to the use of sensitive gonadotrophin assays which have enabled us (i) to make an early diagnosis of the tumour; (ii) to determine precisely the duration of chemotherapy; and (iii) to spot promptly the primary drug resistant cases and to administer immediately a second cytotoxic drug. All three are essential to successful management of choriocarcinoma and require further elaboration:

Early diagnosis: It has been erroneously established that choriocarcinoma produces large amount of H.C.G. and failure to find this has frequently been responsible for the serious delay in establishing the diagnosis and initiating treatment. The daily output of H.C.G. in the present series with choriocarcinoma ranged from 100-150 i.u./24 hours to 20,000,000 i.u./24 hours. In the early days when frog tests were employed four out of 61 cases of advanced choriocarcinoma were found to be negative. After we started to use sensitive gonadotrophin assays by mouse uterine weight tests with concentrated urine and radioimmuno-assays we found 26 out of 54 cases or 48 per cent had H.C.G. levels under 8,000 i.u./24 hours and the early diagnosis of these cases would surely have been missed if only frog tests were used. Of the remaining 28 cases, 52 per cent had levels over 8,000 i.u./24 hours which could be detected with any pregnancy tests.

Tests with a sensitivity of over 1,000 i.u./24 hours such as the frog, Aschheim

Zondek or Freedman test and hemagglutination inhibition tests without modification cannot detect early trophoblastic tumours because the quantity of hormone excreted is small.

Duration of treatment: The decision to discontinue chemotherapy should be based primarily on H.C.G. studies. Tumours of visible or palpable size or of size demonstrable radio-graphically (by X-rays, isotope scannings or arteriograms etc.) may soon disappear under treatment but H.C.G. remains detectable long after clinical or radiological remission. Even at hormonal remission, chemotherapy should be given for a further period of 6 months to ensure complete eradication of any residual tumour tissue which is too small to be detectable by clinical, radiological or even sensitive gonadotrophin assays. If the treatment is discontinued before this is achieved, then a relapse may occur varying in duration from days to months! the worst of all is the difficulty in bringing such a tumour into remission as it is often resistant not only to the drug previously used but also to another drug. The following case illustrates the points raised in this paragraph:

C.K.H. G202/1965, age 30, gravida 5, Fig. 1

(i) Twenty two months after a hysterectomy to terminate a hydatidiform mole, the frog tests became occasionally positive though the patient remained well. This aroused the suspicion of trophoblastic disease but there was no clinical or radiological evidence and no treatment was given.

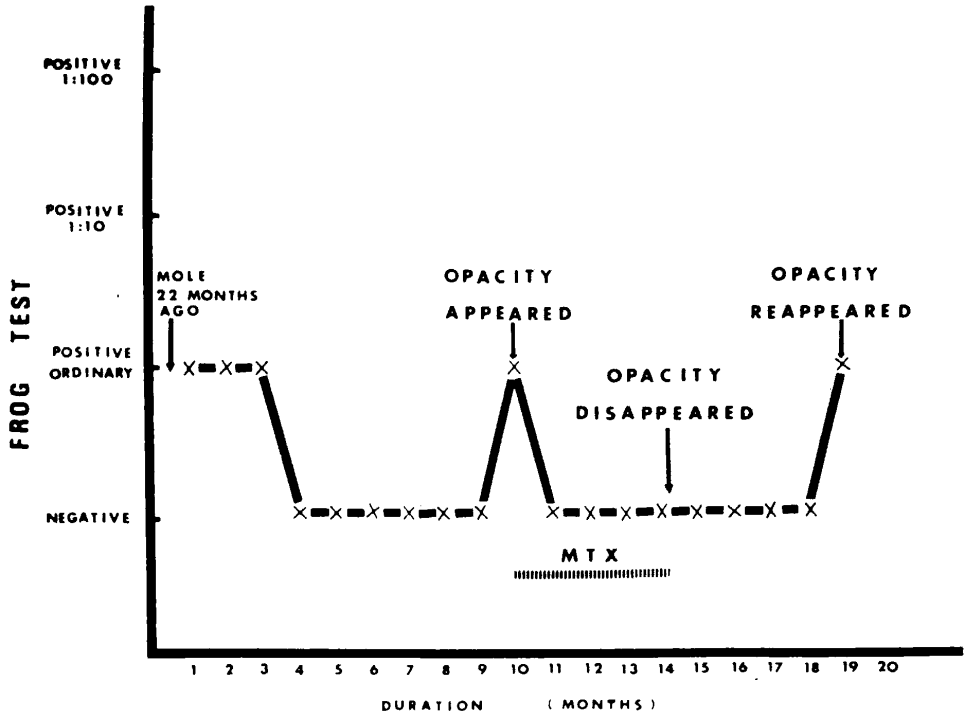
(ii) Nine months later, a small shadow began to appear in the chest films. Though the frog tests were now constantly positive, the patient remained well with no clinical evidence of trophoblastic disease. However, she was treated with methotrexate until the chest shadow disappeared and the frog tests became negative for one month.

(iii) Eight months later, the chest shadow reappeared and the frog tests were again positive. In spite of further methotrexate, actinomycin D and other cytotoxic drug therapy the tumour spread and became manifested clinically. She died of extensive metastatic choriocarcinoma.

Comments: (i) The tumour was revealed by biological tests before it became clinically or radiologically evident. (ii) The tumour could not have been completely eliminated during the primary cytotoxic drug therapy because sensitive gonadotrophin assays were not used. After discontinuing methotrexate, the residual tumour increased in size until it became radiologically evident again 8 months later. (iii) The tumour was not only resistant to the primary drug (methotrexate) used but also actinomycin D and other cytotoxic drugs.

Drug resistance: During cytotoxic drug therapy, it is important to follow the response with weekly assessment of H.C.G. levels. The usual indication for changing from one drug to another is a failure of response or drug resistance shown by a persistently elevated H.C.G. levels after an initial decline. Although it is better to exhaust the effectiveness of a drug before changing to another, too much time must not be wasted. Over the years, we (Ma et al. 1971) have had the opportunity of treating 18 cases of methotrexate resistant tumours with actinomycin D (Table XII).

In nine patients in whom the drug resistance lasted for 6-12 weeks, seven went into complete hormonal as well as clinical and radiological remissions; the other two patients died after receiving less than two courses of actinomycin D. Both these two patients might have responded to treatment had they not died so soon by repeated attacks of cerebral haemorrhage from lesions involving the brain in one case and vaginal haemorrhage from lesions involving the bony pelvis in the other. Of the seven who recovered, all had metastases in the lungs. In addition, one also had liver and the other had ovarian metastases.



(Fig. 1)

TABLE XII

Remission Rates of Methotrexate Resistant Tumours

Duration	*Total No.*	*Remission*		*Dead*	
		No.	*Per cent*	*No.*	*Per cent*
6 — 12 weeks	9	7	77.8	2	22.2
> 12 weeks	9	3	33.3	6	66.7

Of the other nine patients who had drug resistance lasting for more than 12 weeks, only three went into remission and six died of the disease without showing any response.

Thus, in order to bring more patients into remission, drug resistant cases should be spotted early and treated with a second drug promptly. There lies the importance of using sensitive gonadotrophin assays.

TABLE XIII

Surgical Treatment for 115 Cases

	No.	*Per cent*
Hysterectomy*	73	63.5
D. & C.	36	31.3
Lobectomy	3	2.6
Partial Nephrectomy	1	0.8
Miscellaneous	5	4.3

* Including one Wertheim hysterectomy.

Surgery-Hysterectomy was performed in 73 cases (63.5%), eleven to arrest uterine haemorrhage, two to remove cytotoxic drug resistant tumours and 60 as primary treatment Table XIII). Bagshawe records that the response to chemotherapy was less satisfactory in cases where hysterectomy had been done but we have found that the results are the same with or without prior hysterectomy.

Hysterectomy as primary treatment was more frequently performed in the pre-chemotherapeutic era but the results are not satisfactory. Our findings have shown that hysterectomy alone is rarely successful in treating choriocarcinoma because of the metastases even in early cases. It should therefore be avoided, especially in young patients. Six of our patients had successful pregnancies following chemotherapy.

Dilatation and curettage was carried out in 36 patients (31.3%) but only 33 per cent of the results were positive due to the inability to obtain tumour tissue when it is hidden in the myometrium. Diagnostic D. & C. however has now been largely replaced by the more accurate sensitive gonadotrophin assays.

There were three instances of *lobectomy* for removal of isolated nodue in the lung and the patients remained well for up to four years but eventually died from the disease.

Partial nephrectomy was performed in one patient to arrest haemorrhage from bleeding metastases but bleeding soon recurred and the patient died in spite of repeated blood transfusion as the tumour was resistant to chemotherapy.

Plication of vaginal nodules to stop bleeding was successful in three cases. Biopsy was not attempted as it could give rise to uncontrollable haemorrhage.

Radiotherapy: Dilworth et al. (1950) found that radiotherapy was of little use and reported that five cases succumbed to the disease nine months following treatment. Three of our patients so treated also showed no response.

Enzyme therapy: L-Asparaginase though found to be effective in treating some cases of leukaemia was used on one case of drug resistant tumour but there was no response.

Immunotherapy: Spontaneous regression of proven choriocarcinoma occurs in 1-2 per cent of cases. There was one such case in our series reported by Chun and Hou (1957). The patient recovered completely from haemothorax and all metastatic nodules in the chest resolved following hysterectomy for the removal of the primary in the uterus.

Methods of inducing immunological reaction by using skin graft or white blood corpuscles from the husband have not been successful. Bagshawe (1969) described a case who rejected an unrelated donor graft at nine days, her husband's at 20 days. After further immunolization with the husband's W.B.C., a further skin graft from the husband was rejected in five days. Despite his second set graft response, the patient subsequently died from the tumour. We have also tried it out with no success.

Final Results

Table XIII shows the final results of the 115 cases of choriocarcinoma treated in the four periods. With the marked drop in fatality of this disease the remission rate has been elevated from 20 per cent in the first period to 76 per cent in the last. This compares well with those of the published reports (Table XIV) with a remission rate varying from 6.3 per cent to 78 per cent. Nevertheless, the mortality of 24 per cent in recent years is still high and we should aim not only at improvement of management but also at prevention.

Conclusions

The conclusions we can confidently draw from our present study are two; firstly, with certain modification of the old methods and the selective use of chemotherapy in the

TABLE XIV

Remission Rates of Carcinoma Treated with Chemotherapy

Author	*No. of cases*	*Remission*		*Treatment*
		No.	*%*	
Brewer et al. (1964)	19	10	52.6	Acts D, MTX
Hertz (1967)	83	44	53.0	MTX, VLB, Act. D
Hreshchyshyn & Holland (1967)	8	4	50.0	MTX, DiCIMTX
Kaku (1962)	16	1	6.3	NM, MTX
Manahan et al. (1964)	32	22	68.8	MTX
Rybakova (1964)	36	2	0.99	MTX
Bagshawe (1969)	100	78	78	MTX, 6MP, Act. D etc.
Present series (1966-1970)	38	29	76	MTX, Act. D, VLB etc.

management of hydatidiform mole, the most frequent antecedent pregnancy complicated with choriocarcinoma, it has been shown that the latter is a preventable disease. Our post molar choriocarcinoma has been reduced from the highest of 11.8 per cent to 1.3 per cent adjusted to zero per cent. Secondly, with the introduction of chemotherapy together with the use of sensitive gonadotrophin assays, the mortality has been brought down from 80 per cent to 24 per cent.

In summing up, allow me to say that I hope my talk this evening on the findings just completed on the treatment and prevention of choriocarcinoma will serve as a useful reference for future research, just as Professor Digby's many contributions have served us in our work.

I now wish to quote a sentence from an appreciation of James Jaig Ferguson by the late Professor James Young. It reads as follows: "Great as were his gifts and his service to his friends, he will remain rather a presence which was precious in its possession of those qualities of heart and mind that are above the ordinary world's measurement". With humble respect I submit that this is an appropriate epitaph for Professor Digby, whose life and work this lecture commemorates.

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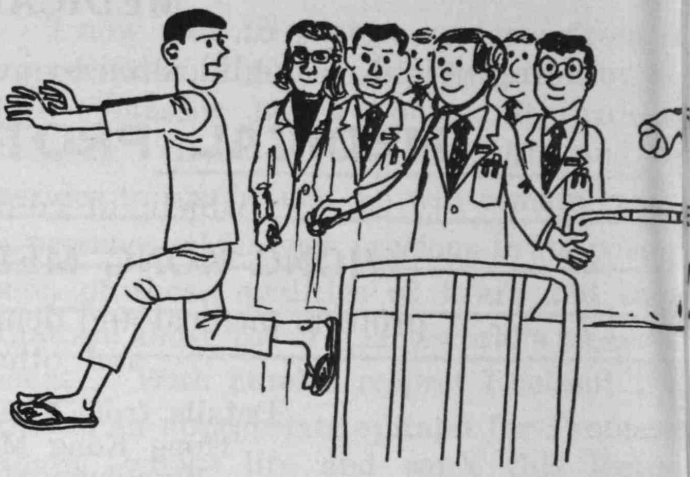
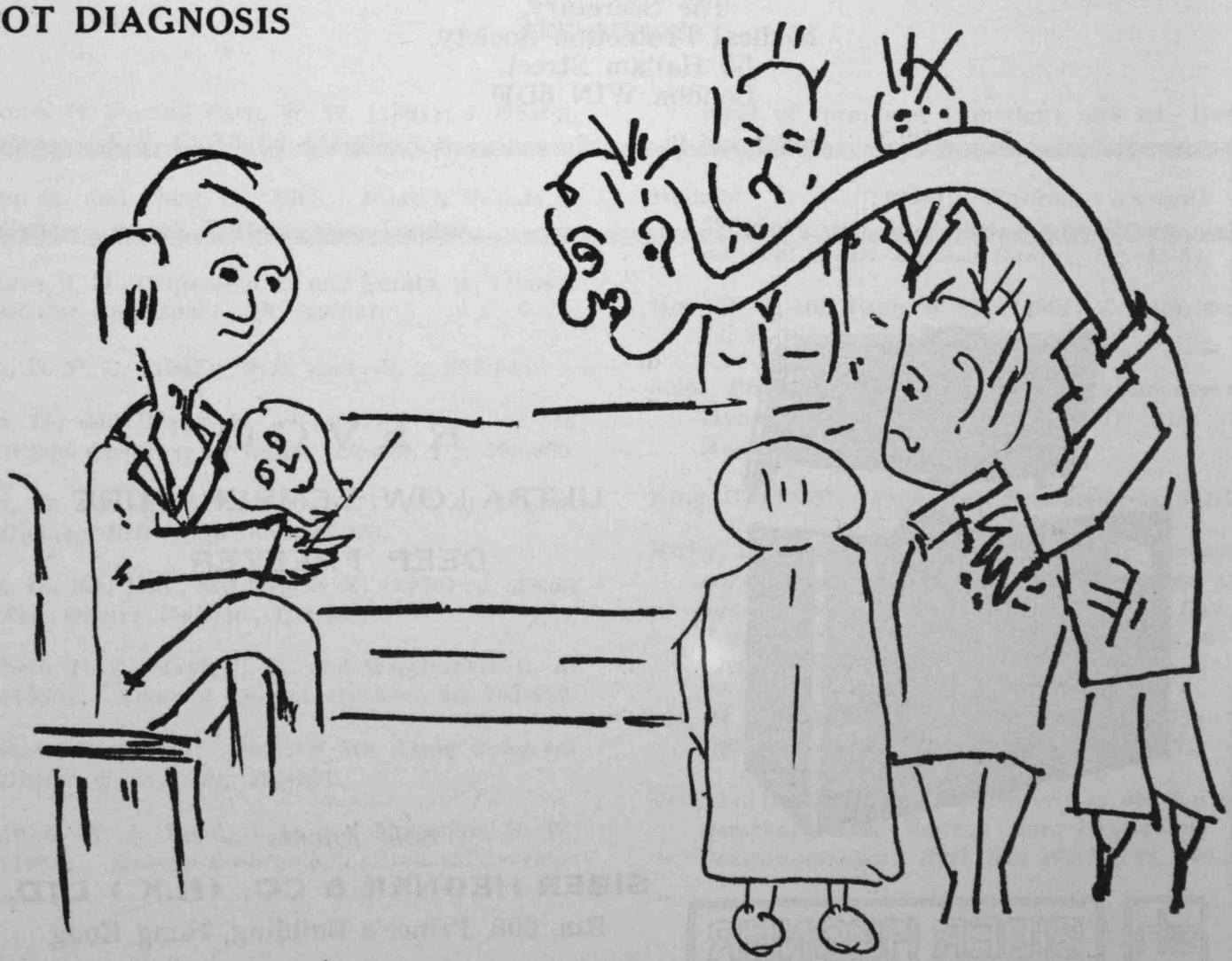
STUDENT PATIENT RELATIONSHIP



SPOT DIAGNOSIS



Answer:—

The most 'eager' one in your class

THE AILING ANUS

by

A. VAN LANGENBERG, F.R.C.S., F.R.C.S.E., F.A.C.S.

Senior Lecturer in Surgery, University of Hong Kong

Most ano-rectal conditions are not fatal or even life-threatening. For this reason the subject is often regarded as mundane and lacking in excitement, especially in comparison with achievements in the more spectacular branches of surgery. It is, however, difficult to think of another group of conditions as irritating, troublesome, and as widespread as ano-rectal ailments. Consider your own circle of friends and relatives and this fact will probably become apparent to you. It is almost impossible to have a roomful of people without someone in the group who has or has had anal problems.

The ailing anus is as old as antiquity itself. Probably the earliest record of a practising proctologist is an Egyptian inscription dating back to 3000 B.C. which reads: "Opthalmologist and Guardian to Pharoah's Anus". What the connection is between opthalmology and proctology,

Fig. 1

Rectal examination from a fourteenth century manuscript, the Surgery of Theodoric.

however, I do not know! The study of ano-rectal surgery traces the progress of surgery through the ages and reveals a great deal about the men who developed and practised the art. Much of the practice was in the hands of quacks (as in Hong Kong today) but steady progress was made by succeeding generations of men of vision. Many accumulated great wealth such as the surgeon Felix, who in 1686 successfully operated on Louis XIV of France for anal fistula and won for himself a farm, a title, and the present day equivalent of $250,000. We will never know what would have happened to him if he had failed, but we do know that at one time heavy penalties were inflicted on surgeons for failure, even to the extent of having a hand cut off (Code of Hammurabi. Babylon 2250 B.C.)[1]. The oldest known scientific document, the Smith Papyrus (1700 B.C.),[2] refers briefly to anal diseases:

> "If thou inspecteth a man ailing in his anus, whether standing or sitting, suffering very greatly with seizures in both his legs, thou shouldst give a recipe, an ointment of great protection: Acacia leaves, ground, triturated and cooked together. Smear a strip of fine linen therewith and place in his anus, that he may recover immediately."

Exotic pharmacy such as the above, was very commonly practised in those days as witness the following treatment for prolapse found in another ancient document, the Ebers Papyrus (1500 B.C.)[3]:

> "Another remedy for the dislocation of the anus: Myrrh, Frankincense, rush-nut from the garden, celery, coriander, oil, salt; are boiled together, applied in seed-wool and put into the hinder part."

Fig. 2

A fifteenth century illustration of a surgeon Probing an anal fistula.

Later, in the era of early Greek culture descriptions of surgical operations are found. In the Hippocratic Treatises (460 B.C.)[4] we find a description of the ligature operation for haemorrhoids:

> "And Haemorrhoids in like manner you may treat by transfixing them with a needle and tying them with a very thick and large woolen thread. When you have secured them, use a septic application, and do not foment until they drop off, and always leave one behind."

The suggestion "and always leave one behind" is interesting. The same advice is sometimes still given to young surgeons dealing with large circumferential piles, lest too much mucosa be removed and a stricture result. Could it be that stricture was known in those days? If it does, then this operation must have been quite commonly practised even in that period. In the same document we find an early attempt at explaining the aetiology of haemorrhoids:

> "The disease of haemorrhoids is founded in this way: if bile or phlegm be determined to the veins of the rectum, it heats the blood in the veins: and these veins becoming heated attract blood from the nearest veins and being gorged the inside of the gut swells outwardly, and the heads of the veins are raised up and being at the same time bruised by the faeces passing out and injured by the blood collected in them, they squirt out blood, most frequently along with the faeces but sometimes without faeces."

An interesting and vivid account, though not quite accurate. Others considered piles to be a natural safety valve in the portal system and the disease was thereby linked to cirrhosis of the liver when there is obstruction to the flow of portal blood. However no explanation was given as to why haemorrhoids are usually found without similar dilatation of the other tributaries of the portal vein and how it can occur without any evidence of portal obstruction. Morgagni (1794)[5] came closer to a rational concept when he wrote:

> "And therefore, to omit other things, the very great length, which is peculiar to this one vein (the superior haemorrhoidal) among the others, so that it is much more difficult for the blood to be carried upwards, from this vein, than from others especially as the situation of the human body requires it, which, without doubt, is one of the reasons why other animals are not subject to piles. And if you ask why, in those bodies in which there is any impediment to the quick motion of the blood upwards, the veins of the legs in particular are dilated into varices, you will find the same thing to be the cause of them chiefly which we assign for the piles."

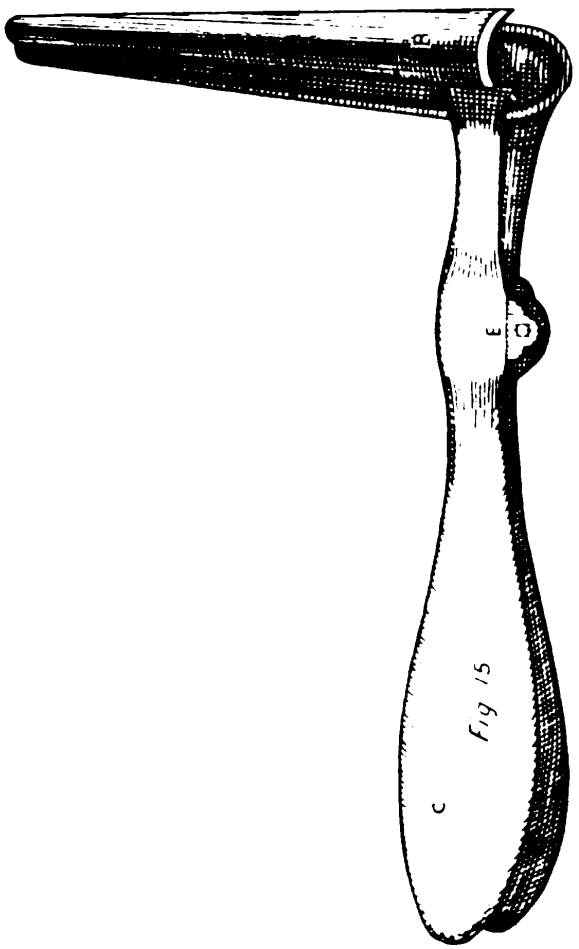
Morgagni regarded piles (and varicose veins of the lower limbs) as the price Man pays for the dignity of the erect posture. The relation of heightened pressure with the haemorrhoidal veins and the erect posture has more recently been demonstrated by making manometric readings within the veins of patients in the horizontal and sitting positions while under saddle block[6]. In the horizontal position the pressure varied from 230-250 mm. of water and this rose to between 600 and 750 mm. of water in the sitting position. Indeed some present day authorities regard haemorrhoids as a condition we are born with, and which may, in later life, progress to a state to produce symptoms such as bleeding and prolapse.

Examination of ancient literature reveals many accounts of the ligature operation similar to that attributed to Hippocrates and this was widely held to be the most effective means of dealing with the problem. Later ligature was combined with excision of the piles. However it appears that little distinction was made between the sensitive anal lining and the rectal mucosa because this operation consisted in applying a ligature to the entire haemorrhoid, including the skin covered portion. It follows that the patients of those pre-anaesthetic times were no strangers to pain. Later, when the facts were clearer Brodie (1835)[7] taught:

> "The application of the ligature to internal piles in general causes little pain, and only a slight degree of inflammation follows, for the mucous membrane has nothing like the sensibility of the skin and does not resent an injury in like manner."

Fig. 3

Anal retractor from Heister's Textbook of Surgery (1739).



In 1774 Jean Petit published a three-volume surgical text in which he recorded a case of severe rectal stricture following excision.[8] He rejected both the ligature and excision operations because of the sacrifice of mucosa and described how the piles alone should be dissected off through an incision in the mucosa. This required gentle and precise technique. Despite its obvious good sense, however, it was rejected by most of his contemporaries because it was too difficult and tedious. In recent years his operation has enjoyed a revival and has become the standard method of haemorrhoidectomy in many hands.[9] Present day haemorrhoidectomy developed from Frederick Salmon, founder of St. Mark's Hospital, who published a book on rectal surgery in 1828.[10] He showed that the vascular pedicle of a pile descends in the long axis of the bowel and can be dissected off the underlying muscle with ease. He therefore modified the old ligature method by incising the perianal skin and lifting the plexus of veins away from the anal musculature, finally ligating the pedicle. The modern Milligan-Mogan operation (1937)[11] is but a modification of Salmon's method. Salmon also believed that a degree of anal narrowing was partly responsible for the development of haemorrhoids and regularly dilated the sphincters of his patients before haemorrhoidectomy. This concept in fact had originated in France where for a long time rectal bouginage was used for the conservative management of piles. This like Petit's submucosal haemorrhoidectomy, has also been re-introduced to modern surgery. Lord (1968)[12] claimed that

forcible dilatation of the sphincters destroys the constricting "pecten band" which he believes is an important aetiological factor. This is followed by regular bouginage using a large perspex dilator. Excellent results are claimed. Other "modern" methods have also been inspired by ancient thought such as the clamp and cautery procedure. The Hippocratic Treatise dealt with it briefly:

> ". . . . . force out the anus as much as possible with the fingers, and make the irons red hot, and burn the pile until it is dried up, so that no part may be left behind."

Even phenol injection, one of our present mainstays of treatment was first used about a hundred years ago. The method was apparently first devised and used by quacks and it was not until many years later that it was investigated by the medical profession and put to good use[13].

What then, have we learned about the treatment of piles and what methods have survived? Phenol injection is still the most acceptable means of dealing with the smaller piles causing symptoms mainly by bleeding. Haemorrhoidectomy of the Milligan-Morgan or Petit variety is used for the more serious cases especially when prolapse is the main complaint. Lord's anal dilatation is widely used — perhaps too widely used. It has the advantage of simplicity but has no acceptable rationale behind it. I feel it is only useful to provide rapid but temporary relief for painful piles which are prevented from returning to the anus by the spastic internal sphincter, which after all is what the "pecten band" really is. These piles will later have to be dealt with on their merits by the other methods. Clamp and cautery is still practised but with a declining popularity because of the excessive tissue slough produced. The simple ligature operation too has a modern representation — the Barron's ligator[14] which is a special appliance to ensnare the mucosal portion of the pile with a tight rubber band. This is proving to be a surprising successful means of reducing the number of patients requiring haemorrhoidectomy and may well find a permanent place in our armamentarium.

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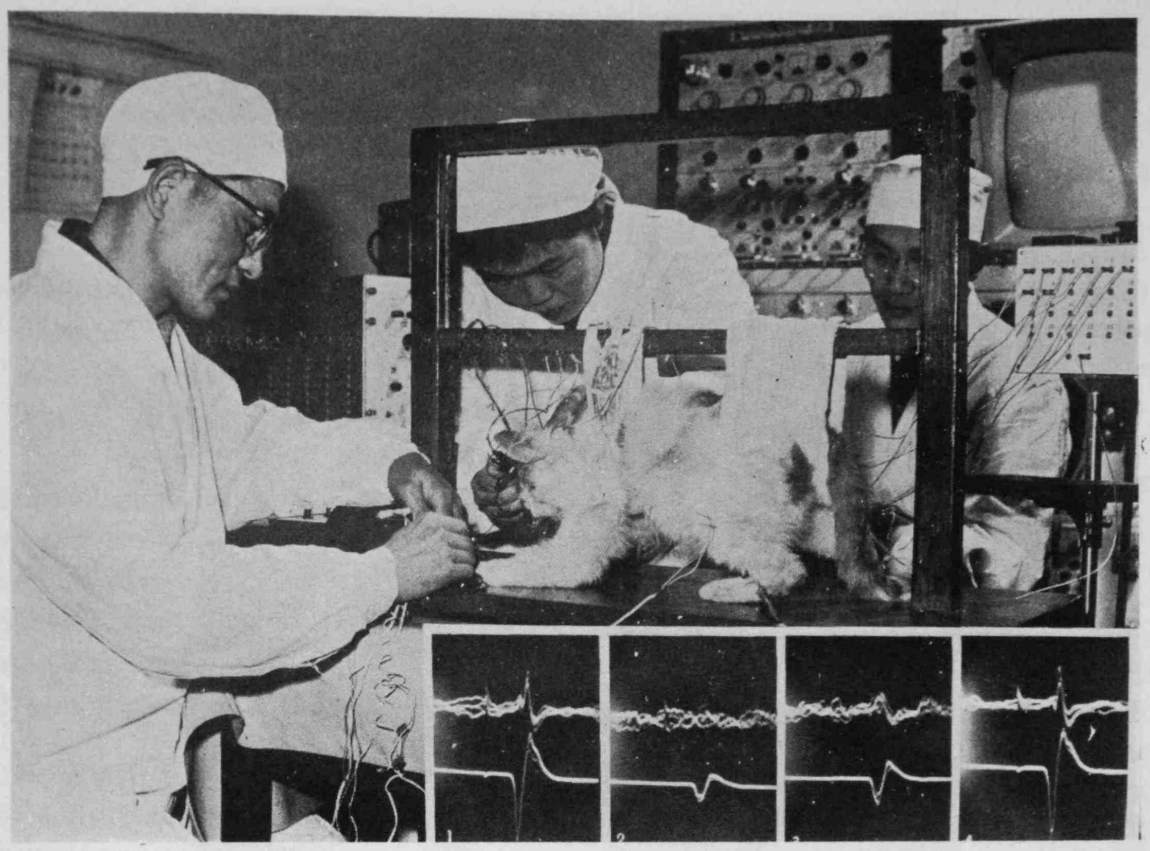
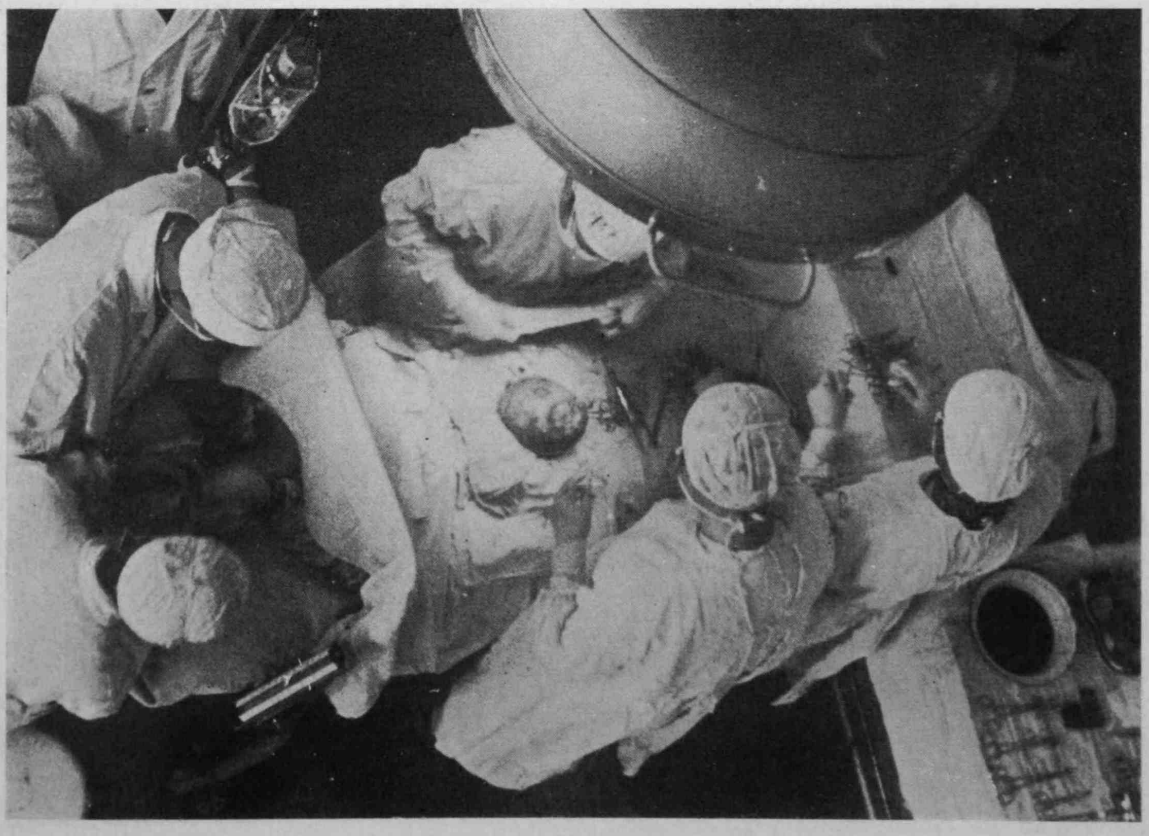
Childhood and genius have the same master-organ in common-INQUISITIVENESS.

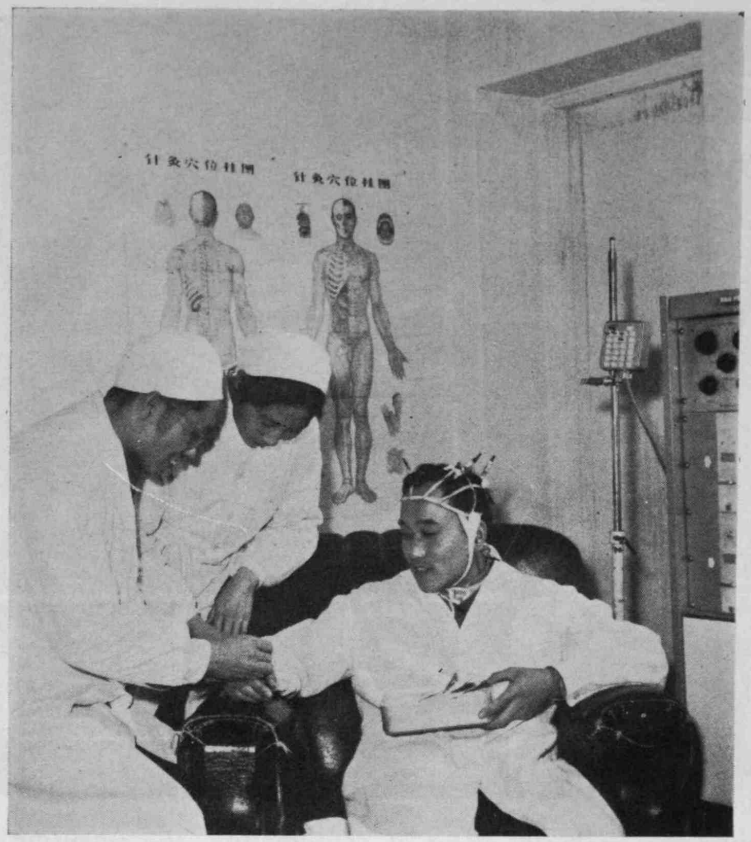
— E. G. Bulwer-Lytton.



For the purpose of studying the analgesic effect of acupuncture, the scientific workers have carried on experiments on animals by means of modern physiological and biochemical methods. Photo: Experimenting on a waking cat. Right corner insets show the results of the stimulation test of the cat's dental pulp. Picture 1: Before needle sitmulation. Picture 2: Immediately after needle stimulation stopped. Picture 3: Three minutes after needle stimulation. Picture 4: Twenty minutes after needle stimulation. The pictures show a remarkable inhibition both of electrocorticogram (ECG) evoked by the stimulation of cat's dental pulp, and electromyogram (EMG) after acupuncture.



Acupuncture anesthesia is being widely used in hospitals and clinics in China's cities and rural areas. Operations from tooth extraction to pulmonary resection can be performed under acupuncture anesthesia on patients ranging from new-born babies to the aged. Photo: Ovario-cystectomy done with acupuncture anesthesia.



Through repeated clinical observations and scientific experiments, Chinese medical workers have discovered that acupuncture can accelerate cerebral metabolism, coordinate the brain function and keep the brain in an active state. Photo shows members of a research group on the theory of acupuncture anesthesia in Peking making experiments on themselves to study the effect of acupuncture on the central nervous system.

Acupuncture anesthesia has been developed on the basis of extensive clinical practice. Photo: Medical workers of the Peking Tuberculosis Research Institute perform a lung operation by inserting a single needle into the body of the patient to induce anesthesia. The operation proved a success.

ACUPUNCTURE.....

By Dr. D. Yu

The recent blossom of acupuncture into the limelight has attracted the masses of professionals and layman alike as moths unerringly towards this aesthetic flame. It is perhaps for this reason that I have been asked to contribute to the spawning articles written on the subject. As one that has been exposed to a discipline less traditional and even to the extent of "revolutionary" as compared with the philosophy of Chinese medicine, one can only express one's own thoughts and perspective in this field.

It would be sheer folly to dismiss acupuncture as purely a form of quackery in the present context. Acupuncture has not only withstood the test of time, but also enjoyed a recent upsurge of fascination and interest never as acute as in its whole existence. It has been transformed by entering a new era, free from the apron strings of myriads of closely and jealously guarded family secrets, to a respectable art even in medical literature. The stories, actual documentations, experiments, claims and counter claims attesting to the effectiveness of acupuncture in the treatment of a multitude of illnesses are legion, appearing both in the lay press and professional journals alike. It is time to sit back and ponder what subsequent course can acupuncture evolve. Simply because of an "over-kill" in the claims, to witness acupuncture pass away like a fickle female fashion fad would be tragic. It would equally be disastrous to mimic to course taken by immunology in its infantile days, when indiscriminate claims of successful desensitization for practically all ills by allergist had put back the progress of immunology for at least 10 or more years.

Hippocrates once observed: *"Experience is fallacious and judgement difficult"*. This is attributable to a highly selective built-in bias in the retention of the human brain. To be able to recall agreeable and pleasant experience and conveniently forget the disagreeable or unpleasant ones, is a human in-born error that even physicians cannot escape. A catalogue of examples in Western medicine to substantiate this point would be simply impossible because of sheer magnitude. One of the best examples perhaps concerns the use of venesection in the treatment of lobar pneumonia. Just so happened that an eminent clinician had the clinical impression of patients recovering from lobar pneumonia following empirical venesection, this form of therapy became the standard regime of the day. Many of such patients had been virtually exanguinated with dire consequences until a controlled trial later showed conclusively that venesection not only had no therapeutic value at all but produced greater morbidity and mortality. It is but a healthy attitude to challenge authority and be a rebel with a cause in the search and isolation of facts from fancy.

Despite the well documentation in the therapeutic effaciacy of acupuncture in countless diseases, one would really require the following basic minimum knowledge before one can be in a better position to comprehend and perhaps to judge. To start off with, objective instead of subjective evidence of improvement should be available, occuring in a majority of patients suffering from well-defined disease states. The objective evidence of improvement should clearly be better than any placebo effects. Even so, the effect of suggestion or hypnosis in any particular study should be excluded as a cause or significant contribution to the improvement. These are particularly relevant as many diseases pursue a highly variable course in their natural history, and suggestion or hypnosis can exert a strong influence on the immediate and sometimes long-term course of the disease. Bronchial asthma is a classical example of this type. Lastly but not the least, the severity and frequency of side effects should be minimal and acceptable. These points can only be answered in carefully designed stingently controlled clinical trials or experiments, and not by haphazard clinical impressions or pseudo-scientific documentations. It is unfortunate that

the available literature with meaningful and adequate studies of acupuncture is still disappointingly few.

Looking at the brighter side of the perspective, the recent dissemination of acupuncture represents a golden opportunity to enable the use of the well developed present scientific principles to restudy the techniques and therapeutics of the past. A new and exciting investigative horizon is now opened for the inquisitive minds to weed out the unsubstantiated wild claims and to consolidate the genuine facts in acupuncture. In combining the philosophies of the two disciplines — both traditional Chinese and Western — acupuncture may prove to contribute to the therapeutic armamentarium of certain diseases. Since major advances in the understanding of the function of the human body has evolved from the study of diseases particularly in the recent years, hopefully, the study of acupuncture in diseases may permit advancement in the insight of bodily function in health. Blind faith can only ultimately erode the standing of acupuncture. Critical appraisal can and will strengthen this valuable art and Chinese heritage.

A quotation from Francis Bacon aptly summarises my views on acupuncture in therapy: *"If a man will begin with certainties, he shall end in doubts; but if he will be content to begin with doubts, he shall end in certainties."*

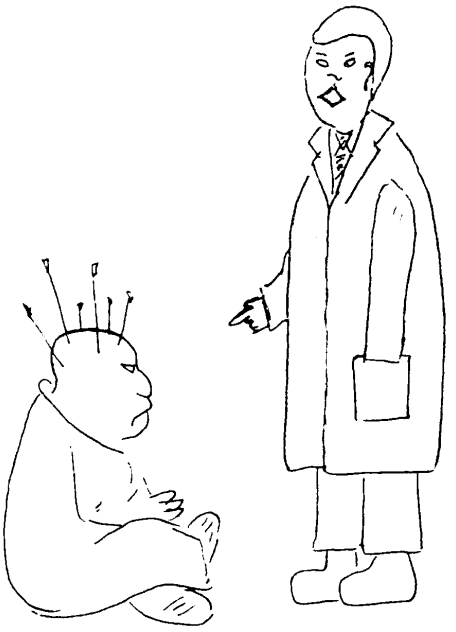
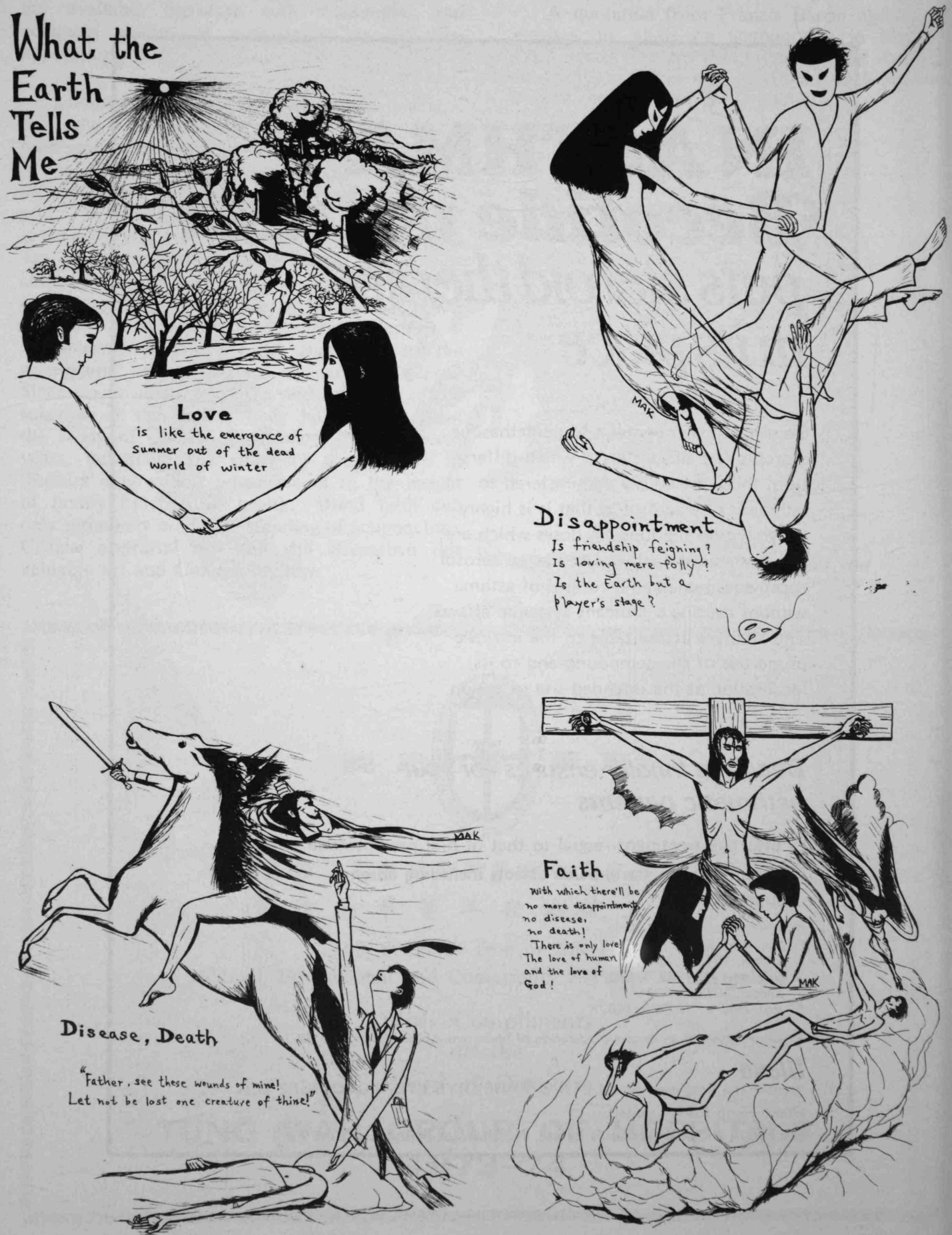


Fig. 1
"Really, Wong, why don't you take some aspirins?"


What the Earth Tells Me
MAK
Love
is like the emergence of Summer out of the dead world of winter
MAK
Disappointment
Is friendship feigning?
Is loving mere folly?
Is the Earth but a player's stage?
MAK
Disease, Death
"Father, see these wounds of mine!
Let not be lost one creature of thine!"
Faith
With which there'll be no more disappointments, no disease, no death!
There is only love! The love of human and the love of God!
MAK

THE FAIRER SEX

Substance: Woman

Biological Symbol: ♀

Discover: Man.

Molecular Weight: Accepted at 110, but is known to have isotopes varying from 90 to 140.

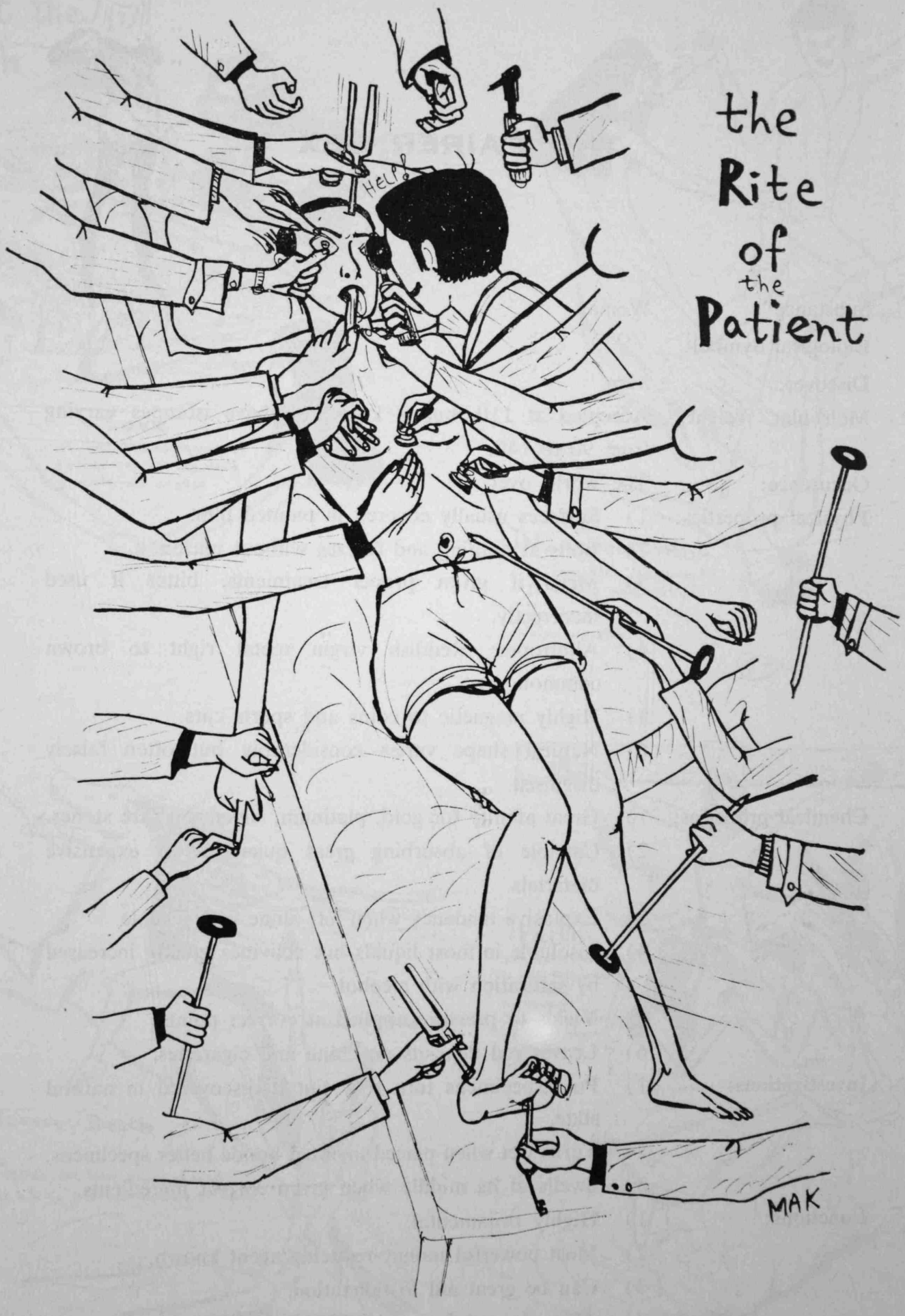
Occurence: The world over.

Physical properties:
1) Surfaces usually covered in painted film.
2) Boils at nothing and freezes without reason.
3) Melts if given proper treatments, bitter if used incorrectly.
4) Allotropes: Reddish virgin metal right to brown common ore.
5) Highly magnetic to coins and sports cars.
6) Natural shape varies considerably but often falsely disguised.

Chemical properies:
1) Great affinity for gold, platinum, silver and rare stones.
2) Capable of absorbing great quantities of expensive materials.
3) Explosive tendency when left alone with a male.
4) Insoluble in most liquids but activities greatly increased by saturation with alcohol.
5) Yields to pressure applied at correct points.
6) Leaves red deposits on china and cigarettes.

Investigations:
1) Pure specimens turn rosy tint if discovered in natural state.
2) Turns wet when placed inverted beside better specimens.
3) Swells at its middle when given correct ingredients.

Functions:
1) Highly ornamental.
2) Most powerful money-reducing agent known.
3) Can be great aid to relaxation.
4) A good asset for social functions.


the Rite of the Patient
HELP
MAK

MEDICAL ETHICS: A CHRISTIAN VIEW

Mok Chiu Yau

It is a pity fact that our Faculty of Medicine, perhaps the best and most advanced medical school in S.E. Asia, cannot even provide its students with sound teachings of the basic concepts of medical ethics which is so unique and characteristic of the medical profession. The practice of good medical ethics is vital for the society to have faith in medical men. There is no need to say why presently in Hong Kong the medical profession is "respected" but not dignified.

No other profession has so long a history of established professional ethics as that exemplified in our Hippocratic Oath, dated from about 200 B.C. Medical ethics is indeed our glorious inheritance. "Ethics" has been defined as the science of moral duty, or, more broadly, the science of the ideal human character and the ideal ends of human action; the chief problems with which ethics deals concern the nature of the highest good, the origin and validity of the sense of duty, and the character and authority of moral obligation[1]. As medical practice and experimentation concern human beings, totally unlike many other sciences which deal with non-living things (e.g. inorganic chemistry), some kind of ethics is more than appropriate here, all the more so if we consider it as a transaction with the health and lives of men.

Throughout the history of medical ethics idealism is the common attitude. Although a doctor may not be required to take an oath at graduation, he is expected to uphold the highest standard of practice, and this is to be done at all costs. A brief look at the Hippocratic Oath[2], whose influence is felt through many centuries up to the present, would make this obvious. In 1948 a modernised version of the Hippocratic Oath was adopted by the World Health Organisation in Geneva — the Declaration of Geneva[3]. This was adopted in 1949 by the General Assembly of the World Medical Association as an International Code of Medical Ethics, meant to be observed by all members of the profession in all countries comprising the Association.

From time to time small tracts on medical ethics were published. Perhaps the best-known early book in English on the topic is that by Dr. Thomas Percival[4] (1740-1804), a Manchester physician. His "Medical Ethics" had guided the many codes of the English-speaking world, including the American Medical Association Codes. In 1953 the British Medical Association published the booklet "Ethics and Members of the Medical Profession". A special issue of The Practitioner on "Medical Etiquette" (i.e. conventional rules of behaviour) was out in July, 1957. However, in general, works on medical ethics are poorly represented on library shelves as contrast to those on clinical and therapeutic sciences. A good illustration is given in our Medical Library which contains only about 20 to 30 books on medical ethics.

The value of a code of ethics is easily seen. But what are its limitations? In summary, the Hippocratic Oath embodies four main principles: our aim is to advance the Profession and not the individuals; we should not use our knowledge to injure, but to help patients; we should defer to specialist assistance when this is for the best of the patients; we must maintain professional secrecy. There are several limitations for any code like this.

Firstly, there are philosophical questions on the authority of the code: Why must the health of the patient be my first concern? Is this solely for conscience's sake or based on some absolute truth? Why should we maintain a certain kind of doctor-patient relationship? Is this just for society's sake? Why do we think certain relationship as good, or in fact, what is 'good'?

Secondly it is not all-embracing. There are situations in which no relevant principles of the

code can be applied. For example, the Hippocratic Oath does not contain principles governing medical research through human experimentation and these have to be provided by the Declaration of Helsinki by the World Medical Association in 1964.

Thirdly a code can only judge actions but not motives while the two are equally important in any inter-personal transaction.

Fourthly in some situations, obedience to laws may precipitate headlong conflict when one principle can only be followed at the expense of another. Professional ethics may have conflict with morality in general.

Lastly, a code is limited by time and place. Society's concepts of 'good' and 'bad' may change with time, and countries of different cultures may need to modify the code.

In the past few decades, advances in chemotherapy, neurosurgery, methods of birth control, transplantation, provision of State Health Systems in many countries and the rivalry among different professional classes pose ever-increasing problems which call for a fresh look on our professional ethics if we are to advance welfare for humanity and dignity of our profession.

Christian Ethic

Christianity, though it claims to be authoritative in matters concerning the meaning of life and gives guidelines of conduct for the best of human welfare[5], does not set any permanent code to be followed for its sake. Jesus Christ has taught us the golden rule: **You shall love the Lord your God with all your heart,** and **with all your soul,** and **with all your mind.** This is the great and first commandments. And a second is like it, **you shall love your neighbour as yourself.** On these two commandments depend all the law and the prophets.[6] Christ's teaching has much in support for the Hippocratic Oath and Christians should whole-heartedly endorse the main principles of it. However, in some fundamental aspects the Christian ethic differs from natural ethics[7].

1. The authority of natural ethics lies in the opinion of the majority of people while that of the Christian ethic lies in God — the Creator of man and things. A basic Christian belief is that God created man and things, loves them and gives man a perfect goal towards which man should strive in life. There is true 'good' — anything in harmony with the personality and will of the perfect God. Men's utmost happiness is experienced through obedience to God's will — both directly through worshipping God and indirectly through doing their duty among people on earth. Moreover, man is made in the image of God[8] (with personality, intellect, emotion and will) and is loved by Him, so that care for one another, whether medically or otherwise, is a sacred and necessary duty to be done with joy and respect.

2. Natural ethics deal with actions; the Christian ethic is primarily concerned with motives. Love[9] is the supreme law and the keeping of all other laws should be motivated by love. It often involves sacrifice on one's part for the good of others. Christ teaches us to do good, not to bring praise to ourselves, but out of love, to deny ourselves. We should ask ourselves more: why did I take up the medical profession? Why am I studying so hard to get qualification? What prompts me to choose a certain specialty?

3. The demands of natural ethics can be satisfied to the letter; the love of Christian ethic knows no limit. We may fulfill all the routine work of history taking, physical examination, making diagnosis, doing investigations, giving treatment and follow-up with a full sense of responsibility. However, do we often try to know the patient more personally, thinking of him as a 'person to be helped' and not a 'case to be treated', understanding his anxiety and desires? How much time and energy do we spend to help him and his relatives to understand his situation and to solve problems which may not have any clinical significance? Christ has set us a good example: "As he went ashore he saw a great throng and he had compassion on them, and healed their sick."[10]

4. Natural ethics are sometimes practised according to classes, whether of race or socio-economy; the Christian ethic is universal. We may, in a private hospital for the rich, practise the Hippocratic Oath quite successfully, making the patients our first consideration, securing a respect for the Profession, calling specialist assistance when necessary and keeping professional secrecy, besides earning enough for our living. But how often do we think of the poor and under-privileged? Can we notice that nearly all patients staying in government hospitals or attending their out-patient departments are of the low socio-economic class, suffering the horrible inefficiency of and neglect by the medical staff? We may not be able to do much to improve the system of medical and health care or the patients' economy; but at least do we wish to give first class medical care to these people? How often do we use these excuses: 'Medicine is a big field in itself', 'We are too busy', 'We'll never finish it if we care so much', for the neglect of people's health and happiness? Christ teaches us to love our neighbours as ourselves and our neighbours are those around us whom we can help.

After all, one may say Christianity is not unique in these as occasionably one may come across some non-Christian doctors who have good motives alongside actions, whose patience and concern for the sick seem so great and who can fulfil his duty to all under his care. But is it not just these things that we fail to do with joy and love, constantly and persistently, because of our corrupted nature in all its self-centredness? Yet Jesus Christ, the Son of God, had come into our world to live out as example for us a perfect pattern of life, and through his death on the cross and resurrection from the grave, enables us, if we so will, to restore a proper relationship with our Creator and Father, and gives us new life and power to carry out our duty to our fellow human beings, either as members of the medical profession or otherwise, to fight for perfect human happiness. This is the Christian answer.

[1] Webster's New International Dictionary.

[2] See Appendix 1. Hippocrates (460-377 B.C.) was a Greek physician born in the Island of Cos in the south-east of the Agean Sea and called the father of medicine. He had been given the distinction of being the first to reject the early ignorance and superstition about diseases and to base the practice of medicine on observation and study. The Hippocratic Oath was not written by him.

[3] See Appendix 2.

[4] Thomas Percival was an English physician and author. While still a student, he was elected a fellow of the Royal Society; it was said that he was the youngest man at that time on whom that honour had been conferred.

[5] Christianity is the way of life based on the sole authority of the Old and New Testaments which are the written Word of God.

[6] New Testament.

[7] Natural ethics here means the ethical systems whose origin is the tradition, experience, and reason of man.

[8] Old Testament.

[9] Love here means the will to respect people, desiring to help to attain the highest good for them, even at the expanse of one's own benefit.

[10] New Testament.

REFERENCES

1. The Distinctive Christian Ethic in Medical Practice (Douglas MacG. Jackson, M.D., F.R.C.S., David S. Short, M.D., F.R.C.P.)

2. Encyclopaedia Americana.

3. Dictionary of National Biography.

APPENDIX 1.

The Hippocratic Oath (A translation by W. H. S. Jones)

'I swear by Apollo, Physician, Asclepius, by Health, by Panacea and by all the gods and goddesses, making them my witness, that I will carry out, according to my ability and judgment, this oath and this indenture. To hold my teacher in this art equal to my own *parents;* to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobdy else. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even verily on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now, if I carry out this oath and break it not, may I gain for ever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me.'

APPENDIX 2.

The Declaration of Geneva (W.H.O. 1948)

'At the time of being admitted as a member of the Medical Profession I solemnly pledge myself to consecrate my life to the service of humanity.

I will give to my teachers the respect and gratitude which is their due;

I will practise my profession with conscience and dignity; the health of my patient will be my first consideration;

I will respect the secrets which are confided to me;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession; my colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.'

EXTRACTS FROM THE GAZETTE
1973

HONOURS

Mr. C. T. Yung, laboratory superintendent in the Department of Pathology: *British Empire Medal.*

Dr. Alberto Cruz de Barros Lopes, honorary Lecturer in Obstetrics and Gynaecology, has been made a Commander of the Ordem de Infante Dom Henrique (Order of Prince Henry the Navigator) by the Government of Portugal.

PERSONALIA

Professor F. P. Lisowski visited the following institutes during April to August 1972: the Universities of Basle, Birmingham, Amsterdam, Berlin, Bonn, and Singapore, and the Guy's Hospital Medical School; the Institutes of Anthropology in Berli nand Mainz; the Palaeontological Institute in Frankfurt; the Institute of Molecular Biology in Geneva; and the Institute of Comparative Medicine at the London Zoo. He delivered lectures on human variations in Berlin and Bonn and gave a seminar on locomotor adaptations in the lower limb of primates in Mainz. He also took part in a conference on human growth and development held at the World Organization headquarters in Geneva.

Dr. T. K. Chan, Lecturer, and Dr. S. C. Tso, Senior Lecturer in Medicine, have been elected Fellows of the International Society of Haematology.

Dr. F. C. Y. Cheng, Dr. A. van Langenberg, Dr. C. H. Leong, and Dr. P. C. K. Yue, Senior Lecturers in Surgery, have been elected Fellows of the Amreican College of Surgeons.

Professor J. L. M. Dawson attended the Twentieth International Congress of Psychology held in Tokyo, and delivered two invited papers. He also acted as representative for the Hong Kong Psychological Society at the International Union of Psychological Science Council meetings.

Professor K. Singer has been appointed to serve on the editorial board of Social Science and Medicine.

Professor A. R. Hodgson was guest speaker at the New England Orthopaedic Association meeting from May 30 to June 2, 1972, and gave three papers. He attended the Canadian Orthopaedic Association meeting held in Quebec from June 10 to 15, 1972, and the American Orthopaedic Association meeting held in Bermuda from June 23 to 30, 1972. He delivered papers at the British Orthopaedic Association meeting held from September 20 to 24, 1972; at the SICOT meeting held in Tel Aviv in October 1972; at the international scoliosis seminar held in Jerusalem in October 1972; and at the South African Orthopaedic Association meeting held in Durban from October 25 to 30, 1972. He was visiting professor at the University of São Paulo from November 3 to 10, 1972, and gave three papers in a postgraduate educational seminar on anterior spinal surgery. He was also guest speaker in the American Academy of Orthopaedic Surgeons seminar on scoliosis held in New York from November 12 to 14, 1972, and gave three papers.

Dr. P. K. Das, Lecturer in Biochemistry, attended the Eighth International Congress on Clinical Chemistry held in Copenhagen from June 18 to 23, 1972, and acted as chairman for the session entitled 'Enzymes of erythrocytes and leukocytes'. Four papers with himself as co-author were presented at the Congress. He also organized a study group on cholinesterases and visited the Clinical Chemistry Laboratory of Regshospital of Copenhagen.

Professor K. K. Cheng attended the Fifth International Congress on Pharmacology held in San Francisco from July 23 to 28, 1972.

Dr. S. T. Chou, Lecturer in Pathology, attended the Fourth International Congress of Histochemistry and Cytochemistry held in Kyoto, from August 21 to 26, 1972.

Dr. A. K. Y. Lee, Lecturer in Medicine, attended the International Liver Congress held in Capetown from January 22 to 26, 1973, and presented a paper entitled 'Australia antigen in Hong Kong Chinese'.

Dr. C. C. Liang, Lecturer, and (Miss) Cheung Yuen Ming, Assistant Lecturer in Physiology, attended the regional meeting of the International Union of Physiological Science held in Sydney, from August 21 to 25, 1972. Dr. Liang presented a paper entitled "Renal Cholinergic nervous reflex arising from stimulation of the portal circulation receptor" and Miss Cheung presented a paper jointly with Dr. J. C. C. Hwang, Senior Lecturer in Physiology, entitled "A technique for measuring changes of sarcomere lengths in single striated muscle fibres.

Dr. M. G. P. McCabe, Senior Lecturer in Biochemistry, attended the 3rd European Symposium on connective tissue research held in Turku, Finland, from August 17 to 19, 1972. He also attended the eighth meeting of the Federation of European Biochemical Societies from August 20 to 25, and a colloquium on bitochondrial respiration from August 26 to 27, 1972, both held in Amsterdam.

Dr. W. C. Chan, Senior Lecturer in Pathology, attended the Fifth International Congress of Nephrology held in Mexico City, from October 7 to 14, 1972, and presented a paper at the renal biopsy session. He was elected a member of the Australasian Society of Nephrology in March 1972.

Professor J. L. M. Dawson attended an Asia Society symposium entitled 'Education and human resources: individual modernization in school and non-school settings' held in Chiangmai, Thailand, from November 30 to December 3, 1972, and delivered a paper entitled 'Theoretical and measurement problems in the study of individual modernity with particular reference to East Asia.'

Dr. C. K. Mok, Lecturer in Surgery, attended and presented a paper at the Fifth Asian Pacific Congress of Cardiology held in Singapore from October 7 to 14, 1972.

Dr. Doris E. Gray, Reader in Biochemistry, attended the annual chemical congress of the Royal Institute of Chemistry held at the University of Wales from March 26 to 30, 1973.

Dr. F. C. Y. Cheng, Senior Lecturer in Surgery, attended the First Asian Pacific Congress of Endoscopy held in Kyoto from April 2 to 4, 1973, and presented a paper entitled 'Peritoneoscopy in primary carcinoma of liver' prepared jointly with Professor G. B. Ong and Dr. J. L. Taw, Lecturer in Surgery. He chaired one of the sessions entitled 'Benign lesions of the gastrointestinal tract'.

Professor F. P. Lisowski visited, at the invitation of the Academia Sinica, a number of institutes and medical colleges in China from April 8 to 30, 1973. He gave lectures and held seminars during these visits.

Dr. (Mrs.) Huang Chan Shuk-Tsz, Reader in Anatomy, attended and presented a paper at the eighty-sixth meeting of the American Association of Anatomists held in New York from April 9 to 12, 1973.

Dr. J. C. C. Hwang, Senior Lecturer in Physiology, attended the international school of biophysics on synapses held in Eric, Italy, from April 23 to May 9, 1973.

Professor C. T. Huang attended the twelfth southeast Asian regional seminar on tropical medicine and public health and the fourth seminar of tropical medicine both held in Seoul from May 28 to June 2, 1973. He participated in the panel discussion on problems of the chemotherapy of parasitic and enteric infection.

Dr. C. H. Leong, Senior Lecturer in Surgery, has been elected a Member of the International Society of Nephrology.

Dr. P. K. W. Chan, Dr. K. O. Leung, Dr. S. C. So, and Dr. H. H. Y. Yu, Lecturers in Surgery, have been elected Fellows of the Royal Australasian College of Surgeons.

Professor P. H. Teng has been appointed as a founder member & elected a Fellow of the Faculty of Community Medicine of the Royal Colleges of Physicians, United Kingdom.

Dr. V. Y. H. Yu, Lecturer in Paedicatrics, has been awarded the Diploma in Child Health by the University of London. He has also been elected a Member of the Royal College of Physicians, United Kingdom.

SENATE

Senate membership

Dr. W. C. Chan and Dr. C. W. Ogle have been elected by the non-professorial members of the Board of the Faculty of Medicine as members of the Senate for the periods ending respectively March 31, 1974, and November 30, 1975.

Elected as Members of Senate for the period ending August 31, 1974.

Faculty of Medicine: Mr. Au Tak Jor.

External Examiners

The following have been appointed External Examiners:

Professor W. A. Gillespie, Professor of Bacteriology at the University of Bristol, in Microbiology, for three years from 1973 to 1975.

Professor W. A. J. Crane, Joseph Hunter, Professor of Pathology at the University of Sheffield, in pathology, for 3 years from 1973 to 1975.

Professor Phoon Wai On, Professor of Social Medicine and Public Health at the University of Singapore, in Preventive and Social Medicine, for three years from 1973 to 75.

Professor H. B. Wong, Professor of Paediatrics at the University of Singapore, in Paediatrics for the Final M.B., B.S. Examination in January 1973.

Professor R. J. Kellar, Professor of Obstetrics and Gynaecology at the University of Edinburgh, in Obstetrics and Gynaecology, for the Final Examination in May 1973.

Professor I. Donald, Regius Professor of Midwifery at the University of Glasgow, in Obstetrics and Gynaecology, for the Final Examination in May 1974.

COUNCIL

Gifts and grants

Mr. Yip Kwing Kwong: $10,000 for the Department of Medicine research fund.

The Wing Lung Bank, Ltd.: $1 million to establish a 'Wing Lung Bank Medical Research Fund' in commemoration of its fortieth anniversary.

FACULTY OF MEDICINE

Appointments

Frank Cheng Chi Yan, M.B., B.S. (Hong Kong), F.R.C.S. (Edinburgh and England), Lecturer, appointed Senior Lecturer in Surgery from November 1, 1972.

The following appointed as Lecturers in Surgery:

Thevakaruna Thavaratnarajah Alagaratnam, M.B., B.S. (Ceylon), F.R.C.S. (Edinburgh and England), from January 3, 1973.

David Chan Wing Hoi, M.B., B.S. (Hong Kong), F.R.C.S. (Edinburgh), and Lam Kam Hing, M.B., B.S. (Hong Kong), from February 1, 1973.

Leung Kwok On, M.B,. B.S. (Hong Kong), from January 10, 1973.

Pannalal Nandi, M.B., B.S. (Calcutta), F.R.C.S. (Edinburgh and England), from March 16, 1973.

Chan Woon Cheung, M.B., B.S. (Hong Kong), Ph.D. (London), M.R.C. Path., Senior Lecturer, appointed Reader in Pathology from March 1, 1973.

Yeung Kwok Keung, M.B., B.S. (Hong Kong), M.Sc. (Michigan), M.R.C.O.G., Lecturer, appointed Senior Lecturer in Obstetrics and Gynaecology from March 1, 1973.

Eva E. Cerny, B.Sc. (Wayne State University), M.Sc. (Michigan State University), Ph.D. (Louisville), appointed Lecturer in Anatomy from April 30, 1973.

Chow Shew Ping, M.B., B.S. (Hong Kong), L.M.C.C. (Canada), appointed Lecturer in Orthopaedic Surgery from April 1, 1973.

(Mrs.) Lily Tung Ma. Dip.Med. (Tientsin Medical College), appointed Lecturer in Pathology from April 1, 1973.

Tom Robin Caine Boyde, B.Sc. (Durham), M.D. (London), appointed to the Chair of Biochemistry from September 1, 1973.

(Mrs.) Huang Chan Shuk Tsz. M.B. (National Chung Cheng Medical College), Ph.D. (Hong Kong), Senior Lecturer, appointed Reader in Anatomy from June 1, 1973.

Thomas King Kwong Chen, M.D. (Edinburgh), M.R.C.P., Lecturer, appointed Senior Lecturer in Medicine from July 1, 1973.

Samuel Chan Hing-Hun, B.Sc. (Chinese University of Hong Kong), Ph.D. (Indiana), appointed Lecturer in Physiology from September 1, 1973.

Chan Kow Tak, M.B., B.S. (Hong Kong), appointed Clinical Pathologist from July 1, 1973.

Kwan Yiu Lam, M.B.,B.S. (Hong Kong), and So Shun Yang, M.B.,B.S., (Hong Kong), appointed Lecturers in Medicine from July 1, 1973.

Peter Lam How Mun, M.B.,B.S. (Hong Kong), Lee Nim Wang, M.B.,B.S. (Hong Kong), Christopher Joseph Fat Lim Chui Wan Cheong, M.B., Ch.B. (Edinburgh), and Peter Lui Wan Woon, M.B..B.S. (Hong Kong), appointed Lecturers in Surgery from July 1, 1973.

Ng Man-lun, M.B., B.S. (Hong Kong), appointed Lecturer in Psychiatry from May 1, 1973.

Lou Te Yong, M.D. (Aurora), Dip. A.B. Path., appointed temporary Lecturer in Pathology for two months from September 1, 1973.

Honorary Visiting Professor

Professor I. C. Lewis, M.B., Ch.B., M.R.C.P., D.C.H., M.D., D.P.H., F.R.C.P. appointed Honorary Visiting Professor in Paediatrics for the duration of his visit from January 18 to March 18, 1973.

Visiting Lecturer

Dr. P. Slezak, M.B., B.S. (Sydney), M.R.A.C.P., Senior Medical Registrar at Sydney Hospital, appointed Visiting Lecturer in Medicine under the Bristol-Myers Medical Exchange Scheme, for three months from April 1, 1973.

Resignations

Dr. Minnie W. Y. Pang, Lecturer in Pathology, from Jauary 31. 1973.

Dr. W. T. Lee, Lecturer in Surgery, from February 23, 1973.

Dr. C. K. Mok, Lecturer in Surgery, from May 31, 1973.

Dr. R. Y. H. Yu, Senior Lecturer in Medicine, from August 31, 1973.

Dr. P. C. Hsieh, Lecturer in Surgery, from June 30, 1973.

Dr. S. P. Lee, and Dr. M. Wong, Lecturers in Medicine, from June 30, 1973.

Expiry of contract

Dr. R. L. Hay, Lecturer in Orthopaedic Surgery, on February 6, 1973.

Prizes

The following prizes have been awarded:

Hong Kong University Alumni Prize has been awarded to Mr. Lam Wah Kit.

Ng Li Hing Prize: Mr. Jack Cheng Chun Yiu.

Li Shu Fan Prize in Physiology: Miss Karen Lam Siu Ling.

Li Shu Fan Prize in Biochemistry: Mr. Chan Ka Kam.

Ho Fook Prize: Miss Karen Lam Siu Ling.

Janet McClure Kilborn Prize: Miss Karen Lam Siu Ling.

Ho Kam Tong Prize in Preventive and Social Medicine: Mr. Yan Tung Wing.

Mun Gold Medal: Mr. To Luen Bik.

R. M. Gibson Medal: Mr. Chan Ka Wah.

DEPARTMENT OF PATHOLOGY:

CHAN WOON CHEUNG,

M.B.,B.S. (Hong Kong), Ph.D. (London), M.R.C.Path.

Dr. W. C. Chan, Senior Lecturer, has been appointed Reader in Pathology from March 1, 1973.

Dr. Chan was born in Hong Kong and obtained the degrees of M.B., B.S. from this University in 1957. Upon his graduation he first worked as a house obstetrician in the Tsan Yuk Hospital and subsequently as a house physician in the University Medical Unit, Queen Mary Hospital. From 1958 to 1960 Dr. Chan was a demonstrator in pathology in this University.

Dr. Chan spent the years 1960 to 1962 as a Sino-British Research Fellow in the University College Hospital Medical School, University of London, working under the late Sir Roy Cameron, F.R.S. During the following year he was an M.R.C. research assistant to Professor Tom Symington, F.R.S.E., and concurrently an honorary registrar in pathology in the University Department of Pathology at the Royal Infirmary, Glasgow.

On his return to Hong Kong, Dr. Chan rejoined the University in January 1964 as Lecturer in Pathology and was promoted to a Senior Lectureship in 1966.

Dr. Chan was awarded the degree of Ph.D. by the University of London in 1963 and the became a Member of the Royal College of Pathologists in 1966. His current research interests are renal diseases and environmental carcinogens.

DEPARTMENT OF ANATOMY:

HUANG CHAN SHUK TZE,

M.B. (National Chung Cheng Medical College), Ph.D. (Hong Kong)

Dr. S. T. Chan, Senior Lecturer, has been appointed Reader in Anatomy from June 1, 1973.

Born in Kwangtung, China, Dr. Chan was educated at Lingnan University Medical College, Canton, and the National Chung Cheng Medical College, Kiangsi, where she obtained the degree of M.B. in 1947. Upon graduation Dr. Chan joined the Canton Hospital for two years as an assistant resident and part-time instructor in obstetrics and gynaecology. Coming to Hong Kong in 1951 Dr. Chan became a demonstrator in anatomy at this University, and was subsequently appointed assistant lecturer in 1960, and lecturer in 1963. While on leave in the United States in the year 1968-69, Dr. Chan was a visiting assistant professor of anatomy at the State University of New York at Buffalo. Returning to Hong Kong in 1969 she was promoted to a senior lectureship in the same year.

Dr. Chan's current research interests lie in the study of the bone marrow cells, particularly basophils, and the investigation of the growth and development of Chinese children in Hong Kong, and she has written many articles on these subjects.

積汚塵的頭髮，笑容滿面地幫我提行李，媽媽看看我身上那件自己做的、死板板的花布裙子，稱讚不已，長得簡直認不出來的弟弟妹妹們「姐姐，姐姐」的叫個不停，我自己呢？千頭萬緒之中，像有千言萬語要傾吐，但一切終在不言之中表達了。

十二天的與家團聚，生活是美滿甜蜜，不可忘懷的。爸爸說他每天回公司上班，總是想着我，一放工就趕着回來。媽媽在家伴着我，煲了些我小時候喜歡吃的，連我自己現在亦記不起的食物。無情的歲月，營役的生活，雖爲爸爸媽媽留下了衰老的痕跡，亦是我初時所不忍心見到的，但一切隨即溶於一片融洽的親情之中。牙牙學語的弟弟妹妹，現在已聰明伶俐地長大，兄妹兩人不停地向我講述着他們小時候的生活瑣事，弟弟學會了吹口琴，又練了一手挺拔秀麗的毛筆及鋼筆字，妹妹長得和我一般高，白皙的皮膚，藏着一對炯炯有神的眼睛，和逗人發笑的酒渦，比我記憶中的小妹妹漂亮得多了，於萬里晴空的假日大好時光，合家盡情遊玩於風景怡人的公園裡，留下了不少忘我的歡笑，輕盈愉快的足跡；於涼泌泌的泳池裡，妹妹一片活潑天眞的散發，惹得我亦只得一陣兒的癡笑；最難得可貴的，還是於繁星點點，月兒彎彎的夏夜，納涼於陽台上，一家人不知時間早晚，不覺疲倦的暢談至深夜，要傾吐，要交換的東西，實在太多了，每個人都想在十幾天中，拾回失落於十幾年的眞情，每一分每一秒的光陰，都是滿溢着純眞的愛情，在指間溜過的，不僅是時光，而將是一堆不能磨滅的回憶哦！照了不少相片，這可能是往後唯一有形的回憶吧！亦翻閱了家裡的舊相簿，一張張的相片，一個個生活的片段，一股股的親情溫流，叫我以後怎能忘得下，放得開？爸爸替我買了幾本書，我即在書的第一頁上寫下「親情難忘」幾個字。弟弟妹妹們送了我一些他們寫的字，及手工勞作小品，笑盈盈的要我永遠記得他們，眞的，我怎會把他們在腦中拭去呢？只有在腦海中過多的盤桓，使我嘗試更多離別的苦楚。但無論如何，於思念之苦，發出的將不應是惆悵的嗚咽，而是喜悅的哀嘆，悲悽的微笑。

兒時的伙伴，往外地工作的不少，弄堂裡留下的相識的同伴，相見時只有在驚訝之餘淡然一笑，偶然亦有互作殷切的問候，帶給大家的，眞不知是一片對於歲月流逝的感慨，還是一般眞正重逢的殷喜。長久的分離，到底是將人的感情拉得更牢，更增相逢時的喜悅，還是悄悄地使人與人之間的隔閡之牆，越築越高？滄海桑田，白雲蒼狗，世間之事，又怎能會在人的意料之中？

……

當再一次坐上火車時，紊亂之中，只想告訴自己，應做一枝疾風中的勁草；只想告訴自己，窗外的一切，是柔和調洽的，陽光是絢爛溫暖的，太陽落了復升，月亮缺了又圓，星星滅了又亮，人別了又聚，聚了又別的，實是常情，但抑制不住的淚珠，還是像遇缺了口的堤壩，源源不絕地流了下來。

草於七三・八・二十三晚香港

探親小記

—靜—

三個月的悠悠暑期，又在燠熱夾着倦怠之中來到了。但無論如何，我是心花怒放，興緻勃勃地迎接它的。儘管夏日炎炎，但放假的時光，總是寫意的啊！多少在讀書時得不到的鬆弛，做不到稱心如意的事情，應在假期中如願以償；多少在繁忙時堆積起的人情債，現在應可盡情的重温朋友之情，同學們有的踏上迢迢千里、回大陸觀光的旅途，有的喜氣洋溢的飛向台灣寶島，祖母說我亦應趁着放假，北上探親一次，於是，我開始了十八天的回鄉探親生活。

祖母陪我去領了回港證，又要我同去黃大仙燒香拜佛的懇求菩薩保佑我一路平安，其實，我是不相信廟裡的菩薩的呀！祖父亦橫不放心，豎不放心我一個人的單獨北上，替我買了車票，滙了錢，還是每天晚膳時千叮萬囑的要我小心。我應該帶些什麽東西回去呢？爸爸媽媽需要什麽？弟弟妹妹喜歡什麽？一連幾個下午，奔馳、徘徊於彌敦道、上海街、廟街的大公司及小商店，遵照祖母的意思，替爸爸買了些他喜歡吃的東西，替媽媽剪了些布，好讓她替家人做衣服，自己替弟弟買了一枝鋼筆，一盒顏色筆，幾本封面燦爛的練習簿，替妹妹買了幾條鮮艷奪目的絲帶及花邊，一個小巧玲瓏的銀包，一件游泳衣。多少個黃昏，沐浴於淡淡的夕陽餘暉之中，打開了衣櫃箱子的，在舊衣堆裡搜索些仍可應用的衣物，於殘舊之中，找尋到不少仍然嶄新的東西，但亦勾起了不少早已埋於蠻荒之中的回憶！

於一個陰雨綿綿的早上，踏出家門，跨上旅途，一路上，人山人海，肩摩踵擊，回鄉探親，拖兒帶女的眞不少。在一片喧嘩嘈雜之中，踏着急不容緩的步子，走過羅湖橋，經過行李檢查站……直到坐上廣滬綫的火車，才能如釋重負的喘上一口氣，但緊隨着片刻安寧而來的却是一片洶湧澎湃的思潮。多少年來對於父母的懷念，手足的思念，眞的已被飛逝的歲月冲淡不少，人是健忘的呀！感情是可被麻木的呀！但一霎那間，一張張又似熟稔、又似模糊的面孔，湧上心頭，驀地感到在這十餘年中失去的父母之愛，手足之情，原本應是蘊藏着多麽可珍的温馨！一連串的往事，一連串失落的辛酸，觸起我一連串的落寞之感，一連串的滿眶熱淚！

隆隆的火車，飛馳奔過廣東省層巒叠峰的丘陵地帶，及華中遼闊平坦的原野。夏日當頭，一切山丘、湖水、樹木、稻田、菜畦、農人、漁帆……原是顯得多麽安祥、靜謐。所謂十年樹木，百年樹人，但多少年才能建立一個强大繁榮的國家？欣欣向榮的面貌，日新月異的發展，普衆同慶的歡樂，這是我在火車上，爲這一片可愛的山河，勤奮的人民，默默許下的祝福。

時光老人拖着緩慢的步子，載着我一顆歸家似箭的心，從容不迫地把我帶回故鄉。火車一進站，更是心亂如麻，悲喜交雜。踉蹌地下了車，就在人堆裡找尋分別了十餘年的親人，這是夢中之眞，還是眞中之夢？爸爸不斷地撫摸着我滿

視人體爲陰陽對立面的統一體，惟獨經常保持陰陽兩者的相對平衡，才是保健的眞諦，否則便會形成病態。茲舉實例以示之：

神經衰弱症便是健全的神經失去了陰陽平衡而釀成的。這恰正與現代學說認爲係大腦皮質的興奮與抑制過程失去了平衡如同一轍。原來高級神經活動的基本過程有兩種：那就是興奮與抑制。這兩種基本過程是相互爲用，相互誘導，相互協調，有規律地進行生理活動，才能保持神經的健全，以致整體的健全。這一段話豈不是和陰陽學說不謀而合？興奮屬陽，抑制屬陰，陰陽相互爲用，相互誘導，相互協調，神經便保持强健，不會衰弱。若興奮活動過度能使神經細胞疲勞並產生一定程度的損耗，而保護性抑制過程則能使神經細胞消除疲勞而避免精力的消耗。假使人而生活過於緊張，神經系統便會負擔不了，因而促使神經活動過分劇烈波盪，興奮與抑制過程的正常關係被破壞，大腦皮質的功能就會發生紊亂，失却了健康生活上應有的規律活動。由於大腦皮質的功能失調，換句話說也就是陰陽失調，在人體上即發生神經系統的機能破壞，而致衰弱。

因此，應用中國醫藥治神經衰弱的原則如下：

一、凡偏於興奮性的神經衰弱症，以鬆弛神經爲主。

二、凡偏於抑制性的神經衰弱症，以强壯神經爲主。

兩法異途同歸，俱爲旨在調和陰陽之偏勝而抵於平衡而已。前者側重解除神經緊張而使其鬆弛，後者側重培補神經而使其强壯。

綜合以上的論述，可知中醫治療體系的核心，側重整體療法而以治本爲基礎，佐以隨證治之以通應其個別病者的病情與症候，其基本精神是合乎科學原理的，其成就並非倖致的。

（接上第一三二頁）

於是我們又發現了傳聞往往過於事實的眞理。

（八）參觀了山族——其實山胞們早已受文明的洗禮，跳山地舞的姑娘，髮式趨時，化裝濃郁，換去山裝後必然比我們更時髦。

（九）「出外靠朋友」、「朋友有通財之義」的實行——假期將完之際，我們高唱「梅、蘭、梅、蘭，我愛你。」其雄壯歌聲遠近可聞，原來新台幣一元的正面是梅花，反面是蘭花。這個時候，我們對朋友之義眞是感激萬分。

（十）絕食的本領——最後一天，山窮水盡，餓肚子過了一天，赫塞說：「你能絕食，就能够安靜地等待，沒有焦躁，沒有需求，並能把飢餓忽視掉。」所以這最後一天的訓練及所領悟的令我終生受用。

經過多天來十項全能的訓練，現已大徹大悟，他朝必能成大器，父親可拭目以待。肅此敬請

福安

小女兒上　×年×月×日

從學術思想體會中國醫學的成就

陸奎生

從學術思想體會中國醫學的成就，其獨特的治療體系，厥爲視人體的一切活動現象是對立的統一。陰陽相互抑制，相互依存的現象是保健的基本條件。

人體維持健康的狀態，莫過於「陰平陽秘，精神乃治」。這就是說祇有人體的機能處於平衡狀態之下，才能維持正常的生理活動。反之，當陰陽的相對平衡被破壞之際，就會發生疾病。所以疾病無非陰陽任何一方偏盛或偏衰的結果。

我國的經典醫籍——內經云：「亢則害，承乃制」，就是說過於亢奮的偏差，必須予以承制。承制者，猶今人所謂抑制也。

考陰陽學說乃我國固有的哲學思想體系。在二千多年前就被引用到中國醫學理論，並連繫養生保健學說，與醫療實踐相結合，成爲中國醫學的基本概念。在內經裏並應用陰陽學說來解釋和說明生理、病理、藥理、診斷、治療以及一應相對待的事物。因此，陰陽學說不僅在內容上貫穿了內經的中心，抑且形成整個中國醫學理論與治療的體系。

內經陰陽應象大論云：「陰陽者，天地之道也，萬物之綱紀，變化之父母，生殺之本始，神明之府也。治病必求其本」。這就說明了宇宙間的自然規律是一切事物的綱紀。萬物變化的起源。生長消亡的變化，莫不導源於此。明白了這生化的道理，從可知治病必求其本者，本於陰陽也。

關於病機，也習用陽來代表亢進、興奮、激動，陰來代表衰退、抑制、微弱諸見端。是以陰陽調和，身體就健康而獲得正常的發展。故內經調經論說：「陰陽和調，則血氣澤滑利」。反之，陰陽篇說：「陰勝則陽病，陽勝則陰病」。這些都反覆地說明了其間的互相關係和依存的關鍵，而以平衡爲正常的生理狀態。蓋中國醫學理論結合實踐，視有機體的人的發病機轉爲人體內對立的陰陽均衡的破壞，陰陽的均衡破壞後，欲使其調和而復原，恢復健康，就必須加以正確的治療。這種從本質上用藥而獲致疾病治愈的機轉，乃是治病必求其本的眞蹄。

觀乎「陰平陽秘，精神乃治。陰陽離決，精神乃絕」。可見陰陽學說在中國醫學學術的理論上是首居領導地位的。因此在治療上就應該根據陰陽偏盛偏衰的不同病情而給予適當的療法，使其歸於協調而抵於平衡，疾病就徹底治愈。這是治本的特長，非治標之劑所能望其項背也。內經云：「審其陰陽，以別柔剛。陽病治陰，陰病治陽」。「見於陰者，以陽法治之；見於陽者，以陰法救之」。這些定律乃是中醫治療上的基本法則。臨牀之際能掌握此基本原則靈活運用，便無往而不利。

在治病必求其本的大前題下，根據病者的體質不同所採取的治法也應顧及。譬如陰虛陽亢的病人就要應用養陰滋陰的療法，陽虛的人就要應用升陽益氣的療法，而其宗旨也脫不了使陰陽協調的總原則。然後結合個別疾病所表現的症候羣而隨證治之。爲什麼要隨證治之呢？因爲經過正確的治療之後，其症候群的表現隨時在轉變，所以必須視其機轉而及時當機立斷，作出切合病性的療法。

內經靈樞生氣通天論云：「生之本，本於陰陽」，是以

寶島遊記

翁若梅

父親大人膝下：

孩兒在寶島暢遊了十五天，有賴父親鼎力解囊，衷心感激，現稟告父親，此行可謂不枉，其利無窮。孟子曾曰：「何必曰利」。可是由於時之遷、勢之易，曾幾何時，孟子的思想落伍了。「無利不爲」是當今之名言。我等暢遊完畢，獲益良多，茲分述如下，幸邀清聽。

（一）吾等遊名山、逛大湖、觀日出、賞晚霞，親臨湖光山色，亭臺樓閣的美景，增廣見聞，茅塞頓開。

（二）接受古希臘先哲人式的訓練，在德、智、體、群育各方面都有均勻發展。

忍耐力的訓練是最重要的一門功課；且先說咱們離開香港那天，適逢颱風襲港，無可奈何地在機場呆坐七小時，抵達台北市，却巧碰松山機場關閉，只有在上空兜圈子，這回除了忍耐力可還加上胆量的考驗呢。此後的日子，我們常要靜坐等候公路、鐵路有否被颶風摧毀的消息，一坐就是老半天，所以我現在的忍耐力非昔日可比。

體能練習是無日無之的；我們勞師遠行，風塵僕僕，乘坐了三數小時的旅遊車抵達風景區，但每每由於時間短缺，只有半句鐘可資參觀，於是馬上開步飛奔上山，在極短的時間中不但跑遍整個山頭，覽閱了風光，還完成任務——拍照留念。

體能鍛鍊中有一項是舉重，同學們對於捧大理石用具、厚旬旬的醫書，眞可謂「不遺餘力」。

更有一項是體質比賽，參加人仕可隨意隨處吃隨量的水果，但瀉者即被淘汰出局，多日下來，能適應生存的比賽者所餘無幾。

智力方面有數學，與「實用辯駁」的訓練，在每次購物中我們都可以運用所學。我們的心算速度，乘除數由其是七進位的，進步一日千里。（港幣對台幣一比七）

在群育方面，我們學會了與人相處之道在於容忍和禮讓；當七、八個人被分配到一間房子裏時，除了互相遷就，別無他法。雖然如此，我們還是覺得樂也融融。

藝術方面着重歌唱，我們的導遊小姐最有志於發掘我們中有歌唱天才者，經常請我們輪流表演。

我還從事了「美術創作」；有一次，我想借用熨斗，却忘了「熨」字的寫法，出盡了我的廣東語、英語、客語、新學的國語，甚至啞劇都不能使人明瞭，我終於劃了一幅圖畫，侍者們才彷然。這雖然令我異常尷尬，但亦因此使我領悟到當文字、語言都未有之前，最原始的表達方式應該是圖畫了，於是，我對考古學又有一些心得了。

（三）得悉光陰的寶貴——我們定下盟約，凡於集合時間遲到者，每分鐘十元，正是「寸金寸光陰」，大家都守時守信。但早上五、六時便起床，疲倦自是理所應當，很多人便在旅遊車中再續好夢，大家笑稱這是夢遊寶島。

（四）亞Q式精神發揚光大——我們衣飾簡單進入一間豪華大餐廳，對女侍們的白眼自是不會無所覺，可是我們很豁達，說此章是「虎落平陽被犬欺」，以她們「有眼不識泰山」，倒也不和她們計較，依然故我，坐得適其所哉。這正是亞Q式精神的表現，在香港我們也只是窮學生幾名，吊兒郎當，既從未被看重過，也從來都不是「虎」！

我們中有人認爲這是女侍們重男輕女的表現，於是我們便從事科學考證，請同團的男孩子親往該餐廳大吃大喝，而我們則靜坐候消息，果然，根據他們報導，那些侍者們和顏悅色，殷勤招呼，我們聽後都笑過前仆後仰，人馬翻天。

（五）我們目睹了比股票跌得更快的東西，那就是明信片，珠鍊類的紀念品，當旅遊車的引擎燃着了時已經開始減價，車動一寸，更減一分，當車子開出後，販賣的小孩頑皮地，朗聲宣報了一個價錢——一個教那些買了貨物的同學聞之「心痛」的價錢，然後捧腹大笑，對她們的作弄，我們只有報以苦笑。

（六）體會到思家的滋味——男孩子們於解囊盡空之際，思家情之切，只可與女孩子們看到男女通用的洗室之時可比，其時不但思家，簡直懷念香港了。

（七）表現了大無畏的精神——我們乘搭內陸飛機，內心甚有顧忌，但擺出一副從容的神情，慷慨赴機，想金像獎演員亦不外如是，過後發覺機身甚穩，根本無需恐懼；

（轉入第一三〇頁）

望義兄放我過，百萬兄弟俱係洪。烏雲蓋月映長沙，洪姓同來共一家；路上相逢通名姓，風雲至正雨開花。」

甚至連職位名稱及分配，都以水滸爲藍本。可見水滸跟洪門關係之深切。

他們的團結互相幫助，使人在危難中得到一種支持與溫暖而減少其孤立感。另一個特色，就是幫會的立法和施法。他們認定幫規是重於國法，這樣便或多或少對政府法例有所侵害。然而，這並非表示其幫規必定跟國法抵觸，反之可能輔助個人的安份，給予一定的道德價值標準。

試看洪門所訂之「十條十欵」，「三綱五常」，「五倫八德」，「三君子四賢人」等，無不以個人修養爲重。其他的「三十六誓」，「二十一則」，「十禁」，「十刑」及「十八章律書」，則爲針對幫內弟兄行爲而設。（其內容可參閱附註之書籍）。試舉一例爲證，對不忠洪門或犯了規則的會員，有家法「五刑」來處分。

一、極刑：凌遲或刀殺。

二、重刑：挖坑活埋，或沉水溺斃。

三、輕刑：三刀六眼，或四十紅棍。

四、降刑：降級，或掛鐵牌。

五、黜刑：抓去光棍，或降入生堂，永不復用。

由此觀之，洪門之精密嚴謹，所抱負之理想，鮮非一般組織所及。清從建國至覆亡，一直都受洪門等幫會所干擾。其勢力之盛，可見一斑。

× × ×

洪門與中國：

洪門不但在口號上及理想上針對清朝，行動上也常使清廷不勝其擾。清入侵初年，抗暴行動使清兵大受打擊，清代中業仍有間歇性的反抗，後更輔助洪秀全建立太平天國，幾乎使清廷覆亡，後雖因將士意見分歧而敗，但也使清元氣大傷，一發不振。加上外國欺凌，終導至孫中山先生之革命。

民國之革命成功，實有賴洪門人士之大力支持，不但財政上，更實際地參予革命行動，故洪門會黨才是眞正的「革命之母」。

孫氏在民國前十八年於檀香山建立興中會，而入會者多爲洪門中人。其後爲求洪門協助，更加入爲「洪棍」。時洪門組織散漫，乃舉行洪門總註冊，修定章程，使其成一革命團體。後來由孫氏開辦的同盟會，也因欲强大勢力而集體加入洪門。民國革命始得成功，推翻千百年來的君主政體。

其後袁世凱擁兵竊國，帝制自雄，引至第二次革命，也有賴洪門協助。中日八年抗戰時，洪門子弟也曾盡其力量挽救國難，在前綫與敵苦鬥，在後方暗裏破壞，才使中國逃過滅亡厄運。

結語：

洪門子弟本其浩然之氣，反暴政於一朝。惜流傳至今，眞貌盡失，暴戾有餘，俠義不足。蓋清廷屢立嚴令，故幫中符文隱語，皆口傳心授，即有記載，亦一鱗半爪，或顚倒亂排。故爲不良所乘，墮爲花流洪門，此其悲也。故盼重振聲威，本先哲仁心，再圖大業，表中華於天下。

「知我者謂我心憂，不知我者謂我何求，悠悠蒼天；此何人哉」？

附註：

一、中五祖爲楊仗佑、方惠成、吳天成、林大江、張敬之。後五祖即李式地、洪太歲、吳天佑、林永超、姚必達。

二、孫文，建國方畧有志竟成篇。

三、王雲五編，「一百二十回的水滸傳」萬有文庫，商務印書館，第五十六頁。

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三、飛烈，洪門搜秘，澳門洪福出版社，民國四十五年。

四、馬超俊，中國幫會史，現代出版公司，民國五十年。

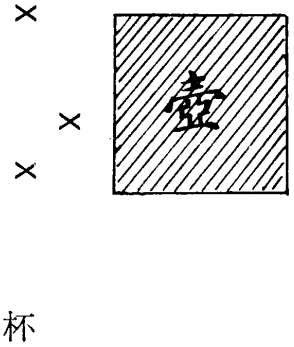
五、羅爾綱，天地會文獻錄，正中書局，民國三十二年。

六、勞思光，中國文化要義，崇基書院，一九六五年。

洪家子弟之日常對答，開會儀式，甚至喝茶的動作，都以「反清復明」爲原則。在詩篇互答內，充滿沉痛激昂的反清情緒，如包頭詩云：「紅巾一條在手中，包在頭中訪英雄。

招集五湖並四海，殺滅清朝一掃光。」

又試觀吃茶時，壺杯所擺之陣法，其反清之志，也可見一斑。



由於洪門是極力反清，因此受到清廷重重壓迫。康熙年間，定有嚴禁異姓結拜的法例。乾隆時更變本加厲，最初祇以「謀叛未行」來治罪，法至絞決而止；續訂加爲「斬絞」，最後更是不論首從皆「斬立決」。

是故洪門子弟行事極爲秘密，免招殺身之禍。而「政府之爪牙爲官吏，官吏之耳目爲士紳」。故「洪門之拜會，則以演戲爲之，蓋此最易動群衆之視聽也。……其口號暗語則以鄙俚粗俗之言以表之，此最易使士大夫聞而生厭遠而避之者也。其固結團體，則以博愛施之，使彼此手足相顧，患難相扶，此最合江湖旅客無家游子之需要也。」（註二）

由於洪門是如此秘密之組織，加上用種種方法暗語去掩飾身份，清廷竟無法將之清除。每當朝廷大事偵緝，其子弟則逃至海外，各立山堂，勢力日發增大。

水滸與洪門：

洪門之建立，是以追求理想爲基根，一方面以反清爲大業，一方面以門人忠肝義胆作爲團結。他們對現實不滿，便尋求自己的世界，去建立自己的天地；而當時盛行的水滸傳給予這群人很美麗的幻想，因此，其組織、行政及思想，無不以水滸傳爲根本。

水滸傳對當時的民間有着很大的影響力，先是在萬曆年間所流行的水滸牌，是以水滸人物做成的賭具，演變下來成了今天的麻將牌。其次就是其「奉天倡義，官迫民反」的思想，成了民變的口號。更重要的，就是在民間種下了「草澤英雄」的意識。明末之際，遺民感國運無法挽救，因而轉向盼望草澤英雄布衣之士出現，作驅逐異邦之大業。這個意識使不少有志之士出來領導，也使一般百姓加入這些組織。對民族如斯大的影響，實非施耐庵所能猜想到的。

水滸傳的理想團體大綱，可見於七十一回：「忠義堂石碣受天文，梁山泊英雄排座共」。其下的一段節錄文字，正好表示出其基本目標：

「帝子神孫，富豪將吏，並三教九流，及至獵戶、漁人、屠兒、劊子，都一般兒哥弟稱呼，不分貴賤。同胞手足，捉對父母，與叔姪郎舅，以及跟隨主僕，爭鬥冤讎，皆一樣的酒筵歡樂，無問親疏。或精靈，或粗鹵，或村樸，或風流，或筆舌，或刀槍，或奔馳，或偷騙，各有偏長，眞是隨才器使。……心情肝胆，忠誠信義並無差。」（註三）

這個「不分貴賤」，「無問親疏」，「隨才器使」，及「忠誠信義」的原則，正好作爲一個反清平民團體的律規。

洪門詩歌中有謂「忠義堂前無大小，不欺富貴不欺貧。」又謂「當日花亭前講過，千祈不念舊冤讎。」正好符合了水滸的平等主義，以兄弟相稱不記昔讎。

在行火坑儀式中，有如此的詩歌：「紅旗灣灣跳過山。有忠有義，壽比南山；不忠不義，喪在其間。」這足以表現出以忠誠信義維繫幫衆的原則。

水滸的理想組織是一個「八方共域，異姓一家」的團體。洪門的理想，也以此爲據。有云：「佛祖古城在路中，洪家兄弟四海通；萬

洪門——中國幫會簡介

·光·

引言

查中國屢歷巨變，外則列强，內則黨爭。然能轉危爲安，亡而復甦，實賴國民團結精神。先哲賢士，開殺身成仁之風，啓後嗣捨生取義之理。世禍危亂，一呼而百出，拯斯民於水火，保河山於危殆。

今河山分裂，各自從政。列强再作奢想，趁機而爲。八年仇恨猶未了，倭寇再侵釣魚台。而我國政府竟聽而不聞，視而不見，任家國遭蹂躪。實痛心疾首之行，有負先聖所望。

故爲文記述我國幫會組織，以圖再勵人心。蓋此等組織建立之初，皆重團結互助精神。及至社禝危殆，則起而救國。此俠義精神，實足吾等借鏡。其中表表者，非洪門莫屬，故以此爲材，一論中國幫會。

民間組織源流：

我國之民衆集團，源於墨家。墨翟以「天志」、「尙同」及「天下之利」作爲立家組黨之準則。其組織之嚴謹，非各家所及，其下各朝，雖有相類之組織，然其謹密性及組織力，則跟墨家相去甚遠，及至明末清初，始有舉足輕重之幫會建立。

一般民間組織不出三類，一爲從宗教思想立論的會社，鮮有眞正之政治理想。一爲同業幫會，互相結合以保障利益之團體。最後一者爲政治之組織，既有一定目標，又有謹密組織，故爲三者中最具影响力；演變下來而成今之黑社會。

此等幫會皆有崇拜對象及私法，故對社會並無正面意義，然其團結互助，可使患難得安慰，其功實不可沒。故曰：「合群爲人之本性，起於志同道合。歸趨者越衆，力量越厚，往往揭櫫主氣，蔚爲風氣，其名稱或曰黨、曰會、曰幫，雖形態與稱謂繁多，而其所由成群衆力量者則鮮殊異。」

創會經過：

明末之際，有志之士目睹河山破碎，而一般士大夫降志辱身，反不及販夫走卒，市井之徒；遂以墨家之組織方法，參以水滸傳的俠義精神，將此等屠狗賣漿之輩加以組織。志在反清復明推行民族革命。

蓋洪門爲一秘密組織，而其成員又多非知識份子，故無可靠之典籍史書可考，且時日已久，各地山堂又無統一說法，以訛傳訛，又多神話怪誕之辭。是故，起源之說多不可靠，僅以其大約言之。

洪門起於清初，由殷洪盛（洪英）所創。殷氏初隨大同鎭守爲參贊軍機，招收各路豪傑，如蔡德忠、方大法、馬超興、李式開、胡德帝等人（卽洪門之前五祖）。後率衆投史可法，奉史命至燕京窺探清廷虛實，沿途遍訪志士顧炎武、王夫之、傅青主及黃梨洲等人，創「漢留」組織，以圖反清。及史殉國，殷洪盛招撫殘餘士將，再作死戰，終率於三汊河，時爲崇禎十八年。

及至清順治十八年，鄭成功推進「漢留」組織，派蔡等五人投福建少林寺。康熙十一年，少林僧一百一十八人爲清廷平定西魯之亂，爲朝廷所重。惜後因叛僧馬福儀，聯同奸臣陳文耀、張近秋向朝廷力進讒言，引至火燒少林寺之慘劇，僅十八人逃離火場。再於黃泉村爲追兵殺死十三人，僅餘蔡、方、胡、馬、李五人；他們誓言復仇，曰：『天之長，地之久，縱歷千萬年，亦誓報此仇。』其後再得中五祖及後五祖之助（註一），始得逃出生天。

後於萬雲山萬雲寺得遇萬雲龍及陳近南，互相結拜；更遇崇禎帝之孫朱洪竹，擁之爲盟主。至康熙十三年，於紅花亭結義，先來者爲兄，後來者爲弟。時近黃昏，天發紅光，衆人以爲天意助成，而朱洪竹之「洪」字與紅光之「紅」字相與輝映，又屬同音，故以「洪」字爲姓，拆「洪」字爲「三八二十一」，作爲會中暗記。視紅花亭爲出身之地，同盟日爲誕生之日，以此大會爲「洪家大會」。至此，「漢留」組織遂成洪門。

當時巴黎爲歐陸學術界的泰山北斗，而經過革命洗禮後，物質主義乘時而興；尤其在科學領域中，科學家開始摒棄迷信，而專心於有系統的研究工作。物理學家和化學家分別提出劃時代的自然界中基本理論；這些理論對其他科學包括醫學的發展有很大的幫助。雷氏生於斯時，收獲最大，尤其是雷氏勤奮向學，專心事業，前途當然無可限量。

雷氏之勤奮可以從他跟隨葛氏最初三年之學習精神便可知其一二。當時，他爲四百位病人寫出極詳細的病歷，這些病歷成爲他以後研究和發明的基石。

雷氏在就讀未畢業時，已經鶴立鷄群，獨佔鰲頭了。他曾經得過內科及外科兩項首獎。就讀時，他已經發表一份有關心臟疾病的報告，一份有關腹膜炎的論文，和對伯耳氏Belts性病論文的評論。

二十三歲時六月十一日他獲得畢業文憑，正式成爲醫生。畢業後五年內担任一份醫學雜誌的總編輯，同時又作過病理解剖學兩年的演說。平均每年他都能寫出三份有份量的醫學論文，並且登稿往各醫學雜誌及百科全書，字典及醫學辭源等。

一八一六年時，雷氏在巴黎之Necker Hospital工作，並將剖驗屍體時的病理報告和該病人的臨床辨症發現連繫起來(Clinico pathological correlations)，對病理學作出了很大的貢獻。

同年，他開始生出發明聽診器的念頭。當時胸部的檢查方法（臨床辨症法）只有望診、觸診、叩診和直接聽診法Immediate auscultation.。後者是將耳朵擺在胸壁旁邊，盡力傾聽，以圖聽出端倪。其時間接聽診方法Mediate auscultation還未有頭緒，理論還只在擬定過程中。至於叩診法雖然在一七六一年已由Anenbrynzer發表，但早已被人遺忘，當時由葛氏再度提出，前後已相隔五十年有多了。

雷氏發明聽診器的過程相當有趣，而後來雷氏數度改良聽診器，務求精益求精，可見雷氏不墨守成規，力爭上游的精神，這是值得我們學習的。

雷氏自習醫以來，經年利用直接聽診法，希望聆聽到呼吸聲和心跳聲。失敗的次數多過了成功的次數很多倍，但雷氏並不灰心而放棄。有一天，他利用紙張捲成筒狀，將一端放在病人胸前心臟的位置，另一端則放在耳邊。該次的發現可將他樂死了，他所聽到的清晰有如旁人在耳語細訴，自此展開了雷氏改良聽診器和編出運用聽診器的方法及理論。雷氏在他的發現後，改用木管製出聽診器，當時只是單耳收聽方式的，其後雷氏創出雙耳收聽方式，發覺效果更佳；同時他將橡膠或塑膠管代替木管，此等原料使該聽診器容易屈曲，更加方便携帶及使用。到現在，聽診器的形狀改變得很少，但原料方面已改用合金了。

一八一六年五月雷氏開始發表間接聽診方法的報告書，並且公開示範聽診器的用法。自此起雷氏專心致力於證明聽診器的用途，在一八一八年六月，他將該研究的結果呈上給科學學院Academy of Science。該學院特別組成一委員會專門研究此結果報告書的價值；經過詳細的研究後，委員會一致通過承認聽診器用途是無可置疑的，並且撰文褒揚雷氏在醫學上作出的貢獻。

雷於是忙於將該報告書付梓；後來努力過度，因勞成疾，逼於無奈暫時養病家中。一八一八年十一月恢復工作，一八一九年該書不負衆望終於面世。

一八二二年，雷氏事業達巔峯境界，被委任爲College of France的內科教授，其後更繼承其師葛氏爲內科教授。一八二六年報告書二版面世。雷氏因辛勞，再度病倒。自此身體並無好轉，加上他先天體弱，雖然一八二六年已經回家退隱，仍然要和病魔糾纏，後來在八月十三日終於病逝，時年方四十五。

我們欽佩的是雷氏苦學不倦的精神，羨慕的是他的良師益友，而衷心感謝的是他那萬世不朽的聽診器，它對病人和醫生永遠都是一種帮助。

Reference: Farbes "Life of Laennec".
Wisthayer's "Laennec".

聽診器的發明者：雷內克

漠然

聽診器即Stethoscope，爲每一位醫生必備的工具之一，除Preclinical students未有臨床經驗而不需備有聽診器外，其他醫學生必需携帶，從而可知聽診器對臨床辨症的重要性。

聽診器有數種，其中比較普遍的有雙耳聽診器 Binaural Stethoscope，單耳聽診器 Uniaural Stethoscope，鑑別聽診器 Differential Stethoscope 及多管聽診器Multiple Stethoscope等多種。其中最通行的應算雙耳聽診器，今畧介紹如下：

一具完整的雙耳聽診器應包括一條膠管，(Plastic tube)或合金管 (Alloy tube)，其中一邊通往胸端 (chestpieces)，另外一邊通往耳端(earpieces)。胸端有兩面，一面爲 Bell，另一面爲 Diaphragm，分別對不同頻率的聲音有最高的敏感度。至於耳端則有二，狀如耳塞，用時塞在耳內。聲浪從聲源經過膠管通往雙耳，得到的效果是很清晰的聲音。

通常、臨床辨症法分二階段，詳問病歷及引出各樣病徵；而探討病徵又分四階段：望診 Inspection，觸診 Palpation，叩診Percussion 及聽診 Auscultation。其中聽診在檢查胸部 Chest 時是不可忽畧的一個步驟，因爲呼吸系統和循環系統的情況可從聽診得到很多準確的資料。從聽診器中，醫生可以聽到呼吸的聲音 Respiratory sound，它的頻率、高低，特色等；心臟搏動的聲音Heart beat；此外更可以聽到偶發聲音 Adventitious sound 及難音 murmurs 等。同時，在某種情況下，聽診器可以用來聆聽腸蠕動的聲音 Bowel sound 在腹膜炎 Peritonitis，及腸道阻塞 Intestinal obstruction 兩種情況下，聽診器尤其起作用，其他情形下，如動脈瘤 Arterial aneurysm，動靜脈瘻 Arteriovenous fistula，甲狀腺毒症 thyrotoxicosis，聽診器均可能探出雜音 Bruit。

很多同學會對聽診器用法有極深的認識，但很可能他們對聽診器的歷史，發明者和發明及演變的經過却諱莫如深。他們可曾想像過該發明人當檢查每個病人時都俯耳側聽從胸壁下傳出來的聲音時的不厭其煩的情形，每次徒勞無功後的沮喪的神態；及後來終於利用管狀物體清晰地聽到那神祕聲音時的乍驚乍喜的表情。一切都是這樣戲劇化的，但那位發明人却幫了後來醫生一個很大的忙；他的發明可以說是劃時代的。

這個發明者是誰？就是雷內克氏。他的原名是 René Théphile Hyacinthe Laennec。他除了是聽診器的發明者外，每一位上過病理學課的同學應該認識到他的名字是和肝硬化連在一起的 (Laennec's Cirrhosis)。

雷內克氏生於Quimper, Lower Brittany 於一七八一年二月十七日誕生。雷氏的幼年時代不很好過，五歲便死了母親。殺害他母親的兇手是肺結核菌，此後肺結核菌時常困擾雷氏，最後到雷氏終結其短暫的生命及輝煌的事業。他的父親並未有負起養育兒女的責任，很快便將他送到他的叔伯輩。很僥倖地，他輾轉被一個身居醫學教授要位的叔父收容，該叔父居於Nantes，名叫 Guillaume Francois Laennec。他與這位醫學教授的關係使他幼受薰陶，很少時便得到醫學上的啓蒙。另外一位對雷氏有深厚影响的人是Courisart。雷氏在十九歲時畢業後便在巴黎跟隨 Couroisart 葛氏行醫。當時正值大動盪時期，法國正在醞釀革命，而拿破崙乘時崛起，嶄露頭角。拿氏素有知人之明，慧眼識英雄，委命葛氏爲其私人醫師。葛氏與雷氏雖爲師徒關係，但交誼很深，葛氏時常鼓勵雷氏，對雷氏所提出的意見亦甚表推崇。

生活

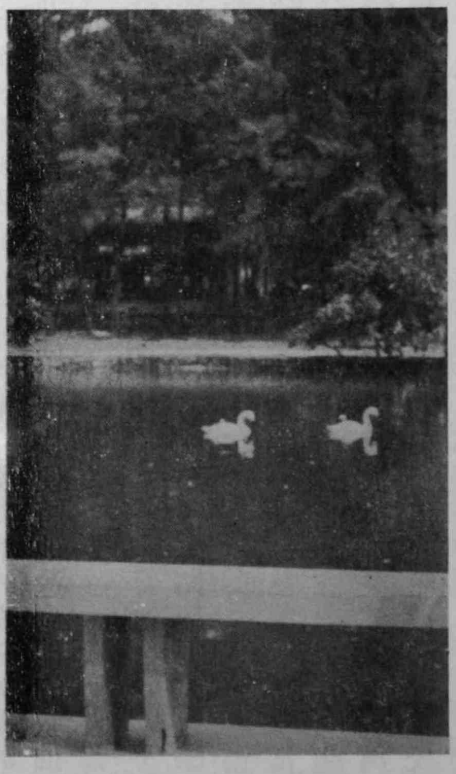
浩

太陽出來了，把張了好幾天的暮簾拉開，碧藍的晴空泛了幾縷的白雲，網在平靜，淡藍的海面上，紫藍的遠山繞在網邊，原在雨中亮着晶瑩墨綠的光的樹子，也被燦爛的太陽照出翠綠油亮的光采，我並不討厭雨天，陰沉、積滿水氣的空間，清新、畧有寒意的空氣，幔在在半山的暮，被暮分割成一重重的遠山……都構成一幅好美的畫，與生俱來就有一種追求完美的熱忱，在大自然的和諧中，總有很幸福和不能瞭解的感激心情。

我很愛樹，總覺得它包涵着不少堅定，倔强與靈秀氣。粗壯結實的樹榦，就已給人可信靠的好感。倔强的橫枝，瀟脫地向四圍的空間舒展，支持了許多充滿生氣與活力的綠葉，不論是喬木或灌木，榦與枝總是縱橫交錯，凌亂不整齊中却又有其規矩，總構成很優美的綫條圖案，葉子却各顧各地向四處張望，搖擺在風中，在雨天、晴天或陰天裡，發散着不同的綠。

中學時候，課室外有棵象樹，有很墨綠、强壯的葉子。在下雨天，葉子被洗得很晶瑩，更墨綠，那深沉、寧靜的色彩，至今仍刻在腦中。

我很喜歡荷花池旁那幅雖小却仍美麗的草坪，周圍豎立着許多樹木，遠處的雲與山，和草坪邊的紅磚屋也配襯得宜，早上踏着草坪返學，永遠都感到一般清新的氣息，生命的雀躍。某某說，在趕上課時，衝下這段路，是個大浪費。在遲歸的夏日黃昏，斜陽撒下了一片金黃在草坪上，穿過這華麗的空間，彷彿沾去不少光華，有些下雨或陰暮的日子，這小草坪好像是一塊世外的天地，四處泛着暮水氣，泛在泥土上，掛在樹腰間；泥土散發着特別的紅，各種不同的綠亦各放光采。間中，石隙間會冒出陣陣烟暮，令這本來已很不眞實的地方顯得更加出奇。



我愛飛，放風箏的念頭在我們的心中盤旋了許久。在圖書館外，看見一條白綫斜插入天空，滿心高興以爲可以看見一隻凌空翱翔的風箏，隨風飄揚，可惜找不着綫之引處，覓不到綫端的風箏。

早上在學理學大樓旁，看見一隻黑白雙色的鳥，俯衝下海，低頭看到祇能步踏步的雙腿，感覺着蠕行的身軀，不由對那乘風滑去的鳥產生了欣慕，希望它能加入 Jonathan Seagull 的行列，能爲完美與超越奮鬪，能在飛行中享受着飛行。若我是一隻鳥，我願冒艱辛飛向山巔，飛入雲層，探高處之「寒」，磨練己之堅，我亦願自高處猛衝向下，探求己之能，感受着己之「勁」。

我愛綠與飛，常覺得體內有一股動力在滾動，驅着自己邁向前方，在創造與滾動中，我能感覺到自己的存在，感覺到自己呼吸的氣息。

賭博合法化

不平

香港是一個「崇金主義」的社會，大部份居民只顧自己的生活及利益，高視「小我」，忽畧「大我」，面對香港的隱憂，漠不關心。市民對市政局議員選舉的冷淡與股票交易的畸形狀況這兩件事，充份透露了香港人的特徵。但政府不着眼改變居民的陋習，却間接及直接地助長本港的賭風，最近港府高層人士主張由明年開始實施外圍賭博合法化，並進行研究「每日一獎券」的提議，以「滿足華人賭博慾望」及「同時爭取每日花在博彩中爲數二千萬之賭注」作爲此建議的後盾。此外，還希望把「外圍博彩」合法化後所得的稅款，撥作社會福利之用。

政府視賭博爲華人的嗜好，並不考究賭風的根源，在中國大陸及台灣，純粹華人聚居的地方，賭聞從未有之，在星加坡，大多數都是華籍居民，在上位者執法嚴明，不受賄賂，故賭博消聲匿跡，這反映博彩並非華人的嗜好。在英國、澳洲及蒙地卡羅，都有馬場、狗場、賭館及賭波公司的設立，捧場大不乏人，假若英人、澳人不嗜賭，這些場館還能存在嗎？港人的嗜賭，應歸咎於政府及社會本身：殖民地政策，貪污及不健全的教育課程，實與華人的喜愛無關。

香港是英國的殖民地，若港府與英倫方面的利益相背馳，港人的意見便被擱置，如「儲備金的應用問題」和「葛柏事件」，因此市民便對政府漸漸失去信心，視香港爲絆脚石，對本港的前途，拋諸腦後，只顧眼前利益及享樂，這便是「金錢主義」的泉源，爲求早日致富，便沉迷於賭博，況且九龍半島的租期快要完結，益減市民對港府的信心。故此香港缺乏了一個「爲它的前途而奮鬥」的理想，供市民追尋的目標，這是本港賭風的根源之一。

本港警務人員的貪污例子，屢見不鮮，外圍狗馬及字花的昌盛，有目共覩，每逢週末，部份茶樓更有告示張貼在門前，暗示招待賭客，相信警務人員，亦知悉此等情況，奈永不登門查察。假若貪污能被消除，警察盡忠職守，試問還有賭檔的存在否？博彩是貪心之過，人皆有之，不分種族，若沒有誘惑，此念頭便不會產生；反之。若賭館林立，聖人也不能忍手。總之，貪污一天不能被消除，賭風自然日趨嚴重。

本港的教育，亦與賭風息息相關，表面上本港的教育確實發展迅速，小學免費教育，强逼教育，中學三年補助教育，相繼實施，但高等教育並不普及，發展緩慢，並不能與本港的繁榮成正比例，這可能是殖民地政策之一，因此青年人的教育水平並不高，況且本港多數學生，平素只顧應付繁重的功課，而教師亦不會多灌輸課本以外的知識與學生，形成他們缺乏獨立思考及判斷能力，對於人生哲理，甚少談論，所以本港很多青年人，對金錢與物質享受，追求甚烈，忽畧了人生的眞諦。基此原因，他們便很易爲金錢所誘惑而沉迷於賭博，對本港的現狀及將來，不聞不問。

港府在計劃將外圍賭博合法化前，應愼重考慮此政策對市民的影响，不該以「消滅不合法賭檔及增加稅收以作福利之用」爲藉口，在不合法的情況下，市民在賭館博彩，仍不免存有戒心，青年人亦恐懼館內之黑社會人物而不敢內進。因此，非法賭博對社會的爲害，並不甚明顯。若合法化後，在肆無忌憚的情況下，男女老幼，便很容易被貪念冲昏了頭腦，一旦大敗，勢必悞入歧途，後果堪虞，相信有過賭博經驗的人，不論是「搓四圈」或「鋪草皮」，都會體會到它的後果，它會侵蝕人的時間，使人將正常工作擱置一邊，拆散幸福的家庭，導致夫妻分離，父子不睦，使人虧空公欵，做出各種卑鄙的行爲，本港近年罪惡日增，實與日盛的賭風有着直接聯繫。合法賭博只適合那些全無經濟獨立能力的城市，如澳門、蒙地卡羅等，「賭」是這些地方的經濟命脈，但那裏的賭客全是外國遊客，對本地人並沒有影响。香港在目前環境，每年稅收皆有大量盈餘，工商業發達，實不須賴開賭以維持生計，倘若賭博合法化，勢必影响民生，打擊工商業，縱使稅收增加，福利充足，亦得不償失。

港府若顧及上述各點，爲本港四百萬市民設想的話，便應打消外圍賭博合法化的建議，盡力掃除貪污，嚴懲開賭的魁首。教育方面，應著重啓發思考能力，培養學生對音樂書畫及閱讀課外書籍的興趣，使他們的生活多方面化及認識「大我」的重要。「清潔運動」及「反罪惡動」帶給香港表面上的清潔及美觀，若政府能鼎力推行「反賭博運動」，相信效果必定令人鼓舞，因本港內臟的污穢能藉此一掃而空，這才是眞正的清潔。期望全港市民及輿論界，不爲政府的「滿足華人賭慾」政策所蒙蔽，深入體察賭的爲患，群起反對「賭博合法化」，以申正義。

由衷之言

劍子

香港大學醫學院的前身是創立於一八八七年的香港西醫書院（College of Medicine for Chinese, Hong Kong），其實西醫書院應正名爲「爲中國人而設立的醫學院」，以符合當日創辦人何啓博士愛國憂時的本意。至今，香港大學醫學院可以說是已有八十六年的歷史了。這八十餘年攏統的可以分爲三段時期。早期的醫學院是中國革命的溫牀；中期是抗日時期，萬衆一心，產生了不少正直的，爲國家爲同胞服務的志士；晚期則是近廿餘年來專心出產內外全科醫學士的夕陽無限好「黃金」時代。適逢此夕陽「黃金」時代，我在這最高學府之最高學院混得一份白金飯碗，本應感激流涕，安份守己的做個乖乖，以期他日退休之時或能拿個 M.B.E. 勞什子，可是一班同學偏又吩咐我一定要爲 ELIXIR 寫幾個字，於是就放肆的在此對香港大學醫學院抒發出一些可能是逆耳的己見。由於醫學院是校方，教職員和同學三方面所構成，缺一不可，因此我對香港大學醫學院的期望也是三方面：

（一）校方：爲達到國際一流水準，我希望這醫學院能自己設有放射科、眼科、耳鼻喉科、神經科、泌尿科和老人科等。我認爲這醫學院不一定要走純粹英國傳統路綫，應採納其他先進國家的教學和考試制度的優點，不必太注重英國皇家醫學院的認許，事實上究竟有多少香港畢業生眞的在英國老家懸壺問世呢？我相信過去廿年來的畢業生，無論是移民或落籍，多半是到美、加和澳洲去，而根本這些國家早已要港大的學生參加他們當地甄別試。我又希望校方能多聽一些來自那百多二百名講師和助教的心聲，不要只是片面的聆取那拾餘名特權階級的教授主任之言。

（二）教職員方面：我切望教員間不要玩弄權勢，以圖提高個人地位，要放下那可笑的優越感和自卑感，消除階級觀念，別太重名利，少做些「私人工作」，把花於搬弄是非、挑撥離間、明爭暗鬥、派系之爭及搞「公共關係」的時間和精神，轉而放在實際教學方面，更藉研究來充實自己，脚踏實地的工作。

（三）同學方面：我深深的期望他們有年青人應有的朝氣，熱情和幹勁，更應敢作敢爲。惰性和奴性是萬萬不可有，更不要未老先頹，以賭博、三字經和跑車爲「高級」醫學生之標誌，總要有求知的精神，把眼光放遠。書本之外，還有許許多多的事物是要去認識和思想的，當然自己要捫心一問，究竟讀醫是爲了甚麼？就算不談到「認同」和「回歸」等問題，身居香港，身受其益，總得對香港有一點點的反哺義務，別只顧夢想着畢業後如何移民，如何「刮龍」，不要迷信傳統（Tradition），但也不要走極端爲更改而更改，有機會應到處看看，弄清楚究竟祖國的醫生是否特權人物，英國老家的醫生是否天之驕子。要是在學生時代能對人，對社會、對國家都關心，日後才堪當「醫生」「大夫」之名而無愧。

最後我希望某些行政職員少打官腔，不要自認是「主管人」，自高身價，作威作福。要清楚他們的職責原是協助各教學部門。

以上我對醫學院似乎只是「有彈有讚」，實際上無論校方、教職員和同學都有他們美好的一面，不過我是特意指出一些應改良之處，以祈香港大學醫學院止於至善。

鄭寶剛醫生
(Dr. Constant Cheng Po-Kong)

鄭寶剛醫生生於重慶，早年攻讀伊利沙伯中學。一九六二年完成大學預科，獲三優。進港大醫學院後，寄宿莫理遜堂，爲港大學生會橋牌組代表四年，一九六七年畢業。獲藥理及社會醫學優異，且獲社會醫學獎。畢業後在瑪麗和伊利沙伯醫院任實習醫生。一九六八年受聘於港大生理科，現任講師。他的研究工作範圍是有關心血管性生理學，曾發表關於河豚毒素對心作用的論文，最近完成研究急性肺水腫的血流動力學。他對臨床生理學特感興趣，最近獲英國聯邦獎學金及獲得博士學位。

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楊美博博士(Dr. Mabel Yang Mei-Po)

楊美博博士在北京生長，一九五七年畢業於北京醫學院，並在北京兒童醫院任駐院醫生。來港後，於一九六五年受聘於港大生理科任助教。其後擢陞爲講師。一九七〇年獲港大生理學哲學博士學位。現正從事研究荷爾蒙對炭水化合物新陳代謝的影響。楊博士是一位虔誠的基督徒。

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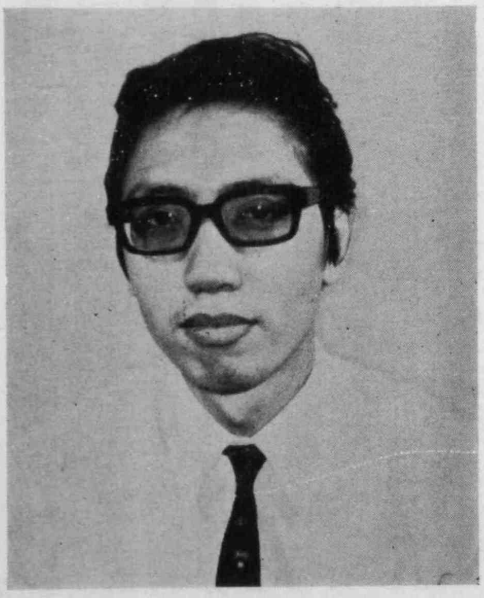
顧克仁醫生(Dr. Anthony Koo)



顧克仁醫生是民生英文書院中學畢業生，復在皇仁書院完成大學預科。一九七〇年畢業港大醫學院，曾在瑪麗醫院任實習醫生一年。一九七一年受聘於港大生理科，現任講師。顧醫生現正忙於腦微循環的研究工作。

裘大任醫生(Dr. Daryl Chiu Ta-Jen)

裘大任醫生畢業於上海第二醫學院。一九六七年任本校生理科助教，其後爲助理講師。一九七〇年晉陞爲講師。裘醫生的理學碩士論文是研究垂體切除對冒寒鼠子的影響。他最近完成一個量度鼠子心輸出量的新方法來擴展他在寒冷適應作用方面的研究。

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張婉明女士

張婉明女士是伊利沙伯中學畢業生，一九七〇年獲倫敦大學生理學理學士學位。回港後，在港大生理科任助教。一九七一年九月擢陞助理講師。張女士對神經生理學方面特感興趣。她喜愛的業餘消遣是旅行，游泳及攝影。

黃志昭博士(Dr. J. C. C. Hwang)

黃志昭博士於一九六二年獲美國奧立岡州大學博士學位。此後歷任研究及教職於華盛頓大學醫學院生理系，哥倫比亞大學醫學院神經系及香港中文大學。一九六八年黃博士受聘於華盛頓大學醫學院生理及生物物理系爲研究員，旋擢陞爲高級研究員。一九七〇年至港大生理科履職，現爲該系高級講師。黃博士乃美國科學協會名譽院士及若干科學學會會員。現從事研究內耳對外動眼肌之影响。閒時黃博士好觀察及寫作有關各「小圈子」之衆生相。

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梁其瑾博士(Dr. Liang Chi-Chin)

國立清華大學生物學學士，倫敦大學哲學博士。曾以高級研究員身份參與加拿大英屬哥倫比亞大學之 Kinsmen Neurochemistry Research Institute 之研究工作。

梁博士於一九四八年開始受聘於港大；他的主要研究對象爲硫胺素缺失之失物化學；乙酰胆碱對腦組織之藥理學；動物中之各種不同血紅蛋白之研究。現在梁博士之主要研究工作爲對由肝門靜脉系統所激發之反射對腎臟血液流量的影响。

梁博士對音樂欣賞甚有興趣，並爲一出色的業餘聲樂家。

王紀慶醫生(Dr. James Wang Chu-Ching)

王紀慶醫生畢業於上海第二醫學院。曾在港大解剖系任助教二年，一九六六年被委任爲生理科助理講師，一九六八年擢陞爲講師。王醫生的研究著作包括他的理學碩士論文「去甲腎上腺素對氧耗量的研究」及「河豚毒素對呼吸衰竭的機制」。去年赴美國紐約州立大學醫學院，在高逢田教授督導下進修呼吸生理學。最近才回港。目前正在進行利用交互循環探討多種不同的因素對呼吸中樞的作用。

認識我們生理系的老師

鄭國翹教授
(Professor Cheng Kwok-kew)

鄭教授幼時僑居日本橫濱，在大同小學及聖若瑟學院肄業。十五歲來港，初時就讀於拔萃男校，繼而轉讀於聖若瑟書院。大學預科考獲優等後，進香港大學攻讀醫科，一九三九年畢業。時值日軍進侵，中國抗戰求存，鄭教授志願投身戰時服務，加入中國紅十字會救護總隊，在貴州圖雲關總隊部受訓後，調往第七十二醫療隊工作，繼任第七二一隊小隊長，管轄一小組醫務人員。一九四〇至一九四二年期間，鄭教授在廣東及廣西戰區工作。首先在廣西柳州傷兵收容所及遷江第四十五兵站醫院服務，當時的工作是護理那些在崑崙關會戰後沒人照顧的傷病兵。其後調赴廣東西江（白土）和東江（黃村）前綫，駐第一五九師野戰醫院，第六十四軍第三野戰醫院及第六十一軍第一野戰醫院服務。一九四三年調貴州貴陽軍政部戰時衞生人員訓練所任防疫學組少校教官。一九四四年獲准長假進修病理學，赴四川成都國立中央大學醫學院病理科任助教，由康錫榮教授督導進修。據鄭教授說，首先激發他畢生致力於研究病理生理學的人是康教授。一九四五年世界大戰結束時，鄭教授參加教育部官費留學生全國考試。這是當時全中國唯一的留學獎學金考試。鄭教授被錄取爲官費留英病理學研究生。赴英後，他在倫敦大學醫院醫學院，由馳譽世界的病理生理學權威 Roy Cameron 爵士指導下，繼續深造。一九四八年獲倫敦大學 Graham 病理學研究獎學金繼續研究，按此項獎學金，當時甚少授予非英國籍之研究工作者。在一九五一至一九五八年期內，鄭教授受聘於英國醫學研究評議會毒理學研究組爲研究員，其後擢陞爲高級研究員。一九五九年回港，任香港大學婦產科研究員，一九六〇年被聘爲本大學生理學講座教授迄至於今。鄭教授是英國生理學會及病理學會會員。他愛好研究心血管性病理生理學，尤其關於毒素影响循環系統作用的機制。他個人及與同僚合作在國際知名雜誌發表的論文，包括肺血管阻塞血流的影响，研究鋳性肝壞死部份分佈的機制，腎上腺素引起肺水腫的機制，河豚毒素對降血壓的作用，腎上腺素對肝竇隙中紅血球流速的影响等。鄭教授業餘的嗜好是打網球和滑雪。

李冠民博士(Dr. Kwan-ming Li)

李冠民博士是南京金陵大學動物學理學士畢業生。一九五二年受聘於香港大學，現任生理科高級講師。一九六六年獲港大生理學哲學博士學位。

李博士曾發表關於太平洋熱帶區魚類毒素及中毒事件等論文多篇，最近致力研究各種漢藥對降血壓的功效。

密度如此高，部份原因是由於有大量醫生在研究及教育機構裏做事。這些醫生其實並非負責照料病人的，事實上，英國國家保健制度的目標，亦不過是計劃每二千五百名有一名醫生而已。如果以這個數字作爲我們的目標，目前一比二千的比例已是相當理想。不要忘記我們還未把准用醫生及中醫計算在內。

故此，香港醫生荒的問題，只是一種表面現象，而並非實有其事，眞正的問題，在於私家診所的醫生與政府診療機構的醫生，有不平均的分配的二一六〇名註冊醫生中，約有三分一是在政府工作，三分二則自行掛牌，對於政府醫生缺乏，一般大衆自然感到敏感，這種不平均的分配，是全世界所有國家的問題。因爲醫生多集中於經濟上較富裕的大都市。例如美國，醫生與人口的平均比例爲一比八五〇，但在很多地區，往往有超過一萬人以上，始有一名醫生。

在香港，私家醫生已是超度飽和。幾年前，中華醫學會會作過調查，看看有多少會員願意撥出部份時間在政府診療所工作，竟超過二百名醫生响應，他們一共所能付出的時間，相等於五十名全職醫生。據最近醫務衞生處的消息，政府的醫務空缺有五十九個，其中有二十個將由曾往海外深造的醫生回來担任，換言之，在超過七百名政府醫務官中，只有三十九個空缺，這種情況顯示無需設立第二間醫學院。再者，如果私家醫生撥出部份時間替政府工作的計劃可以完成的話，則目前的空缺就會填滿了。

未來又怎樣，我所指的未來，是指未來的二、三十年，因爲沒有人知道二、三十年後會怎樣。目前，提議設立第二間醫學院的主要目標，不外是產生更多醫生來應付日增的人口，根據香港家庭計劃會主席最近的報告，香港在一九八一年的人口約有五百二十萬，與目前的四百一十萬相較，一共增加了一百二十萬，至於香港新增的醫生，我們知道在一九七四年，香港大學醫學院的畢業班，會有一百五十名學生，因爲過去幾年來，醫學院的新生已漸漸增加，即使有不少學成後跑往外國的醫生，但在未來的二十年，香港顯然會有超過二千名以上的醫生，是可應付人口的生長率，到了那時候，醫生與人口的比例，就會少過一比二千了，事實上，從下面的統計顯示，在過去五年來，醫生不斷漸漸增加，每年平均約增加一百名：——

年份	註冊醫生數目
1966	1507
1967	1584
1968	1730
1969	1892
1970	1975
1971	2160

由於未來的生活及教育水準會漸漸提高，故亦有人建議醫療服務處更進一步的繁複，我以爲，我們可向全世界最富裕的國家——美國，學習很多東西，那裏的醫生與人口之比例是一比八五〇，目前有一〇八間醫學院（並非每一百萬人有一間醫學院）每年所收的新生有一萬二千名，美國的醫學界領袖，亦明瞭到培養足够的醫生來應付需求，幾乎是無可能的，故此目前已有了各種不同的改革。由於大部份病人的投訴，均屬小卷，實在無須靠受過訓練的醫生來作私家照料。故此美國的很多地區，已增加採用受訓過的小兒科，內科及外科助手。這種辦法，可使這些醫生專家只處理那些需要他們診療的病症，另一個解決的辦法，就是縮短醫生受訓的期限。還有一個愈來愈受注重的計劃，就是保健計劃，所着重的是健康而非疾病，使人們保持健康，應無需去看醫生了，所有這些優點，都值得我們密切注視及研究。

我在前面已經說過，我不以爲香港的中國人，會單單依靠西醫的日子會來臨，基於此點事實，我認爲香港目前需要有一間中醫學院，設立這間學院有很多好處。這間學院可作爲研究中心，因爲許多中藥均有治療價值，這間學院又可作爲比較中西醫的中心，例如，我們最近獲悉，治療折骨可用中國傳統方式或西方的方式或中西醫結合的方法最佳，這間學院又可研究中國大陸目前所實行的針刺痲醉，目前不少人對該項手術未敢確定甚至加以懷疑，故此香港尚沒有人敢去採用。而且，中醫亦可因此而標準化，使大衆免受一些黃綠醫生所害。由於西方國家的醫生對中醫愈來愈感興趣，故此這間學院，可作爲示範中心，更希望藉此能成爲溝通中西之間的橋樑。

香港需要第二間醫學院嗎？

（陳立僑醫生於十二月十七日在西區扶輪社演講）

過去幾年來，香港的醫生荒一直成爲大家的話題，要解決醫生荒，其中一項建議，提及或者會在中文大學設立第二間醫學院。有這種想法的人，辯稱要解決醫生荒，最明顯的，辦法就是訓練更多醫生；既要訓練醫生，就有需要設立第二間醫學院了。亦有人爭辯說，由於醫務日益繁雜，醫生人手日益需要，故此每一百萬人，就應要有一間醫學院了。但在未研究贊成與反對的雙方面意見之前，讓我們首先研究一下其大前提，香港目前究竟有沒有醫生荒？又或者在可見的將來，會不會有醫生荒？

建議設立第二間醫學院的人士利用醫生與人口的比例來支持其見解，指出香港有醫生荒。他們指出，在紐約城；醫生與人口的比例是一比四五〇；倫敦是一比七〇〇；東京是一比八〇〇；台北是一比九〇〇；漢城是一比一九五〇；而香港則是一比二二〇〇。但問題是：這種比較是否適當？

香港一比二二〇〇的比例；是把香港的總人口，相除註冊醫生的總數。目前這類註冊醫生一共有二一六〇名。我們可採用二千的總數，因爲有些醫生可能移民往其他國家，而其名字則仍留在註冊簿上，故其比例大約是一比二千，我所要爭論的，就是以這個比例與上述的世界都市作比較是不適當的，理由如下：

第一：在香港，除註冊醫生外，尚有一大羣所謂非法註冊的准用醫生（正如教育界的准用教師一樣）這類醫生多在中國大陸受訓，有小部份則在德國及法國受訓。在一九六四年，超過四百名的這類醫生，經過一組專家的試驗及口試後，獲准在已註冊的診療所行醫，這類診療所早已遍佈港九。那些考試不及格的，不是轉行，就是掛起中醫的招牌，我懷疑，亦有不少人在做所謂「黑市醫生」。

第二：在另一方面來說，香港亦與其他世界都市頗有不同，因爲有大部份中國人，對中國的傳統醫學有所依賴，而且存有信任。在一九六九年，中華醫學會會與政府的人口登記局合作過，調查香港究竟有多少人以中藥行醫，結果顯示出各式各樣的中醫一共有三二五一名，另外尚有一〇〇八名是跌打醫生及二四七名是針灸醫生，這些人均一律行醫，對人羣作出醫療照顧。故此，要定下醫生與人口的比例，這羣醫生又怎樣忽畧？

各種各樣的中藥，在香港的大部份人口流傳，已是盡人皆知，最流行的模式是，病人先往中藥店找一些中藥吃，若是沒有效果，才再去看中醫，看了幾次中醫，服了幾劑中藥，而病況仍沒有起色的話，始會跑去看註冊西醫。這一過程亦可以相反的，看了幾次西醫而沒有起色的話，也會跑去看中醫，就好像一場乒乓球賽一樣，許多人亦承認香港有大部份中國人，若有扭傷或斷骨的情形，他們喜歡看跌打醫生，多於看受過科學訓練的骨科專家，甚至有許多高等教育出身的中國人，他們雖受西化教育，外表西化，但仍採取同樣態度，最近有一間著名英文學校的校長，曾扭傷了足踝，她看了數星期的西醫，覺得沒有什麼起色，但她校裏的許多中國老師，都一致勸她去看跌打醫生，當我遇見她時，她正在起程去看跌打醫生呢。

選擇中醫或西醫，絕非價錢的問題，因爲看中醫或看跌打醫生，費用並不便宜，相反來說，由於中藥太貴，某些病者被迫要採用經濟實惠的西藥，否則他們是會採用中藥的，除了某些例外，半身不遂的患者，在病況發作時，會去看針灸醫生，中國大陸方面又有消息說，可用針刺來代替麻醉，故此我們不難想像，針灸療法在未來會愈來愈普遍。

根據這些事實，我們就不得不作出如下結論：希望香港的中國人，單依靠西藥的日子是不會來臨的。這種情況顯然與倫敦或紐約有所不同。

第三：另外一點我們不能忘記的，就是上述的大城市，其醫生

寫給「ELIXIR」

鄭國翹

我初時想寫一些陳腔濫調的東西來敷衍一下，後來想一想還是借這個機會談幾點某些人認爲會引起麻煩的問題。

首先要談談以祖國語言傳達的重要性。港大校規是要用英語講授課程，但我認爲現在是應該用中文授課的時候了，最低限度也要中英文並用。對異邦人來說，英文是一種難以學習的語言，如果一個人要偏搜腦海，苦索枯腸的找尋適當語詞來表達思想或觀念時，他的表達力甚或思考力也會受到限制。港大學生們本來可以用他們祖國語言直接了當的向教師有效地表示意見的，但現在因被强迫使用英語，以致發生言語上的困難，往往弄到辭不達意，這是很不合理的。傳達的重要性可自日本的科技快速進展方面看到。這進展實有賴於科學日文化，致使日本科學家及工程師均能用他們的祖國文字語言來表達思想及意見。

爲了達到上述的目的，港大必需聘請更多語熟中文的教職員。而最有效的方法就是就地取材，訓練更多有足够資格的本港畢業生來任職。同時，我認爲香港大學應訓練更多本港畢業生來填補空缺。我記起十一年前，一位來參加慶祝港大五十週年紀念的代表曾向我問及爲什麼五十年後，港大仍須僱用這麼多的外來教職員？過去我們未曾如星加坡和馬來西亞一樣訓練當地區畢業生就任大學職位。現在我們應效法星馬，首先在香港登報聘請，如不能物色適當人選，才向外登廣告聘徵，而又必須將見習職位保留給與本地人。

另外，我懷疑港大是否眞正需要維持教師與學生的比率爲一與十之比。這樣的比率無疑地會改良教學的程度。但這是只在極先進的國家的幾間大學才享有的比率。倘若我們不增加教師，而收容更多的學生，甚至降低教學程度在所不惜，這樣每年被擯諸港大門外的學生就會少些了。

此外，我也懷疑我們現在從外邀請來港的校外考試委員那種浪費的考試制度是否仍然需要。我認爲一間新大學或開辦新學位課程時才需要這樣的制度來評定程度。但成立多年的部門，現在應該不需外來的助力而能够維持相當的程度了，何況我們現在着重於一個經常的評定學生的程度？我想較爲合理的改進我們畢業生的程度方法是儘量方便他們在本大學繼續進修和深造。

假如上述的一些提議被接納，英國醫學評議會可能撤消承認我們醫學院畢業生的學位。但這可能對香港是一件好事，因爲會使我們醫學院畢業生留在香港，爲本地人民服務。聞說一九七〇年的醫學院畢業生有四分一已離港他往。既然目前大多數港大學生是受政府津貼的，這是對不起香港的納稅者。

我可能已說得太多了。這可能使我在港大不受歡迎，甚至會被稱爲一個不負責任的人！但在我而言，却是如梗在喉，不吐不快。

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